SPSO decision report

Case: **201901023, Angus Health and Social Care Partnership**
Sector: Health and Social Care
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C attended a health centre complaining of chest pain. A doctor attended to C and an ambulance was called. The ambulance attended around an hour later and C was taken to hospital and diagnosed with Type B aortic dissection (a tear in the inner layer of the aorta, the large blood vessel of the heart) and admitted to the coronary care unit (a specialised hospital ward dedicated to caring for people with serious or acute heart problems).

C complained about the urgency of the care provided at the health centre and that the incorrect priority level of ambulance was requested initially. In response to the complaint, the partnership said that the doctor conducted all basic examinations and recordings required; they explained the circumstances with respect to doctor cover during lunch and confirmed a yellow priority ambulance was initially requested, but this was upgraded in response to C's condition.

We took independent clinical advice. We concluded that the care and treatment provided to C in response to the chest pain was reasonable. However, following communications with the partnership, it was established that there was an error in arranging the correct priority of ambulance initially; when this was discovered the correct priority of ambulance was requested. We concluded that this error was unreasonable and we upheld the complaint on this basis only.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for initially requesting the incorrect priority of ambulance to attend for treatment. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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.