Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Belfast Health & Social Care Trust

NIPSO Reference: 18432

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

I received a complaint from a man (the complainant) about the care and treatment provided to his late mother (the patient) by the Belfast Health & Social Care Trust (the Trust). The man complained that the Trust missed an opportunity to diagnose his mother's cancer on computerised tomography (CT) scans[1] taken in May and August 2016. A CT scan conducted in September 2016 identified widespread metastatic disease, and his mother was seen by palliative care on 4 October 2016. She sadly passed away on 21 October 2016. The man believed that the Trust's failure to diagnose his mother's cancer in the May and August scans resulted in her not receiving timely palliative care. He also believed that the failure resulted in her family missing the opportunity to spend more time with her prior to her passing.

As a result, my investigation of this complaint will focus on the diagnosis and treatment that would have been offered to the man's mother had the abnormal lesion been identified in the May 2016 CT scan. My investigation will also consider when she would have received access to palliative care, and the options that would have been available to her. In addition, I will review the subsequent actions taken by the Trust in relation to the misread scans in May and August 2016.

The man also complained that his mother was discharged from the Mater Hospital in August 2016 with pneumonia and back pain. He believes that the pain his mother was suffering at this time was related to her undiagnosed cancer.

Issues of Complaint

I accepted the following issues of complaint for investigation:

Issue 1: What diagnosis and treatment would have been available if concerns had been noted following a CT scan on 4 May 2016?

[1] A scan which combines a series of x-ray images taken from different angles around the body and uses computer processing to create cross sectional images of the bones, blood vessels and soft tissues inside your body.

Issue 2: Was it reasonable to discharge the patient from the Mater Hospital with pneumonia and back pain in August 2016?

I investigated the complaint and found that as a result of the Trust's failure to identify the metastatic disease in the May 2016 CT scan, the patient had delayed access to palliative care. I consider that she ought to have had access to palliative care in July 2016, as opposed to October 2016.

I am satisfied that this failure in care in treatment caused her to suffer the injustice of distress and loss of opportunity to have more timely access to palliative care services to assist with symptom control.

However, I consider that the complainant is also a person aggrieved. As a result of the Trust's failure to achieve a timely diagnosis, I am satisfied that he suffered the injustice of loss of opportunity to spend more time with his mother prior to her passing.

I recommended that the Trust issues the complainant with an apology in accordance with the NIPSO guidance for the injustice identified in this report within **one month** of the date of my final report.

I also recommended the Trust makes a payment of £450 to the complainant by way of solatium in respect of the injustice I have identified, namely loss of opportunity, **within one month** of the date of my final report.

I note the Trust has undertaken an internal review and recognised the error of misdiagnosis and misinterpretation of the May and August 2016 CT scans. As a result, I note the Trust highlighted the discrepancies to the Radiologist and submitted the case to the LDM meeting at the Mater Hospital for shared learning purposes. On review, I am of the opinion that the Trust has taken appropriate follow up actions to ensure that it minimises such errors in future.

I am pleased to note the Trust accepted my findings and recommendations.

THE COMPLAINT

1. The complainant said that the Trust missed an opportunity to diagnose his mother's cancer on CT scans[2] taken in May and August 2016. A CT scan conducted in September 2016 identified widespread metastatic disease, and his mother was seen by palliative care on 4 October 2016. She sadly passed away on 21 October 2016. The complainant believed that the Trust's failure to diagnose his mother's cancer in the May and August scans resulted in her not receiving timely palliative care. He also believes that the failure resulted in her family missing the opportunity to spend more time with her prior to her passing.

2. In October 2017, the Trust completed an internal independent review of the scans taken in May, August and September 2016. Following this review, the Trust's Imaging Service apologised to the complainant and his family for missed opportunities, and acknowledged that the lung pathology was visible in both the May and August CT scans. In addition, the Trust acknowledged that had the patient's cancer been diagnosed at an earlier stage, she would most likely have benefited from more timely access to a palliative pathway.

3. As a result, my investigation of this complaint will focus on the diagnosis and treatment that would have been offered to the patient had the abnormal lesion been identified in the May 2016 CT scan. My investigation will also consider when she would have received access to palliative care, and the options that would have been available to her. In addition, I will review the subsequent actions taken by the Trust in relation to the misread scans in May and August 2016.

4. The complainant also said that his mother was discharged from the Mater Hospital in August 2016 with pneumonia and back pain. He believed that the pain she was suffering at this time was related to her undiagnosed cancer.

[2] A scan which combines a series of x-ray images taken from different angles around the body and uses computer processing to create cross sectional images of the bones, blood vessels and soft tissues inside your body.

Issues of complaint

5. The issues of complaint which I accepted for investigation were:

Issue 1: What diagnosis and treatment would have been available to the patient if concerns had been noted following her CT scan on 4 May 2016?

Issue 2: Was it reasonable to discharge the patient from the Mater Hospital with pneumonia and back pain in August 2016?

INVESTIGATION METHODOLOGY

6. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice

7. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- **FRCP (P IPA)** – A senior physician and gastroenterologist, with extensive experience in all aspects of clinical patient care in gastroenterology and endoscopy.
- **MD, FRCP, FRCR, MB, Ch.B (O IPA)** – A consultant clinical oncologist of 24 years. Lead clinician for cancer services. Treats patients with cancer with chemotherapy and radiotherapy.
- **MB, FRCP, FRCR (R IPA)** – A Radiologist routinely involved in the investigation and staging of lung cancer and melanoma, and lung biopsy procedures.
- **MB, ChB, FRCS, CTh., MD (TS IPA)** – A Consultant Thoracic Surgeon with over 10 years' experience.

8. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with

'advice'; however how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

10. The general standards are the Ombudsman's Principles[3]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Public Services Ombudsmen Principles for Remedy

11. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the Trust staff whose actions are the subject of this complaint.

12. The specific standards relevant to this complaint are:

- National Institute for Health and Care Excellence (NICE) Guidelines on Lung Cancer: diagnosis and management, published April 2011 (NICE Guidelines on Lung Cancer)
- NICE Guidelines on Carmustine implants and temozolomide for the treatment of newly diagnosed high-grade glioma, Appendix C. WHO performance status classification, published on 27 June 2007 (WHO performance status classification)
- NICE Guidelines on Pneumonia in adults: diagnosis and management, published December 2014 (NICE Guidelines on Pneumonia)
- Royal College of Radiologists, Standards for Learning from Discrepancies

[3] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

Meetings, 2014 (RCR Guidance)

- British Thoracic Society (BTS) Guidelines for the Investigation and Management of Pulmonary Nodules, published August 2015 (BTS Guidelines for Pulmonary Nodules)

13. I have not included all of the information obtained in the course of the investigation in this report, but I am satisfied that everything I consider to be relevant and important has been taken into account in reaching my findings. A copy of this draft report was shared with and the complainant for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: What diagnosis and treatment would have been available to the patient if concerns had been noted following her CT scan on 4 May 2016?

