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# The investigation of a complaint against Welsh Ambulance Services University NHS Trust and Swansea Bay University Health Board

A report by the
Public Services Ombudsman for Wales
Cases: 202302966 and 202307480

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## Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

We have taken steps to protect the identity of the complainant and others, as far as possible. The names of the complainant and other involved people have been changed. The report therefore refers to the complainant as Mr B.

## Summary

Mr B complained about a lack of care and treatment provided to his late mother, Mrs C, by the Welsh Ambulance Services University NHS Trust ("the Trust") and Swansea Bay University Health Board ("the Health Board") in September 2022. The Ombudsman's investigation considered whether the triaging of the emergency calls, and the priority they were allocated by the Trust, was reasonable and appropriate. The investigation also considered whether the advice provided by Trust staff during the calls was reasonable and appropriate. Finally, the investigation considered whether Mrs C was appropriately assessed and managed by the Health Board following her arrival at the Emergency Department of Morriston Hospital on 15 September.

The Ombudsman found that the emergency calls were correctly triaged and prioritised by the Trust's emergency call handlers. However, a clinician on the Clinical Support Desk ("CSD" – a team of clinically trained practitioners who work as part of the Trust's control room) should have reviewed Mrs C's case, identified that she was at serious risk and then considered escalating the ambulance response category. If this had happened, an ambulance may have been allocated to Mrs C sooner. This might have reduced the time she spent lying on the floor, which would have been extremely distressing, painful and undignified for her. This complaint against the Trust was upheld.

The Ombudsman was concerned that the Trust missed several opportunities to identify this service failure, and that it only acknowledged failings after she shared the views of her Paramedic Adviser in April 2024. The Ombudsman considered that this raised serious concerns about the robustness of the Trust's investigations of the complaints it receives, particularly as this was not the only case in which she had identified deficiencies in the Trust's complaints investigation process.

In respect of the advice provided by the Trust's staff, particularly the advice not to move Mrs C, the Ombudsman found that this was clinically appropriate because moving her could have worsened her injuries and caused her more pain. This complaint against the Trust was not upheld.

The Ombudsman found that Mrs C received appropriate care, investigations and treatment whilst she was in the ambulance outside the Emergency Department and after she was admitted to Morriston Hospital. Although there was a missed opportunity to have stopped the administration of nephrotoxic medication (medication that can damage the kidneys) at an earlier stage, there was no suggestion that this caused Mrs C harm or affected her outcome. This complaint against the Health Board was not upheld. However, the Health Board was invited to share this report with the relevant staff and consider how it could improve the training its clinicians receive in recognising and managing patients at high risk of acute kidney injury.

The Ombudsman made a number of recommendations, which the Trust accepted. These included:

- An apology to Mr B, an explanation about the shortfalls in the investigation process and payments totalling £2,750 for the distress, loss of dignity and uncertainty caused and for Mr B having to pursue his complaint.

- To share the report with the Trust's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future.

- To share the report with the Trust's Quality and Patient Safety Committee to consider my findings and include its learning from these recommendations in its Annual Report on the Duty of Candour.

- To share the report with all appropriate staff and remind them of the importance of fully reviewing information recorded in the Command & Dispatch system at the time of the call.

## The Complaint

1. Mr B complained about the care and treatment provided to his late mother, Mrs C, by the Welsh Ambulance Services University NHS Trust ("the Trust") and Swansea Bay University Health Board ("the Health Board"). The investigation considered the following:

a) Whether the triaging of the emergency calls and the priority they were allocated by the Trust was reasonable and appropriate in the circumstances.

b) Whether the advice provided by Trust staff during the calls was reasonable and appropriate.

c) Whether Mrs C was appropriately assessed and managed by the Health Board following her arrival at the Emergency Department of Morriston Hospital on 15 September 2022.

## Investigation

2. My investigator obtained comments and copies of relevant documents from the Trust and the Health Board and considered those in conjunction with the evidence provided by Mr B. They also obtained clinical advice from 2 specialist advisers, Mr Tom Burns, a paramedic ("the Paramedic Adviser") and Dr Robert Barker, a consultant in acute medicine and geriatrics ("the Consultant Adviser").

3. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

4. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

5. Mr B, the Trust and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

## Relevant guidance

6. National Institute for Health and Care Excellence ("NICE") Guideline NG148, "Acute kidney injury: prevention, detection and management", December 2019 ("the NICE Guidance").

7. An agreement exists between the Trust, Welsh health boards and the Welsh Government which states that the handover of patient care at hospitals should take no more than 15 minutes (Welsh Government NHS Wales Hospital Handover Guidance, issued 5 May 2016).

8. The Medical Priority Dispatch System ("the MPDS") is used by the Trust to dispatch the most appropriate medical resource to an incident. Emergency calls are answered by the Trust's emergency call handlers, who process calls using the MPDS. The software generates a questioning script based on the medical issue described by the caller and determines the most appropriate response based on the answers to these questions. A response code is then allocated to the call:

- Red, the highest priority response for immediately life-threatening situations (for example, respiratory or cardiac arrest).
- Amber 1, high clinical priority for potentially life-threatening emergency calls.
- Amber 2, for incidents considered serious but not immediately life threatening.
- Green 2, for not clinically serious or life-threatening.
- Green 3, for calls deemed suitable for clinical telephone assessment.

9. The Trust's Clinical Safety Plan version 1.1.1, January 2022 ("the CSP"). This provides a framework for the Trust to respond to situations when the demand for its services is greater than its available resources. The CSP "provides a set of tactical options that are flexible and immediate so that [the Trust] can dynamically react to situations to ensure those patients with the most serious conditions or in greatest

need according to their presentation remain prioritised to receive services." Section 5 of the CSP, "Reducing Risk", states that the Clinical Support Desk ("the CSD" – a team of clinically trained practitioners who work as part of the Trust's control room) should be tasked with reviewing the ambulance queue to identify high-risk patients. As part of the review of high-risk patients, CSD clinicians conduct clinical triages of waiting calls and are able to change the priority of ambulance responses according to the outcome of these assessments.

10. The National Health Services (Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011, often referred to as the Putting Things Right Regulations ("the PTR Regulations"), provide guidance to Health Boards and NHS Trusts on how to effectively handle concerns about NHS treatment and services.

11. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. The overriding principle (set out in accompanying Welsh Government Guidance) is that "being open with service users and their representatives when things go wrong in their care is the right thing to do". This is in addition to any professional duty of candour a healthcare professional will be subject to under their own professional practice regimes and specifically applies when a healthcare provider is responding to complaints about a service.

## The background events

12. At around 19:00 on 13 September **2022** Mrs C, aged 93, fell at her home address and was unable to get up. The fall went unnoticed until approximately 13:00 on 14 September when her family visited and found her on the floor. Mrs C complained of pain to her right leg and buttock.

13. Mrs C's family made 6 emergency calls to the Trust between 13:00 on 14 September and 04:27 on 15 September. The first 3 calls were categorised as Green priority calls. During the fourth emergency call at 21:20 Mrs C's family reported that she was no longer completely alert. Calls 4, 5 and 6 were categorised as Amber 1 priority. An ambulance arrived at Mrs C's address at 04:49 on 15 September. This was around 16 hours after the first emergency call was made and almost 34 hours after Mrs C fell.

14. Mrs C was taken to Morriston Hospital ("the Hospital") and arrived at 06:44. Due to a lack of available beds in the Emergency Department ("the ED") Mrs C waited in the ambulance outside the Hospital. Whilst in the ambulance, Mrs C was reviewed by an advanced nurse practitioner. A diagnosis of a fall with a long lie (when a person falls and spends over 1 to 2 hours on the floor because they are unable to get up) was made and a hip or knee fracture was queried. Mrs C underwent investigations and treatment with intravenous fluids ("IV fluids" – liquids given to replace water, sugar and salt that are administered directly into a vein through a drip).

