Scottish Parliament Region: Mid Scotland and Fife

Case 200600637: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; Accident and Emergency; diagnosis, complaint handling

Overview

The complainant, Mr C, broke his leg while playing rugby. He complained about his treatment at Queen Margaret Hospital (the Hospital), where the Accident and Emergency doctor (the Doctor) diagnosed a soft tissue injury. Mr C was also dissatisfied about how his complaint was handled.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C's fracture was not diagnosed (*upheld*);

(b) Mr C's indication of the location of the pain was ignored both by the Doctor and the bank radiographer (*no findin*g);

(c) different treatment would have been provided, had the fracture been diagnosed earlier (*not upheld*); and

(d) Mr C's complaint was not handled adequately (*upheld*).

Redress and recommendations

The Ombudsman recommends that Fife NHS Board (the Board):

(i) share this report with the Doctor and the clinicians in the Accident and Emergency Department to allow them to reflect on it; and

(ii) remind staff of the importance of obtaining information from all staff, including locum and bank staff, in relation to complaints; and

(iii) remind staff to respond to complaints in a timely manner or to request an extension if they are unable to do so, in line with the NHS complaints procedure.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Mr C injured his right leg while playing rugby on 11 March 2006. He was taken by ambulance to Queen Margaret Hospital (the Hospital) where the Accident and Emergency doctor (the Doctor) diagnosed a soft tissue injury. Mr C was later found to have broken his leg. Mr C complained about the failure to diagnose the fracture and that information provided by him about the source of the pain was ignored by medical staff. Mr C said that the failure to diagnose the fracture led him to receive inappropriate treatment. He made a formal complaint but remained dissatisfied about how his complaint was handled and subsequently complained to the Ombudsman.

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

(a) Mr C's fracture was not diagnosed;

(b) Mr C's indication of the location of the pain was ignored both by the Doctor and the bank radiographer (the Radiographer);

(c) different treatment would have been provided, had the fracture been diagnosed earlier; and

(d) Mr C's complaint was not handled adequately.

Investigation

3. In order to investigate this complaint I have had access to Mr C's hospital records and the correspondence in relation to the complaint. I have made enquiries of both Mr C and Fife NHS Board (the Board). I have received advice from an adviser to the Ombudsman who is a Consultant in Emergency Medicine (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report can be found in Annex 1. A glossary of the medical terms used in this report can be found in Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) Mr C's fracture was not diagnosed; and (b) Mr C's indication of the location of the pain was ignored by both the Doctor and the Radiographer

4. Mr C said that, when he arrived at the Hospital's Accident and Emergency Department, he was seen promptly by the Doctor, who sent him for an x-ray. The Radiographer took an x-ray of Mr C's right ankle, which he was told did not disclose any broken bones. The Doctor told Mr C that he had ligament damage and he was treated for this and discharged. Mr C said that when the pain failed

to subside and the restriction in his movement continued, he attended his GP on 2 May 2006 who arranged for him to have a further x-ray at his local hospital the following day. This x-ray revealed that Mr C had broken his right fibula (the smaller, non-weight bearing bone in the lower leg). Mr C complained that this fracture had not been diagnosed at the Hospital.

5. In making his complaint to the Board on 8 May 2006, Mr C said that he told the Doctor and the Radiographer that the pain in his leg was emanating from the mid-shin area but he was ignored. He said the Doctor ordered an x-ray of his right ankle and the Radiographer x-rayed this area despite Mr C's protests that his pain was in the mid-shin area. Mr C said that the Radiographer said that she could only take an x-ray of the area requested by the Doctor. Mr C asked whether the Radiographer had simply accepted the Doctor's request without question and whether that was appropriate. Mr C said that it had led to the wrong part of his leg being x-rayed.

6. In response to his complaint, the Director of Nursing wrote to Mr C on 9 June 2006. She said that, on the basis of the information provided by Mr C regarding how he came by his injury and the examination findings, the Doctor considered that Mr C had sustained a soft tissue injury. The Director of Nursing apologised for the fact that the fracture was missed.

