SPSO decision report

Case: **201801934, Scottish Ambulance Service**
Sector: Health
Subject: failure to send ambulance / delay in sending ambulance
Decision: upheld, recommendations

Summary

Ms C's brother (Mr A) collapsed at home and an ambulance was called. It took around 45 minutes to arrive and, upon arrival, the crew found Mr A to be in cardiac arrest. He was pronounced dead shortly after. Ms C complained about the failure to send assistance to Mr A sooner, including that a community first responder (CFR) was not used. She also complained that the crew did not carry out cardiopulmonary resuscitation (CPR).

The Scottish Ambulance Service (SAS) responded to Ms C's complaint and then carried out their own internal clinical review with the ambulance crew to enable further reflection on the incident. SAS identified that the call had been inappropriately downgraded from a cardiac arrest to chest pain category. It was identified that a satellite navigation failure contributed to the delay in the ambulance arriving. It was also noted that a CFR was not showing as available due to software and systems issues, and was therefore not used.

We took independent clinical advice which agreed with some of SAS's findings. We noted that there were differing interpretations of the guidelines on when CPR should or should not be attempted. We found that the crew should have taken steps to establish all the available facts in order to fully inform their decision-making in this regard. Therefore, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C that SAS were unable to utilise a CPR due to software/systems issues; that a satellite navigation system failure added to the ambulance response time; and that the ambulance crew failed to take steps to determine with more accuracy the facts of the cardiac arrest, in order to support the decision-making process prior to the cessation of resuscitation. The apology should meet the standards set out in the SPSO guidelines on apology available at: www.spso.org.uk/information-leaflets.

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

- Steps should be taken to establish all available facts before taking the decision to terminate CPR, including asking relevant questions of family/friends. SAS should give consideration to ways in which aide memoire/checklists might be used to support clinical decision-making during resuscitation attempts.
- There should be confidence that control dispatchers are able to identify logged on CFR when checking for available resources.
- Call handlers should be familiar with Medical Priority Despatch System (MDPS) protocol and should ensure calls are accurately categorised.
- SAS should confirm they have a suitable organisational back-up system in place for directing crews to an incident in the event of a failure of satellite navigation systems.

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.