SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case ref: 201806286, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Summary

Mr C complained about the care and treatment that he received from Greater Glasgow & Clyde NHS - Acute Services Division (the Board) after he sustained a navicular fracture to his left foot (a fracture of the navicular bone on the top of the midfoot). Mr C also complained that the Board failed to respond reasonably to his complaint.

In March 2017, Mr C attended the Emergency Department (ED) of the Queen Elizabeth University Hospital, Glasgow (the Hospital). Mr C was assessed by a junior doctor and found to have pain on touching some of the bones in his foot. An x-ray was ordered, which the junior doctor interpreted as showing an un-displaced fracture (a fracture where the bone fragments do not separate) of one of the metatarsal bones (the 'forefoot' bones linking the toes to the middle part of the foot). Mr C was given a walking boot, advice and discharged. Two days later, the x-ray was reported by a radiologist as showing no acute joint or bony injury.

At the start of May 2017, Mr C attended again at the ED following a referral from the GP out-of-hours service as his foot was swollen and he was still in pain. Further x-rays were taken. Mr C was reviewed by the on call orthopaedic doctor. The doctor's diagnosis was that there was possibly a hairline fracture (a very fine fracture) of the fourth metatarsal. Mr C said he was advised nothing further could be done and was sent home. The following day, Mr C attended the orthopaedic out-patients department at the Hospital following a call asking him to attend. He was advised by an orthopaedic doctor that the third and fourth metatarsal were broken, in addition, the navicular bone was broken in three parts with a 5mm gap.

Subsequently, Mr C underwent surgery to address the fracture. However, he continued to experience problems with his foot. Mr C had a major limb amputation of the lower part of his left leg in October 2019.

We took independent advice from a consultant in emergency medicine, a consultant orthopaedic surgeon and a consultant radiologist.

We found that it was not unreasonable that the ED junior doctor did not identify Mr C's fracture in March 2017 as it was uncommon to see a patient present at the ED with a navicular fracture and a junior doctor will rarely see a patient present with this type of fracture and often not at all. In addition, the fracture was subtle on the x-ray. On account of this, the junior doctor who saw Mr C made an understandable, reasonable, mistake in not diagnosing that he had sustained a navicular fracture.

Notwithstanding this, Mr C's fracture should have been identified in the radiology report of the x-ray taken in March 2017 and although the fracture of the navicular on the x-ray was subtle; it was unreasonable that the radiologist did not report this fracture.

Mr C was diabetic. We found that the clinical history supplied on the request for the radiograph did not include this information. While we did not consider the failure to identify and include this information in Mr C's clinical history amounted to an unreasonable standard of treatment, had the information about Mr C's diabetes been supplied it may have further alerted the reporting radiologist to the possibility of a stress fracture.

We found that when Mr C re-attended the Hospital in May 2017 after being referred by the out-of-hours service, a further opportunity to identify the navicular fracture was missed.

In conclusion, we found that overall the Board failed to provide Mr C with a reasonable standard of care and treatment and that it was likely that the failure to identify Mr C's fracture in March 2017 had a detrimental impact on his outcome. In light of the failings identified, we upheld this aspect of Mr C's complaint

Finally, we found that the Board failed to handle Mr C's complaint reasonably and upheld this aspect of his complaint.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mr C:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	The Board failed to provide Mr C with a reasonable standard of care and treatment The Board's own complaint investigation did not identify or address the failings in Mr C's medical care	Apologise to Mr C for the failings in care and treatment identified in the report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 19 September 2020

We are asking the Board to improve the way they do things:

Complaint number	What we found	What should change	What we need to see
(a)	The Board unreasonably failed to identify Mr C's navicular fracture	X-rays of patients attending hospital with a possible fracture should be appropriately reported. Patients re-attending should have their presenting symptoms fully assessed and investigated	Evidence that the case has been discussed at a radiology Learning from Discrepancies meeting. Evidence that the Board have reflected on the failings identified in Mr C's case and given consideration to any required changes to processes and guidance. Evidence that these findings have been fed back to the relevant staff and managers in a supportive manner that encourages learning, including reference to what that learning is (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). By: 19 November 2020

We are asking Greater Glasgow and Clyde NHS Board to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
(b)	The Board's own complaint investigation did not identify or address the failings in Mr C's medical care	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified; and that learning from complaints is used to drive service development and improvement.	Evidence that the Board have reviewed why its own investigation into this complaint did not identify or acknowledge the failings highlighted here, what learning they identified, and what action has been taken as a result. My findings have been shared with relevant staff in a supportive way for reflection and learning. By: 19 November 2020

Feedback

Points to note

- While it was not unreasonable that the junior doctor did not identify the navicular fracture when Mr C first attended the ED in March 2017, the Board may wish to consider raising awareness of a navicular fracture with junior doctors joining the ED on placement.

