Avoidable death of woman after nine month delay in cancer diagnosis

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Date investigation closed

April 2017

The complaint

Mr D complained that his mother was diagnosed with bladder cancer too late for her to receive appropriate treatment and that she died as a result.

He also complained that the Trust did not recognise these failings in its investigation which meant they could not prevent the same mistakes happening to others.

Background

Mrs D was referred to the Trust by her GP in February 2015 with suspected bladder cancer. The hospital investigated it by carrying out a cystoscopy where a small camera is put into the bladder. The images were poor due to debris in the bladder so a repeat test was ordered for two weeks later.

An ultrasound showed her kidneys were swollen. A CT scan confirmed the swollen kidneys and that the urinary bladder neck was enlarged. The radiologist concluded it was inflammation. Two repeat cystoscopies were carried out in April and May which showed inflammation and evidence of bleeding.

The Trust planned to review Mrs D within six weeks so that it could take an X-ray of the kidney and ureter and an examination of the upper urinary tract but this did not happen due to the hospital not having sufficient staff capacity to meet demand.

In July a waste product called creatinine that is expelled in urine had risen to 152 which is too high and shows that the kidney function was failing. A scan showed significant impairment of the right kidney.

Various blood tests showed progressive deterioration of the kidneys but these were not acted upon. The creatinine in Mrs D's urine increased again to 220. Normal creatinine clearance for healthy women is 88-128 mL/min. Mrs D was admitted to hospital in September suffering from kidney failure and her creatinine level was now at 449. She had a cystoscopy under general anaesthetic but no bladder biopsies were taken.

Mrs D was again admitted to hospital in January 2016 as an emergency with worsening kidney function. Her creatinine level was 501. She had a repeat

endoscopy which revealed bladder cancer and an MRI scan showed it was at an advanced stage.

She was referred to a separate Trust who told her that the cancer was too advanced for her to have it removed surgically. She was treated with palliative radiotherapy in March 2016 but sadly died in May 2016.

What we found

We fully upheld this complaint. We found that the Trust failed to identify the cancer at an early stage and subsequent investigations were delayed and inadequate. The presence of debris in the bladder and an obstructed right ureter are highly suggestive of cancer. A prompt examination under general anaesthetic with biopsies being taken would have enabled the Trust to diagnose cancer in March 2015.

The Trust would have been able to give chemotherapy and radiotherapy treatment in March 2015 as the tumour would have been smaller and Mrs D's kidney function better. She would have had almost a 70% chance of surviving if she had been diagnosed in March 2015. By the time Mrs D was diagnosed nearly a year later in January 2016 her cancer was too far advanced so that treatment was no longer possible. This nine month delay meant that Mrs D was more likely to die than survive and meant she had to endure painful symptoms of kidney failure.

The Trust's investigation did not identify these failings or acknowledge that if it had provided the right care and treatment then she could have survived, causing her son significant distress.

Putting it right

We recommended that the Trust write to Mr D to acknowledge and formally apologise for the failings in his mother's care and treatment. The Trust paid £10,000 to Mr D to reflect the emotional impact of knowing his mother would not have died when she did, had she received the right care and treatment. We also recommended that they outline to Mr D what changes they have made to prevent this service failure from happening again.