7. In the Board's response to Mr C, dated 2 August 2006, the Doctor said that he remembered Mr C well. He arrived in Accident and Emergency having injured his ankle playing rugby. He had examined Mr C immediately and found he had bruising and swelling over his right lateral malleolus (the outer side of the ankle bone) and was tender there. On examining the rest of his leg, he was not tender on his tibia or the proximal (inner) fibula. The Doctor said that he was concerned that Mr C may have sustained a distal (outer) fibular fracture and so arranged an x-ray of his ankle. The x-ray did not show any fracture. The Doctor said that he thought Mr C had sustained a ligament injury. As Mr C was able to walk having had no analgesia, he arranged for him to be fitted with a double tubigrip to be worn during the day and gave him advice to rest for a few days, elevate the limb, use simple analgesia as required and mobilise as the pain would allow. The Doctor said that Mr C had not expressed any concerns that the proximal part of his leg had not been x-rayed nor did he express any other concerns at the time. The Doctor said that he was sorry to learn of Mr C's diagnosis and regretted not diagnosing the fracture when he saw him.

8. The Radiographer was not initially asked for her comments when Mr C complained to the Board but the Diagnostic Imaging Services Manager said that radiographers are professionals in their own right and do use their judgement in deciding which area to x-ray, based on the clinical information provided and the patient's comments. Radiographers do query any request which they feel is inappropriate. The Diagnostic Imaging Services Manager could only assume that, on this occasion, the Radiographer felt the request was appropriate. In response to my enquiries, the Radiographer was asked for her comments but, unfortunately, had no recollection of the case. The Radiographer said, however, that it would be her normal practice to take into consideration what the patient says within the context of the x-ray request. If she judged that the information the patient provided warranted a discussion with the clinician then she would do so. The outcome of such a discussion may be to alter or add to an examination request, as appropriate.

9. In response to my enquiries, Mr C's mother and his partner both said that they were present with Mr C after he returned from x-ray. Both agreed that Mr C told the Doctor that he had pain in the mid-shin area of his leg and thought it was broken. They said that, in response, the Doctor had asked Mr C to stand and put his weight on his leg which he did. The Doctor said that the fact that Mr C could weight bear on the leg, with no analgesia, indicated to him that the leg was not broken.

10. The Adviser said the records showed that when Mr C was brought to Accident and Emergency he was first seen by the triage nurse, who noted that he had sustained a possible 'ankle? tibial' [the other main bone in the lower leg] injury when playing rugby. The history she took from Mr C indicated that his boot had become stuck and his ankle had twisted. The nurse noted normal pulses but limitation of movement. She also noted deformity and swelling. The Doctor described the mechanism of injury (Mr C was tackled from behind, foot planted and twisted, landed on right side). Examination was recorded as 'bruising and swelling and small abrasion right lateral malleolus, tender, non-tender tibia, proximal fibula, medial malleolus etc'. The Doctor's provisional diagnosis at this point was '?fracture'.

11. The Adviser said that there were two injuries. The soft tissue injury to the lateral ligaments of the ankle which was correctly identified and the fibula fracture which was missed. The Adviser said that the Doctor based his

conclusions on an apparently thorough examination. The Adviser said that a mid-shaft fracture was missed due to the failure to appreciate the need for an x-ray of that part of Mr C's leg. The Adviser said that whether or not the Doctor should have picked up the fibula injury depended upon the signs (swelling, tenderness) and symptoms (localised pain). The Adviser said that the areas remote from the ankle are recorded as having been examined and noted to be non-tender. The Adviser said that it is not uncommon for this type of fracture to be missed because it may initially be accompanied by very little swelling and the ability to fully weight bear. In the presence of the bruising and swelling over the ankle the symptoms and signs of the fibula fracture were, therefore, less obvious. The Doctor considered that the fact that Mr C was able to weight bear without any analgesia indicated that he did not have a broken leg. That turned out to be incorrect. The Adviser said that it is because this type of fracture can be accompanied by very little swelling and the ability to weight bear that it is commonly missed but the Doctor should have picked it up through recognising the need for an x-ray of the mid-shaft part of the leg in the event of any description of pain in that area and localised bony tenderness.

(a) Conclusion

12. I note that Mr C sent the Board a copy of the x-ray subsequently taken of his leg, which clearly showed that the fibula was broken. The Board accepted that the fracture was missed when Mr C attended the Hospital on 11 March 2006 and apologised for that. The advice I have received is that the fracture should have been picked up, however, no further action appears to have been taken in an effort to ensure that any learning from this case is shared. In all the circumstances, therefore, I uphold this complaint.

(a) Recommendation

13. The Ombudsman recommends that the Board share this report with the Doctor and the clinicians in the Accident and Emergency Department to allow them to reflect on it.

