Scottish Parliament Region: Lothian

Case 201204063: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Gastro-intestinal; Genito-urinary (Urology)

Overview

The complainant (Miss C) raised a number of concerns about her late father's (Mr A) prostate cancer diagnosis. This included Mr A's concerns at being advised that he did not have prostate cancer resulting in his treatment being stopped. Miss C was also dissatisfied with the lack of information and support given to Mr A and the family about the diagnosis, prognosis and side effects of the treatment.

Specific complaints and conclusions

The complaints which have been investigated are that Lothian NHS Board (the Board):

(a) did not provide reasonable care and treatment to Mr A from May 2011 onwards (*upheld*);

(b) unreasonably withheld information about his condition from Mr A and his family (*upheld*); and

(c) did not reasonably handle Miss C's complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review their prostate cancer guidance to ensure it is consistent with national guidelines for the management of patients with widespread prostate cancer when a biopsy is not indicated;	21 May 2014
(ii) ensure timely involvement by a specialist cancer nurse shortly after diagnosis of prostate cancer;	26 March 2014
(iii) ensure Doctor 4 discusses the failings identified in this report at his next appraisal;	21 May 2014
(iv) ensure clinical staff clearly record any verbal responses they provide to patient correspondence;	26 March 2014

(v)	apologise to Miss C and the family for the failings identified in this report; and	26 March 2014
(vi)	ensure that complaint responses are consistent, accurate and set out in a structured manner.	26 March 2014

Main Investigation Report

Introduction

1. Mr A was diagnosed with prostate cancer in May 2011 and shortly thereafter began a course of hormone therapy treatment. A few months later, Mr A said that a different doctor told him that he did not have prostate cancer and stopped the treatment. The certainty of the diagnosis fluctuated for a few months until late November 2011 when prostate cancer was again diagnosed and the treatment resumed. By the middle of January 2012, the cancer had advanced and further tests showed that Mr A's prognosis was very poor and palliative care was put in place. Mr A died six months later. Mr A's daughter (Miss C) complained to Lothian NHS Board (the Board) in August 2012. In responding to the complaint, the Board had two meetings with Miss C and provided a written reply in February 2013. Miss C remained unhappy with the response and raised the matter with my office.

2. The complaints from Miss C which I have investigated are that the Board:

(a) did not provide reasonable care and treatment to Mr A from May 2011 onwards;

(b) unreasonably withheld information about his condition from Mr A and his family, and

(c) did not reasonably handle Miss C's complaint.

Investigation

3. In order to investigate the complaint, I have reviewed copies of the complaint correspondence and Mr A's clinical records. In addition, my complaints reviewer: made further enquiries with the Board; discussed the complaint with Miss C; and sought independent advice from a consultant urologist with a special interest in urological oncology and prostate cancer (the Adviser).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Miss C and the Board were given an opportunity to comment on a draft of this report.

Background

5. On 20 May 2011 Mr A was urgently referred to the Renal department at the Western General Hospital (the Hospital) by his GP due to problems with his kidney function. An ultrasound was carried out six days later in order to

examine his kidneys. The results of the ultrasound were abnormal and Mr A was seen at the Hospital on 30 May 2011 by a renal doctor (Doctor 1) who undertook blood tests including, a prostate specific antigen (PSA), which was shown to be significantly elevated at 76.9. Doctor 1 arranged for Mr A to be reviewed that same day by an on-call specialist registrar in urology (Doctor 2) who carried out a Digital Rectal Examination (DRE) and examined Mr A's prostate which was found to be hard and irregular in contour. Doctor 2 considered that Mr A most likely had prostate cancer, needed further investigations, and commenced Mr A on hormone therapy treatment. In a letter dated 20 June 2011, Doctor 1 notified Mr A's GP of these findings and also wrote to a consultant urologist specialising in prostate cancer (Doctor 3) at the Hospital who was a senior colleague of Doctor 2. Doctor 1 explained to Doctor 3, that Doctor 2 had diagnosed Mr A with prostate cancer and was arranging an urgent CT KUB (a scan to look at the abdomen, including the kidneys and urinary tract) but said that she could not see whether it had been done. A copy of this letter was also sent to Doctor 2.

