The Leeds Teaching Hospitals NHS
NHS Trust

Date: 14th December 2015
Our Ref: YO/A-MW/CI2015/4/DC
Your Ref: NJM/de/tji/47264-2015

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Dear Ms Mundy

INQUEST TOUCHING THE DEATH OF DOROTHY COOPER (Deceased)

I refer to your correspondence of 21st October 2015, received on 26th October, regarding the inquest touching the death of Dorothy Cooper and the Regulation 28 Report to Prevent Future Deaths in respect of this case. Your letter, addressed to Linda Pollard, has been forwarded on for me as Chief Medical Officer for the Trust to respond to.

I can confirm that the contents of your Regulation 28 Report have been shared with the relevant staff to enable us to provide you with a comprehensive response.

In your report you highlight that your matters of concern are:

(1) The absence of clear procedures for those in MDT meetings to proactively follow-up inadequately completed referral forms;
(2) Lack of procedures to proactively obtain information to complete gaps in clinical history

In your summary you have indicated that had all the information been made available to the MDT in Mrs Cooper's case, the clinical picture would have pointed more towards an infective process having been responsible for her condition rather than cholangiocarcinoma and thus alternative management would have been indicated.

The team has considered the contents of your correspondence very carefully and the responses to the matters of concern you have raised in the report are detailed below.

The clinical team have advised me that Ms Cooper was a 75 year old lady who suffered complications following surgery at Doncaster in September 2014 and she had a prolonged hospital stay (29/09/14-14/10/14).

She was subsequently admitted to Pinderfields Hospital on 16/10/14 where she was noted to be very unwell and frail and she was treated appropriately for sepsis. Radiology suggested the possibility of a bile duct cancer/liver cancer and this was sent to our liver cancer MDT meeting for review. The referring radiologist requested previous radiology from Doncaster for comparison to discuss with the local clinicians.

The clinical details given to the MDT were vague and the radiology assessment was that there was a possible tumour but not definite and it was felt that a clinic review and further investigation was appropriate.

Clinic reviews failed for a variety of reasons, including the wrong address being provided to the ambulance crew to bring her to clinic from Pinderfields and subsequently because the patient was too frail. However in between she did attend for further scans.

Further scan review and MDT discussion clarified the overall picture was one of liver abscesses which by this time had been treated appropriately. The patient was still too frail to come to clinic but was improving at home so the clinical team at Leeds felt it was appropriate to suggest a clinic review and further imaging after 3 months and this was arranged after a clinic review with relatives on 15/12/14.

Sadly, Mrs Cooper suffered a relapse of sepsis (which can occur) and was admitted to Doncaster on 06/01/15, she presented in a moribund state and died that day.

The MDT has noted that you have raised concerns that they reviewed Mrs Cooper's case at their MDT meeting without adequate clinical details. They wish to highlight the fact that they did make attempts to obtain the details by way of correspondence with Mid-Yorkshire NHS Trust (Pinderfields General Hospital). The team is clear however that the lack of details did not influence the final diagnosis, treatment or outcome.

The Specialist Hepatobiliary Team is a multi-disciplinary group, which provides a service covering a population of nearly 5 million both within and outside the Yorkshire Cancer Network. The aim of the specialist MDT is to ensure a co-ordinated and multi-professional approach to diagnosis, treatment planning and care provision for patients diagnosed with a suspected or definite cancer, ensuring timely communication with the appropriate agencies.

The role and remit of the Specialist MDT along with the referral form was first published by the Yorkshire Cancer Network in April 2012 (Perihilar Cholangiocarcinoma Cancer Network Pathway). This was updated in line with the re-designed pathway between the West Yorkshire Diagnostic MDT and the Leeds Specialist Hepatobiliary (HB) MDT in October 2014. Mid-Yorkshire NHS Trust is part of the Yorkshire Cancer Network and, along with all the other organisations in the network, are aware they should work to this pathway.

The MDT takes place every Friday morning and details of patients for discussion at the meeting must be submitted by 3pm on the previous Wednesday by the referring clinicians, using the agreed MDT pro-forma.

In Mrs Cooper's case the form was not submitted until 13th November for discussion on 14th November.

Recently the MDT time allocation has been expanded from 8-11am to 8-12.30pm. On average 55-60 cases are reviewed. The demand on the service is huge and increasing. The staff in the MDT do their reasonable best to obtain the information they need. The MDT is supported by an MDT Co-ordinator/Data Manager who collates the cases for review and records the outcomes of the decisions. There is an increasing tendency to determine a management plan from a provisional or 'working' diagnosis made on the basis of radiological and blood tests but this must be regarded as provisional and ultimately a tissue diagnosis from a biopsy or complete resection of the abnormality is required to confirm the impression, or alternatively the patient is monitored to assess the response to empirical treatment, for example with antibiotics

in the case of infection. At the conclusion of the first MDT meeting where Mrs Cooper's case was discussed, the provisional diagnosis from the referring hospital was not changed but the plan was made to assess the fitness of the patient in clinic, allowing more clinical detail to be obtained and an assessment of the fitness of the patient.

The MDT has acknowledged the importance of having sufficient clinical information to be able to come to an informed decision. However, they have concluded that they cannot agree to reject any MDT referrals that are not 100% complete because this would add inherent delay into the system and potentially delay urgent cancer treatment.

To reiterate the importance of submitting relevant clinical information, the Hepatobiliary MDT Co-ordinator has re-circulated the pathway document that was updated in October 2014 and highlighted the need for completion of the referral form as fully and accurately as possible.

In addition, the clinical team has altered the MDT reply forms to state in bold on each response: **"The Leeds MDT is pleased to offer advice but responsibility for patient care remains with the referring team until the patient has been seen in Leeds".** Mrs Cooper was never seen in Leeds in the clinic.

Thank you for bringing these matters to my attention.

Yours sincerely

[redacted]
Chief Medical Officer
Leeds Teaching Hospitals NHS Trust