The investigation of a complaint by Mrs D against
Cwm Taf Local Health Board

A report by the Public Services Ombudsman for Wales

Case: 201001569

Contents

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

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 Mrs D.

Summary

Mrs D complained about the treatment her late father, Mr A, received at the Royal Glamorgan Hospital ("the Hospital") in 2007 and 2008. At that time, the Hospital was the responsibility of the former Cwm Taf NHS Trust ("the Trust"). Due to NHS re-organisation in Wales during 2009, the obligations of the former Trust now lie with the Cwm Taf Local Health Board ("the LHB").

Mrs D said that the Hospital did not properly investigate, diagnose or treat Mr A, during two admissions in late 2007 and early 2008. The admissions were soon after Mr A had received successful surgery and radiotherapy to treat a rectal tumour. They resulted from general but undiagnosed ill health. Mr A sadly died in January 2008, whilst in the Hospital, due to shock caused mainly by a gastric ulcer. Mrs D stated that the Hospital did not diagnose that Mr A had a pelvic abscess during his first admission, noting that his post mortem concluded that this was a contributory factor in his death. She maintained that during the second admission, the gastric ulcer should have been identified and treated. She also complained that a drug had not been administered properly. Mrs D also expressed dissatisfaction with the Trust's complaint handling. She asserted that the former Chief Executive should not have signed the complaint response, as a clinician involved in Mr A's care was a close relative of hers. Mrs D also said that the Trust's complaint response to her mother, did not deal with all the issues.

The Ombudsman did not uphold the complaint about the first admission. However, he found serious failings with regard to the second admission. He found that there was no systematic approach to diagnosing Mr A's condition, no plan about when clinical reviews should take place and no decision made about the frequency that nursing staff should record observations for Mr A. In the event, a doctor did not review Mr A the day before his death and observations were not sufficient or carried out properly. Had those failings not occurred, the problem with Mr A's undiagnosed gastric ulcer might have come to light. The Ombudsman concluded that there was a chance that had that happened, the sad outcome might have been different. The Ombudsman also found that Mrs D was right about the poor administration of a drug. He concluded that the former Chief Executive should not have signed the complaint

response without informing the family of the connection between her and a clinician who had been involved in Mr A's care, even though that clinician was not criticised in his report.

The Ombudsman made numerous recommendations to the LHB, which it has accepted. These included paying £1500 to Mrs D as an acknowledgement of the uncertainty she has to live with concerning whether her father might have survived the episode with better care; providing evidence that effective systems are in place regarding nursing observations; carrying out an audit to ensure that patients requiring daily clinical reviews are receiving them and introducing a written conflict of interest policy.

The complaint

1. Mrs D complained to me about Cwm Taf Local Health Board ("the LHB") regarding the care her father, Mr A, received at the Royal Glamorgan Hospital ("the Hospital") in 2007 and 2008. At that time, the relevant health body was Cwm Taf NHS Trust ("the Trust"). (In October 2009, the LHB took over the responsibilities of the Trust due to NHS re-organisation in Wales.) Sadly, Mr A died on Sunday morning of 13 January 2008 whilst in the Hospital, aged 72. Mr A's wife, Mrs A, originally submitted the complaint to the Trust. Sadly, she has since died in September 2009.

2. Mrs D stated that the Hospital did not properly investigate, diagnose and treat Mr A during two emergency admissions in late 2007 and early 2008. This was soon after the Trust had treated Mr A via a surgical procedure for a rectal tumour and subsequent radiotherapy. Mrs D made the following specific points:

- That a possible diagnosis of a pelvic abscess, made during the first admission, was not pursued. She noted that Mr A's post mortem concluded that a pelvic abscess was a contributory factor in his death.
- During the second admission, there was no investigation of the possible pelvic abscess by ultrasound or other appropriate imaging techniques; no appropriate investigation in the form of gastroscopy or barium study undertaken in response to Mr A's presentation of severe and persistent abdominal pain and no surgical opinion sought. Mrs D confirmed that the post mortem found that Mr A had died of "shock" due to "gastric ulceration".
- That nurses had not administered a drug called Sando K properly because they did not follow manufacturer instructions on appropriate dilution. Mrs D added that this drug has a known possible consequence of gastric irritation.

3. Mrs D said that the Trust regarded Mr A as having terminal cancer. She pointed out that the Trust's response to Mrs A's complaint confirmed this. Therefore, she suggested that the Trust had effectively, "written him off". She said the failures to investigate his condition properly occurred in that context. Nevertheless, Mrs D explained that

pre-operative scans confirmed no evidence of metastatic disease (the cancer spreading) and the post mortem found no evidence that Mr A still had cancer.

4. Mrs D was also dissatisfied with the response of the Trust to her mother's complaint. She said that it did not fully address the issues that Mrs A had raised. She also claimed that the Trust's Chief Executive, who had signed the main complaint response letter had, "a vested interest" in not finding significant fault, as she was related to one of the clinicians involved.

