SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

# Investigation Report

UNDER SECTION 15(1)(a)

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**Scottish Parliament Region: Lothian**

**Case ref: 201305392, Scottish Ambulance Service**
**Sector:** Health
**Subject:** Ambulance; clinical treatment; diagnosis

**Summary**
Mr A had collapsed at home. He had phoned for an emergency ambulance and explained that he had a condition called idiopathic thrombocytopenic purpura (ITP - a disorder that can lead to excessive bruising and bleeding including bleeding into the brain which can be fatal). Mr A also had alcohol-related health issues, and was in contact regularly with healthcare services. When the ambulance arrived at his home, he explained to the paramedic and technician that he suffered from ITP. After assessing him, the ambulance crew did not transport him to hospital. The following day he was found dead at home, and ITP was recorded as one of the causes of death. Mrs C, who complained on behalf of Mr A's son, complained that the ambulance crew should have taken Mr A to hospital when they attended, and was concerned they did not do so because of his alcohol-related health issues and the fact that he had previously called for an ambulance on several occasions. The ambulance service said that from the records, it appeared that Mr A had been observed appropriately, and he had declined hospital treatment.

I took independent medical advice on the complaint from a paramedic adviser, who told me that the assessment of Mr A was not reasonable, as Mr A's symptoms (along with the readings taken at the time and his pre-existing ITP diagnosis) indicated that he needed assessing at hospital, and he should have been advised of this. The paramedic's statement that reflected on the number of Mr A's previous hospital visits should not have influenced the decision-making as to his treatment on that occasion.

Whilst my adviser recognised that the paramedic should not necessarily have had knowledge of the condition ITP, the records show no sign of them having tried to get more information about it: they should have sought more specialist advice before diagnosing a simple faint and advising Mr A, on that basis, that he did not need to go to hospital. The advice I received is that the paramedic involved failed a significant number of professional standards, and this led to Mr A being given insufficient information, or a reasonable assessment to make a decision as to whether he should go to hospital.

It is also clear to me that the ambulance service's investigation into what happened was extremely poor. They appeared to have taken the crew's statements at face value without further investigation, and they failed to recognise the clinical failings and take action to address them. I upheld the complaint and made a number of recommendations.

**Redress and recommendations**

| The Ombudsman recommends that the Scottish Ambulance Service: | *Completion date* |
|---|---|
| (i) consider the Adviser's comments in relation to the paramedic and ensure they take appropriate action; | 24 August 2015 |
| (ii) provide evidence they have procedures in place for paramedics to obtain clinical advice when on scene with complex patients; | 24 August 2015 |
| (iii) inform us of how they intend to improve and monitor record-keeping; | 24 August 2015 |
| (iv) inform us of how they intend to ensure their investigations into complaints are thorough and robust; and | 24 August 2015 |
| (v) apologise to Mr A's family. | 24 August 2015 |

**Who we are**

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms

used to describe other people in the report are explained as they arise and in Annex 1.

## Introduction

1. Mrs C complained to the Ombudsman on behalf of Mr A's son about the way Scottish Ambulance Service (the Service) staff assessed Mr A on 9 March 2013 and said that they should have taken him to hospital particularly in light of his underlying condition. Mr A died the following day. The complaint from Mrs C I have investigated is that staff failed to adequately assess Mr A at his home on 9 March 2013 (*upheld*).

## Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer examined all the information provided by Mrs C and discussed her complaint with her by telephone. They also reviewed a copy of Mr A's clinical records and the Service complaint file which included a copy of witness statements and a transcript of the 999 call Mr A made to emergency services on 9 March 2013. Finally, they obtained independent advice from an experienced paramedic adviser (the Adviser) on the clinical aspects of the complaint. In this case, we have decided to issue a public report on Mrs C's complaint because the failings I found led to a significant personal injustice to Mr A, and to ensure there was no recurrence.

3. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Service were given an opportunity to comment on a draft of this report.

