

Hospital fails to diagnose breast cancer

A report by the Health Service Ombudsman
on an investigation into West Hertfordshire
Hospitals NHS Trust

Hospital fails to diagnose breast cancer

A report by the Health Service Ombudsman
on an investigation into West Hertfordshire
Hospitals NHS Trust

Presented to Parliament pursuant to Section 14(4)
of the Health Service Commissioners Act 1993

Ordered by
the House of Commons
to be printed on 22 October 2014

HC 697

© Parliamentary and Health Service Ombudsman copyright 2014.

The text of this document (this excludes, where present, the Royal Arms and all departmental and agency logos) may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not in a misleading context.

The material must be acknowledged as Parliamentary and Health Service Ombudsman copyright and the document title specified. Where third party material has been identified, permission from the respective copyright holder must be sought.

Any enquiries regarding this publication should be sent to us at phso.enquiries@ombudsman.org.uk.

This publication is available at <https://www.gov.uk/government/publications>

Print ISBN 9781474111393

Web ISBN 9781474111409

Printed in the UK for the Williams Lea Group on behalf of the
Controller of Her Majesty's Stationery Office

ID P002679043 10/14

Printed on paper containing 75% recycled fibre content minimum

Contents

Foreword	2
Ms G's complaint	3
Our decision	3
Our investigation	4
Summary of recommendations	16
Conclusion	17

Ms G's complaint

1. Ms G complains that in February and May 2010 West Hertfordshire Hospitals NHS Trust (the Trust) misdiagnosed her with mastitis. Ms G complains that she was not adequately assessed during these appointments and Trust staff did not carry out appropriate tests. Ms G is concerned that an opportunity to diagnose her with breast cancer was missed at these appointments in 2010. She was diagnosed with breast cancer and with secondary cancers in January 2012. Ms G complained to us because she felt the Trust had not been fully open and honest with her about what happened when it responded to her complaint in July 2012.
2. Ms G is still undergoing aggressive cancer treatment, although her condition is now terminal. She believes the aggressive treatment might not have been necessary and that her prognosis would not now be terminal had the Trust not missed opportunities for early diagnosis and treatment. In addition, Ms G says that as a result of her diagnosis she has had to give up work and she is no longer able to return to South Africa as she had planned because she is too ill to do so. As an outcome of her complaint, Ms G is seeking financial remedy and service improvement at the Trust.

Our decision

3. We fully uphold Ms G's complaint. The Trust's failure to take appropriate action in May 2010 and its decision to discharge her in August 2010 led to the delay in diagnosing cancer. This meant that by the time Ms G's cancer was diagnosed, it was less likely that she could be cured.

Our investigation

4. Ms G brought her complaint to us in October 2013. During our investigation, we gathered all the relevant documentary and medical evidence from the Trust and discussed the circumstances of the case with Ms G and with the Trust's complaints department. We examined the relevant standards applicable at the time (*Early and locally advanced breast cancer: Diagnosis and treatment*, NICE clinical guideline 80, published February 2009, (the NICE guideline) and *Best practice diagnostic guidelines for patients presenting with breast symptoms* (2010) (the diagnostic guidelines)), produced by the Department of Health. We also obtained information from the doctor who saw Ms G at her appointment in May 2010 (the second doctor).
5. To help us consider this case, we also took clinical advice from a consultant breast specialist (the breast specialist) and from a consultant oncologist (the oncologist). In addition, we referred to *Judicial College Guidelines for the Assessment of General Damages in Personal Injury Cases* (the Judicial College guidelines) in order to reach a view on a remedy for Ms G.
6. From that information, we relied on the following evidence to come to a decision about Ms G's complaint:
 - Ms G's medical records
 - complaint correspondence between Ms G and the Trust
 - clinical advice from the breast specialist
 - clinical advice from the oncologist
 - the NICE guideline

- the diagnostic guidelines and
 - the Judicial College guidelines.
7. In reaching our decision about Ms G's complaint, we looked at the relevant evidence (including the applicable standards) to establish what should have happened and what did happen in her case. Having identified that Ms G did not get the right care, we assessed the impact of that on Ms G and sought to identify an appropriate remedy for her. We have explained this in more detail in paragraphs 37 to 55.