5. Mrs D said that the death of her father had caused her and her family profound, immediate and ongoing distress. This was exacerbated by the loss of Mrs A while she was trying to obtain "justice" for her late husband. Mrs D stated that the grief is much worse because she is certain that her father's death was avoidable if the Hospital had investigated and treated him appropriately.

Investigation

6. The investigation started on 8 November 2010. My Investigator obtained comments and copies of relevant documents from the LHB. I have considered those in conjunction with the evidence provided by Mrs D. I have taken due account of the advice of two of my professional advisers: a Surgical Adviser and a Nursing Adviser. The Surgical Adviser is a Consultant Surgeon. He has over 25 years experience in general surgery, including 17 years as a consultant in the NHS. His name is Magdi Shehata. The Nursing adviser is a Senior Nurse with extensive experience in acute care. Her name is Rona McKay. Both Mrs D and the LHB have had an opportunity to comment on a draft version of this report.

7. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

Relevant guidance

8. In 2003, the Welsh Assembly Government issued its guide on complaint handling for NHS bodies in Wales. (It should be noted that

the Welsh Assembly Government has put new arrangements in place in 2011.) Chapter 1.4 of the 2003 guidance states that:

> "The Chief Executive [of the relevant body] is responsible…for the effective handling of complaints and must sign the final letter to the complainant as part of Local resolution."

Chapter 1.86 says that the Chief Executive can send a brief covering letter with a detailed report from another member of staff or respond in detail over their own signature.

The background events

9. On 26 July **2007**, clinicians found that Mr A had a potentially aggressive cancerous tumour in his rectum. Subsequent tests indicated that the tumour had not spread.

10. On 3 September, the Hospital admitted Mr A. Staff recorded Mr A's clinical history. This included inactive acromegaly (a hormonal disorder); hip replacements; deep vein thrombosis in his right leg; sleep apnoea and surgery for an aortic aneurysm (bulging of the aorta – the largest artery in the body).

11. On 4 September, Mr A underwent a Hartmann's procedure, which was a variation from the planned intervention, under a consultant general surgeon ("the Surgeon"). In a Hartmann's procedure, a surgical team removes the diseased section of the bowel. It then brings one end of the bowel through the patient's skin as a colostomy and closes off the other end. In Mr A's case, the Surgeon noted that he had a tumour that extended into the pelvis and had invaded surrounding tissues. The Surgeon wrote in the operation note that, "…there is definitely residual disease". The Surgeon wrote that the procedure had been "palliative".

12. On the same day, there is a record of staff discussing Mr A's condition with his family. The notes state that a doctor working under the Surgeon explained that the operation had, "…been a lot bigger than expected". He added that, "…not all the tumour had been removed". He described the prognosis as "guarded". The doctor said that no further

surgery was indicated but that radiotherapy might be required. The note also included the following:

> "The family asked some questions about long term issues which the [doctor] declined to answer. They understood his reasons why."

13. On 19 September, the Hospital discharged Mr A home.

14. The Hospital admitted Mr A as an emergency on 15 October. He remained there until 18 October. He was under the care of a consultant physician ("the first Consultant"). Mr A's presenting symptoms were shivers and sweats and increased frequency in passing water. According to the notes, the first Consultant queried a pelvic abscess as a possible diagnosis. Various investigations, including an ultrasound scan, are documented in the medical records. The Surgeon also reviewed Mr A. Clinicians considered that Mr A probably had a urinary tract infection. The first Consultant treated him with antibiotics.

15. In October and November, Mr A underwent radiotherapy.

16. On 21 November, a Trust staff member referred Mr A's case to the Palliative Care Team ("the Team"). The paperwork generated by the Team described Mr A as, "a lovely gentleman". The document said that it was, "extremely likely" that the cancer would recur. It described Mr A's family as "supportive". It said that they were aware that Mr A's treatment had not cured his cancer.

17. On 7 January **2008**, Mr A was admitted to the Hospital, again as an emergency. The records indicated that he had recently suffered a C-Diff infection and a further urinary tract infection. The drug chart noted that Mr A was receiving long-term doses of Omeprazole (a drug that decreases the amount of acid produced in the stomach). His main symptoms were vomiting and diarrhoea. The admission notes mentioned that Mr A had brown sputum about once every week and occasional brown liquid in his stoma bag. Mr A was treated under a consultant physician ("the second Consultant"). Various investigations were undertaken. Medical records indicated that the second Consultant

decided to treat Mr A with antibiotics for an infection and check kidney function and acromegaly.

18. On 8 January, nurses recorded Mr A's observations at regular intervals. These observations were respiratory rate, oxygen saturation, temperature, blood pressure and heart rate.

19. On 9 January, the medical notes stated that the diarrhoea was "settling" and Mr A had vomited once during the afternoon. The notes mentioned pain in his abdomen. Nurses took the following observations on two occasions: oxygen saturation, temperature, blood pressure and heart rate.

20. On 10 January, the second Consultant saw Mr A. Mr A presented with a "gripping" pain in his abdomen. The second Consultant opted to arrange an ultrasound scan. Nurses took observations twice relating to oxygen saturation, temperature, blood pressure and heart rate.

