Scottish Parliament Region: North East Scotland

Cases 200502065 & 200502179: Tayside NHS Board and A Medical Practice, Tayside NHS Board

Summary of Investigation

Category

Health: Hospitals; oncology\clinical treatment; diagnosis
Health: FHS; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns about the treatment her late husband (Mr C) received from his General Practitioner (GP 2) and at Ninewells Hospital, Dundee (the Hospital). Mrs C complained this led to an unreasonable delay in diagnosing that Mr C was suffering from colon cancer, which later spread to his liver.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was delay by GP 2 in referring Mr C to the Hospital in January 2004 (*not upheld*);
(b) there was delay by the Hospital in diagnosing Mr C's cancer (*upheld*); and
(c) there was delay by the Hospital in obtaining the results of a CT scan (*upheld*).

Redress and recommendations

The Ombudsman recommends that Tayside NHS Board (the Board):

(i) issue Mrs C with a full formal apology for the failures identified in part (b) of the complaint and for the distress that this caused. The apology should be in accordance with the Ombudsman's guidance note on 'apology' (which sets out what is meant and what is required for a meaningful apology);
(ii) review their procedures for the reporting of CT scan results, particularly where more than one hospital is involved, to ensure that delay in reporting such results, such as occurred with Mr C, does not recur; and
(iii) issue Mrs C with a full formal apology for the failures identified in part (c) of the complaint and for the distress and anxiety that this caused. The apology should be in accordance with the Ombudsman's guidance note on

'apology' (which sets out what is meant and what is required for a meaningful apology).

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

Main Investigation Report

Introduction

1. The complainant (Mrs C)'s husband (Mr C) wrote to a doctor (GP 1) in his general practice (the Practice) in March 2005 and to Ninewells Hospital, Dundee (the Hospital) in April 2005 with his concerns about delay in diagnosing that he was suffering from colon cancer, which had spread to his liver. Mr C said that he was now terminally ill and considered the cancer should have been diagnosed earlier. Mr C died on 14 October 2005.

2. On 28 October 2005, Mrs C brought a complaint to the Ombudsman's office. Mrs C complained that there was unreasonable delay by a doctor (GP 2) from the Practice and by the Hospital in diagnosing that Mr C was suffering from cancer. She considered that if Mr C's cancer has been diagnosed earlier then his life may have been prolonged.

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

(a) there was delay by GP 2 in referring Mr C to the Hospital in January 2004;
(b) there was delay by the Hospital in diagnosing Mr C's cancer; and
(c) there was delay by the Hospital in obtaining the results of a CT scan.

Investigation

4. The investigation of this complaint involved obtaining all the background documentation relating to the complaint and Mr C's medical records. Advice was also obtained from three clinical advisers to the Ombudsman (Adviser 1, Adviser 2 and Adviser 3). During the course of the investigation, additional written enquiries of Tayside NHS Board (the Board) were also made by this office. The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

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, the Practice and the Board were given an opportunity to comment on a draft of this report.

(a) There was delay by GP 2 in referring Mr C to the Hospital in January 2004

6. On 2 March 2005 Mr C wrote to GP 1 concerning delays, starting in January 2000, in diagnosing his cancer. He said that he understood that if the cancer had been diagnosed earlier it need not have spread to his liver.

7. GP 1 replied to Mr C on 7 March 2005. In his response, GP 1 informed Mr C that he had a barium enema and gastroscopy in 2000. The barium enema showed diverticulosis and the gastroscopy showed mild gastritis and a polyp in the duodenum. He said that in his opinion these results did not have any bearing on recent developments.

