Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint

by Mrs A

against Cwm Taf University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201405352

Contents	Page

Introduction

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

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 A.

Summary

Mrs A complained that Cwm Taf University Health Board ("the Health Board") discharged her daughter, Ms B, from the Royal Glamorgan Hospital too quickly. She pointed out, in that regard, that Ms B had died shortly after her discharge.

The Ombudsman upheld Mrs A's complaint. He found that the Health Board did not assess Ms B's physical condition properly before discharging her. He also determined that the Health Board's response to Mrs A's concerns, about Ms B's discharge, was inadequate and misleading. He recommended that the Health Board should:

(a) **Apology** - Write to Mrs A to apologise for the failings identified.

(b) **Financial redress** – Pay Mrs A a nominal sum of £3000 in recognition of the distress and uncertainty associated with the possibility that Ms B might have survived if the clinical failings identified had not occurred.

(c) **Action plan** – Prepare an action plan which details how it will address the clinical failings identified and specifies when it will complete these actions.

(d) **Undertaking** - Give him a formal written undertaking in which it agrees to comply with its action plan.

The Health Board agreed to implement these recommendations.

The complaint

1. Mrs A complained that Cwm Taf University Health Board ("the Health Board") discharged her daughter, Ms B, from the Royal Glamorgan Hospital ("the Hospital") too quickly. She pointed out, in that regard, that Ms B had died shortly after her discharge.

Investigation

2. The Ombudsman's Investigation Officer obtained comments, a copy of Ms B's medical records for the relevant period and other information from the Health Board. She acquired documents from HM Coroner. She also obtained advice from two of the Ombudsman's Professional Advisers ("the Advisers"). The first of these Advisers ("the First Adviser"), Dr Sami Hoque, is a Consultant Physician and Gastroenterologist. The second, Dr Jamal Grayez, is a Consultant Respiratory Physician ("the Second Adviser"). The Ombudsman considered the Advisers' advice, the material supplied by the Health Board and the information provided by HM Coroner in conjunction with the evidence supplied by Mrs A. He gave Mrs A and the Health Board an opportunity to comment on two draft versions of this report.

3. The Ombudsman has not included every detail investigated in this report but he is satisfied that nothing of significance has been overlooked.

Background

4. Ms B had a history of alcohol misuse and deliberate self-harm.

5. On **27 April 2013** the police were informed that Ms B had been 'missing' from home since approximately 2.00am on that day. The identity of the informant is unclear. The police found Ms B, more than 12 hours later, in an outdoor area ("the Area"), at approximately 2.36pm. An ambulance crew attended the scene. It recorded that Ms B had taken a methadone[1] overdose and that she had been in the Area since approximately 7.00am that morning. It

[1] Methadone is a drug that is prescribed as a heroin substitute.

noted that her Glasgow Coma Scale ("GCS")[2] score was three. It gave Ms B two naloxone[3] infusions and took her to the Hospital. Ms B was 43 years old at that time.

6. A Doctor ("the First Doctor") assessed Ms B, in the Hospital's Emergency Department, at approximately 3.50pm. S/he noted that Ms B had been 'cold and unresponsive' when the police found her. S/he indicated that Ms B appeared to have been lying on the ground for a long time. S/he also noted that Ms B smelled of alcohol. S/he determined that Ms B was hypothermic.[4] S/he indicated that a temperature management unit should be used and that warm fluids should be given to Ms B, through her veins, to treat her hypothermia. S/he noted that Ms B's respiratory rate[5] was 12. S/he indicated that she was receiving extra oxygen at a flow rate of 15 litres per minute ("15 lpm") and that her oxygen saturation level[6] ("O_2 level") was 100%. S/he recorded that Ms B's chest was clear. S/he noted that her GCS score was 12. Ms B's admission blood test results showed that her white cell[7] and neutrophil[8] counts were high at 21.1 and 16.4 respectively and that her C-reactive protein ("CRP")[9] level was normal.