This issue will consider:

- When would a diagnosis have been confirmed?
- What treatment options would have been available?
- When would the patient have received access to palliative care, and the options that would have been available?
- What follow up actions have been taken by the Trust in relation to the misread scans in May and August 2016?

14. The complainant said that the Trust missed an opportunity to diagnose his mother's cancer on CT scans taken in May and August 2016. A CT scan conducted in September 2016 identified that she had widespread metastatic disease, and she was seen by palliative care on 4 October 2016. She sadly passed away on 21 October 2016.

15. The complainant believed that the Trust's failure to diagnose his mother's cancer in the May and August scans resulted in his mother not receiving timely palliative care. He also believed that the failure resulted in his family missing the opportunity to spend more time with her prior to her passing.

16. In October 2017, the Trust completed an internal review of the May and August 2016 CT scans. Following this review, the Trust's Imaging Service apologised to the complainant and his family for missed opportunities and acknowledged that the lung pathology was visible in both the May and August CT scans. In addition, the Trust acknowledged that had the patient's cancer been diagnosed at an earlier stage, she would most likely have benefited from more timely access to a palliative pathway.

17. As a result, my investigation of this complaint will focus on the diagnosis and treatment that would have been available to the patient had concerns been

identified in the May 2016 CT scan. My investigation will also consider when the patient would have received access to palliative care, and the options that would have been available to her. In addition, I will review the subsequent actions taken by the Trust in relation to the misread scans in May and August 2016.

Evidence Considered

18. I considered the NICE guidance on Lung Cancer, which states:

*'**Diagnosing and staging lung cancer***

If you have had a chest X-ray that shows you could have lung cancer or a chest specialist thinks you may have lung cancer, you will be offered other tests…

Having a CT scan

Often you'll be offered an appointment to have a CT scan before you see the chest specialist…

Having a PET-CT scan[4]

If the CT scan suggests you have cancer at an early stage and you are fit enough for treatment, you should be offered another type of scan called a PET-CT scan… If the PET-CT scans shows that the cancer has spread to lymph glands in the chest (local spread) you should be offered a biopsy of the glands…

Having a bronchoscopy[5] and biopsy[6]

If the CT scan shows signs of cancer in the central part of your chest, you should be offered a test called a bronchoscopy… If possible, the healthcare team will take a tiny sample of the affected area (by bronchial biopsy or

[4] A combination of a CT scan and a positron emission tomography (PET) scan. A PET scan is used to produce three-dimensional images of the inside of the body.
[5] A test to visualise the inside of the airways in your lungs.
[6] The extraction of sample cells or tissues for examination to determine the presence or extent of a disease.

bronchial wash) so that lung cells can be checked under a microscope in the laboratory…

If the CT scan shows that it's likely the cancer has spread to the glands in your chest or neck, you might be offered another type of scan (an ultrasound scan) of your neck with a biopsy of neck glands instead of a bronchoscopy and bronchial biopsy.

If you don't want or can't have a bronchoscopy and biopsy and there are signs of possible cancer in the central part of your lung, you should be offered sputum cytology…

Other types of biopsy

If the CT scan shows signs of cancer near to the edges of the lung, you should be offered another type of biopsy (called a transthoracic needle biopsy) rather than a bronchoscopy…

If you're not able to have the biopsies described above or you've had one (or more) but it didn't give a clear answer, you might be offered a surgical biopsy…

19. I also considered the WHO performance status classification[7]:

'The WHO performance status classification categorises patients as:

- *0: able to carry out all normal activity without restriction*
- *1: restricted in strenuous activity but ambulatory and able to carry out light work*
- *2: ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours*
- *3: symptomatic and in a chair or in bed for greater than 50% of the day but not bedridden*
- *4: completely disabled; cannot carry out any self-care; totally confined to bed or chair.'*

[7] Performance status is a score that estimates a patient's ability to perform certain activities of daily living without the help of others. This score is used to shape prognosis and to determine the best treatment for a patient.

20. I considered the RCR Guidance, specifically in relation to the recommended standards for LDMs [Learning from Discrepancies Meetings]:

'4. Causes of a reporting discrepancy
It is well recognised that radiology discrepancies occur…
Radiologist-specific causes include…
- Observational: the finding is identifiable but was missed…

5. Running LDMs
There is no prescriptive ways of running the LDM. A successful meeting will, however, make a significant contribution to patient safety by:

- *Focusing on shared learning*
- *Encouraging constructive discussion of contributing factors*
- *Producing a consensus on structured learning outcomes, learning points and follow-up actions*
- *Recognising professional responsibilities to consider the potential for patient harm'.*

21. I also considered BTS Guidelines for Pulmonary Nodules, which recommends that clinicians *'Offer a PET-CT scan to patients with a pulmonary nodule[8] with an initial risk of malignancy of > [more than] 10% (Brock Model[9]).'*

Listed Authority's Response to investigation enquiries

22. In response to investigation enquiries, the Trust provided the following timeline detailing the care and treatment the patient would have received had concerns been identified following the CT scan in May 2016. The proposed care pathway has been provided from the perspectives of a Consultant Physician, a Consultant Radiologist and a Consultant Clinical Oncologist.

[8] A small round or oval-shaped growth in the lung.
[9] A multivariable module that estimates the risk that a pulmonary module on a CT scan is a lung cancer.

Consultant Physician

23. The Consultant Physician caring for the patient at the Mater Hospital advised that *'if the abnormal lesion had been noted on the CT of abdomen and pelvis in May 2016 then she would have arranged further investigations to determine the cause of the abnormality.'* She stated that *'the most likely investigation would have been a CT scan of the chest.'*

24. She advised that *'she would have discussed this case with the Radiologists and/ or discussed the case at the multidisciplinary meeting, regarding the appropriate investigations to obtain a tissue diagnosis and treatment.'* In addition, she stated that as the *'biopsy of the lesion on the left twelfth rib in September 2016 showed metastatic (secondary) cancer, the patient would have been referred to the oncologists for further management.'*

Consultant Radiologist

25. The Consultant Radiologist at Belfast City Hospital advised that if the left basal nodule had been noted in the CT scan in May 2016, *'the first test likely to have been recommended would have been a dedicated CT Chest.'* He advised that as an inpatient, her CT Chest *'would have been completed in a few days'*, and the next options would have been to progress to a PET CT or CT follow up.