What happened in Ms G's case

8. Ms G first attended the breast clinic on 18 February 2010 and saw a breast specialist (the first doctor) following an urgent two-week referral from her GP. She reported swelling, pain and some hardness in her left breast. Clinic staff carried out an ultrasound scan. The first doctor diagnosed her with mastitis, prescribed antibiotics and advised Ms G to return to the clinic in three weeks' time for follow up.
9. Ms G was unable to keep her follow-up appointment and rescheduled it for 6 May, when she saw another breast specialist (the second doctor). The second doctor did not request a further ultrasound or mammography and diagnosed mastitis. Ms G was advised to attend for follow up in three months' time but was unable to attend. In August 2010 the Trust discharged Ms G from the service but said she could access the breast clinic again via a new GP referral if she needed to.
10. Fourteen months later, the Trust received a new referral from Ms G's GP and saw Ms G at the breast clinic on 30 December 2011. Ms G had an ultrasound scan and mammography at the breast clinic

that revealed a 9cm mass in her breast. Biopsies revealed that Ms G had advanced inoperable breast cancer and secondary cancers of the liver, brain and bone.

11. After Ms G's diagnosis, she received palliative chemotherapy. Advanced breast cancer is not curable and treatment is offered to control symptoms and extend life. Ms G's prognosis was measured in a few months.
12. Ms G complained to the Trust in May 2012 and asked how the diagnosis of mastitis (Ms G said the doctor had referred to this as '*smokers breast*') had been reached. She also asked why she had been refused further screening at her second appointment even though her condition had not improved between February and May 2010, despite the antibiotics. In addition, Ms G asked for information about the follow-up procedures in place at the breast clinic.
13. The Trust responded in July 2012. It said that the first doctor's diagnosis of mastitis in February 2010 was reached through clinical examination and an ultrasound scan that '*did not show any features of malignancy*'. The Trust said that at the first appointment staff decided not to carry out mammography because Ms G's breast was swollen and sore so the process would have been unduly painful.
14. When discussing the diagnosis made by the second doctor in May 2010, the Trust explained that the second doctor no longer worked for it and could not be contacted for her comments. It stated that Ms G's records indicated that there was no clinical change in her condition between February and May 2010 '*hence [the second doctor] again made a diagnosis of periductal mastitis*'. It said

that the second doctor considered but ruled out a biopsy because this could have caused further problems. The Trust pointed out that the decision whether to do mammography was a discretionary matter for the clinician, but it accepted that with the benefit of hindsight, it should have been performed. The Trust clarified, however, that the diagnostic guidelines did not specifically advocate mammography for patients aged 35 to 39 years old. (The diagnostic guidelines cited by the Trust were published in November 2010, several months after the initial events in this case. The diagnostic guidelines deal specifically with the process of triple assessment up to the point of diagnosis. The guidelines were designed to be used alongside existing guidance including the NICE guideline, which was published in February 2009.)

15. In terms of what might have happened if Ms G had attended her follow-up appointment in August 2010, the Trust considered that mammography would probably have been ordered then. It accepted, however, that in retrospect it should have given her more robust information in her discharge letter. The Trust said it had implemented the national guidelines for investigations and follow up of symptomatic disease and signposted Ms G to the Association of Breast Surgery website, should she wish to look at these.
16. The Trust apologised for the use of the term '*smokers breast*'. It clarified that there is a much higher instance of mastitis in smokers than in non-smokers and that mastitis often clears up when the patient stops smoking. The Trust said that it apologised if Ms G had been given the impression that her clinical condition had been caused by smoking.