8. GP 1 also told Mr C that in January 2004 GP 2 had referred him urgently for a surgical opinion to the Hospital and enclosed a copy of the referral letter. He was seen at the Hospital's Surgical Clinic on 4 May 2004 and a sigmoidoscopy and barium enema were requested. The sigmoidoscopy only showed haemorrhoids. The barium enema showed a filling defect in the wall of the right side of the large bowel which was considered to be suspicious. A colonoscopy was performed on 25 August 2004 which again was suspicious but the biopsies were inconclusive at that time and there was no mention of spread to other organs. GP 1 also stated that in October 2004 Mr C was seen by a Consultant Surgeon in Surgery and Oncology (Consultant 1) at the Hospital who recommended an operation. GP 1 concluded that he hoped his letter clarified the sequence of events for Mr C but he would be happy to discuss matters further with him if he wished.

9. Mr C's medical records were reviewed by Advisers 1, 2 and 3 on this part of the complaint.

10. Adviser 1 said that:

11. From a GP perspective, Mr C was treated appropriately in 2000/01 when he was diagnosed with severe diverticulitis following an appropriate referral from the Practice to the Hospital.

12. In January 2004 when Mr C next informed GP 2 of abdominal problems, he was referred to the Hospital immediately. The GP records have an entry for the referral dated 29 January 2004 which is marked as an 'urgent' referral to the general surgeons. In Adviser 1's view the referral of Mr C was arranged

appropriately in 2000 and also in 2004 when, with the increasing pain and a strong family history of cancer of the bowel, the referral letter was marked as 'urgent'. Accordingly, the care of Mr C by GP 2 was both reasonable and appropriate.

13. Adviser 2 said:

14. Following Mr C's attendance with GP 2 in January 2004 with colonic symptoms, he was immediately referred for investigation to the Hospital. Having reviewed the referral letter, he was of the view that this indicated a clear 'urgent' referral by GP 2.

15. Adviser 3 said that:

16. He had carefully reviewed Mr C's GP records. In particular, he had considered the period from 2000, when Mr C had first been referred to the Hospital, to January 2004 when Mr C was again referred to the Hospital. During this period, he can find no reference to any consultation, laboratory result or correspondence pertaining or possibly pertaining to Mr C having cancer of the colon in that time period.

17. He also reviewed the referral letter from GP 2 to the Hospital in January 2004 which is marked 'urgent'. In his opinion, in view of Mr C's presenting symptoms and the family history of bowel cancer, the urgent referral by GP 2 was appropriate and reasonable.

(a) Conclusion

18. I have taken account of the advice I have received from Adviser 1, Adviser 2 and Adviser 3. Adviser 1, Adviser 2 and Adviser 3 are of the view that the referral of Mr C to the Hospital was arranged entirely appropriately. I accept their advice and conclude, therefore, there was no delay by GP 2 in referring Mr C to the Hospital. I do not uphold this part of the complaint.

(*a) Recommendation*

19. The Ombudsman has no recommendation to make on this part of the complaint.

(b) There was delay by the Hospital in diagnosing Mr C's cancer

20. Mr C wrote to the Hospital in April 2005. In his letter he raised concerns about delays in diagnosing that he had cancer of the colon which had spread to his liver. He said this had led to him now being terminally ill.

21. Mr C said that he was first referred to the Hospital in October 1999 with rectal bleeding. Investigations in November 1999 led to an endoscopy investigation in January 2000 which revealed a polyp in the duodenum. During 2000 he had had several consultations at the Hospital including x-rays in April 2000 and a barium meal in November 2000.

22. In December 2003, during a holiday in New Zealand, he underwent blood tests as a hospital out-patient and was advised to see a doctor on his return home. In January 2004, he consulted GP 2 who referred him to the Hospital. (See paragraphs 6 to 8 above). In May 2004 he had a consultation with Consultant 1. Blood tests at that time suggested 'something wrong but nothing to worry about'.

23. In August 2004, an endoscopy followed by a colonoscopy revealed cancer in the colon and he was told he would need a small operation. A CT scan in October 2004 showed that the cancer had spread to his liver and was terminal and led to his operation being cancelled at the last minute. He felt that the cancer should have been detected earlier before his condition was terminal.

24. The Board replied to Mr C's complaint in June 2005. They informed Mr C that the investigation undertaken in 2000 revealed that he had diverticular disease with no evidence of anything more serious at that time.

