Scottish Parliament Region: Glasgow

Case 200501228: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Cancer; Clinical diagnosis and treatment; Response to complaint.

Overview

The complainant's (Mrs C) father (Mr A) died on 28 December 2004 following treatment in Gartnavel General Hospital (the Hospital). She was concerned that there was an unreasonable delay in diagnosing his cancer and that he was not provided with adequate treatment on admission to the Hospital. Mrs C also felt that there were unreasonable delays in the handling of her complaint by Greater Glasgow and Clyde NHS Board (the Board).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was an unreasonable delay in diagnosing Mr A's cancer (*not upheld*);

(b) during Mr A's admission to the Hospital in November and December 2004, he was not provided with adequate treatment; in particular, there was a delay before any attempt was made to arrange a stent and radiotherapy (*upheld*);

(c) Mr A had an unnecessary second bronchoscopy (*upheld*); and

(d) there were undue delays in the handling of the complaint by the Board (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board, reflecting on this case:

(i) review their guidelines to ensure that in cases similar to this one, staff understand the need for the appropriate multi-disciplinary team to meet at

[1] On 1 April 2006 the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by Argyll and Clyde Health Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of Argyll and Clyde Health Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to Greater Glasgow and Clyde Health Board as its successor.

the earliest possible opportunity to discuss all options for investigation, treatment or non treatment. She also recommends that options are discussed in detail with patients and/or with their family in such circumstances;

(ii) review the circumstances in which it may be appropriate to provide palliative treatment prior to firm diagnosis, and that they include their findings in revised clinical guidelines for staff. The Ombudsman asks that the Board inform her of the outcome of this review and the actions taken; and

(iii) review their methods of obtaining information from internal sources with a view to ensuring that there are no resultant avoidable delays in responding to complaints.

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

Main Investigation Report

Introduction

1. On 7 August 2005 the Ombudsman received a complaint from Mrs C that Greater Glasgow and Clyde NHS Board (the Board) failed to diagnose her father (Mr A)'s medical condition properly, and failed to provide him with the appropriate treatment during a five week stay in Gartnavel General Hospital (the Hospital), immediately prior to his death on 28 December 2004. Mrs C questioned whether her father's condition had been misdiagnosed in June 2004. She felt that her father's last few months were spent in unnecessary pain because he did not receive the correct treatment. Finally, Mrs C complained about an unreasonable delay by the Board in responding to her complaint about her father's treatment. Mrs C complained through the NHS complaints process but remained dissatisfied at the conclusion.

2. The complaints from Mrs C which I have investigated are that:

(a) there was an unreasonable delay in diagnosing Mr A's cancer;

(b) during Mr A's admission to the Hospital in November and December 2004, he was not provided with adequate treatment; in particular, there was a delay before any attempt was made to arrange a stent and radiotherapy;

(c) Mr A had an unnecessary second bronchoscopy; and

(d) there were undue delays in the handling of the complaint by the Board.

3. In investigating Mrs C's complaints I reviewed the relevant correspondence between her and the Board, corresponded with the Board and examined Mr A's clinical records. I also obtained clinical advice from a clinical adviser to the Ombudsman (the Adviser) and my conclusions are based on that advice. This report contains medical terms, and I have included explanations of these in a glossary (Annex 2).

4. In line with the practice of the Ombudsman's office, the standard by which I have judged the actions of the medical staff was whether they were reasonable. By that, I mean whether the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Investigation

6. Early in 2003 Mr A was admitted to hospital suffering from a collapsed lung. Following treatment and a chest x-ray, which did not reveal any abnormality, it was established in May 2003 that, with no recurrence of his symptoms of breathlessness, chest pain and discomfort, Mr A appeared to have recovered.

7. In April 2004 Mr A attended his General Practitioner (GP) suffering from recurrent chest pains. He was referred to the chest clinic at the Hospital.

8. He had an examination and x-ray in June 2004. He was known to have Chronic Obstructive Pulmonary Disease. A pleural plaque on the x-ray was considered to have resulted from previous occupational asbestos exposure. The respiratory consultant (Consultant 1) considered that the chest pain was musculoskeletal in nature. There was no clinical or chest x-ray evidence of underlying cancer in either Mr A's respiratory system or gullet. Mr A was prescribed painkillers and an inhaler and his GP was notified of the diagnosis.