The first appointment – February 2010

17. We have reviewed the notes of Ms G's appointment with the first doctor in February 2010. It is clear from these notes that the first doctor considered Ms G's history and the referral information sent by her GP appropriately. The notes show that at the appointment Ms G reported that her breast was swollen and painful at times and that it was itchy and had hardened skin around the areola area (the darker skin around the nipple). We have seen from the notes that the first doctor examined Ms G's breast and noted mild tenderness and some scabbing on the areola.
18. We asked our breast specialist whether Ms G's symptoms meant it was appropriate for the first doctor to carry out an ultrasound and to reach a diagnosis of mastitis. Our breast specialist considered Ms G's symptoms and confirmed that the first doctor's decision to order an ultrasound scan was reasonable. The ultrasound showed no abnormality, so the diagnosis of mastitis was also reasonable at that time. Our breast specialist explained that the decision not to perform a mammogram was sensible in light of the ultrasound results and because Ms G was under 40.
19. The NICE guideline states that for most patients, whether they are referred following breast screening or after a visit to their GP, diagnosis in the breast clinic is made by triple assessment (clinical assessment, mammography and/or ultrasound imaging, and core biopsy and/or fine needle aspiration cytology – the examination of cells to diagnose disease). It is best practice to carry out these assessments at the same visit.
20. Having reviewed our breast specialist's advice and the NICE guideline, we consider that the tests the first doctor carried out, an ultrasound and clinical examination, were appropriate, and that he made a reasonable diagnosis during the appointment in February 2010. We also note that the first doctor arranged for Trust staff to make an appropriate follow-up appointment for Ms G. In doing so, the first doctor ensured that the diagnosis could be reviewed if Ms G's symptoms did not improve, and an alternative diagnosis could be explored. It is clear from the notes that when he arranged the follow up appointment, the first doctor recommended that it should involve '*careful examination to rule out inflammatory lesions*'.
21. We recognise that Ms G is specifically concerned that a mammogram was not conducted during the appointment in February 2010. However, we hope she will accept that, while the first doctor could have undertaken a mammogram, it was reasonable that he decided not to because the ultrasound and clinical examination suggested a diagnosis of mastitis. The first doctor recognised that there could be cause for concern and so arranged for an appropriate follow-up appointment in three weeks' time, when a potentially more serious diagnosis could have been explored if necessary.
22. In response to Ms G's complaint about this, the Trust said that the first doctor did not request a mammogram because Ms G had reported tenderness in her breast. A mammogram would have involved compressing the breast, so would have been painful for her. We have seen that while both the first doctor and Ms G (on her breast clinic questionnaire)

recorded that her breast was tender, the decision not to carry out a mammogram because of the tenderness was not clearly documented.

23. We are satisfied that the decision not to conduct a mammogram was appropriate. However, if part of the first doctor's reasons for not undertaking one was the pain it would cause Ms G, this should have been clearly documented in her notes. We shared our concerns about this with the Trust, and it has accepted that the record keeping for this first appointment could have been better. The Trust has assured us that frequent record keeping courses are in place for staff, as are regular audits of the records. The Trust also told us that record keeping will be included in the first doctor's upcoming appraisal, and that it will monitor this so it can be confident that his record keeping has improved.
24. The record keeping was not as it should have been for the first appointment, so we partly uphold the complaint about this appointment. We recommend that the Trust documents its appraisal discussion with the first doctor and its plan to monitor his compliance with this.

The second appointment – May 2010

25. Ms G was unable to attend her follow-up appointment and attended the breast clinic again on 6 May 2010, when she was seen by the second doctor. Records of this appointment show the second doctor noted that there was a thickening of the skin around the areola and a new '*spot*' on the skin that had not been visible at Ms G's first appointment. The second doctor recorded that she had decided against a punch biopsy because of the risk of a mammary duct fistula (a blockage in the duct, which can become inflamed) that could have caused Ms G problems in the future. The notes record that the second doctor advised Ms G to stop smoking and arranged a three-month follow-up appointment.
26. Our breast specialist said that Ms G's history of inflammatory breast symptoms, the new '*spot*' on her skin, and the previous request for a three week review to check for signs of lesions indicating cancer, should have prompted the second doctor to arrange further tests. The specialist said that the second doctor should have taken steps to exclude the possibility of cancer by arranging either a biopsy or further imaging such as mammography or ultrasound. Our breast specialist concluded that Ms G's symptoms meant it was inappropriate for the second doctor to arrange follow up three months later without first excluding the possibility of cancer.
27. This is in line with the NICE guideline, which indicates that tests should have been carried out at this appointment. They were not.
28. Taking into account the advice from our breast specialist and the NICE guideline, we found failings in the second doctor's assessment at the appointment in May 2010. At this stage further tests – a mammogram, a biopsy or both – should have been performed to rule out cancer. Therefore, we find that the failings we have identified in this appointment amount to service failure. In order to consider the impact of these failings on Ms G, we also have to examine how her follow-up appointment and her discharge from the service in August 2010 were arranged. We turn to these next.