6. In a letter dated 30 May 2011 (but not typed until 26 July 2011), Doctor 2 advised Mr A's GP that Mr A most likely had prostate cancer and that he had booked an urgent whole body bone scan. Doctor 2 also advised that he had given Mr A a handwritten prescription for hormone therapy treatment and that he would be reviewed in six to eight weeks at Doctor 3's out-patient clinic at the Urology department.

7. Mr A had the bone scan on 29 June 2011 which showed no evidence of bone metastases. Doctor 2 wrote to Mr A advising him that an appointment would be made to see him again in order to discuss the bone scan results. Mr A also had the CT KUB scan on 25 July 2011 which showed an abnormality.

8. On 3 August 2011, the urological cancer multi-disciplinary team (MDT) met to discuss Mr A's case. It was noted that the bone scan showed no evidence of bone metastases and that his PSA was 0.6. There was an entry stating 'Assess why started Hormones' but no reference to the significantly high PSA of 76.9 taken at the Renal department on 30 May 2011.

9. As Doctor 2 then left the country to work abroad, Mr A saw Doctor 4 at the Urology department on 10 August 2011. At this appointment, Doctor 4 performed a DRE but did not consider there was anything suspicious. Therefore, he appeared to conclude that Mr A did not have prostate cancer and

stopped the hormone therapy treatment. At this time, Doctor 4 was only aware of a PSA level of 0.6 from the multi-disciplinary meeting (MDM) record of 3 August 2011, and unaware of the high PSA result of 76.9 on 30 May 2011.

10. A further MDM took place on 17 August 2011 which noted that Doctor 4 had stopped the hormone therapy treatment. However, the PSA of 76.9 on 30 May 2011 had still not been noted by the MDM. Doctor 4 saw Mr A again at this time and after the appointment he noted in a letter to the GP and the Renal department that he had become aware that the result of Mr A's PSA on 30 May 2011, and a further result on 31 May 2011, were significantly high. Doctor 4 said that he had the difficult situation of informing Mr A that the prostate cancer was still a possible diagnosis, and would arrange for a specialist cancer nurse to provide Mr A with support and counselling. A copy of this letter was also sent to one of the specialist cancer nurses (Nurse 1).

11. On 30 August 2011, the Renal department responded to Doctor 4's letter and advised that Mr A's PSA of 76.9 had been highlighted to the Urology department in the letter Doctor 1 sent to both Doctor 2 and Doctor 3 on 20 June 2011.

12. In a letter dated 2 September 2011, Mr A wrote to Doctor 4 expressing concern about the change in Doctor 2's initial diagnosis, the time taken to tell him this, and that he wanted to ask further questions. Miss C said that she hand delivered the letter to the Urology department three days later but it was never acknowledged or answered.

13. Miss C said that Mr A attended an appointment at the Hospital on 26 September 2011 where Doctor 4 advised Mr A of the likelihood of prostate cancer. Miss C also said that Mr A asked Doctor 4 about his prognosis but no information was given. It was noted that the PSA had risen from 0.6 to 9.6. Doctor 4 said that he would check it again in six to eight weeks and would consider whether to resume the hormone therapy treatment if it were to significantly rise.

14. On 25 November 2011, Doctor 4 noted at a clinic appointment that Mr A's PSA had risen to 56.3 and that a DRE indicated malignancy. Doctor 4 informed Mr A and the GP that Mr A definitely had prostate cancer and recommended the hormone therapy treatment be resumed long term. Doctor 4 also asked the GP to monitor Mr A and to refer him back if the PSA rises to 20.

15. On 18 January 2012, Miss C arranged to meet with Doctor 4 in order to gain more information about Mr A's prostate cancer and prognosis. Miss C said that Doctor 4 advised her that the cancer was advanced. However, when she highlighted to Doctor 4 that they were unaware of this from all the appointments they attended with Mr A, Doctor 4 said that this information had been given to him. Miss C also said that Doctor 4 then advised her to speak to one of the specialist cancer nurses (Nurse 2) who had not been involved until now.