- When a patient attends with a fracture at the ED, the Board may wish to give consideration to recording past clinical history as this can provide a potential alert for subsequent care and treatment.

- Adviser 2 commented that the subsequent management of Mr C's case by the Board's consultant orthopaedic surgeon after the navicular fracture had been identified should be commended.

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

Introduction

1. Mr C complained to me about the care and treatment he received from Greater Glasgow and Clyde NHS Board (the Board) after he sustained a navicular fracture to his left foot (a fracture of the navicular bone on the top of the midfoot).

2. The complaints from Mr C I have investigated are that:

(a) the Board failed to provide Mr C with a reasonable standard of care and treatment (*upheld*); and

(b) the Board did not respond reasonably to Mr C's complaint (*upheld*).

Investigation

3. I and my complaints reviewer considered all the information provided by Mr C and the Board. This included Mr C's relevant medical records and the Board's complaint file. We also obtained independent professional advice from a consultant in emergency medicine (Adviser 1), a consultant orthopaedic surgeon (Adviser 2) and a consultant radiologist (Adviser 3). In considering the case, the advisers had sight of Mr C's relevant medical records; the Board's complaint file and relevant professional guidance.

4. I appreciate that at this time, the whole of the NHS is under considerable pressure due to the impact of COVID-19, and that the Board has experienced the highest number of positively diagnosed cases. Like others I recognise, appreciate and respect the huge contribution everyone in the NHS (and public services) is making. However, much as I recognise this, I also recognise that patient safety, personal redress, and learning from complaints are as relevant as ever and it is important that we do not miss opportunities to learn for the future.

5. I have decided to issue a public report on Mr C's complaint. This reflects my concern about the serious failings identified in Mr C's care and treatment; the significant personal injustice Mr C suffered; and the potential for wider learning from the complaint.

6. I have not included every detail of the information considered but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to provide Mr C with a reasonable standard of care and treatment

Background

7. Mr C was aged 43 years at the time in question, and has a background of diabetes. He suffered a trip while walking outside on 26 March 2017.

8. On 27 March 2017, Mr C attended the Emergency Department (ED) of the Queen Elizabeth University Hospital, Glasgow (the Hospital).

9. Mr C was assessed by a junior doctor and found to have pain on touching some of the bones in his foot. An x-ray was ordered, which the junior doctor interpreted as showing an un-displaced fracture (a fracture where the bone fragments do not separate) of one of the metatarsal bones (the 'forefoot' bones linking the toes to the middle part of the foot). Mr C was given a walking boot, advice and discharged.

10. The x-ray was later reported by a radiologist as showing no acute joint or bony injury on 29 March 2017.

11. On 1 May 2017, Mr C attended again at the ED following a referral from the GP out-of-hours service as his foot was swollen and he was still in pain. Further x-rays were taken. Mr C was reviewed by the on call orthopaedic doctor. The doctor's diagnosis was that there was possibly a hairline fracture (a very fine fracture) of the fourth metatarsal. Mr C said he was advised nothing further could be done and was sent home.

12. On 2 May 2017, Mr C attended the orthopaedic out-patients department at the Hospital following a call asking him to attend. He said that he was advised by an orthopaedic doctor that the third and fourth metatarsal were broken, in addition, the navicular bone was broken in three parts with a 5mm gap.

13. Subsequently, Mr C underwent surgery to address the fracture. However, he continued to experience problems with his foot. Mr C had a major limb amputation of the lower part of his left leg in October 2019.

The Board's response

14. In response to Mr C's complaint, the Board said that Mr C had presented to the ED with sudden onset of pain in his foot. Following an x-ray, no bony abnormalities were detected. They said, however, that this was not conclusive as Mr C may have had a subtle fracture of the second, third and fourth metatarsals. They explained that

fractures of the metatarsals, which are very small and fragile, would not necessarily be identified on an x-ray.

