Investigation Report

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

NIPSO Reference: 201913103

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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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Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant. The complainant was diagnosed with breast cancer in April 2012. She raised concerns with me about the radiology and oncology care and treatment she received in relation to two CT scans conducted in March 2013 and September 2014 to investigate whether her cancer had spread to her brain. She also complained to me about ophthalmology care and treatment she received in August and October 2014, following a referral from her GP for a condition unrelated to her cancer.

The complainant expressed concern that she was not given intravenous contrast at the time of the March 2013 CT scan, and that the scan report referred to her *'not being keen'* to have contrast, which she disputes. The complainant also raised concern that appropriate action – such as arranging a further scan - was not taken in follow up to an unenhanced scan having been conducted. In addition, she complained that when she was told about the result of the September CT 2014 scan, she was not made aware that the radiologist had reported that one of two brain metastases identified at that time might have been identifiable on the March 2013 CT scan. She complained too that the Trust only initiated its learning from discrepancy process because she complained to it about the handling of her CT scans.

In relation to her ophthalmology care and treatment, the complainant said proper account was not taken of the visual disturbance symptoms she reported at an initial consultation on 11 August 2014, particularly given her history of cancer. She also complained that these symptoms were not properly followed up at a review consultation on 6 October 2014. The complainant said too that the consultant ophthalmic surgeon she saw accessed her electronic medical records, without first obtaining her permission.

I obtained from the Trust all relevant documentation together with its comments on the issues the complainant had raised. I also obtained independent professional advice from a consultant radiologist, a consultant neuroradiologist, a consultant oncologist and a consultant ophthalmic surgeon. In addition, an Investigating Officer interviewed a number of Trust staff.

My investigation found several failings in the care and treatment the Trust provided to the complainant, as well as instances of maladministration.

In relation to the complainant's radiology and oncology care and treatment, I identified a failure to document properly the discussions and decisions that led to the complainant not having a contrast-enhanced CT scan in March 2013; a failure to properly document the consideration of the complainant's neurological symptoms following that scan; and a failure to share with the complainant, at the earliest opportunity, information about the findings of the September 2014 review of the March 2013 CT scan. I considered these were failings in the complainant's care and treatment.

In addition, I found there was a failure to initiate the Trust's learning from discrepancy process as soon as a potential issue with the reporting of the March 2013 CT scan was identified; and a failure to document decisions relating to the grading that was assigned to the complaint the complainant submitted to the Trust about the reading of the March 2013 CT scan. I considered these failures constituted maladministration.

In relation to the complainant's ophthalmology care and treatment, I did not identify any failing in the care and treatment she received at the initial consultation on 11 August 2014. I did, however, find that there was a failure to take appropriate follow up action at the review appointment on 6 October 2014, in relation to the visual disturbance symptoms the complainant had reported at the initial consultation some eight weeks previously. I also found that the accessing of the complainant's electronic records on 6 October 2014, without her consent, constituted maladministration.

I was satisfied that the failings in care and treatment and the maladministration disclosed by my investigation caused the complainant to experience the injustice of uncertainty, distress, frustration and a loss of opportunity to receive the standard of care and treatment she was entitled to expect.

I partially upheld the complaint. I recommended that the Trust's Chief Executive provide a written apology to the complainant and that the Trust implement a number of service improvements.

The Trust accepted my findings and recommendations.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant raised concerns about the radiology and oncology care and treatment she received in relation to two CT scans that were performed to investigate the potential spread of her cancer. She also complained about the care and treatment she received following a referral by her GP to the Trust's Ophthalmology service.

Background

2. The complainant received care and treatment from the Trust after a breast cancer diagnosis in April 2012. Following surgery and other treatment, the complainant attended regular outpatient cancer review appointments.

3. At a review appointment on 27 February 2013 with the consultant breast surgeon who had performed her surgery ('the Surgeon'), the complainant reported that she had been experiencing a 'pressure feeling' on the left side of her head during the previous few weeks. The Surgeon referred the complainant for a CT scan of her brain. A CT scan was performed on 8 March 2013 ('the March 2013 CT scan'). The scan was performed without intravenous (IV) contrast[1] being given to the complaint.

4. The report of March 2013 CT scan was prepared by a specialist trainee 2 registrar ('the Radiology Registrar') who was being supervised at the time by a consultant radiologist ('Radiologist A'). The scan report recorded, *'no acute parenchymal abnormality identified'.* The report also documented that the complainant had been *'not keen to have IV contrast.'*

5. On 12 March 2013, the complainant attended a review appointment with her consultant oncologist ('the Oncologist'). The Oncologist did not raise any concern about the March 2013 CT scan having been performed without contrast, and he did not refer the complainant for any further scans of her brain.

6. In June 2014, the complainant's GP referred her to the Trust's Ophthalmology service regarding ptosis.[2] A consultant ophthalmic surgeon ('the Ophthalmic

[1] Contrast is a 'dye' that is given intravenously to a patient prior to a CT scan to provide increased visibility of the structures in the brain
[2] Drooping of the upper eyelid

Surgeon') saw the complainant on 11 August 2014. During the consultation, the complainant and the Ophthalmic Surgeon discussed the ptosis. The complainant also reported symptoms of flashings of light and 'floaters' in her left eye, which she had been experiencing during the previous week. The Ophthalmic Surgeon's opinion was that these symptoms were related to posterior vitreous detachment.[3] He did not request any scan of the complainant's brain and arranged to see her again in eight weeks' time.

7. The complainant attended a further review appointment with the Surgeon on 10 September 2014. She reported peripheral vision symptoms affecting her left side. The Surgeon requested another CT scan of the complainant's brain. A CT brain scan was performed, with contrast, on 23 September 2014 ('the September 2014 CT scan'). It identified two lesions in the complainant's brain that were consistent with metastases.[4] The consultant radiologist who reported the September 2014 CT scan ('Radiologist B') recorded, *'… on review of the previous CT there may be a very small mass adjacent to the posterior hemispheric fissure at that stage which was virtually invisible without IV contrast.'*

8. The Oncologist reviewed the complainant on 1 October 2014. The Oncologist did not discuss the potential implications of the March 2013 CT scan having been performed without contrast, nor did he mention the '*virtually invisible'* comment Radiologist B had made in the report of the September 2014 CT scan.

9. The Ophthalmic Surgeon reviewed the complainant on 6 October 2014. The Ophthalmic Surgeon addressed the complainant's ptosis but did not ask her whether she was still experiencing the flashing lights she had reported at the previous consultation on 11 August 2014. At the end of the consultation, the complainant informed the Ophthalmic Surgeon of the results of the September 2014 CT scan. The Ophthalmic Surgeon, without seeking the complainant's consent, accessed the scan report via her electronic record held on the Northern Ireland Electronic Care Record (NIECR)[5] system, and he spoke to her about the content of that report.

[3] When the vitreous in the eye becomes detached from the retina.
[4] The development of secondary malignant growths at a distance from the primary cancer site.
[5] An electronic record system that pulls together key information about a patient's care from other health and social care systems.

Issue(s) of complaint

10. I accepted the following issues of complaint for investigation:

Issue One: Whether the care and treatment provided to the complainant with respect to oncology/radiology (in relation to CT scans) from March 2013 to October 2014 was appropriate, reasonable and in accordance with relevant guidance/procedures.

Issue Two: Whether the care and treatment provided to the complainant with respect to ophthalmology (in relation to medical history, symptoms, appropriate personal data use and subsequent complaint input) from August 2014 to April 2015 was appropriate, reasonable and in accordance with relevant guidance/procedures.

INVESTIGATION METHODOLOGY

11. In order to investigate this complaint, I obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's handling of complaints the complainant submitted to it about the care and treatment she received. An Investigating Officer also conducted interviews with relevant Trust staff.

Independent Professional Advice

12. After further consideration of the issues raised, I obtained independent professional advice from the following independent professional advisors (IPAs):

- A Consultant Radiologist with experience in working in an NHS department dealing with general radiology reporting ('the Radiology IPA');
- A Professor of Medical Oncology with more than 20 years' experience ('the Oncology IPA');
- A Consultant Ophthalmic Surgeon, with more than 15 years' experience, with a specialist interest in oculoplastics, ('the

Ophthalmology IPA'); and

- A Consultant Neuroradiologist with 14 years' experience in clinical practice as a diagnostic and interventional neuroradiologist ('the Neuroradiology IPA').

13. The IPAs provided me with 'advice'. How I weighed that advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

14. 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. I also refer to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles:[6]

- The Principles of Good Administration; and
- The Principles of Good Complaints Handling.

15. The specific standards and guidance are those which applied at the time the events complained of occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- Cancer Research UK Guidelines – cancer treatment follow up
- NICE Guideline NG99, 'Brain tumours (primary) and brain metastases in adults', 2018, in draft form from 2016 onwards
- Royal College of Radiologists 'Standards for Radiological Discrepancy Meetings', 2014
- Royal College of Radiologists 'Standards for Patient Consent', 2012
- General Medical Council – Good Medical Practice, 2013
- Belfast Health and Social Care Trust Guidelines for Radiology

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

Discrepancy Meetings, 2013

- Belfast Health and Social Care Trust Guidance for undertaking internal or external reviews of imaging, 2017
- Belfast Health and Social Care Trust Policy and Procedure for the Management of Complaints and Compliments, 2013
- NIECR Privacy Notice
- Department of Health Social Services and Public Safety Regional Health and Social Care Complaints Procedure Guidance (2009)
- Health and Social Care Board (HSCB) – Serious Adverse Incident (SAI) Procedure, 2013.

16. I did not include in this report all the information obtained in the course of the investigation, but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

17. I shared a draft of this report with the complainant, the Trust and the clinicians, whose actions are the subject of the complaint, to enable them to comment on its factual accuracy and the reasonableness of my proposed findings and recommendations. The complainant and the Trust submitted comments in response. Each of the clinicians - Radiologist A; the Oncologist; the Surgeon; and the Ophthalmic Surgeon – informed me that they did not wish to submit any comments directly to me on the draft report. I gave careful consideration to all the comments I received before finalising this report.

THE INVESTIGATION

Issue One: Whether the care and treatment provided to the complainant with respect to oncology/radiology (in relation to CT scans) from March 2013 to October 2014 was appropriate, reasonable and in accordance with relevant guidance/procedures.

Detail of Complaint

18. The complainant expressed concern about the radiology and oncology care and treatment she received. Specifically, she raised a number of issues regarding the CT brain scans that were performed in March 2013 and September 2014 to investigate the potential spread of her cancer.

19. The complainant said that in February 2013 she told the Surgeon that she had *'a pressure feeling'* in her head and that the Surgeon *'requested a red flag*[7] *head CT'.* The complainant said that the CT brain scan that was conducted on 8 March 2013 as a result of the Surgeon's request (that is, the March 2013 CT scan) was her '*first ever head scan'*.

20. The complainant said that the Oncologist reported the result of the March 2013 CT scan to her as, *'all was fine'*. She said the pressure feeling in her head had nevertheless continued but that she had considered this was her *'new normal'*.