*Background*

4. In 2009, Mr A was diagnosed with idiopathic thrombocytopenic purpura (a disorder that can lead to excessive bruising and bleeding including bleeding into the brain which can be fatal). Mr A also had alcohol-related health issues, and was in contact regularly with healthcare services. On 9 March 2013, Mr A became unwell. In the evening, his condition deteriorated and he collapsed. He telephoned for an emergency ambulance for assistance and told the operator he may have had a blackout and that he had 'ITP'. A paramedic (the Paramedic) and a technician attended Mr A who explained that he suffered from idiopathic thrombocytopenic purpura. After assessing him, the ambulance crew did not transport him to hospital. On 10 March 2013, he was found dead (at home). Cause of death was reported as retroperitoneal haemorrhage, idiopathic thrombocytopenic purpura, acute pancreatitis and chronic alcohol abuse.

**Complant: Staff failed to adequately assess Mr A at his home on 9 March 2013**

5. Mrs C complained that the ambulance crew should have taken Mr A to hospital when they attended on 9 March 2013. She was concerned they did not do so because of his alcohol-related health issues and the fact that he had previously called for an ambulance on several occasions.

*The Service's response*

6. The Service said that from the records, it appeared the crew observed all of Mr A's necessary vital signs and recorded them appropriately (noting that none of the observations were outside expected levels). The crew reported that there was no medical reason to take Mr A to hospital, which he appeared to agree with. The Service went on to say that he had capacity to decline transport to hospital and there was no evidence of confusion or visible medical emergency (and there was no requirement to notify others). Staff supported and respected a patient's choice to stay at home and decline the offer of transport to hospital. All crews were aware of the Service equality and diversity policy and would not discriminate against patients due to their personal circumstances.

7. During the Service's investigation into the complaint, the Paramedic who attended Mr A made a statement. They stated that:

> 'on this occasion there was not sufficient reason to take this patient to hospital. Reflecting that at other times, when [they] had transported [him] to hospital, he did not stay in for very [sic] before being discharged, discharging himself. [They] felt that very likely this would be the case again… Total number of calls made by this patient to control… over the year, to be around 25 to 30.'

*Medical advice*

8. My complaints reviewer asked the Adviser if the crew's assessment and management of Mr A was reasonable, particularly in light of his condition (idiopathic thrombocytopenic purpura). The Adviser said the assessment was not reasonable. The contemporaneous patient form detailed almost no clinical assessment or history, it was of an extremely poor standard and below that expected of a reasonable paramedic. Furthermore, contrary to the Service's response to the complaint, Mr A's observations were not within the expected levels and his symptoms, together with his complex medical history, clearly indicated that he required further assessment within hospital and that he should

have been strongly advised of this. It was not sufficient for one of the crew members to suggest that his fast heartbeat was due to vomiting and there was no indication that blood pressure was recorded appropriately or that a heart tracing had actually been carried out (contrary to the paramedic's statement). The Adviser also pointed out that the paramedic's reasoning concerning Mr A's previous hospital visits was irrelevant to the condition that the patient presented with at the time of this particular attendance, and his previous attendances or number of calls for help should have no bearing on the decisions surrounding his treatment for each individual encounter.

9. The Adviser said of further concern was the Service's statement supporting the patient's decision to stay at home and decline hospital transfer. While this in itself was reasonable, a patient could only make a safe decision surrounding their own care if they were given an appropriate amount of correct clinical information about the situation and potential consequences of the decision to either attend or not attend. The extremely poor documentation did not indicate that the attending crew had any real knowledge of idiopathic thrombocytopenic purpura. In this situation, the Adviser said it was hard to understand how they would have been able to have given reasonable advice to Mr A about his presenting condition and its associated risks to have allowed him to make an informed decision about whether to attend hospital or not. However, it appeared from the evidence available that, despite not knowing any real information about Mr A's underlying medical condition and the risks associated with it, the ambulance crew diagnosed a simple faint and advised him that he did not need to attend hospital. It was, therefore, understandable why, when given this information by healthcare professionals, Mr A would decline hospital. Unfortunately, it did not appear he was properly informed before making this decision.