The follow-up appointment and discharge

29. The second doctor should have made Ms G aware of the importance of attending the follow-up appointment when she arranged it, given Ms G's symptoms and that the second doctor had not performed tests to exclude cancer at the appointment in May 2010. She did not do so.
30. Ms G was not aware of the importance of the follow-up appointment and did not attend it in August 2010. Following her non-attendance, the Trust wrote to Ms G telling her that she had been discharged from the service but advising her that she could return if she had further worries.
31. Because cancer had not been ruled out in Ms G's case, it was inappropriate to discharge her after one non-attendance. Rather, the Trust should have given her another appointment and explained why it was important that she attend. Our breast specialist explained that mastitis is a diagnosis by exclusion and should only be confirmed once other, more serious options, such as breast cancer, have been dismissed. Our breast specialist clarified that inflammatory breast cancer can have similar symptoms to mastitis and must always be considered and excluded before a firm diagnosis is reached. When the Trust discharged Ms G from the service, it had not performed appropriate tests to eliminate the possibility of cancer and it did not give her any information about what to do if her symptoms did not fully resolve.
32. The Trust did not tell Ms G about the potentially serious cause of her condition and why she should attend her follow-up appointment. The Trust was wrong to discharge Ms G when it did. Both the Trust and the second doctor agreed with us that Ms G should not have been discharged from the service without a firm diagnosis, and that she was discharged without having been made aware of the seriousness of her situation.
33. In addition, we are concerned about the standard discharge letter that the Trust sent Ms G. Ms G's symptoms meant that it was inappropriate for the Trust to send her a standard discharge letter automatically generated by its computer system. Staff should have checked Ms G's records and either offered her another appointment or enclosed additional information in the letter. The standard discharge letter did not explain what Ms G should do if her symptoms did not resolve completely. Because of this, Ms G was discharged with the belief that she was suffering from mastitis only and no one at the Trust highlighted to her that a diagnosis of cancer was a possibility.
34. The Trust also issued the standard discharge letter to Ms G's GP and so did not make the GP aware of the potentially serious nature of Ms G's condition. This meant that both Ms G and her GP were under the impression that a diagnosis of mastitis had been made and there were no concerns about the presence of anything more serious.
35. We uphold these aspects of Ms G's complaint. This is because the Trust failed to tell Ms G that it was important to attend the follow-up appointment and when she did not attend it, the Trust inappropriately discharged her. By discharging her, the Trust failed again to make Ms G aware of the potentially serious nature of her condition and instead left her and her GP with the impression that she was suffering from mastitis.

36. We next consider the impact these failings, and the ones identified at the appointment in May 2010, had on Ms G.

The impact on Ms G

37. We have identified failings in the second doctor's handling of the appointment of May 2010 and in the way that Ms G was discharged from the service in August 2010. The question for us is what the impact of the failing was on Ms G's prognosis. It is helpful to deal first with any delay in referring Ms G back to the Trust after her discharge in August 2010. Ms G continued to experience symptoms after her discharge, but was not referred back to the Trust for another 14 months.
38. We consider that in the circumstances of this case, that is, Ms G had been seen by two different breast clinicians at the Trust who had both diagnosed mastitis, it was reasonable that Ms G and her GP did not question the diagnosis. They had been reassured by the diagnosis. This is even more understandable when we consider that the Trust also failed to warn Ms G and her GP that she might need further tests if her symptoms did not resolve completely. We therefore believe it was understandable that Ms G did not pursue an alternative diagnosis herself after her discharge from the Trust.
39. We now consider the impact of the Trust's actions on Ms G. We wanted to know whether cancer would have been detectable in May 2010, had the Trust carried out appropriate tests. To answer this, we sought advice from the oncologist. The oncologist said that it was more likely than not that the cancer was present in 2010, and could have been detected. The oncologist pointed out that samples could have been taken from the lymph glands

identified on the February 2010 ultrasound scan and that these samples could have been used to detect the cancer. Both the oncologist and the breast specialist agreed that mammography and biopsy should have been carried out in May 2010 and that an opportunity to diagnose the cancer and to begin treatment in 2010 was lost. This allowed the cancer to develop and spread undetected.