21. At 09.00am on 11 January, nurses recorded Mr A's observations, concerning temperature, blood pressure and heart rate.

22. At 12.15pm on 11 January, the medical records indicated that Mr A was still suffering from the pain in his abdomen. However, the examining doctor wrote that Mr A's diarrhoea had settled and he had "stable" observations. The notes also summarised a meeting between that doctor and the family. The family were said to be concerned about cancer returning and that Mr A was depressed. The notes said that the doctor explained that Mr A's symptoms had eased but the pain in his abdomen required further investigation. The doctor prescribed Sando K to Mr A. The drug's purpose is to raise potassium levels in the blood. The drug requires appropriate dilution in water before being taken.

23. At 09.00am on 12 January, nurses took Mr A's observations relating to temperature, blood pressure and heart rate.

24. During the evening of 12 January, the nursing notes indicated that Mrs A was dissatisfied with her husband's medical treatment, in particular the failure to carry out Mr A's ultrasound scan. The nurse

apparently told Mrs A that Mr A was comfortable and asleep. She said that she would pass on the concerns to morning staff.

25. On 13 January, Mr A sadly died. The medical records show that at 7.22am, nursing staff made a cardiac arrest call. The medical notes said that on arrival, Mr A was "unresponsive" with Haematemesis (vomiting blood). The notes show that attempts to resuscitate Mr A, including CPR, failed.

26. Later the same day, a doctor met with family members. The notes indicated that the doctor told the family that:

- she (or he) was not part of the team that treated Mr A but did attend the emergency call
- the lack of an ultrasound scan, which the family had complained about, made no difference to the outcome
- Mr A had not vomited blood since his admittance and that he was on Omeprazole to prevent this
- Mr A may have had a bleed from a gastric ulcer, thus causing the Haematemesis.

The notes show that the family were angry about Mr A's clinical treatment, particularly the lack of an ultrasound scan, the failure to treat Haematemesis and the focus on acromegaly. They said that Mr A had vomited blood in the Hospital but had not reported it to the nursing staff. They requested a post mortem.

27. On 9 April, the post-mortem report was issued. It stated that the cause of Mr A's death was "shock" due to "Haematemesis" which in turn was due to, "stress induced gastric ulceration". Other factors listed as contributing to Mr A's death were the pelvic abscess, coronary heart disease and bronchopneumonia.

28. On 11 August, a solicitor acting on behalf of Mrs A wrote a formal complaint letter to the Trust. The letter set out the background clinical events. It listed a series of complaint issues as follows:

- clinicians did not pursue the possible diagnosis of pelvic abscess

- clinicians did not consider that Mr A may have been bleeding in his stomach despite evidence recorded on admission such as black faeces
- despite the continued pain in Mr A's abdomen in January 2008, no surgical opinion was sought
- nurses administered Sando K wrongly
- a gastroscopy was not carried out
- Omeprazole was administered at a "maintenance" dose not a "treatment dose"
- failure to perform an ultrasound scan.

29. In September and October, the Trust wrote to Mrs A's solicitor. The letters acknowledged the complaint and apologised for a delay in responding.

30. On 17 November, the Trust's Chief Executive wrote to Mrs A's solicitor. She explained that a senior staff member had investigated the complaint and the resulting analysis formed the basis of the response. The key points were as follows:

- the letter apologised for the delayed response
- the Chief Executive expressed condolences to Mrs A
- the 2007 procedure was palliative and the family were aware of that
- although the first Consultant had queried the possibility that Mr A had a pelvic abscess, reviews and investigations had indicated that Mr A had a kidney obstruction
- on admittance in January 2008, the second Consultant felt that Mr A had symptoms of C-Diff but tests later ruled this out
- the diarrhoea settled but the gripping pains in Mr A's abdomen were noted
- the second Consultant requested an ultrasound scan
- the family's concern that bowel cancer had returned was noted
- Mr A's sad death on 13 January was sudden due to a cardiac arrest
- there was no documented evidence in the notes about dark vomit containing old blood
- Sando K was not administered incorrectly

- the request for the ultrasound did not reach the Radiology Department which was, “not acceptable” and the writer apologised
- there was no pelvic abscess in October 2007 when the ultrasound was carried out
- the pelvic abscess would have probably resulted from radiology treatment and, “very little” could have been done, as it would have been related to the dying tumour.

31. In **2009** and **2010**, there was an exchange of correspondence involving the LHB, its legal advisers and solicitors for Mr A’s family. This concerned a possible legal case against the LHB. However, no legal proceedings began.

32. In September 2009, Mrs A sadly died.

33. On 10 December 2010, my office received Mrs D’s complaint about the care of her late father, Mr A.

Mrs D’s evidence

34. Mrs D explained her late mother, Mrs A, had framed the complaint. A solicitor submitted it to the Trust in August 2008 on behalf of Mrs A. She said that her mother had died whilst trying to obtain "justice" for her father. Mrs D stated that she had taken over the task of leading the complaint on behalf of the family after her mother died.