10. The Adviser went on to say that while it was reasonable for the Paramedic not to have any real knowledge of idiopathic thrombocytopenic purpura, they should have sought clinical advice from a more senior medical source to better inform their decision. There was no evidence that the ambulance crew made any effort to find out any information on the condition before deciding that Mr A had had a faint and advising him that he did not need to go to hospital contrary to Health Care Professionals Council (HCPC) Standards of Proficiency for paramedics. Moreover, there was no (as there should have been) contemporaneous documentation surrounding Mr A's decision to decline hospital despite it being a specific section within the patient report form so it

was not clear if Mr A was properly informed of the risks of not attending hospital despite his presenting condition and underlying idiopathic thrombocytopenic purpura.

11. The Adviser said that the Paramedic involved failed a significant number of the HCPC standards of proficiency, and standards of conduct, performance and ethics in terms of poor assessment, poor communication, poor clinical care pathway and no evidence of any learning from the incident. The Adviser said that there was little to suggest that the same situation would not easily occur again. The injustice was that Mr A was not given sufficient information nor a reasonable clinical assessment or account taken of his medical history to allow him or the ambulance crew to come to a safe, informed decision surrounding his care. The Adviser also said that the Service should refer the Paramedic to the relevant body for fitness to practice. Given the record-keeping failings, the Service should improve and monitor documentation standards, particularly with patients who were not transported to hospital including recording which ambulance staff were present on scene and times recorded. The Adviser was also critical that at no point the Service asked the Paramedic involved about their clinical decision-making or why they left a patient presenting as Mr A did at home despite not having an understanding of his underlying medical conditions or why they failed to address this knowledge gap before making a decision. The Service should also ensure they have procedures in place for paramedics to obtain clinical advice whilst on scene with complex patients.

**Decision**

12. Mrs C complained that the Service failed to adequately assess Mr A on 9 March 2013. In reaching my decision, I have taken into account the information Mrs C provided and Mr A's clinical records. The advice I have accepted is that there were a number of significant failings in the crew's assessment of Mr A. The Adviser said there was no evidence that the crew took Mr A's presenting symptoms or medical history into account. I am highly critical that they failed to find out more about Mr A's underlying condition before allowing him to remain at home. Moreover, it is clear to me from the Paramedic's statement that the number of calls Mr A had previously made to the Service wrongly influenced their decision making. The considerable failings in the assessment of Mr A led to a significant injustice in that the decision-making surrounding his care was not safe or informed. It is also clear to me that the Service's investigation was extremely poor. The Service appeared to have taken the crew's statements at face value, for example that a heart tracing

was undertaken despite this not been recorded anywhere, and they failed to recognise the clinical failings and take action to address them. I uphold the complaint.

**Recommendations**

| 13. | I recommend that the Service: | *Completion date* |
|---|---|---|
| (i) | consider the Adviser's comments in relation to the Paramedic and ensure they take appropriate action; | 24 August 2015 |
| (ii) | provide evidence they have procedures in place for paramedics to obtain clinical advice when on scene with complex patients; | 24 August 2015 |
| (iii) | inform us of how they intend to improve and monitor record-keeping; | 24 August 2015 |
| (iv) | inform us of how they intend to ensure their investigations into complaints are thorough and robust; and | 24 August 2015 |
| (v) | apologise to Mr A's family. | 24 August 2015 |

14. The Service have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Service are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

**Annex 1**

**Explanation of abbreviations used**

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|---|---|
| Mrs C | the complainant |
| Mr A | the aggrieved |
| the Service | Scottish Ambulance Service |
| the Paramedic | a paramedic at Scottish Ambulance Service |
| the Adviser | one of the Ombudsman's advisers who specialises in paramedics |
| HCPC | Health Care Professionals Council |

**Annex 2**

## Glossary of terms

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|---|---|
| acute pancreatitis | sudden inflammation of the pancreas that can have severe complications and high mortality despite treatment |
| idiopathic thrombocytopenic purpura (ITP) | a disorder that can lead to excessive bruising and bleeding including bleeding into the brain which can be fatal |
| retroperitoneal haemorrhage | rare and potentially life-threatening condition of blood loss with significant mortality |