7. At approximately 6.45pm another Doctor ("the Second Doctor") assessed Ms B. S/he indicated that the methadone, taken by Ms B, had not belonged to Ms B. S/he recorded that Ms B's respiratory rate was 22 and that her O_2 level, with the support of oxygen at a rate of 15 lpm, was 100%. S/he also noted that Ms B's chest was clear. S/he recorded that her GCS score was 15. S/he noted that Ms B had had two naloxone infusions since her admission to the Emergency Department. Ms B's respiratory rate subsequently fell to four and she was given another naloxone infusion.

[2] The GCS is a tool used to rate the severity of a coma following an assessment of an individual's ability to open his/her eyes, move and speak. Generally, GCS scores of 3 – 8 (you cannot score lower than 3), 9 – 12 and 13 – 15 indicate severe, moderate and mild losses of consciousness respectively.
[3] Naloxone is a drug that can temporarily reverse the effects of a drug like methadone.
[4] The term hypothermic is used when a person's core body temperature has fallen below 35°C.
[5] The term respiratory rate refers to the number of breaths that an individual takes during one minute while at rest. Generally, the normal respiratory rate range for an adult is 12 – 18 breaths per minute.
[6] Oxygen saturation is a term used to describe how much oxygen the blood is carrying. It is expressed as a percentage of the maximum amount that the blood could carry. Oxygen saturation levels ranging between 95 – 100% are normal.
[7] The normal range for white blood cells is 4-11.9 $x10^9$/L. An increase in their number can indicate infection or stress.
[8] The normal range for neutrophils is 1.7-7.5 $x10^9$/L. An increase in their number can indicate acute infection.
[9] CRP is made in the liver. An increase in its level can indicate acute infection and/or inflammation.

8. Ms B was transferred to the Medical Clinical Decisions Unit at approximately 7.55pm. The Health Board completed a chest X-ray shortly after this. The Radiologist reported that there was an area, which lacked transparency, overhanging Ms B's right lung root. However, s/he suggested that this had been caused by a shadow and not by any underlying disease.

9. On 28 April, at approximately 7.50am, the Health Board recorded that Ms B's O_2 level, with the support of oxygen at a rate of 10 lpm, was 100%. A Consultant Physician ("the Consultant") reviewed Ms B at approximately 8.10am. He determined that Ms B required a mental health review and that she was medically fit for discharge on that day. A Community Psychiatric Nurse ("the CPN") assessed Ms B. She decided that Ms B's 'apparent' self-harm risk was low. Ms B was discharged, from the Hospital, later that day.

10. Tragically, on 29 April, at approximately 8.00am, Ms B was found dead, in her bedroom, at home.

11. An inquest was held on 4 September. HM Coroner determined that pneumonia,[10] combined with the taking of methadone and citalopram,[11] had caused Ms B's death. She concluded that Ms B had died of natural causes.

12. On **20 February 2014** Mrs A and other family members met the Consultant and a Patient Support Officer ("the Patient Support Officer").

13. Mrs A and another family member met a Consultant Psychiatrist, a Senior Mental Health Nurse ("the Senior Nurse") and the Patient Support Officer, on 8 April. It was agreed that a second opinion about Ms B's medical care, as distinct from her mental health care, would be sought.

14. On 27 May the Patient Support Officer wrote to Mrs A.

15. Mrs A telephoned the Health Board on **9 January 2015**. She indicated that she remained concerned about the medical care that Ms B had received at the Hospital.

16. On 13 April the Chief Executive wrote to Mrs A.

[10] Pneumonia is a condition in which the tissue in one or both of the lungs becomes inflamed and fluid and/or pus collects in one or both of them. An infection, caused by germs, usually gives rise to this condition.
[11] Citalopram is a drug that is used to treat depression.

Mrs A's evidence

17. Mrs A told the Ombudsman that Ms B was discharged, from the Hospital, during the morning, on 28 April 2013. She said that the Health Board should have kept Ms B at the Hospital longer for observation purposes. She suggested that Ms B would still be alive if it had done this. She said that she felt that the Health Board had not taken "enough care" of Ms B "because of what she had done".

18. Mrs A confirmed that she did not have any concerns about the mental health service provision, made for Ms B, before her discharge from the Hospital on 28 April.