15. As a treatment measure, the advice given to Mr C was to wear a 'moon' (walking) boot and rest was appropriate. They said that given the standard approach to fractures of the metatarsals is one of conservative management, (the avoidance of invasive treatment such as surgery) the ED would not have arranged a follow-up appointment for Mr C.

16. The Board noted Mr C was seen by the orthopaedic team on 1 May 2017 when a further x-ray was requested. As before, the small fractures of the metatarsals were not obvious on the x-ray. They said that a CT scan would not have been arranged at this attendance as there was no clinical evidence at that time to suggest a fracture.

17. The Board said that it was documented in Mr C's clinical notes that the attending orthopaedic doctor had examined Mr C's foot for signs of 'charcot' which they explained was a clinical condition causing pain and swelling of the foot and which may cause fractures, due to nerve damage, and the weakening of the bones causing difficulty in healing. It is also associated with diabetes.

18. Mr C was then contacted by the out-patient orthopaedic service to attend the Hospital on 2 May 2017. It was only when Mr C's x-rays were examined and reported by a specialist radiographer that the fracture was confirmed.

19. The Board said that the primary treatment of rest for fractured metatarsals had not improved Mr C's pain and discomfort, and the support of a moon boot had not provided his foot with the support to heal. They said that, regrettably, for some patients, the secondary course of treatment is surgery.

20. The Board commented that, unfortunately, the fragility of the metatarsal bones and the close proximity of nerves can make for a prolonged and complex recovery following fracture and/or surgery.

21. The Board said that while they were 'sorry' that Mr C had been in pain they were 'assured' the treatment he received when he initially presented at the ED was appropriate.

Relevant policies, procedures, legislation

22. In reviewing the case, the advisers had sight of relevant guidance, including:

- National Institute for Health and Care Excellence (NICE) guidance on *Fractures (non-complex): assessment and management* (NG38, February 2016).

Emergency medicine advice: Mr C's first attendance (27 March 2017)

23. Adviser 1 noted that Mr C received an x-ray and this was assessed by a junior doctor in the ED. Adviser 1 said that it was relatively uncommon to see a patient present at the ED with a navicular fracture. They explained that a junior doctor will usually spend about four to six months in an emergency department and may see only one patient present with a navicular fracture and often not at all. Therefore, while the junior doctor who saw Mr C made a mistake in not diagnosing that he had sustained a navicular fracture, this was a reasonable mistake given how uncommon it is to see a patient with this type of injury. Adviser 1 said that on the other hand a metatarsal fracture is a much more common type of foot injury seen in an emergency department.

24. Adviser 1 observed that the x-ray interpretation was incorrect. Mr C had a navicular fracture. That said, Adviser 1 considered the navicular fracture was very subtle on the x-ray and missed by a number of specialists subsequently. In that context, Adviser 1 considered it was not unreasonable that the ED junior doctor did not recognise it.

25. Adviser 1 considered the advice given to Mr C for the management of his injury as diagnosed (i.e. a metatarsal fracture), was consistent with the ED Discharge Advice policy for this type of injury. This advice was that he should take regular pain medication and walk on the foot as much as the pain allowed. If he continued to experience significant pain at three months then he should contact the Hospital. However, Adviser 1 said that if a navicular fracture had been diagnosed when Mr C first presented to the ED they would have expected different patient advice information to have been issued to him. The advice for a patient diagnosed with a navicular fracture would have been to immobilise the foot and be non-weight bearing. In addition, the patient would have been referred to orthopaedics for follow-up.

26. Adviser 1 noted that Mr C had diabetes but this had not been reported. Adviser 1 said that while it was good practice to find out a patient's past history as this might change their management down the line, to not do so, was not unreasonable.

27. Adviser 1 also commented that if Mr C's navicular fracture had been diagnosed subsequently by radiology on 29 March 2017 then Mr C would have been recalled back to the Hospital.

Radiology advice: Mr C's first attendance (27 March 2017)

28. Adviser 3 reviewed the x-ray taken on 27 March 2017. The clinical history was 'sudden onset mid foot pain while walking'. Adviser 3 observed that the clinical history supplied on the request for the radiograph did not include the information that Mr C was diabetic. Adviser 3 noted diabetic patients may suffer with impaired pain sensation and numbness (peripheral neuropathy) and be more prone to stress fractures. An orthopaedic clinic letter of 17 May 2017 indicated that Mr C had early neuropathy affecting the forefoot. Adviser 3 said if this information had been supplied the reporting radiologist would have been further alerted to the possibility of a stress fracture.

