Ombudsman
Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

The investigation of a complaint against Aneurin Bevan University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201807774

Contents

Contents	Page
Introduction	1
Summary	2
The complaint	4
Investigation	4
The background events	5
Miss Y's evidence	6
The Health Board's evidence	6
Professional advice	7
The Health Board's response to the draft report	11
Further Professional Advice	12
Analysis and conclusions	15
Recommendations	17

Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Miss Y, and the aggrieved as Mr X.

Summary

Miss Y complained on behalf of her partner, Mr X, that there was a failure to accurately diagnose his cancer between February and June 2018. Mr X had been first seen at the Royal Gwent Hospital ("the Hospital") in February, and had undergone tests including an MRI scan in June (MRI" – the use of strong magnetic fields and radio waves to produce detailed images of the inside of the body). On reviewing the MRI (at a Multi-Disciplinary meeting – "MDT" - in July) the Hospital told Mr X that his cancer was organ confined to the prostate. It was recommended he undergo a RALP (a prostatectomy – removal of the prostate gland), which was performed on 25 September. On a subsequent Hospital review of the MRI imaging, Mr X was told in November that his cancer was being upstaged and that it was not organ confined. It had spread outside the prostate. Mr X was told that the MRI scan in June had missed this. Miss Y complained that the Hospital had missed the extent of Mr X's cancer on the original scan leading to him undergoing the unnecessary RALP, which had resulted in him suffering debilitating side effects. Further, she said that Mr X was not able to properly consent to the RALP procedure, not being in possession of the full facts, or therefore having the opportunity to consider any alternative treatments.

The investigation identified numerous failings in Mr X's care in the period concerned. These included the following: a failure to note enlarged pelvic lymph nodes on the June scan, which were suspicious, and so incorrectly staging them and reporting them as being normal; only one view had been taken whereas an axial sequence should have been performed in accordance with recognised guidance (which may have better identified the pelvic nodes as suspicious); the suspicion of metastatic cancer should have been raised from a lesion's appearance (its size passing the threshold of suspicion); the MDT record in July was insufficient, so that it was not possible to discern if all the images and reports had been considered at the meeting. There was no clear evidence that Mr X was informed about possible alternative treatments to the RALP and, given the above failings, he consented to and underwent an unnecessary procedure (a RALP is only suitable for patients with organ confined cancer), so suffering the severe after effects he complained about. This was a significant injustice to him. From advice received during the investigation, nevertheless, the failings

were unlikely overall to have significantly altered Mr X's overall prognosis, but the failings found were significant ones and the complaint was upheld. The following recommendations were made, which the Health Board agreed to implement over a period of 6 months:

a) Apologise to Miss Y and Mr X for the identified failings.

b) Make a redress payment of £5000 to Mr X for the failings in his care.

c) Remind all clinicians about properly documenting the meeting/preparing minutes of MDTs.

d) To review its prostate MRI protocol to ensure a pelvic sequence view is taken (as per guidance to better allow for pelvic lymph node evaluation).

e) To provide evidence of the review of MDT meeting arrangements the Health Board indicated it had since introduced, to the Ombudsman.

f) Consider an MDT review of all prostate cases (from June 2018 to the present day) where subsequent pathology placed the patient into a higher risk category from the initial staging.

g) Reviews its MDT procedure to consider implementing a routine audit of MDT reporting against pathology outcomes.

The Complaint

1. Miss Y complained on behalf of her partner, Mr X about:

- A failure to accurately diagnose Mr X's cancer between February and June **2018** (noting it to be organ confined with no evidence of metastatic spread).

- This inaccurate diagnosis meant Mr X was not in full possession of the facts about his health to enable him to make an informed decision about future treatment (including sourcing any alternative treatment options).