21. The complainant said too that at a subsequent appointment with the Surgeon in September 2014 she reported she had been experiencing *'reduced peripheral awareness symptoms'* and *'the same flashings'* she had reported to the Ophthalmic Surgeon on 11 August 2014. The complainant said the Surgeon *'immediately ordered a red flag head CT'*, and that following a CT brain scan on 23 September 2014 (that is, the September 2014 CT scan), the Surgeon informed her, on 24 September 2014, that *'two masses'* had been detected in her brain.

22. The complainant said that she saw the Oncologist at a review appointment on 1 October 2014. She said the Oncologist *'read selectively'* from the 23 September 2014 CT brain scan report and that he did not show the report to her.

23. The complainant also said that it was at the outpatient ophthalmology appointment with the Ophthalmic Surgeon on 6 October 2014 (a matter to which I will return later in this report) that she became aware that the report of the September 2014 CT scan referred to the possibility of one of the identified masses having been present at the time of the March 2013 CT brain scan.

24. The complainant made a complaint to the Trust on 21 October 2014 about the performing of the March 2013 CT brain scan without contrast and the reading of that scan ('the Imaging Complaint'). The Trust provided a written response

[7] 'Red flag' is the term used to indicate that the referral is for a patient suspected of having cancer.

to the Imaging Complaint on 11 March 2015. The response stated that following receipt of the complaint, the Trust had arranged to present both the March 2013 CT scan and the September 2014 CT scan to a radiology discrepancy meeting. The March 2013 CT scan and the September 2014 CT scan were reviewed at a meeting of the Trust's radiology discrepancy group on 19 November 2014 ('the Radiology Discrepancy Meeting'). Also, in its response to the Imaging Complaint, the Trust offered to arrange an independent review of the March 2013 CT scan and the September 2014 CT scan. This review ('the Independent Review') was conducted by a consultant neuroradiologist and its findings were set out in a report issued in April 2018.

25. The complaint complained to my Office about the following issues:

- The failure of Radiologist A to perform the March 2013 CT scan with contrast, despite the scan request form (completed by the Surgeon) having highlighted a query about possible brain metastases. The complainant said that if she had been given contrast at the March 2013 CT scan, her brain metastases may have been identified and treated much sooner than was the case.
- The failure of the Oncologist to remark or act on the March 2013 CT scan having been performed without contrast, and to advise the complainant that the scan report stated she had been *'not keen'* to have contrast. The complainant said that if the Oncologist had done so, she would have disputed that she had declined to have contrast, and the scan could have been repeated as a matter of urgency.
- The failure of the Oncologist to remark or act on the report of the September 2014 CT scan having referred to the possibility of a mass, which was *'virtually invisible without IV contrast'*, having been identifiable on the March 2013 CT scan. The complainant said the Oncologist's duty of candour to her was *'woefully absent'.*
- The failure to launch an investigation into the issues raised by the September 2014 CT scan (that is, the possibility of a mass having been visible on the March 2013 CT scan), prior to the Trust's receipt of the Imaging Complaint. The complainant said she considered the review the

Trust carried out only took place only because she had indicated she was going to refer the matter to the General Medical Council. She said too that it was clear that the Trust's radiology discrepancy procedures had not been followed.

Evidence Considered

Standards and Guidelines

26. I considered the following standards and guidelines:

- Cancer Research UK Guidelines – cancer treatment follow up
- NICE Guideline NG99, 'Brain tumours (primary) and brain metastases in adults', 2018, in draft form from 2016 onwards
- Royal College of Radiologists 'Standards for Radiological Discrepancy Meetings', 2014
- Royal College of Radiologists 'Standards for Patient Consent', 2012
- Belfast Health and Social Care Trust Guidelines for Radiology Discrepancy Meetings, 2013
- Belfast Health and Social Care Trust Guidance for undertaking internal or external reviews of imaging, 2017
- Belfast Health and Social Care Trust Policy and Procedure for the Management of Complaints, 2013
- Regional Health and Social Care Complaints Procedure, 2009
- Health and Social Care Board (HSCB) – Serious Adverse Incident Procedure, 2013.

Relevant extracts of these standards and guidelines are at Appendix Two to this report.

Relevant Documentation

27. I completed a review of the documentation I obtained from the Trust, which included the complainant's medical records and the Trust's file relating to the Imaging Complaint. Relevant extracts of the documentation reviewed is at Appendix Three to this report.

28. Based on my review of the documentation, I compiled a chronology of key events relating to the concerns the complainant raised about her radiology and oncology care and treatment. This chronology is at Appendix Four to this report.

The Trust's response to investigation enquiries

29. In responding to investigation enquiries, the Trust said. *'Although the [March 2013 CT scan] had been performed without contrast, [the complainant's] symptoms had resolved, therefore further imaging at that point was not indicated.'*

30. The Trust also said, '*[The Oncologist] informed [the complainant] during an appointment on 27 October 2014 that he had brought the CT scan reports taken of her brain in March 2013 and September 2014 to … [the Clinical Director for Radiology].'*

31. The Trust said too that *'[the Clinical Director for Radiology] …forwarded [the complainant's] case to the radiology discrepancy meeting which reviewed both scans to decide whether there had been a failure to detect a lesion that should have been picked up on routine scanning. It is [the Oncologist's] recollection that the radiology team reviewed the imaging at the discrepancy reporting meeting and reviewed the imaging at the Neuro-oncology Multi-Disciplinary Team (MDT) Meeting.'*

32. In addition, the Trust stated, *'…see the report from the Radiology Learning Discrepancy Meeting dated 19/11/2014. There was no investigation required as it was recorded on the report of the March 2013 scan that the patient was not keen to have contrast administered.'*

33. The Trust also commented on its grading of the Imaging Complaint and the consideration given to whether it met the Serious Adverse Incident (SAI) reporting criteria. The Trust indicated that the Imaging Complaint was graded as a 'medium risk' complaint. It explained that the Governance Lead and the Imaging Services Manager had considered whether the complaint should be graded as 'high risk' but that *'On review of the images by Radiologists it was considered that there was unlikely to have been any discrepancy and therefore the patient did not*

come to any harm as a result of the interpretation of the images being incorrect. The Trust said that since the Imaging Complaint was graded 'medium risk', it did not warrant consideration of the SAI reporting criteria.

Interviews with Trust staff

34. An Investigating Officer conducted a series of interviews with Trust staff to gain a better understanding of events and decisions relevant to the concerns the complainant raised about the care and treatment she received. The Trust staff interviewed included:

- The CT radiographer who conducted the March 2013 CT scan ('the Radiographer');
- The Radiology Registrar, who prepared the March 2013 CT scan report;
- Radiologist A, who reported the March 2013 CT scan (supervising the Radiology Registrar);
- Radiologist B, who reported the September 2014 CT scan;
- The Oncologist, who reviewed the complainant following the March 2013 CT scan and the September 2014 CT scan; and
- The Trust's (former[8]) Imaging Services Manager, who investigated the Imaging Complaint.

35. I consider the following key points from the information provided to the Investigating Officer during the interviews are particularly relevant to this issue of complaint:

- The Radiographer had only a *'vague recollection'* of the March 2013 CT scan.
- Neither the Radiology Registrar nor Radiologist A had any recollection of interacting with the complainant at the time of the March 2013 CT scan.
- The request the Surgeon made on 27 February 2013 for a CT brain scan was designated 'red flag' by the supervising CT radiographer, following

[8] Until 2015

receipt of the radiology request form in the radiology department.

- A ‘red flag’ request for a scan means that the scan should be performed within two weeks and normally means that there is a query about the presence of cancer.

- The Trust’s normal protocol for a CT brain scan, where there were suspected brain metastases, was to perform two scans – a first scan without contrast being administered, followed by a second scan after intravenous contrast had been given to the patient.

- It was usual practice for radiographers to explain this two-stage process to patients at the beginning of the CT brain scan procedure.

- It was observed at interview that the radiology request form for the March 2013 CT scan had been annotated with the results of a blood test conducted on 19 December 2012 to check the complainant’s kidney function. It was explained that contrast could not be given to a patient with poor kidney function. It was also explained that the documented blood test result indicated the complainant had good kidney function.

- The radiology department recorded on the CT request form of 27 February 2013 that the type of scan conducted on 8 March 2013 was ‘*CSKUH’*, which is the code for a CT brain scan without intravenous contrast being administered. It was observed at interview that another scan code had also been partially recorded on the request form, and then scored out. It was believed that this other code was *‘CSKUC,’* which is the code for a CT brain scan with contrast being administered.

- It was observed at interview that the entry in the radiology department’s CT scanner logbook for the March 2013 CT scan documented (in the ‘Exam’ column) that the type of scan conducted was *‘CSKUH’* (the code for a CT brain scan without intravenous contrast being administered).

- It was observed at interview that a different entry had been made originally in the ‘Exam’ column in the CT scanner logbook for the March 2013 CT scan, but this other entry had been subsequently ‘removed’ using ‘Tipp-

Ex'. It was observed that the original entry was just visible under the applied Tipp-Ex and was believed to be *'CSKUC'* (the code for a CT brain scan with intravenous contrast being administered).

- The Radiographer was not certain but believed that prior to the administration of contrast for the second scan on 8 March 2013, the complainant may have indicated she had poor venous access and did not want to have contrast.

- There was no record of the Radiographer having any difficulty in obtaining intravenous access into the complainant's arm.

- The Radiographer had no recollection of whether an attempt had been made to gain intravenous access to administer contrast to the complainant but believed that if such an attempt had been made, and had been unsuccessful, this would have been documented, in accordance with the usual procedure.

- The CT scanner logbook entry for the March 2013 CT scan recorded in the 'Contrast' column the comment, *'No IV as per [Radiologist A]'.*[9]

- The comment in the report of the March 2013 CT scan to *'patient not keen on contrast'* was not recorded anywhere on the CT request form.

- Radiology staff were of the view that the idea of '*patient not keen on contrast'* could only have been communicated verbally between the Radiographer and Radiology Registrar and/or the Radiologist A.

- If a radiographer encountered an issue with gaining intravenous access, or a patient was seeking reassurance about receiving contrast for a CT scan, assistance would be sought from the relevant consultant or registrar.

- Radiologist A disagreed strongly with the finding of the Independent

[9] Following the interviews conducted with Trust staff, Radiologist A was asked about this entry in this radiology logbook. Radiologist A responded that he had no recollection of meeting or speaking to the complainant at the time of the March 2013 CT scan. He said the logbook entry indicated that either the Radiographer or (more likely) the Radiography Registrar '*confirmed with [him] that [the complainant] had declined to have contrast and that a non-contrast enhanced scan only could be performed.'*

Review that there was approximately a 50% chance of a contrast-enhanced CT brain scan in March 2013, had one been conducted, identifying metastases.

- Radiologist A presented data at interview, which he said showed that in only 2.5% of cases, the first site of metastatic disease for breast cancer was the brain, and that of patients who were diagnosed with brain metastases, 40% were asymptomatic. Radiologist A was of the view that this data indicated there was only approximately a one per cent chance of brain metastases having been present at the time of the March 2013 CT scan.

