SPSO decision report

Case: **201204507, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mr C injured his neck and back when he fell from his bike. He attended hospital, where he was admitted, treated and discharged. Several weeks later he had a scan at an out-patient appointment at another hospital. This identified a small fracture in one of his vertebrae (the bones of the spine) and injuries to discs in his back. When Mr C complained to the board that only the second hospital identified this, the board acknowledged that the small fracture had been visible on the first hospital's x-rays, although they said they did not believe that this had led to Mr C's later problems. Mr C was also unhappy that the board told him that the damage to his discs had been caused by an existing, underlying condition and not the fall.

We took independent advice from one of our medical advisers, an experienced consultant in orthopaedic and trauma surgery. He reviewed Mr C's medical records and also the x-rays taken in the first hospital. He said that, although the fracture had been visible on these x-rays, it was difficult to identify. He also said that if it had been identified then, it would not have merited additional investigation nor would it have changed Mr C's treatment at the time. The adviser also explained that Mr C's disc injuries were caused by wear and tear over a period of years, and added that the fact that Mr C had not felt any symptoms before his accident did not mean that the accident had caused them. We also took advice from our hospital adviser. He indicated that it is standard practice for x-rays and scans to be formally reported upon fairly soon after they are taken. However, in Mr C's case, there was a delay – which he indicated was not ideal - between a scan being taken at the first hospital and then being formally reported upon. He noted that the fracture was identified in the formal report available after Mr C's discharge.

We accepted the advice and, on balance, considered that Mr C's treatment – based on the information available at the time and without the benefit of hindsight - had been reasonable. We did not uphold his complaints although, in light of the delay in the formal report of the initial scan, we did make a recommendation.

Recommendations

We recommended that the board:

- review departmental processes for formal imaging reports, in light of the Royal College of Radiologists' guidance.