SPSO decision report

Case: **201804510, Scottish Ambulance Service**
Sector: Health
Subject: failure to send ambulance / delay in sending ambulance
Decision: upheld, recommendations

Summary

C complained that the Scottish Ambulance Service (SAS) failed to respond reasonably to the request for an ambulance from their late relative (A). C also complained about the way their complaint to SAS about the matter was handled.

Through its own investigation, SAS found that the second call from A was not handled appropriately because medical priority despatch system was not utilised to assess A's symptoms and the level of response required. In addition, the first crew to attend A's home did not follow clinical practice guidelines and policy in relation to consent. The crew felt A did not want any help. SAS also found that information on the patient report form was limited and did not meet the expected standards of clinical reporting.

We took independent advice from a paramedic. We found that SAS took reasonable corrective action in response to failings highlighted through its investigation. However, we noted that there was a missed opportunity for interaction between the ambulance control centre (ACC) clinical advisor, who had spoken with A, and the clinician who attended A's home. This may have afforded the attending clinician the necessary information to prompt a more comprehensive clinical assessment of A. There was also an opportunity for the attending clinician to seek clarifying information and question the ACC on the requirement to send a frontline ambulance to A. This would have stimulated discussion and provided an opportunity to share both information and the decision-making responsibility prior to ending the engagement with A. Finally, having listened to the recordings available, a call made from the ACC to A was not ended properly. We upheld this complaint.

In relation to complaints handling, we found that C was not kept reasonably informed about what was happening with the complaint and the investigation itself took a long time. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to handle their complaint reasonably and for for the failure to handle contact with A appropriately. 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:

- SAS should take steps to ensure the process for ending calls is improved; review/implement a process for passing complex background information to the attending clinician to assist clinical judgement and decision-making; and introduce procedures as preventative measures to ensure that a paramedic would seek clarification from the ACC when a patient denies calling for an ambulance or the patient cannot be located.

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.