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

Report Reference: 202003205

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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: Southern Health and Social Care Trust

SUMMARY

This complaint was about care and treatment the Southern Health and Social Care Trust (the Trust) provided to the patient between 2016 and 2018.

The patient's GP made an urgent referral to the Trust's Breast Clinic[1] on 15 February 2016. The Trust triaged the referral and downgraded it to routine[2]. The patient attended the clinic in September 2016, seven months after the GP's referral. In October 2016, the Trust diagnosed the patient with a probable grade II infiltrating duct carcinoma[3] (IDC) in her left breast. The patient believed the Trust failed to arrange her breast clinic appointment within an appropriate timeframe which caused a '*delay*' in her cancer diagnosis.

The investigation found the Trust failed to appropriately triage the GP referral. It also did not communicate its decision to downgrade the referral to the patient or her GP. The investigation found the failure caused the patient to experience a seven-month delay before she received her diagnosis and treatment.

The patient also said she asked the Trust to perform a CT[4] or MRI[5] scan in the summer of 2017. However, it did not do so. She believed this would have given her an earlier diagnosis for her metastatic cancer, which was subsequently diagnosed following a general surgery referral, in September 2018. The investigation found the Trust acted in accordance with relevant guidance in relation to its decision on the request for a CT or MRI scan.

[1] At a breast clinic, healthcare professionals evaluate potential breast abnormalities, often to determine if symptoms indicate breast cancer or another condition.
[2] Non-urgent, not requiring immediate attention.
[3] An IDC is an intermediate grade of breast cancer that grows more quickly than low-grade, but not as aggressive as high-grade cancers.
[4] A Computed Tomography scan is a medical imaging technique that uses X-rays and computers to create detailed images of the inside of the body.
[5] A Magnetic Resonance Imaging scan uses strong magnetic fields and radio waves to create detailed pictures of the inside of the body.

The patient raised an additional concern regarding what she believed was a failing by the Trust's Gynaecology department as it did not diagnose metastatic cancer during an appointment in August 2018. Whilst I acknowledge the Trust did not make its diagnosis until approximately a month after the initial Gynaecology consultation, the investigation found it conducted its investigations in accordance with relevant guidance and standards.

I recommended the Trust apologise to the patient for the failure identified and injustice sustained. I also recommended actions for the Trust to implement to prevent a failure such as that identified reoccurring.

THE COMPLAINT

1. This complaint was about care and treatment the Southern Health and Social Care Trust (the Trust) provided to the patient. The Trust provided care and treatment to the complainant on various occasions when she was diagnosed with different cancers between 2016 to 2018. The complainant is referred to as the patient in this report.

Background

2. The patient's General Practitioner (GP) forwarded an urgent referral to the Trust's Breast Clinic in February 2016. The patient attended the Breast Clinic in September 2016, where she was diagnosed with a probable grade II infiltrating duct carcinoma[6] (IDC) in her left breast .

3. The patient said that given her family history of cancer, she asked the Trust in the summer of 2017 to perform a CT or MRI scan. The Trust did not arrange for the patient to have such a scan.

4. After completing her treatment for breast cancer, the patient attended her GP with abdominal pain in July 2018. Her GP referred her to Gynaecology within the Trust. The Trust informed the patient there were no gynaecological concerns. The patient subsequently insisted on a red flag referral[7] to general surgery given her worsening symptoms. The patient attended the Trust in September 2018 and was diagnosed with High Grade Serious Ovarian Carcinoma[8], which she was told was inoperable.

Issue of complaint

5. I accepted the following issue of complaint for investigation:

[6] An IDC is an intermediate grade of breast cancer that grows more quickly than low-grade, but not as aggressive as high-grade cancers.
[7] An urgent referral for patients with suspected cancer, requiring immediate investigation.
[8] High-grade serous carcinoma (HGSC) is an aggressive type of ovarian cancer that's the most common and deadliest form of the disease. It's also known as high-grade serous ovarian cancer.

Whether the care and treatment provided to the patient by the Southern Health and Social Care Trust was appropriate and in accordance with relevant standards and procedures.

INVESTIGATION METHODOLOGY

6. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the patient raised. This included documentation relating to the Trust's complaint process.

Independent Professional Advice Sought

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

    - A Breast Cancer Oncologist (MBBS (Distinction), MRCP, CCT Clin Oncology, MBA, MPH, DBA, with 13 years' experience (O IPA);
    - A Breast Cancer Surgeon (BSC MBBS MS MD(Hons) FRCS(Ed, Eng and Glasg.) FRCS Gen, with 23 years' experience (BS IPA); and
    - A Consultant Gynaecologist (FRCOG) with 24 years' experience (G IPA).

    I enclose the clinical advice received at Appendix two to this report.