29. Adviser 3 noted that on reviewing Mr C's radiograph, there was, in technical terms, a subtle un-displaced longitudinal stress fracture running through the navicular that appears to involve both of its articular surfaces. The clinical information was suggestive of abnormality in the mid foot, and so it would have been expected that this region of the foot would have been closely reviewed.

30. Adviser 3 considered it was unreasonable that the navicular fracture was not reported.

Emergency medicine advice: Mr C's second attendance (1 May 2017)

31. Adviser 1 noted that Mr C attended the ED again on 1 May 2017. He was then reviewed by a senior member of the orthopaedic team (an ST (speciality trainee) 5). Adviser 1 explained this grade of doctor has been qualified for at least five years, and on the orthopaedic training scheme for two to three of those years. The doctor's diagnosis was that there was possibly a hairline fracture of the fourth metatarsal. However, Adviser 1 considered Mr C's navicular fracture was clear on the x-ray at this stage. Adviser 1 noted the fracture was ultimately diagnosed when the x-ray was reported on 2 May 2017.

Orthopaedics advice: Mr C's second attendance (1 May 2017)

32. Adviser 2 echoed the concerns of Adviser 1. In particular, Adviser 2 considered that the x-ray performed on 1 May 2017 showed that Mr C's fracture had become markedly displaced (at least 5mm). Adviser 2 considered the navicular fracture was obvious, and, therefore, the missed diagnosis by the ST5 was unreasonable.

33. Adviser 2 noted that the Board had stated a CT scan would not have been arranged as there was no clinical evidence to suggest a fracture. Adviser 2 considered the fact that Mr C had ongoing pain after five weeks and ongoing swelling of the entire foot should have raised the suspicion of a fracture. Adviser 2

considered it was unreasonable to suggest there was no clinical evidence of a fracture.

Orthopaedics advice: Impact of failings on Mr C's outcome

34. Adviser 2 explained that un-displaced navicular body fractures are treated with immobilisation in a plaster or a walking boot for six to eight weeks with little or no-weight bearing. Early recognition of these injuries and prompt accurate treatment may minimise long term morbidity (occurrence of medical problems). However, Adviser 2 observed that in Mr C's case, the fracture was not identified early and he did not receive prompt immobilisation. As such, the fracture displaced and by 1 May 2017 had become widely separated and comminuted (there were lots of fragments). Adviser 2 said the navicular bone has a poor blood supply, and, therefore, when displaced, as in Mr C's case, the chance of successful reconstruction is unlikely.

35. Adviser 2 considered, on balance, that the failure to identify the fracture and treat with immobilisation led to the fracture displacing, made reconstruction very challenging, and contributed significantly to Mr C undergoing subsequent multiple surgeries.

36. Adviser 2 also commented that the subsequent management of the case by the Board's consultant orthopaedic surgeon should be commended for its high standard.

(a) Decision

37. Mr C complained that the Board failed to provide him with a reasonable standard of care and treatment. The basis on which I reach conclusions and make decisions is reasonableness. My investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question. I do not apply hindsight when determining a complaint.

38. I have received advice from Advisers 1, 2 and 3, and I accept their advice. Taking into account this advice, as well as the information I have received from Mr C and the Board, I have found there were unreasonable failings in the care and treatment provided to Mr C.

39. I have found it was not unreasonable that the ED junior doctor did not identify Mr C's fracture on 27 March 2017. The advice I have received and accept from Adviser 1 is that it was uncommon to see a patient present at the ED with a navicular fracture and a junior doctor will rarely see a patient present with this type of fracture and often not at all. In addition, the fracture was subtle on the x-ray. On account of this, the junior doctor who saw Mr C made an understandable, reasonable, mistake in not diagnosing that he had sustained a navicular fracture.

40. Notwithstanding this, it is clear that Mr C's fracture should have been identified in the radiology report of the x-ray taken on 27 March 2017. I accept Adviser 3's advice that although the fracture of the navicular on the x-ray of 27 March 2017 was subtle; it was unreasonable that the radiologist did not report this fracture.