35. In submitting the complaint to me, Mrs D emphasised the alleged failure to diagnose and treat Mr A. She maintained that Mr A died mainly due to the effect of a gastric ulcer, with a pelvic abscess as a contributory factor. She said clinicians should have diagnosed and treated both conditions. Mrs D noted that Mr A had undergone a, "high quality" operation to treat cancer. He later had radiotherapy. She said that Mr A had recovered from the cancer, as proven by the post mortem findings. She commented that he was "healthy" and died of preventable conditions.

36. Mrs D said that the clinicians, who treated Mr A during late 2007 and early 2008 in the Hospital, were guilty of a, "catalogue of errors". She pointed out that the possibility that Mr A might have had an

abscess was put forward during his first admission in October 2007 but not fully considered. Mrs D remarked that Mr A was in severe pain in his abdomen during his second admission in January 2008. She stated that proper clinical care would have involved full investigations of the possibility of an abscess and an ulcer via investigations such as an ultrasound scan and a gastroscopy. Mrs D did not accept the LHB's views about the contribution that the pelvic abscess had to Mrs A's death. She pointed out that the post mortem report was clear in that regard. Mrs D added, in the context of these matters:

> "I contend that any reasonable physician or surgeon should consider gastroscopy as the urgent investigation of choice in an adult male presenting with undiagnosed severe, persistent epigastric pain."

Mrs D maintained that the Trust clinicians involved were collectively responsible for her father's death.

37. Mrs D said that the second Consultant seemed obsessed with the notion that acromegaly was a factor in Mr A's condition. Mrs D reported that her father had often expressed frustration about the amount of times the second Consultant wanted to see his tongue in January 2008, which was enlarged because of acromegaly. She said that the family later discovered that the second Consultant was developing an expertise in the subject of acromegaly. Therefore, they took the view that he was putting his own career ahead of treating Mr A.

38. Mrs D explained the complaint about the administration of the drug Sando K. She said that there was nothing written on the drugs chart to show special instructions. This was despite the fact that appropriate dilution in water is important as the drug can irritate the stomach. Mrs D stated that nurses gave Mr A the drug in a small container and told him to add water. She said that the container was just for holding the drug but Mr A filled it with water. Mrs D observed that the drug needed more water than the container held. Therefore, the drug was not diluted properly. Mrs D said this was a failure in her father's care and may have contributed to his deterioration.

39. Mrs D expressed the view that Mr A had been, "written off" due to the clinicians' attitude to his cancer and that may have accounted for the lack of proper care. She added that theTrust had apparently labelled her father as a palliative care patient. She made the point that this did not fit with the family's understanding of Mr A's health. Moreover, staff had not informed the family of Mr A's status in that regard. Mrs D commented that whether it was appropriate or not for clinicians to conclude that Mr A should be treated as a palliative care patient, he did not die of cancer.

40. Mrs D explained that her understanding of the complaint response to her mother was that it did not fully address all the main issues. She also suggested that because the Chief Executive was a close relative of one of the clinicians involved, it undermined the validity of her response, as she would have had an interest in not upholding parts of the complaint.

41. Mrs D provided a moving account of how losing Mr A in such circumstances had affected her and the wider family. She also submitted copies of her mother's diary entries relating to the period around Mr A's death. The documents demonstrate how concerned the family became about Mr A during the days leading to his death. It also shows that the family had some major misgivings about his general care at that time. Mrs D said that staff did not appear to feel any urgency and rigour in their care of Mr A, despite the pain and distress he was suffering. In addition, she doubted that staff recorded matters properly. In this context, Mrs D took issue with the medical records of 13 January 2008, relating to the discussions that Mr A's family members had with clinical staff after his death. She said that Mrs A would not have failed to report it to nursing staff if Mr A had vomited blood. Mrs D remarked that this left her wondering if other vital points that he mother and others may have raised, were not acted upon or added to the record.

42. Mrs D explained how the loss of both her parents has deeply affected her. She described herself as a, "shattered human being". However, she said:

> "It is a privilege to continue the fight for justice...on behalf of my mother and father and now the immediate family".

The LHB's evidence

43. The LHB provided Mr A's relevant medical records, the full complaint file and some comments on the main aspects of the complaint. It said that the second Consultant was no longer employed by the LHB.

44. With regard to the clinical aspects of the case, a consultant physician reviewed the medical records and provided the LHB with an analysis of Mr A's care. The LHB's response, as informed by that analysis, included the following main points:

- regarding the admission in October 2007, there was no evidence to suggest a pelvic abscess,
- clinicians arranged and considered a scan in October 2007, which did not indicate the presence of an abscess
- during January 2008, the medical team did not consider that Mr A exhibited symptoms of an abscess
- Mr A's ongoing abdominal pain led clinicians to request an ultrasound scan on 10 January 2008 but sadly Mr A died before it took place
- an ultrasound scan on 10 January would not have shown the presence of a gastric ulcer, therefore the failure to carry out the scan did not contribute to Mr A's death
- the LHB has no evidence about how Sando K was administered but the consultant carrying out the review, "has never seen a case of gastric ulceration secondary to Sando K"
- Mr A's symptoms in January 2011 were not indicative of a gastric ulcer
- Mr A was receiving medication to prevent gastric ulceration (Omeprazole)
- Mr A's symptoms were indicative of gastroenteritis, which was the initial working diagnosis
- Mr A was rightly regarded as a palliative care patient as it was inevitable that the residual cancer would grow
- it was normal for the post mortem not to show evidence of cancer as the residual disease would be there but not detectable.