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice', however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those 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[9]:

- The Principles of Good Administration

10. The specific standards and guidance referred to are those which applied at the time the events 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:

- Northern Ireland Cancer Network Surgical Guidelines for the Diagnosis, Treatment and Management of Breast Cancer, Version 4 July 2014 (NICaN Guidelines);
- The National Institute for Health and Care Excellence Suspected Cancer: Recognition and Referral, Guideline NG12, Published 23 June 2015; Endorsed in Northern Ireland on 19 August 2015 (NICE NG12);
- The National Institute for Health and Care Excellence Early and Locally Advanced Breast Cancer: Diagnosis and Treatment, Clinical Guideline CG80, published 25 February 2009 (NICE CG80) Endorsed in Northern Ireland in July 2010;
- The National Institute for Health and Care Excellence Clinical Guideline for Ovarian Cancer: recognition and initial management, published 27 April 2011 (NICE CG122);
- The Belfast Health and Social Care Trust Systemic anti-cancer therapy (SACT) guidelines for breast cancer, published October 2008; updated in consultation with the Northern Ireland Breast Oncologists Group August 2014 (the Trust's SACT);
- The Royal College of Radiologists Recommendations for cross-sectional imaging in cancer management, Second edition – Breast

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

Cancer, published May 2014 (RCR Guidelines); and

- The British Association of Surgical Oncologists Surgical Guidelines for the Management of Breast Cancer, Association of Breast Surgery, 2009 (BASO Guidelines).

I enclose relevant sections of the guidance considered at Appendix three to this report.

11. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

THE INVESTIGATION

Whether the care and treatment provided to the patient by the Southern Health and Social Care Trust was appropriate and in accordance with relevant standards and procedures.

In particular this will consider:

- Referral to the Breast Clinic on 15 February 2016;
- Decision not to perform a CT or MRI scan in summer 2017; and
- Investigative tests carried out in relation to gynaecological concerns.

Detail of Complaint

(a) Referral to the Breast Clinic on 15 February 2016

12. The patient said the Trust arranged an appointment for her at the Breast Clinic seven months after her GP referred her to the Trust. The patient said she asked the Trust why she had '*waited so long*.' She said the Trust told her they were short staffed and that was the waiting time for an urgent appointment. The patient believed the Trust '*downgraded*' her appointment from red flag to routine.

13. The patient believed the Trust caused a delay in her cancer diagnosis. The patient felt an earlier diagnosis could have given her a '*better prognosis*.'

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following legislation/policies/guidance:

- NICaN Guidelines;
- NICE NG12;
- NICE CG80; and
- BASO Guidelines.

Trust's response to investigation enquiries

15. A summary of the Trust's responses to this office's enquiries are at Appendix four of this report.

Relevant Independent Professional Advice

16. I include the O IPA's advice at appendix two of this report. I outline my consideration of that advice in the analysis and findings below.

Analysis and Findings

17. The records evidence the Trust received an urgent referral for the patient on 15 February 2016. The referral outlined the patient's symptoms, presentation, and relevant history including '*family history of sarcoma (brother and sister)*'.

18. In response to enquiries, the Trust confirmed it downgraded the urgent referral it received to routine. The O IPA advised the medical records did not document the Trust's reasons for its decision to downgrade the referral. However, in its response to enquiries, the Trust said it considered the patient's breast pain symptom as '*benign*'. Therefore, it did not meet the criteria for a red flag referral. It said this was in accordance with the NICaN guidelines.

19. The NICaN guidelines require clinicians to make an urgent referral for patients who at '*any age [with] discrete, hard lump with fixation, +/- skin tethering'* or patients who are '*30 years and above [with] discrete lump that persists after next period, or presents after menopause*…' I also note that section 1.4.1 of NICE NG12 states clinicians should refer patients '*using a suspected cancer pathway referral (for an appointment within 2 weeks)*' if they are over 50 years old and experience '*changes of concern'* in the breast.

20. The O IPA advised the Trust '*probably downgraded'* the patient because of the intractable breast pain alone. However, it is clear from the GP's referral that the patient also presented with '*bilateral lumpy breasts'*. Therefore, based on the relevant guidance and the evidence available, I accept the O IPA's advice that the Trust should have triaged the patient as urgent, in accordance with the relevant guidance.

21. Standard 15 of the GMC Guidance requires clinicians to '*adequately assess the patient's conditions, taking account of their history*'. It also requires clinicians to '*promptly provide or arrange suitable advice, investigations or treatment where necessary'* and refer patients in line with their needs. I have not viewed any evidence that would lead me to conclude that the Trust considered all information on the referral form when it made its decision. I therefore consider the Trust failed to act in accordance with this GMC standard. I am satisfied this represents a failure in the patient's care and treatment.

