SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Central Scotland

Case 201400437: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospitals; clinical treatment; diagnosis

Overview

The complainant (Ms C) raised concerns that her late sister (Ms A) was not told of her diagnosis for three weeks after having a scan which showed she had cancer. Ms A was then told she would be referred to oncology, but no appointment was offered for a further three weeks. Sadly, Ms A died a few days before the appointment was offered.

Specific complaints and conclusions

The complaints which have been investigated are that Lanarkshire NHS Board (the Board) unreasonably delayed:

(a) in informing Ms A of her diagnosis (*upheld*); and

(b) in offering Ms A an oncology appointment (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) undertake a specific internal enquiry to determine why the results of Ms A's scan were missed by both Accident & Emergency staff and radiology. The investigation should identify process improvements to ensure this situation does not reoccur, and the results of the investigation should be shared with Ms A's family, if they wish;	15 April 2015
(ii) issue a written apology to Ms C and her family for the failings this investigation identified;	18 February 2015
(iii) raise the findings of this investigation with Consultant 1 for reflection as part of their next performance appraisal; and	18 March 2015
(iv) review the Board's complaints handling processes and templates to ensure that: complaints involving	18 March 2015

more than one hospital are fully investigated and addressed, with input from all relevant staff (regardless of where the complaint is received); and any failings are clearly identified, and the causes for these, and any action to address them, explained.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 22 April 2014, my office received a complaint from Ms C regarding delays in the diagnosis and treatment of her late sister (Ms A). Ms C said Ms A was not told of her diagnosis of cancer until three weeks after having a scan which showed the cancer. Ms C also raised concerns that Ms A was told she would be referred to oncology, but no appointment was offered for a further three weeks. Sadly, Ms A died a few days before the offered appointment.

2. The complaints from Ms C which I have investigated are that Lanarkshire NHS Board (the Board) unreasonably delayed:

(a) in informing Ms A of her diagnosis; and

(b) in offering Ms A an oncology appointment.

Investigation

3. My complaints reviewer considered the documents provided by Ms C and by the Board, and made further enquiries of the Board. My complaints reviewer also reviewed Ms A's medical records and sought independent advice from one of the Ombudsman's medical advisers (the Adviser).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

(a) The Board unreasonably delayed in informing Ms A of her diagnosis

5. Ms A, a 54-year old woman, had a past medical history of breast cancer, and had received treatment from the breast team at Wishaw General Hospital (Hospital 1), including chemotherapy, a right-sided mastectomy and radiotherapy.

6. Several years later, Ms A attended her annual review at the Hospital 1 breast clinic, where no issues were noted. However, very soon after this Ms A began to experience breathlessness and abdominal pains and about five weeks later Ms C accompanied her to the Accident and Emergency Department (A&E) at Hairmyres Hospital (Hospital 2). A chest x-ray was taken during her admission, and the clinician told Ms A that the x-ray was clear (although there was a shadow that could be due to breast scar tissue). Ms A was discharged home.

7. Ms A continued to feel unwell, and about three weeks after her chest x-ray, she was admitted to Hospital 2. She had a CAT (computerised axial tomography) scan the next day, which showed that her breast cancer had returned and spread.

8. Following Ms A's death, Ms C asked the Board to re-check the chest x-ray from Ms A's admission to Hospital 2 A&E, which she had been told was clear. The Board told Ms C that both a chest x-ray and a lumbar spine x-ray were carried out during that admission. While the chest x-ray was clear, the lumbar spine x-ray was positive for spinal metastatic disease (showing that Ms A's cancer had returned and spread to her spine). The Board said they were unsure if this was communicated to Ms A at the time, but noted that Ms A was informed of her diagnosis when she was admitted to hospital three weeks later. The Board apologised if staff had failed to communicate this to Ms A or her GP at an earlier stage.

9. The Board provided my complaints reviewer with a copy of Ms C's complaints file. An internal email in this file from a consultant radiologist to the Board's complaints area stated that Ms A's lumbar spine x-ray was not reported by radiology. The email suggested this may have been due to a lag in transferring the images to the radiology information system, leading the reporting radiologist to believe that the lumbar spine x-ray was not carried out. The email noted that the x-ray was positive for spinal metastatic disease, and queried whether the referring clinician had commented on the x-ray.

