PRELIMINARY SCREENING REPORT

This report is not to be disclosed to the opposing side and/or The Courts and is for internal use only. This is a "Brief Advisory report" and "Not for Use as a CPR35 Report".

Prepared by

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Dated: 10th November 2024

[redacted]

Case Synopsis: The Deceased, suspected of urological and head/neck cancer, experienced diagnostic delays over two months, leading to rapid deterioration and death on [redacted]
Expert Reference [redacted]
Prepared at the request of [redacted]

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1.CURRICULUM VITAE

Mr. Krishnan Anantharamakrishnan
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Qualified University of Madras 1990
16 years' experience as a consultant urology
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2. SUMMARY OF INSTRUCTIONS AND ISSUES TO CONSIDER

Specific Questions

Breach of Duty

The Claimant considers that there may have been some delay between urgent referral by the Deceased's GP to urology and the date that the Deceased was first seen by urology. It is also of some concern to the Claimant that the Deceased primary carcinoma was not identified. Further, she raised some concern that the Deceased was not referred for review with oncology by urology earlier that she was.

1. Please consider the records and advise us if you consider there to be an unreasonable delay between the date the GP referred the Deceased under the 2 week wait urgent referral pathway for urological cancers and the date that the Deceased was first seen by urologist?

2. If there was a delay, was it acceptable to delay in light of the concurrent investigations by the Head and Neck surgeons who were considering the bilateral neck lymph node enlargement at the same time?

3. Please consider the investigations carried out form January 2023 onwards. Do you consider that appropriate investigations were carried out to attempt to identify the primary carcinoma?

4. Was it reasonable for the urologists to consider transitional cell carcinoma the most likely source of the Deceased's symptoms?

5. In your view, should the Deceased have been referred to oncology sooner, even if the precise source of the primary cancer was not confirmed?

Causation

It is accepted that the Deceased's condition appeared to be well advanced at the time of her referral to the Defendant.

6. On the balance of probabilities, but for any breach of duty identified above, do you consider the client's outcome would have been different?

I am instructed by the [redacted] and this report is prepared by an independent expert. This report is not to be disclosed to the opposing side and/or The Courts and is for internal use only. This is a "Brief Advisory report" and "Not for Use as a CPR35 Report".

My full declaration is set out at the end of the report.

3. DOCUMENTATION, MATERIALS AND INFORMATION PROVIDED

1 [redacted]
2 [redacted]
3 [redacted] 24
4. [redacted]

4. HISTORY AS GIVEN BY THE CLAIMANT/LETTER OF INSTRUCTION

The circumstances giving rise to this matter are the Deceased was referred by her GP to the Defendant via the 2 week wait pathway to [redacted] for suspected urological/renal cancer after presenting with blood in her urine in the absence of infection.

At almost exactly the same time, the Deceased was seen by ENT for a routine appointment where it was noted that she had lymph node enlargement about the neck. She was referred by ENT for urgent investigation via the 2 week wait pathway for suspected head and neck cancer.

On [redacted] the Deceased was seen urgently by the Head and Neck surgeons. They recorded that: 'She notices bilateral neck lumps 4 weeks ago and this was initially tender and has gradually

increased in size. She did not present with any red flags.' 'On examination, she was well. There were palpable single. Mobile supraclavicular nodes on either side of her neck, measuring about 3cm, and are more prominent on the right side. Examination of her oral cavity and oropharynx was unremarkable. Flexible nasolaryngoscopy did not show evidence of sinister pathology. There was lymphoid hyperplasia in the base of tongue.'

O[redacted] the urologists noted that the Deceased was under investigation for bilateral neck lymph node and possible lymphoma and that she was also listed for urgent flexible cystoscopy. On 25 January 2023, urine cytology suggested that the Deceased may have a suggestion of transitional cell carcinoma. [redacted] the CT report says: 'Enlarged lymph nodes. Viscera – bowel, liver NAD. NO bony lesions. Some mediastinal shift. Structures within the neck essentially normal save for lymph node enlargement.' No primary cancer was found.

On 31 January 2023, the Deceased underwent a CT scan of the head. The report says: 'No SOL, no infarct, no midline shift, no ventricular megaly' "And:" "'Enlarged lymph nodes in the neck chest and abdomen as described, suggesting lymphoproliferative disease. Haematological (sic) MDT review suggested.'

O[redacted], the Deceased underwent flexible cystoscopy. No obvious abnormality was found to explain the visible haematuria experienced by the Deceased. On 8 February 2023, the Deceased underwent guided lymph node biopsy under the Head and Neck surgeons. A MRI and CT scan was ordered. On 14 March 2023 the Deceased underwent both MRI and CT scanning. The MRI report says: 'No definite primary malignancy could be detected in the neck. Bilaterally enlarged supraclavicular and superior mediastinal nodes; likely metastatic.' The CT scan report says: 'Irregular lobulated outline of the left kidney with loss of corticomedullary differentiation and enlarged retroperitoneal lymph nodes as described. The differential includes renal cell carcinoma and lymphoma. The renal MDT review is suggested.'