- The delay in accurate diagnosis (made in December **2018**) impacted adversely on Mr X's prognosis and his quality of life.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Aneurin Bevan University Health Board ("the Health Board") and considered those in conjunction with the evidence provided by Miss Y. My investigator sought advice from 2 of my Professional Advisers, Dr Tristan Barrett, a Consultant Radiologist ("the First Adviser") and Mr Thiru Gunendran, a Consultant Urologist ("the Second Adviser"). The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by referring to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. In commenting on the first draft issued of this report, the Health Board challenged some of the conclusions of the First Adviser. Where such a challenge to the professional advice provided to me is mounted by any health board's Medical/Clinical Director, and so affects my provisional findings, it is my practice to consider seeking fresh advice. I did so in this

case and procured further advice from a second Consultant Radiologist, Dr Erini Vrentzou ("the Third Adviser") who considered matters in line with my standards outlined in paragraph 2 above.

4. Both Miss Y and the Health Board were given the opportunity to see and comment on an initial, and a second, draft of this report before the final version was issued.

The background events

5. On 15 August **2017** Mr X's GP referred him with symptoms of painful ejaculation. On 7 February **2018** at the Royal Gwent Hospital ("the Hospital") firmness was noted at the base of the prostate, and Mr X had a prostate specific antigen test ("PSA" – a blood test for prostate cancer). On 16 February Mr X's PSA was 8.7 ng/ml (nanograms per millilitre), 4 -10 ng/ml is the normal range for young men, slightly higher in older men. Mr X's PSA had risen from 4.1 ng/ml in 2015 to 9.9 ng/ml on 25 May. A Magnetic Resonance Imaging scan ("MRI"- the use of strong magnetic fields and radio waves to produce detailed images of the inside of the body) was requested on an "urgent suspected cancer" basis.

6. On 7 June **2018** Mr X's MRI reported prostate abnormality. On 10 July Mr X was informed of the MRI result, and a prostate biopsy was arranged for 16 July. On 25 July a Multi-Disciplinary Meeting ("MDT") reviewed Mr X's scan and biopsy.

7. On 1 August, the results were explained to Mr X, and on 25 September he had a robotic assisted laparoscopic prostatectomy ("RALP" – removal of the prostate gland). On 9 November Mr X was told that the prostate cancer was upstaged from organ confined to extending outside the prostate to the seminal vesicles (tubes that carry the semen). On 21 December Mr X was informed that the post-operative PSA test suggested metastatic cancer (the spread of cancer).

Miss Y's evidence

8. Miss Y complained that during consultation they were told the cancer was confined within the prostate, otherwise Mr X would not have been considered for RALP. She said that there was no discussion that the cancer could be metastatic. Miss Y said that on 21 December Mr X was told the cancer had spread, but the original scan had not detected this. Miss Y said that the removal of Mr X's prostate was unnecessary, and the side effects were debilitating.

The Health Board's evidence

9. The Health Board said that, on 7 February **2017**, Mr X was assessed with features consistent of prostatitis (a swelling of the prostate gland) having mainly ejaculatory pain. It said that such pain is a common symptom of prostatitis which can cause an elevated PSA; it is not a typical feature of prostate cancer. On 16 February it was noted that Mr X's PSA was raised, and he was to be tested again in 3 months' time because variables, such as a urine infection, can inflate the PSA score. It said that another PSA test in less than 3 months was not clinically indicated.

10. The Health Board said that, on 25 May, Mr X's increased PSA level was noted, and an urgent scan and prostate biopsies were requested. The 7 June MRI scan characterised the abnormality as PI-RADS 5 (Prostate Imaging Reporting and Data System - highly likely that cancer was present). It was thought the cancer was organ-confined, with no enlarged regional pelvic lymph nodes. It said that Mr X was informed of the result on 10 July, and a prostate biopsy was arranged for 16 July. The MDT on 25 July reviewed the MRI scan and biopsies. It was decided that Mr X should be offered RALP or external beam radiotherapy ("EBRT").

