Scottish Parliament Region: Mid Scotland and Fife

Case 201101474: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; General Medical; clinical treatment; diagnosis

Overview

The complainant, Mrs C raised a number of concerns about the way in which her husband (Mr C) was cared for and treated while he was a patient in Queen Margaret Hospital, Dunfermline.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a lack of urgency and avoidable delays in investigating Mr C's condition and providing him with a definitive diagnosis (*upheld*);

(b) there were avoidable delays in chasing up test results from Royal Infirmary Edinburgh following Mr C's mediastinoscopy on 15 March 2010 (*upheld*);

(c) there was unnecessary delay in referring Mr C to the Western General Hospital (*not upheld*);

(d) it was unnecessary and inappropriate to move Mr C so often (*upheld*); and

(e) staff attitude was unreasonable (*not upheld*).

Redress and recommendations

The Ombudsman recommends that Fife NHS Board (the Board):	*Completion date*
(i) apologise to Mrs C for their delays in this matter;	20 April 2012
(ii) arrange for the Urology MDT cancer network to review this case and act upon any recommendations made;	21 May 2012
(iii) look at their monitoring and follow-up procedures with a view to making them more robust;	20 April 2012
(iv) formally apologise to Mrs C for moving Mr C 13/14 June 2010; and	20 April 2012
(v) consider their own bed transfer policy and practice with regard to the findings of this part of the	20 April 2012

complaint and to ensure that they are appropriate.

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) was first referred by his GP to Queen Margaret Hospital (the Hospital) in April 2009. At that time his symptoms were a cough of three months standing, shortness of breath and splenomegaly (enlargement of the spleen). Although Mr C had an operation to remove his left kidney in July 2009 as a large tumour was found, it was not until a year later that he was also determined to have metastatic renal cancer with pulmonary lymphangitis.

2. Mrs C was aggrieved at the length of time it took for her husband to receive a diagnosis. She said there was a lack of urgency and avoidable delays. She was of the view that it took too long to refer him to the Western General Hospital in Edinburgh. She also alleged that whist he was a patient in the Hospital, Mr C was moved at inappropriate times (midnight on 13/14 June 2010) and at 11:00 on the day he died. She said that, generally, the attitude of staff concerned with his care was unreasonable.

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

(a) there was a lack of urgency and avoidable delays in investigating Mr C's condition and providing him with a definitive diagnosis;
(b) there were avoidable delays in chasing up test results from Royal Infirmary Edinburgh following Mr C's mediastinoscopy on 15 March 2010;
(c) there was unnecessary delay in referring Mr C to the Western General Hospital;
(d) it was unnecessary and inappropriate to move Mr C so often; and
(e) staff attitude was unreasonable.

Investigation

4. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mrs C and the Board. My complaints reviewer has had sight of the Board's complaint's file and the relevant clinical and nursing records. She also obtained independent advice from a specialist nurse and from a specialist physician and this has been referred to.

5. While this report does not include every detail investigated, 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.

(a) There was a lack of urgency and avoidable delays in investigating Mr C's condition and providing him with a definitive diagnosis and (b) There were avoidable delays in chasing up test results from Royal Infirmary Edinburgh following Mr C's mediastinoscopy on 15 March 2010

6. Mrs C said that in November 2008 Mr C started to cough and as it did not get any better, he went to see his GP on 13 April 2009. His symptoms were a cough, shortness of breath and splenomegaly. His GP prescribed medication but said that if his condition did not improve arrangements would be made for Mr C to have an x-ray. Mr C was x-rayed in May 2009, followed by a CT (Computerised Tomography) scan on 26 May 2009 which, Mrs C said, highlighted a kidney problem. Mr C was subsequently referred to Urology where he was informed that he had a large cancerous tumour in his left kidney which required to be removed. A date for his operation was set for 7 July 2009.

7. Meanwhile, Mrs C said that Mr C continued to have a cough and problems with breathlessness and on 28 May 2009 was referred to a Consultant in Respiratory Medicine (Doctor 1) whose view was that it would be better to wait until after Mr C's kidney surgery before determining further action. A further appointment was made with him on 4 August 2009. By the time of this meeting Mrs C said that Mr C was coughing less but still recovering from his operation, and Doctor 1 thought it would be too soon to form an assessment and, therefore, arranged to meet Mr C again in November 2009.