On 22 March 2023, the Deceased had a PET scan. The report says: 'There are multiple enlarged lymph nodes in both sides of the neck - levels 3 to 5 on the right and levels 4 and 5 on the left, as well as left supraclavicular fossa. This shows marked uptake (max SUV 15.4). There are enlarged left axillary and left subpectoral lymph nodes showing moderate/marked uptake. No FDG avid lesion in the upper airways. There are some small mediastinal and para-aortic lymph nodes within the thorax showing moderate uptake. There are multiple retrocrural and upper retroperitoneal lymph nodes showing moderate/marked uptake. No further lymphadenopathy demonstrated. No significant abnormal activity elsewhere. Striking bowel activity noted which could be physiological or due to Metformin usage. The liver and spleen are clear. There is a tiny subpleural nodule posteriorly in the left lung (CT image 118) which is too small to characterise and can be followed up on subsequent imaging. IMPRESSION: Extensive lymphadenopathy above and below the diaphragm. Radiologically lymphoma would be a

likely diagnosis, but I note the suspicion of carcinoma. No potential primary site for carcinoma is identified.'"

On 24 March 2023, urology recorded that the primary origin of the Deceased's cancer was unknown. On 31 March 2023, urology considered that the Deceased would be for chemotherapy as her performance status was calculated as 2. On 2 May 2023, the urology recorded that they considered it 'highly likely this is a metastatic TCC from the left kidney.' On 3 May 2023, the Deceased was referred to oncology by urology. She was seen a[redacted] Ultimately the Deceased did not begin chemotherapy. The Deceased sadly deteriorated quickly in June 2023 and died at home on 28 June 2023.

5. SUMMARY OF RELEVENT MEDICAL RECORDS

The following summary is based on my review of the [redacted]
Medical records.

The records show that [redacted] attended the GP surgery on 09 November 2022 for visible haematuria and passing blood clots for last few months. An urgent 2WW referral completed as was evidenced page 66/292 paginated bundle. I would peruse the medical records for the important details such as performance status which is 3 [three] i.e., capable of only limited self-care, confined to bed or wheelchair for more than 50% of waking up hours. See evidence page 67/292. This is important in the context of our future discussion going forward. Needed transport to visit hospitals. I note that DB has multiple co-morbidities such as back pains, depression, COPD, Type II diabetes mellitus, MRSA carrier, Asthma, hypertension, mixed anxiety and depressive disorder, polymyalgia rheumatica, and on multiple repeat medications such as sevredol, quinine sulphate, prochlorperazine, sukkarto, verapamil, Ventolin inhalers, omeperazole, baclofen, atorvastatin, alogliptin, citalopram, laxido orange, fostair, empaglifozin, and ramipril. Page 68/292. I would use the following 3 pages as evidence to underpin our discussions and opinion.

Suspected Urology Cancer 2WW Form

Northamptonshire Integrated Care

Dr Mugisa Notes
1. This form is for adults with suspected urological cancer.
2. The patient should be available for an appointment in the 2 weeks following referral.
3. Please provide patient with a 2WW leaflet

Person details	
NHS number	[redacted]
Surname	[redacted]
Forenames	
Title	Mrs
Date of Birth	[redacted]
Gender	Female
Ethnicity	British or mixed British - ethnic category 2001 census
Contact details	
Home address	[redacted]
Postcode	[redacted]
Email address	[redacted]
Mobile number	[redacted]
Home telephone	[redacted]
Communication preferences	If the patient has specific preferences in the way they would like to be contacted, please provide this information below
Practice details	
Surgery	[redacted]
GP	[redacted]
Completed by	[redacted] Date completed: 09 Nov 2022
Contact number	[redacted]

Other information			
First Language	Main spoken language English		☐ Interpreter required
Hearing impairment			☐ Signer required
Sight impairment			☐ Guide dog in use
Physical impairment			☐ Wheelchair used
Cognitive impairment			☐ Learning disability
Military Service	☐ Veteran	☐ Reservist	☐ Family member

Pathway Guidance
Indicate the clinical/radiological features giving rise to a suspicion of urological cancer. Do not refer suspected lichen sclerosis of the penis as 2WW ☒ I confirm that pre-referral MSU and U&Es have been requested

[redacted]

[redacted]

Krishnan Anantharamakrishnan, Consultant Urological Surgeon, prepared only for [redacted] Services Ltd)

Suspected Urology Cancer 2WW Form

Northamptonshire Integrated Care

Testis	From puberty onwards
☐ Swelling or mass in relation to body of testis	
Penis	
☐ Penile mass	☐ Penile ulcer (STI excluded)
Prostate	Exclude UTI as cause of raised PSA and repeat borderline results
☐ Prostate feels malignant on digital rectal examination ☐ PSA levels are above the age-specific reference range	
Visible Haematuria	Must be aged 45 or over
☒ In the absence of urinary tract infection ☐ Persists or recurs after successful treatment of urinary tract infection	
Non-Visible Haematuria	Must be aged 60 or over
☐ Symptomatic non-visible haematuria, proven on microscopy, in the absence of urinary infection	
Imaging Abnormal	Include a copy of the report
☐ USS ☐ CT ☐ MRI	