41. I note that the clinical history supplied on the request for this radiograph did not include the information that Mr C was diabetic. Adviser 1 considered that it was good practice to find out a patient's past history as this might change their management down the line, however, not doing so was not unreasonable. In addition, Adviser 3 told me that if the information about Mr C's diabetes had been supplied it may have further alerted the reporting radiologist to the possibility of a stress fracture. While I do not consider the failure to identify and include this information in Mr C's clinical history amounted to an unreasonable standard of treatment, it is an important learning point so I have provided feedback on this to the Board at the end of my report.

42. It is also clear from the advice I have received that when Mr C re-attended Hospital on 1 May 2017 a further opportunity to identify the navicular fracture was missed.

43. In conclusion, I have found that overall the Board failed to provide Mr C with a reasonable standard of care and treatment in that there were multiple failures to identify the navicular fracture; when Mr C's x-ray was reviewed by radiology on 29 March 2017 and again when Mr C re-attended the Hospital on 1 May 2017.

44. Finally, I have found that it is likely that the failure to identify Mr C's fracture in March 2017 had a detrimental impact on his outcome. I have noted the advice from Adviser 2 that a patient with a navicular fracture should be immobilised and kept non-weight bearing. As this did not happen for Mr C, it likely contributed to his fracture displacing, making reconstruction very challenging, and was likely a factor leading to the subsequent multiple surgeries and the major limb amputation of his left foot. Learning this will undoubtedly be very difficult and upsetting for Mr C. He has my utmost sympathy.

45. In light of the failings identified, I uphold this complaint. My recommendations for action by the Board are set out at the end of this report.

(b) The Board did not respond reasonably to Mr C's complaint

Concerns raised by Mr C

46. Mr C said he was dissatisfied with the way the Board dealt with his complaint. In particular, he felt it was not properly investigated and was impersonal.

Background

47. Mr C complained to the Board via email on 9 September 2018.

48. The Board acknowledged Mr C's complaint in their email of 11 September 2018 and stated that it was their aim to respond within 20 working days and enclosed a copy of the Board's complaint leaflet.

49. Mr C sought an update on the complaint on 2 October 2018.

50. The Board advised Mr C by email of a delay in the process on 3 October 2018 explaining they were currently awaiting information from the services involved.

51. The Board sent a subsequent email to Mr C on 5 October 2018. They stated they were still awaiting a response from the relevant services and apologised for the upset caused to Mr C by the delay. The Board also said they had followed up on this, and aimed to respond within the next 10 to 14 working days.

52. Subsequently, Mr C sought a further update on his complaint from the Board on 22 October 2018.

53. The Board issued their final response to the complaint on 22 October 2018.

The Board's response

54. The Board did not provide any comments to our office on their handling of Mr C's complaint.

Relevant policies, procedures, legislation

55. In reviewing the case, I have had sight of relevant guidance, including:

- The Board's Complaints Policy and Procedure (2017)
- NHS Scotland Model Complaints Handling Procedure (MCHP) (2017)

56. The Complaints Policy and Procedure gives organisations considerable discretion as to how to investigate a complaint, although it notes: '*An investigation aims to establish all the facts relevant to the points made in the complaint and to give the person making the complaint a full, objective and proportionate response that represents our final position*.'

57. The MCHP sets out complaint handling standards and procedures.

(b) Decision

58. In considering this complaint, my role is not to reconsider the substantive issues of Mr C's complaint to the Board. These concerns have been addressed in my consideration of complaint (a) above. What I have considered here is how the Board handled Mr C's complaint. In doing so, I have reviewed the correspondence between Mr C and the Board and taken into account the requirements of the Board's Complaints Policy and Procedure (2017) and the MCHP.

59. I do not consider there was unreasonable delay by the Board in responding to the complaint. While under the Board's complaint procedure and the MCHP the investigation should be completed within 20 working days, when the Board became aware they could not meet this timescale Mr C was appropriately updated and a full response was issued within the revised timescale. Given the complaint covered two different departments (ED and Orthopaedics) with responses required from both, I consider the timescale for responding was reasonable.

60. Mr C raised the concern that his complaint was not properly investigated. From a review of the Board's complaint records, as noted above, the Board's investigation involved seeking comments from their ED and Orthopaedics departments, which are essentially reflected in their response letter to Mr C of 22 October 2018. However, in my view, the investigation carried out by the Board could have been more thorough.

61. The Board's investigation did not involve a radiology review, which may have identified the issue with the failure to identify that Mr C had sustained a navicular fracture of his left foot in March 2017. The Board's response letter throughout refers to fractured metatarsals and the fact that Mr C had sustained a navicular fracture of his left foot was not addressed although Mr C had clearly referred to having sustained this injury in his initial complaint correspondence. Accordingly, I have found the complaint handling investigation was unreasonable.