10. My complaints reviewer asked the Adviser to comment on the failure to report the lumbar spine x-ray. The Adviser explained that, when an x-ray is carried out in A&E, the requesting clinician may review the film themselves, but the film is also reviewed by a radiologist, who issues the formal report on the x-ray. The Adviser noted that it can be difficult for radiology departments to report all the images performed on the same day, and sometimes A&E staff have to interpret images themselves, and are expected to be reasonably competent to do so and to ask for specific help from the radiologists when they are uncertain. In this case, while the medical records show the A&E clinician reviewed both of the films themselves, they detected no abnormality in the lumbar spine x-ray. Furthermore, no formal report was issued by the radiology department on the lumbar spine x-ray. The Adviser noted the Board's internal correspondence on this, and said that the suggestion that there was a time lag in transmitting the images was only a partial explanation. This would not

explain why the film was not reported later that day, or on a subsequent day, even if it was not reported at the same time as the chest x-ray. The Adviser considered that, even if Ms A had left A&E by the time the film was received, the Board should have reported the x-ray and called Ms A back in to give her the diagnosis.

11. The Adviser was concerned that there was no professional anxiety by the radiologists that Ms A had had a significantly abnormal x-ray, but this was not communicated to her clinicians, or to her. The Adviser was also critical of the Board's complaints handling in this regard, as the Board told Ms C they were unsure if the abnormal lumbar spine x-ray was communicated to Ms A at the time, when it was clear from the A&E notes that it was not.

12. Overall, the Adviser considered there were serious failings in relation to this aspect of Ms A's care. The cause of the delay in diagnosis was twofold: first, the A&E clinician failed to correctly interpret the lumbar spine x-ray; second, the radiology department failed to report on this x-ray. The Adviser was critical that the Board failed to pick up on the scan, and also that the Board did not properly investigate the delay in diagnosis. The Adviser noted that, without an internal investigation, it would not be possible to identify why and where the local process of reporting failed and why the A&E clinicians missed the diagnosis from the x-ray. The Adviser commented that it is not even clear from the complaints handling record whether the relevant A&E clinician is aware that they missed the scan.

(a) Conclusion

13. The basis upon which we make our decisions is 'reasonableness', that is, were the actions taken, or not taken, reasonable in the circumstances and in light of the information available to those involved at the time. As this matter is about clinical issues, in reviewing this complaint I have given considerable weight to the advice I have received from the Adviser.

14. On the basis of the medical advice obtained and the Board's internal complaint correspondence, I have concluded that the three week delay in Ms A's diagnosis was caused by the Board's failure to note the abnormalities in the lumbar spine x-ray taken during Ms A's admission to Hospital 2 A&E. I accept the Adviser's explanation that this was caused, first, by the A&E clinician's failure to recognise the abnormalities on the x-ray and, second, by the failure of radiology to report on the x-ray.

15. I am critical that a scan showing a positive result of cancer was entirely missed by Hospital 2. While Ms A's cancer was diagnosed three weeks later, this was due solely to Ms A's perseverance in seeking treatment for her symptoms. Had Ms A not sought further investigation, the delay in diagnosis could have continued indefinitely. I consider that the Board's delay in informing Ms A of her diagnosis, as a result of the missed scan, was unreasonable. Therefore, I uphold this complaint.

16. I am also concerned at the failure of Board staff properly to investigate the missed scan when it was brought to their attention by Ms C's complaint. The Board told Ms C that they were 'unsure' whether Ms A had been informed of the results of her lumbar spine x-ray. This information was easily available from the A&E records, but the complaints investigators do not appear to have checked these records, or sought comments from the A&E clinician who reviewed the scan. This may be due to the fact that Ms C initially complained to Hospital 1, while the failings identified occurred at Hospital 2. I am concerned that the Board does not appear to have adequate procedures to deal with the situation where a complaint against one hospital reveals errors at a different hospital.

17. I am also concerned that, as the Adviser noted, there does not appear to have been any professional anxiety by the radiologists who discovered that the scan was never reported. Although the radiology department acknowledged that the scan appeared to have been missed, there was no attempt to investigate why this happened or how to prevent a reoccurrence.