15. Mrs C remained in the ambulance outside the Hospital for around 14 hours. She was transferred to the ED at 21:00 on 15 September. By this time around 50 hours had passed since her fall. On 16 September Mrs C was diagnosed with a fractured right knee, a chipped bone in her right hip and rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fibre contents into the blood, caused by direct or indirect muscle injury) that led to her developing an acute kidney injury ("AKI" – a sudden reduction in kidney function). Despite treatment with fluids, Mrs C's kidney function worsened, and she stopped passing urine.

16. Mrs C sadly died on 20 September. The inquest into her death determined the cause of death to be pneumonia and acute kidney injury second to rhabdomyolysis caused by a fall and long lie at home on 13 September, contributed to by a delayed ambulance response.

## Mr B's evidence

17. Mr B said that his mother's wait for an ambulance and then outside the ED was unacceptable and shocking. He said that the information his family were given about ambulance arrival times was misleading and that if they had been given transparent advice, they could have taken Mrs C to hospital themselves. Mr B said that the advice not to move their mother and to wait for an ambulance caused her to develop pneumonia (inflammation and fluid in the lungs that is usually caused by an infection) and an AKI, which ultimately led to her death. Mr B said that the poor care Mrs C received deprived her of dignity and left him and his family deeply traumatised.

18. Mr B said that the joint complaint response provided by the Trust and the Health Board was totally inadequate as it failed to address any of his concerns or take any accountability for Mrs C's death. He said that the response was written in jargon and concerned how the Trust and the Health Board intended to respond to problems in the future rather than addressing why they had failed Mrs C.

## The Trust's evidence

19. In its response to Mr B's complaint, the Trust explained that its call handlers are not medically trained, so they must follow call scripts and provide instructions generated by the MPDS to ensure that all patients receive consistent assessment and responses. It said that having reviewed the calls made about Mrs C, it was satisfied that its call handlers provided the correct advice to Mrs C's family. It said that the instruction "do not move her unless she's in danger" was provided to Mrs C's family in line with MPDS instructions to reduce the risk of Mrs C experiencing further injury.

20. The Trust said that at the time Mrs C was awaiting an ambulance it was experiencing an increase of high priority emergency calls and severe delays in handovers at hospital, so its response times were significantly protracted. Between 14 and 15 September 2022, the longest handover time at the Hospital was 16 hours and 7 minutes.

21. The Trust said that all calls made by Mrs C's family were correctly prioritised and that there were no missed opportunities to have responded differently or attended sooner to Mrs C.

22. Following receipt of advice from the Paramedic Adviser, my investigator asked the Trust further questions about the role of the CSD, how it reviewed patients and how it managed Mrs C's clinical risk. The Trust said that upon further review, it had identified failings in the care provided. The Trust said that the CSD clinician reviewing the calls made about Mrs C ("the CSD Clinician") decided not to undertake a full clinical review of the information provided during the second call, and this decision was based on the information from the first call. The Trust said that the clinician should have undertaken a telephone triage following the second call. Had this taken place, on the balance of probability, the call

would likely have been escalated to an Amber response. This might have resulted in an ambulance being allocated to Mrs C sooner. The Trust said that this was an individual human error and not indicative of a wider issue with its processes.

23. The Trust could not say why this failing was missed during its investigation. It said that at the time, the CSD did not have an internal process for managing its investigations. Since then, it has developed an internal process of managing concerns, including audits, individual clinical feedback, action plans and reviews of practice, with dedicated clinical staff responsible for identifying learning opportunities. It said that future investigations would be more robust and monitored as a result of these developments.

24. The Trust explained that in May 2024 it began making considerable changes to how it responds to emergency calls. It said that the changes aim to ensure that all patients, except those in extremely high acuity cases (where patients require high levels of medical care or monitoring because their condition cannot be easily managed, such as patients in cardiac arrest), are clinically triaged over the phone before an ambulance is sent. The Trust said that these changes will address the issue of low acuity calls (where patients have conditions that are less severe and not immediately dangerous) that result in patients experiencing long lies while awaiting an ambulance response.

## The Health Board's Evidence

25. The Health Board said that on 15 September, the Hospital was on escalation level 4, the highest level of escalation below business continuity. This is where an event or occurrence causes normal service delivery to fall below acceptable levels, and special arrangements have to be put into action to ensure it can still deliver critical services. At escalation level 4, the Health Board experiences:

- delays of over an hour in releasing the Trust's crews from hospital
- patients waiting over an hour for triage

- 12 hour waits for patients in the ED.