8. In the interim, after his operation, Mr C had been back to Urology and had a further scan. He was told that everything looked good and that he required no further treatment. Mrs C said this information was confirmed at a later Urology appointment on 27 November 2009 and a follow-up appointment was made for three months time.

9. Mr C saw Doctor 1 in November as arranged (see paragraph 7) and at that point Mrs C said that he did not think there had been much change in his condition. A further appointment was made for December 2009 but, because of holidays, this was later rescheduled for January 2010. When Mr C met with Doctor 1 again, he recommended that Mr C have a bronchoscopy (a technique for visualising the inside of the airways for diagnostic/therapeutic purposes).

This was carried out on 11 February 2010, but the results were inconclusive. The following month (on 15 March 2010), Doctor 1 arranged for Mr C to have a mediastinoscopy (a type of key-hole surgery that allows doctors to look inside the chest and can also be used to take samples for further testing) at the Royal Infirmary Edinburgh. Mrs C said that after five weeks as she had not received the results, she contacted Doctor 1's secretary who confirmed that nothing had been heard back. Mrs C said that although she asked, the secretary refused to chase up the results so Mrs C telephoned herself to obtain them. She advised that it took six telephone calls before the results were faxed to the Hospital.

10. Mr C saw Doctor 1 on 26 April 2010 who told him that the results of the mediastinoscopy were inconclusive. He suggested that a PET (Positron Emission Tomography) scan be carried out. (Such scans are used to produce a detailed three dimensional picture of the inside of the body. They are commonly used to help in the diagnosis of a range of different cancers and to determine the best ways of treating them.)

11. Mrs C said that in May 2010, Mr C received a letter from Urology saying that his case had been discussed at a MDT (Multi-Disciplinary Team) meeting on 28 April 2010 and it had been confirmed that while it was not exactly clear what was happening in his chest, a recent CT scan showed that, '… everything inside your abdomen is looking absolutely fine'. The letter confirmed that Doctor 1 had started Mr C on steroids and was arranging a PET scan. The Urologist said that it would be important to wait to see what the PET scan highlighted and how Mr C responded to steroids before planning anything further. Mrs C wrote in response to this letter expressing concern that it had not yet been possible to diagnose Mr C and asking the Urologist whether there was anything further that could be done to speed up matters (as a PET scan had still not been arranged) and whether to seek a further opinion. On 21 May 2010, the Urologist replied confirming the difficulties in obtaining a diagnosis for Mr C and adding that '… the patterns expressed by the nodules in [Mr C]'s lungs they are (sic) not indicative of either or renal other causes'.

12. On 10 June 2010, Mr C was admitted to the Hospital and at this stage Mrs C said staff were still unclear why he was still deteriorating. Mrs C said that she was totally frustrated with the lack of progress and put this down to Doctor 1. It was about this time that Mrs C said she was taken aside at visiting time to be asked by a nurse whether pastoral care was available. She told Mrs C that palliative care would be available for Mr C but Mrs C said that at this

time she did not appreciate that any of this would be required as there was still no firm diagnosis. Mr C was discharged home on 25 June 2010.

13. Mr and Mrs C met with Doctor 1 at the Hospital on 12 July 2010 when it was confirmed that Mr C would be passed to the Western General Hospital, Edinburgh for care. His first meeting there was on 20 July, followed by another on 17 August 2010. Mr C was admitted to the Hospital on 27 August 2010 as his condition had worsened and Mrs C said that a chest infection was suspected. He had an x-ray and scan but, sadly, on 28 August 2010, he died.

14. Mrs C complained that there was a general lack of progress and urgency relating to Mr C's care. She said that she was never aware that he was close to death and he had no type of hospice care. Mrs C was aggrieved that she was deprived of precious time together and she would have chosen for him to be at home. She felt that he was treated '… as no more than a parcel'.

15. Mrs C raised a complaint with the Board on 12 October 2010, highlighting what she considered to be Doctor 1's lack of interest in Mr C and on 17 December 2010 a meeting was arranged between Mrs C, the Patient Relations Officer and Doctor 1. Mrs C was accompanied to the meeting by a friend. On 25 February 2010, Mrs C was sent the notes of the meeting and the actions the Board were to take as a result of her concerns. Essentially, Doctor 1 explained that he had had concerns following assessment of Mr C that he was not suffering from sarcoidosis but that the cancer had spread. While he had shared these concerns with Mr C's GP and with Urology, he had not mentioned them to Mr C as he had no unequivocal evidence and he preferred to seek a firm diagnosis. Doctor 1 acknowledged Mrs C's concerns about this but refuted her allegation that he did not care about Mr C.