11. The Health Board said that, on 1 August, the results were explained to Mr X and treatment options discussed. It said that the MRI scan had not shown any adverse features to suggest extensive locally advanced cancer. It said that during Mr X's procedure, on 25 September, the cancer was found to have extended into the seminal vesicles. It said that following RALP, radiotherapy is offered when the procedure alone fails to result in undetectable PSA, while detectable PSA suggests metastatic cancer.

12. The Health Board said that on 9 November, Mr X was told the disease was upstaged[1] from stage T2 to stage T3b (locally advanced cancer). It said that this suggested the scan underestimated the extent of the disease as it reported that the regional pelvic lymph nodes appeared normal and were not enlarged. The Health Board said that despite the MRI being correctly performed, it focused on the prostate by design and not the whole pelvis. It said that in rare circumstances images may not reflect, or can under-represent, the cancer's extent. The Health Board said that only microscopic assessment of the removed prostate gave the cancer's accurate assessment and its T3b staging. It said that despite the cancer being upstaged, the operation appeared to have been successful.

13. The Health Board said that on 21 December, when Mr X was told the PSA level suggested metastatic cancer, it was likely the prostate cancer spread from a primary site to a secondary site at the time of diagnosis. A subsequent computerised tomography scan ("CT scan" – the use of X-rays and a computer to create an image of the inside of the body) of the abdomen and pelvis raised suspicion of enlarged lymph nodes in tissue surrounding the rectum, and in front of the sacral bone deep at the back of the pelvis. It said that these areas are not typically affected by prostate cancer and are not included on standard prostate MRI fields. A bone scan arranged after Mr X's surgery had not reported evidence of bony metastatic deposits.

Professional Advice

14. The First Adviser said that Mr X's MRI scan on 7 June correctly identified a suspicious tumour, and although its size was not stated, the terminology used ("diffuse" and "throughout the peripheral Zone") implied a large lesion. He said that whilst the Health Board said that its scanners were "state of the art 3 Tesla scanners", the scanner used was a 1.5 Tesla strength MRI. He said that, nevertheless, the study was to an acceptable diagnostic quality, and the scan correctly interpreted the disease from the point of view of lesion detection, but not its staging.

[1] Different types of staging systems are used for types of cancer. Stage 2 - the cancer has grown but not spread. Stage 3 – the cancer is larger and may have spread to surrounding tissues and/or lymph nodes. The T3a stage - the cancer has extended outside the gland. The T3b stage - the cancer has invaded the seminal vesicles.

15. The First Adviser said that the initial MRI showed the staging was at least T3a, and likely T3b. He said that the Health Board's diagnosis of an organ-confined cancer was not reasonable. He said that the pre-sacral lymph nodes identified on the sagittal plane series (a longitudinal image) on the initial MRI should have been reported as suspicious for metastatic cancer. He said that this would have been easier to determine had the recommended axial plane imaging (a view obtained by rotating around the axis of the body) also been performed. He said that the subsequent knowledge of high-grade cancer would have made the nodules more suspicious had a re-review been performed in the MDT setting. He said that it was not reasonable to consider there was no definitive evidence of metastatic spread.

16. The First Adviser said that the MRI reported the seminal vesicles as unremarkable with no disease affecting the lymph nodes. He said that the report had not considered the spread of cancer to be present and noted that the seminal vesicles and lymph nodes were not affected. He said that at this stage, it was not reasonable to consider there was no definitive evidence of metastatic spread.

17. The First Adviser said that the Health Board's account was not correct when it said that the regional lymph nodes (nodes that directly drain the region of the prostate and include nodes in the pelvis) appeared normal and were not enlarged. He said that the axial and coronal plane images did not show abnormal lymph nodes, but the sagittal plane image showed 2 suspicious lymph nodes measuring 8.5mm and 7mm in the pre-sacral space (inside the pelvis, behind the rectum and in front of the coccyx). He said that lymph nodes above 8mm are suspicious for the spread of prostate cancer. He said that the rounded appearance, lack of fat within the hilum (structure where blood vessels and nerves enter an organ) and the unusual location made the nodes suspicious and should have been noted as such in the MRI report. He said that the MRI only included images centred on the prostate, which was contrary to guidelines.[2] A further sequence should have been taken for extensive coverage of the pelvis.