26. As the patient's nodule was bigger than 0.8cm, the Radiologist suggested that it was likely that a PET CT scan would have been recommended, however this scan '*may have taken a couple of weeks to schedule'*. He advised that metastatic disease *'may well have demonstrated… at this point in time, but clarifies that this is a speculative comment.'* He stated that 'i*f there was no other concerning lesion then the case would have been discussed at the Lung MDT [Multidisciplinary Team Meeting] as a query new lung cancer.'*

27. He advised that *'options for histological diagnosis [tissue examination] would have then been considered and would have included bronchoscopy, CT guided lung biopsy or surgery.'* He suggested that, given the patient's '*extensive listed comorbidities… a CT guided lung biopsy may have been the*

likely outcome but again notes that this comment is speculative.' He also suggested that the biopsy *'may have taken four to six weeks e.g. until late June/ early July 2016 depending on inpatient/ outpatient scheduling.'*

28. If the disease had been localised on imaging/ PET CT, which the Radiologist thinks *'would have been unlikely given the rapid progression in this case, then options would have been radical surgery with left lower lobe resection or radical radiotherapy.'* Given the patient's comorbidities, he suggested *'that he does not believe that the patient would have been a surgical candidate but acknowledges that he would defer to his clinical oncology colleagues in terms of decision making in this respect.'* He noted *'that the rib disease is visible on the CT in August 2016. He suspects PET CT would have shown this before that point in time if it had been done. [The Radiologist] notes that the metastatic disease was demonstrated in August 2016 and that if there had been more complete workup earlier in late May/ June it is possible that we could have known this earlier.'*

29. The Radiologist noted that *'in some respects the rapid progression and growth seen on the August and September 2016 scans infers an aggressive tumour and given this, it is likely that [the patient] would have had a smaller volume metastatic disease at the time of the May 2016 presentation.'*

30. He stated that if metastatic disease had been demonstrated earlier, which was *'likely given rapid progression in this case'*, then the options open to the patient would have been palliative chemotherapy or palliative support care/ symptomatic treatment. He stated that *'given the listed comorbidities there is a chance that [she] may well not have been fit enough for chemotherapy.'* He suggested that *'supportive palliative care would have been the most likely treatment option during the summer of 2016.'*

Consultant Clinical Oncologist

31. The Consultant Clinical Oncologist at Belfast City Hospital advised that *'there was a small lesion at the base of the left lung on the scan of May 2016.'* He stated that the next investigation would have been a PET/ CT scan. He advised that *'a biopsy is generally preferred to make a cancer diagnosis,*

however the lesion was small and may have been difficult to access with a CT guided biopsy.'

32. He advised that *'treatment is based on the stage of the disease and the fitness of the patient.'* When the patient was reviewed by Oncology in October 2016, the Oncologist stated that *'she was described as poor [WHO] performance status (PS 2) with multiple co-morbidities, and taking significant medication such as spironolactone[10].'* He advised that '*it is difficult to know what her performance status was in May 2016 and it is also difficult to know what the stage of the disease was in May 2016. Certainly by September 2016, there were multiple nodules in the pleura and a metastasis in the left rib.'* On review of the CT scan from 10 August 2016, he advised that *'lesions can also be seen then.'* Therefore, he advised that it was *'most likely that disease was metastatic in May 2016 in the pleura.'* He stated that he based *'this opinion on the speed of progression of the lesions and the appearance of new lesions between May 2016 and August 2016.'*

33. If the disease was localised, he suggested that *'radical radiotherapy could have been attempted with a five year overall survival of 20% (cure rate).'* He stated that he *'would not have thought that surgery would have been considered but a thoracic surgeon may give a better opinion.'* As the disease had progressed by the scan in August, he advised that *'it was likely to be metastatic in May 2016.'*

34. The Consultant Oncologist advised that *'in the metastatic setting, palliative approaches would have been considered to improve symptom control and quality of life. Palliative chemotherapy is not usually offered for patients in their 80's with poor performance status and co-morbidities, because of the risk of toxicity.'* He stated that palliative radiotherapy could have been offered, and noted that the patient received this on 6 October 2016. He advised that *'this does not extend survival time but can help with symptoms such as pain.'* He also stated that *'symptomatic medication would have been offered with her*

[10] Used to treat high blood pressure and heart failure.

GP and potentially the Macmillan team' and noted that she *'was already receiving analgesia with her GP.'*

35. At the point of diagnosis, he advised '*that palliative approaches would have been considered… given that palliative chemotherapy was unlikely to be offered the main approach would have been adjusting symptomatic management with her GP.'* He noted that this *'did seem to occur as [the patient] was on codeine and paracetamol.'* He also stated that *'Palliative radiotherapy could have been considered in May 16, although this is sometimes reserved until there are more symptoms.'*

Trust's actions as a result of the misread May and August CT scans

36. The Trust stated that the *'discrepancy on the May and August CT Abdomen and Pelvis reports were highlighted to the reporting Radiologist and submitted for discussion at the Learning from Discrepancies meeting in the Mater Hospital for shared learning purposes.'* It stated that this in line with the Trust's Learning from Discrepancy meetings policy, which is based on the RCR Guidance.

37. In October 2017, the Trust stated that an internal review of images was completed, and the results were shared with the patient's family. It stated that the Imaging Services Manager, the Site Lead, Mater Hospital), and the Governance and Quality Manager also met with the complainant and his sister on 23 October 2017 to discuss the findings of the review of the images.

Relevant Independent Professional Advice

38. As part of the investigation, I received independent professional advice from a Consultant Physician (P IPA), a Consultant Radiologist (R IPA) a Consultant Clinical Oncologist (O IPA) and a Thoracic Surgeon (TS IPA). Each advisor considered the Trust's proposed care pathway for the patient, specifically in relation to their area of expertise.

Consultant Physician

39. The P IPA advised that the proposed care pathway suggested was *'reasonable… and within guidelines of good practice.'* The P IPA advised that the proposed pathway, had the May 2016 CT abdomen and pelvis been accurately reported, was a *'further CT chest, attempt at tissue diagnosis and referral to MDT [Multidisciplinary Team Meeting] with a view to further treatment by oncologist.'* In addition, the P IPA advised that the physician made it *'very clear in her response',* that *'she would have discussed the case with the radiologist and/ or discuss[ed] the case at the relevant MDT [Multidisciplinary Team Meeting], regarding the appropriate investigation to obtain a tissue diagnosis and treatment.'*

40. Had the scan in May 2016 been accurately reported, the P IPA advised that '*further CT scan of Lungs, PET CT of lungs and further investigations to obtain tissue diagnosis through bronchoscopy or CT guided biopsy, would have resulted in earlier diagnosis of cancer.'* However, the P IPA advised that *'whether it would have revealed metastatic disease even at that stage in May remains speculative.'* In addition, the P IPA advised that *'if a definitive diagnosis had been established early and there were no metastasis then an attempt to treat the primary cancer with chemotherapy or surgery would have been considered and would have been advised by the lung MDT [Multidisciplinary Team Meeting].'*

