SPSO decision report

Case: **201606959, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained on behalf of her husband (Mr A) about the care and treatment he received from the board at Dumfries and Galloway Royal Infirmary. Mrs C complained that there was an unreasonable delay in diagnosing that Mr A was suffering from renal cancer, that there was an unreasonable delay in providing him with treatment and that staff had failed to communicate appropriately with Mr A and his family about his diagnosis and treatment.

We took independent advice from a consultant urologist who said that there was a severe failure to follow-up on a radiologist's report of a scan. The radiologist had suspected that an area of abnormality which showed in Mr A's kidney was renal cancer and had made a recommendation that the scan should be discussed at a urology multi-disciplinary team meeting (MDT). The radiologist's recommendation to discuss this at MDT was not actioned. There was also a failure to mention the scan finding in any of the correspondence on Mr A's discharge from the hospital. As a result, the suspected renal cancer was neglected until the same renal mass was found, by chance, a number of months later when Mr A had a scan to investigate a problem that was unrelated to his renal cancer. While it appeared that Mr A's tumour had not progressed when found, we found that the delay was unacceptable and that the diagnosis, management and treatment of his renal cancer was well below an expected standard. We upheld Mrs C's complaints about delays in diagnosis and treatment.

We also took independent advice from the consultant urologist, as well as a nursing adviser, about how staff communicated with Mr A and his family about his diagnosis and treatment. We did not find any reference in Mr A's medical records of medical staff having a discussion with him about his cancer diagnosis and treatment. We found that the actions taken by nursing staff had fallen short of the standard expected and needed for Mr A and his family at the time. We upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C and Mr A for:
- an unreasonable delay in diagnosing that Mr A was suffering from renal cancer;
- an unreasonable delay in providing treatment to Mr A; and
- a failure in communication.
- The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- A system should be in place to ensure that unexpected findings of scans are appropriately reported and acted upon in a timely manner.
- It should be ensured that radiology are summarising any significant incidental findings at the end of a scan report, as per the requirements of a previous audit, and that these findings are brought to the attention of

relevant staff in a timely manner.

- Staff should be aware of the importance of communication with patients and their families. Newly appointed staff should be supported and mentored in this regard and provided with appropriate training.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.