- The Oncologist was clear that if the complainant had reported the same 'pressure feeling' symptom, or any other symptom, such as blurred vision, when he reviewed her following the March 2013 CT scan, he would have arranged an MRI scan; however, as the complainant was well at the appointment and her symptom had resolved, he considered no further action was warranted from an oncology standpoint.

- The Oncologist relayed the outcome of the September 2014 scan to the complainant at the review appointment on 1 October 2014 but did not disclose to her at that time that the scan report referred to a mass being *'virtually invisible'* on the March 2013 CT scan because he had wanted to first clarify the content of the report with radiology staff. The Oncologist was also conscious of not adding to the complainant's distress by disclosing that information before obtaining clarity regarding the report's content, and of the need to ensure her focus at that time remained on the brain metastases diagnosis and decisions about appropriate treatment.

- The Oncologist recalled that following the review appointment with the complainant on 1 October 2014, he spoke to Radiologist A and Radiologist B; Radiologist A had been certain that no mass was identifiable on the March 2013 CT scan and Radiologist B had said she was no longer so sure about what she had stated in the September 2014 CR scan report regarding the 'virtually invisible' mass on the March 2013 CT scan.

- The Oncologist's recollection was that it was his bringing of the March 2013 CT scan and the September 2014 CT scan to the attention of the (then) Clinical Director for Radiology that had led to the Trust's radiology discrepancy process being initiated.

- The Imaging Services Manager considered it was the Imaging Complaint that had initiated the Radiology Discrepancy Meeting's consideration of the March 2013 CT scan and the September 2014 CT scan.

- Radiologist B had no role in the referral of the March 2013 CT scan and the September 2014 CT scan to the Radiology Discrepancy Meeting.

Independent Professional Advice

The Radiology IPA

36. The Radiology IPA advised that the March 2013 CT scan and the September 2014 CT scan were both *'reported accurately'* and that there was *'no error'* in relation to the interpretation of the imaging.

37. In relation to the March 2013 CT scan, and specifically the reference in the scan report to the complainant being *'not keen to have IV contrast'*, the Radiology IPA advised, *'The only contemporaneous evidence of a conversation between patient and radiology staff is that which is stated in the report and the brief note in the radiographer [logbook]. Patient consent, that is specific for the use of contrast, is not usually documented on the radiologist's report. The fact that it was noted suggests a discussion had taken place between patient and staff … There is no other evidence of a conversation between the patient and staff regarding the benefits/risk and refusal of contrast.'*

38. In relation to the impact of contrast not being administered for the March 2013 CT scan, the Radiology IPA advised, *'It is not possible to say whether metastases would have been detectable with contrast [in March 2013].'* He advised too that he agreed with the Radiology Discrepancy Meeting's conclusion *that 'there was nothing on the scan to explain the patient's symptoms at that time.'*

39. With regard to the reporting of the September 2104 CT scan, in particular, the reference to the March 2013 CT scan and the comment about a mass being *'virtually invisible without IV contrast',* the Radiology IPA advised, '*The term*

"virtually invisible" is ambiguous. If a lesion were virtually invisible the author is in effect saying that some part of the lesion is visible. This has been judged to be inaccurate as both the external independent reviewer and the internal discrepancy panel felt that the scan from 2013 was normal. Notwithstanding, there is interobserver variation in image interpretation and a radiologist is justified in mentioning a finding which they feel is significant.'

40. Also, in relation to the *'virtually invisible without IV contrast'* comment in the report of the September 2014 CT scan, the Radiology IPA advised, *'[Radiologist B's] decision that the lesion could be seen previously, is likely influenced by a hindsight bias. The effect this bias [had] on the radiologist's decision process is not quantifiable.'*

41. The Radiology IPA further advised, *'[Radiologist B] may have used the phrase "virtually invisible" to justify why the abnormality, which they spotted, was initially overlooked. However, having suggested that there was an abnormality on the initial scan, and realising the potential implications [Radiologist B] could have submitted the case for discrepancy themselves.'* He continued however, '*Ultimately there was no significant delay in the process as the clinical team forwarded the scan to discrepancy shortly after it was written.'*

42. In commenting on the impact of any failing or deficiency he had identified on the part of the Trust, the Radiology IPA advised, *'The first report from [March] 2013 correctly indicated that contrast had not been administered and a reason why. It then falls on the clinical team to read the report and decide subsequently if a repeat scan is indicated based on the patient's symptoms. The CT scan from 8/3/13 showed no cause for the patient's symptoms and the subsequent scan from 23/9/14 was requested based on a change in clinical symptoms. I feel that this method of management based on a combination of clinical assessment and radiological correlation is appropriate.'*

43. The Radiology IPA commented on learning identified in the consideration of this complaint. He highlighted the need for clear documentation regarding decisions about contrast, and the need for radiologists, rather than the clinical team, to put the case to a discrepancy meeting, where it is considered there is an error in a

previous report, in order to avoid the risk of misinterpretation by third parties and miscommunication to the patient.

44. The Radiology IPA's full advice report is at Appendix Five to this report.

The Oncology IPA

45. The Oncology IPA advised, '*The [March 2013] scan result was described by [the Oncologist] in his letter of 12.3.13 as being normal. There is no statement in the notes by [the Oncologist] that [the complainant's] headache had resolved or was ongoing at the appointment of 12.3.13. Had her headache persisted it would have been appropriate to conduct an MR brain scan with contrast. If the symptoms had resolved then good practice would have been to follow her up according to the guidelines below.*[10] *Largely, [the Oncologist's] decision making, treatment plan and record-keeping seemed reasonable and in keeping with guidance.'*

46. The Oncology IPA further advised, '*[The Oncologist's] consultation and management in September 2014 was appropriate. Specifically, the March 2013 brain scan was reviewed by the local peer review team and by an external neuro-radiology expert, all of which concluded that there was no relevant abnormality on the March 2013 scan. [The Oncologist] and colleagues managed [the complainant] in keeping with current guidelines (section 1.7 NICE guideline NG99, Brain tumours (primary) and brain metastases in adults, 2018).'*

47. The Oncology IPA's full advice report is at Appendix Six to this report

The Neuroradiology IPA

48. The Neuroradiology IPA explained the benefits, in the circumstances seen in the complainant's case, of a patient having a contrast-enhanced CT brain scan rather than one performed without contrast. He advised, *'Cerebral metastases … lead to a loss of integrity of the "blood brain barrier"*[11] *of the involved tissue. This leads to an increased concentration of the contrast agent within the metastases which "light up" on the post contrast scans making it easier to*

[10] The Oncology IPA provided hyperlinks to Cancer Research UK's and the American Cancer Society's guidelines on follow-up care after breast cancer treatment

[11] A layer of tightly packed cells that make up the walls of the brain capillaries and prevent substances in the blood from diffusing freely into the brain.

identify them. On a non-contrast study the CT density of a metastasis can be identical to normal brain tissue thus making their identification very difficult or even near impossible, hence it is standard practice to obtain post contrast studies in patients who are suspected to have brain metastases.'

49. In relation to the March 2013 CT scan, the Neuroradiology IPA advised, *'The reading and reporting of the non contrast scan from 8/3/2013 was correct. No acute intracranial abnormality of metastases are identifiable on the scan.'*

50. The Neuroradiology IPA continued, *'It is documented in the report that the patient was not keen to have IV contrast … in a patient who is suspected to have metastatic disease it is ideal that the study is performed after contrast administration. There are some occasions when the patient either refuses contrast/has severe contrast allergy/very poor kidney function. In such cases the CT scan may be performed as a non contrast study, however is followed up by scanning using another modality such as MRI scan especially if the index of suspicion of having metastatic disease is high. This decision is generally made after discussion between the referrer and the radiology team.'*

51. With regard to the September 2014 CT scan, the Neuroradiology IPA advised, *'Whereas the reporter has correctly identified the intracranial metastases, I disagree with the comment that the lesions were identifiable on the original CT scan from 8 March 2013. The reporter has "hindsight bias".'*

52. I asked the Neuroradiology IPA for his advice regarding the finding of the Radiology Discrepancy Meeting that it was *'clinically highly unlikely that a brain metastasis was present [at the time of the March 2013 CT scan] as this would not explain the presenting symptoms and there was no radiology record of pressure and altered feeling symptom progression until almost 18 months later.'* The Neuroradiology IPA said he agreed with this finding. He advised, *'It would be highly unusual for an intracranial metastasis to be quiescent for 18 months without causing any worsening/new symptoms in the time interval. Generally intracranial metastases grow pretty rapidly over the period of a few weeks to months. On the balance of probability it would be highly unlikely that the brain metastases were present at the time of the original scan from 8 March 2013.'*

53. The Neuroradiology IPA also advised that he agreed with the Radiology Discrepancy Meeting's finding that the administration of contrast was *'very unlikely to have made a difference as it [was] very unlikely a metastatic lesion was present [at the time of the 8 March 2013 CT brain scan].'*

54. I asked the Neuroradiology IPA for his advice on whether it was possible to state the likelihood of a CT brain scan in March 2013, with contrast administered, having identified the lesions that were seen in contrast-enhanced CT brain scan performed in September 2014. The Neuroradiology IPA advised, *'Although it is not possible to comment with absolute certainty as to whether the metastases in question would have been visible (or not as the case may be) had a contrast enhanced scan been performed at the initial presentation, in my opinion, it is highly unusual to have intracranial metastases that remain clinically quiescent for a period of 18 months (as was the time interval between the two scans).'*

55. The Neuroradiology IPA continued, '*Intracranial compartment is a closed cavity inside the skull. Metastases incite brain oedema (swelling) and consequently present with symptoms of raised intracranial pressure or neurological dysfunction rapidly (in a matter of a few weeks, few months). Considering the long-time interval (18 months) between the scans and paucity of symptoms of neurological dysfunction in the interim, the likelihood of a contrast enhanced scan performed at the initial presentation in March 2013 identifying the lesions in question is low.'*

56. In relation to any learning identified from the consideration of this complaint, the Neuroradiology IPA advised that consideration should be given to the performing of an MRI scan in patients with suspected metastatic disease who, due to an allergy or renal failure, are unable to have IV contrast or who refuse to have IV contrast for a CT scan.

57. The Neuroradiology IPA's full advice report is at Appendix Seven to this report.

Analysis and Findings

58. The complainant raised concerns with my Office about the failure to administer

contrast at the March 2013 CT scan; the failure to later remark or act on the March 2013 CT scan having been performed without contrast, and to advise her that the scan report stated she had been *'not keen'* to have contrast; the failure to inform her that the report of the September 2014 CT scan referred to the possibility of a brain metastasis being visible on the March 2013 CT scan; and the failure to investigate this matter by initiating the radiology discrepancy process at the earliest opportunity. My findings on each of these matters are set out below.

Contrast not administered at March 2013 CT scan

59. The complainant considers that if contrast had been administered at the March 2013 CT scan, her brain metastases may have been identified and treated much sooner than was the case.