(b) Conclusion

14. It appears from the records that the signs of Mr C's injury, as observed by both the nurse and the Doctor when he first attended Accident and Emergency, were concentrated around the area of his ankle. This area was also noted to be tender. Neither the nurse nor the Doctor recorded that Mr C complained, at that stage, of having pain in his shin area. The x-ray disclosed no fracture in Mr C's ankle. Mr C said that he told the Radiographer that he had pain in his mid-shin

but the Radiographer has no recollection of the incident and no-one else was present. Following the x-ray, Mr C said that he told the Doctor that he had pain in his shin and he thought his leg was broken. Mr C's mother and his partner agreed that was what Mr C told the Doctor, following the x-ray. They said that the Doctor asked Mr C to stand up and weight bear on his leg. They said that the Doctor made this request in response to Mr C's indication of where he felt pain. While this points towards the Doctor having regard to Mr C's complaints, Mr C clearly felt that his concerns were ignored by both the Doctor and the Radiographer because no x-ray was taken of the area he complained about, in order to exclude the possibility that he had a fracture. The Doctor also indicated when responding to Mr C's complaint that Mr C had not expressed any concerns that the proximal part of his leg had not been x-rayed nor did he express any other concerns at the time.

15. Clearly, there is a difference in Mr C's recollection of events and that of the Doctor. I have noted that Mr C's mother and partner were present when the Doctor examined Mr C and they back up Mr C's recollection of events. Nevertheless, in the absence of any truly independent witnesses, it is difficult for me to make a finding based on competing recollections of events. After careful consideration, on balance, I have decided that I am unable to make a finding on this part of the complaint.

(c) Different treatment would have been provided, had the fracture been diagnosed earlier

16. In his complaint to the Board, Mr C said that, by the time the fracture was diagnosed at his local hospital, he was told that applying a cast would be counter productive and the healing process would take much longer. Mr C said that he therefore had additional pain, suffering and lack of mobility which he would not have had if his fracture had been diagnosed. Mr C asked to have additional treatment to accelerate the healing process. He said that his preference would be for treatment at a specialist sports injury clinic or similar. Mr C also asked for compensation.

17. The Doctor said that, as Mr C was able to mobilise well having had no analgesia, he arranged for him to be fitted with a double tubigrip to be worn during the day and advised him to rest for a few days, elevate the limb, use simple analgesia as required and mobilise as the pain would allow. The Doctor said that Mr C had declined analgesia in Accident and Emergency. The Doctor said that as ankle injuries are very common he regularly gives advice (rest, ice,

compression, elevation) and is particular in advising early mobilisation. He would have advised similar treatment if the fracture had been diagnosed.

18. In his letter to the Board on 20 June 2006, Mr C said that he had not been provided with the advice indicated by the Doctor. He had declined analgesia and had only been told to rest. If his fracture had been diagnosed he would have also expected to be referred to a follow-up clinic. Mr C's mother and partner both said that Mr C had been treated with a tubigrip bandage and told to rest the leg for ten days.

19. The Board asked the Clinical Director of the Department of Orthopaedics (The Director) to comment on Mr C's complaint. The Director said that if Mr C's fracture had been diagnosed on day one the treatment would have been exactly the same. They would not have immobilised the fracture in plaster as that would have increased the risk of deep vein thrombosis and also caused stiffness to the ankle subtalar joint. The fracture would have been treated with tubigrip support and mobilisation as soon as the pain allowed. The Director said that, ideally, it would have been better if the fracture had been picked up initially so that it could have been explained to Mr C why he would have pain but the treatment would have been the same. The Director said that Mr C did not require any specialist treatment nor any compensation for protracted pain because his symptoms would have been exactly the same had the fracture been found. The Director was asked for further comment when he reviewed the x-ray of Mr C's leg, which showed the fracture. He said that, in his experience, such a fracture should be treated without a plaster. The Director said that, in his opinion, a plaster would only be advocated by inexperienced doctors who automatically thought a patient should be put into plaster but that was old fashioned thinking. He agreed with Mr C that, ideally, his fracture should have been spotted on day one and a proper explanation could have been given but it had not altered the prognosis in his case.

20. The Adviser said that from Mr C's clinical records the treatment prescribed was DTG (double tubigrip - an elastic bandage), RICE (rest, ice, compression, ie, the tubigrip bandage and elevation) and analgesia. Mr C said that he was only told to rest his leg but it is clear that he was also fitted with a tubigrip bandage to provide compression and offered analgesia, although he declined. The Adviser said that 'no analgesia' was recorded. The Adviser said that Mr C's treatment was appropriate and would have been essentially the same if the fracture had been diagnosed. The Adviser said that the only difference would

have been that the advice would have been different, in that the symptoms would have been correctly explained and the course of progress more accurately discussed.

