SPSO decision report

Case: **202203262, Scottish Ambulance Service**
Sector: Health
Subject: Clinical treatment / Diagnosis
Decision: upheld, recommendations

Summary

C contacted the Scottish Ambulance Service (SAS) when they began experiencing abdominal pain. An ambulance attended but did not take C to hospital. The crew provided advice to contact the service again if their symptoms worsened. C contacted the service again the following day. A telephone assessment was completed but no ambulance was sent. C later made their own way to hospital where they required surgery for a perforated bowel.

C complained that the SAS failed to recognise the seriousness of their symptoms and failed to provide appropriate care and treatment. C said that as a result, they required more extensive surgery than if they had been taken to hospital sooner.

We took independent advice from a paramedic. We found that the ambulance crew had unreasonably failed to carry out an adequate assessment of C. The crew assessed that C had withdrawn consent for further assessment, and did not provide adequate advice on the benefits of assessment or the risks of not completing the assessment. We also found that the telephone assessment the following day was inadequate and was poorly documented. Therefore, we upheld C's complaints.

Recommendations

What we asked the organisation to do in this case
Apologise to C for failing to conduct an adequate assessment, failing to recognise the potential seriousness of their symptoms, and failing to provide them with the care that they required. 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:

- Clinical staff are aware of Kehr’s sign and are able to recognise symptoms of potentially serious abdominal conditions.
- Clinical staff ensure that benefits of assessment, treatment and transport to hospital, and the risks of declining care, are fully discussed with the patient and recorded.
- Clinical staff reflect on and learn from patient experience to improve future practice.

In relation to complaints handling, we recommended:

- Relevant staff and senior managers are familiar with the Adverse Events Policy, understand the criteria for a Significant Adverse Event Review, and apply it correctly.

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.