SPSO decision report

Case: **202008024, A Medical Practice in the Lothian NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the practice failed to refer them for an x-ray following a fall, which contributed to a delay in diagnosing fractured vertebrae.

C attended A&E following their injury and then attended the practice a few days later (first consultation). C then had a GP telephone appointment the next day due to ongoing pain (second consultation), and subsequently attended the practice again in person some weeks later (third consultation). C complained that their symptoms were not fully investigated and an obvious bend in their neck was overlooked.

We took independent medical advice from a GP. We found that the practice's actions at the first and second consultations were reasonable in relying on the outcome of the recent A&E assessment, and that an onward referral for x-ray imaging was not indicated at that point. We found, however, that C's ongoing pain should have been considered persistent by the time of the third consultation, and that their spinal tenderness should have been regarded as significant. We found that these symptoms should have been regarded as 'red flag' symptoms (possibly indicative of a more serious pathology), and should have triggered onward referral for imaging assessment.

Instead, C was referred for physiotherapy following the third consultation. C subsequently contacted the practice on a fourth occasion to request that this referral be expedited. A GP received this message and concluded that C did not meet the criteria for an urgent referral. The GP did so without taking a history and/or examining C. We found that it was unreasonable to make this decision without evidence. If an examination had been arranged following this fourth contact by C, it may have given rise to an x-ray referral.

We concluded that the practice unreasonably missed opportunities to refer C for an x-ray at the third consultation, as well as at the time of C's subsequent contact regarding the physiotherapy referral. On balance, we upheld this complaint. We noted the practice had already reflected extensively on their management of C and identified things they would do differently in future.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to refer them for further investigation following the third consultation, and for concluding that they did not meet urgent referral criteria without taking a history or examining C. 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:

- Patients should be referred on for appropriate investigation when they present with red flag symptoms.

The practice should ensure that they follow relevant guidelines and that they are aware of and alert to red flag symptoms.

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.