40. Having considered the relevant medical records and the secondary cancers, the oncologist considered that when Ms G attended the breast clinic in 2010 she had '*early stage*' breast cancer, which meant that the cancer would have been confined to her breast and surrounding lymph nodes. By the time her diagnosis was made in 2012, she had '*advanced*' breast cancer and secondary cancers that were inoperable and incurable.
41. The oncologist said that had the cancer been detected in 2010, Ms G would have been offered surgery, either in the form of a mastectomy (removal of the breast) or removal of the cancerous tissue followed by a course of radiotherapy. By the time the cancer was detected in 2012, it was inoperable.
42. We have considered carefully the oncologist's advice and agree that it is likely that, at the time of the appointment in May 2010, Ms G had early stage breast cancer. As we have already concluded that the Trust failed to undertake appropriate tests in May 2010 to rule out cancer, we find that the failure to undertake those tests meant the Trust did not detect Ms G's breast cancer when it could have done. Having reached that view, we asked the oncologist what Ms G's prognosis would have been had the Trust detected the cancer in May 2010.

43. The oncologist used the test results from Ms G's medical records to calculate what her prognosis would have been if she had been diagnosed by May 2010. The calculations show that, at best, Ms G had early stage breast cancer that was curable. At worst, assuming she had a large tumour, she would still have had a 62% chance of surviving for at least ten years after diagnosis. The oncologist said that most women in Ms G's position in 2010 would be expected to have '*long term survival*' with appropriate treatment.
44. So, Ms G, at only 40 years of age, is living with a terminal diagnosis that could have been avoided. She has lived with the distress of suffering from a terminal illness for two years, and she lives with constant uncertainty about how much time she has left with her son, who she is bringing up alone. During this time, Ms G has lost her job because the treatment regime has been intense and she has felt too unwell to work. This in turn has caused her further anxiety, as being out of work has made her financial situation difficult. She has told us that she cannot now afford to move back to South Africa to be near her family.
45. Taking into account the advice we have received, we fully uphold Ms G's complaint about the appointment of May 2010 and her discharge from the Trust. It is clear that the failures identified have had a very serious impact on her prognosis to the extent that it seems likely her life has been cut short because of the Trust's actions. She has also had to undergo more intense treatment than she could have expected if her cancer had been diagnosed in 2010, and this has clearly negatively affected her work and home life. In paragraphs 56 to 61 we consider the steps the Trust has taken and the steps we expect the Trust to take to try to put matters right (as far as it

possibly can) for Ms G. That also draws on how the Trust handled Ms G's complaint, which we turn to next.

The complaint response

46. We reviewed the Trust's response to the complaint and found that it did not acknowledge the full extent of the Trust's failings or their full impact on Ms G's life and prognosis.
47. The response focuses on the first appointment, which we agree was conducted reasonably. It makes little reference to the second appointment, for example in response to Ms G's question '*how did [the Trust] resolve it was periductal mastitis?*' the Trust referred only to the first appointment and why the diagnosis of mastitis was reasonable. That rather misses the point.
48. We also note that there is some confusion in the response when it refers to Ms G's three-month follow up. Ms G attended her first appointment on 18 February 2010 and returned on 6 May 2010. That effectively meant the second appointment was the three month follow up and Ms G's symptoms were unresolved at this appointment. The letter implies that mammography would have been performed had Ms G attended her scheduled appointment in August. However, for the reasons we have explained, we believe that mammography should have been carried out in May. Again, the complaint response did not accept or acknowledge this.
49. We recognise that the Trust apologised for its failure to carry out mammography (although it did not acknowledge that the second doctor should have requested this in May 2010) and for discharging Ms G without giving her detailed information

about what to do if her symptoms did not resolve. However, having apologised, the Trust failed to acknowledge the extent of the failings and the serious impact they had on Ms G and her prognosis.