16. Doctor 1 explained that when he had first seen Mr C his condition was stable, as was his x-ray, and that this, by and large, was not in keeping with a diagnosis of cancer. Doctor 1 said that he was focussed on obtaining confirmation of whether cancer was present or not and this involved a sequence of tests. However, the bronchoscopy achieved less than he had hoped and there was a delay with the mediastinoscopy over which he had no control. Later, he said, that it was the decision of the anaesthetist not to proceed with the PET scan as he considered that Mr C was unfit.

17. On 18 April 2010, the Board's Chief Executive wrote to Mrs C confirming the actions the Board intended to take as a consequence of Mrs C's complaint, however, as she remained unhappy, she decided to pursue the matter with this office and wrote on 19 July 2011.

18. The SPSO formally advised the Board of the complaint on 11 August 2011 and the Board provided copies of their complaints file and Mr C's clinical records. On 11 November 2011, they also provided details of an overview of Mr C's case which had been compiled by the Board's Medical Director.

19. The Medical Director expressed a view that in terms of the renal cancer from which Mr C suffered, the Board made their diagnosis within two weeks. However, he confirmed that a definitive diagnosis for Mr C's chest condition was not achieved until some 416 days after his original referral. He explained that there had been a working diagnosis of sarcoidosis (a disease in which abnormal collections of chronic inflammatory cells form as nodules in multiple organs. The lungs are often affected.) but that in December 2009, serious concerns were raised that this diagnosis was not robust and the need to obtain a tissue diagnosis was recognised. The Medical Director said that, unfortunately, it took three different procedures to achieve a diagnosis (bronchoscopy, mediastinoscopy and an endoscopic ultrasound guided biopsy) on 2 July 2010. He recognised, however, that there were elements of unacceptable delay: the first in getting the results of the mediastinoscopy (see paragraph 9 above). He said that while this procedure was performed on 15 March 2010, the letter informing Doctor 1 of the results was not dictated to him until 15 April 2010 although it was not clear when he received it but the results were discussed with Mr C on 26 April 2010 (see paragraph 10). The Board said that it was arguable who should have taken responsibility for this - Doctor 1 who should have been chasing the result or the team at the Royal Infirmary Edinburgh who should have ensured that the results were provided in a timely manner. Consequently, the Medical Director said that it was his intention to contact both teams involved.

20. The second period of delay the Medical Director identified concerned the PET scan (paragraphs 10 and 11) which Doctor 1 requested be carried out on 28 April 2010 but which it appears never occurred. The Medical Director said that it transpired that the team at the Royal Infirmary Edinburgh vetoed the PET scan but failed to advise Doctor 1 or any staff at the Hospital. In the meantime, Doctor 1 arranged for Mr C to have an endoscopic ultrasound but the Medical

Director thought that this would have happened earlier if he had been told about the vetoing of the PET scan.

21. As part of this investigation, my complaints reviewer obtained advice from a specialist physician on the care and treatment given to Mr C. The specialist physician adviser said that Mr C's case was a very complicated one and that lymphangitic carcinomatosis was uncommon, and rarely associated with renal cell cancer. He added that the stability of the early radiological changes in Mr C's lungs was similarly unusual. However, it was clear to him that before Mr C had his kidney removed in July 2009 both a chest x-ray and a CT scan (carried out in May 2009) showed abnormalities and a differential diagnosis was reported. He said that in his view, at this stage, metastatic lung malignancy should have been confirmed or excluded by confirmatory histology but the clinical notes showed that Radiology were convinced that the lung pathology was related to the renal cancer despite the CT scan report, although Doctor 1 remained unconvinced. The specialist physician adviser added that it was the responsibility of the Urology MDT to accurately stage Mr C's renal cancer (including the investigation and biopsy of the enlarged pulmonary lymph nodes) but the problem in his case represented an incorrect interpretation of the scans and delayed investigations. He said that it seemed to him that Doctor 1 had the sole responsibility for investigating Mr C's lung pathology.