21. I note that, following his subsequent x-ray when his fracture was seen, Mr C's GP wrote to him on 10 May 2006. He said that he had the result of the x-ray, which disclosed a healing fracture through the mid-shaft of his fibula. He noted that Mr C had been discharged and no follow-up had been recommended. The GP said that meant that Mr C's fibula would be quite sore for the next weeks to months but would appear to be healing. He invited Mr C to make an appointment if he would like to see the physiotherapist.

(c) Conclusion

22. The hospital where Mr C was subsequently seen did not recommend that Mr C had any further treatment. The Adviser agreed with the Director that the treatment which Mr C received was appropriate and would have been the same if his fracture had been diagnosed. He would have received more accurate advice but it is clear that the appropriate treatment would not have been any different. I, therefore, do not uphold this complaint.

(d) Mr C's complaint was not handled adequately

23. Following his initial complaint on 4 May 2006, the Board wrote to Mr C on 8 May 2006. They said that they would investigate his concerns and respond to him in due course. Mr C wrote to the Board again on 5 June 2006. He said that he had failed to receive a response within 20 working days of his complaint being received, as required by the statutory complaints procedure. (The NHS complaints procedure requires that complaints are dealt with within 20 working days or, if that is not possible, that an extension should be sought.) The Director of Nursing sent a substantive response to Mr C on 9 June 2006, which was delivered to him by hand. Mr C wrote to the Board again on 20 June 2006. This letter was acknowledged on 23 June 2006 and a further response sent to Mr C on 2 August 2006. In his complaint to the Ombudsman Mr C said that he did not consider that the Board had responded to his complaint adequately, in that they had failed to contact the Radiographer concerned and had made assumptions about what she would have done, based on departmental policy. In addition, they had failed to investigate fully the Doctor's involvement and, in particular, the discrepancies between the Doctor's account and his own recollection of events.

24. From the complaint correspondence it is clear that the Board made no attempt to contact either the Doctor (who was a locum on a temporary contract and had since left) or the Radiographer (who was a bank radiographer who did not hold a permanent post within the Board area) to respond to Mr C's initial complaint. After Mr C wrote again, the Board wrote to the Doctor on 7 July 2006. He received the letter on 12 July 2006 and responded on the same day. I asked the Board why they had not contacted the Radiographer. As a result of my enquiry, the Diagnostic Images Services Manager spoke to the Radiographer but, unfortunately, she could no longer remember the events of that day.

25. The Adviser said that the Board failed to complete its investigation, by not taking a full statement from the Radiographer concerned at the time. Depending on what the Radiographer said, it may also have been appropriate to take statements from any nursing staff involved.

26. In response to my enquiries the Board said that, on reflection, the Radiographer should have been contacted at the time. They were aware that the issue had been raised in previous Ombudsman reports and had had discussions with the Patient Relations Team about the matter. They are now ensuring that all staff dealing with complaints are made aware of the importance of contacting either clinicians who are either no longer employed by the organisation or who do not hold a permanent post. They hoped this would prevent a similar situation occurring.

(d) Conclusion

27. It is clear that the Board did not take appropriate steps to contact either the Doctor or the Radiographer in response to Mr C's initial complaint. It is unfortunate that, by the time the Radiographer was spoken to, she could not recall the events of that day at all. It would also have been better if the Doctor had been contacted earlier. The Board also failed to respond to Mr C's complaint within the 20 days laid down in the complaints procedure or ask for an extension. I, therefore, uphold this complaint.

(d) Recommendations

28. The Ombudsman recommends that the Board:

(i) remind staff of the importance of obtaining information from all staff, including locum and bank staff, in relation to complaints; and

(ii) remind staff to respond to complaints in a timely manner or to request an extension if they are unable to do so, in line with the NHS complaints procedure.

29. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Fife NHS Board
The Hospital	Queen Margaret Hospital
The Doctor	The locum Senior House Officer on duty in Accident and Emergency on 11 March 2006
The Radiographer	The bank radiographer on duty on 11 March 2006
The Adviser	A consultant in emergency medicine
The Director	Clinical Director of the Department of Orthopaedics

Annex 2

Glossary of terms

Distal	Outer/peripherally located i.e. nearer fingers or toes
Fibula	The smaller, non-weight bearing bone in the lower leg
Proximal	Inner/centrally located ie, nearer the central body
Right lateral malleolus	The outer side of the ankle bone
Subtalar	A joint in the ankle
Tibia	The weight-bearing main bone in the lower leg
Tubigrip	Elastic bandage