The Health Board's evidence

19. The Consultant reported, on 20 February 2014, that Ms B's observations[12] were monitored regularly. He said that Ms B's chest X-ray had been clear and that her blood test results had not shown any signs of infection. He stated that the development of an infection had seemed unlikely because Ms B's observations had been stable overnight. He also noted that Ms B had not had a temperature and that her blood pressure had been normal.

20. On 27 May 2014 the Patient Support Officer reported that she had asked the Health Board's Clinical Director ("the Clinical Director") for a second opinion, as agreed. She indicated that the Clinical Director had been concerned that:

- Observations had been stopped when Ms B was still receiving oxygen at a rate of 10 lpm.
- There was no documentation to show that Ms B's O_2 level was satisfactory without oxygen support.
- Ms B's white blood cell count was not repeated before her discharge.

[12] The term observations refers to the measurements taken of an individual's vital signs, which include his/her respiratory rate, blood pressure, pulse rate and temperature. These measurements provide key information about an individual's physical condition.

- The start time for Ms B's last naloxone infusion was not recorded.

- The CPN did not record the time at which she saw Ms B.

- The time of Ms B's discharge from the Hospital is unclear.

She reported that the Clinical Director did not believe that the outcome for Ms B would have been different if these apparent failings had not occurred. She indicated that the Senior Nurse and the Clinical Director had reminded staff members of the need for accurate record keeping.

21. On 13 April 2015 the Chief Executive said that the Consultant had determined, on 28 April 2013, that Ms B was medically stable and suitable for discharge, 'after a further few hours of observation.' She maintained that Ms B's blood test results, examinations and observations had shown 'no evidence of infection'. She also said that Ms B's chest X-ray had been 'reported as normal'. She stated that there was 'no evidence of pneumonia' when Ms B was assessed by the medical team. She acknowledged that there did 'not appear' to be any documentation demonstrating that observations, in respect of Ms B, were taken after the Consultant had seen her. She also apologised 'for this oversight.' She told Mrs A that the Health Board had not identified any breach in its duty of care to Ms B.

22. The Health Board confirmed, during this investigation, that it did not have a discharge policy at the time of the matters complained about. It also reported that its Nursing Directorate was developing such a policy.

23. The Patient Services Director, when commenting on a draft version of this report, noted that the Health Board had obtained advice from a Consultant Chest Physician ("the Chest Physician"). She indicated that it had done this because the Clinical Director had been concerned that the Ombudsman had suggested, in light of Ms B's chest X-ray results and the First Adviser's advice, that the Health Board had 'missed a chest infection developing.' The Chest Physician acknowledged that Ms B's chest X-ray results were not normal. However, he said that 'the changes shown' were not 'typical for pneumonia' or 'indicative of early infection'. The Clinical Director also suggested that she would not have expected the Consultant to have examined Ms B's chest

clinically, when he saw her, by listening to it with a stethoscope, because Ms B's chest had been 'clear' on admission and her chest X-ray results had been 'unremarkable'.

24. A Senior Complaints Officer noted, in response to another draft version of this report, that the relevant guidance ("the Guidance")[13] recommends that a patient's CRP level should not be re-tested within 24 hours of 'an initial request'. She also indicated that the Health Board did not accept that Ms B's CRP level should have been re-tested, before her discharge, as a result.

Professional advice

First Adviser

25. The First Adviser asserted that Ms B should have been cared for in a closely monitored environment, like a High Dependency Unit, following her admission to the Hospital, due to her clinical history and associated needs. He observed, in that respect, that she needed naloxone infusions, to improve her respiratory rate and consciousness, for a considerable period of time. He also pointed out that she required a significant amount of oxygen support, throughout her admission, to maintain an adequate O_2 level.

