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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Mrs F against Hywel Dda Local Health Board

A report by the Public Services Ombudsman for Wales

Case: 201102690

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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 F.

Summary
Mrs F complained about matters concerning her daughter's treatment at one of Hywel Dda Health Board's hospitals in 2011. She explained that her daughter, Miss F, had a severe form of endometriosis, which is a gynaecological condition. Mrs F said that the hospital mismanaged her medical care, failed to refer onward to a more specialist hospital in another area and mishandled her complaint.

The Ombudsman upheld her complaints. He noted that the hospital had operated on Miss F twice. The second operation was poorly planned and Miss F was badly prepared psychologically and physically. Moreover, she should have been referred to a more specialist unit after the first operation. In the event, Miss F's second operation was abandoned without success and clinicians decided to refer her to the other hospital. The Ombudsman concluded that the hospital played a part in the referral initially failing. In addition, he criticised the Health Board concerning the handling of Mrs F's complaint.

The Ombudsman recommended that the Health Board apologise to Miss F and pay her £3250 as an acknowledgement of the injustice she suffered due to the failings identified. This included an unnecessary operation. He made a number of further recommendations including work to ensure that patients are prepared properly for gynaecological operations, action to prevent a recurrence of the planning failures in Miss F's case and improving referral pathways. The Health Board accepted the Ombudsman's recommendations.

The complaint

1. Mrs F complained about Hywel Dda Health Board ("the Health Board") on behalf of her daughter, Miss F. Mrs F explained that in June 2011, her daughter had an operation for a gynaecological condition in a hospital managed by the Health Board ("the Hospital"). During the procedure, the Locum Gynaecological Consultant ("the Consultant") diagnosed Miss F with an additional gynaecological problem. This was a severe form of endometriosis.[1] Mrs F said that in September her daughter had a second surgical procedure. This was envisaged by the Consultant as a joint operation between the Consultant and a Colorectal Surgeon ("the Surgeon"). Mrs F remarked that the Consultant decided to proceed in this manner as the endometriosis involved the bowel in Miss F's case. Mrs F added that the surgery was abandoned without success. This was because the Surgeon was not able to attend and no further surgical help was available.

2. Mrs F explained that, after the second operation, Consultants at the Hospital decided that the Health Board should refer Miss F to a hospital under the management of Cardiff and Vale University Health Board ("the UHB") for ongoing treatment. However, she said that the referral failed. According to Mrs F, this left her daughter without an appropriate treatment plan. She faced major delays without a clear indication of when she would re-commence treatment.

3. Mrs F also made the point that she had to chase a response to her complaint about these matters and the Health Board's response was late. She did not regard the response as adequate.

4. Mrs F maintained that the failure to successfully treat her daughter and make a successful referral caused ongoing physical suffering and mental anguish for Miss F. It prevented Miss F from planning for her wedding. She said the matter left Miss F in "despair" and described the quality of her life as "rubbish".

[1] This is a gynaecological problem, where tissue, similar to the womb lining, grows in other areas of the body.

Investigation

5. The investigation started on 6 January 2012. My investigator obtained comments and copies of relevant documents from the Health Board. I have considered those in conjunction with the evidence provided by Mrs F. I acquired some information from the UHB. Mrs F and the Health Board have had the opportunity to comment on a draft version of this report. I have taken advice from one of my professional experts. He is an experienced Consultant Gynaecologist and Obstetrician. He has working knowledge of endometriosis, including carrying out surgical procedures to treat the condition. His mane is John Orrell Davies.

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

7. In considering an aspect of this complaint, I have taken into account relevant complaints provisions. In April 2011, the Welsh Assembly agreed a new complaints regime for the NHS.[2] The Welsh NHS has produced leaflets for the public to help them raise concerns (complaints) under the new provisions. The "Putting Things Right" leaflet makes it clear that a complaint should be investigated. It states that the healthcare provider should provide the final response within 30 working days of receipt of the complaint.

The background events

Introduction to this section

8. Please note that a more detailed analysis of Miss F's treatment and a commentary thereon is included later under "professional advice". I will also include further details of events in the Health Board's evidence section of this report.