16. On 8 February 2012, the GP sent an urgent fax to Doctor 4 asking for Mr A and his family to be seen again regarding on-going, and worsening back pain. The GP also asked if a further bone scan could be considered and highlighted that neither Mr A nor the family understood the diagnosis or prognosis, and had wanted to discuss this further with Doctor 4. The GP also highlighted that Mr A's PSA was rising rapidly to 64.8 and his liver function test had deteriorated.

17. On 22 February 2012, Doctor 4 advised the GP that a specialist cancer nurse had liaised with Miss C to clarify the on-going concerns and that a Magnetic Resonance Imaging (MRI) scan had been organised. Doctor 4 said that it was unusual to see metastatic disease into the liver with prostate cancer. He also commented that it was difficult to give a prognosis with no obvious extensive advance and metastatic disease, however, the prognosis would have to be guarded now given the rapidly rising PSA. Furthermore, he suggested that the rising PSA level may indicate the development of hormone resistant phase of prostate cancer. Doctor 4 outlined that he and one of the specialist cancer nurses had mentioned the diagnosis and explained the relevance of hormone therapy treatment to Mr A and the family.

18. On 24 February 2012, the result of the MRI scan showed multiple bone metastases in Mr A's spine and a neck lesion which was noted to be due to the possibility of a separate disease process as it was not typically seen in prostate metastases. There was involvement with the family by Nurse 1 at this time.

19. An MDM held on 29 February 2012 recommended further scans of Mr A's neck and further discussion took place with Nurse 1 regarding the MRI scan results that showed the cancer was widespread. Miss C said that she asked Nurse 1 in March 2012 how long Mr A had to live and that she was advised three to six months.

20. The Board also advised that Mr A was offered two appointments with the oncology team for further assessment of the neck lesion in March 2012 but he was unable to attend. Palliative care was thereafter put in place and Mr A passed away on 14 July 2012.

(a) That Board did not provide reasonable care and treatment to Mr A from May 2011 onwards

21. Miss C was dissatisfied that Doctor 4 incorrectly advised Mr A on 10 August 2011 that he did not have prostate cancer and stopped the hormone therapy treatment. She had concerns that Doctor 4 was unaware of the high PSA on 30 May 2011 at this time, and even when he did identify it around a week later, the treatment was not restarted until the end of November 2011. Furthermore, Miss C complained that no information was given about the side effects of the treatment by either Doctor 2 or Doctor 4.

22. Miss C was also unhappy that Doctor 4 did not advise Mr A or the family in November 2011 about the stage of the cancer and that no further scans were carried out at this time to determine its extent. Miss C said that it took until January 2012 to find out that the cancer was advanced and to meet a specialist cancer nurse. Miss C said that she highlighted a lump in Mr A's neck to Nurse 2 who advised that prostate cancer was normally contained in the abdominal area and it was unlikely the cancer would have travelled that high up. Miss C felt that Doctor 4 could have monitored Mr A more closely after he confirmed the diagnosis on 25 November 2011 rather than advising the GP to do so.

23. In response to the complaint, the Board initially met with Miss C and the family on 12 October 2012 to discuss their concerns. The Board provided an overview of the care Mr A had been given. It was explained that, although Doctor 4 had advised Mr A that he did not have prostate cancer, he could not rule out any other cancers. The Board also said that no further scans were carried out around November 2011 when Doctor 4 became fully aware that Mr A had prostate cancer, because there was no evidence of the cancer having spread from the previous scans in June and July 2011. In addition, any further scan would not affect his treatment as this would be hormone therapy treatment in any case.

24. The Board further outlined that rapid progression of the cancer could not be controlled by the hormone therapy treatment by March 2012. Although it

was acknowledged by another consultant urologist (Doctor 5) at the meeting, that he would not have stopped and started the hormone therapy treatment, the family were advised that Mr A's outcome would have been exactly the same had treatment been continuous. The Board also commented that any treatment to shrink the lump on Mr A's neck, would only alleviate his symptoms.

25. The Board accepted that there had been communication issues regarding Mr A's care, including that a specialist cancer nurse had not been involved until 18 January 2012 and this could be taken on-board and improved. The Board also noted there was a significant delay in letters being typed and sent to the GP.

