SPSO decision report

Case: **201508555, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

The mother and partner of Mr A complained about the care and treatment that he received from Dumfries and Galloway Royal Infirmary following a lung biopsy. The biopsy was carried out after a scan indicated the spread of cancer to the lungs and Mr A was later diagnosed with testicular cancer. Mr A's mother and partner were concerned that he did not receive timely treatment following the biopsy. They also felt that Mr A should have been admitted to hospital, rather than being discharged home to await the biopsy results.

After taking independent advice on this case from a consultant physician and a consultant urologist we upheld the complaint that Mr A had not received timely treatment. The advice we received was that the pathology team had not been provided with all the relevant clinical information to help them accurately report the primary site of Mr A's cancer. The advisers also both considered that there had been an unreasonable delay in arranging a specific blood test that can highlight testicular cancer. We considered that the delay in arranging this test was unreasonable as earlier scans had pointed towards testicular cancer and clinicians should have been aware of the potential for this diagnosis. The advice we received was also critical that there was not a more proactive approach to Mr A's care following a urology referral and that his case was not discussed with oncology when it became clear that there would be a delay in the biopsy result becoming available. We made a number of recommendations to address these findings.

We did not uphold the second complaint regarding the decision to discharge Mr A following his biopsy. The advice we received was that it was clinically safe to discharge Mr A and that the board should have been able to manage his care as an urgent patient without admission being necessary.

Recommendations

We recommended that the board:

- apologise for the failings identified in this investigation;
- take steps to ensure that all relevant clinical information is supplied to pathology to assist their analysis of biopsy samples;
- discuss this case at an appropriate clinical governance meeting and highlight the findings of this investigation to relevant staff for reflection; and
- take steps to ensure that referrals are acted on in an appropriate and timeous manner.