41. However, if a definitive diagnosis was established early and metastasis was seen at this stage, the P IPA advised that '*referral to MDT [Multidisciplinary Team Meeting] with early referral to palliative care team may have led to better care of symptoms of pain control, and possibly that of overall better wellbeing and acceptance of diagnosis and understanding of prognosis.'* The P IPA also advised that *'given that the tumor appears to have behaved in an aggressive fashion, it would be speculative to say whether there would have been any better outcome in terms of health or prolonged life span.'*

Consultant Radiologist

42. The R IPA advised that the National Health Service Board in England and Northern Ireland *'operate 62 day targets from referral with suspected cancer to beginning definitive treatment.'* Therefore, the R IPA advised that the investigation pathway suggested by the Radiologist, had the lung nodule been identified in May, *'is consistent with the recommended investigation of suspected lung cancer, as per NICE lung cancer diagnosis and management guidelines.'*

43. In addition, the R IPA was asked what effect the proposed care pathway would have had on the patient's health and wellbeing. The R IPA advised *'active investigation and management and achieving a timely diagnosis does give the whole family time to prepare, and builds a better relationship with the clinical teams and family.'*

Thoracic Surgeon

44. On review, the TS IPA advised that the May 2016 CT scan *'showed a speculated lesion 11mm x 9mm in the left lower lobe. The chances of this being malignant using the Brock scoring system… is 28.5%.'* The TS IPA advised that according to BTS Guidelines for Pulmonary Nodules, *'[The patient] should have underwent a PET scan at this stage… PET scans are usually performed within 2 weeks of the request date.'* The TS IPA advised that *'the PET scan may have shown metastatic disease at this stage and palliative care commenced… if the lesion showed no or faint uptake, due to [her] co-morbidities, she is likely to undergo CT surveillance at 3 months.'*

45. However, the TS IPA advised that '*If the PET scan had shown the lesion to have moderate or intense uptake, with no evidence of metastatic disease elsewhere, then stereotactic radiotherapy or CT surveillance at 3 months would have been considered. In my opinion CT surveillance would have been the probable option.'* Had stereotactic radiotherapy been an option, the TS IPA advised that *'in my opinion this would have made no difference to the survival of [the patient]… Even if no metastatic disease was identifiable on the*

PET scan it is more than likely occult disease (cancer than cannot be seen on scans) would have been present.'

46. On review of the scan from August 2016, the TS IPA advised that it *'shows probable metastatic carcinoma.'* The TS IPA advised that following this scan, the patient *'would have undergone a staging CT of the thorax and then a biopsy. This process is likely to take around 2 – 3 weeks to obtain a tissue diagnosis. She would then be referred to palliative care.'*

47. As part of investigation enquiries, the TS IPA was also asked to respond to the Clinical Oncologist's comment that he *'would not have thought that surgery would have been considered but a thoracic surgeon may give a better opinion.'* The TS IPA advised that *'[The patient's] case is very complex due to her multitude of medical problems.'* The TS IPA advised that *'given [her] morbidities, and the diagnosis of metastatic squamous cell carcinoma, there would have been no role for surgery. Even if a PET scan had been performed in May 2016 and shown the lesion to have moderate to intense uptake, and no evidence of metastatic disease, due to the co-morbidities I do not believe surgery would have been an option.'* In addition, the TS IPA advised that *'I do not believe diagnosing metastatic squamous cell carcinoma at an earlier stage would have had any effect on prognosis.'*

Consultant Clinical Oncologist

48. The O IPA advised that if the biopsy performed on 26 September 2016 showed metastatic melanoma, then the patient would have had metastatic disease with earlier diagnosis. Given her age and co-morbidities, the O IPA advised that *'palliative and supportive care only would have been offered and palliative radiotherapy for symptom relief as was offered.'* The O IPA advised that these would *'likely'* have been offered 'a*t the same time.'*

49. In addition, the O IPA advised that the pathway described by the Trust, adheres to NICE Guidelines on Lung Cancer. The O IPA advised that in particular, *'chemotherapy should only be offered to patients with [good] performance status 0 or 1.'* The O IPA advised that with diagnosis of the

disease *'just a few months earlier',* it *'would have been widespread by May 2016 and radical local treatment with radiotherapy thus not appropriate.'*

50. The O IPA was also asked what effect the Trust's proposed care pathway, in relation to the Oncologist's actions, would have had on the patient's health. The O IPA advised that *'since the treatment would have been the same effectively, there would have been no difference other than earlier involvement of palliative care services to assist in symptom control.'* The O IPA advised that *'with earlier diagnosis the treatment and outcome would have been unchanged.'*

Trust's follow up actions as a result of the misread May and August scans

51. On review, the P IPA advised that the Trust *'has fully accepted responsibility and liability for the missed diagnosis of metastatic cancer due to misinterpretation of CT scans in May and August 2016.'* The P IPA advised that '*the error of misdiagnosis and misinterpretation of CT scan from May 2016 has been recognised by the internal investigation undertaken by the Trust and that learning points have been taken on board and service improvements have already been put in place. Further, these have been shared with family.'* The P IPA also advised that the trust has *'put in place all remedial measures to avoid any such errors in future.'*

52. The R IPA also advised that the Trust had reviewed *'the initial film where a nodule was overlooked… in a departmental governance meeting for learning.'* The R IPA advised that this was in line with the RCR Guidance, and noted that *'overlooking abnormalities on films is not uncommon.'*

The Trust's response to IPA

53. The Trust was given an opportunity to comment on the advice provided by the IPAs in relation to its proposed timeline for the patient's care and treatment had the cancer been identified in the May 2016 CT scan. The Trust stated that it had *'no comments to make… and believes the content of the reports present the facts accurately.'*

Analysis and Findings

54. I have investigated the complaint by carefully examining and testing the proposed timeline of care and treatment which would have been offered to the patient by the Trust had the abnormal lesion been identified in her May 2016 CT scan. I will consider the issue under the following headings:

(i) When would a diagnosis have been confirmed?
(ii) What treatment options would have been available?
(iii) When would the patient have received access to palliative care, and the options that would have been available?
(iv) What follow up actions have been taken by the Trust in relation to the misread scans in May and August 2016?

(i) When would a diagnosis have been confirmed?

55. As part of my investigation, I have sought to establish the pathway of the patient's diagnosis, had the abnormal lesion been identified in her May 2016 scan.

PET/ CT scan of the chest

56. I note the Consultant Physician advised that had the abnormal lesion been noted on the May 2016 CT scan of the abdomen and pelvis, *'she would have arranged further investigations to determine the cause… the most likely investigation would have been a CT scan of the chest.'* I note she also advised that *'she would have discussed the case with the Radiologists.'* This investigation path was supported by the Trust's Consultant Radiologist and I note he also suggested that a CT/PET would have been appropriate.