9. Mrs C told me that the painkillers and inhaler did not help her father, so he went to his GP to see if any other help could be given. His GP changed the painkillers but unfortunately the new prescription did not help to ease his pain. It became apparent that Mr A was not getting better and was in terrible pain, so Mrs C telephoned the GP for advice. In responding, the GP referred to Consultant 1's letter, which confirmed that her father did not have a tumour. Mr A's painkillers were changed again but the new painkillers did not help and Mr A was in constant pain.

10. Mrs C told me that her father decided not to return to his GP, choosing instead to wait for his next appointment at the chest clinic on 13 September 2004, in the hope that they would help him. By that time, Mrs C felt that her father would probably be admitted to hospital as he was unable to eat properly and had lost a lot of weight. At this appointment, however, Mr A was simply referred to a bone clinic and given an appointment to revisit the chest clinic in three months.

11. Shortly after this Mr A attended his GP surgery, where a locum examined him. He was referred for an endoscopy, which was completed on 12 October 2004. A barium swallow x-ray was performed on 25 October 2004 and Mr A was admitted to the Hospital on 14 November 2004. The following

day a computed tomography (CT) scan indicated that he had a tumour. It was decided to carry out a bronchoscopy to establish if this was a lung tumour and this procedure was completed on 25 November 2004.

12. On 1 December 2004 Mr A had a second bronchoscopy. Mrs C told me that she felt that at this stage of her father's illness this was unnecessary. She told me that she believed that the procedure caused her father further suffering and contributed to the development of pneumonia.

13. Mr A's treatment was reviewed at a multi-disciplinary team meeting with the Oncology Team on 10 December 2004. A decision was taken to consider palliative radiotherapy and, in view of Mr A's difficulty in swallowing, an oesophageal stent was considered necessary.

14. The stent was inserted on 15 December 2004 but Mr A continued to experience problems in maintaining his nutrition. His health gradually deteriorated until, sadly, he died on 28 December 2004.

(a) There was an unreasonable delay in diagnosing Mr A's cancer

15. In June 2004 Mr A was seen at the chest clinic of the Hospital following a referral from his GP, as he was suffering from chest pains.

16. Mr A was examined and chest x-rays were taken. He was assessed as having a moderate degree of Chronic Obstructive Pulmonary Disease, with pains in his chest most probably being musculoskeletal. Hospital records indicate that at that time there was no clinical or x-ray evidence to indicate cancer. Painkillers and inhaled medicine were prescribed and a follow-up appointment was made for Mr A to attend again in three months to assess his chest pain.

17. The records show that, at the follow-up appointment in September 2004, a Respiratory Staff Grade Physician examined Mr A. Mr A reported that his breathlessness was no worse than previously reported, however, he did say that he experienced central chest pain when lying down or bending and he had difficulty in swallowing, with acid regurgitation. The physician recommended a specialist referral to investigate his gastric symptoms.

18. Shortly after this appointment, and with a growing concern for her father's failing health, Mrs C made an appointment for her father with a locum GP, who

referred Mr A to the Hospital for an endoscopy. This was completed on 12 October 2004. A barium swallow x-ray was performed on 25 October 2004 and Mr A was admitted to the Hospital on 14 November 2004. The following day a CT scan indicated the presence of a tumour.

19. I reviewed Mr A's clinical records and consulted the Adviser to decide whether or not there was an unreasonable delay in diagnosing Mr A's cancer.

20. The Adviser has said that none of the symptoms described were suggestive of cancer and there was no indication of cancer on Mr A's chest x-rays. His medicine was adjusted and a three month review to reassess his chest pain was scheduled. The Adviser has pointed out that the tumour was positioned in the centre of Mr A's chest and so, even if present in June 2004, it would not normally have been visible on the chest x-ray. Tumours in this region are not normally visible on a plain x-ray.

21. In September 2004 Mr A attended the chest clinic for his follow-up appointment. He described a central chest pain, worse on lying or bending forward, and he complained of difficulty in swallowing and acid regurgitation. These symptoms are all suggestive of an oesophageal problem and the Adviser has said that the decision to increase the dose of Mr A's acid blocking drug was, therefore, reasonable.