26. The Board concluded that events could have happened in a more organised and timely fashion. They acknowledged the psychological trauma the family had suffered, especially the confusion caused to Mr A about his diagnosis.

27. A further meeting took place between the family and the Board on 11 December 2012 at the request of Miss C. The Board acknowledged and apologised that the MDM process should have been given more information on Mr A. This appeared to include the high PSA level on 30 May 2011. Doctor 4 was present at the meeting and apologised for the confusion over the diagnosis. He set out that the bone scan was carried out at the correct time, and that his decision to stop hormone therapy treatment was the correct thing to do and caused no harm as the treatment slows progression of the disease and does not cure it. Doctor 4 further commented that stopping the treatment, even up to 12 months, was a good indicator if disease was present, and that further scans would not have changed anything.

28. In response to Miss C's complaint about the lack of prognosis given around November 2011, Doctor 4 advised that it was difficult to put a timescale on this as some patients can go on for considerable periods of time although, Mr A had co-morbidity issues.

Clinical Advice

29. The Adviser outlined that a proper initial assessment with appropriate tests were not carried out before Mr A started the hormone therapy treatment. The Adviser explained that, whilst it is acceptable to make a diagnosis of prostate cancer without a biopsy in certain patients, he would have expected a bone

scan as well as PSA blood tests (in line with national guidelines[1]) to show if the cancer had spread before starting treatment.

30. The Adviser said that hormone therapy treatment was the correct treatment for Mr A and that he had a good response to it because his PSA fell from a pre-treatment level of 76.9 in May 2011 to 0.6 in July 2011. However, by the time the bone scan was completed on 29 June 2011, evidence of the cancer appeared to have been removed by the hormone therapy treatment. The Adviser explained that the effect of the treatment had changed the clinical picture and led to the mistaken clinical assessment by Doctor 4 that Mr A did not have prostate cancer. The Adviser and my complaints reviewer were unable to establish why Doctor 4 had not known that the PSA was significantly high in May 2011, given Doctor 1 had notified the Urology department on 20 June 2011. In addition, my complaints reviewer highlighted that the blood results would have been available on the computer system.

31. My complaints reviewer noted an entry in the MDM record of 3 August 2011 stating 'Assess why started Hormones'. Despite this entry, the Adviser told my complaints reviewer that stopping the hormone therapy treatment on 10 August 2011 was a significant decision for Doctor 4 to make without evidence to show that he had fully queried why Mr A had been put on it. The Adviser commented that stopping hormone therapy treatment was based on an incorrect assessment of the facts, and while it is difficult to detail the exact extent of stopping hormone therapy treatment in this case[2], it would not be considered acceptable practice given the full facts. My complaints reviewer noted that the national guidelines outline that the long term effectiveness of hormone therapy treatment is unknown when it is stopped then restarted:

> 'Intermittent androgen withdrawal may be offered to men with metastatic prostate cancer providing they are informed that there is no long-term evidence of its effectiveness.'

32. The Adviser was also critical that Doctor 4 did not resume the hormone therapy treatment until such time the PSA increased over a particular level. In the Adviser's opinion, it was not ideal as Mr A had already been on the treatment which, in a matter of a few weeks, changed the clinical picture. In other words, the appearance of cancer can disappear quickly after hormone

[1] The National Institute of Clinical Excellence Guidance 58, 1.2.3
[2] The National Institute of Clinical Excellence Guidance 58, 1.7.5

therapy treatment is commenced. Therefore, it was important for Doctor 2 to have either carried out the bone scan or biopsy before starting the hormone therapy treatment or soon after at the very least, and not four weeks after treatment was commenced.

33. My complaints reviewer noted from the Board's internal correspondence that there had been concerns raised by the Renal department with the Urology department in relation to the way in which Doctor 2 had informed Mr A that he had prostate cancer on 30 May 2011. The Adviser explained that it is normal practice from the outset for a formal out-patient appointment to be made to explain the cancer diagnosis, prognosis and treatment plan once appropriate test have been completed. This did not appear to have happened in Mr A's case.

