# SPSO decision report

**Case:** **202000766, Scottish Ambulance Service**
**Sector:** Health
**Subject:** Clinical treatment / Diagnosis
**Decision:** upheld, recommendations

## Summary

C complained about the treatment of their spouse (A) by the Scottish Ambulance Service (SAS). A became unwell at home and whilst on route to hospital in an ambulance they experienced a cardiac arrest and later died in hospital. C complained that the ambulance took a long time to arrive; that the care and treatment A received in their home was poor; that there was a delay in transporting A to the hospital; that C was asked to commence cardiopulmonary resuscitation (CPR) on A whilst on route to hospital and that C was not assisted by the ambulance technician and that they alone performed CPR on A until they arrived at hospital.

C was dissatisfied with the way in which their complaint was investigated. It was initially investigated by the SAS, however, when contacted by SPSO, SAS requested to reinvestigate the complaint in light of an error that they identified in their initial response. C remained unhappy after receiving the SAS's further response and asked us to consider the matter.

We took independent advice from an emergency and retrieval medicine adviser. We found that the way in which the dispatch of the ambulance was handled was unreasonable, that the initial care provided to A in their home was reasonable, nevertheless it should have been clear to the ambulance crew that A was seriously unwell and that the time spent on scene was unreasonable and that the decision to ask C to perform CPR in the ambulance was not reasonable.

We found that the initial investigation was not sufficient, although we acknowledged the proactive steps taken by SAS to address this issue and acknowledge failings, including asking C to commence CPR. We also found that in this case the full crew should have been interviewed. We upheld C's complaints.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified that have not already been acknowledged in previous responses including the length of time taken to assess A in their home and the delay in transporting A to hospital, the failure to follow clinical guidelines appropriately and the failure to handle C's complaint 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:

- Complaint investigations should be thorough and accurate in the first instance.
- For patients suffering cardiac arrest out of hospital such as in this case, relevant clinical guidelines should be followed by ambulance crew. Ambulance crew should accurately record what treatment was performed to demonstrate adherence to the clinical guidelines.
- When it is clear from initial assessment that a patient is seriously unwell, their transfer to hospital should

be expedited and delays should be avoided.

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.