# SPSO decision report

**Case:** **201601668, Scottish Ambulance Service**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Decision:** upheld, recommendations


## Summary

Mr C called 999 when his wife (Mrs A) became very unwell. A paramedic arrived five minutes later, and told Mr C that an ambulance would be on its way. However, the ambulance did not arrive for about half an hour, and only after the paramedic called to request back-up. During this time, Mrs A stopped breathing. The paramedic assisted her breathing and she recovered to some extent. However, after the ambulance arrived, Mrs A suffered a cardiac arrest. Staff carried out cardio-pulmonary resuscitation (CPR - where the heart and/or breathing is re-started if it stops), which was successful at restoring her pulse. Staff transferred Mrs A to the ambulance and took her to hospital. While in the ambulance, Mrs A suffered a second cardiac arrest. Staff again began CPR, and this was continued until Mrs A was handed over to hospital staff. Hospital staff continued the CPR, but this was unsuccessful and Mrs A died in hospital shortly after her arrival. Mr C complained about the delay in the ambulance arriving and the lack of communication from ambulance service staff, including the way they handled his complaints.

The ambulance service upheld Mr C's complaints and apologised. They said there were opportunities to send an ambulance earlier, but these were missed. The ambulance service said they would discuss the communication complaint with the staff involved and senior managers would review their procedures to ensure that ambulance support is provided earlier in future. Mr C was dissatisfied with this response, and he brought his complaint to us.

We took independent advice from a consultant in emergency medicine. We found the delay in sending an ambulance was unreasonable, and a lack of clarity in the ambulance service's policies had contributed to this. However, we noted that the ambulance service have now updated their policies and adopted a new response model, which should prevent a recurrence of the failings in this case. We found the treatment of Mrs A's respiratory and cardiac arrests was appropriate. However, the clinical records were poor so it was not possible to determine whether the overall care and treatment was reasonable. We also found the ambulance service took an unreasonable time to respond to Mr C's complaint and did not provide a detailed explanation of the events, despite the investigating officer telling Mr C they would provide this. We upheld all of Mr C's complaints.


## Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the poor records kept by the paramedic and ambulance crew as this poor record-keeping meant it was not possible to determine whether the overall care and treatment given to Mrs A was reasonable. This apology should comply with SPSO guidance on making an apology, available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Adverse incidents such as this should be reported and investigated through the ambulance service datix system (a system for tracking and reporting incidents).

- The Ambulance Control Centre dispatcher involved should reflect on and learn from Mr C's family's experience, with appropriate support.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.