50. Having considered the content of the Trust's response in light of what we now know about the failings we have found and the impact they have had on Ms G, we find that the response to this complaint was unreasonable. It failed to recognise the failings we have identified and so did not consider the impact these had on Ms G.
51. We shared our views on the complaint response with the Trust, and it has agreed that its complaint investigation and response were unacceptable. The Trust has reviewed its investigation into this complaint and concluded that it should have sought input from the cancer team to help it understand what happened, and that it should have sought input from the second doctor (who had left the Trust by the time the complaint was investigated). The Trust said it should have done more to investigate the gap between what happened and what should have happened in Ms G's case. It agreed that its response failed to acknowledge the seriousness of what happened to Ms G and the impact this has had on her life and prognosis.
52. The Trust told us that it conducted a review of the complaints procedure in 2013 and identified a skills gap for staff responsible for investigating complaints. In response to this, the Trust jointly developed and commissioned a complaint handling course with the University of Hertfordshire for staff who investigate complaints. All attendees will develop individual action plans, which will be monitored by their line managers as part of their values-based appraisal. The Trust has also told us that the quality of investigations and responses to complaints now goes through an internal quality approval process. This training and focus on good complaint handling at the Trust should help to prevent a repetition of the complaint response that was given to Ms G.
53. In addition to the complaint response itself, we agree with the Trust that it should have treated Ms G's case as a 'Serious Incident' when she was diagnosed with cancer in January 2012. The Trust acknowledged that had this occurred, it could have considered Ms G's interactions with it at an earlier date and considered learning and service improvement much sooner than it did. Since this incident, the Trust has been assessed, by the local clinical commissioning group, as compliant with reviewing serious cases in line with the Trust's Serious Incident and Being Open Policy.
54. We find that the complaint response was inadequate, because it did not acknowledge the failings that we have found or the impact these failings had on Ms G. This no doubt caused Ms G additional distress at a time when she was facing a terminal illness. As a result, we fully uphold this aspect of her complaint. We welcome the initiatives the Trust has already introduced to improve complaint handling and are pleased to see that it has enhanced relevant monitoring systems.
55. While the Trust has put appropriate steps in place to improve its complaint handling, it has not put right the personal injustice its complaint handling caused Ms G. In the next section, we consider what steps we expect the Trust to take to put matters right for Ms G, taking into account the difficulties she faced in complaint handling, as well as the problems in diagnosis and discharge.

Putting things right – our approach to remedy

56. When we look at remedy, we usually expect an organisation to return a person to the position they would have been in had the service failings we identified not occurred. However, that is not possible here because it is clear that if the service failure had not occurred, it is likely that Ms G would not now be suffering terminal cancer. That is a very difficult position for anyone to be in, especially someone who is a single parent and whose family do not live in England.
57. When we consider what the Trust should do to put matters right, we are also mindful that the Trust's failure to deal with Ms G's complaint appropriately meant that she was put to the trouble of complaining at a time when she was battling a terminal illness.
58. So as a first step, we expect the Trust to give Ms G a full and sincere apology. The Trust said that its chief executive would like to meet Ms G and apologise to her in person for the failings identified in this report. He also wants to talk to her about changes made at the Trust since 2010 in the hope of offering her some reassurance that similar failings will not occur again. We recommended that the Trust wrote to Ms G offering to arrange for the chief executive to visit her to apologise, and if Ms G was not able to have that visit, the chief executive should convey the relevant apologies and explanation in writing. We are pleased to see that, as a first step in arranging that meeting, the chief executive wrote to Ms G on behalf of the Trust on 26 June 2014 with an unreserved apology for the failings in complaint handling, and offered to meet Ms G personally. Ms G is still considering this suggestion.

We were also pleased to see that the Trust said it would comply fully with our recommendations to ensure that what happened in this case did not happen to anyone else.

59. We now turn to the issue of financial compensation. The failings we identified have had a serious impact on Ms G and she now faces a terminal illness that could have been avoided. It is clear that in these circumstances, financial compensation is appropriate. The question for us is, how much? In order to consider this, we looked at Ms G's personal circumstances and the emotional and physical impact of her diagnosis (which we outlined in paragraphs 37 to 45). We also considered recommendations we had made in other cases we have investigated and took into account the *Judicial College Guidelines for the Assessment of General Damages in Personal Injury Cases*.
60. We referred to the sections of the Judicial College guidelines that make recommendations in cases in which someone has developed cancer as a result of failings by an organisation. We recognise that Ms G did not develop cancer as a result of the Trust's failings, but we saw this as comparable as the cancer went undetected because of the Trust's failings. Had Ms G's cancer been detected and treated in 2010, her prognosis would have been much better and the cancer was unlikely to have been terminal. We have taken this into account and recommend that the Trust pay Ms G £70,000 in recognition of the pain, suffering and distress caused by the failings identified during our investigation.
61. In response to our draft investigation report, the Trust agreed to make the payment to Ms G, and has already done so. We welcome the Trust's readiness to

accept these recommendations and that it has put in place an appropriate remedy for this complaint.

Why did the failings happen?

