SPSO decision report

Case: **201202307, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained that a hospital made mistakes in the reporting of an x-ray that her late mother (Mrs A) had taken on 10 April 2012 after falling in her care home and injuring her left knee. Mrs A was discharged from hospital that day but was admitted to a second hospital three days later because she was in severe pain and unable to put weight on her left leg. She was eventually found to have fractured her knee. When the second hospital asked the first hospital to carry out another x-ray seven days after the first, the first hospital found that there had been an error in the reporting of the original x-ray.

Mrs C felt that the board had delayed in taking action to investigate whether there was a problem with the x-ray or arrange a follow-up, when Mrs A's symptoms did not resolve. Mrs C was also concerned that there was a failure to establish the reasons why the x-ray was wrongly interpreted. The board had explained that the likely cause of the error was a problem with their software system for viewing x-rays, which meant that a much older image of Mrs A's knee was superimposed on the new image. They advised that the error was a rare and unusual incident but that they had made relevant staff aware of the matter to ensure it did not happen again. However, our investigation identified that there was also an error with the reporting of the x-ray that was requested seven days after Mrs A fell, as it too was initially noted as showing no fracture. The board said of this that the x-ray image on 10 April 2012 had been displayed when trying to view the image taken seven days later.

We could not say for certain whether the errors in reporting the x-rays were as a result of a failure in the software system, or the wrong x-ray being opened, or if the correct x-ray images were viewed and the fracture was simply not identified. We concluded, however, that the board had not provided sufficient evidence that they had carried out a thorough investigation into both x-ray incidents. However, we noted that the first hospital had promptly arranged for Mrs A to return the following day for a second x-ray after the fracture was identified. We upheld Mrs C's complaints about interpretation of the x-rays, but not about their follow-up action.

Recommendations

We recommended that the board:

- undertake a significant event analysis into the reporting of the x-rays taken after Mrs A's fall, to establish clearly where the fault lay in order to reduce the likelihood of this happening again; and
- apologise to Mrs C for the failings identified.