25. The Board told Mr C that they had asked Consultant 1 to comment on his complaint. Consultant 1 stated that he saw Mr C for the first time at his out-patient's clinic on 4 May 2004. He said that Mr C had features suggesting that he should have colonic investigation and he submitted the appropriate requests. A barium enema was undertaken on 29 June 2004 and he received the report on 23 July 2004 when he returned from leave. The report stated that there was a filling defect in the wall of the right side of the large bowel which was considered to be suspicious. He considered that they were not in a position to make a definitive decision on Mr C's management based solely on the barium enema and he felt it was reasonable to arrange a colonoscopy to confirm his situation.

26. Consultant 1 stated that he requested an urgent colonoscopy to clarify the situation, which was carried out on 25 August 2004. He has also said that this timescale was not that for a non-urgent referral at that time.

27. The colonoscopy confirmed the presence of a lesion which was probably malignant and several biopsies were taken. The cover page of the report said 'malignant colonic tumour'. The biopsy reports were issued on 27 August 2004. The biopsy report said '… the biopsies themselves are not diagnostic. However, given the endoscopic picture, the lesions should be treated as malignant and removed'.

28. It was established that the waiting list of a Consultant Surgeon in Surgery and Oncology at Perth Royal Infirmary (Consultant 2) was shorter than his own. Therefore, Consultant 2 agreed to take over surgical management of Mr C.

29. Consultant 1 acknowledged that there were delays in obtaining the necessary investigations but he did not believe that this ultimately made any difference to Mr C's prognosis.

30. The Board, in a written enquiry from the Ombudsman's office, were asked who had triaged the referral from GP 2 to the Hospital in January 2004 and why the referral had been triaged as 'soon' rather than 'urgent'. The Board, in their response, stated that they were unable to provide the name or designation of the member of staff who triaged Mr C's referral from GP 2 from 'urgent' to 'soon' as a signature has not been provided on the triage documentation. In addition, there was no documentation relating to the reason why Mr C's referral was triaged as 'soon' rather than 'urgent'. Consultant 1 has also said that he was not involved in the decision.

31. The Board also stated that at the time of Mr C's referral to the Hospital's Surgical Department there was no 'fast track' procedure in place to deal with referrals of suspected cancer patients. A fast track procedure was implemented within the Surgical Department in Spring 2004. Following the implementation of this procedure the Hospital's Medical Director initiated a new procedure whereby clinicians are required to complete a form if they are downgrading any patient referrals. A copy of this form has been supplied to me.

32. Mr C's medical records and the Board's response to the written enquiry made by this office on this part of the complaint were reviewed by Advisers 2 and 3.

33. Adviser 2 has given his views of the treatment Mr C received, and these are summarised in paragraphs 34 to 40 below:

34. The initial referral and investigations of Mr C's bowel symptoms from August 2000 were entirely appropriate. A diagnosis of diverticular disease of the colon was made. However, in view of Mrs C's concerns that there was a delay in diagnosing Mr C's cancer, he considered it reasonable to explore whether Mr C's cancer may have been present in 2000. Colon cancers of the type that Mr C had usually arise from a pre-existing polyp. He also wished to check whether the appropriate area of Mr C's colon, the ascending colon, had been adequately examined.

35. He, therefore, carefully reviewed the barium enema performed on Mr C in November 2000. He could see no evidence to suggest the presence of a pre-existing polyp or carcinoma in the ascending colon at that time. In his view, it is likely that Mr C's colonic symptoms in 2000 were unrelated to his subsequent cancer in 2004.

36. Mr C was immediately referred by GP 2 for urgent surgical opinion by letter within 24 hours of his appointment in January 2004. However, the referral was downgraded from 'urgent' to 'soon' by the Hospital. In Adviser 2's opinion, despite there being no identifying signature on the referral identifying the staff member who downgraded Mr C's referral, Consultant 1 should have been aware of the system by which patients who had been referred to him were normally triaged.