57. As an inpatient, I note the Consultant Radiologist advised that the chest CT scan *'would have been completed in a few days'.* I note he advised that given the patient's lesion was bigger than 0.8cm, it is likely a PET CT scan would have been subsequently recommended, and this *'may have taken a couple of weeks to schedule'.*

58. On review of the proposed pathway, I note the TS IPA advised that the May 2016 CT scan *'showed a speculated lesion 11mm x 9mm in the left lower lobe. The chances of this being malignant using the Brock scoring system… is 28.5%.'* I refer to BTS Guidelines for Pulmonary Nodules, which recommends that clinicians *'offer a PET-CT scan to patients with a pulmonary nodule with an initial risk of malignancy of > [more than' 10% (Brock Model).'* As a result, the TS IPA agreed that *'[the patient] should have underwent a PET scan at this stage.'* I note the TS IPA advised that *'PET scans are usually performed within 2 weeks of the request date.'*

59. I refer to NICE Guidance on Lung Cancer, which states if *'a chest specialist thinks you may have lung cancer, you will… offered an appointment to have a CT scan… if the CT scan suggests you have cancer at an early stage… you should be offered another type of scan called a PET-CT scan.'* As per the TS IPA's advice, I consider that the Trust's proposed plan to conduct a PET scan would have been appropriate. I note that this would have been performed within a *'couple of weeks'* of the May 2016 CT scan.

60. Depending on the results of the PET scan, I note the TS IPA advised that there would have been a number of potential outcomes, including CT surveillance, or early referral to palliative care. I note the Consultant Radiologist advised that if there was *'no concerning lesion'* identified on the PET scan, *'then the case would have been discussed at the Lung MDT [Multidisciplinary Team Meeting] as a query new lung cancer'.* I note the Consultant Physician also advised that *'she would have discussed this case… at the multidisciplinary meeting, regarding the appropriate investigations to obtain a tissue diagnosis and treatment.'*

61. In addition, I note the Consultant Radiologist speculatively advised that metastatic disease *'may well have demonstrated… at this point in time.'* I note the Consultant Radiologist advised *'that the rib disease is visible on the CT in August 2016… if there had been more complete workup earlier in late May/ June it is possible that we could have known this earlier.'* I also note he stated that *'in some respects the rapid progression and growth seen on the August*

and September 2016 scans infers an aggressive tumour and given this, it is likely that [the patient] would have had a smaller volume metastatic disease at the time of the May 2016 presentation.' I note that this opinion was echoed by the O IPA and the Clinical Oncologist who advised that the disease *'was likely to be metastatic in May 2016.'* I note the TS IPA advised that the next course of action would have likely been a *'CT of the thorax and then a biopsy'.*

62. As per the O IPA's advice, due to the probability that the metastatic disease would have likely been identified in the May 2016 scan, then I consider that the patient would have subsequently underwent a biopsy.

Biopsy

63. I note that the Consultant Radiologist advised that had metastatic disease been identified, options for tissue examination '*would have then been considered'.* I note he advised that given the patient's '*extensive listed comorbidities… a CT guided lung biopsy may have been the likely outcome but again notes that this comment is speculative.'* I note the Consultant Oncologist advised that a biopsy would have been preferred to make a cancer diagnosis. However, given that *'the lesion was small',* I note he advised that it *'may have been difficult to access with a CT guided biopsy.'*

64. I note the TS IPA advised that it may have taken '*2 – 3 weeks to obtain a tissue diagnosis*'. However, on review I note the Consultant Radiolgist suggested that the biopsy *'may have taken four to six weeks e.g. until later June/ early July 2016 depending on inpatient/ outpatient scheduling.'*

65. I note the R IPA advised that the National Health Service Board in England and Northern Ireland *'operate 62 day targets from referral with suspected cancer to beginning definitive treatment.'* Therefore, I note the R IPA advised that the investigation pathway suggested above, had the lung nodule been identified in May, *'is consistent with the recommended investigation of suspected lung cancer, as per NICE lung cancer diagnosis and management guidelines.'*

66. I also note the P IPA advised that the proposed care pathway suggested by the Consultant Physician was *'reasonable… and within guidelines of good practice.'* Had the scan in May 2016 been accurately reported, I note the P IPA advised that '*further CT scan of Lungs, PET CT of lungs and further investigations to obtain tissue diagnosis through bronchoscopy or CT guided biopsy, would have resulted in earlier diagnosis of cancer.*

(ii) What treatment options would have been available?

67. In relation to treatment options, I note the Consultant Oncologist advised that *'treatment is based on the stage of the disease and the fitness of the patient.'* I note the Consultant Physician stated that as the *'biopsy of the lesion on the left twelfth rib in September 2016 showed metastatic (secondary) cancer',* it is likely that the patient *'would have been referred to the oncologists [following biopsy] for further management.'* As part of my investigation, I have reviewed the treatment options that may have been offered to the patient by Oncology, and assessed whether they would have been appropriate.

Chemotherapy

68. I note the P IPA advised that *'if a definitive diagnosis had been established early and there were no metastasis then an attempt to treat the primary cancer with chemotherapy … would have been considered and would have been advised by the lung MDT.'* However, I note the O IPA advised that *'chemotherapy should only be offered to patients with [good] performance status 0 or 1.'*

69. I note the Consultant Oncologist advised that Oncology '*described [The patient] as poor [WHO] performance status (PS 2) with multiple co-morbidities, and taking significant medication such as spironolactone'* in October 2016. I refer to the WHO performance status classification, which states that patients with a WHO performance status classification of two are *'ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours.'*

70. I note the Consultant Oncologist advised that '*it is difficult to know what her performance status was in May 2016 and it is also difficult to know what the stage of the disease was in May 2016.'* However, on review of the CT scan from 10 August 2016, I note the Consultant Oncologist advised that *'lesions can also be seen…* [therefore it is] *most likely that disease was metastatic in May 2016 in the pleura.'*

71. On review of the available evidence, I accept the O IPA and the Consultant Oncologist's advice that given the patient's WHO performance status rating and the likelihood of the metastatic disease been identified in May 2016, chemotherapy would not have been a possible treatment option offered to the patient.

Radical Radiotherapy

72. I note the Consultant Oncologist and the Consultant Radiologist advised that if the disease was localised on the PET scan then '*radical radiotherapy*' could have been offered to the patient. I note the Consultant Oncologist advised that radical radiotherapy has *'a five year overall survival of 20% (cure rate).'* However, I note the O IPA advised that with diagnosis of the disease *'just a few months earlier',* it *'would have been widespread by May 2016 and radical local treatment with radiotherapy thus not appropriate.'*

73. As a result of the O IPA's advice, I consider that radical radiotherapy would not have been a treatment offered to the patient.