[2] PI-RADS guidelines (version 2 [2015] as well as the updated version 2.1 [2019], state "at least one pulse sequence should use a field-of view ("FOV") that permits evaluation of pelvic lymph nodes to the aortic bifurcation" (a full pelvic coverage not confined to the prostate).

18. The First Adviser said that the scan incorrectly reported from a staging perspective. He said that the provisional staging should have been at least stage T3a, the image suggested this to be "highly probable". An experienced reader would have raised the possibility of T3b involvement of the seminal vesicles (which he described as "likely"), with a possible view to re-visit staging at the MDT, when pathology was known. The First Adviser disagreed that the images underestimated the extent of the cancer, they showed probable stage T3a, and likely stage T3b, but this was not reported upon.

19. The First Adviser said that the CT scan performed on 7 January **2019** showed a cluster of 3 lymph nodes in the pre-sacral region, that correlated to the 2 nodes identified on the MRI scan. He said that they were likely to have become more prominent in the interval. He said that he detected the nodes without the benefit of hindsight when reviewing the MRI images and before he viewed the CT which showed the same nodes even more clearly.

20. The First Adviser said that the MDT record was brief. It did not mention pathology and radiology results, document attendees or the outcome of its opinion. He said that although the results were listed within the MDT report, it was not recorded whether the images and pathology were re-reviewed, or the original reports discussed. He said that it was important to know the type of review undertaken as radiological findings may have been interpreted differently on re-review with knowledge of the biopsy result being of a high-grade tumour, which cannot be determined without a contemporaneous recording of items reviewed.

21. The Second Adviser said that at the 7 February consultation Mr X's prostate examination found firmness, and it was explained that ejaculatory pain was because of inflammation within the prostate typical of prostatitis, and a PSA test was arranged. The PSA test was elevated, and a repeat was advised within 3 months to see whether the level declined, as would have been expected had the initial PSA level been caused by infection or inflammation. He said that there is no guidance about when a PSA test should be repeated but it is usually within 2 to 3 months. He said that it was reasonable to have waited for a repeat PSA before further investigations, as raised PSA is not specific to prostate cancer. This was an acceptable management plan.

22. The Second Adviser said that on 25 May the Registrar who saw Mr X requested an MRI scan because his PSA levels had increased, and the prostate examination was abnormal. The rectal examination findings and the PSA result were explained to Mr X, and that further investigation by MRI scan for possible prostate cancer was needed.

23. The Second Adviser said that in view of the First Adviser's opinion that Mr X's MRI scan showed 2 suspicious lymph nodes in the pre-sacral space, suspicious of spread from prostate cancer, retrospectively, it was likely Mr X had locally advanced prostate cancer at the outset. He said that had Mr X been correctly staged a radical prostatectomy was not an appropriate treatment option. It is likely Mr X would, instead, have started hormonal treatment and been referred to the oncologist. He said that the initial MRI report had not commented on the lymph nodes, and the delay before Mr X's locally advanced prostate cancer was correctly detected led to an avoidable prostatectomy, and he was left with the side effects of surgery.

24. The Second Adviser said that when Mr X was subsequently seen on 21 December, his raised PSA indicated ongoing prostate cancer despite his prostate being removed. He said that, in his opinion, Mr X's overall prognosis is unlikely to have altered significantly. As Mr X evidently had locally advanced cancer from the outset, the incorrect staging had a minimal impact on his life expectancy.

25. The Second Adviser agreed with the First Adviser's observations about the MDT's documentation. He said that he could not find evidence Mr X was given an opportunity to see a radiotherapist (specialist clinical oncologist) to discuss the radiotherapy option in more detail, or to make an informed choice about treatment options. He said that it was unclear whether Mr X was warned about the potential risks of treatment failure and metastatic disease given his high-risk prostate cancer. The Second Adviser said that, in his view, Mr X was not provided with enough evidence to make an informed choice about treatment options.