62. We have set out a number of failings in the care and treatment given to Ms G and the way in which the Trust responded to her complaint. We have discussed the improvements the Trust has made to its complaint handling, and we welcome these.
63. However, we have also considered how the failings in the appointment of May 2010 and Ms G's discharge in August 2010 were able to happen. We turn first to the appointment of May 2010. We contacted the second doctor and asked for her response to the failings we had identified. The second doctor told us she would like to apologise for the delay to Ms G's diagnosis that occurred as a result of the failings identified in this report. The second doctor has now accepted that Ms G should have been referred for further tests to confirm the diagnosis of mastitis in May 2010 and to rule out the possibility of breast cancer at this appointment. It appears that the decision not to undertake further tests at this appointment was an error on the part of the second doctor. She has said that it was not in line with her usual practice.
64. There is clearly important learning in this case for the second doctor and we have made her aware of this. As the second doctor no longer works at the Trust, we have recommended that the Trust shares the learning from this case with the second doctor's current employers. This is because we want to ensure that the second doctor's new employers are aware of our concerns about the care provided and can make sure that the learning is embedded.
65. However, given the serious nature of the failings in the appointment of May 2010, we considered whether we should do more than ask for the learning from this case to be shared with the second doctor's new employers. We decided that we should do more because we saw no evidence during our investigation that the second doctor had understood and accepted the impact her errors had had on Ms G. For example, when she responded to our findings, the second doctor said only: *'I understand that Ms G is critically ill. I apologise unreservedly to Ms G for the inconvenience and distress caused by the delayed diagnosis'*. That does not reflect in any way the impact her failings have had on Ms G.
66. In addition, having seen our findings, the second doctor said she acknowledged that she failed to arrange appropriate tests in May 2010 and said that this was not her normal practice. She acknowledged that further training may be of benefit but made no firm commitment to arrange this. We wanted to share our investigation report with the second doctor's Responsible Officer (all doctors have a Responsible Officer so that they can discuss performance and complaints in order to learn and improve). However, the second doctor has not given us details of her Responsible Officer.
67. Having considered the second doctor's comments, we are not persuaded that she has accepted the seriousness of the failings in this case and the devastating impact the events have had on Ms G's life. As the second doctor has shown no evidence of learning from this complaint, we consider that this represents a risk to patient safety.

If, as in this case, we believe there is a risk to patient safety, the law (section 15 of the *Health Service Commissioners Act 1993*) allows us to share information about our concerns with the General Medical Council, which makes decisions about an individual doctor's fitness to practise. We will share this report with the General Medical Council in order to take this forward.

68. While it would appear that the failings in the May 2010 appointment were caused by human error, we have also considered whether appropriate support mechanisms were in place at the Trust for junior doctors, such as the second doctor. We asked the Trust about this and it said that all junior staff were issued with the unit's clinical guidelines and only allowed to see patients independently after the consultant had approved them following supervision. It also said that all junior doctors were encouraged to seek advice from the consultants if they were not sure about patient management. Those arrangements did not give the necessary support that the second doctor needed, as they meant that once approved, she was able to work with little or no actual supervision. The process relied on a junior doctor understanding that they had made a diagnosis they should have been less sure about.
69. We are pleased to see that since this incident there have been appropriate changes at the Trust that should help to prevent a reoccurrence of the failings we found in this case. We accept that consultants cannot review the outcome of all appointments handled by doctors they have already approved. However, there should be a process in place to ensure that if a risk has been identified, appropriate

measures are taken to protect patients. We are pleased to see that the Trust has now done this.

70. The Trust has introduced regular discussion of patient complaints and associated governance issues at its quarterly unit meetings, alongside discussion at general surgery departmental governance meetings. This presents the opportunity for sharing learning with junior staff and the entire unit. The Trust said that any junior doctor making an excess of errors will be more closely supervised and told to discuss all patients with a consultant. Junior doctors are also still encouraged to seek advice from consultants when they are unsure or have concerns.
71. In addition, the Trust told us that since 2010 it has set up a mandatory training programme for all tumour site doctors (doctors dealing in cases where there is a possibility of cancer). The training includes national standards and guidance around cancer waiting times, training on the Trust's cancer pathway, operating standards and communication with referring doctors. The breast team started training in May this year. Had this training and the new governance arrangements been in place in May 2010, it might have prompted the second doctor to undertake appropriate tests at the appointment in May 2010, or to have raised questions about what action to take with more senior physicians.
72. We turn next to the discharge letter and the way in which follow-up appointments are arranged. It is clear that one factor at play in this case was that the Trust made neither Ms G nor her GP aware of the seriousness of her situation and why it was so important that she return for further tests. When Ms G was seen and discharged by the Trust in 2010, it had no

mechanisms in place to review patients like Ms G to ensure that they were made aware of the importance of attending their appointments, or to manage their discharge appropriately. That meant that Ms G was able to be discharged from the Trust even though she had not had the appropriate tests to rule out cancer.