(a) Conclusion

22. In considering the diagnosis, I have taken account of the fact that Mr A suffered from moderate Chronic Obstructive Pulmonary Disease. When Consultant 1 saw Mr A in June 2004, and at the three month review appointment in September 2004, there were no specific symptoms to suggest cancer and no indication that further investigations were appropriate at that stage. The Adviser, therefore, considers that management of Mr A's condition at this stage was reasonable and I accept that advice.

23. Once the locum GP referred Mr A back to the Hospital, the sequence in which the clinical investigations were carried out was appropriate and they were completed in a reasonable time frame. I conclude, therefore, that there was not an unreasonable delay in diagnosing Mr A's cancer. I do not uphold this aspect of the complaint.

(b) During Mr A's admission to the Hospital in November and December 2004, he was not provided with adequate treatment; in particular, there was a delay before any attempt was made to arrange a stent and radiotherapy

24. Mr A was admitted to the Hospital on 14 November 2004. A repeat endoscopy on 19 November 2004 showed compression of the oesophagus and the CT scan indicated a large mass was causing this compression, which was considered likely to be a tumour. He was referred to the respiratory team on 22 November 2004, who carried out a bronchoscopy on 25 November 2004 to establish whether or not the large mass was a lung tumour. A second bronchoscopy was scheduled for 29 November 2004, however, this was cancelled and the procedure performed on 1 December 2004. (I discuss these procedures in the next section of my report.)

25. A multi-disciplinary team eventually discussed findings and possible treatment for Mr A on 10 December 2004.

26. An internal letter from the consultant surgeon (Consultant 2) in relation to Mrs C's complaint referred to Mr A's CT scan of 17 November 2004 as indicating 'a large mass within this patient's chest which clearly appeared malignant'. I asked the Board why, in that case, there was not an earlier request for an oncology opinion. In their response the Board said 'although the CT scan indicated bronchial carcinoma, any form of palliative chemotherapy or radiotherapy requires a laboratory diagnosis'.

27. On his admission to the Hospital, Mr A had been ill for some time and had lost weight, as he had difficulty in eating properly. Mrs C said that the endoscopy nurse told her on 19 November 2004 that her father had a tumour and that a stent might help her father start eating again. After further continued clinical assessment and a multi-disciplinary team meeting on 10 December 2004, the question of a stent was specifically discussed and decided to be necessary. An attempt to insert a stent was made on 15 December 2004 but this was unsuccessful and Mr A continued to experience problems in eating.

28. Mr A's condition was deteriorating and was further complicated when he developed pneumonia. The Adviser has said that, by that stage, the prospects of him receiving any benefit from radiotherapy were negligible. The Adviser has, however, also pointed out that although it is possible that earlier treatment

could have been helpful, given Mr A's rapidly deteriorating condition any benefit would inevitably have been very short term and would not have changed the eventual outcome.

(b) Conclusion

29. Mr A had serious and incurable cancer and the only real option was to treat the symptoms. Sadly, the outcome of his illness was never in doubt but the Adviser has said that his clinical management during his final weeks could have been better, pointing out delays in arranging a stent and radiotherapy.

30. Management of patients in such circumstances is normally decided as the result of discussions by the multi-disciplinary team involved in the patient's care. In Mr A's case, he was admitted to hospital on 14 November 2004 but the multi-disciplinary team did not discuss his care until 10 December 2004. A much earlier meeting of this team should have taken place to consider investigation and treatment options, including the need for a stent. The Adviser has also suggested that an earlier request for oncology opinion should have been sought.

31. The lack of a definitive diagnosis should not have precluded obtaining the opinion of the oncologist or discussing Mr A's case at an earlier multi-disciplinary team meeting. The Adviser has said that, based on the seriousness of Mr A's illness and the clinical information already held, decisions on Mr A's management could have been considered in advance of full clinical diagnosis.