Surgery

74. I note the TS IPA advised that *'given the patient's morbidities, and the diagnosis of metastatic squamous cell carcinoma, there would have been no role for surgery'* in her case. I note the TS IPA also advised that even *'if a PET scan had been performed in May 2016 and shown the lesion to have moderate to intense uptake, and no evidence of metastatic disease, due to the patient's co-morbidities I do not believe surgery would have been an option.'*

75. Therefore, on review of the available evidence, I accept the TS IPA's advice that surgery would not have been a treatment offered to the patient.

Palliative care

76. I note that palliative care would have been a treatment option available to the patient. This treatment option has been reviewed under the heading below.

(iii) When would the patient have received access to palliative care, and the options that would have been available?

77. I note the Consultant Radiologist stated that if metastatic disease had been identified earlier, which was *'likely given rapid progression in this case'*, then the options open would have been palliative chemotherapy or palliative support care/ symptomatic treatment. I note the Consultant Radiologist suggested that *'supportive palliative care would have been the most likely treatment option during the summer of 2016.'* Likewise, I note the Consultant Oncologist advised that *'the main approach would have been adjusting symptomatic management with [the patient's] GP'* and *'potentially the Macmillan team'.* I note the Consultant Oncologist advised that symptomatic management '*did seem to occur as the patient was on codeine and paracetamol.'*

78. The Consultant Oncologist advised that this treatment approach would have assisted in *'improv[ing] [the patient's] symptom control and quality of life.'* I note the P IPA advised that earlier referral to palliative care *'may have led to better care of symptoms of pain control, and possibly that of overall better wellbeing and acceptance of diagnosis and understanding of prognosis.'*

79. In addition, I note the Consultant Oncologist stated that palliative radiotherapy may have been offered to the patient, and noted that she received this on 6 October 2016. The Consultant Oncologist noted that this is '*sometimes reserved until there are more symptoms.'* I note the Consultant Oncologist advised that *'this does not extend survival time but can help with symptoms such as pain.'*

80. I also note the Consultant Oncologist advised that '*Palliative chemotherapy is not usually offered for patients in their 80's with poor performance status and co-morbidities, because of the risk of toxicity.'* I note the Consultant Oncologist stated that *'palliative chemotherapy was unlikely to be offered.'* Likewise, I note the Consultant Radiologist advised that *'given the listed comorbidities there is a chance that [the patient] may well not have been fit enough for chemotherapy.'* I also note the O IPA agreed that given the patient's age and co-morbidities, *'palliative and supportive care only would have been offered and palliative radiotherapy for symptom relief as was offered.'* I accept the O IPA's advice, and consider that had the metastatic disease been identified following the biopsy, she would have received symptomatic palliative treatment, including palliative radiotherapy, during the summer of 2016.

Timeline of proposed care and treatment plan

81. On review of the available evidence and as per the IPA's advice, I consider that the following diagnosis and treatment path would have been available to the patient if the abnormal lesion had been identified on 4 May 2016 CT scan:

    - A **CT scan** of the chest would have been conducted within a couple of days of the CT scan on 4 May 2016 i.e. within the first week of May;
    - Subsequently, a PET CT scan would have been conducted within approximately two weeks i.e. the third or fourth week of May;
    - On the balance of probabilities, it is likely that metastatic disease would have been visible on this PET CT scan. Therefore, the next course of action would have been to perform a biopsy to obtain a tissue diagnosis.
    - A biopsy would have been undertaken within approximately four to six weeks of the PET CT scan i.e. last week of June/ first week of July.

82. As per the IPA's advice, the biopsy is likely to have confirmed the metastatic disease, and the patient would have been referred to Oncology for treatment. Due to the patient's age and co-morbidities, the only treatment available to her at the start of July 2016 would have been symptomatic palliative care,

including palliative radiotherapy. I note that this is the treatment that the patient was provided in October 2016.

83. Therefore, although errors were made by the Trust in failing to identify the abnormal lesion on the May 2016 scan, the patient's prognosis appears to be the same. I note the patient would have been offered the same palliative care that she did ultimately receive. However, I note that earlier diagnosis would have allowed her and her family more time to prepare. I also consider that it would have removed the distress caused when she and her family were advised that an opportunity for earlier diagnosis had been missed, and the questions which consequently arose following that disclosure.

Effect of earlier access to palliative treatment

84. If the patient had received earlier access to palliative care, I note the P IPA advised that *'given that the tumour appears to have behaved in an aggressive fashion, it would be speculative to say whether there would have been any better outcome in terms of health or prolonged life span.'* I note the TS IPA advised that *'I do not believe diagnosing metastatic squamous cell carcinoma at an earlier stage would have had any effect on prognosis.'*

85. In addition, I note the O IPA advised that *'since the treatment would have been the same effectively, there would have been no difference other than earlier involvement of palliative care services to assist in symptom control.'* I note the O IPA advised that *'with earlier diagnosis the treatment and outcome would have been unchanged.'*

86. However, I note the R IPA advised that *'active investigation and management and achieving a timely diagnosis does give the whole family time to prepare, and builds a better relationship with the clinical teams and family.'* I agree with the R IPA's advice that earlier diagnosis would have allowed the patient's family more time to prepare. However, I also acknowledge that the outcome would have remained unchanged.

(iv) What follow up actions have been taken by the Trust in relation to the misread scans in May and August 2016?

87. In October 2017, the Trust undertook an internal review of the patient's CT images. As a result of the review, I note the P IPA advised that '*the error of misdiagnosis and misinterpretation of CT scan from May 2016… [was] recognised.'* The R IPA advised that *'overlooking abnormalities on films is not uncommon.'* I refer to the RCR Guidance, which states that *'it is well recognised that radiology discrepancies occur.'* The RCR Guidance states that radiologist specific causes of discrepancies can be *'observational'*, indicating that *'the finding is identifiable but missed.'*

88. I note the Trust stated that the '*discrepancy on the May and August CT Abdomen and Pelvis reports was highlighted to the reporting Radiologist and submitted for discussion at the Learning from Discrepancies meeting in the Mater Hospital for shared learning purposes.'* I note the R IPA advised that this action was in line with RCR Guidance. I refer to the RCR Guidance, which states that a successful LDM will contribute to patient safety by *'focusing on shared learning… producing a consensus on structured learning outcomes, learning points and follow-up actions.'*

89. On review, I note the P IPA advised the Trust *'has fully accepted responsibility and liability for the missed diagnosis of metastatic cancer due to misinterpretation'* of the scans. I note the P IPA advised that the Trust has *'put in place all remedial measures to avoid any such errors in future.'*

90. Following the LDM, I note the P IPA advised that the results of the investigation were shared with the patient's family. I note the Trust also stated that they met with the complainant and his sister on 23 October 2017 to discuss the findings of the review of the images.

91. On consideration of the R IPA and P IPA's advice, and the RCR Guidance, I am of the opinion that the Trust has conducted appropriate follow up actions.