MRI suitability			
Contraindications ☐ None	☐ Pacemaker	☐ Implanted defibrillator	☐ Cochlear implant
	☐ Infusion pumps	☐ Neurological stimulators	
Cautions ☐ None	☐ Prosthesis	☐ Claustrophobia	☐ Weight over 140kg
	☐ Metal foreign body	☐ Allergy to contrast material	

Performance Status

0 ☐ Able to carry out all normal activities without restriction
1 ☐ Restricted in physically strenuous activity. Able to walk and do light work
2 ☐ Able to walk and capable of all self-care. Unable to work. Up and about more than 50% of waking hours
3 ☒ Capable of only limited self-care. Confined to bed or more than 50% of waking hours
4 ☐ Completely disabled. Cannot carry out any self-care. Totally confined to bed or

Cancer Discussion

☐ Not discussed ☒ Patient ☒ Family ☐ Other

Additional Information

Patient has been having visible haematuria on and off for last few months , also in last 2 days had 4 occasions of big clots of blood in urine , urine culture on 02/11/22 showed no growth . Kindly urgently review patient

PSA & Renal Function

eGFR: 52.1, 02 Nov 2022
Creatinine: 101 umol/L, 02 Nov 2022
Latest 3 PSA:

Blood Results (Last 2m):

FBC	02 Nov 2022	Hb 133 g/L, WCC 13.2 10^9/L, Plts 340 10^9/L, MCV 86.5 fL, Neut 9.5 10^9/L
UE	02 Nov 2022	Na 136 mmol/L, K 4.9 mmol/L, Urea 7.7 mmol/L, Creat 101 umol/L, eGFR 52.1

Mrs Belcher 04 Sep 1965 438 738 4077

Suspected Urology Cancer 2WW Form

Northamptonsh Integrated Care

LFT	12 Oct 2022	ALT 14 iu/L, Alk Phos 106 U/L, Bili 4 umol/L, Alb 39 g/L, GGT , Serum globulin , Total Protein 73 g/L		
CRP	02 Nov 2022	46 mg/L	**ESR**	
TFTs	12 Oct 2022	TSH 0.93 miu/L, Free T4	**INR**	
Bone		Ca cor , adj , Phos		
Iron		Ferritin , Saturation , TIBC		
Vitamins	12 Oct 2022	B12 357 ng/L, Folate 6.8 ng/ml		
Lipids	12 Oct 2022	Chol 2.3 mmol/L, LDL , HDL 1 mmol/L,Chol:HDL ratio , 0.9 mmol/L		
Random Glucose			**Fasting Chol.**	
Fasting Glucose			**HbA1c**	19 Oct 2022, 65 mmol/mol

Reason for Referral:

Medical Problems:

Back pain (XM1GI), Aug 2010
Carpal tunnel syndrome (XE15g), Apr 2011
Depression NOS (XaB9J), Sep 2011
Type II diabetes mellitus (X40J5), Oct 2011
[V]MRSA-Multiple resistant staph aureus infection carrier (XaCLw), Oct 2012
Asthma (H33..), Dec 2013
Hypertension (XE0Ub), May 2017
Suspected coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 (situation) (Y20cf), May 2020
Tonsillectomy, Apr 1986
Mixed anxiety and depressive disorder, May 2002
Polymyalgia rheumatica, Feb 2003
Type II diabetes mellitus, Oct 2011
[V]MRSA-Multiple resistant staph aureus infection carrier, Oct 2012
Asthma, Dec 2013
Hypertension, May 2017

Medication:

Acutes CareSens PRO testing strips (Spirit Healthcare Ltd), use as directed
Repeats Sevredol 10mg tablets (Napp Pharmaceuticals Ltd), two morning, two lunch, one teatime, two at night
Quinine sulfate 300mg tablets, use as directed
Prochlorperazine 5mg tablets, take one Three Times Daily
Sukkarto SR 1000mg tablets (Morningside Healthcare Ltd), take 1 twice daily
Verapamil 40mg tablets, 2 To be taken Twice Daily
Ventolin 100micrograms/dose Evohaler (GlaxoSmithKline UK Ltd), inhale 2 doses as needed
Sumatriptan 100mg tablets, take one as directed
Omeprazole 20mg gastro-resistant capsules, take one daily
Baclofen 10mg tablets, take one and half tabs: three times a day
Atorvastatin 20mg tablets, take one daily
Alogliptin 25mg tablets, Take ONE tablet daily
Citalopram 20mg tablets, take one daily
Laxido Orange oral powder sachets sugar free Ltd), one sachet twice daily
Fostair 100micrograms/dose / 6micrograms/dose inhaler (Chiesi Ltd), two puffs twice daily
Empagliflozin 25mg tablets, take one daily
Ramipril 5mg capsules, take one daily

Allergies:

MODECATE
Peanut allergy
Adverse reaction to diazepam
Checking for drug allergy

[redacted]

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Krishnan Anantharamakrishnan, Consultant Urological Surgeon, prepared only f[redacted]
Services Ltd)

History of smoking for 27 years noted page 98/292. Wheelchair bound for more than 20 years and allergy to iodine only from letters. Blood test results at this point of time creatinine 101 and eGFR 52- page 67/292.