34. My complaints reviewer further noted that whilst the national guidelines recommend the use of MDTs in order to improve treatment standards and the overall experience of cancer patients, there is no specific information on when they should take place. In the Adviser's opinion, it is normal practice that all new cancer cases be discussed in a timely fashion with the MDT and this did not happen in Mr A's case after Doctor 2 diagnosed him with prostate cancer on 30 May 2011. The Adviser highlighted that had the MDM gone ahead around this time (and not two months later), it was likely that the bone scan would have gone ahead sooner than it did. The Adviser expressed that this approach would have clarified the diagnosis and likely prognosis from the outset, therefore, preventing confusion and Doctor 4's subsequent wrong exclusion of the prostate cancer diagnosis. Furthermore, the appropriate communication with the family would have taken place, including the involvement of the specialist cancer nurse from the beginning, in order to provide support and counselling to Mr A and the family.

35. In response to Miss C's concerns that the side effects of the hormone therapy treatment were not properly explained to Mr A, my complaints reviewer said that the national guidelines[3] state:

> 'Men with prostate cancer should be clearly advised about potential longer term adverse effects of treatment and when and how to report them.'

[3] The National Institute of Clinical Excellence Guidance 58, 1.3.19

36. My complaints reviewer highlighted that whilst Doctor 4 advised in August 2011 that he would be making arrangements for Mr A to be supported by the specialist cancer nurse when he suspected prostate cancer, it appears that this did not happen until 18 January 2012 after Miss C raised on-going concerns about the lack of information regarding the diagnosis and prognosis. The Adviser highlighted that it was normal practice for a specialist cancer nurse, as a key-worker, to be involved at the outset, in order to ensure on-going communication was correct at all times with Mr A, the family and the GP.

37. My complaints reviewer asked the Adviser whether a further bone scan should have been carried out in light of the rising PSA in November 2011. The Adviser said that a further bone scan was likely to be unhelpful due to the hormone therapy treatment having changed the clinical picture at the end of June 2011. In addition, the Adviser said that the secondary tumour in the neck came later, and even if a chest Computed Tomography scan had been carried out around July 2011, it was unlikely to have helped identify it.

38. The Adviser concluded that he could not say for certain what Mr A's outcome would have been had he remained on the hormone therapy treatment because prostate cancer could, at a point in time, become resistant to the treatment. The Adviser said that, given the widespread and aggressive nature of the cancer, it is likely that the outcome would not have been much changed by the sequence of events but much of the stress suffered by the family could have been avoided with better communication and support.

39. The Adviser also highlighted that the Board's guideline for prostate cancer in place at the time of Mr A's care, and their revised version, did not contain sufficient information relating to the patient's pathway for the management of prostate cancer. My complaints reviewer noted that there was little guidance regarding the early management of patients with a high PSA and abnormal DRE where a biopsy was not to be carried out. In addition, when asked, the Board did not provide any supplementary guidance to clearly show the patient pathway in terms of involvement by the MDT and specialist cancer nurse.

(a) Conclusion

40. I acknowledge that Doctor 2 indicated that he was going to arrange an urgent bone scan after diagnosing Mr A on 30 May 2011. However, from the advice I have received, the scan should have ideally been carried out before the hormone therapy treatment was commenced or shortly thereafter, and not four weeks later.

41. I recognise Miss C had concerns that further scans should have been carried out on Mr A's chest around July 2011 and on his neck towards the end of 2011. However, from the clinical advice I have received, it was unlikely that further scanning would have been helpful around these times. Mr A's prostate cancer was particularly aggressive in nature, and I am unable to say for sure whether or not his prognosis would have been any different given that the cancer can become resistant to the hormone therapy treatment at a point in time.

42. The aim of MDTs is to bring together health professionals with knowledge of diagnosis and treatment to improve communication and decision making. Therefore, had the MDM gone ahead shortly after initial diagnosis, it is likely the bone scan would have been done earlier. In addition, it would have ensured more accurate communication between the Hospital doctors, the GP, Mr A and his family.