22. The O IPA advised the failing identified caused a seven month delay in the patient's diagnosis of breast cancer and subsequent treatment. I consider this delay concerning. The O IPA advised the delay '*did not have a significant impact on [the patient's] disease and her prognosis*'. However, I have no doubt that those seven months were an incredibly worrying time for the patient. I therefore consider the failure caused the patient to sustain the injustice of anxiety, uncertainty, and a loss of opportunity to receive earlier diagnosis and treatment. I uphold this element of the complaint.

23. I note from the records that the Trust did not notify the complainant of its decision to downgrade her referral to routine and the impact this had on her

waiting time. My Own Initiative report, 'Forgotten', identified the impact failing to communicate triage decisions has on patients. My report also acknowledged steps the Department took to improve the level of information available to patients, including the recent introduction of the 'My Waiting times NI' website and the introduction of a digital integrated care record (Encompass). While these steps do not benefit the patient in this case, I recognise that the changes implemented will benefit future patients and help to prevent such a failure from recurring.

Detail of Complaint

(b) Decision not to perform a CT or MRI scan in summer 2017

24. The patient said that following her cancer treatment, and during an appointment with her Consultant in 2017, she requested a full body CT[10] or MRI[11] scan to check for any other signs of cancer which may have been present. She explained that due to the prevalence of cancer in her family, she wanted to know the extent of her risk of developing further cancers. The patient said the Trust refused to arrange either of these scans.

Evidence Considered

Legislation/Policies/Guidance

25. I considered the following legislation/policies/guidance:

- The Trust's SACT; and
- The RCR Guidelines.

[10] A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of inside the body.
[11] Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

Trust's response to investigation enquiries

26. I made enquiries of the Trust about the issues the complainant raised. A summary of the Trust's response is at Appendix four of this report.

Relevant Independent Professional Advice

27. I included the BS IPA's advice at appendix two to this report. I outline my consideration of that advice in the analysis and findings below.

Analysis and Findings

28. The patient said when she requested a full body CT or MRI scan following treatment for her breast cancer diagnosis in the summer of 2017, the Consultant Surgeon told her they were not necessary.

29. The Trust said it discussed the patient's case during its Multidisciplinary Meetings (MDMs) including whether there was any requirement for a CT or MRI scan. The Trust stated it followed the NIBOG and RCR guidelines on the staging of breast cancers. The guidelines recommend staging CT scans for patients who present with node positive disease[12] and who have symptoms of metastatic breast cancer at diagnosis. The Trust said the patient did not meet either of these criteria. I also note the Trust stated it '*has not documented*' any request from the patient regarding a CT or MRI scan.

30. I considered the BS IPA's advice that in early 2017, '*there was no indication for either a CT scan or a breast MRI*'. This was because the patient presented with a *'node negative T1 early breast cancer'*. Also, despite the patient's family history of sarcoma, she did not meet the threshold for *'Li Fraumeni syndrome[13] (P53 mutation)'*. The IPA advised that even if the patient did meet this threshold, it *'is not particularly associated with ovarian cancer in any case.'*

[12] Cancer that has spread to the lymph nodes.
[13] Li-Fraumeni syndrome is a rare hereditary disorder that increases the risk you and your family members will develop cancer. Li-Fraumeni syndrome cannot be prevented. But early and consistent cancer screenings and treatment can limit the syndrome's impact on your life and your family's lives.

31. I accept this advice. I appreciate the patient was rightly concerned at that time given her previous experience and diagnosis of breast cancer. However, based on the guidance and evidence available, I do not consider there was any clinical indication for the Trust to perform either an MRI or CT scan for the patient at that time. I have not identified a failing in the care and treatment of the patient. As such, I do not uphold this element of the complaint.

Detail of Complaint

(c) Investigative tests carried out in relation to gynaecological concerns

32. The patient said that during the summer of 2017, she developed severe abdominal pain and bloating. Her GP contacted the Trust's Oncologist to make an urgent referral for a CT scan. The patient said the Trust did not respond to the referral. The patient said that due to no response from the Trust, her GP instead referred her to gynaecology, and she attended an appointment on 22 August 2018.

33. The patient said the Trust told her all was well, and she had '*no gynae problem*.'

Evidence Considered

Legislation/Policies/Guidance

34. I considered the following guidance:

- NICE CG122; and
- NICE NG12.

Trust's response to investigation enquiries

35. I made enquiries of the Trust about the issues the complainant raised. A summary of the Trust's response is at Appendix four of this report.

Relevant Independent Professional Advice

36. I include the G IPA's advice at appendix two to this report. I outline my consideration of that advice in the analysis and findings below.

Analysis and Findings

37. In response to enquiries, the Trust explained the patient's GP did not refer her to Oncology for a CT scan as she believed, but rather wrote to her Oncology Consultant to update her on the patient's ongoing symptoms. A review of medical records confirmed this to have been the case. I am satisfied the patient's GP did not make a referral to Oncology at this time.