Miss F's clinical care

9. On 18 April **2011**, Miss F's GP referred her to a gynaecologist at the Hospital.

[2]The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

10. On 13 May, the gynaecologist referred Miss F to the Consultant. The referral letter said that the writer hoped that the Consultant would carry out a "diagnostic laparoscopy"[3] and possibly an "ovarian cystectomy/oophorectomy.[4] On the same day, that gynaecologist wrote to Miss F's GP. The letter outlined the diagnosis and the treatment plans. It said that Miss F would be seen in the pre-operative assessment clinic prior to surgery.

11. On 21 June, the Hospital admitted Miss F. She had a laparoscopy the next day. After the laparoscopy, the Consultant referred Miss F to the Surgeon with a view to joint surgery taking place involving the two doctors. The referral letter said that Miss F had "severe endometriosis" with bowel involvement.

12. On 22 June, the Consultant wrote to Miss F's GP. The letter included the following:

- the diagnosis after the laparoscopy was endometriosis involving ovaries and bowel
- Miss F requires "appropriate counselling" due to the "extensive" nature of "operative laparoscopy need"
- Miss F would need "bowel preparation" before the operation
- the operation should be a joint procedure with a colorectal surgeon
- there is a possibility of a colostomy, which should be discussed with her prior to surgery
- there would be an outpatient's appointment in six weeks for "counselling surgery and risks".

13. On 7 July, a Registrar saw Miss F on behalf of the Surgeon. The Registrar wrote to the Consultant. He said that he had reviewed Miss F. The letter outlined some of the issues involved in carrying out surgery to treat the endometriosis. The letter said that the Surgeon would prefer surgery on a Wednesday. It added that he should be kept informed of "plans".

[3] A Laparoscopy is a surgical technique. It involves a small incision, through which a viewing tube (laparoscope) is inserted. The viewing tube has a small camera. This allows a doctor to examine the abdominal and pelvic organs on a video monitor connected to the tube. Other small incisions can be made to insert instruments to perform procedures.
[4] This refers to a procedure that could result in the removal of ovaries.

14. On 7 September (a Wednesday), surgery under the Consultant commenced. The Surgeon was unable to attend. Surgery was not completed.

15. On 8 September, the Consultant referred Miss F to the UHB. The letter said that Miss F had "severe endometriosis" involving "severe abdominal pain". He explained that there was bowel involvement. He requested an urgent response.

16. On 23 September, the UHB wrote to the Consultant. The letter said that the referral was not accepted.

17. On 19 December, a senior finance officer in the Health Board sent an email to a counterpart in the UHB. The email mentioned general problems with tertiary referrals between the two bodies. The email highlighted the case of Miss F. Two days later, the UHB confirmed that it had accepted Miss F's referral.

18. On 23 January **2012**, a Consultant Gynaecologist at the UHB wrote to the Consultant. The letter said that he had examined Miss F. It said that she was on the waiting list and he "assumed" that the referral start date had been backdated to the original referral in September.[5] Miss F's treatment at the UHB is not relevant to this report.

19. On 3 February, the Consultant replied to the above letter from the UHB. The letter said that he had "found severe endometriosis with dense bowel adhesions" at the June laparoscopy. The Consultant explained that he had abandoned the surgery in September because the Surgeon was "busy" and another surgeon had "felt it may be better dealt in a higher centre".

The complaint to the Health Board

20. On 15 September 2011, Mrs F complained to the Health Board. The complaint focussed on the provision of information, delay and the abandoned second operation. She expressed anger that the operations had been unsuccessful.

[5] The UHB has confirmed the referral date has been taken as September for purposes of Miss F's waiting time. Mrs F said that this is also her understanding.

21. On 23 November, the Chief Executive responded to Mrs F's complaint. The letter apologised for the delay in responding. It said that:

> "[Miss F] was diagnosed with endometriosis during her first laparoscopic surgery. [Miss F] was referred to the surgical team for consideration of a joint procedure…Due to the severity of the endometriosis, there was a possibility that it could lead to a permanent colostomy. The procedure was abandoned and [Miss F] was referred to a higher centre for a better outcome."