26. He emphasised, with regard to the diagnosis of pneumonia, that the interpretation of chest X-rays varies greatly. He noted, nevertheless, that Ms B's chest X-ray results were not normal. He also indicated that Ms B's history of prolonged lying on the ground and a very low GCS score was, in terms of these results, significant. He explained, in that respect, that Ms B had been at particular risk of developing pneumonia because her stomach contents and/or saliva could have entered her airways and she would have found it very difficult to remove this material, and/or any excess mucus and/or fluid from her lungs, by coughing. He noted that the presence of these substances can enable germs, which can cause pneumonia, to grow and multiply. He explained that the findings made during a clinical examination are often 'more sensitive' than chest X-rays, when diagnosing pneumonia 'at

[13] 'National Minimum Re-testing Interval Project: A final report detailing consensus recommendations for minimum re-testing intervals for use in Clinical Biochemistry' – Dr Tim Lang (Project Lead) (The Association for Clinical Biochemistry & Laboratory Medicine) (2013).

the initial stage', because X-ray changes lag behind clinical findings by several hours or more. He said that the Consultant should have examined Ms B's chest clinically, when he saw her, by listening to it with a stethoscope. He observed that there is no evidence which demonstrates that he did this.

27. He stressed, when considering the Health Board's response to a draft version of this report, that he was concerned that the Health Board had failed to appreciate the significance of the 'clinical context' when evaluating Ms B's chest X-ray results. He also maintained that the Consultant should have examined Ms B's chest clinically, when he saw her, given her clinical history, the evolving nature of her clinical condition and the fact that a significant amount of time had elapsed since such an examination had last been completed.

28. He said that the Consultant should have arranged for Ms B's ability to breathe spontaneously and to maintain a satisfactory O_2 level, without the provision of extra oxygen, to have been assessed, before deciding to discharge her. He noted that if Ms B had been unable to maintain an acceptable O_2 level, further examination, investigations and/or treatment could have been instigated.

29. He stated that Ms B should have had more blood tests, on 28 April 2013, when her body temperature had returned to normal, because the results of her admission tests had shown that her white cell and neutrophil levels were significantly raised. He acknowledged that a 'stress' response to hypothermia could have caused these level increases. However, he said that infection, or blood poisoning caused by such an infection, could equally have been responsible for them. He indicated that it is not unusual for the CRP levels, of people who are starting to develop an infection, to be normal. He said that a normal CRP level does not therefore rule out the development of a serious infection. He noted that serial measurements of CRP levels are helpful as a consequence. He pointed out that another measurement of Ms B's CRP level would have been especially instructive for two reasons. Firstly, she had been hypothermic when her CRP level was measured and this could have adversely affected the accuracy of that measurement. Secondly, she might have had liver disease, given her history of alcohol misuse, and this could have compromised her ability to produce CRP.

30. He confirmed, when considering the Health Board's response to another draft version of this report, that it would not have been appropriate for the Health Board to have re-tested Ms B's CRP level within 24 hours of her initial CRP test, that is before 3.50pm on 28 April 2013. However, he said that it would have been fitting and Guidance-compliant for the Health Board to have re-tested Ms B's CRP level 24 hours later, that is after 3.50pm on 28 April 2013.

31. He stated that the Health Board's clinical assessment of Ms B was not robust. He also confirmed that the Health Board should have kept Ms B at the Hospital longer for observation purposes. He concluded that the Health Board failed to diagnose 'probable early pneumonia' and to start 'effective antibiotic therapy', before discharging Ms B, because of these assessment deficiencies.

32. He observed that the clinical records do not show when Ms B was assessed by the CPN or when she was discharged from the Hospital. He indicated that these recording failings are unacceptable.

33. He noted that the inadequacy of the Health Board's clinical assessment of Ms B, combined with its poor record keeping, make it difficult to form a view about whether the outcome, for Ms B, would have been different if the Health Board had discharged her later. However, he said that, 'on the balance of probability', 'it is likely' that the outcome for Ms B 'would have been different' if she had been closely observed, at the Hospital, for longer.

Second Adviser

34. The Second Adviser confirmed that Ms B had, due to her clinical history, been at 'high risk' of developing pneumonia. He noted that her chest X-ray results had shown minor, 'non-specific changes in both lungs'. He said that these changes did not necessarily indicate that Ms B was developing pneumonia. He confirmed that the Consultant should have examined Ms B's chest clinically, when he saw her, by listening to it with a stethoscope. However, he indicated, given the outcome of Ms B's earlier chest examinations and her chest X-ray results, that the Consultant would probably not have 'picked up any clinical signs', which would have altered his discharge decision, if he had

completed such an examination. He also pointed out, with reference to relevant guidance,[14] that Ms B had had no 'clinical symptoms' of pneumonia before her discharge from the Hospital.