45. The LHB also commented on the lack of medical records for 12 January 2008. It said that 12 January was a Saturday and therefore, it was not unusual that there were no records because medical staff, "do not routinely visit patients at weekends". It added that a doctor saw Mr A on 11 January and then spoke at length to the family. The LHB said that there was nothing in the nursing records that suggested any deterioration in Mr A's condition during 12 January.

46. The LHB also sought the comments of the Surgeon. He said that it was clear from the post mortem report that Mr A died of Haematemesis due to the stress ulcer. The LHB explained the Surgeon's view as follows:

> "…there needs to be clear understanding of what pathologist's findings really mean, rather than to take these words in isolation as there seems little doubt that [the abscess] had no part in [Mr A's] subsequent demise".

The Surgeon commented that the "prognosis" was "poor" regarding Mr A's cancer. Therefore, it was felt that the surgery that he carried out in 2007 was palliative.

47. The LHB explained its position regarding nursing observations relating to Mr A whilst he was in hospital from 7-13 January 2008. It said that there was no evidence that medical staff requested a specific frequency of observations. The LHB added:

> "In the absence of specific instructions, it appears that observations were carried out [five] times during 8 January when all results were deemed to be within normal range. Due to these findings and in the absence of a medical request, the nursing staff changed the observations to twice daily, which occurred until 11 January 2008 when they were subsequently changed to once daily. [The Divisional Nurse who reviewed this matter in response to my Investigator] has confirmed that throughout this period there was no change in these observations to warrant an increase in frequency".

48. The LHB added that:

- the failure to check Mr A's respiratory rate from 9 January was "unacceptable"
- once daily observations on 11 and 12 January were "unacceptable"
- the LHB now has a standardised observations system whereby a patient has recordings made 12 hourly on acute wards
- the LHB now utilises the "Modified Early Warning Score" or "MEWS" system to assist nurses to respond appropriately to at risk patients
- the issue regarding nursing observations had not been identified by any of the clinical staff who have commented on this case.

49. Despite the above, the LHB maintained that if Mr A had been experiencing a gastric bleed through 11 and 12 January, the observations that were taken would have indicated this. It explained that blood pressure and heart rate would have been abnormal indicating, "a shocked state".

50. The LHB commented on the aspect of Mrs D's dissatisfaction concerning complaint handling. The Chief Executive signed the response in that regard. She made the point that complainants who progress to the Ombudsman obviously consider that the health body concerned had failed to deal with the issues to their satisfaction. With respect to the conflict of interest allegation, she said that she was not involved in the investigations into Mrs A's complaint. She added:

> "…it was and currently still is part of the complaints procedure that the Chief Executive of all organisations signs formal responses. I accept that this should have been made clear in the response to [Mrs A]."

The LHB also said in its main response that:

> "[The Surgeon] is…deeply hurt by the implication that there was collusion between him and [the Chief Executive] in the investigation of this matter."

Professional advice

Surgical Adviser

51. The Surgical Adviser confirmed that he had reviewed the complaint file, the LHB's responses to my Investigator, the medical and nursing records and the post mortem report.

52. The Surgical Adviser explained that the procedure Mr A underwent in September 2007 was unable to remove the entire tumour. Therefore, the procedure was, "technically palliative…rather than curative". He added that the Surgeon considered that Mr A had a locally advanced but "extensive" disease. The Surgical Adviser said that this meant that it was reasonable to assume that cancer cells were present in Mr A's lymphatic system (a network of tubes that are part of the immune system) and blood stream.

53. The Surgical Adviser noted that clinicians decided Mr A would benefit from radiotherapy. That took place in October and November of 2007. He commented, based on the post mortem report, that Mr A's cancer had been "controlled" by the surgery and radiotherapy. He added that the prognosis for Mr A, with regard to cancer only, was that he would have had a 50% chance of surviving for five years.

54. The Surgical Adviser stated that Mr A's treatment, with regard to cancer, appeared to have been "appropriate". However, he criticised the palliative care documentation, which staff had produced after Mr A was referred to the relevant team. He said:

> "The palliative care document was rather short with no detailed explanation of the plan of care and future management of complications and hospital admissions. This was not reasonable practice. There was no reference made…regarding end of life care strategy and whether this had been discussed with the family."

55. The Surgical Adviser said that the palliative care focus should be on making patients comfortable. He explained that this involved how to prevent and treat symptoms and side effects and to consider the

physical, psychological and social needs of the patient and carers. He said:

> "The palliative care document indicated that when Mr A was referred to the Palliative Care Team, he was aware of his condition and his wife and daughter were aware that cancer was incompletely resected. I could find no reference to any form of physical or psychological assessment (Mrs A indicated that her husband was depressed). Furthermore, there was no documented evidence of any advice on how to deal with side effects such as nausea, constipation, pain etc and who to contact on emergency."