60. My investigation found that the March 2013 CT scan was performed as a result of the complainant having reported to the Surgeon at a review appointment on 27 February 2013 that she had been experiencing 'a pressure feeling', mainly on the left side of her head, during the previous few weeks. I note that when the Surgeon wrote to the complainant's GP about that review appointment, she stated, *'Obviously this is causing [the complainant] some concern and as this area has not been imaged previously, I have arranged for her to have a CT scan for completeness …. She shall be reviewed in due course post the CT scan.'*

61. I note that the examination the Surgeon requested on the radiology request form she completed on 27 February 2013 was *'CT Brain';* that the form referred to the complainant having reported *'pressure "effect" left side of head, altered feeling also'*; and that it recorded the Surgeon's provisional diagnosis as *'CT Brain ? Mets'.*

62. I note that an Investigating Officer was informed at interview that the handwritten annotation *'Red Flag'* on the radiology request form was made by the supervising CT radiographer, following the form's receipt in the radiology department. I note the Investigating Officer was also informed at interview that the term 'Red Flag', when applied to a requested scan, signifies that the scan should be performed within two weeks of request and generally means that

there is a suspicion of cancer.

63. I note that in its response of 11 March 2015 to the Imaging Complaint, the Trust informed the complainant that it was its *'normal practice for patients to be given a contrast media, injected through the arm, at the time of the scan'* as this *'can help to identify certain types of brain lesions'*. In addition, I note that evidence Trust staff provided to the Investigating Officer at interview confirmed that it is the Trust's normal protocol to perform two CT brain scans in patients with suspected brain metastases: a first scan without contrast, followed by a second scan after the administration of contrast intravenously. The Investigating Officer was also informed at interview that radiographers would normally explain this two-stage process to patients at the beginning of the CT brain scan procedure.

64. The Neuroradiology IPA provided me with advice on why it was important for a patient with suspected brain metastases to have a contrast enhanced CT brain scan. He advised that when contrast is administered, metastases are much easier to identify because they *'light up'*. I note the Neuroradiology IPA advised that it is *'very difficult or even near impossible'* to identify brain metastases in a non-contrast CT scan.

65. It was important therefore that contrast was administered to the complainant at the March 2013 CT scan, as this would have resulted in a much better opportunity to identify any abnormality that existed at that stage. I consider the available evidence - the explanation Trust staff gave at interview regarding the second 'scored-out' CT code on the radiology request form; the change that was made to the CT code entry in the radiology logbook; and, most significantly, the documenting of the checking of the complainant's renal function prior to the scan - indicates that there was an intention to perform a contrast-enhanced CT brain scan on 8 March 2013. There is, however, clear evidence - the entry in the radiography logbook that states, *'No IV as per [Radiologist A]'*; the report of the March 2013 CT scan which documents that an 'unenhanced' scan was performed; and the Trust's response of 11 March 2015 to the Imaging Complaint, as well as its response to my investigation enquiries, both of which confirm a non-contrast scan was performed – which demonstrates that did not happen.

66. It is unclear why contrast was not administered at the March 2013 CT scan. The only contemporaneous records that give any indication of a possible reason for contrast not having been given are the March 2013 CT scan report, which states, *'The patient was not keen to have IV contrast'*, and the radiology logbook, which states, *'No IV as per [Radiologist A].'*

67. The complainant maintains there was no conversation about the administration of contrast at the March 2013 CT scan. I note, however, that at interview, the Radiographer, although not clear in her recollection, said she believed the complainant may have had some issue with venous access and had indicated she did not wish to have contrast. In this regard, I note the complainant's medical records document that on 10 July 2012, she was unable to have contrast administered for a CT scan of other areas of her body *'due to inability to obtain IV access'*. In addition, on 23 November 2012, less than four months before the March 2013 CT scan, the Oncologist documented that due to the complainant's *'poor venous access'*, a particular nurse from another hospital was going to attend a CT scan the complainant was to have on 30 November 2012 at the NI Cancer Centre *'to cannulate [the complainant] as she thinks [that particular nurse] is the only person who can get her veins.'* That said, while these references in the complainant's records indicate venous access issues in July and November 2012, there is no way of knowing for certain whether she was still experiencing such issues at the time of the March 2013 CT scan.

68. In addition, although the complainant states that there was no conversation about contrast at the time of the March 2013 CT brain scan, I am mindful that the Radiology IPA advised that the fact that the scan report documented that complainant was not keen to have contrast, when it is not usual for a scan report to make any reference to patient consent for contrast, '*suggests a discussion had taken place between patient and staff* '.

69. I note that neither Radiologist A nor the Radiology Registrar have any recollection of interacting with the complainant at the time of the March 2013 CT scan, so they could provide no further information about why contrast was not given.

70. I note too that when the Trust responded to the Imaging Complaint, it provided

no explanation as to why the complainant did not receive contrast at the March 2013 CT scan, referring only to *'the misunderstanding that occurred'.*

71. I gave careful consideration to all the available evidence relating to the performing of the March 2013 CT scan. On balance, I am satisfied that it indicates that there was an intention to perform a contrast-enhanced scan on that occasion. The available evidence is, however, insufficient to allow me to reach a conclusion as to why, in the event, contrast was not administered.

72. This highlights the inadequacy of the Trust's records relating to the March 2013 CT scan. Those records ought to clearly and fully document the reason why contrast was not administered, particularly given that not performing a contrast-enhanced scan on that occasion was a departure from the Trust's normal CT protocol in cases where there is suspicion of brain metastases. The reference in the scan report to the complainant being *'not keen'* to have contrast, in the absence of any further explanation, either on the radiology request form or in the radiology computer system, is, in my view, insufficient to explain properly the decisions that were taken regarding the administration of contrast at the March 2013 CT scan.

73. Furthermore, the Trust's records do not demonstrate whether, if the complainant did express reluctance or refuse to have contrast, there was any discussion with her about the benefits of having contrast and/or the risks of her declining it. I consider that if the complainant did express any such reluctance or refusal to have contrast administered, then she ought to have been properly counselled on the importance of a contrast-enhanced scan so that she could make an informed decision about whether or not to have contrast.

74. I cannot overemphasise the importance of public bodies making and maintaining records that will allow others to follow their decision-making processes and understand the basis for their decisions. This point is made clear in the Principles of Good Administration, which are included at Appendix One to this report. In particular, the Third Principle, '*Being Open and Accountable'*, requires that public authorities create and maintain reliable and usable records as evidence of their activities, and to give reasons for their decisions.

75. In a clinical setting, the making and maintaining of proper records is a vital component of providing a patient with effective care and treatment. It is also essential for demonstrating that a patient has received care that is reasonable and in accordance with relevant standards, and that has been provided with the patient's informed consent. Effective and supportive communications skills are key to providing compassionate care for cancer patients, eliciting their concerns and ensuring truly informed consent. The paucity of documentation and absence of evidence of decision-making regarding the administration of contrast at the March 2013 CT scan raises concerns about the process of informed consent and whether the necessary healthcare information was communicated.

76. I consider that the failure of radiology staff to make a proper record of the discussions and decisions that resulted in the complainant not having a contrast enhanced scan on 8 March 2013 is a failing in her care and treatment.

77. Although unable to establish why contrast was not administered at the March 2013 CT scan, I considered it important to examine what impact, if any, the conducting of an unenhanced scan had on the care and treatment the complainant received. This was because she is of the firm view that if a contrast-enhanced scan had been performed in March 2013, her brain metastases may have been identified and treated much sooner than was the case. I am in no doubt that the reference in the report of the September 2014 CT to the possibility of a brain metastasis, which was *'virtually invisible without IV contrast'*, having been present at the time of the March 2013 CT scan, only heightens the complainant's concern in this regard.

78. I note that the Radiology IPA and the Neuroradiology IPA both considered that the March 2013 CT scan was read and reported correctly. I accept the IPAs' advice. I note too that although the Radiology IPA and the Neuroradiology IPA considered that Radiologist B correctly identified intracranial masses on the September 2014 CT scan, they were both of the view that the reporting of that scan, in relation to the possibility of one of the masses being identifiable on the March 2013 scan, was likely to have been influenced by *'hindsight bias'*. Again, I accept this advice from the IPAs.

79. I note that when the Radiology Discrepancy Meeting reviewed the two CT

scans, it concluded that it was *'clinically highly unlikely'* that any brain metastases were present at the time of the March 2013 CT scan because *'this would not explain the presenting symptoms and there was no radiology record of pressure and altered feeling symptom progression until almost 18 months later.'* I note the Radiology IPA agreed that there was *'nothing on the [March 2013 CT scan] to explain [the complainant's] symptoms at that time'.*

80. In addition, I note that the Independent Review also found that there was *'no convincing abnormality'* in the March 2013 CT scan. The Independent Review, however, reached a different conclusion with regard to the likelihood of brain metastases having been identified at that time, had contrast been administered. It considered that there was *'approximately a 50% chance of [a contrast scan in March 2013] showing [brain metastases]'*, although I note the Independent Review report provided no detail of the basis for that view.

81. I note that at interview with an Investigating Officer, Radiologist A presented data which he said demonstrated that there was only approximately a one per cent chance of the complainant's brain metastases being present at the time of the March 2013 CT scan.

82. I note the Radiology IPA was uncertain as to whether the performing of a contrast-enhanced scan in March 2013 would have allowed *'early detection of a lesion'*, and that the Neuroradiology IPA advised that it would be *'highly unusual for an intracranial metastasis to be quiescent for 18 months without causing any worsening/new symptoms'* in the intervening period.

83. I am mindful that the complainant maintains that the 'pressure feeling' in her head, which prompted the Surgeon to request the March 2013 CT scan, continued after the scan result was reported to her, and that she (the complainant) accepted this as her *'new normal'*. My examination of the complainant's medical records found no evidence of her having reported the pressure feeling again, or any further neurological or visual symptoms, following the March 2013 CT scan until she attended a consultation with the Ophthalmology Surgeon on 11 August 2014. She did, however, report a number of other non-neurological/non-visual symptoms over the same period to clinicians involved in her care and treatment.

84. In this regard, I note that when the Oncologist wrote the complainant's GP on 1 October 2014, following the September 2014 CT scan, he referred to the complainant not having reported any *'further symptomatology'* after the pressure feeling in March 2013 *'despite having other problems on follow up.'* I note too that when the complainant made the Ophthalmology Complaint to the Trust, she stated that the flashing lights symptoms she had reported to the Ophthalmic Surgeon on 11 August 2014 '*had started on Wednesday 30th July 2014'*.

85. In my view, it is not possible to say whether the brain metastases identified on the September 2014 CT scan were present at the time of the March 2013 CT scan and, importantly, if they were present, whether they would have been identified at that time, had contrast been administered. On balance, however, I find the Neuroradiology IPA's advice regarding *'the paucity of symptoms of neurological dysfunction'* in the 18-month period between the March 2013 CT scan and the September 2014 CT to be persuasive. I accept the Neuroradiology IPA's advice that this indicates a low likelihood of a contrast-enhanced scan in March 2013, had one been performed, identifying the brain metastases seen in the September 2014 CT scan.