38. In relation to the patient's referral to Gynaecology, the G IPA advised the patient was referred by her GP on 6 August 2018. The patient was assessed by Gynaecology on 22 August 2018. I appreciate this was slightly outside the two-week target for red flag referrals. However, I accept the G IPA advice that this waiting time was appropriate.

39. During the patient's appointment, the Trust performed a transvaginal scan, which did not indicate any abnormality. It also tested for CA125[14], which was 23. I note this is within normal range. The Consultant Gynaecologist documented in his letter to the patient's GP that she did not '*have a gynae problem at the moment however I will refer her to the clinical geneticists for assessment with a view to ovarian screening.'*

40. NICE NG12 outlines the diagnostic tests for ovarian cancer in secondary care as: '*measure serum CA125 in secondary care in all women with suspected ovarian cancer, if this has not already been done'*. It also states, '*perform an ultrasound of the abdomen and pelvis as the first imaging test in secondary care for woman with suspected ovarian cancer*.' The G IPA advised that therefore, the Trust conducted appropriate investigative tests. Based on the relevant guidance, I accept that advice.

[14] A CA125 test is a blood test that measures the level of a protein called CA125 in your blood. A CA125 test is used to help diagnose ovarian cancer. A CA125 level above 35 units per millilitre (U/mL) is considered high.

41. I note that even though the gynaecology investigations were negative, the patient's Consultant Gynaecologist wrote to the Trust's Clinical Geneticists for advice regarding ovarian screening, as she had a significant family history of cancer. I considered this to be good practice given the patient's family history of cancer[15].

42. When the patient re-presented to her GP a short time later, because of worsening abdominal pain and bloating, the GP made a red flag referral to general surgery on 3 September 2018. The patient was seen by general surgery on 6 September 2018, and had a CT scan of her chest, abdomen and pelvis. The Consultant Surgeon wrote to the patient's GP to advise that the result of this CT scan was '*grossly abnormal'* suggesting '*peritoneal and omental metastatic disease[16] in the abdomen and possible lung metastasis.'* The same Consultant Surgeon also made a red flag referral back to Gynaecology noting the patient's CA125 was normal in spite of the CT result. The Consultant Surgeon advised the patient had '*the omental cake percutaneously[17] biopsied[18]'* and that *'histology[19] has confirmed a serous adenocarcinoma[20] of likely gynae origin.'*

43. I appreciate this finding came as a shock to the patient, especially given the gynaecology tests produced negative results. However, the G IPA advised the primary cancer identified is '*extremely rare'* and the failure to diagnose it *'would not be considered as substandard by NHS standards*.' As such, I have not identified a failing in the Trust's care and treatment of the patient regarding her gynaecological investigations. Therefore, I do not uphold this element of the complaint.

[15] https://www.macmillan.org.uk/cancer-information-and-support/ovarian-cancer/primary-peritoneal-cancer

[16] Peritoneal cancer and omentum cancer are both rare cancers that affect the abdomen. Peritoneal cancer affects the peritoneum, the tissue that lines the abdomen. Omentum cancer affects the omentum, the fatty tissue that drapes over the abdominal organs. They are both considered a form of ovarian cancer.

[17] A procedure that involves taking a small tissue sample from the body using a needle that passes through the skin.

[18] A percutaneous image-guided biopsy of an omental cake is a procedure that uses ultrasound or CT guidance to remove tissue from the omentum for diagnostic purposes.

[19] Histology is the study of the microscopic structure of tissues and cells.

[20] Serous cancer is a type of cancer that forms in the serous epithelial layer of the ovaries, uterus, or peritoneum. It can be high-grade or low-grade, and is often aggressive.

CONCLUSION

44. I received a complaint about care and treatment the Trust provided to the patient from 2016 through to 2018.

45. I recognise this was a most difficult time for the patient, and that she had to wait a considerable time to received confirmed diagnoses.

46. The investigation identified the Trust's decision to downgrade the patient's referral to routine was not in line with relevant guidance. I consider this a failure in the Trust's care and treatment of the patient.

47. I also recognise the impact this failure had on the patient, who understandably sustained the injustice of uncertainty, anxiety, and a loss of opportunity for earlier diagnosis and treatment.

Recommendations

48. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failure identified (within **one month** of the date of this report).

49. I also recommend that within **one month** of the date of this report, the Trust shares this report with relevant staff and asks them to reflect on the failures identified.

50. I further recommend that within **three months** of the date of this report, the Trust provides training to relevant staff on the importance of considering all information presented on a referral form when making triage decisions. This training should also direct relevant staff to fully document their rationales for their triage decisions. The Trust should ensure a copy of the rationale for the decision is retained with the patient's records.

51. The Trust should provide me with evidence that it implemented these recommendations to confirm it took appropriate action (including relevant training records).

MARGARET KELLY **July 2025**

Ombudsman

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.