The letter was predominantly comprised of comments from the Consultant and the Surgeon. The Consultant was reported as saying that Miss F was listed for definitive surgery on 7 September. He said a mutual date for joint surgery had been agreed after "liaison" with the Surgeon's team. He added that during surgery, he noted that the situation was difficult. The Surgeon could not attend and other surgeons were either unavailable or unable to assist. The Consultant said that the on-call Surgeon decided that the case was so "severe" that the operation should be aborted. Later, referral to the UHB was agreed. The Chief Executive's letter reported the Surgeon as stating that he had agreed to help if available. In the event, he was not available as he was alone running an endoscopy session. The Chief Executive apologised that Miss F's "overall experience of the service provided by our [HB] has not been a positive one". He added that the system for arranging joint procedures required review.

The Health Board's evidence

22. The Health Board said that the Consultant did not see Miss F before a meeting on 22 June 2011, which was the day of surgery. However, he "counselled" Miss F about risk factors. The Health Board said that Miss F was content for surgery to go ahead involving possible removal of the ovary.

23. The Health Board explained that the diagnostic laparoscopy of 22 June identified that Miss F had endometriosis and bowel adhesions. The Consultant decided that the best way to treat her was by joint surgery with the Surgeon. The Health Board acknowledged various

flaws in its actions thereafter in response to questions posed during the investigation:

- the Consultant discussed the need for joint surgery with Miss F, the day after the surgery of 22 June but this was not recorded
- the Consultant reported that he should have considered referral to the UHB after the first procedure and his practice has changed because of this complaint
- there was no follow-up meeting for Miss F with the Consultant after the June procedure
- the Surgeon did not meet Miss F (although his Registrar did), did not review her notes and did not discuss the case with the Consultant
- the plan for joint surgery went wrong, apparently due to a communications breakdown, mainly attributable to the Surgeon's Registrar, who no longer works for the Health Board
- the Consultant apologised for failing to arrange bowel preparation prior to surgery on 7 September.

24. The Health Board commented that the on-call Surgeon who had attended in the Surgeon's absence felt that Miss F was at risk of a permanent colostomy and should be referred to a tertiary centre. The Health Board said that the UHB has an Endometriosis Team that could treat patients with severe endometriosis involving the rectum. The Health Board confirmed that it has no equivalent.

25. The Health Board reported comments made during my investigation by the Consultant. Although he accepted that he should have considered an earlier referral to the UHB, he confirmed that he has experience assisting with surgery to treat complex and advanced endometriosis. Moreover, he explained the initial considerations which led to his decision to arrange joint surgery within the Health Board. This is a complex explanation. Essentially, he believed that:

> "…if a surgeon could dissect and free the bowel attachment from the ovary and the uterus, he would be able to remove the endometritic cyst."

The Health Board added that Miss F's endometriosis appeared "moderate" rather than "severe" after the first laparoscopy, "even though [the Consultant] has stated in his letters it was severe endometriosis." The Health Board said that the images of the second laparoscopy were a "surprise" to the Consultant, indicating a more difficult situation than the images from the first laparoscopy implied.

26. The Health Board explained the situation regarding the problematic referral to the UHB. It said that initially the UHB declined to accept.[6] The Health Board said that it should have been able to make a successful referral. However, the Consultant was new to the Health Board and not aware of "referral pathways". The Health Board commented that he took advice internally but was incorrectly informed. As a result, he did not challenge the UHB's decision. The Health Board stated that Mrs F made representations to it. This led to HB staff contacting the UHB. The UHB then accepted the referral just prior to Christmas 2011. The Health Board said that during this period, Mrs F was kept informed of developments. It also said that its understanding was that the UHB had actioned the referral as if it had been successfully made in September 2011.

27. The Health Board explained that it had already started to review the case. It reported that "it is apparent that there are a number of learning points". It said that when joint care is occurring, there must be direct contact between consultants. In addition, staff should follow the Health Board's protocols on joint surgery. It stated that its review into the case was ongoing.

