Maidstone and Tunbridge Wells NHS
NHS Trust

Complaint case study for publication on Trust website November 2014:

Mrs L raised concerns about a delay in diagnosing spinal fractures when her brother, Mr P, presented to A&E.

Mr P suffered a serious fall from his bicycle and was brought to Tunbridge Wells Hospital A&E department by ambulance. Mr P underwent investigations in the department and while this was taking place, both he and his sister alerted staff that he was experiencing pins and needles in his limbs and he was unable to move his right leg. They were reassured by staff that this was probably due to shock. After several hours, the doctor assured Mr P that there was no problem with his spine; the neck collar and spinal board were removed and Mr P was allowed to sit up.

Mr P was subsequently reassessed by a different doctor in A&E. His symptoms had not changed and the doctor undertook a neurological examination. As a result of this examination, the doctor reapplied the neck brace and spinal board as a spinal injury was suspected, which was later confirmed.

Mrs S was seeking an explanation as to how this injury was missed.

Our findings

The complaint was investigated by a Consultant in Emergency Medicine. As a result of the investigation, the complaint was upheld.

Investigation of the complaint revealed a number of oversights that contributed to the delay in diagnosing Mr P's neck fracture. Although the paramedics had noted that Mr P could not move his legs and was experiencing pins and needles, there was a breakdown in communication during the handover process which meant that this information was not highlighted. In response to this, we introduced specific trauma documentation for use by clinical teams attending to trauma calls; handover will now be documented within this new booklet to ensure valuable clinical information is not overlooked.

Following initial assessment by the trauma team, a log-roll examination of Mr P's spine was attempted. The orthopaedic team documented that he was moving his legs but found it difficult to assess his neurology (level of sensation), because Mr P struggled to co-operate due to the head injury he had sustained. The plan was to repeat this examination but the repeat examination was never carried out.

The clinical guidance on management of neck injuries was not followed and apologies were offered for this. A number of measures were implemented in response to this complaint including increased education for middle grade doctors and senior house officers, raising awareness of the correct protocol via posters promoting the correct clinical guidance, updating the junior doctor handbook and reminders issued to the junior orthopaedic team to undertake repeat assessments where required. The case was also presented at the clinical governance meeting to highlight and share the lessons learned amongst the wider team.

Given the mechanism of injury, a CT scan of Mr P's head, face and cervical spine was arranged. The CT scan was reported as showing no cervical spine fracture or dislocation. Spinal cord injury without radiological abnormality is an unusual but well documented phenomenon which the trauma team are trained to identify and manage. As the CT scan was reported as normal, the doctor removed the collar and sat Mr P up in bed. The doctor should have reassessed Mr P's neurology himself, prior to removing the collar and apologies were offered that this did not happen. The management of this case was discussed in detail with the doctor to facilitate learning.

Opinion was sought from a consultant neurosurgeon who offered reassurance that despite the errors in Mr P's clinical management, this was unlikely to have contributed to his neurological injury.