73. We asked the Trust to tell us about any changes or improvements it had made to its service that would impact on patients being referred to it by their GP today. The Trust told us it has set up a dedicated team to arrange all 'two week wait' appointments (this is the type of appointment requested when there is a possibility that a patient may have cancer, as in Ms G's case). The team is responsible for arranging appointments but also for communicating the importance of these appointments to patients and making sure they understand that there is a possibility that they may have cancer. The team has also been issued with standard operating procedures so that follow-up appointments are arranged in line with the diagnostic guidelines.
74. Once a patient has been identified as a 'two week wait' patient with the possibility of cancer, the Trust places the patient on its cancer patient tracking list. The Trust has set up weekly meetings at which the cancer patient tracking list is reviewed and patient progress on the cancer pathway is discussed. This meeting is chaired by the cancer services manager and the Trust's chief operating officer is in attendance. These meetings should allow the Trust to track patient progress and to identify quickly if a patient has not received the follow up they require.
75. The Trust's new 'two week wait' team is responsible for issuing letters to suspected cancer patients, and the Trust has worked

with clinicians to develop suitable wording for letters so that patients are aware of the seriousness of their situation. If the team had been in place in 2010, both Ms G and her GP would have been made aware of the importance of her returning to the Trust for tests. Clinical letters to GPs are included in the training programme described above and staff have been reminded of their mandatory obligation to copy any letter sent to a GP to the patient as well.

76. We are pleased to see the additional measures that the Trust has put in place. They demonstrate that the cancer pathway now gets serious relevant senior staff input. The introduction of the 'two week wait' team should ensure that patients in a similar situation to Ms G, and their GPs, are now fully informed about the seriousness of the patient's condition and can make an informed choice about how they engage with their treatment plan. In addition, the weekly meetings to look at patients on the cancer patient tracking list should ensure that patients are not discharged from the service before staff have carried out appropriate checks.

Summary of recommendations

77. In order to remedy the injustice we have found in this case, and to bring about improvements for other service users, we have recommended the following:

- the Trust said that the first doctor's record keeping would be discussed at his upcoming appraisal. We recommend that this discussion takes place and is documented.
- The Trust said that it would like to apologise to Ms G for the failings identified in our report and that the chief executive would like to do this in person if Ms G is willing. We recommended that the offer of a personal apology be made to Ms G and that a written apology should be given if Ms G is unable to meet the chief executive. To that end, the chief executive wrote to Ms G on 26 June 2014 with an unreserved apology and an offer to meet her personally. Ms G is still considering this offer.
- The Trust agreed to share information about our investigation with the second doctor's current employer so that she has a further opportunity to learn from this complaint. We recommend that the Trust does this when it receives our final report; and
- the Trust pays Ms G £70,000 for the pain, suffering, additional medical treatment and distress over a lengthy period caused by the service failure detailed in our report and the exasperation produced by the way it handled her complaint. The Trust has already made the requested payment to Ms G.

78. We have asked the Trust to provide us with evidence that the outstanding actions have been completed within six weeks of the date of this report.

Conclusion

79. We have found evidence of service failure by West Hertfordshire Hospitals NHS Trust that has led to a significant unremedied injustice to Ms G. It is for this reason that we have decided to uphold this complaint. It is a shame that the Trust cannot now fully put matters right for Ms G but we hope that the financial compensation the Trust has paid her will help give her some reassurance about her financial position at this difficult time. We also hope that she will be reassured, as we have been, about the improvements that the Trust has made since she received her initial assessments there in 2010.

Parliamentary and Health Service Ombudsman

Millbank Tower
Millbank
London SW1P 4QP

Tel: 0345 015 4033

Fax: 0300 061 4000

Email: phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

Follow us on



If you would like this report in a different format, such as DAISY or large print, please contact us.

ISBN 978-1-4741-1139-3



9 781474 111393