The Health Board's response to the Draft Report

26. The Health Board said that Mr X's cancer staging of organ-confined cancer was reasonable. It said that its Clinical Director of Radiology ("the Director"), without the benefit of hindsight, reviewed the 7 June **2018** MRI scan. He said that the PIRAD-5 disease was obvious, it was close to the seminal vesicles, but there was no definite, discernible macroscopic invasion, so T2b staging was reasonable. The Director said that the MRI report was not 100% accurate, the presacral nodes were missed and they should have been commented upon. He said that this was a highly unusual site for prostate cancer spread and the nodes were not of prostatic origin. He said that even had the presacral nodes been reported, it would not alter the T2b staging, as assessed by reasonably competent peers. He disagreed that the MRI scan showed "probable stage T3a cancer, likely T3b" as noted by the First Adviser. He said that the First Adviser's terms "likely" and "probable" implied a degree of doubt, so it was not then reasonable to assert that the cancer was under staged.

27. The Health Board said that the specimen taken during the prostatectomy, upgraded the cancer to T3b. It said that given the biopsy's aggressive histology, the cancer possibly progressed to T3 between the scan and operation on 25 September. It said that the cancer was reasonably staged and, therefore, the prostatectomy was appropriate.

28. The Health Board said that the Consultant Urologist's ("the Consultant") letter of 1 August noted that the treatment options were discussed and that Mr X "might be better off thinking of surgery in combination with radiotherapy". It said that the Consultant recalled discussing, in detail, the pros and cons of surgery against radiotherapy, and that Mr X's preference was for RALP. The Consultant explained that there was a high chance Mr X might also need radiotherapy, and the option of a clinical trial was discussed. It said that it was the Consultant's usual practice to compare treatment options, and ensure patients were not pushed to decide on the treatment choice, and that he usually reiterated that a patient could still change their mind when they decided on a treatment path.

29. The Health Board said that it was documented that Mr X's key worker had an opportunity to discuss treatment options and answer his questions. Mr X was given 5 different information leaflets (Open Prostatectomy, Robotic prostatectomy, Pelvic floor exercises, Information about Radiotherapy, and Treating Prostate Cancer Questions and Answers leaflets) which outline all treatment options.

30. The Health Board said that MDT entries are brief for transcription onto CANISC (the software used for cancer diagnosis) and the National Prostate Cancer audit. It was not possible for minutes of all discussions to be taken. It said that a register of attendees was kept but not shown on the MDT report. It said that lessons could be learnt, and that all attendees will be shown on each MDT summary in future.

Further professional advice

The Third Adviser

31. The Third Adviser said that Mr X's tumour was staged at T2b. The T stands for, and looks at, the tumour within the prostate and just adjacent to it. She said that the MRI showed some signs the tumour extended beyond the prostate involving the seminal vesicles which lie on top of the prostate - so suggestive of stage T3b. She said that the PI-RAD v2 document considers these signs indicative of seminal vesicle involvement.

32. The Third Adviser said that concerns should have been raised in the MRI report and MDT about seminal vesicle involvement given the MRI findings which she described as "subtle". She said that even if the radiologist thought the seminal vesicle was not involved, the subtle sign should have been mentioned as being present, as a precaution, and so concerns raised about their involvement. She said that as concerns were not raised, it suggested that the sign was missed. She said that it may not have affected the decision to proceed with surgery as it was not 100% certain from the MRI that the staging was T3b.

33. The Third Adviser said that as Mr X's plan was to proceed with surgery and radiotherapy, it did not matter whether he was staged at T2b or possible T3b. The Third Adviser said that it was acceptable Mr X was staged at T2b, as the MRI sign indicating seminal involvement was subtle.