18. Ms A passed away about five weeks after the A&E scan was carried out. As a result of the Board's failure to diagnose her cancer at this stage, Ms A was unaware of her diagnosis for more than half of this time. Ms C told my office that Ms A had left hospital on the day of the scan feeling a 'fraud' for having taken up so much time in A&E. Ms C acknowledged that it is now too late for the Board to offer Ms A any explanation or apology, however, she hoped that our investigation of her complaint would improve the Board's practices and procedures so that no other patient would have to endure the 'nightmare period of time' between Ms A's illness and her death. I have recommended that the Board apologise to Ms C for the failings my investigation found (see recommendations following complaint (b) below). I have also recommended that the Board undertake a specific internal investigation into the actions of staff in this case, to determine why the results of the lumbar spine x-ray were missed

by both A&E staff and radiology, and to identify process improvements to ensure this does not reoccur. Finally, I have made recommendations to address the failings in complaints handling my investigation brought to light (see recommendations following complaint (b) below).

(a) Recommendation

19. I recommend that the Board:	*Completion date*
(i) undertake a specific internal enquiry to determine why the results of Ms A's scan were missed by both A&E staff and radiology. The investigation should identify process improvements to ensure this situation does not reoccur, and the results of the investigation should be shared with Ms A's family, if they wish.	15 April 2015

(b) The Board unreasonably delayed in offering Ms A an oncology appointment

20. Ms C told my office that the consultant in charge of Ms A's care at Hospital 2 (Consultant 1) informed Ms A of her diagnosis on the day she was discharged. Consultant 1 also told Ms A he had written and telephoned the breast team at Hospital 1 to request assessment by them. In particular, Consultant 1 said he was trying to get in touch with the consultant in charge of Ms A's care during her previous episode of breast cancer (Consultant 2).

21. A consultant breast surgeon at Hospital 1 (Consultant 3) recalled that Consultant 1 telephoned her to discuss Ms A's care plan. Consultant 3 said they agreed Consultant 1 would refer Ms A to the oncology clinic to discuss treatment, rather than being referred to the breast team.

22. However, thinking that a referral had been made to the breast team at Hospital 1, Ms C telephoned a nurse in this team (Nurse 1) a few days after Ms A's discharge, to ask for an urgent review of Ms A. The MacMillan Nurse assisting Ms A also telephoned the team the following day to ask about this. Nurse 1 recalled advising Ms C that Consultant 1 needed to make a referral for Ms A, either to the breast team or to the oncology team. After the telephone call, Nurse 1 recalled noting that Ms A's case did not appear on the multi-disciplinary team meeting and no oncology appointment appeared to have been made. Nurse 1 telephoned a different oncology centre to find out if they had received a referral. Nurse 1 could not recall the response she received, but

remembered checking the patient management system some time later and seeing that an appointment had been made for the oncology clinic at Hospital 2.

23. About two weeks after Ms A's discharge from Hospital 2, Ms A saw her GP, who referred her for readmission and specifically requested that she be given an oncology appointment at Hospital 2 (as no appointment had yet been made for Hospital 1). The day after Ms A's admission, the junior doctor on the ward made this referral, and an appointment was made for nine days later. Sadly, Ms A passed away four days before the planned appointment.

24. Following Ms A's death, Ms C complained to the Board about the delay in diagnosis and treatment. The Board told Ms C that, although Consultant 1 had indicated that a referral would be sent at the time of Ms A's discharge, Consultant 1's team actually sent this referral two weeks later. Ms C queried this, as she thought that the referral which was ultimately made (to oncology at Hospital 2) had been made by Ms A's GP, while Consultant 1 had said he would refer Ms A to Hospital 1. However, the Board confirmed that the referral to oncology at Hospital 2 was made by Consultant 1, albeit two weeks after he told Ms C and Ms A he would make the referral.