A second referral was made for haematuria and visible clots in urine as a 2WW 30 December 2022 paginated bundle 80/292. Suspected head and neck referral was made 30 December 2022 at the same time for unexplained neck lumps. Page 76/292.

Seen by department of head and neck 11 January 2023 for bilateral supraclavicular lymph nodes? Lymphoproliferative diseases and asked to have investigations such as Body CT scan and core biopsy of the lymph node for histology page 137/292 and co-morbidities recorded include high BMI, alcohol, smoking and being wheelchair bound.

If confirmed to be lymphoma, to transfer care to haematology.

On 18 January 2023 reviewed by urology in [redacted] with eGFR note of 64 and Locum Urologist making a remark about the CT thorax, abdomen, and pelvis *albeit* a note of allergy to iodine mentioned but no further clarification obtained from the deceased that which represents a missed opportunity. The doctor had placed her on an urgent flexible cystoscopy list page 140/292 – this is the first urology contact since the original referral of 9 November 2022. Represents 67 days since first referral.

On 31 January 2023, page 144/292 underwent cystoscopy inspection of urinary bladder and a clear mention of the urine cytology results of atypical cells and raising a suspicion of transitional cell carcinoma of the urinary tract also page 232/292. The urologist had mentioned this but takes no further action other than clarifying that the cystoscopy examination is normal and passes the baton back onto the head and neck team for CT scan performed 26.1.23 and that which was not reported yet. The doctor makes no effort to ask the radiologist to expedite the report nor does he review that himself. This is clinical negligence. The locum doctor also states that he could not explain the visible haematuria although there is evidence of abnormal cells in urine cytology.

In page 146/292, [redacted] says that he had face to face appointment with the daughter and said that they must wait for the ultrasound guided biopsies results and ignores the fact that the CT Urogram was cancelled that which he mentions in the letter. And again, he reiterates that following haematology consultant review that he would plan a CT Urogram with contrast, that which is contradictory conclusion. This does not make sense and reflects poor practice of substandard value. The doctor takes no stock of the renal tract findings from the non-contrast CT scan Chest Abdomen Pelvis which demonstrates bulky left kidney.

Suspected Urology Cancer 2WW Form

Northamptonshire Integrated Care

Notes
1. This form is for adults with suspected urological cancer.
2. The patient should be available for an appointment in the 2 weeks following referral.
3. Please provide patient with a 2WW leaflet

Person details	
NHS number	[redacted]
Surname	[redacted]
Forenames	
Title	[redacted]
Date of Birth	[redacted]
Gender	Female
Ethnicity	British or mixed British - ethnic category 2001 census

Contact details		
Home address	[redacted]	
Postcode	[redacted]	
Email address	[redacted]	
Mobile number	[redacted]	If the patient has specific preferences in the way they would like to be contacted, please provide this information below
Home telephone	[redacted]	
Communication preferences		

Practice details			
Surgery	[redacted]		
GP	[redacted]		
Completed by	[redacted]	Date completed	[redacted]
Contact number	[redacted]		

Other information			
First Language	Main spoken language English		☐ Interpreter required
Hearing impairment			☐ Signer required
Sight impairment			☐ Guide dog in use
Physical impairment			☐ Wheelchair used
Cognitive impairment			☐ Learning disability
Military Service	☐ Veteran	☐ Reservist	☐ Family member

Pathway Guidance

Indicate the clinical/radiological features giving rise to a suspicion of urological cancer.
Do not refer suspected lichen sclerosis of the penis as 2WW
☒ I confirm that pre-referral MSU and U&Es have been requested

Mrs [redacted]

Suspected Urology Cancer 2WW Form

Northamptonshire Integrated Care

Testis	From puberty onwards
☐ Swelling or mass in relation to body of testis	
Penis	
☐ Penile mass	☐ Penile ulcer (STI excluded)
Prostate	Exclude UTI as cause of raised PSA and repeat borderline results
☐ Prostate feels malignant on digital rectal examination ☐ PSA levels are above the age-specific reference range	
Visible Haematuria	Must be aged 45 or over
☒ In the absence of urinary tract infection ☐ Persists or recurs after successful treatment of urinary tract infection	
Non-Visible Haematuria	Must be aged 60 or over
☐ Symptomatic non-visible haematuria, proven on microscopy, in the absence of urinary infection	
[redacted]maging Abnormal	Include a copy of the report
☐ USS ☐ CT ☐ MRI	