86. I do not, therefore, conclude that the diagnosis and subsequent treatment of the complainant's brain metastases was delayed because a contrast-enhanced CT scan was not performed in March 2013. I do, however, conclude that the Trust's failure to make a proper record regarding discussions and decisions about the non-administration of contrast at the March 2013 CT scan caused the complainant to experience the injustice of uncertainty, distress and frustration because she cannot be assured that decisions about the care and treatment she received on that occasion were made for the right reasons, and that they had regard to her informed consideration of all the relevant factors.

87. I uphold this element of the first issue of complaint.

Communication of the result of the March 2013 CT scan

88. The complainant is aggrieved that when the Oncologist informed her of the result of the March 2013 CT scan, he did not comment about, or act on, the fact that the scan had been performed without contrast, and he did not make her

aware that the report stated that she had been *'not keen'* to have contrast.

89. My investigation established that following the March 2013 CT scan, the complainant attended a review appointment with the Oncologist on 12 March 2013. I note that in his letter to the complainant's GP about that review appointment, the Oncologist wrote, *'[The complainant] … had a CT scan of her brain on [8 March 2013] … this thankfully shows no obvious abnormality.'* There is no reference in the GP letter to the Oncologist having any concern that an unenhanced CT scan had been performed or to him having noted, and discussed with the complainant, that the scan report stated the reason an unenhanced scan had been conducted was because she had been *'not keen to have IV contrast'*. There is no reference either to the Oncologist having asked the complainant whether the pressure feeling, which had prompted the March 2013 CT scan, had resolved (or not), nor is there any indication that the complainant reported any neurological or visual disturbance symptoms at that time.

90. My investigation found too that when the Surgeon - the clinician who had requested the March 2013 CT scan - wrote on 15 March 2013 to the complainant's GP, she advised that she had telephoned the complainant that day to inform her of the CT scan result. The Surgeon stated in the GP letter, *'CT was normal with no acute area of clinical abnormality identified.'* I note there is no reference in the Surgeon's letter to her having any concern that an unenhanced scan had been performed or to her having noted, and made the complainant aware, that the scan report indicated an unenhanced scan had been conducted because she (the complainant) had been *'not keen'* to have contrast administered. There is no reference either to the Surgeon having asked the complainant whether she was (or was not) still experiencing the pressure feeling in her head.

91. In commenting on a draft of this report, the Trust stated that both the Oncologist and the Surgeon (as well as the complainant herself - a matter to which I will return) were *'clear that [the complainant's] symptom of headache had gone away by the time [she] was reviewed to discuss [her] scan results.'* While I note the Trust's position, it remains the case that there is an absence of

documentation relating to the discussion of the complainant's neurological symptoms, either resolved or persisting, when the Oncologist and the Surgeon spoke to her about the result of the March 2013 CT scan. In relation to the complainant's position on this matter, I note that in commenting on a draft of this report, she maintained there was no discussion of the pressure feeling in her head when she was reviewed by the Oncologist on 12 March 2013. The complainant reasserted too that her symptom was still evident at that time but that she had accepted this as her 'new normal'.

92. In the circumstances, it is not possible to be certain if the two clinicians, in informing the complainant of the result of the March 2013 CT scan, did take the necessary steps to establish whether the pressure feeling that had led to the scan had resolved or whether its persistence warranted further investigation. This is an important point, given the Radiology IPA's advice that it was for *'the clinical team to read the [March 2013 CT scan] report and decide subsequently if a repeat scan [was] indicated based on the patient's symptoms'*, and the Oncology IPA's advice that had the complainant's headache persisted, *'it would have been appropriate to conduct an MR brain scan with contrast.'*

93. Furthermore, the absence of documentation regarding the consideration given in March 2013 to the continuing presence, or absence, of neurological symptoms means that it is not possible to be certain whether proper regard was given to the potential impact of an unenhanced CT scan having been performed. Again, this is significant, given the Neuroradiology IPA's advice that the identification of a brain metastasis on a non-contrast scan is *'very difficult or even near impossible.'*

94. I note that at interview with an Investigating Officer, the Oncologist said that if the complainant had reported the same pressure feeling symptom, or any other neurological or visual disturbance symptom, to him at the review appointment on 12 March 2013, he would have arranged an MRI scan but that since the complainant had been well at that time, and her pressure feeling symptom had resolved, he did not consider any follow-up action, in terms of a further CT scan or MRI scan, was warranted at that time. I have no reason to doubt that the Oncologist (and/or the Surgeon) would have considered the need for further

investigation had the complainant indicated that her pressure feeling symptom was persisting. However, there is no evidence in the complainant's medical records that either the Oncologist, or the Surgeon, established that the symptom had, in fact, resolved.

95. I consider the failure of the Oncologist, and the Surgeon, to make a proper record of their consideration of the complainant's neurological symptoms, following the March 2013 CT scan, particularly given that the scan report made clear that an unenhanced scan had been conducted and it stated the reason for that was that the complainant had been '*not keen to have IV contrast'*, is a failing in the complainant's care and treatment. I am satisfied this failing caused the complainant to experience the injustice of continuing uncertainty, distress and frustration because she cannot be assured that the decision not to refer her for a further brain scan had proper regard to her presenting symptoms at that time.

96. I uphold this element of the first issue of complaint.

Communication of the result of the September 2014 CT scan

97. The complainant expressed concern that when the Oncologist informed her of the result of the September 2014 CT scan, he did not disclose that the scan report referred to the possibility of one of the identified brain metastases having been present at the time of the March 2013 CT scan, and to this mass being *'virtually invisible without IV contrast.'*

98. My investigation found that following the September 2014 CT scan, the complainant attended a review appointment with the Oncologist on 1 October 2014. By that time, the complainant had already been reviewed by the Surgeon, on 24 September 2014, and had been informed of the scan result. She had also had an MRI brain scan on 29 September 2014, which had confirmed the brain metastases identified on the September 2014 CT scan.

99. I note that when the Surgeon wrote to the complainant's GP on 24 September 2014 about her review of the complainant that day, she stated, *'[The complainant] had been complaining of some visual disturbances and we arranged for her to have an urgent CT brain … Unfortunately this CT has shown evidence of a lesion … measuring 2cm in size. There is also a 6mm lesion … I*

will arrange for her to be reviewed by [the Oncologist] with the results of the MRI … Obviously this has been difficult news for [the complainant] to hear today.' I note the Surgeon's letter to the complainant's GP made no reference to the report of the September 2014 CT scan having highlighted a possible issue with the reading of the March 2013 CT scan, that is, that one of the two brain metastases identified at that time may have been visible on the earlier scan.

100. In relation to the Oncologist's review of the complainant on 1 October 2014, I found he recorded in his notes, *'… CT scan of brain which took place on 23rd September 2014 … this unfortunately showed 2 intracerebral metastases … MRI of head on 29th September 2014 has not been fully reported but does suggest that there are 2 metastases … I have gone over the results with [the complainant] this afternoon ...'*

101. I also found that the complainant's medical records document that when the Oncologist spoke with her, by telephone, on 9 October 2014, she asked if any lesions had been identified on the March 2013 CT scan. (By that time, the complainant had been made aware by the Ophthalmic Surgeon, on 6 October 2014, that the September 2014 CT scan report had raised a possible issue with the reading and/or reporting of the March 2013 CT scan) I note the Oncologist recorded that he informed the complainant that *'the current report of her imaging … indicates that there may be some slight abnormality at the site of the occipital metastases on the CT in 2013 which was not reported by the Radiologist at the time.'*

102. The complainant's medical records also document that when the Oncologist again reviewed her on 20 October 2014, he advised that when he had first seen her following the September 2014 CT, he had been concerned about the need *'to be clear about the information [in the scan report] before [he] delivered this to her hence the reason why [he] had not delivered this information to her …'*

103. I note that at interview with an Investigating Officer, the Oncologist confirmed he did not inform the complainant on 1 October 2014 that the September 2014 CT scan report referred to the possibility of a mass being present at the time of the March 2013 CT scan, and to this mass having been *'virtually invisible'* without

intravenous contrast. I note the Oncologist explained why he did not disclose that information to the complainant at that time. He said that he had wanted to first clarify and confirm these aspects of the scan report with radiology colleagues. He said too that the complainant had been distressed and he had not wanted to add to that distress by sharing the full detail of the report at that time, and that he had not wanted to deflect the complainant's focus that day from discussion of the diagnosis and decisions about treatment.

104. I note the Oncologist also said at interview that following the review appointment with the complainant on 1 October 2014, he spoke to Radiologist A and Radiologist B about the reference in the September 2014 CT scan report to a mass being *'virtually invisible'* on the March 2013 CT scan, and that he brought both scans to the attention of the Director of Radiology.

105. It is not in dispute then that, as the complainant maintains, the Oncologist did not disclose the full detail of the report of the September 2014 CT scan when he reviewed her on 1 October 2014. It is apparent too that the Surgeon did not share that information with the complainant either, when she reviewed the complainant on 24 September 2014 and informed her of the September 2014 CT scan result.

106. It was most unfortunate, and undoubtedly highly distressing for the complainant, that it was within the context of the unrelated ophthalmology consultation on 6 October 2014, that she became aware of the September 2014 CT scan report's reference to the possibility of a brain metastasis being visible on the March 2013 CT brain scan

107. Since that unforeseen development on 6 October 2014 meant the matter was effectively taken out of the Oncologist's hands, I am not in a position to say whether he would have disclosed the full content of the September 2014 CT scan report to the complainant at a later stage. Nevertheless, having reviewed the complainant's medical records and taken account of her views and those of the Oncologist, I consider that the Oncologist ought to have informed the complainant that Radiologist B had identified that there may have been an abnormality on the March 2013 CT scan. While I understand the Oncologist's reluctance to add to the distress the complainant was already experiencing that

day, and his awareness of the need to ensure the complainant's focus remained on decisions regarding treatment for her brain metastases, I consider that candour was required, even if at a later point clarification of the interpretation of the March 2013 CT scan was necessary.

108. Equally, there was a duty on the Surgeon to be candid and to inform the complainant about the findings of Radiologist B's review of the March 2013 CT scan report.

109. I consider the failure of the Oncologist, and the Surgeon, to disclose to the complainant information about Radiologist B's review of the March 2013 CT scan to be a failing in the complainant's care and treatment. I am satisfied this failing caused the complainant to experience the injustice of distress and uncertainty.

110. I uphold this element of the first issue of complaint.

Escalation of imaging issues raised in September 2014 CT scan report

111. The complainant expressed concern that the Trust failed to launch an investigation into the issues raised by the September 2014 CT scan report (that is, the possibility of a mass having been identifiable on the March 2013 CT scan) prior to its receipt of the Imaging Complaint, which she made to the Trust on 21 October 2014.

112. My investigation established that a potential issue with the reporting of the March 2013 CT scan was highlighted by Radiologist B in her report of the September 2014 CT scan. Radiologist B stated in her report, *'… on review of the [March 2013] CT there may be a very small mass adjacent to the posterior hemispheric fissure … which was virtually invisible without IV contrast.'* The investigation found too that the March 2013 CT scan and the September 2014 CT scan were reviewed at the Radiology Discrepancy Meeting, which took place on 19 November 2014.