At this level, the matter is escalated for oversight by senior managers in the Health Board and steps are taken, such as diverting patients to other facilities and cancelling all meetings, study days and non-urgent elective appointments and surgery, so staff can be used in acute care areas to manage demand.

26. The Health Board said that it was at escalation level 4 on 15 September because of the high level of patients being admitted to the Hospital with significant health problems and the high demand experienced by the ED on that day. Between 15 September and the early hours of 16 September, there were up to 13 ambulances waiting outside the ED unable to handover patients.

27. The Health Board said that all patients awaiting handover would have been triaged, assessed and admitted to the ED in order of clinical priority. It explained that it took actions to reduce waiting times for patients requiring admission to the ED, including re-directing patients to other hospitals in the area and reviews of potential patient discharges.

28. The Health Board said that when Mrs C arrived at 06:44 on 15 September there were already 9 ambulances outside the ED waiting to handover patients. It said that Mrs C remained in the ambulance for 15 hours because it was not possible for her to be transferred from the ambulance at an earlier point. The Health Board said that despite her wait in the ambulance, Mrs C was appropriately triaged, assessed and managed following her arrival at the ED.

29. The Health Board said that Mrs C underwent investigations while she remained in the ambulance. It said that Mrs C's blood test results showed that her creatine kinase (a protein in the blood that can indicate muscle damage) was raised and her kidney function was slightly abnormal, so treatment with IV fluids started while she was in the ambulance. The Health Board said that it did not feel that the delay Mrs C experienced in being transferred from the ambulance to the ED significantly affected the level of care she received or her eventual outcome.

## Professional Advice

### The Paramedic Adviser

30. The Paramedic Adviser explained that to ensure the reliability and accuracy of the MPDS, call handlers must follow the questioning script word for word so that questions are not asked incorrectly or misinterpreted. This ensures that call handlers give appropriate advice, and the correct triage category is allocated to a call.

31. The Paramedic Adviser said that the advice provided by the Trust's staff during the calls, especially the advice not to move Mrs C, was clinically appropriate. He said that Mrs C needed to be assessed by a clinician before being moved as she was complaining of pain in her leg and knee. It would not have been appropriate to advise Mrs C's family to move her or arrange alternative transport to hospital as doing so could have worsened her injuries.

32. The Paramedic Adviser said that during all the calls made by Mrs C's family, the correct questions were asked by the Trust's emergency call handlers and the appropriate triage categories were reached, in keeping with the MPDS. He said that although Mrs C appeared to be deteriorating during the wait for an ambulance, the information provided during the second and third calls did not suggest that her condition at the time had become urgent, immediately or potentially life-threatening. Accordingly, the MPDS system would not have escalated the response from Green to Amber or Red.

33. The Paramedic Adviser said that during the fourth call made at 21:20 it was noted that Mrs C was not fully alert, so the MPDS escalated the response to Amber 1, indicating that her condition had become serious and potentially life-threatening. The Adviser said that escalation to this triage category was appropriate given the time Mrs C had spent on the floor and her gradual deterioration. It was also appropriate that the fifth and sixth calls did not trigger an escalation to a Red response as there was nothing to indicate that Mrs C's condition had deteriorated to the point that it was immediately life-threatening.

34. The Paramedic Adviser said that the Trust's records show that the first call made about Mrs C was placed in both the ambulance response queue and in the CSD queue for a call back and re-assessment by one of the Trust's clinicians. He explained that these concurrent actions are taken to ensure that the patient receives help or re-assessment if an ambulance response or clinician call back are delayed.

35. The Paramedic Adviser said that the CSD Clinician identified that Mrs C required an ambulance response and a face-to face clinical assessment, so removed the call from the CSD call back list. The Paramedic Adviser said that by not keeping the call on the list for a clinician review as well as an ambulance response, the opportunity for further review and identification of risk factors by a clinician was removed. The Paramedic Adviser stated that it would be reasonable to expect that a CSD clinician reviewing Mrs C's case (93 years old, long lie of 18 hours) would have identified that she was at serious risk and considered upgrading the call triage category to a more time critical level. He stated that this is especially relevant when considering that there were already severe delays in responding to potentially life-threatening emergency calls.

