UNISON

West Midlands Ambulance Branch

Quotations from court cases that highlight the important of good note keeping in the ambulance service.

All of this information is in the public domain, as no court restrictions were in place at any of these cases.

Case one Leeds crown court - Edwards v Yorkshire Ambulance Service.

This case revolves around the care provided to a patient with a placental abruption which subsequently resulted in the baby suffering significant cerebral hypoxia.

Only one set of observations were poorly recorded on the Patient report form with incorrect times documented for a patient journey of 25 minutes.

The judge said to the paramedic is this a true and accurate record of clinical events that took place in the ambulance?

To which the paramedic replied no. I carried out other tasks such as taking a blood pressure, gave oxygen etc but did not write it down as I did not consider it necessary. My main concern was looking after the patient not writing things down.

The solicitor for the patient then stated, in view of the poor quality of note keeping by the paramedic the creditability of his care is called into question due to a negligent approach in keeping critical patient records.

As the case progressed this solicitor challenged every statement from the paramedic, each time referring him back to the patient report form and a perceived breach duty of care.

The ambulance trust lost the case and multi-million pound compensation was awarded against the NHS.

Learning point: Due to the poor quality of documentation on the patient report form, the paramedic was unable to demonstrate a satisfactory level of pre hospital care. Once this poor documentation had been established in open court, it gave the solicitor ammunition to challenge anything and every thing the paramedic had done or not done. Had the paramedic recorded the full set observations with the correct times on the PRF it would more than likely have satisfied the court that the duty of care was not breeched. The solicitors task of proving the paramedic was negligent would have been made so much more difficult.

Case Two Royal courts of justice Pemberton v Dorset Ambulance NHS Trust.

This case revolves around a patient who received bi lateral pnueumothoraces following an RTC and suffered a PEA cardiac arrest.

The patient was successfully resuscitated from PEA and left hospital with no neurological deficit.

However the patient's voice had changed and it was held that the paramedic had caused damage to the cartilages in the larynx during endo tracheal intubation, due to excessive force.

The case went to court and the opening argument from the prosecuting solicitor was as follows, "Mr. Smith I note that you are an established and experienced paramedic with several commendations for your actions, furthermore you must be congratulated on resuscitating my patient from an PEA cardiac arrest, whereby I understand that in such circumstances, patients have a very poor chance of survival".

Mr. Smith then sat in court reflecting on what a good job he had done.

The solicitor then drew to Mr. Smith's attention to the documentation surrounding this case. He asked Mr. Smith the PRF and ECG were a true and accurate, comprehensive record of the clinical care you provided to my client, to which Mr. Smith replied yes.

The solicitor asked at or about what time did you attend to my patient, to which Mr. Smith stated about 1500 hrs to which the solicitor reply yes that is the time recorded on the PRF.

However I note that the time on the ECG is 1600hrs one hour after you say that you treated my client.

I put it to you that this is not the ECG from my client, due to the uncertainty of the time frame of documented evidence presented in this court today.

I further put it to you that my client never suffered a cardiac arrest and therefore did not require intubation.

Therefore he would not have suffered the injury we are looking at here today. This ECG is from a patient you treated later in the day, what have you to say?

Mr. Smith stated that the clocks had changed three days previously and that the clock on the cardiac monitor /defibrillator had not been reset.

The solicitor then asked Mr. Smith, what is the only class one intervention you carry on your ambulance? to which Mr. Smith replied I don't know what you mean.

The solicitor replied you clearly don't know, the only class one intervention on your ambulance is defibrillation and you are telling this court you failed to ensure the only

class one intervention on your ambulance which you say you used on my client was un-calibrated to show the correct time.

Is they anything else you want to tell the court in relation to your negligence or about the treatment of my client.

Each time the solicitor questioned the paramedic, he referred to this issue and introduced a bad character reference in relation to the paramedic.

The ambulance trust lost the case, mainly due to the uncertainty the solicitor had introduced to the court in relation to the quality of ambulance documentation and its accuracy recorded by the paramedic.

Learning point:

Always ensure that all recorded times and dates on all patient documentation is consistent.

Case three Birmingham Coroners Court

An ambulance crew attended a terminally ill elderly lady who had passed away and correctly confirmed her death. Ie no pulse, prolonged asystole, etc.

Unfortunately the paramedic managing the incident documented the wrong date on both the PRF and recognition of death form. As the date on ambulance documentation was not the date the lady died, both the GP and coroner would not accept the ambulance crews assessment of the recognition of life extinct at the time the paramedic stated.

The GP could have signed the death certification as he had seen the patient the day before (and was therefore within the legal time frame to issue a death certificate.) The lady could have then been buried or cremated as the family saw fit.

However due to the uncertainty of the facts of the case (from the paperwork) the GP and coroner insisted this elderly lady had a post mortem examination prior to being buried.

The trust received complaints from HM Coroner, the GP and the patient's family. Stating this terminally ill lady was subjected to a post mortem examination which was as a result of the uncertainly introduced by the ambulance paramedic surrounding this ladies death.

Learning point: Ensure you always write down the correct date on all paperwork, be particularly careful at midnight.