Issue 2: Was it reasonable to discharge the patient from the Mater Hospital with pneumonia and back pain in August 2016?

Detail of Complaint

92. The complainant said that his mother was discharged from the Mater Hospital in August 2016 with pneumonia and back pain. He believed that her back pain was related to her undiagnosed cancer.

Evidence Considered

93. I considered GMC Guidelines, specifically Standards 15 and 16, which state that clinicians must *'provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*

a. Adequately assess the patient's conditions, taking account of their history…

b. Promptly provide or arrange suitable advice, investigations or treatment where necessary...

In providing clinical care you must…

b. Provide effective treatments based on the best available evidence.'

94. I also considered NICE Guidelines on Pneumonia, in particular:

'Timely diagnosis and treatment…

1.2.9 Offer antibiotic therapy as soon as possible after diagnosis… to all patients with community-acquired pneumonia who are admitted to hospital…

Monitoring in hospital

1.2.19 Consider measuring a baseline C-reactive protein concentration in patients with community-acquired pneumonia on admission to hospital, and repeat the test if clinical progress is uncertain after 48 to 72 hours…'

The Trust's response to investigation enquiries

95. As part of investigation enquiries, the Trust was asked to respond to the complaint.

96. The Consultant Physician advised that the patient was admitted to the Mater Hospital on 9 August 2016, via the emergency department, following referral

by her GP for diarrhoea and abdominal pain. The Consultant Physician stated that the patient was known to have a history of Crohn's disease, and had previously underwent surgery for this. The Consultant Physician also noted that she was known to have an incisional hernia in her abdomen.

97. On admission, the Consultant Physician advised that a CT scan of the patient's abdomen and pelvis was arranged, *'to exclude any problem in her abdomen that may have been causing her symptoms of abdominal pain and diarrhoea.'* She stated that the scan *'reported to show changes in [her] right lung (consolidation) in keeping with pneumonia.'*

98. The patient was treated with antibiotics for her pneumonia, and the Consultant Physician explained that *'patients with pneumonia are normally… followed up with an x-ray of the chest about six weeks after treatment, to ensure that the changes in the lungs (consolidation) have resolved.'* The Consultant Physician stated that the repeat x-rays are normally completed on an outpatient basis, and further investigations would be arranged if the pneumonia is not responding to treatment or if the changes on the chest x-ray do not resolve.

99. The Consultant Physician stated that the patient's pneumonia responded to treatment with antibiotics, and her *'C-reactive protein (a blood test which is a marker of infection/ inflammation) had come down prior to discharge.'* She also stated that her abdominal pain and diarrhoea had settled prior to discharge. The Consultant Physician advised that the patient was due to be reviewed at her outpatient clinic on 26 September 2016, and that she had planned to repeat the chest x-ray at that stage. In addition, the Consultant Physician noted that she had a chest x-ray in the Royal Victoria Hospital on 20 August 2016, when she attended the emergency department, which *'reported to show clear lung fields with no focal abnormality.'* She stated that a further chest x-ray taken in the Royal Victoria Hospital on 20 September 2016, '*showed the right lower lobe consolidation that had been seen on the 8 August 2016 had resolved.'*

100. In regards to the patient's back pain, the Consultant Physician stated that she first complained of it *'a few days'* after admission. The Consultant Physician

stated that the patient said *'she had pulled a muscle in her back several weeks before admission, and the pain had started at the time of that injury.'* The Consultant Physician advised that *'back pain can be caused by a wide variety of conditions [and] given the correlation of the onset of the pain with the injury, the pack pain was thought to be most likely muscular. There were no abnormal findings on clinical examination to suggest that the pain was due to cancer.'* She stated that the CT scan of the patient's abdomen and pelvis *'was not reported to show possibility of cancer. There was no reason to attribute the pain to an underlying cancer at that stage.'*

101. Therefore, the Consultant Physician stated that the patient was started on Tramadol [painkillers] for the pain. She stated that she *'reported feeling much better, and that the pain had eased, on the day that she was discharged.'* On the day of discharge, the Consultant Physician stated that the occupational therapist had seen her, *'and had documented in the clinical notes that she was feeling much better, and she was mobilising independently.'*

Clinical Records

102. I considered the patient's Emergency Department admission sheet, dated 8 August 2016:
'Presenting complaint: Skin infection. Recently applying deep heat following back pain for pulled muscles. ?reaction to same no relief from abx [antibiotics] from GP. Ongoing 24hr hx [history] of vomiting, diarrhoea & abdo [abdominal] pain. GP attended house this am [morning] & advised presentation.'

103. I also considered the patient's Occupational Therapy notes, dated 16 August 2016, which state:
'OT [Occupational Therapy] observed pt [patient] mobilising [independently] around [bedside] – [Independently] in/out of bed & [independently] on/ off chair. Pt [Patient] reports feeling much better today.'

104. In addition, I considered the patient's discharge letter from the Mater Hospital, dated 16 August 2016:
'Primary diagnosis
Right lower lobe pneumonia

Musculoskeletal back pain…

Clinical summary of admission

Admitted with lower abdominal pain and diarrhoea… Commenced on oral amoxicillin for right lower lobe pneumonia. She has also complained of pain left lower posterior chest. Pain started after pulling muscle. Likely musculoskeletal pain. Pain has settled with tramadol…'

Relevant Independent Professional Advice

105. On admission to the Mater Hospital, the P IPA advised that the patient was *'diagnosed as pneumonia based on her investigations including X-ray Chest & Abdomen, [and] CT scan [of the abdomen and pelvis].'* The P IPA advised that the CT scan reported '*consolidation of [the] right side which means pneumonia and based on x-rays and this report… [The patient] was appropriately treated for pneumonia.'*

106. In addition to the tests above, the P IPA advised that prior to the patient's discharge from the Mater Hospital she had *'blood tests… regular nursing and medical assessments as per hospital inpatient care… [and] [the patient] also underwent [a] Physiotherapy Occupational therapy assessment.'* The P IPA advised that the patient's discharge summary records '*that she had declined any package of care before her discharge.'*

107. The P IPA advised that the patient was prescribed '*Antibiotics, initially Clarithromycin [and] Doxycycline, then Amoxicillin[11], Pentasa[12], [and] Fenbufen[13].'* The P IPA advised that *'further antibiotics [were] added'* and morphine, codeine and paracetamol were used for pain control. On review, the P IPA advised that *'these appear to be appropriate for the treatment of the diagnosis of pneumonia that was made along with posterior chest and back pain.'* In addition, the P IPA advised that it was noted that the patient's pain *'could have been musculoskeletal as she gave history of sprain to this site a few days earlier.'*

[11] Antibiotics used to treat various bacterial infections, including pneumonia
[12] Used to treat inflammatory bowel disease, including Crohn's disease
[13] A non-steroidal anti inflammatory drug

108. In relation to the follow up appointments arranged for the patient's review, the P IPA advised that *'given that the diagnosis of pneumonia was made based on evidence of X ray and [the] CT scan report… the treatment given and the follow up appointment that was scheduled for The Consultant Physician's OPD [Outpatient Department] in six weeks was appropriate, within a reasonable timeframe and within good practice guidelines.'*

109. The P IPA advised that *'it appears that the diagnosis of pnuemonia, the treatment provided for this diagnosis, and the discharge that followed after treatment during the August 2016 admission episode of the patient was appropriate and within guidelines of good practice.'* As a result, the P IPA advised that *'there [are] no recommendations for identifying any learning or service improvements.'*

The Trust's response to IPA

110. As above, the Trust stated that it has *'no comments to make [in relation to the IPA]… and believes the content of the reports present the facts accurately.'*

Analysis and Findings

111. I have investigated the complaint by carefully examining the care and treatment provided to the patient prior to her discharge from the Mater Hospital in August 2016.