25. However, the Adviser considered there was no evidence that Consultant 1's team ever made a referral to oncology. While Consultant 1's discharge summary (written some months after Ms A's death) states that he 'sent on-going referrals to oncology consultants', there is no referral from Consultant 1 in Ms A's medical records. The Adviser explained that the ward notes made by Consultant 1 conclude with a note: 'Home. Letter to [Consultant 2]. Copy to [Consultant 3].' After speaking to Ms A about her diagnosis, Consultant 1 wrote 'we will write to [Consultant 2]'s secretary.' This is also confirmed in the nursing notes from the same time, which state 'letter to [Consultant 2]'. The immediate discharge letter also states that a follow-up appointment had been made with Consultant 2. However, there is no referral to Consultant 2 (at Hospital 1) in the medical records.

26. The Adviser noted that a referral was made two weeks later to the oncologists at Hospital 2, but explained that this appears to have been made by the team looking after Ms A following her readmission to Hospital 2, rather than by Consultant 1's team. While the Board told Ms C that this referral was made by Consultant 1 (albeit two weeks after Ms A's discharge), this information appears to be based on an internal email in the Board's complaint file, which

confirmed that the referral at this time was made by 'a consultant' (rather than Ms A's GP). The referral document itself appears to have been completed by a junior doctor and authorised by a named consultant other than Consultant 1.

27. The Adviser considered Consultant 1's failure to make the planned referral a significant failing. The Adviser explained that the admission involved draining some fluid from Ms A's lung and informing her of her diagnosis of metastatic cancer, but no arrangements were been made for palliative care review, oncology review, or review to see if the fluid drained from her lung had recurred. The Adviser was critical that someone with advanced cancer had such poor consideration of her future health needs, and a failure to do the single action which was planned.

28. The Adviser referred to the General Medical Council Guidance 'Treatment and care towards the end of life: good practice in decision making', which states:

> 'Most treatment and care at the end of life is delivered by multi-disciplinary and multi-agency teams, working together to meet the needs of patients as they move between different health and social care settings and access different services… You must communicate effectively with other members of the health and social care team or teams involved in a patient's care, sharing with them the information necessary to provide the patient with safe, effective and timely care.'

The Adviser considered that Ms A did not receive this level of care. Her admission was directed at a single problem (the fluid identified in her lung), rather than considering her overall needs.

29. The Adviser was also critical that the Board did not make more effort to involve Consultant 1 in the complaint process, as it appeared Consultant 1 may not even be aware that the referral was not made as planned.

30. My complaints reviewer asked the Adviser whether Consultant 3 (the breast surgeon at Hospital 1) should have done more to follow up Ms A's treatment, as she was aware from the telephone conversation with Consultant 1 that he intended to refer Ms A. The Adviser explained that the clinician responsible for Ms A's care was Consultant 1. While Consultant 3 was asked for advice, the severity of Ms A's condition at this time meant that she was unable to provide any care for Ms A. It was, therefore, the responsibility of

Consultant 1 to ensure the referral was made. From their telephone conversation, Consultant 3 would not have been expecting a referral to her team (as Consultant 1 planned to refer to the oncology team instead).

31. My complaints reviewer also asked the Adviser whether Nurse 1 should have done more to follow up on Ms A's care, as she was aware from her telephone call with Ms C that Ms A had expected a referral to the breast team. The Adviser was not critical of Nurse 1, as the referral was the responsibility of medical staff. The Adviser considered it was the failure by Consultant 1's team to make the referral, not the subsequent actions of nursing staff, which resulted in the poor outcome for Ms A.

32. The Adviser noted that Ms A's condition was rapidly progressing and advanced at the time of her diagnosis, such that it was unlikely she would have been offered any further treatment by the oncologists. However, the delay in referral meant the prospect of potential treatment was offered to Ms A, but never delivered, which would have been a cause of significant and unnecessary distress for Ms A. Overall, the Adviser considered Ms A's care in this regard fell below a level she could reasonably have expected.

(b) Conclusion

33. I have explained above that the basis for our decisions is reasonableness. In this case, I had to consider whether the Board's delay in referring Ms A to oncology was reasonable.