Professional advice

28. My Adviser explained that endometriosis can involve "debilitating" symptoms. He said that it is characterised by "cyclical bleeding", which can form a cyst if present on the ovaries.

29. My Adviser commented that at the time of the referral to the Consultant, the provisional diagnosis in Miss F's case was "an

[6] Mrs F has not complained about the UHB. I have not investigated the UHB. Therefore, it is not appropriate to comment on its role at this stage. However, I can state that I have not seen papers which lead me to conclude that the initial failure was the Health Board's fault.

endometriotic cyst affecting the left ovary". He stated that it was explained to Miss F that the referral was for a laparoscopy but that surgery might be undertaken at the same time to remove the left ovarian cyst. My Adviser considered this approach appropriate and in line with good practice. However, he said that the Consultant should have met with Miss F in clinic prior to admission for the laparoscopy as indicated when the referral was made. He acknowledged that the Consultant discussed matters with Miss F on the day of surgery as part of the consent process. However, My Adviser remarked that this gave inadequate time for the patient to consider the situation fully. My Adviser maintained that this was "not good enough".

30. My Adviser said that the laparoscopy of 22 June 2011, "describes and the diagram shows extensive endometriosis". He noted that this affected the left ovary and the bowel. My Adviser explained that the Consultant decided that "definitive surgery" should be undertaken. My Adviser said that the Consultant was correct not to attempt that surgery on 22 June and definitive surgery was indicated.

31. My Adviser stated that definitive surgery was necessary. However, he maintained that guidance[7] is clear that cases of severe endometriosis should be referred to a:

> "unit that can offer all available treatments in a multi-disciplinary context …and this would include advanced laparoscopic surgery"

My Adviser said that he could find no justification in Miss F's case for not making such a referral after the June procedure. He noted that the Consultant appears to have accepted the point according to the Health Board's response to me.

32. My Adviser was critical of the Health Board's failure to arrange an appointment for Miss F as planned prior to the second laparoscopy. He said the appointment was necessary given that Miss F faced the possibility of a colostomy. My Adviser noted the Health Board's explanation that the Consultant discussed matters with Miss F during the

[7] Investigation and Management of Endometriosis, Royal College Obstetricians and Gynaecologists, Greentop Guidelines No. 24, 2008, page 2.

afternoon after surgery on 22 June. He commented that the explanation was inadequate. My Adviser said that a discussion with a patient so soon after surgery was not appropriate without follow-up, although would have been merited before discharge. Moreover, the Consultant did not record the meeting. This did not accord with guidelines.[8] My Adviser added that a follow-up appointment would have provided an opportunity to review the decision to operate locally. Moreover, it would have allowed Miss F the time to weigh up the implications of surgery in advance of admission in September.

33. My Adviser discussed the plans for Miss F's surgery in September 2011. He made the point that the Surgeon should have acquainted himself personally with Miss F's case, even bearing in mind that he did not necessarily expect to be involved. Also in a case such as Miss F's, there should have been personal discussion between the two main clinicians involved. My Adviser commented that there was a significant communication breakdown about the plans for the September Laparoscopy and different perspectives on what went wrong thereafter. He said that this failed to accord with guidance.[9]

34. My Adviser said that in terms of Miss F's physical preparation for the second laparoscopy, it was "incomplete". He said that Miss F should have had a sigmoidoscopy procedure.[10] Carrying out such a procedure in a case such as Miss F's is recommended in relevant guidance.[11] He said that this procedure provides information about whether the endometriosis has infiltrated through the bowel wall and involved the bowel lining. He noted that alternative approaches to assessing the degree of bowel infiltration in Miss F's case were not carried out. My Adviser said that a sigmoidoscopy was later ordered, quite rightly, in connection with the referral to the UHB. He also stated that proper bowel preparation was also not done. This should have involved emptying the bowel fully before operating. My Adviser stated that carrying out the planned procedure in September without proper bowel

[8] GMC – Good Medical Practice, paragraph 3j.
[9] As above, paragraph 41b.
[10] A sigmoidoscopy is a procedure to assess the lining of the bowel.
[11] Royal College Obstetricians and Gynaecologists, Green-top Guidelines N.24, 2008, page 6.

preparation would have increased the risk of a colostomy becoming necessary.