34. The Third Adviser said that the difference to the outcome for Mr X was the N staging (N being local lymph nodes), which was incorrectly interpreted. She said that the enlarged pelvic lymph nodes in the presacral space were overlooked and staged as N0 (no abnormality/suspicious lymph nodes present). She said that Mr X's stage was N1 (presence of local/pelvic lymph nodes involved by tumour). She said that had the lymph nodes been described and correctly given an N stage, Mr X would not have had a prostatectomy. She said that patients with N1 stage cancer are treated with hormones and pelvic radiotherapy.

35. The Third Adviser said that all high-risk tumours need M staging (distant metastases) before treatment commences. She said that Mr X's cancer was high risk, however, M staging was not undertaken before surgery.

36. The Third Adviser said PI-RADS v2 guidelines state that an MRI of the prostate should incorporate an additional sequence for pelvic nodal staging. She said that the sagittal view showed 2 presacral lymph nodes that appeared mildly enlarged, measuring 8mm and 9mm. She said that the addition of a large field of view sequence to the diagnostic MRI protocol, may have made the presacral lymph nodes more conspicuous.

37. The Third Adviser said that it was unclear whether a different radiologist reviewed the MRI at the MDT. She said that it is not uncommon for a second reading to identify missed pathology. She said that when there is a discrepancy between radiology and pathology staging, there should be an MDT review to identify retrospectively whether the MRI visibly under, or over, stated the disease. She said that feedback from pathology staging is important for a radiologist's learning and quality assurance. It was unclear whether this happened.

The Second Adviser's review of the Health Board response

38. The Second Adviser said that the 25 July MDT reported Mr X was suitable for EBRT or RALP. He said that the Consultant's 1 August letter did not note Mr X was given the opportunity to see an oncologist to discuss radiotherapy in more detail. He said that patients should have an opportunity to discuss the range of treatments and their side effects with both a urological surgeon regarding the radical prostatectomy and a specialist oncologist about radiotherapy options. He said that Mr X was not referred to the specialist clinical oncologist (radiotherapist) to make an unbiased informed choice. The Second Adviser said that the Consultant's letter stated that the treatment options were discussed, but that given Mr X's extensive Gleason 9 disease he might be better considering surgery with radiotherapy. He said that this appeared to be the Consultant's opinion. Had Mr X been offered the opportunity to see a radiologist to discuss radiotherapy, and declined, it would have been appropriate, but the letter did not evidence this.

39. The Second Adviser agreed with the Third Adviser that the lymph nodes visible on the MRI were overlooked and were only visible on 1 of many MRI sequences. He said that based on the Third Adviser's advice, although the presacral nodes were unusual, the high-risk (Gleason 9) prostate cancer should have prompted more caution and a detailed review of the scan. He said that given the presence of suspicious presacral nodes in the setting of high-risk prostate cancer, it was not appropriate to proceed with radical prostatectomy. He said that RALP was not appropriate.

40. The Second Adviser said that in view of the Third Adviser's advice, it was acceptable that Mr X's cancer was staged at T2b. He said that the Health Board's Director acknowledged that the MRI report was not 100% accurate, and that the presacral nodes were missed and should have been commented upon.

41. The Second Adviser said that as the Health Board gave a list of leaflets provided to Mr X it was reasonable that the RALP procedure was covered in a more general aspect within these leaflets.

Analysis and conclusions

42. In reaching my conclusions I have taken account of the detailed advice I have received from my Advisers (paragraphs 14 – 25 and at, 31- 41), which I will not reiterate. I will deal with each of Miss Y's complaints in the order set out in paragraph 1.

A failure to accurately diagnose Mr X's cancer between February and June 2018

43. I consider that there were significant failings in Mr X's treatment, and I have identified the following failings:

- The MRI scan on 7 June showed the enlarged pelvic lymph nodes in the presacral space but these were overlooked as being suspicious and so incorrectly staged as N0. Mr X's stage was N1. This failure led to Mr X undergoing an avoidable and unnecessary procedure (RALP).

- The Health Board's suggestion that the scan report reported normal lymph nodes, which were not enlarged, was therefore incorrect.