113. I note that the Trust's Guidelines for Radiology Discrepancy Meetings state the purpose of discrepancy meetings '*is to validate reported discrepancies and to facilitate learning thereby improving patient safety'.* The Guidelines also state that a radiology reporting discrepancy occurs when *'a retrospective review or*

subsequent information about patient outcome, leads to an opinion different from that expressed in the original x-ray report.' In my view, the finding of Radiologist B, that a mass (one that was *'virtually invisible without IV contrast'*) may have been identifiable on the March 2013 CT scan (and which was not reported at that time) met that definition. I note, however, that Radiologist B did not submit the case for review through the radiology discrepancy process.

114. I note too that in response to my investigation enquiries, the Trust said that the Oncologist informed the complainant on 27 October 2014 that he had brought the reports of the March 2013 CT scan and the September 2014 CT scan to the attention of the Clinical Director for Radiology, who had referred the imaging to the Radiology Discrepancy Meeting for review. This statement is in keeping with the evidence the Oncologist provided at interview with an Investigating Officer. The Oncologist said that after he became aware of the comment in the September 2014 CT scan report about the possibility of a mass being visible on the March 2013 CT scan (and had discussed the matter with Radiologist A and Radiologist B) he brought the issue to the attention of the (then) Clinical Director for Radiology who, in turn, had referred the scans for consideration at the Radiology Discrepancy Meeting.

115. This account of events is, however, at odds with the Trust's response of 11 March 2015 to the Imaging Complaint. In that response, the Trust stated that following receipt of the complaint, the Imaging Services Manager met with the Imaging Clinical Director and the Imaging Site Lead for Belfast City Hospital and '*It was then decided that the best way to evaluate if the lesion was clearly visible on [the March 2013 CT scan] was for both scans to be presented at a "discrepancy meeting".'* This statement is consistent with the evidence the Imaging Services Manager provided at interview with an Investigating Officer. He said he understood that it was the Imaging Complaint the Trust received from the complainant on 21 October 2014 that had led to the radiology discrepancy procedure being initiated.

116. It is evident then that there are differing recollections as to how the March 2013 CT scan and the September 2014 CT scan came to be reviewed at the Radiology Discrepancy Meeting on 19 November 2014. On balance, however, I

am not persuaded, on the basis of the evidence available to me, that the potential issue Radiologist B identified with the reporting of the March 2013 CT scan would have been referred for review had it not been for the complainant submitting the Imaging Complaint to the Trust.

117. The First Principle of Good Administration, '*Getting it Right',* requires public bodies to act in accordance with their policy and guidance. The Trust failed to meet this standard of good administration when it failed to initiate the learning from discrepancy process as soon as a potential issue with the reporting March 2013 CT scan was noted. I consider this failing to be maladministration, which caused the complainant to experience the injustice of frustration.

118. I uphold this element of the first issue of complaint.

119. I should also record that in considering this element of the complaint, I had regard to whether the Trust ought to have contemplated initiating a SAI investigation in relation to the potential issue with the reporting of the March 2013 CT scan that Radiologist B had highlighted in the report of the September 2014 CT scan.

120. I note that the Trust's Policy and Procedure for the Management of Complaints and Compliments states that all complaints received are to be graded using the risk grading process outlined in the Trust's Adverse Incident Reporting Policy and Procedure. It states too that where a complaint is graded as 'high risk' (category 'red'), *'consideration should … be given to ascertain if this will meet the [SAI] reporting criteria.'*

121. I note that in response to investigation enquiries, the Trust stated that the Imaging Complaint was graded as a 'medium risk' complaint. I note the Trust explained that consideration was given at the time to whether the Imaging Complaint should be graded as 'high risk' but that *'On review of the images by Radiologists it was considered that there was unlikely to have been a discrepancy and therefore the patient did not come to harm as a result of the interpretation of the images being incorrect.'* The Trust also said that it had been appropriate therefore to take forward the Imaging Complaint via the complaints process rather than as an SAI.

122. I accept that under the Trust's Policy and Procedure for the Management of Complaints and Compliments, there was no requirement for the Trust to consider whether a medium risk complaint met the SAI criteria. In the case of the Imaging Complaint, however, I note the Trust was unable to produce any documentation to support the account it provided of how the complaint came to be graded as medium.

123. I previously highlighted in this report the importance of public bodies creating and maintaining contemporaneous records to document their reasons for the decisions they take, and I pointed out that this is a requirement of the Third Principle of Good Administration, '*Being Open and Accountable'*. I consider the Trust's failure to create and/or maintain a record of the basis for its decision that the Imaging Complaint should be graded 'medium risk' is maladministration. I am satisfied this maladministration caused the complainant to experience the injustice of uncertainty and frustration because she cannot be assured that that the Imaging Complaint grading decision was taken for the proper reasons, and that it was appropriate that the SAI reporting criteria were not considered.

Summary of findings on Issue One

124. My investigation of this first issue of complaint examined whether the care and treatment the Trust provided to the complainant with respect to the March 2013 CT scan and the September 2014 CT scan was appropriate, reasonable and in accordance with relevant guidance and/or procedures.

125. I found that:

- there was a failure to make a proper record of the discussions and decisions that resulted in the complainant not having a contrast-enhanced scan on 8 March 2013;

- there was a failure to make a proper record of the consideration of the complainant's neurological symptoms following the 'normal' but unenhanced March 2013 CT scan;

- there was a failure to disclose to the complainant, at the earliest opportunity, that the September 2014 CT scan reported referred to the possibility of a brain metastasis being visible on the March 2013 CT scan;

- there was a failure to initiate the learning from discrepancy process, in relation to a potential issue with the reporting March 2013 CT scan, at the earliest opportunity; and

- there was a failure to document the decision taken about the grading of the Imaging Complaint.

126. I uphold this first issue of complaint.

Issue Two: Whether the care and treatment provided to the complainant with respect to ophthalmology (in relation to medical history, symptoms, appropriate personal data use and subsequent complaint input) from August 2014 to April 2015 was appropriate, reasonable and in accordance with relevant guidance/procedures.

Detail of Complaint

127. The complainant raised concerns about the ophthalmology care and treatment she received. She said that she attended an initial consultation with the Ophthalmic Surgeon on 11 August 2014, following a referral from her GP to the Trust's Ophthalmology service. The complainant said the referral was due to her concern about ptosis (drooping of her eyelid) following a private practice procedure.

128. The complainant said that at the consultation on 11 August 2014, the Ophthalmic Surgeon performed an eye examination and discussed the ptosis. She said she told him that on eight separate days she had been experiencing *'flashing lights … coloured lights and had reduced peripheral awareness left side.'* She said that the Ophthalmic Surgeon concluded the appointment by asking her to book a review appointment in eight weeks' time.

129. The complainant informed me that she had further appointment with the Ophthalmic Surgeon on 6 October 2014. She said the Ophthalmic Surgeon

'only dealt briefly with the ptosis' and *'asked nothing about flashings etc*.' The complainant also expressed concern that without her knowledge, the Ophthalmic Surgeon accessed the report of the September 2014 CT scan, via the NIECR, and that he *'blurted out that the tumour was there over a year ago'*.

130. The complaint complained to my Office about the following issues regarding her ophthalmology care and treatment:

- The failure of the Ophthalmic Surgeon to treat *'the patient in front of him, namely one with a recent history of an aggressive cancer'* and to consider *'what the significance of flashings etc could have/mean for such an individual'.*
- The failure of the Ophthalmic Surgeon to refer her for a scan in view of the visual disturbance symptoms she reported to him at the 11 August 2014 appointment. She said the Ophthalmic Surgeon ought to have referred her for a brain scan or least referred her symptoms back to the Oncologist for consideration.
- The Ophthalmic Surgeon's accessing of her electronic medical records on the NIECR, without her consent. She said the Ophthalmic Surgeon did not access the records in an emergency, nor could he offer her direct care in relation to her recently diagnosed brain metastases.

Evidence Considered

Standards and Guidelines

131. I considered the following standards and guidelines:

- Belfast Health and Social Care Trust Policy and Procedure for the Management of Complaints and Compliments, 2013; and
- Department of Health Social Services and Public Safety Regional Health and Social Care Complaints Procedure Guidance, 2009.
- NIECR Privacy Notice

Relevant extracts of these standards and guidelines are at Appendix Two to this report.

Relevant Documentation

132. I completed a review of the documentation I obtained from the Trust, which included the complainant's medical records and the Trust's file relating to the Ophthalmology Complaint. Relevant extracts of the documentation reviewed is at Appendix Three to this report.

133. Based on my review of the documentation, I compiled a chronology of key events relating to the concerns the complainant raised about her ophthalmology care and treatment. This chronology is at Appendix Eight to this report.

The Trust's response to investigation enquiries

134. In responding to investigation enquiries, the Trust provided me with screen shots taken from the NIECR system when an individual is accessing a patient's electronic care record. These screen shots indicated that in order to access a record, the user must:

- (where the patient is present) state whether the patient grants or withholds consent for the record to be accessed;
- (where the patient is present but unable to grant consent) state whether the record is being accessed in a *'medical emergency'* or *'in the patient's best interest*;*'*
- (where the patient is not present) state the reason why access is required (possible reasons are: '*new referrals'; 'preparation', 'follow up', 'clinic coding', 'medicine reconciliation', 'data quality'*, and *'other'* (such as the investigation of a complaint).

135. The information the Trust provided about accessing the NIECR system also indicated, *'User access is based on staff role … e.g. medical staff having level 1 – full access … Access is granted for DIRECT PATIENT CARE only.'*

Interviews with Trust staff

136. An Investigating Officer conducted a series of interviews with Trust staff to facilitate a better understanding of the sequence of events and decisions relevant to the concerns the complainant raised about the care and treatment she

received. The Trust staff interviewed included:

- The Ophthalmic Surgeon, who provided care and treatment to the complainant in August and October 2014; and
- The Trust's Ophthalmology Services Manager, who investigated the Ophthalmology Complaint.

137. I consider the following key points from the information provided to the Investigating Officer during the interviews are particularly relevant to this issue of complaint:

- The Ophthalmic Surgeon's consultations with the complainant on 11 August and 6 October 2104 resulted from a referral by her GP.
- At the time of both consultations, the Ophthalmic Surgeon considered the 'flashing lights' symptom the complainant reported at the initial consultation on 11 August 2014 was due to posterior vitreous changes, and he did not request any brain scans.
- Given that posterior vitreous detachment can cause a retinal detachment, the Ophthalmic Surgeon decided at the 11 August 2014 consultation to review the complainant in six to eight weeks *'as a precaution'*.
- Discussion during the 6 October 2014 review consultation focused on the complainant's concerns about ptosis. It had not been until the end of the consultation that the complainant raised the flashing lights symptom she had reported at the initial consultation on 11 August 2014.
- The Ophthalmic Surgeon accessed the complainant's electronic records via her NICER towards the end of the 6 October 2014 consultation
- The Ophthalmic Surgeon discussed with the complainant the contents of the report of September 2014 CT scan, including the reference to a brain lesion being *'virtually invisible'* on the March 2013 CT scan.
- The Ophthalmic Surgeon considered there was *'an inferred consent'* for him to access the complainant's records via her NIECR on 6 October 2014. He considered it unlikely that a patient would object to a doctor having full

information that was relevant to their care or their history, while they were present.