112. On 9 August 2016, the patient was admitted to the Mater Hospital, via the emergency department, following a referral by her GP for diarrhoea and abdominal pain. I note the Consultant Physician stated that she had a history of Chron's disease and was known to have an incisional hernia in her abdomen. I refer to Standard 15 of the GMC Guidance, which states that clinicians must *'adequately assess the patient's conditions taking account of their history.'*

113. I note the P IPA advised that the patient was *'diagnosed as pneumonia based on her investigations including x-ray chest & abdomen [and] CT scan [of the abdomen and pelvis].'* I refer to Standard 15 of the GMC Guidelines, which states that clinicians must *'promptly provide or arrange… investigations.'* As a

result of the investigations and diagnosis, I note the Consultant Physician stated that the patient was treated with antibiotics. I note the P IPA advised that she *'was appropriately treated for pneumonia.'* I refer to Standard 16 of the GMC Guidelines, which state that clinicians must *'provide effective treatments based on the best available evidence.'* I also refer to the NICE Guidelines on Pneumonia, which stated that clinicians should *'offer antibiotic therapy as soon as after diagnosis.'*

114. I note the Consultant Physician advised that the patient's pneumonia responded to antibiotics, and her C-reactive protein came *'down prior to discharge.'* I refer to NICE Guidelines on Pneumonia, which state that clinicians should *'consider measuring a baseline C-reactive protein concentration in patients… and repeat the test if clinical progress is uncertain after 48 to 72 hours.'*

115. Following treatment, I note the Consultant Physician advised that *'patients with pneumonia are normally… followed up with an x-ray of the chest about six weeks after treatment, to ensure that the changes in the lungs (consolidation) have resolved.'* I note the Consultant Physician advised that the patient was scheduled to be reviewed at her clinic on 26 September 2016, to repeat the chest x-ray. Prior to this scheduled appointment, I also note the Consultant Physician advised that the patient had chest x-rays at the RVH on 20 August 2016 and 20 September 2016, which showed *'clear lung fields with no abnormality'* and that the *'right lower lobe consolidation… seen on the 8 August 2016 had resolved'*.

116. I note the P IPA advised that *"given that the diagnosis of pneumonia was made based on evidence of X ray and [the] CT scan report… the treatment given and the follow up appointment that was scheduled for the Consultant Physician's OPD [Outpatient Department] in six weeks was appropriate, within a reasonable timeframe and within good practice guidelines.'*

117. In relation to the back pain, I note the Consultant Physician advised that the patient stated that she had *'pulled a muscle in her back several weeks before admission, and the pain had started at the time of that injury.'* I note the P IPA

advised that the patient's pain *'could have been musculoskeletal as she gave history of a sprain to this site a few days earlier.'* Due to the correlation of the injury and the onset of back pain, I note the Consultant Physician advised that the pain *'was thought to be most likely muscular…. There were no abnormal findings to suggest that the pain was due to cancer.'* I note the Consultant Physician referred to the CT scan of the patient's pelvis and abdomen which *'was not reported to show possibility of cancer.'* I also note the patient's discharge letter from the Mater Hospital, which states that her back pain had *'settled with tramadol',* and the P IPA advised that the pain medication provided was *'appropriate for… posterior chest and back pain'.*

118. On discharge from the Mater Hospital, I note the P IPA advised that he patient underwent *'blood tests… regular nursing and medical assessments as per hospital inpatient care took place… [and she] also underwent [a] Physiotherapy Occupational therapy assessment.'* I note her occupational therapy notes, dated 16 August 2016, record that she was observed *'mobilising [independently]… pt [patient] reports feeling much better today.'* I note the Consultant Physician advised that the patient's abdominal pain and diarrhoea had also settled prior to discharge. In addition, I note the P IPA advised that she '*declined any package of care before her discharge.'*

119. Overall, I note the P IPA advised that '*the discharge that followed after treatment during the August 2016 admission episode of the patient was appropriate and within guidelines of good practice.'* As a result, the P IPA advised that *'there is no recommendations for identifying any learning or service improvements.'*

120. I appreciate that with hindsight, we now know that the metastatic disease was not identified in the patient's May and August 2016 CT scans. However, based on the information available to the medical staff at this time, as per the P IPA's advice, I consider that the care and treatment provided to the patient on her discharge from the Mater Hospital in August 2016 was appropriate.

CONCLUSION

121. The complainant submitted a complaint about the care and treatment provided by the Trust to his late mother.

122. I have investigated the complaint and have found that as a result of the Trust's failure to identify the metastatic disease in the May 2016 CT scan, the complainant's mother had delayed access to palliative care. I consider that she ought to have had access to palliative care in July 2016, as opposed to October 2016.

123. I am satisfied that this failure in care in treatment caused her to suffer the injustice of distress and loss of opportunity to have more timely access to palliative care services to assist with symptom control.

124. In this case, I consider that the complainant is a person aggrieved. As a result of the Trust's failure to achieve a timely diagnosis, I am satisfied that he suffered the injustice of loss of opportunity to spend more time with his mother prior to her passing.

Recommendations

125. I recommend that the Trust issues the complainant with an apology in accordance with the NIPSO guidance for the injustice identified in this report within **one month** of the date of my final report.

126. I also recommend the Trust makes a payment of £450 to the complainant by way of solatium in respect of the injustice I have identified, namely loss of opportunity, **within one month** of the date of my final report.

127. I note the Trust has undertaken an internal review and recognised the error of misdiagnosis and misinterpretation of the May and August 2016 CT scans. As a result, I note the Trust highlighted the discrepancies to the Radiologist and submitted the case to the LDM meeting at the Mater Hospital for shared

learning purposes. On review, I am of the opinion that the Trust has taken appropriate follow up actions to ensure that it minimises such errors in future.

128. I am pleased to note the Trust accepted my findings.

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.

- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.