56. The Surgical Adviser was not critical of Mr A's care during his admission in October 2007. He said that Mr A had prompt investigations; was reviewed by various specialists; was seen by the Surgeon and had relevant scans. He stated that there were, "no shortcomings". The Surgical Adviser said that investigations did not indicate that Mr A had a pelvic abscess. He commented that the abscess found at post mortem was probably related to the aftermath of surgery and radiotherapy.

57. The Surgical Adviser analysed Mr A's treatment at the Hospital during January 2008. He addressed the central complaint made by Mrs D concerning the failure to investigate, diagnose and treat the stomach ulcer that caused Mr A's death. The Adviser explained that a gastric ulcer could have various causes such as a weak immune system, bacterial infection and liver damage. Medication such as Omeprazole can help to prevent it but cannot guarantee to do so. The Surgical Adviser accepted that a gastroscopy or barium study would have diagnosed the ulcer. However, on balance he did not consider that these investigations were justified in Mr A's case. He gave the following reasons:

- there was no documented history of Mr A vomiting blood
- Mr A was taking Omperazole, making a stomach ulcer less likely to develop
- there were no symptoms that clearly indicated a stomach ulcer apart from the pain

- Mr A did not have risk factors for a stomach ulcer such as smoking or previous history
- it is plausible that doctors would have attributed Mr A's abdominal pain to liver metastases as his cancer had not been cured (although this thinking was not well documented).

The Surgical Adviser commented that a high level of suspicion is generally required to diagnose a stomach ulcer.

58. The Surgical Adviser noted the failure of the Trust to organise the ultrasound scan, which the second Consultant had decided was necessary after seeing Mr A on 10 January. He said it was, "quite difficult" to provide an opinion on the significance of this. He stated that an earlier scan would not have diagnosed the stomach ulcer but might have indicated the pelvic abscess. The Surgical Adviser said that the post mortem shows that the pelvic abscess may have contributed to Mr A's death but it did not cause it. He maintained that, "on balance" a prompt scan would not have altered the outcome.

59. Despite the above, the Surgical Adviser made further criticisms of Mr A's treatment in January 2008. He said that in general there was a lack of a, "systematic approach to Mr A's symptoms". He explained:

> "I could find no evidence in the medical records of a plan of investigation apart from requesting an ultrasound scan on 10 January. In particular, there is no evidence of a request for serum amylase (check for inflammation of the pancreas). All together these suggest that the medical team did not consider an acute pathology causing the pain but rather the effect of the cancer."

60. The Surgical Adviser stated that there were also failures in planning concerning antibiotic and pain medication. He said that for a patient who continued to have a raised white cell count after treatment, further action should have been discussed with a microbiologist. With regard to pain management, he suggested that a review should have taken place after a few days. Neither of these took place.

61. The Surgical Adviser agreed to some extent with Mrs D about the administration of the drug, Sando K. He said that he would not expect to see special instructions written up for this drug. However, he added that he would have expected nurses to have diluted the tablets for Mr A. Nevertheless, he said that it was, "highly unlikely" that inappropriate dilution would have caused or worsened a stomach ulcer.

62. Whilst the Surgical Adviser did not consider that any of the failures described thus far were very significant in affecting the outcome, he took a different view with regard to two other linked issues. First, the Surgical Adviser was very critical that Mr A was not reviewed by a clinician on Saturday 12 January 2008. He said that Mr A was on empirical antibiotics and complained of constant abdominal pain. He maintained that this mandated review by junior doctors, "even on a Saturday".

63. Second, the Surgical Adviser identified that nursing observations were inadequate for 11 and 12 January. He pointed out that on those days, Mr A's respiratory rate and oxygen saturation were not noted. In addition, nurses only recorded his temperature and blood pressure once on each day. The Surgical Adviser stated:

> "It would be expected that for a patient who was admitted with infection to have his observations…recorded at least twice daily. The concern here is that Mr A had a cardiac arrest and died of a shock secondary to bleeding from an ulcer in a hospital ward without any clinical signs. Patients suffering from gastrointestinal bleeding would show signs of shock including raised pulse, increased respiratory rate and low blood pressure. Other symptoms such as agitation, sweating and pallor would also be obvious. It is therefore reasonable to suggest that had Mr A had regular observations in the ward, signs of bleeding might have been picked up."

64. The Surgical Adviser explained, in the above context, what might have happened if staff had identified that Mr A was suffering a stomach bleed. He said:

> "The reported mortality rate from bleeding gastric ulcers ranges from 50-70%. Treatment includes resuscitation (fluid and blood), gastroscopy and injecting the bleeding point. Failing that surgery may be necessary to remove part of the stomach. Based on the post mortem findings that Mr A's cancer had been well controlled…had the ulcer been diagnosed and treatment initiated earlier, the outcome might have been different."

Nursing Adviser

65. The Nursing Adviser based her advice on the relevant medical records and the investigation files. My Investigator asked her to focus on the issue of Mr A's observations and the complaint about the administration of Sando K.