- The Ophthalmology Services Manager obtained detailed comments from the Ophthalmic Surgeon, which formed the basis of the Trust's response to the Ophthalmology Complaint.

Independent Professional Advice

The Ophthalmology IPA

138. In relation to the complainant's initial consultation with the Ophthalmic Surgeon on 11 August 2014, the Ophthalmology IPA advised, *'I believe the clinical record and dictated letter suggest that the consultation…was appropriate, reasonable and in accordance with routine practice. I agree that the symptoms of photopsia being reported as unilateral, in the presence of a posterior vitreous detachment would not have precipitated a scan of the brain being requested.'*

139. In relation to the review consultation on 6 October 2014, the Ophthalmology IPA advised, *'I believe the clinical record and dictated letter suggest that the consultation…was appropriate, reasonable and in accordance with routine practice.'* The Ophthalmology IPA continued, *'A weiss ring was noted in the left consistent with the previous photopsia being attributed to the posterior vitreous changes. It was not documented that [the Ophthalmic Surgeon] enquired if the symptoms of flashing had continued. Equally [the complainant] did not offer this information and advised of the result of the scan only at the end of consultation.'*

140. The Ophthalmology IPA also advised, *'As a consultant ophthalmologist I would not have routinely requested a brain scan (CT or MRI) on a patient with unilateral symptoms of photopsia in the presence of a documented posterior vitreous detachment and weiss ring. Symptoms of photopsia are very common and normally associated with issues of the retina and vitreous … Patients with brain stem lesions or a mass effect causing raised intracranial pressure can present with either mobility and/or swelling of the optic discs (all excluded here on clinical examination … I … would not [have] requested a brain scan based on symptoms in August (CT or MRI) in spite of the history of breast cancer.'*

141. In relation to the Ophthalmic Surgeon's accessing of the complainant's records via the NIECR, the Ophthalmology IPA advised that she believed this was '*entirely appropriate'* as it was *'vital for all clinicians caring for a patient to be able to access pertinent patient information.'*

142. The Ophthalmology IPA's full advice report is at Appendix Nine to this report.

Analysis and Findings

143. The complainant expressed concern that, in light of her presenting symptoms and given her previous cancer diagnosis, the Ophthalmic Surgeon did not provide appropriate care and treatment at the ophthalmology consultations on 11 August and 6 October 2014. The complainant also raised concern that the Ophthalmic Surgeon accessed her electronic records, without her consent, during the 6 October 2014 review consultation. My findings on each of these elements of this second issue of complaint are set out below.

Ophthalmology care and treatment provided on 11 August 2014

144. The complainant considers that the Ophthalmic Surgeon did not have appropriate regard to the significance of the flashing lights symptom she reported to him at the initial consultation on 11 August 2014, particularly given her history of cancer. She considers that in the circumstances, the Ophthalmic Surgeon ought to have referred her for a brain scan.

145. My investigation established that on 12 June 2014, the complainant's GP referred her to the Trust's Ophthalmology Services. The GP's referral letter highlighted the complainant's cancer diagnosis in April 2012 and provided brief details of her subsequent cancer treatment.

146. I note the reason the GP gave for the ophthalmology referral was the complainant's concerns about *'persistent left ptosis'*, which she considered was a result of a private practice procedure (unrelated to her cancer treatment) which she had undergone some ten months previously. I note the GP sent a further referral letter to the Trust on 25 July 2014, in an attempt to expedite an ophthalmology appointment for the complainant, again stating that the reason for the referral was ptosis. I note neither referral letter mentioned

any visual disturbance symptoms. This is in keeping with the complainant's statement in the complaint she made to the Trust on 20 October 2014 (that is, the Ophthalmology Complaint) that the flashings of light she reported to the Ophthalmic Surgeon on 11 August 2014 had started on 30 July 2014

147. My examination of the complainant's medical records found that when the Ophthalmic Surgeon wrote to the complainant's GP about the initial consultation on 11 August 2014, he stated that on examining the complainant, he found she had '*bilateral upper lid ptosis … more marked on the left side'.* The Ophthalmic Surgeon documented that he had noted the complainant's history of cancer and chemotherapy. He also documented that he explained to the complainant how the action of the private practice procedure she had undergone may have been affected by the medication she had had for the treatment of her cancer.

148. I note the Ophthalmic Surgeon also informed the GP that at the 11 August 2014 consultation the complainant reported *'an episode of photopsia and floaters in her left eye in the past week'*, and that he considered this was *'related to posterior vitreous detachment'.* He wrote too that he *'warned'* the complainant about *'retinal detachment symptoms'* and that he arranged to see her again in eight weeks' time '*for further assessment'.*

149. I note that when the Ophthalmic Surgeon provided comments to the Ophthalmology Services Manager on 28 October 2014 (for the purposes of informing the Trust's response to the Ophthalmology Complaint) he (the Ophthalmic Surgeon) advised that at the 11 August 2014 consultation, he had examined the complainant's eyes *'to exclude evidence of pupillary abnormality or orbital abnormality to suggest secondary problems relating to her previous breast cancer.'*

150. I note the Ophthalmic Surgeon also advised in his comments on the Ophthalmology Complaint that he examined the complainant's eyes in relation to both her ptosis and the new symptom of flashing lights that she had first experienced approximately ten days previously. The Ophthalmic Surgeon stated that his examination had found '*evidence of collapse of the vitreous gel*

(posterior vitreous detachment)', which he had considered was the most likely cause of the flashing lights symptom. I note the Ophthalmic Surgeon also commented that he had advised the complainant to report any further flashing lights (and other retinal detachment symptoms) and that he had arranged to review the complainant *'as a precaution'.*

151. I further note that when he commented on the Ophthalmology Complaint, the Ophthalmic Surgeon stated, '*Photopsia/flashing lights caused by brain metastases are very uncommon. Scanning of the brain would not be an initial part of the work up for these symptoms and when I saw her on the 11th August 2014 she had only had these symptoms for just over a week.'*

152. I note that when the Trust responded on 22 December 2014 to the Ophthalmology Complaint, it addressed the complainant's concerns that the Ophthalmic Surgeon did not appropriately assess her symptoms of flashing, including that he ought to have requested a brain scan for her. In this regard, the Trust stated, *'[The Ophthalmic Surgeon] has advised that your ocular examination showed left posterior vitreous detachment, which is the most common cause of flashing symptoms. A scan would not normally be warranted, unless the flashing continued over a significant period of time, and would not normally be a first line investigation at onset of symptoms. A scan would be indicated if the flashing symptoms were on-going, and if there was no ophthalmic cause found on clinical examination.'*

153. I note the Ophthalmology IPA advised that based on the available records, she considered the initial ophthalmology consultation on 11 August 2014 *'was appropriate, reasonable and in accordance with routine practice.'* I note the Ophthalmology IPA also advised, *'… the symptoms of photopsia being reported as unilateral, in the presence of a posterior vitreous detachment would not have precipitated a scan of the brain being requested.'* I note the Ophthalmology IPA further advised, *'I … would not [have] requested a brain scan based on the reported symptoms in August (CT or MRI) despite the history of breast cancer.'* I accept the Ophthalmology IPA's advice.

154. The available evidence relating to this element of the complaint therefore demonstrates that at the initial consultation on 11 August 2014, the Ophthalmic

Surgeon had regard to the complainant's cancer history, and that he examined her eyelids in relation to the ptosis (the reason for the ophthalmology referral) and her eyes in relation to the flashing lights (the new symptom she reported at the consultation). The evidence shows too that the Ophthalmic Surgeon considered the most likely cause of the flashing lights was the posterior vitreous detachment he found in the complainant's left eye; that in the circumstances (the presence of the posterior vitreous detachment and the fact that the complainant had only recently begun to experience the flashing lights symptom), he considered a brain scan was not warranted but that it was appropriate to review the complainant in around eight weeks' time.

155. This evidence, along with the advice provided by the Ophthalmology IPA, which I accept, leads me to conclude that the ophthalmology care and treatment the Ophthalmic Surgeon provided to the complainant at the initial consultation on 11 August 2014 was reasonable and in accordance with relevant standards.

156. I do not uphold this element of the second issue of complaint.

Ophthalmology care and treatment provided on 6 October 2014

157. I note when the Ophthalmic Surgeon wrote to the complainant's GP about the review consultation on 6 October 2014, he stated that that it was after he and the complainant *'had a long conversation'* about her ptosis that she informed him that the September 2014 CT scan and the MRI brain scan she had had on 29 September 2014 *'had shown an intracranial tumour'.* I note the Ophthalmic Surgeon informed the GP that he *'had a look at the reports of [the complainant's] scans [that day]*' and was of the view that neither of the lesions identified would explain the complainant's eyelid position but *'could explain the photopsia on the left side'*, although he still considered the complainant's posterior vitreous detachment was *'a more common cause of photopsia.'*

158. I note that when he provided comments to the Ophthalmology Services Manager on the Ophthalmology Complaint, the Ophthalmic Surgeon stated that a brain scan '*would normally not be warranted unless photopsia continued',* and that he pointed out that despite '*having been invited to do so'*, the complainant had made no contact with him during the period between the two ophthalmology consultations.

159. I note the Ophthalmic Surgeon also commented that the complainant did not mention the flashing lights symptom during their discussion of the ptosis at the review consultation, and that given her *'normal retinal exam'*, he had been of the view that the flashing lights symptom had resolved. I note too that the Ophthalmic Surgeon commented that it had only been at the end of the consultation that the complainant had enquired whether he was going to ask her about the flashing lights symptom.

160. I note that at interview with an Investigating Officer, the Ophthalmic Surgeon said that discussion during the review consultation on 6 October 2014 had focused on the complainant's concerns about ptosis. He said too that it was after the complainant had raised the flashing lights symptom at the very end of the consultation (by enquiring whether he was going to ask her about it) that they had spoken about it.

161. I note the Ophthalmology IPA advised that the review consultation on 6 October 2014 was '*appropriate, reasonable and in accordance with routine practice.'* In addition, the Ophthalmology IPA pointed out that the Ophthalmic Surgeon did not document if he enquired whether the complainant's flashing lights symptoms persisted, and also highlighted, *'Equally [the complainant] did not offer this information and advised of the result of the scan only at the end of consultation.'*

162. It is not in dispute that the Ophthalmic Surgeon did not specifically enquire about the complainant's flashing lights symptom when he reviewed her on 6 October 2014. The Ophthalmic Surgeon has said this was because he believed that the symptom had by then resolved – the complainant did not mention it during the course of the consultation, nor had she contacted him about the symptom during the period between the two consultations, despite having been invited to do so, should the symptom persist. The account the complainant gave of the 6 October 2014 consultation when she submitted her complaint to my Office confirms that she did not mention the flashing lights symptom until she was leaving the consultation room.