22. The specialist physician adviser said that it was unclear to him why the bronchoscopy was delayed until February 2010, when histology was required to establish the diagnosis of sarcoidosis or malignancy at the earliest opportunity. He said that it was also not clear to him why it had not been carried out in May 2009. The bronchoscopy was then inconclusive, as was the mediastinoscopy carried out in March 2010. He said that it was the responsibility of the doctor at the Royal Infirmary Edinburgh to have told Doctor 1 about the results without delay. Additionally, the PET scan was then vetoed without communication with Doctor 1. It was the specialist physician adviser's view that combined, these delays showed a lack of urgency and a diagnosis should have, and could have been made earlier. However, he added that an earlier diagnosis may not have changed Mr C's prognosis, but it would have certainly allowed Mr and Mrs C the time to have been better prepared.

(a) Conclusion

23. I am satisfied after taking into account the Medical Director's assessment and the specialist advice given to my complaints reviewer that there were

avoidable delays in investigating Mr C's condition and that there was a relative lack of urgency. While not all of these delays rested with the Board (see paragraph 22) I nevertheless uphold this complaint and make the following recommendations;

(a) Recommendations

24. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for their delays in this matter; and	20 April 2012
(ii) arrange for the Urology MDT cancer network to review this case and act upon any recommendations made.	21 May 2012

(b) Conclusion

25. Histological investigations and a bronchoscopy should have been carried out at an earlier date (May 2009). There was a failure to chase up mediastinoscopy results and there was an associated failure on the part of another hospital to deliver them within a reasonable time. This other hospital also vetoed carrying out a PET scan without informing Doctor 1. As a consequence, there was a significant delay in determining a diagnosis for Mr C (until 2 July 2010). I uphold the complaint, nevertheless, I was told that an earlier diagnosis may not have affected the outcome for Mr C but it would have given Mr and Mrs C more time. However, in these circumstances, I make the following recommendations:

(b) Recommendations

26. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for their delays in this matter; and	20 April 2012
(ii) look at their monitoring and follow-up procedures with a view to making them more robust.	20 April 2012

27. Furthermore, as it is clear that the actions of staff at another NHS Board contributed to the delays identified, a copy of this report will also be sent to them for their information and attention.

(c) There was unnecessary delay in referring Mr C to the Western General Hospital

28. Mrs C said Mr C should have been referred to the Western General Hospital in Edinburgh at an earlier date where she thought he would have been better cared for. She believed that if this had happened they might have had more time together.

29. At the meeting on 17 December 2010, Doctor 1 indicated that with the benefit of hindsight he would probably have referred Mr C to the Western General Hospital at an earlier date to have surgery to obtain a biopsy and hence a definitive diagnosis.

30. In connection with this aspect of the complaint the specialist physician adviser explained that the Western General Hospital is the Edinburgh Cancer Centre but that it was not his view that referral there was essential. He said that it would only have been so, if it had been decided that a thoracic surgeon's expertise was required to achieve histology from lung or lymph node biopsy.

(c) Conclusion

31. I have taken very careful account of Mrs C's views on this matter and of what Doctor 1 said with hindsight. I have taken account of the advice I have been given. Nevertheless, I have decided that it does not appear conclusive that surgery was required at an earlier stage because histology and bronchoscopy in May 2009 could have provided a diagnosis for Mr C. This being the case, I do not uphold this aspect of the complaint.

(d) It was unnecessary and inappropriate to move Mr C so often

32. Mr C was admitted to the Hospital on 10 June 2010 as his condition was deteriorating (see paragraph 12) but Mrs C complained that at midnight on 13/14 June he was moved. She said that his possessions were packed up and put on the bed with him. This was followed by his oxygen cylinder which, it was suggested, was to be held between his feet. Mrs C complained that this was totally inappropriate.

33. Similarly, with regard to Mr C's last admission on 27 August 2010, Mrs C said that despite her request not to, on 28 August, the day he died, he was moved at 11:00.

34. As part of this investigation, the Board were advised of the terms of the complaint to give them an opportunity to respond. The information subsequently provided to this office included copies of staff statements. One, from a Senior Nurse confirmed that on his June 2010 admission, Mr C was initially admitted to Ward 8 on 10 June where he stayed until 12 June. It was confirmed that he was moved to Ward 20 at 21:10. It was explained that Ward 8 was an acute medical unit where patients came to be seen and assessed. They then move to a 'downstream' ward to continue their care and treatment. Ideally, the Senior Nurse said it was preferred to do this earlier during the day but at times, as with Mr C's case, beds only became available later in the evening. She said this should have been explained. However, she said, while it was safe to place Mr C's belongings at the bottom of the bed, the oxygen tank should not have been placed between Mr C's legs, particularly as there are holders on the end of beds for this. The Senior Nurse apologised sincerely for the distress this may have caused.