66. The Nursing Adviser said that nursing staff deciding what observations were necessary and their frequency, was not necessarily wrong. However, in Mr A's case, she added some significant criticisms:

- there was no indication anywhere in the paperwork concerning when and why nurses took decisions regarding observations
- there is a line on the observation chart where the frequency of observations should be noted; it was left blank
- the lack of recorded decision making by clinical or nursing staff regarding Mr A's observations was, "not a reasonable standard of care"
- although 12 hourly observations took place up to and until 10 January 2008 (and were appropriate), that was a minimum period for Mr A and once each day thereafter was not good enough
- the observations were not complete, which represented, "poor nursing practice".

67. The Nursing Adviser included information from the National Institute of Clinical Excellence ("NICE") relating to observations. She quoted guideline 50 issued in 2007 called, "Patients in Hospital, Recognition of and response to acute illness in adults in hospital" ("NICE guidance"). I re-produce the quoted extract here from 1.2.1 of the NICE guidance:

"Adult patients in acute hospital settings, including patients in the emergency department for whom a clinical decision to admit has been made, should have:

- physiological observations recorded at the time of their admission or initial assessment
- a clear written monitoring plan that specifies which physiological observations should be recorded and how often. The plan should take account of the:

  - patient's diagnosis
  - presence of comorbidities
  - agreed treatment plan.

  Physiological observations should be recorded and acted upon by staff who have been trained to undertake these procedures and understand their clinical relevance.

  Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings.

- Physiological observations should be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient."

68. The Nursing Adviser maintained that even without the NICE guidance, Mr A should have had 12 hourly observations at least. This was due to his status as an acute patient.

69. The Nursing Adviser stated that if Mr A's condition was deteriorating during 12 January, "this would have been apparent if observations had been recorded in a timely manner".

70. The Nursing Adviser said that the MEWS system now apparently used within the LHB is an acceptable response to the NICE guidance. However, the LHB should re-assure me that systems were in place to ensure that staff fully complied with the requirements.

71. The Nursing Adviser agreed with the Surgical Adviser regarding the complaint about Sando K. She provided guidance which shows that the drug should be diluted in, “half a tumbler of cold water”.

Analysis and conclusions

72. I will look at each of the three complaints submitted by Mrs D, as summarised by the bullet points in paragraph 2 of this report. I will then consider issues concerning the palliative care decision relating to Mr A. Finally, I will comment on aspects of complaint handling.

73. Before doing so, I would like to express my condolences to Mrs D, through this report, for both her sad losses. I can see that the events in question have taken a great toll on her. In relation to the LHB, I can state that much of Mr A’s care during the period in question was good. I also accept that Mr A died of an unexpected event. However, I will explain below that Mr A’s care fell below reasonable standards in certain key areas and that without those failings, there is a possibility that the outcome may have been different.

74. Mrs D’s first complaint concerned the failure, as she sees it, to diagnose that Mr A had a pelvic abscess. This was ruled out during Mr A’s admission to the Hospital in October 2007. During Mr A’s stay in the Hospital in January 2008, the second Consultant decided to arrange an ultrasound scan. This did not happen. I note that the Chief Executive apologised to Mrs A in her letter of 17 November 2008. The Surgical Adviser confirmed that the pelvic abscess would have been diagnosed if an ultrasound scan had been carried out. I am guided by his thoughtful analysis. It appears that an earlier scan would have led to treatment of the abscess but, “on balance”, the outcome would not have been altered because Mr A would still have died due to the gastric ulcer. That being the case, I do not uphold that part of Mrs D’s complaint.

75. Mrs D’s second complaint concerned Mr A’s care during January 2008 relating to diagnosis and treatment more generally. The advice that I have received, based on a thorough examination of the records, has led to my conclusion that staff mishandled Mr A’s treatment but not exactly as Mrs D thought.

76. As I have stated above, I do not fully accept Mrs D's complaint about the pelvic abscess. Moreover, the Surgical Adviser has explained to my satisfaction why the gastric ulcer was not predictable. To that end, I do not agree with Mrs D that a gastroscopy or a barium study should definitely have been carried out. However, I am troubled by the advice that both my Advisers have provided. First, it seems that there was no coherent plan regarding investigating Mr A's symptoms. This criticism is mainly about investigation and diagnosis. However, it appears that pain relief and antibiotic regimes were also problematic in that regard. It is possible that such a systematic plan could have led to a gastroscopy and/or a barium study. It certainly would have led to a superior care regime for Mr A as indicated below.

77. The second issue I want to raise in this part of my findings concerns Mr A's observations. In the absence of any medical direction, nursing staff decided on the frequency for recording Mr A's observations. I note, however, that there is no evidence of any considerations or plan to that end. By 11 January, Mr A's care in terms of observations was in breach of NICE guidance and clearly inadequate. Moreover, observations had not been done properly in any case, as my Advisers have pointed out, and the LHB has accepted. Both Advisers have said that timely, sufficient and complete observations on 12 January might have demonstrated that Mr A was deteriorating. This seems a reasonable point as the second set would presumably have been taken at around 9.00pm on 12 January.