163. In the circumstances, it could be considered not unreasonable that the Ophthalmic Surgeon concluded during the ophthalmology review consultation

that the complainant was no longer experiencing the flashing lights. It could also be said, notwithstanding her recent brain metastases diagnosis, that if the complainant was still experiencing the flashing lights symptom at that time, it was important to bring that to the Ophthalmic Surgeon's attention. As I have noted already, the complainant did raise the symptom with the Ophthalmic Surgeon, albeit towards the end of the review consultation.

164. I am mindful that in his comments on the Ophthalmology Complaint, the Ophthalmic Surgeon stated that a brain scan '*would normally not be warranted* ***unless photopsia continued'*** *(*my emphasis). In my view, this indicates that even if the complainant did not raise the flashing lights symptom herself, it was important that the Ophthalmic Surgeon actively followed it up at the review consultation, by asking whether the symptom had settled.

165. Given the potential implications of the reoccurrence or persistence of the complainant's flashing lights symptom, I consider the failure of the Ophthalmic Surgeon to follow up on that symptom at the review consultation on 6 October 2014 was a failing in the complainant's care and treatment.

166. I considered the impact of this failing. I am mindful that by the time of the ophthalmology review consultation on 6 October 2014, the complainant had reported peripheral vision symptoms to the Surgeon on 10 September 2014, and she had had a CT scan on 23 September 2014 and an MRI scan on 29 September 2014, which had identified two brain metastases. The complainant had then seen the Oncologist on 1 October 2014 and arrangements for the management of the metastases had been set in train.

167. However, had circumstances been different, and the complainant had not informed the Surgeon of her visual disturbance symptoms on 10 September 2014, the fact that the Ophthalmic Surgeon did not actively follow up on her flashing lights symptom during the ophthalmology review consultation on 6 October 2014 could have resulted in a missed opportunity to consider the appropriateness of a brain scan, and, potentially, to diagnose the complainant's brain metastases as a result.

168. I am satisfied, therefore, that the failure to follow-up on the complainant's flashing lights symptom at the ophthalmology review consultation on 6 October

2014 caused the complaint to experience the injustice of distress and frustration and a loss of opportunity to receive the standard of care she was entitled to expect.

169. I uphold this element of the second issue of complaint.

Accessing the complainant's electronic records

170. The complainant is aggrieved that the Ophthalmic Surgeon accessed her electronic records, including the reports of the March 2013 CT scan and the September 2014 CT scan, without her consent.

171. My investigation established that at the end of the ophthalmology review consultation on 6 October 2014, as she was leaving the consultation room, the complainant informed the Ophthalmic Surgeon that she had recently had a CT and an MRI scan, which had identified she had two lesions in her brain.

172. As already highlighted, I note that when the Ophthalmic Surgeon wrote to the complainant's GP about that review ophthalmology consultation, he stated that he *'had a look at the reports of [the complainant's] scans [that day]*' and these had confirmed that the complainant had two lesions. I note the Ophthalmic Surgeon went on to state in the GP letter that he considered neither lesion would explain the complainant's ptosis but could explain the flashing lights symptom (although he remained of the opinion that the complainant's posterior vitreous detachment was the more likely cause).

173. I note that at interview with an Investigating Officer, the Ophthalmic Surgeon acknowledged that he had accessed the scan reports via the NIECR and said that he believed he had *'inferred consent'* to do so. I note the Ophthalmic Surgeon explained this comment by stating that he considered it unlikely that a patient would object to a doctor having full information that was relevant to their care or their history, while they were present.

174. There is no dispute then that at the ophthalmology review consultation on 6 October 2014, the Ophthalmic Surgeon did access the complainant's scan reports via the NIECR, without first obtaining her consent. It is clear that the Ophthalmic Surgeon believed it was appropriate for him to do so because the result of the scans – the identification of two brain metastases (which the

complainant had just reported to him) might have been relevant to the flashing lights symptom she had brought to his attention some weeks previously. This is evident from his comment at interview that the complainant's brain metastases could explain that flashing lights symptom.

175. In this same regard, I note the Ophthalmology IPA's advice was that the Ophthalmic Surgeon's accessing of the scan reports was '*entirely appropriate'* as it was *'vital for all clinicians caring for a patient to be able to access pertinent patient information.'*

176. It is my view that in the circumstances of the ophthalmology review consultation on 6 October 2014, it was not unreasonable that the Ophthalmic Surgeon concluded that the complainant's scan reports may be relevant to her ophthalmology care and treatment, and that he therefore considered it was appropriate for him to see them. Importantly, however, the information the Trust provided in response to my investigation enquiries confirms that in circumstances where a patient is present, their NIECR must only be accessed if the patient has given their consent (provided the patient is capable of doing so). It is clear that requirement was not met when the Ophthalmic Surgeon accessed the complainant's NIECR on 6 October 2014.

177. The First Principle of Good Administration, *'Getting it Right*', requires that public bodies act in accordance with their policies and procedures. I consider the Ophthalmic Surgeon's accessing of the complainant's NIECR on 6 October 2014, without first obtaining her consent, is evidence this standard of good administration was not met on that occasion.

178. I should also record that even if there had been no issue with the Ophthalmic Surgeon accessing the scan reports via the NIECR, I consider it was not appropriate for him to have spoken to the complainant about the content of those reports, including the September 2014 CT scan report's reference to the possibility of one of the brain metastases having been present at the time of the March 2013 CT scan. The disclosure of that information to the complainant had no relevance to the ophthalmology care and treatment the Ophthalmic Surgeon was providing to her; that detail of the scan report was a matter for the Surgeon, as the referring clinician, or the Oncologist. Undoubtedly, it was highly shocking

and distressing for the complainant to learn of that aspect of September 2014 CT scan report in the manner she did.

179. I consider the Ophthalmic Surgeon's accessing of the complainant's electronic records via the NIECR on 6 October 2014, without first obtaining her consent, constitutes maladministration. I am satisfied this maladministration caused the complainant to experience the injustice of distress.

180. I uphold this element of the second issue of complaint.

181. It is also important that I highlight my unease with the information the Trust provided to the complainant when it responded to her concern about the Ophthalmic Surgeon having accessed her electronic records. Specifically, when it responded on 22 December 2014 to the Ophthalmology Complaint, the Trust informed the complainant, '*[the Ophthalmic Surgeon] was permitted to access your records via NIECR at the time of your consultation'.* I accept that given his role, the Ophthalmic Surgeon had the appropriate level of authority to access to all of the complainant's electronic records on the NIECR. Importantly, however, on 6 October 2014, the Ophthalmic Surgeon was required to seek and obtain the complainant's consent, before exercising that authority. The Trust's response on the matter was not therefore a true and complete reflection of the rules regarding a clinician's accessing of information on the NIECR.

182. The scope of my investigation does not extend to an examination of the Trust's handling of the Ophthalmology Complaint. As such, it is not appropriate that I make any formal finding on this matter. Nevertheless, it is my expectation that the Trust reflects carefully on this observation.

Summary of findings on Issue Two

183. My investigation of this second issue of complaint examined whether the ophthalmology care and treatment the Trust provided to the complainant was appropriate, reasonable and in accordance with relevant guidance/ procedures.

184. I found that:

- there was a failure to follow up on the complainant's flashing lights symptom at the ophthalmology review consultation on 6 October 2014; and

- the complainant's electronic records on the NIECR were accessed inappropriately on 6 October 2014.

185. I did not find any failing in the ophthalmology care and treatment provided to the complainant on 11 August 2014.

186. I partially uphold this second issue of complaint.

CONCLUSION

187. This complaint concerns the care and treatment the Trust provided to the complainant following her cancer diagnosis in April 2012. My investigation examined the radiology and oncology care and treatment the complainant received in relation to two CT scans conducted in March 2013 and September 2014 to investigate the potential spread of her cancer. It also considered the ophthalmology care and treatment the complainant received in August and October 2014, following a referral from her GP in relation to ptosis.

188. My investigation found several failings in the care and treatment the Trust provided to the complainant, as well as instances of maladministration.

189. In relation to the complainant's radiology and oncology care and treatment, I identified a failure to document properly the discussions and decisions that led to the complainant not having a contrast-enhanced CT scan in March 2013; a failure to document properly the consideration of the complainant's neurological symptoms following that scan in March 2013; and a failure to disclose to the complainant, at the earliest opportunity, the findings of Radiologist B's review, in September 2014, of the March 2013 CT scan. I consider these were failings in the complainant's care and treatment.

190. In addition, I found there was a failure to initiate the Trust's learning from discrepancy process as soon as a potential issue with the reporting March 2013

CT scan was identified; and a failure to document the decision taken on the grading of the Imaging Complaint. I consider these failures constitute maladministration.

191. With regard to the complainant's ophthalmology care and treatment, I did not identify any failing in the care and treatment she received at the initial consultation on 11 August 2014. However, there was a failure to take appropriate follow up action, at the review appointment on 6 October 2014, in relation to the visual disturbance symptom the complainant had reported at the initial consultation. I consider this was a failing in the complainant's care and treatment. I also found that the accessing of the complainant's electronic records on 6 October 2014, without her consent, was maladministration.

192. I am satisfied that the failings in care and treatment and the maladministration disclosed by my investigation caused the complainant to experience the injustice of uncertainty, distress, frustration and a loss of opportunity to receive the standard of care and treatment she was entitled to expect.

193. I should also highlight that for a patient to bring a complaint against the health and social care trust that is responsible for providing her essential oncology treatment, whilst that treatment was still ongoing, is a challenging process, and one which undoubtedly placed increased emotional stress on the complainant at a time when having trust and rapport with treatment providers was key. The complainant then faced the additional burden of bringing her concerns to the Ombudsman's Office.

194. Overall, I partially uphold this complaint.

Recommendations

195. I recommend that within one month of the date of this report, the Trust's Chief Executive provide the complainant with a written apology, made in accordance with NIPSO's 'Guidance on issuing an apology'[12] for the injustice caused as a

[12] https://nipso.org.uk/site/wp-content/uploads/2019/07/N14C-A4-NIPSO-Guidance-on-issuing-an-apology-July-2019.pdf

result of the failings in care and treatment and the maladministration disclosed by my investigation.

196. I also recommend that the Trust consider carefully the learning highlighted by the Radiology IPA (the need for clear documentation regarding decisions on contrast) and by the Neuroradiology IPA (the need to consider and/or perform an MRI scan in patients with suspected metastatic disease who are unable or unwilling to have intravenous contrast for a CT scan), and that it share this learning with relevant staff. The Trust should within three months of the date of this report, provide me with evidence that this recommendation has been implemented.

197. I further recommend that the learning highlighted by the failings identified in this report be communicated to relevant Trust staff. The Trust should, within three months of the date of this report, provide me with evidence that this recommendation has been implemented.

198. In addition, although not a formal recommendation, it is my expectation that the Trust reflect on the fact that when it responded on 22 December 2014 to the Ophthalmology Complaint, it did not provide full and accurate information to the complainant, in relation to the Ophthalmic Surgeon having permission to access her electronic records.

199. The Trust accepted my findings and recommendations.

MARGARET KELLY
Ombudsman **27 March 2023**

Appendix 1

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.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.