

## SPSO decision report

**Case:** 201508249, Ayrshire and Arran NHS Board

**Sector:** health

**Subject:** clinical treatment / diagnosis

**Outcome:** some upheld, recommendations

### Summary

Miss C complained about the care and treatment received by her partner (Mr A) at University Hospital Ayr. Mr A attended the hospital for a urology review as he had been experiencing problems involving his testicles, perineum and groin area. Miss C complained that no cause could be found for his pain and that although he had previously undergone a procedure involving his scrotum, this would not cause the sharp pain about which he was complaining. Mr A was subsequently admitted to hospital as an emergency. A scan showed that there was no blood flow to his left testicle, and it had to be removed.

Miss C complained that Mr A had been discharged too soon and without being seen by the consultant. She also said that the consultant concerned had refused to do further tests to establish the cause of Mr A's problems.

We took independent advice from consultants in emergency medicine and urology. We found that Mr A's treatment in A&E was of a reasonable standard and in line with his presenting symptoms, and that he was admitted and referred to the appropriate specialist in a timely way. We also found that the surgery Mr A had was reasonable. However, the level of documentation justifying the consultant urologist's decision-making and the information given to Mr A to allow him to make informed consent was not in accordance with General Medical Council (GMC) guidance. Furthermore, Mr A received little in the way of explanatory information and he was not examined when he attended for review. We upheld this aspect of Miss C's complaint.

In response to Miss C's complaint to the board, Mr A was referred to a urologist in another area, which we found to be good practice. However, Miss C's complaint to the board was not handled within the relevant timeframe and we upheld this aspect of Miss C's complaint.

### Recommendations

We recommended that the board:

- apologise formally for identified failings;
- ensure that the consultant urologist involved is made aware of the findings of this investigation and remind them of their obligations regarding note-taking and consent as per GMC guidance; and
- remind staff involved of their responsibilities in relation to the complaints process, and the importance of addressing complaints within the relevant time frame.