78. My third concern in terms of the professional advice that I have received relates to the failure to clinically review Mr A on 12 January 2008. The Surgical Adviser maintained that Mr A, as an acute patient without definite diagnosis of his symptoms, should have been seen by a doctor every day. He was 72 years old, had been treated surgically and by radiotherapy for cancer a few months earlier, had suffered various infections recently, had symptoms without definite cause and soon after admission complained of significant and continued upper abdominal pain of unknown causes. Not reviewing Mr A daily was a major failing. I find the LHB's reasoning – that the 12 January was a Saturday – to be glib and alarming. Essential care should not be compromised because it is needed on a weekend. I cannot be certain what may have resulted from

a clinical review on 12 January. However, the Surgical Adviser has said that Mr A's deterioration might have been apparent. It is also possible that a doctor examining Mr A on 12 January might have led to the inadequate observations being highlighted.

79. It seems to me that Mr A's treatment at the Hospital between 7 and 13 January 2008 fell below reasonable standards. There was:

- no systematic approach to diagnosing his condition
- no plan about when clinical reviews should occur
- no decision about frequency of observations

In the event, Mr A's observations were not done a second time on 12 January and a doctor did not visit him on that day. Both Advisers have told me that if either or both had occurred, it is possible that Mr A's bleeding gastric ulcer may have come to light. It appears that he may have had a 30-50% chance of surviving this event, if it had been apparent. I recognise that there is a degree of speculation here. However, I can state that there were failures in care and a chance that the outcome would have been different without those failures. Mrs D will have to live with this knowledge for the rest of her life. That is a major injustice to her. I uphold her complaint.

80. I now turn to Mrs D's third complaint, concerning the drug Sando K. Mrs D is right, the drug should have been diluted for Mr A. I urge the LHB to satisfy itself that nursing staff on this Ward present medication to patients appropriately. However, it seems that it is extremely unlikely that inappropriate dilution would have had any effect on Mr A's condition. For that reason, I cannot uphold the complaint.

81. I have no comment about the Trust's decision concerning the palliative care status of Mr A. I do not believe that clinicians, "wrote him off". Nevertheless, the Surgical Adviser was critical of the palliative care documentation that the relevant team drew up in relation to Mr A in November 2007. I accept his analysis. Moreover, from what Mrs D has said, it appears that staff did not provide the necessary information to the family of Mr A about his prognosis in a clear manner. As it turned out Mr A did not die of cancer. I understand that this may have

happened eventually. Better information by the Palliative Care Team would have helped the Family prepare for Mr A's death, whatever its cause.

82. Mrs D made two points about complaint handling. First, she said the Trust did not deal fully with the issues that her mother had raised. The Chief Executive (who has subsequently retired) said in her response to me that every complainant obviously thinks that if they are moved to submit a complaint to me. She is right of course. I have read the Trust's response to Mrs A dated 17 November 2008. I do not agree with aspects of it. It did not draw the conclusions that I have done. However, I consider that it did deal with the issues raised.

83. The second concern regarding complaint handling concerns the allegation of conflict of interest. I want to make it clear that I do not believe that the former Chief Executive's letter to Mrs A would have been different if she was not related to the Surgeon. In any case, I have made no criticism of the Surgeon's role in Mr A's care. Mrs D did not do so either. The Surgeon's involvement was over before Mr A was admitted to the Hospital in January 2008. The Chief Executive's response to me acknowledged that she should have dealt with the matter differently. I agree. Not doing so, left her open to the (unfair) allegation of bias. The perception of possible bias is the issue here. I believe that complainants have the right to feel that their concerns have been fairly reviewed during a local resolution process. Until now, Mrs D has been denied that. That is an injustice. To that limited extent, I uphold her complaint about the Trust's response.

Recommendations

84. I recommend that within one month of the date of my report, or later if specified, the LHB:

- issues Mrs D with an apology from its Chief Executive for the injustices that I have outlined above
- pays Mrs D the sum of £1500 as an acknowledgment that she will have to live with the uncertainty as to whether her father might have survived his acute illness in early 2008 if his care had been

better and a further £250 for her time and trouble in pursuing the complaint

- supplies me with information about action that has been taken to prevent a re-occurrence of the delay in arranging the ultrasound scan for Mr A
- provides me with satisfactory evidence, or explanation, that appropriate and robust procedures are in place to ensure that nursing staff throughout the LHB comply with the MEWS system for observing patients
- within three months, carries out an audit of its acute wards to ascertain whether there is any evidence that patients requiring daily reviews by a doctor, may not receive them depending on the day of the week and presents me with the results and if necessary, an action plan to address any deficiencies identified
- within four months, carries out a review of a reasonable sample of palliative care documentation, takes appropriate action regarding its findings and provides me with a summary of this work and the results
- within four months, introduces a written conflict of interest policy relating to the investigation of any concerns by patients or their advocates and representatives.

85. The LHB has agreed to implement the recommendations above.

Peter Tyndall
Ombudsman 4 August 2011