MRI suitability			
Contraindications ☐ None	☐ Pacemaker	☐ Implanted defibrillator	☐ Cochlear implant
	☐ Infusion pumps	☐ Neurological stimulators	
Cautions ☐ None	☐ Prosthesis	☐ Claustrophobia	☐ Weight over 140kg
	☐ Metal foreign body	☐ Allergy to contrast material	

Performance Status

0 ☐ Able to carry out all normal activities without restriction
1 ☐ Restricted in physically strenuous activity. Able to walk and do light work
2 ☐ Able to walk and capable of all self-care. Unable to work. Up and about more than 50% of waking hours
[redacted]3 ☒ Capable of only limited self-care. Confined to bed or more than 50% of waking hours
[redacted]4 ☐ Completely disabled. Cannot carry out any self-care. Totally confined to bed or

Cancer Discussion

☐ Not discussed ☒ Patient ☐ Family ☐ Other

Additional Information

Patient has had history of haematuria on 4 episodes with blood clots, each episode lasting for a week, urine culture [redacted] on 13/12/22 showed no growth

PSA & Renal Function

eGFR: 58, 11 Nov 2022
Creatinine: 92 umol/L, 11 Nov 2022
Latest 3 PSA:

Blood Results (Last 2m):

FBC	11 Nov 2022	Hb 133 g/L, WCC 14.5 10^9/L, Plts 335 10^9/L, MCV 86.6 fL, Neut 10.8 10^9/L
UE	11 Nov 2022	Na 142 mmol/L, K 5 mmol/L, Urea 7.7 mmol/L, Creat 92 umol/L, eGFR 58

Mrs [redacted]

Suspected Urology Cancer 2WW Form

Northamptonshire Integrated Care

LFT	11 Nov 2022	ALT 9 iu/L, Alk Phos 83 U/L, Bili 5 umol/L, Alb 41 g/L, GGT , Serum globulin , Total Protein 76 g/L		
CRP	11 Nov 2022	45 mg/L	**ESR**	
TFTs		TSH , Free T4	**INR**	
Bone		Ca cor , adj , Phos		
Iron		Ferritin , Iron Saturation , TIBC		
Vitamins		B12 , Folate		
Lipids		Chol , LDL , HDL ,Chol:HDL ratio ,		
Random Glucose			**Fasting Chol.**	
Fasting Glucose			**HbA1c**	

Reason for Referral:

Medical Problems:

Back pain (XM1GI), Aug 2010
Carpal tunnel syndrome (XE15g), Apr 2011
Depression NOS (XaB9J), Sep 2011
Type II diabetes mellitus (X40J5), Oct 2011
[V]MRSA-Multiple resistant staph aureus infection carrier (XaCLw), Oct 2012
Asthma (H33..), Dec 2013
Hypertension (XE0Ub), May 2017
Suspected coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 (situation) (Y20cf), May 2020
Tonsillectomy, Apr 1986
Mixed anxiety and depressive disorder, May 2002
Polymyalgia rheumatica, Feb 2003
Type II diabetes mellitus, Oct 2011
[V]MRSA-Multiple resistant staph aureus infection carrier, Oct 2012
Asthma, Dec 2013
Hypertension, May 2017

Medication:

Acutes Citalopram 40mg tablets, Take one daily
Repeats Sukkarto SR 1000mg tablets (Morningside Healthcare Ltd), take 1 twice daily
Sevredol 10mg tablets (Napp Pharmaceuticals Ltd), two morning, two lunch, one teatime, two at night
Quinine sulfate 300mg tablets, use as directed
Verapamil 40mg tablets, 2 To be taken Twice Daily
Ventolin 100micrograms/dose Evohaler (GlaxoSmithKline UK Ltd), inhale 2 doses as needed
Sumatriptan 100mg tablets, take one as directed
Prochlorperazine 5mg tablets, take one Three Times Daily
Baclofen 10mg tablets, take one and half tabs: three times a day
Atorvastatin 20mg tablets, take one daily
Alogliptin 25mg tablets, Take ONE tablet daily
Omeprazole 20mg gastro-resistant capsules, take one daily
Fostair 100micrograms/dose / 6micrograms/dose inhaler (Chiesi Ltd), two puffs twice daily
Empagliflozin 25mg tablets, take one daily
Ramipril 5mg capsules, take one daily

Allergies:

MODECATE
Peanut allergy
Adverse reaction to diazepam
Checking for drug allergy
Verification of allergy status

Blood Pressure	128 / 78 mmHg, 11 Nov 2022		
Heart rate	78 bpm, Pulse regular		
Height	1.48 m, 24 Oct 2022	**Smoking Status**	Cigarette smoker,
Weight	86 Kg, 24 Oct 2022	**Alcohol Intake**	Teetotaller,

[redacted]