37. Further, as there was no requirement for the fast track management of suspected cancer patients at the time, this placed responsibility for appropriate management on the individual consultant and increased the importance of an appropriate triage system for referrals.

38. There was then a delay of three months before Mr C was seen by Consultant 1 on 4 May 2004. A barium enema, requested at that clinic attendance, was performed on 29 June 2004, and the report on the enema was acted upon on 23 July 2004, a further three weeks later. The barium enema

was highly suggestive of a malignancy and necessitated biopsies for microscopic examination at a colonoscopy which was performed on 25 August 2004, a further delay of one month. These investigations confirmed cancer of the ascending colon, the first part of the large intestine.

39. Having confirmed a diagnosis of cancer, Mr C was referred, after a further month, on 23 September 2004, to Consultant 2 for his surgical treatment since his waiting list was shorter than that of Consultant 1. It was, therefore, reasonable to proceed to surgery as expeditiously as possible. A CT scan, a more detailed scan of the liver, was then carried out on 22 October 2004. This unfortunately showed extensive spread of the cancer.

40. In Adviser 2's opinion, the diagnosis of Mr C's cancer was delayed.

(b) Conclusion

41. There were clearly system failures in the management of Mr C's care by the Hospital, including a lack of appropriate triaging of referrals, delays while Consultant 1 was on leave, and the timescales for arranging investigations. These all caused delays. Adviser 2 has told me he considers these delays were not acceptable. I also asked him whether the delay adversely affected Mr C's prognosis. He said that if the investigations process had been speeded up by the Hospital this may have altered Mr C's prognosis for the better but he cannot say for certain. Taking into account the failures I have identified and the advice I have received, I uphold this complaint.

42. The Board have informed me that subsequent to Mr C's referral to the Hospital, a fast track procedure to deal with referrals of suspected cancer patients was implemented within the Hospital's Surgical Department in Spring 2004. Following the implementation of this procedure, the Hospital's Medical Director initiated a new procedure whereby clinicians are required to complete a form if they are downgrading any patient referrals.

43. I have reviewed a copy of this form. It is clearly headed 'Downgrading Of Referral Letter Priority From Urgent to Soon/Routine'. Information to be inserted in the form includes the 'clinical reasons for downgrading', the name, signature and designation of the person completing the form. There is a note on the form that it must be attached to the referral letter and returned to the Medical Records Department, with a copy being sent to the Referring Clinician.

44. I understand that since then the system for patients with suspected lower bowel disease has been further revised. There is now a system where a patient's GP refers the patient straight into the system having done some investigations and tests using a special form. The referral is reviewed by a consultant who organises investigation(s) and decides which consultant it is most appropriate for the patient to see.

45. While I acknowledge the action taken by the Hospital to fast track referrals of patients who have been referred to the Hospital with suspected cancer, it is very regrettable, and I anticipate a cause of distress to Mrs C, that such a system was not in place when Mr C was referred to the Hospital in January 2004.

(b) Recommendation

46. The specific recommendation that the Ombudsman is making, resulting from the investigation of this part of the complaint, is that the Board should issue Mrs C with a full formal apology for the failures identified in this part of the complaint and for the distress that this has caused. The apology should be in accordance with the Ombudsman's guidance note on 'apology' (which sets out what is meant and what is required for a meaningful apology).

(c) There was delay by the Hospital in obtaining the results of a CT scan

47. Mr C, in his letter to the Board in April 2005, also complained that there was delay by the Hospital in obtaining the results of a CT scan in October 2004. This meant that he was not told the results of the scan until he was in the operating anaesthetic room which led to his operation being cancelled at the last minute (paragraph 20 to 23 above refers). Following receipt of Mr C's letter, the Board asked Consultant 2 to comment on the letter. Consultant 2 stated that the CT scan was performed several days before Mr C's admission for surgery. However, the report was not available until the day of his surgery. Consultant 2 considered it 'unsatisfactory' that Mr C was in the operating anaesthetic room before the findings of the scan were known and caused his operation to be aborted. In Consultant 2's view, if Mr C's CT scan results had not been so bad and his operation had been cancelled then a valuable operating slot would have been lost and Mr C would have had to wait several weeks longer for treatment.