He added that this error was more marked because he could find no evidence that Miss F was advised about the risk of colostomy.

35. My Adviser analysed events at the September procedure. His main point was that the photographs from the second laparoscopy were not significantly different from those taken at the June operation. He said that "if anything" the first set of photos is more "dramatic" than the second. Therefore, he maintained that the correct decision to refer Miss F to the UHB in September should have been taken in June. He said that the notes taken at the second procedure support his view that findings were unchanged.

36. My Adviser commented that the operation notes from this procedure do not appear to have accurately described what occurred. He explained that definitive surgery was abandoned but the Consultant carried out an ovarian cystectomy. The photographs and the pathology report demonstrated this. My Adviser said that the operation notes only state that scar tissues were removed. He criticised this "failure" to record the operation accurately as relevant guidelines demand.[12]

37. My Adviser suggested that the Health Board:

- establishes appropriate pathways between it and the UHB regarding severe endometriosis
- ensures there are adequate mechanisms for collaborative working between gynaecologists and surgeons
- introduces a policy that any surgeon involved in an operation familiarise him/herself with the case
- reminds the Consultant about the necessity of keeping accurate operation notes.

[12] GMC, Good Medical Practice, paragraph 3j.

Analysis and conclusions

38. Miss F suffered from a debilitating, distressing and complex condition. Her treatment presented challenges to medical staff at the Health Board. It was inevitable that Miss F would have to undergo intrusive and unpleasant ongoing treatment. However, Miss F's treatment at the Hospital was below an acceptable standard. The Health Board then played a part in initially failing to make an effective referral to the UHB. I also consider that the Health Board responded poorly to Mrs F's complaint. Miss F has suffered a major injustice because of the Health Board's failures. I will explain these conclusions below. Findings concerning Miss F's medical treatment are based on the expert opinion that My Adviser has provided.

39. Mrs F effectively raised three separate but linked issues in her complaint to the Ombudsman. These concerned the failure to successfully treat Miss F, the delayed referral to the UHB and complaint handling. I will look at each in turn.

40. I have a number of significant criticisms of the care provided to Miss F. I will discuss them in chronological order. First, the Health Board failed to arrange an appointment for Miss F prior to the June laparoscopy. Not only should this have occurred but it was intended, according to the letter from the Gynaecologist to Miss F's GP of 13 May 2011 (see paragraph 10). Miss F did not have an appropriate period of time to consider the upcoming procedure and its implications.

41. The second criticism concerns the most serious aspect of this case. Miss F should have been referred to the UHB after the June laparoscopy. This is strongly asserted by My Adviser and supported by guidelines. The Health Board should not have been planning definitive surgery in Miss F's case. It seems clear that the correct decision to refer Miss F, taken in September 2011 after the second operation, should have been taken in June. Nothing altered between the two procedures that can explain or vindicate the Health Board's actions. I am pleased that the Consultant has changed his practice in that regard, although I am concerned that he suggested that there were significant differences between the findings at the two procedures and back-tracked on the use of the word "severe".

42. The Third troubling aspect of Miss F's medical care relates to the failure to arrange a suitable outpatient's appointment to discuss the plans and implications of the September operation. Again, there was a letter to Miss F's GP indicting that such an appointment would occur (see paragraph 12). An unrecorded meeting, hours after the first procedure was no substitute.

43. My fourth criticism of the care provided to Miss F concerns the arrangements for the second laparoscopy. A joint operation for a serious and complex case demands careful planning and personal liaison between those involved. Neither occurred. The Consultant and the Surgeon had a radically different view of the plan. Miss F was under the care of the Consultant. He should have ensured that the plan was robust. Abandoning an operation, having started surgery, is a serious matter. Ironically, I consider that the surgery should not have been taking place in any case. However, this is not the point. I am pleased that the Health Board has indicated that it has taken steps to ensure that this episode is not repeated. However, I do not believe that it reflects well on those concerned to blame a more junior member of staff who no longer works for the organisation.