Suspected Head & Neck Cancer 2WW Form

NHS Northamptonshire Integrated Care

Notes
1. This form is for adults with suspected head and neck cancer.
2. This form is also for children and adults with suspected thyroid cancer.
3. The patient should be available for an appointment in the 2 weeks following referral.
4. Please provide patient with a 2WW leaflet

Person details	
NHS number	[redacted]
Surname	
Forenames	
Title	[redacted]
Date of Birth	[redacted]
Gender	Female
Ethnicity	British or mixed British - ethnic category 2001 census

Contact details		
Home address	[redacted]	
Postcode	[redacted]	
Email address	[redacted]	
Mobile number	[redacted]	If the patient has specific preferences in the way they would like to be contacted, please provide this information below
Home telephone	[redacted]	
Communication preferences		

Practice details			
Surgery	[redacted]		
GP	[redacted]		
Completed by	[redacted]	Date completed	30 Dec 2022
Contact number	[redacted]		

Other information			
First Language	Main spoken language English		☐ Interpreter required
Hearing impairment			☐ Signer required
Sight impairment			☐ Guide dog in use
Physical impairment			☐ Wheelchair used
Cognitive impairment			☐ Learning disability
Military Service	☐ Veteran	☐ Reservist	☐ Family member

Pathway	
[redacted]	

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On 6 March 2023, another locum doctor from ENT reviewed the deceased via the telephone with her daughter. The deceased was too unwell to travel. Discussed the findings of cancer in lymph node biopsies 27 February 2023 [but not lymphoproliferative disease] and since he doesn't know where the primary is coming from, and he arranged a PET scan and MRI of the oral and neck to access the primary sites if any. Decision following MDT discussion. Page 148/252.

On 9 March 2023 urology MDT summarises the urine cytology for atypical cells that which is typical of TCC but they also suggest SCC should be raised. However, most importantly it is only here in the MDT that they recognise that the left kidney is bulky and taken with the fact that she had presented with haematuria since November 2022, in conjunction with positive cytology they recognise that this is likely to be metastatic TCC. That had taken 98 days circa to come to this conclusion thus far. This is unacceptable practice. The MDT suggests referral to oncology page 150/292. For the first time a substantiative consultant is involved in this deceased care.

Head and Neck MDT outcome 27 March 2023 confirmed metastatic TCC and formally handed over to urology care page 152/292.

On 30 March 2023, the urology MDT summarised by the ST5 doctor, to review the deceased face to face, and if fit and well and if performance score is less than 2, she can be referred to oncology. There was a rider placed that she would also need rediscussing in the SMDT with consultant pathologist KGH. Page 153/292. The MDT also is puzzled about the CT urogram being cancelled and raised possible iodine allergy. I could see no record of iodine allergy in the GP notes, and clearly, she is not of the performance score 2, but in my opinion and the primary care GP opinion, the performance score was 3, as was mentioned in the GP referrals on multiple occasions.

There was another phone call appointment on 2 April 2024, by another urology middle grade doctor whereby they re-establish that the deceased was too unwell to mobilise being in a wheelchair, and she needed help from daughter to move around or she uses furniture. I could see at this point that the hospital trusts were simply ticking boxes and going through academic motions and noises such as rediscussing in SMDT with pathologist, still considering referral for systemic therapy as though these are going to be life changing for the deceased. Instead, the hospital trusts could have involved the cancer nurse team, Macmillan group, palliative arrangement with oncology, pain team assessment to keep her comfortable. There is clearly lack of direction from the responsible consultant and this is way below the standard expected in a situation like this. Page 155/292.

The urology MDT dated 6 April 2023, now realises that with positive urine cytology, cancelled CT urogram due to possible iodine allergy, non-contrast CT saying lymphadenopathy, biopsy lymph node suggestive of TCC, but also to consider SCC, not typical of lymphoma, less likely options being lung, GIT, breast or thyroid. No primary site was identified formally in the PET Scan and instead a lymphoma suggestion was made but did not favour a diagnosis of carcinoma. They classified this MDT review as

urgent [for a 2WW referral from 2 November 2022 to 6 April 2023 had taken 5 months to consider this an urgent matter - unacceptable] and recommended an MRI and see for a very urgent review in clinic and [redacted]motherapy once MRI is back. Page 157/292. This is clearly unacceptable.

Only at this point a referral to the uro-oncology specialist was made page 159/292.

On 2nd May 2023, page 160/292, the MRI confirmed, soft tissue mass in the vicinity of the renal pelvis nailing the diagnosis as metastatic TCC and this is late indeed for the deceased. A referral to Dr Rahman was made for oncology review.

On 3 May 2023, for the first time a substantiative consultant under whose name she was under reviewed the deceased and could not be explicit or clear about the metastatic TCC prognosis. Also, that was recorded that she has fibromyalgia, needed transport, and has concerns about travelling to [redacted]and the clinician was hoping that chemotherapy would at best control things page 163/292.