- The suspicion of metastatic cancer should have been raised from the appearance of the lesion (including the size of one passing the threshold of suspicion).

- An axial plane large field of view sequence should have been performed to look for enlarged regional lymph nodes.

- The 25 July MDT record is brief, so it cannot be determined whether the meeting re-reviewed the images, or the original reports. Such a recording failure amounts to maladministration.

- Concerns should have been raised in the MRI scan report and MDT about seminal vesicle involvement given the subtle MRI findings.

44. The failings identified amount to service failures that led to an injustice for Mr X. I **uphold** this aspect of the complaint.

Whether Mr X was able to make an informed choice regarding his treatment

45. The Health Board said that it was the Consultant's usual practice to compare treatment options and ensure a patient's treatment choice (see paragraph 26). The Consultant's 1 August letter does not corroborate this account, given it says that Mr X would be better off thinking about surgery with radiotherapy and to consider RALP. I share the view that there is no evidence Mr X was given an opportunity to discuss treatment options with a specialist clinical oncologist (radiotherapist) to make an informed choice, or warned of the potential risks of treatment failure and metastatic disease given his high-risk prostate cancer. Normally I expect to see evidence of any discussion and do not accept claims of "would have" (paragraph 28) as being sufficient evidence. Nevertheless, I do, however, accept that Mr X was provided with leaflets which covered aspects of the RALP procedure, so that some information was imparted by them.

46. As I have concluded, and set out in detail above, Mr X's cancer was not correctly staged as N1. Mr X could only provide informed consent for any procedure based on the information and results relayed to him. Mr X did not have an M staging undertaken before surgery either. The Second and Third Advisers consider the surgical procedure to have been inappropriate. Mr X agreed to undergo an unnecessary procedure.

47. These were service failures that led to an injustice for Mr X, as he was not in possession of the full facts to make an informed decision about his treatment. I **uphold** this aspect of the complaint.

The delay in Mr X's accurate diagnosis (until December 2018) impacted on his quality of life and prognosis

48. The delay in an accurate diagnosis meant that Mr X underwent unnecessary treatment as I refer to above. From the advice received I am satisfied that his overall prognosis, however, is unlikely to have been significantly altered and it will have had a minimal impact on his life

expectancy. However, Mr X's avoidable prostatectomy led to him suffering with the debilitating side effects of surgery which did affect his quality of life. This was an injustice to Mr X, and it is on this basis that I **uphold** this aspect of the complaint.

49. To reflect the injustices caused to Mr X, I am recommending financial redress of £5,000. This amount is to signify that on 6 June Mr X's nodes were incorrectly staged as N0, concerns should have been raised about seminal vesicle involvement, and there was no M staging. It is also to reflect the unnecessary surgery which Mr X underwent, with the significant impact this had on his quality of life thereafter.

Recommendations

50. I recommend that within 1 month of this report the Health Board:

a) Apologises to Miss Y and Mr X for the identified failings.

b) Makes a redress payment of £5,000 to Mr X in recognition of the identified failings.

c) Informs all relevant clinicians about the need to properly record/minute MDTs, and that MDT documentation should include reference to the items reviewed during the meeting.

51. I recommend that within 3 months of this report the Health Board:

d) Reviews its process to ensure that the Prostate MRI protocol requires one axial large field of view sequence of the pelvis to allow for evaluation of pelvic lymph nodes (as per current PI-RADS guidelines, version 2.1).

e) Provides evidence to the Ombudsman of the review of MDT meeting arrangements the Health Board indicated that it had introduced.

52. I recommend that within 6 months of this report the Health Board:

f) Considers an MDT review of all prostate cases (from June **2018** to the present date) where subsequent pathology placed the patient into the higher risk category from a staging review.

g) Reviews its MDT procedure to consider implementing a routine audit of MRI reporting against pathology outcomes.

53. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Nick Bennett 20 January 2021
Ombwdsmon/Ombudsman

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
Email: ask@ombudsman-wales.org.uk
Follow us on Twitter: @OmbudsmanWales