36. The Paramedic Adviser described the decision making in respect of the most suitable care pathway for Mrs C as transactional, in the sense that it did not consider that Mrs C would have benefited from clinician contact and subsequent escalation to an emergency response at an earlier stage. The Paramedic Adviser said that the actions taken by the Trust to minimise the clinical impact of the ambulance delay were not sufficient and there was a missed opportunity for Mrs C to have received improved care.

**The Consultant Adviser**

37. The Consultant Adviser said that despite the circumstances, Mrs C received triage, assessment and appropriate investigations whilst she was in the ambulance outside the ED. He said that Mrs C received pain relief and fluids and underwent regular reviews and pressure area checks in line with guidance. The Consultant Adviser said that whilst the overall standard of care was appropriate, there was a failing in respect of the management of Mrs C's risk of AKI.

38. The Consultant Adviser explained that Mrs C would have been at high-risk of developing an AKI as she was diabetic, over 65, on medication and had experienced a long lie with poor fluid intake. It was noted that her serum creatinine level (a blood test used to check how well the kidneys are filtering the blood), which was above the normal upper limit upon her admission to the ED, rose during her time in hospital. On 16 September her blood pressure level, which was originally within the normal range, became low.

39. Despite being at high risk of an AKI, Mrs C continued to receive her regular medications to treat blood pressure and diabetes until they were stopped on 18 September. The Consultant Adviser noted that continuing to administer these potentially nephrotoxic medications (medication that can damage the kidneys) was contrary to the NICE Guidance. This states that advice should be sought from a pharmacist about optimising medicines and drug dosing in adults with or at risk of AKI. The Consultant Adviser said that there was an opportunity to have stopped the administration of these medications earlier in Mrs C's admission, but that it is unlikely that doing so would have had an effect on her outcome.

40. The Consultant Adviser said that due to Mrs C's frailty and existing health conditions, her deterioration and death were likely to have been unavoidable. He said that even without the delay in an ambulance attending, Mrs C's outcome may have been the same as she had already spent a long time on the floor before she was found, and an ambulance was called.

## Analysis and conclusions

41. In reaching my conclusions, I must consider whether there were failings on the part of the Trust and the Health Board, and if so, whether those failings caused an injustice to Mrs C or her family. In doing so, I have considered whether the actions of the Trust or the Health Board met appropriate standards rather than best possible practice. I have had regard to the advice I have received, which I accept. However, the conclusions reached are my own.

42. This report considers the care and service provided to Mrs C by the Trust and Health Board, and the likely impact of shortfalls in that care. My investigation has also considered whether anything could or should have been done differently to manage Mrs C's wait for an ambulance and clinical risk.

43. I would like to extend my sincerest condolences to Mr B and his family for the sad loss of Mrs C.

**Whether the triaging of the emergency calls and the priority they were allocated by the Trust was reasonable and appropriate in the circumstances**

44. I accept the Paramedic Adviser's advice that all 6 emergency calls were correctly triaged and prioritised by the Trust's emergency call handlers. I share the Paramedic Adviser's view that the CSD Clinician should have reviewed Mrs C's case, identified that she was at serious risk and then considered escalating the ambulance response category.

45. Had the CSD Clinician reviewed the situation, an ambulance may have been allocated to Mrs C sooner. I am satisfied that the failure to review Mrs C represents a significant service failure which caused Mrs C a serious injustice. The time Mrs C spent on the floor waiting for an ambulance would have been extremely distressing, painful and undignified for her, and it would have been upsetting for her family to see her in this condition. This time might have been reduced.

46. I accept the Consultant Adviser's view that even without the delay in an ambulance attending, Mrs C's outcome may have been the same. However, he did not say that this was a certainty and there remains a degree of uncertainty as to whether a quicker ambulance response would have changed Mrs C's sad outcome. I consider this uncertainty amounts to an injustice to Mr B and his family. Accordingly, I **uphold** this element of the complaint.