6. OPINION ON LIABILITY AND CAUSATION

1. Please consider the records and advise us if you consider there to be an unreasonable delay between the date the GP referred the Deceased under the 2 weeks wait urgent referral pathway for urological cancers and the date that the Deceased was first seen by urologist? – Considering the records carefully, there are unacceptable and unreasonable delays between GP referral [9 November 2022] and the date the deceased was first seen by urologist [18 January 2023]. There is breach of duty.
2. If there was a delay, was it acceptable to delay in light of the concurrent investigations by the Head and Neck surgeons who were considering the bilateral neck lymph node enlargement at the same time? No, that was not acceptable for the delay in light of concurrent investigations by the Head and Neck surgeons, since the patient had separate complaint of visible haematuria ongoing for few months prior to in November 2022. The urology department had failed in progressing with the requisite investigations for haematuria and there was no substantiative consultant input until very late in the deceased pathway. There is clinical negligence in the urology pathway too, in that there was no active intervention for the positive urine cytology and the failure to review the renal tract with the radiologist. The left kidney appeared bulky and that was missed and only later in the management pathway did the urology ask for MRI scan. You might wish to obtain a separate radiology consultant report about failure to remark about the left kidney bulkiness that could potentially represent a TCC of the renal pelvis.
3. Please consider the investigations carried out form January 2023 onwards. Do you consider that appropriate investigations were carried out to attempt to identify the primary carcinoma? – I do not consider that appropriate investigations were undertaken. The investigations were

not interpreted correctly enough and there was lack of the trust wide co-ordination of the MDTs. The haematology, urology and head and neck were not working coherently. Once there was a CT neck chest abdomen pelvis was done, the radiologist had failed to identify some abnormality in the left kidney 26 January 2023 page 229. Please get a separate report from the radiology consultant. Once the biopsies confirmed a diagnosis of carcinoma 8 February 2023, there was a lack of urgency in the investigations particularly from the urology point of view particularly with history of haematuria with clots, abnormal urine cytology showing TCC and abnormal looking left kidney. In fact, the urology MDT review and plan on 28 February 2023 confirmed abnormal looking left kidney based on the 26 January 2023 CT, diagnosis is cancer and they have contemplated referring to ENT. Page 199/292, and this is not acceptable. This is clinical negligence; the urology should have arranged an MRI at this stage since the deceased was allergic to contrast. Instead of this, there was another CT asked for that which happened on 14 March 2023 that confirmed renal mass, retroperitoneal nodes and the differential still being RCC and lymphoma. If MRI was done earlier, the diagnosis of TCC could be clinched since the mass was visible in the renal pelvis.

4. Was it reasonable for the urologists to consider transitional cell carcinoma the most likely source of the Deceased's symptoms? – Not only is that reasonable, to consider the transitional cell carcinoma as the most likely source of the deceased symptoms, this should have been picked earlier than that was done, and the resources should have been directed towards that.
5. In your view, should the Deceased have been referred to oncology sooner, even if the precise source of the primary cancer was not confirmed? – I agree that the deceased should have been referred to oncology sooner than that was done. The primary cancer could have been sought out whilst been seen by the oncologist.
6. Causation: On the balance of probabilities, but for any breach of duty identified above, do you consider the client's outcome would have been different? On balance of probabilities, the client's outcome would be no different, but for breach of duty identified as above.

It is my opinion [redacted]eatment of the deceased DB, fell below the expected standards of care.

The care received was substandard and/or negligent in that.

1. There was failure on the part of the hospital trusts to co-ordinate the various MDTs coherently [Haematology, Head and Neck and Urology, as well as cancer of unknown origin department].
2. Raises questions about the urology department practice and policy about the inability to correlate between positive urine cytology [18/1/2023], positive lymph node biopsies [8/2/2023], CT scan 28/2/2023 showing abnormal looking left kidney], and then the Urology MDT still considering referring back to ENT? 28/2/2023. This is substandard practice and at this stage an MRI should have been requested. There is breach of duty in not expediting the deceased investigations.

3. Throughout the journey the deceased had not seen a substantiative consultant until 3 May 2025, when a telephone conversation took place. Even at this time the consultant is unclear about the prognosis and was admitting that he never ever had actually met her. This is substandard clinical practice and a breach of duty of care to the deceased. The implication is that the deceased had never ever had a proper consultation to explain everything and to put all information together for her peace of mind.
4. The deceased had never met the cancer nurse specialist at all until her death and this is breach of duty, the cancer nurse specialist should have been the link as early as the 8 February 2023, and this is breach of duty of care.
5. There was an unacceptable delay of 69 days since the 9th November 2022 2WW referral and to be seen in urology on 18th January 2023.
6. The biopsies from node [8 February 2023] had pointed towards TCC albeit with other differentials, but that was only on 2 May 2023, that was acknowledged that the deceased had metastatic TCC.
7. There was delay in referring to the oncology for consideration of chemotherapy, again very unlikely that would have prolonged her life, but that would have given the family and the deceased that there was correct effort made towards the treatment pathway.
8. That would have been totally reasonable for urology to consider the TCC to be the most likely source of this disseminated cancer at the very early stages.