62. Mr C also raised concerns that the Board's response was impersonal. On review of the Board's response, I can see that the Board acknowledged Mr C's ongoing pain and discomfort and that they apologised for the delay in their investigation. I appreciate this may not have been a sufficiently compassionate or personal response from Mr C's perspective given all that he has endured. However, overall I have not found evidence that the Board's response in this respect was unreasonable.

63. Given I have found the Board's complaint handling investigation was unreasonable, I uphold this aspect of the complaint.

64. I have made a recommendation about complaint handling at the end of the report. The focus of the recommendation is on learning from this specific complaint. I have not recommended action in relation to complaint handling as a whole. This is because my office has been in direct contact with the Board over recent months providing training, advice and support, and as a result I am satisfied that wider action, leading to improvement, is being taken.

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

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Mr C:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	The Board failed to provide Mr C with a reasonable standard of care and treatment The Board's own complaint investigation did not identify or address the failings in Mr C's medical care	Apologise to Mr C for the failings in care and treatment identified in the report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 19 September 2020

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board unreasonably failed to identify Mr C's navicular fracture	X-rays of patients attending hospital with a possible fracture should be appropriately reported. Patients re-attending should have their presenting symptoms fully assessed and investigated	Evidence that the case has been discussed at a radiology Learning from Discrepancies meeting. Evidence that the Board have reflected on the failings identified in Mr C's case and given consideration to any required changes to processes and guidance. Evidence that these findings have been fed back to the relevant staff and managers in a supportive manner that encourages learning, including reference to what that learning is (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). By: 19 November 2020

We are asking Greater Glasgow and Clyde NHS Board to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
(b)	The Board's own complaint investigation did not identify or address the failings in Mr C's medical care	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified; and that learning from complaints is used to drive service development and improvement	Evidence that the Board have reviewed why its own investigation into this complaint did not identify or acknowledge the failings highlighted here, what learning they identified, and what action has been taken as a result. My findings have been shared with relevant staff in a supportive way for reflection and learning. By: 19 November 2020

Feedback

Points to note

- While it was not unreasonable that the junior doctor did not identify the navicular fracture when Mr C first attended the ED in March 2017, the Board may wish to consider raising awareness of a navicular fracture with junior doctors joining the ED on placement.

- When a patient attends with a fracture at the ED, the Board may wish to give consideration to recording past clinical history as this can provide a potential alert for subsequent care and treatment.

- Adviser 2 commented that the subsequent management of Mr C's case by the Board's consultant orthopaedic surgeon after the navicular fracture had been identified should be commended.

Terms used in the report **Annex 1**

Adviser 1	A consultant in emergency management (a specialist in the immediate assessment and treatment of patients with serious and life–threatening illnesses and injuries)
Adviser 2	An orthopaedic consultant (a specialist in diagnosing and treating conditions of the musculoskeletal system)
Adviser 3	A consultant radiologist (a specialist in diagnosing and treating injuries and diseases using medical imaging procedures)
CT scan	A computerized tomography scan, this uses several x-ray images and computer processing to create cross sectional images
hairline fracture	a very fine fracture
metatarsal bones	The 'forefoot' bones linking the toes to the middle part of the foot
Mr C	The complainant
navicular fracture	A fracture of the navicular bone on the top of the midfoot
radiograph	An image produced by X-ray or other rays
radiographer	A healthcare professional who performs imaging scans
ST5	A doctor who has been qualified for at least five years and who is in speciality training

stress fracture	A fracture of a bone caused by repeated (rather than sudden) use
the Board	Greater Glasgow and Clyde NHS Board
the Hospital	Queen Elizabeth University Hospital, Glasgow
un-displaced fracture	A fracture where the bone fragments do not separate
walking/moon boot	An orthopaedic device prescribed for the treatment and stabilisation of severe sprains, fractures, and tendon or ligament tears in the ankle or foot

List of legislation and policies considered **Annex 2**

National Institute for Health and Care Excellence, *Fractures (non-complex): assessment and management* (NG38, February 2016).

Greater Glasgow and Clyde NHS Board, Complaints Policy and Procedure (2017).

NHS Scotland Model Complaints Handling Procedure (MCHP) (2017).