48. The Board, in response to a written enquiry from this office, stated that the CT scan was performed on 22 October 2004 and was verified the following day

by a registrar. As per normal practice within the Hospital's Department of Radiology, the CT scan was verified by a Consultant Radiologist on 28 October 2004 and was then posted on the Central Vision computerized results system on that day, which was the same day that Mr C's surgery was scheduled.

49. Mr C was due to be operated on at another hospital, Perth Royal Infirmary. The CT scan showed the presence of metastases (secondary cancer) in the liver but the CT scan results were not available until the day of Mr C's scheduled surgery.

50. Mr C's medical records and the Board's response to the written enquiry made by this office on this part of the complaint were reviewed by Adviser 2.

51. Adviser 2 stated that:

52. Mr C's CT scan was performed on 22 October 2004 and verified by a registrar, whom he presumes was a radiological registrar, on 23 October 2004. However, the registrar's provisional view of the CT scan was not assessed by the Consultant Radiologist until 28 October 2004, the day of Mr C's proposed surgery. He fully understood both Mr C and Mrs C's distress at the cancellation of surgery at such a late stage. However, while it was difficult to criticise the delay in assessing the CT scan given the difficulties that many radiology departments have to cope with, he found it surprising that the registrar who viewed the scan results on Saturday, 23 October 2004 did not draw them to the attention of a consultant radiologist on the following Monday. In his view, the system of reporting the CT scan results between the Hospital and Perth Royal Infirmary was, under the circumstances, rather slow.

(c) Conclusion

53. I have carefully considered the evidence and the advice which has been provided by the Ombudsman's Adviser, which I accept. In doing so, I have concluded that there was undue delay in the reporting of Mr C's CT scan results which resulted in his surgery being cancelled at such a late stage. I consider that must have been a devastating experience for Mr C and would have caused both him and Mrs C great anxiety and distress at a very difficult time. Accordingly, I uphold this part of the complaint.

(c) Recommendations

54. The specific recommendations that the Ombudsman is making, resulting from the investigation of this part of the complaint, are that the Board should:

(i) review their procedures for the reporting of CT scan results, particularly where more than one hospital is involved, to ensure that delay in reporting such results, such as occurred with Mr C, does not recur; and

(ii) issue Mrs C with a full formal apology for the failures identified in this part of the complaint and for the distress and anxiety that this caused. The apology should be in accordance with the Ombudsman's guidance note on 'apology' (which sets out what is meant and what is required for a meaningful apology).

55. 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.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's husband, and the subject of the complaint
The Practice	Mr C's general medical practice
GP 2	The doctor in Mr C's General Practice who referred him to the Hospital in January 2004
The Hospital	Ninewells Hospital, Dundee
GP 1	The doctor in Mr C's General Practice to whom he wrote on 2 March 2005 concerning delays in diagnosing his cancer
Adviser 1, Adviser 2 and Adviser 3	The Ombudsman's professional clinical advisers
The Board	Tayside NHS Board
Consultant 1	A Consultant Surgeon in Surgery and Oncology at the Hospital
Consultant 2	A Consultant Surgeon in Surgery and Oncology at Perth Royal Infirmary

Annex 2

Glossary of terms

Barium enema	An x-ray of the large bowel
Biopsy	The removal of tiny samples of tissue through a video/fibre-optic instrument introduced through the rectum
Colonoscopy	A procedure which looks at the whole of the inside of the large bowel
Diverticular disease	A condition in which the inner, lining layer of the large intestine (colon) bulges out (herniates) through the outer, muscular layer
Polyp	A benign growth of the layer of cells that line the colon.
Sigmoidoscopy	A procedure which looks inside the rectum and lower part of the large bowel