34. On the basis of the evidence available, I consider the delay was caused by Consultant 1's failure to make the planned referral to Consultant 2. While the Board told Ms C that Consultant 1's team did make a referral (albeit two weeks after Ms A's discharge), I accept the Adviser's conclusion, on the basis of the medical records, that this referral appears to have been made by the team looking after Ms A following her readmission. Furthermore, I note that this referral was directed to oncology at Hospital 2, whereas it is clear from the notes and the recollections of Ms C and Consultant 3 that Consultant 1 had planned to make the referral to Consultant 2 at Hospital 1. The Adviser found that there was no referral from Consultant 1 in the medical records. While it is evident from Consultant 1's notes that he intended to make a referral and even thought he had done so (as noted in the discharge document), I have concluded that Consultant 1 never made any referral. I am critical of this failing.

35. I consider that the delay in offering Ms A an appointment, resulting from the failure to complete a referral for Ms A, was unreasonable. Therefore, I uphold this complaint.

36. As the Adviser has noted, the failure to appropriately refer Ms A meant that the prospect of potential treatment, offered to Ms A when Consultant 1 informed her of her diagnosis, was never delivered. Ms A spent her final weeks waiting for an appointment that never came, a situation which added significantly and unnecessarily to her and her family's distress. Ms C told my office that Ms A 'accepted her diagnosis with great courage and humour, but she did die feeling she had been 'written off' and that is unacceptable'. While it is too late for the Board to apologise to Ms A, I have recommended that the Board issue a written apology to Ms C and her family. I have also made recommendations to address the failings my investigation found.

37. I am also concerned at the Board's poor response to Ms C's complaint in this regard. The factual question of who made the referral for Ms A could easily have been checked from Ms A's medical records, and it is unacceptable that the Board gave Ms C incorrect information on this point on two occasions. The Board's final response also contained a number of factual errors, including the name of the hospital and the date Ms A was advised of her diagnosis. Finally, the Board failed to offer Ms C any explanation or apology for the delay in the appointment, although it was accepted that there was a two week delay from when Ms A was informed a referral would be made to when the referral was actually made. It appears from the complaint file that the inadequate response may be due in part to the fact that Ms C complained to Hospital 1, while the failings identified occurred at Hospital 2. An internal email from Consultant 3 to the complaints handling team queried why Hospital 1 was being criticised, when it appeared the referral was not made by Hospital 2. However, neither Consultant 3 nor any other staff took the initiative in suggesting that comments be sought from the relevant clinician, Consultant 1. This narrow and restrictive approach to Ms C's complaint meant that Ms C received an incomplete and unhelpful response to the genuine and well-founded concerns she had raised. I have recommended that the Board review their complaints handling process to ensure that complaints involving more than one hospital are fully investigated.

38. I note that, in response to the draft version of this report, the Board informed my complaints reviewer that action has recently been taken to improve the handling and co-ordination of complaints concerning two hospitals, by

strengthening the 'Acute Services Division: Enquiries, Concerns and Complaints Management Protocol'. This was also discussed at a meeting of the Patient Affairs Managers on 2 December 2014. However, I remain concerned that the Board's complaints handling processes should ensure input is sought from all relevant staff, and any failings are clearly identified and acknowledged.

(b) Recommendations

39.	I recommend that the Board:	*Completion date*
(i)	issue a written apology to Ms C and her family for the failings this investigation identified;	18 February 2015
(ii)	raise the findings of this investigation with Consultant 1 for reflection as part of their next performance appraisal; and	18 March 2015
(iii)	review the Board's complaints handling processes and templates to ensure that: complaints involving more than one hospital are fully investigated and addressed, with input from all relevant staff (regardless of where the complaint is received); and any failings are clearly identified, and the causes for these, and any action to address them, explained.	18 March 2015

40. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	the complainant
Ms A	Ms C's late sister
the Board	Lanarkshire NHS Board
the Adviser	a medical adviser to the Ombudsman who provided independent medical advice on the complaint
Hospital 1	Wishaw General Hospital
A&E	Accident and Emergency Department
Hospital 2	Hairmyres Hospital
Consultant 1	the consultant in charge of Ms A's care during her first admission to Hospital 2
Consultant 2	the consultant who had been in charge of Ms A's care at Hospital 1 during her previous episode of breast cancer
Consultant 3	a consultant breast surgeon at Hospital 1
Nurse 1	a nurse in the breast team at Hospital 1

Annex 2

List of legislation and policies considered

General Medical Council Guidance, *Treatment and care towards the end of life: good practice in decision making* (20 May 2010)