32. I uphold this aspect of the complaint.

(b) Recommendation

33. The Ombudsman recommends that, reflecting on this case:

(i) the Board review their guidelines to ensure that, in cases similar to this one, staff understand the need for the appropriate multi-disciplinary team to meet at the earliest possible opportunity to discuss all options for investigation, treatment or non treatment;

(ii) options are discussed in detail with patients and/or with their family in such circumstances;

(iii) the Board review the circumstances in which it may be appropriate to provide palliative treatment prior to firm diagnosis, and that they include their findings in revised clinical guidelines for staff. The Ombudsman asks

that the Board inform her of the outcome of this review and the actions taken.

(c) Mr A had an unnecessary second bronchoscopy

34. An initial bronchoscopy procedure was carried out on 25 November 2004. It was then decided, however, that a transbronchial needle aspiration (second bronchoscopy) should also be carried out. Mrs C was concerned that this second procedure was unnecessary. She told me that she believed that it caused her father further suffering and led to the development of pneumonia.

35. The procedure was scheduled for 29 November 2004 but was actually performed on 1 December 2004. The reason that the second bronchoscopy was not completed at the time of the original bronchoscopy is not recorded in Mr A's medical notes. There are no entries there to indicate whether Mr A was assessed the day before or the day of this procedure and so his fitness to have the second bronchoscopy cannot be assessed.

36. The Adviser has said that the decision to perform a second bronchoscopy was, in principle, reasonable as it provides the best means of obtaining cells from the mass identified by the CT scan. In principle, it is also reasonable to pursue confirmation of a diagnosis of cancer because this is helpful in planning treatment. He did, however, express concern about whether or not it was reasonable in the particular circumstances of Mr A's case.

37. I asked the Board to clarify why, in the case of Mr A, the second bronchoscopy was performed and was told 'tissue diagnosis required before further treatment could be considered'. I considered this response to be inadequate and that a fuller explanation than this was required. The Adviser confirmed that obtaining tissue diagnosis wherever possible will help to plan treatment but also pointed out that there are clinical situations where decisions on treatment may need to be taken without full information being available.

38. For example, it would not be good practice to withhold treatment in clinical situations where getting further information would be very difficult to obtain. This situation may occur when a suspected cancer is not easily accessible for biopsy or where the patient is simply too unwell to undergo further investigation. There may also be situations where the patient is so seriously ill that only palliative treatment is possible and specific cancer therapy would not be appropriate.

39. Mrs C told me that she was concerned that the second bronchoscopy caused her father to suffer from pneumonia. Mr A was, of course, very vulnerable due to his Chronic Obstructive Pulmonary Disease, the aspiration from the oesophagus into his lungs and his degree of illness. He could have developed pneumonia at any time.

40. The Adviser has told me that the second bronchoscopy and the accompanying sedation, while not directly causing Mr A's pneumonia, were likely to have contributed materially to its development. This point is acknowledged by the Board in a letter dated 20 September 2005 to Mrs C in which they state, 'Unfortunately, given your father's underlying condition, there was always a risk of this [pneumonia] developing following a procedure under sedation'.

(c) Conclusion

41. I am concerned, and the Adviser has also expressed concern, that this procedure was followed in such a frail patient, in whom the diagnosis of cancer was obvious. While I acknowledge that there was no confirmation of the diagnosis at that point, it is difficult to envisage any finding from a transbronchial biopsy that could have altered Mr A's treatment at such a late stage in his illness. As the Adviser has said (see paragraphs 38 and 39) decisions about Mr A's management at this stage could have been considered without the need for confirmation of cancer.

42. I consider that, on the balance of probabilities, the second bronchoscopy performed on 2 December 2004 did cause Mr A further suffering, was likely to have contributed to the development of his pneumonia and was unnecessary at such a late stage in his illness. I, therefore, uphold this aspect of the complaint.

(c) Recommendation

43. The recommendations made in paragraph 33(i) and 33(ii) apply here also.

(d) There were undue delays in the handling of the complaint by the Board

44. Mrs C wrote to the Board on 24 February 2005 to complain about her father's treatment.

45. The NHS complaints procedure requires the Board to respond to

complaints within three days, to:

- advise what action will be taken to look into the complaint;
- offer the chance to talk to a member of staff about the complaint;
- give information about independent advice and support; and
- provide information about conciliation.

46. It also requires that a full response is normally sent within 20 working days of the Board receiving the original complaint.