43. Whilst the MDM record on 3 August 2011 had not noted the date of the PSA of 0.6, I consider that Doctor 4 should have explored whether a PSA blood test had been taken at the time of diagnosis on 30 May 2011 before concluding Mr A did not have prostate cancer and stopping treatment. Furthermore, when Doctor 4 suspected that prostate cancer was likely, it would have been ideal had the hormone therapy treatment been recommenced at this time, especially in light of the long-term effectiveness of intermittent treatment being unknown.

44. The Board acknowledged the impact caused to Mr A and the family in relation to him being wrongly advised that he did not have prostate cancer. They also took into account that the involvement by a specialist cancer nurse should have taken place sooner, and that clinic letters should have been sent to the GP in a more timely fashion. This would have ensured better advice and support to Mr A and his family which should have been paramount.

45. Overall, I am critical of both Doctor 2's and Doctor 4's management of Mr A's care which resulted in poor co-ordination and communication between key staff. This led to Mr A and the family receiving inaccurate information and poor support from the outset.

46. In view of the above, I uphold the complaint.

(a) Recommendations

47. I recommend that the Board:	*Completion date*
(i) review their prostate cancer guidance to ensure it is consistent with national guidelines for the management of patients with widespread prostate cancer when a biopsy is not indicated;	21 May 2014
(ii) ensure timely involvement by a specialist cancer nurse shortly after diagnosis of prostate cancer; and	26 March 2014
(iii) ensure Doctor 4 discusses the failings identified in this report at his next appraisal.	21 May 2014

(b) The Board unreasonably withheld information about his condition from Mr A and his family

48. Miss C was dissatisfied at the lack of information given to Mr A and the family surrounding Mr A's diagnosis and prognosis by both Doctor 2 and Doctor 4. Miss C said that Doctor 4 had not advised Mr A about malignancy despite it being highlighted in a letter to the GP after the clinic appointment on 17 August 2011. In addition, she was unhappy that Doctor 4 had not replied to the concerns Mr A raised in his letter to him on 2 September 2011 about the problems with his diagnosis. Furthermore, Miss C complained that when Doctor 4 told Mr A he did have prostate cancer on 25 November 2011, there was still no information given to him about the extent or possible stage of the cancer. Miss C highlighted that it was not until 18 January 2012 that Doctor 4 had told them the cancer was advanced after Miss C pressed him on the matter.

49. My complaints reviewer noted that the national guidelines[4] state:

'Men with prostate cancer should be offered individualised information tailored to their own needs. This information should be given by a

[4] The National Institute of Clinical Excellence Guidance 58, 1.1.2

healthcare professional (for example, a consultant or specialist nurse) and may be supported by written and visual media (for example, slide sets or DVDs).'

(b) Conclusion

50. I acknowledge the emotional shock the initial diagnosis by Doctor 2 had on Mr A and the family, along with the confusion caused by Doctor 4 when he incorrectly reached the conclusion that Mr A did not have prostate cancer.

51. There is evidence to support that Mr A and the family had not fully understood matters related to the prostate cancer diagnosis from the outset. The Renal department had raised concerns about the way in which Doctor 2 had given the diagnosis on 30 May 2011. This suggested insufficient information was given to Mr A at this time or shortly thereafter because the MDM did not go ahead until two months later, and the specialist cancer nurse was not involved until January 2012. From the professional advice I have received, this was unreasonable. As set out in findings under complaint (a), had the MDT and specialist cancer nurse been involved much sooner, it is more than likely that Mr A and the family would have had a clearer understanding about how the disease was affecting him and been given accurate information.

52. I noted that Doctor 4 received Mr A's letter of 2 September 2011 and outlined that he had explained to the family matters related to his diagnosis, but the family disputed that Mr A's questions were properly answered. Given that no written acknowledgement or response was given to the letter, I believe there was a missed opportunity to ensure Mr A clearly understood what had happened in relation to his diagnosis around this time. I also have concerns that it took Doctor 4 three months from 10 August to 25 November 2011 to confirm the diagnosis, despite being aware during this time of the significantly high PSA in May 2011, together with the abnormal prostate examination and DRE.

