General Medical Council

Case study 1: Dr Stone

Dr Stone is a surgical doctor working in orthopaedics. He agreed to cover an additional long day shift as one of his colleagues had called in sick.

Mr Jones is a 26-year-old known diabetic who had been involved in a head on car collision and sustained a complex ankle fracture. Dr Stone was called around 8pm to assess Mr Jones and agreed to see him in the Emergency Department (ED) before the night team arrived. Dr Stone reviewed the patient and found he was alert and well in the department.

Mr Jones was prescribed appropriate analgesia and counselled on the need to be admitted with surgical intervention planned the following day. Dr Stone requested that the nursing staff repeat the observations, check his blood sugars and transfer him to ward 2 which is the acute orthopaedic ward.

Dr Stone returned to ward 2 and informed the night sister that he had accepted a 26-year-old complex ankle fracture who had been in an RTA and was a type 1 diabetic. Dr Stone waited for the evening handover, however, the night doctor was running late and therefore handover was conducted over the phone.

The following day the case was discussed at the trauma MDT and the patient booked for theatre. Dr Stone had noticed that the patient had been admitted to ward 4 and not ward 2.

Dr Stone attended ward 4 to take consent for the procedure. He was informed that Mr Jones was admitted directly to ward 4 from the ED - he needed a cubicle as he'd started vomiting after Dr Stone had left him. He had continued to vomit overnight and the nursing staff were concerned that he was lethargic and quiet in the morning.

When Dr Stone attended ward 4, the nursing staff made him aware that the police had been in contact with the ward. They were coming to see Mr Jones as they were concerned that he may have been under the influence of drugs at the time of the accident. His roadside alcohol test had been negative.

Dr Stone assessed Mr Jones and noted that he had vomited several times overnight and was tachycardic with a raised respiratory rate. When he spoke to Mr Jones, he was concerned that the patient was disoriented and confused. In view of the concerns about a significant road traffic accident, vomiting and confusion, an urgent CT head was organised.

Mr Jones returned to the ward following a normal CT head. The critical care team were called after he continued to become increasingly drowsy and was now only responding to pain.

The critical care team arrived and arranged blood gases and BM which identified a severe case of diabetic ketoacidosis and Mr Jones was transferred to the intensive care unit. After 5 days on intensive care, corrective surgery was undertaken and he returned home.

The family have made a formal complaint. The Trust is planning to undertake an internal incident review and have made the family aware under the Duty of Candour.