44. My fifth point concerns Miss F's physical preparation for the September procedure. As My Adviser said and the Health Board accepted, Miss F should have had bowel preparation before the September surgery. A sigmoidoscopy should also have been carried out to gather vital information. These are serious matters. In the event, definitive surgery was not completed. If it had been, it seems that Miss F would have faced a greater degree of risk of having a colostomy due to the lack of bowel preparation.

45. Finally, the operation notes from the September procedure were inaccurate. This is an important failing. It is vital that operation notes correctly reflect the surgery performed, particularly where ongoing treatment is required. It also assists with any review process that needs to take place later.

46. In short, there was a catalogue of serious errors running through Miss F's medical care at the Hospital. She was badly prepared for both procedures psychologically and poorly prepared physically for the second operation. The arrangements for the second operation were not rigorous and the plans floundered. Most importantly, Miss F was subject to an operation that should not have occurred and is having to be repeated at another centre. Miss F suffered the worry, risk and physical trauma of an ill-planned, badly prepared and abortive surgical intervention that should not have been arranged in the first place. It is also the case that Miss F has incurred three additional months waiting time due to the referral in September 2011 not taking place in June. This represents a serious injustice to her. I **uphold** the medical care aspect of Mrs F's complaint.

47. I now turn to the problematic referral to the UHB, first attempted in September 2011. The Health Board played a part in this failure. It was not the Health Board's fault that the initial referral was not accepted. However, as the Health Board has acknowledged, the Consultant took advice and was misled accidently by a colleague. The Health Board should have pressured the UHB earlier than in December. Once the referral was accepted, those involved have ensured that Miss F did not lose out by effectively backdating it. However, she did suffer some unnecessary distress due to an apparent delay in her care. Therefore, on balance, I **partially uphold** this complaint.

50. Mrs F's complaint did not receive the response that it deserved. The Putting Things Right process indicates the need for an investigation. I do not consider that this is what occurred. It seems to me that the response dated 23 November 2011 (see paragraph 21) was superficial. On balance, I do not necessarily think that the Health Board should have uncovered the serious medical failings that my investigation has done because that was not the thrust of Mrs F's complaint to it. However, the response appears to be a re-hash of what a few Health Board staff members said, which are mutually incompatible, with no clear conclusion apart from admitting that the plan for joint surgery went wrong. I think this outcome did not justify taking longer than the stipulated 30 working days. Under the new provisions, the response was late and Mrs F had to chase it.

51. Given the lack of rigour in the investigation, there was no excuse for lateness. Reading such a response to matters which had caused much distress to the family after waiting well over two months, must have been very frustrating and annoying to Mrs F. I **uphold** the complaint.

Recommendations

52. I recommend that within one month of the date of this report, or later where specified, the Health Board:

A. sends a detailed written apology from the Chief Executive to Miss F for the failings that I have outlined above

B. pays Miss F £3250 as a recognition of the additional and unnecessary suffering and distress that she has endured as a result of the failings identified

C. pays Mrs F £250 for her time and trouble in pursuing her complaint

D. within two months, carries out an audit of cases where gynaecologically led operations have taken place to assess the adequacy of pre-operative consultations and plan to act upon the outcome

E. satisfy itself that appropriate and robust mechanisms are in place to plan and carry out joint surgical procedures in the Health Board's hospitals

F. reminds all gynaecological medical staff of the need for proper bowel investigation and preparation prior to relevant procedures

G. reminds the Consultant of the need for accurate record keeping

H. within two months, ensures that there are workable and well understood referral pathways between the Health Board and relevant tertiary centres regarding severe endometriosis

I. within two months carries out a thorough review at senior level of the investigation process into Mrs F's complaint and explains to me and relevant HB staff what lessons have been learned as a result.

53. The Health Board has agreed to implement my recommendations.

Peter Tyndall
Ombudsman 20 September 2012