53. In view of the above, I uphold the complaint.

(b) Recommendations

54. I recommend that the Board:	*Completion date*
(i) ensure clinical staff clearly record any verbal responses they provide to patient correspondence.	26 March 2014

(c) The Board did not reasonably handle Miss C's complaint

55. Miss C remained unhappy with the Board's response to her complaint because she felt they had not fully acknowledged that some aspects of Mr A's care were overlooked. Miss C outlined that when discussing her complaint with the Board, Doctor 4's advice was different to what Doctor 5 had said regarding the hormone therapy treatment, in that Doctor 5 would not have stopped treatment. Miss C was also unhappy that the Board's reference to Mr A having 'another biopsy' was incorrect as he never had one in the first instance.

56. My complaints reviewer noted that Doctor 5 had been asked during the complaints meeting on 12 October 2012 whether he would have taken the same action if Mr A had been his patient. The record of this meeting states:

> '[Doctor 5] advised that he obviously would not have stopped and started the hormone therapy, but ultimately the result would have been exactly the same.'

However, at the complaint meeting on 11 December 2011, the family were advised that:

> '[Doctor 4] made the decision to stop hormone treatment as this was the correct thing to do and caused no harm – the hormone treatment slows the progression of the disease it does not cure the cancer so stopping it and seeing if the PSA rises is a good indicator if disease is present.'

57. My complaints reviewer further noted that the Board had incorrectly referred to Mr A having had a biopsy.

(c) Conclusion

58. Whilst the Board accepted at the complaints meeting held on 11 December 2012 that a specialist cancer nurse should have been involved sooner, I consider that it would have been appropriate for the Board to have also acknowledged that it would have been good practice had the MDM and bone scan gone ahead shortly after diagnosis on 30 May 2011.

59. I am also critical that Miss C had been given conflicting information regarding the stopping of hormone therapy treatment at the two meetings which were held to discuss her complaint. Doctor 5's clinical opinion about continuing hormone therapy treatment appears to be at odds with further responses the family were given at the second meeting. Whilst my complaints reviewer noted that the Board supplied Miss C with a copy of the minutes from both meetings, it

would have been good practice had a letter been issued that methodically detailed the response to the various aspects of the complaint in a structured format. In order to ensure confidence in the NHS complaints procedure, I consider that it is important, that responses are clear, consistent and accurate.

60. In view of the above, I uphold the complaint.

(c) Recommendation

61. I recommend that the Board:	*Completion date*
(i) ensure that complaint responses are consistent, accurate and set out in a structured manner.	26 March 2014

General recommendation

62. I recommend that the Board:	*Completion date*
(i) apologise to Miss C and the family for the failings identified in this report.	26 March 2014

63. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	the patient
Miss C	the complainant who is Mr A's daughter
the Board	Lothian NHS Board
the Hospital	the Western General Hospital
Doctor 1	a renal doctor
Doctor 2	a specialist registrar in urology
Doctor 3	a consultant urologist
MDT	Multi-disciplinary team
MDM	Multi-disciplinary meeting
Doctor 4	a consultant urologist
Nurse 1	a specialist cancer nurse
Nurse 2	a specialist cancer nurse
MRI	Magnetic resonance imaging
Doctor 5	a consultant urologist
the Adviser	a consultant urologist with a special interest in urological oncology and prostate cancer who has provided independent advice to the Ombudsman

Annex 2

Glossary of terms

Androgen withdrawal	treatment that lowers testosterone levels
Co-morbidity	two or more co-existing medical conditions or disease processes that are additional to an initial diagnosis
CT KUB	a computed tomography scan of the abdomen
Digital Rectal Examination (DRE)	a test that is used to detect any lumps in the prostate gland or any hardening or other abnormality of the prostate tissue
Metastases	a tumour growth or deposit that has spread via lymph or blood to an area of the body remote from the primary tumour
Prostate Specific Antigen (PSA)	a protein made by the prostate gland and found in the blood. Prostate cancer and other benign conditions can increase PSA levels in the blood

Annex 3

List of legislation and policies considered

The National Institute of Clinical Excellence Guidance 58 (February 2008)