**Whether the advice provided by Trust staff during the calls was reasonable and appropriate**

47. I accept the Paramedic Adviser's view that the advice provided by the Trust's staff, particularly the advice not to move Mrs C, was clinically appropriate. This was because Mrs C required a face-to-face clinical assessment before being moved. Advising her family to move her could have worsened her injuries and caused her more pain. As such, I **do not uphold** this element of the complaint.

**Whether Mrs C was appropriately assessed and managed by the Health Board following her arrival at the Emergency Department of Morriston Hospital on 15 September 2022**

48. I accept the advice I have received that Mrs C received appropriate care, investigations and treatment whilst she was in the ambulance outside the ED and after she was admitted to the Hospital. Although the Consultant Adviser identified that there was a missed opportunity to have stopped the administration of nephrotoxic medication at an earlier stage, there is no suggestion that this caused Mrs C harm or affected her outcome. As such, I **do not uphold** the complaint against the Health Board. However, I **invite** the Health Board to share this report with the relevant staff and consider how it could improve the training its clinicians receive in recognising and managing patients at high risk of AKI.

**Complaint handling by the Trust**

49. Finally, whilst my investigation did not initially intend to consider the handling of Mr B's complaint by the Trust, in light of the information that has become available during this process, I must address this. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. Whilst not in force at the time of the response to Mr B, it was well known that the duty would be implemented, and in any event, the PTR Regulations under which the Trust responded to Mr B's complaint places an obligation upon it to investigate concerns properly, efficiently and openly. The Trust's response to Mr B fell well short of what the duty promotes and is intended to achieve. The Trust had a second chance to identify service failure at the time I started this investigation when my investigator sought its comments on Mrs C's care. It again did not identify the service failure. It was only after

my investigating officer shared the Paramedic Adviser's views with the Trust that it acknowledged, in April 2024, that there had been failings in Mrs C's case.

50. This raises serious concerns about the robustness of the Trust's investigations of the complaints it receives. Concerningly, this is not the only evidence I have seen of deficiencies in the Trust's complaints investigation process. Alongside this report, I am publishing another public interest report[1] in relation to a different complaint received by my office, which highlights similar shortfalls in this respect. The Trust needs to ensure that in the future it responds openly and honestly to complaints, and that staff involved in formulating/feeding into the response also reflect on both the duty, and their own professional standards obligations when doing so. My recommendations therefore take account of this failure.

51. I consider that I cannot adequately address the significant injustice caused to Mr B and his family without recommending financial redress. I stress that this is in no way to be seen as compensation for the family's loss, but rather to reflect the injustice caused. I consider that the level of financial redress I am recommending appropriately reflects the distressing impact that the failings identified in this report will have on Mr B and the rest of Mrs C's family.

## Recommendations

52. I **recommend** that the Trust, within **1 month** of the date of this report:

a) Provides a meaningful written apology to Mr B and his family for the failures identified in this report and acknowledge that it missed opportunities to minimise the clinical impact of the ambulance delay and provide improved care for Mrs C. The apology should also include an explanation as to why the Trust's investigation did not identify these failings.

[1] Case reference 202306104

b) Offers Mr B redress of £2,000 in recognition of the distress and loss of dignity Mrs C experienced and the uncertainty caused to Mr B. To further offer Mr B redress of £750 for the significant time and trouble he has been put to in pursuing this complaint to gain answers to his concerns.

c) Shares this report with the Trust's complaint investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points to ensure that similar failings are not missed in the future. Any improvements it identifies should be fed back into its complaints handling procedure and shared with my office.

d) Shares this report with the Trust's Quality and Patient Safety Committee to consider my findings and include its learnings from these investigations in its Annual Report on the Duty of Candour.

e) Shares a copy of this report with all appropriate staff and reminds them of the importance of fully reviewing information recorded in the Command & Dispatch system at the time of the call.

53. I am pleased to note that in commenting on the draft of this report **Welsh Ambulance Services University NHS Trust** has agreed to implement these recommendations.

*Michelle Morris*

**Michelle Morris** 4 March 2025
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