35. With reference to Mr C's transfer on the day he died, the Senior Nurse said that as his condition was worsening (although, in commenting on a draft of this report, Mrs C said she was never told this) and as he was accompanied by his family, it was thought more appropriate to move him to an available side room for privacy.

36. The Medical Director added, as part of his review of Mr C's case, that the Board accepted that it was not ideal to transfer dying patients but that this could be necessary for a number of operational reasons which means that '… this becomes inevitable when considering the best interest of all the patients. We try and avoid doing this wherever possible but unfortunately in this case it was necessary'.

37. My complaints reviewer asked the nursing adviser to confirm the information from Mr C's relevant notes. She said that at 00:15 it was recorded that he arrived in Ward 17 (but see paragraph 33) and that he was upset at being transferred so late but staff apologised and explained that this was due to a bed crisis. It was her view that the oxygen cylinder should not have been placed between Mr C's legs and that he should only have been moved at a late hour for clinical reasons, not because there was a bed crisis. In her opinion this move was unreasonable.

38. Concerning Mr C's move on the day he died, she was less critical and said that moving a terminally ill patient to a side room was established good practice as it allowed privacy for open visiting for relatives to attend.

(d) Conclusion

39. I note what the Board have said in this respect, but the advice that I received was that moving a patient at a very late hour without there being significant clinical reason to do so, was not good practice. I accept that there were good reasons to move Mr C to a side room on the day of his death but, overall, I uphold the complaint.

(d) Recommendations

40. I recommend that the Board:	*Completion date*
(i) formally apologise to Mrs C for moving Mr C on 13/14 June 2010; and	20 April 2012
(ii) consider their own bed transfer policy and practice with regard to the findings of this part of the complaint and to ensure that they are appropriate.	20 April 2012

(e) Staff attitude was unreasonable

41. Mrs C said that in their dealings with Mr C the attitude of staff was poor. She alleged that Doctor 1 had been flippant and offhand and that when Mr C had asked for a sleeping tablet after he was moved on the night of 13/14 June 2010, he was told that it was too late. When he queried being moved at that time, he was told to complain to his MSP.

42. At the meeting the Board arranged on 17 December 2010, Doctor 1 said that it had never been his intention to appear flippant and he apologised if at any time he had been. He said he had been reluctant to mention a possible diagnosis which had not been confirmed. The Medical Director's review of Mr C's case commented that communication was 'always difficult when there is diagnostic uncertainty' and that Doctor 1 had tried to gauge how much information Mr C had wanted.

43. With regard to Mr C's request for a sleeping tablet, the Medical Director expressed himself 'extremely disappointed' if this had been what had happened.

44. Both advisers (nursing and the specialist physician) were asked for comment about this but both told my complaints reviewer that there was no information in the nursing or clinical notes to confirm what had happened.

(e) Conclusion

45. I am aware of Mrs C's great concern about this aspect of the matter and I can fully appreciate that if Mrs C thought that communication with Mr C was unhelpful or inappropriate when he was gravely ill, that this must have aggravated her distress. However, I am only able to make a decision on the basis of the evidence available to me and this does not confirm that either Doctor 1 or any other staff behaved in an inappropriate manner towards Mr C. This being the case, I am unable to uphold this complaint.

46. 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

Mrs C	The complainant
Mr C	The complainant's late husband
The Hospital	Queen Margaret Hospital, Dunfermline
The Board	Fife NHS Board
CT scan	Computerised Tomography scan
Doctor 1	A Consultant in Respiratory and Intensive Care Medicine
PET scan	Positron Emission Tomography scan
MDT	Multi-Disciplinary Team

Annex 2

Glossary of terms

Bronchoscopy	A technique for visualising the inside of the airways for diagnostic/therapeutic purposes
Lymphangitic carcinomatosis	A condition in which cancer cells spread from the original (primary) tumour and invade the lymph vessels. The invaded lymph vessels then fill up with cancer cells and become blocked.
Metastatic	The spread of a disease from one organ to another
Mediastinoscopy	A type of key-hole surgery that allows doctors to look inside the chest. It can also be used to take samples for further testing
Pulmonary lymphangitis	A metastatic lung disease
Sarcoidosis	A disease in which abnormal collections of chronic inflammatory cells form as nodules in multiple organs. The lungs are often affected
Splenomegaly	Enlargement of the spleen