47. One of the Board's Patient Liaison Managers (PLM 1) acknowledged receipt on 2 March 2005, saying she aimed to reply within a month. Unfortunately, Mrs C did not receive this letter. On the same day PLM 1 wrote to the Service Managers of the Respiratory Directorate, the Cardiology Directorate and the Digestive Diseases Surgical Division for their input on the issues raised. She asked for a reply by 16 March 2005. From the papers I have seen, she did not receive a reply from any area by that date. It is, however, clear that responses were in preparation in various areas by the end of March 2005.

48. As Mrs C received no acknowledgement or response to her complaint, she wrote again on 31 March 2005 requesting an acknowledgement and asked to be kept informed of progress. On 13 April 2005 she wrote to the Hospital Manager saying PLM 1 had not acknowledged or responded to her letters (she copied this letter to a number of other people, including two MSPs). On 18 April 2005 her letter was acknowledged and she was advised that enquiries would be made into the delay in acknowledging her initial complaint and in responding to the matter. On 21 April 2005 PLM 1 telephoned Mrs C and wrote later that day apologising for the delay in responding in detail. She explained that she still did not have all the information she needed and hoped to write again within two weeks. She provided a copy of her original acknowledgement letter.

49. On 21 April 2005 another Patient Liaison Manager (PLM 2) wrote directly to Consultant 2, who was involved in Mr A's care, asking for a full medical report. She asked for a response by 29 April 2005, pointing out that a reply to Mrs C was very overdue. Consultant 2 replied in a letter dated 29 April 2005.

50. On 23 May 2005, some four weeks after PLM 1 spoke to Mrs C, the Board responded to Mrs C's complaint. In responding, the Board apologised for the delay in replying but did not explain why it had happened.

51. Mrs C was not happy with the response provided by the Board and, between June 2005 and August 2005, she exchanged correspondence with the Board, culminating in her complaint to the Ombudsman.

(d) Conclusion

52. The Board received Mrs C's letter of complaint on 2 March 2005 and sent an acknowledgement the same day. It is unfortunate that Mrs C did not receive this but I am satisfied that her complaint was acknowledged and that PLM 1 took appropriate steps to obtain the relevant information at that time.

53. The Board set an internal deadline for information relating to the complaint to be received by 16 March 2005. This was a reasonable deadline and, if the required information had been received, there would have been sufficient time to prepare a response to Mrs C's complaint within 20 working days of the Board receiving it, as required by the NHS complaints process.

54. Unfortunately, the required information was not received in time, for example, information requested from Consultant 2 on 2 March 2005 was not provided to PLM 1 until 29 April 2005. Further internal delays in progressing the complaint in relevant departments meant that a promised response within two weeks of 21 April 2005 was not met and a full response to Mrs C's complaint was not issued until 23 May 2005, around 59 working days after the complaint had been received.

55. Mrs C asked to be kept updated of progress of the investigation, however, the Board failed to provide her with the required updates. The Board also failed to meet their own internal target for responding to the complaint and failed to meet commitments given to respond during the course of investigating the complaint. This was a complaint relating to the death of Mrs C's father and those involved in providing the information should have recognised that delay in doing so was particularly likely to cause further distress. I uphold this aspect of the complaint.

(d) Recommendation

56. The Ombudsman recommends that the Board review their methods of obtaining information from internal sources with a view to ensuring that there are no resultant avoidable delays in responding to complaints.

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

21 November 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
Mr A	The complainant's late father
The Hospital	Gartnavel General Hospital
The Adviser	The Ombudsman's clinical adviser
GP	General Practitioner
CT Scan	Computed tomography scan
Consultant 1	A respiratory consultant at the Hospital
Consultant 2	A consultant surgeon at the Hospital
PLM 1	A Patient Liaison Manager for the Board
PLM 2	A Patient Liaison Manager for the Board

Annex 2

Glossary of terms

Bronchoscopy	Examination to inspect the interior of the tracheo-bronchial tree
Chronic Obstructive Pulmonary Disease	A disease of chronic diffuse irreversible airflow obstruction
CT scan	Computed tomography scan - radiographic technique that uses a computer to assimilate multiple x-ray images into a 2-dimensional cross-sectional image