The urology department had not acted in accordance with a practice accepted as proper and responsible by a responsible body of medical men skilled in dealing with visible haematuria.

7. SUMMARY OF CONCLUSIONS

It is my opinion that th[redacted] was in breach of duty in failing to provide adequate care and investigations to the deceased [redacted] who was referred as a 2WW. The hospital trust had failed to recognise this lady with multiple co-morbidities who needed cohesive care in the form of coordinated MDT discussions from Head and Neck, Urology, and Haematology. The Urology department had failed the deceased and was in breach of duty in the inability to link the visible haematuria in someone who was not on anticoagulants and who did not have repeated urine infections, The urology department need revamping in that there should be clinical governance discussions about the failure to correlate finding such as positive urine cytology, bulky left kidney from first CT scan in January, negative finding seen on cystoscopy bladder, lymph node biopsies representing TCC. There is breach of duty to the deceased in that she was only seen by a consultant in May since the 9th of November 2022 referral and this is serious and needs scrutinising. Even then in May 2023, the urology consultant could only manage a telephone conversation and this needed rectifying in future. There is a failure in the urology and other teams in not offering the deceased an opportunity to see the clinical oncologist at the earliest [as early as January 2023] to see what could have been offered in the earlier stages of this disseminated cancer. That constitutes a breach of duty and clinical negligence that could be proved beyond doubts. There was negligent delay in diagnosing the deceased with cancer arising

from the urological system and if appropriate care would have been provided at early stages, such as oncology and chemotherapy, her life would have been prolonged. We agree that her condition was incurable, albeit could have been better controlled palliatively.

To underpin our discussions, I have provided the following statements and references. Survival data show the 2WW pathway is associated with the best outcomes in urological cancer in UK. Reference 1.

Outcomes in urological cancer are strongly influenced by route to diagnosis - Jayne L Douglas-Moore, Luke Hounsome, Julia Verne, Roger Kockelbergh, 2017

Route to diagnosis	
2WW	Urgent referral using 2WW guidelines where cancer is suspected
GP urgent or routine	Urgent or routine referral not made under 2WW guidelines
Other outpatient	Elective route starting with outpatient appointment
Inpatient elective	No admission prior to elective waiting list admission
Emergency	Any emergency attendance or admission
Death certificate only	Diagnosis found by registry in the cancer analysis system with no prior HES or CWT data
Unknown	No data from HES or CWT

2WW: two week wait; HES: hospital episode statistics; CWT: cancer waiting times.

International Classifications of Diseases-10 codes were used as follows: penis C60, prostate C61, testis C62, kidney C64 and bladder C67. Age is categorised into 10-year age groups except for a single group for patients aged over 85 years. Deprivation data are categorised into five groups representing national quintiles of the income deprivation score from the Department for Communities and Local Government English Indices of Deprivation.[4]

Results

There were 280,346 prostate cancer diagnoses. For men younger than 79 years, the most common RTD was GP referral. Overall, the most common RTD was GP referral, and prostate cancer was most commonly diagnosed in the least deprived patients.

A total of 70,043 diagnoses of bladder cancer were made between 2006 and 2013, 50,607 in men and 19,436 in women. The most common RTD overall was 2WW referral.

Between 2006 and 2013, there were 55,572 diagnoses of renal malignancy, 34,255 in men and 21,017 in women. More patients are diagnosed with renal cancer by emergency presentation than by 2WW. The most

NICE reference with regards to 2WW for urological cancer Reference 2.
Increases in survival might be delivered through greater use of radical treatment. NHS Digital data offers a population-wide picture of this disease but does not allow individual outcomes to be matched with disease or patient features. Reference 3.

8. REFERENCES

8.1 Douglas-Moore JL, Hounsome L, Verne J, Kockelbergh R. Outcomes in urological cancer are strongly influenced by route to diagnosis. Journal of Clinical Urology. 2017 Jan;10(1_suppl):9-13.

8.2 National Institute for Health and Care Excellence. *Suspected Cancer: Recognition and Referral*, https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#urological-cancers

8.3 Catto JW, Mandrik O, Quayle LA, Hussain SA, McGrath J, Cresswell J, Birtle AJ, Jones RJ, Mariappan P, Makaroff LE, Knight A. Diagnosis, treatment and survival from bladder, upper urinary tract, and urethral cancers: real-world findings from NHS England between 2013 and 2019. BJU international. 2023 Jun;131(6):734-44.

9. EXPERT'S DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.

2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.

3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All the matters on which I have expressed an opinion lie within my field of expertise.

4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.

5. Wherever I have no personal knowledge, I have indicated the source of information.

6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.

8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. That I know of no conflict of interest of any kind, other than any which I have disclosed in my report.

12. That I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.

13. That I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to either of the above two points.

10. STATEMENT OF TRUTH

I can confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Signature:

Date: [redacted]