SPSO decision report

SCOTTISH PUBLIC SERVICES OMBUDSMAN

Case: **201907499, Scottish Ambulance Service**
Sector: Health
Subject: Clinical treatment / Diagnosis
Decision: upheld, recommendations

Summary

C's adult child (A) had anxiety and a functional neurological illness (a condition in which patients experience neurological symptoms such as weakness, movement disorders, sensory symptoms and blackouts). One morning A was found to be anxious and unwell. A's other parent (B) thought it appeared different to A's previous episodes and called the GP who visited A at home.

The GP believed that A should be admitted to hospital and called 999. An ambulance crew attended the scene. There was some discussion between the GP and the hospital about which department A should be admitted to; the Mental Health Unit or the Clinical Assessment Unit. The ambulance crew transported A to hospital where they were quickly assessed and taken to the Intensive Care Unit. A died later that day.

C complained that the Scottish Ambulance Service (SAS) crew did not take A's observations, failed to follow normal protocols and failed to transfer A to the Clinical Assessment Unit straight away.

We took independent advice from a paramedic. We found that the ambulance crew attended promptly and appropriately transferred A to hospital. However, during their time at A's address they did not carry out or document a thorough patient assessment. There were multiple assessment tools (F.A.S.T; blood oxygen saturation levels) which could have been used and were not. When A's breathing rate was abnormally high, further action was not taken as it should have been.

We found that the SAS had not responded to the complaint reasonably and failed to clearly identify errors and what would be done to remedy them going forward. We, therefore, upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Share the findings of this investigation with the ambulance crew and those involved in the reflective learning exercise.

In relation to complaints handling, we recommended:

- SAS should provide as full an explanation as possible in complaint responses as to what mistakes may have occurred (where appropriate) and why they occurred in this case, in order to allow complainants a better understanding of what happened.

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.