35. However, he confirmed that the Health Board should have repeated Ms B's blood tests and established that she was able to maintain a satisfactory O_2 level, without the provision of extra oxygen, before discharging her. He also said that it should have observed Ms B, at the Hospital, for longer because her initial GCS score was 'very low', which meant that she was at increased risk of dying. He noted that, if the Health Board had done this, and completed the assessment steps identified, some of the clinical symptoms and signs of pneumonia might have become apparent.

36. He also indicated that the Health Board should have considered observing Ms B, at the Hospital, for longer because she was 'at risk' of 'further respiratory depression'.[15] He explained, in that regard, that the effects of methadone, in contrast to those of naloxone, continue for an exceptionally long period of time. He also observed that alcohol exacerbates the sedating impact of methadone. He noted that the documentation, which the Health Board completed, in relation to Ms B's naloxone infusions, was inadequate.

37. He concluded that the Health Board's decision to discharge Ms B, on 28 April 2013, was 'unreasonable'. He also said that observing Ms B, at the Hospital, for longer, might have prevented her death.

Analysis and conclusions

38. The Ombudsman has taken account of the Advisers' advice when analysing Mrs A's complaint and reaching his conclusions.

39. The Ombudsman does not consider that the Health Board managed Ms B's discharge appropriately for five reasons. Firstly, it did not repeat Ms B's blood tests for white cells or neutrophils despite the fact that the number of these cells had been noticeably elevated when she was admitted to the Hospital and therefore suggested that she might have had an infection. Secondly, it did

[14] 'Guidelines for the Management of Community Acquired Pneumonia in Adults. Update 2009. A Quick Reference Guide.' – British Thoracic Society (November 2009).
[15] The term respiratory depression refers to a respiratory rate that is less than 12 breaths per minute. Large doses of methadone can cause respiratory depression.

not take another blood test to measure Ms B's CRP level even though its initial measurement of it did not necessarily demonstrate that Ms B did not have an infection and could have been specifically affected by her clinical history. The Ombudsman accepts, given the Guidance, that it would have been clinically inappropriate for the Health Board to have repeated this test within 24 hours of Ms B's initial CRP test. However, he considers that it would have been reasonable for the Health Board to have repeated Ms B's CRP test after that period had elapsed. Thirdly, it did not establish that Ms B was able to sustain an adequate O_2 level, without oxygen support, in spite of the fact that she had needed a significant amount of such support during her admission. Fourthly, it did not, given Ms B's clinical history and the deficient naloxone infusion-related information, observe Ms B for a reasonable period. Finally, it did not record the time at which Ms B was discharged from the Hospital.

40. In the Ombudsman's view, the Health Board should have repeated the blood tests identified, determined that Ms B could maintain a satisfactory O_2 level without oxygen support and observed her for a longer period, before discharging her. It seems to him that it might have identified that Ms B was 'developing' pneumonia, if it had taken these assessment steps. The Ombudsman cannot establish, with any certainty, that the eventual outcome for Ms B would have been different as a result. However, he accepts, with considerable regret, that this is a possibility. He also recognises that the implications of this, for Mrs A and other members of Ms B's immediate family, are immeasurable.

41. The Ombudsman is also very concerned that the Health Board's response to Mrs A's concerns, about Ms B's medical care, was inadequate and misleading. He particularly notes, in that respect, that the Consultant and the Chief Executive both maintained that there had been no evidence of infection, while Ms B was at the Hospital, even though some of her blood test results indicated that she might have had an infection. He observes that the Clinical Director did recognise several of the failings identified by the Advisers. However, he points out that the Chief Executive subsequently failed, when writing to Mrs A, to acknowledge and address the clinical significance of these shortcomings.

42. The Ombudsman **upholds** Mrs A's complaint because the Health Board did not assess Ms B's physical condition properly before discharging her.

Recommendations

43. The Ombudsman **recommends** that, within one calendar month of the date of this report, the Health Board should:

(a) **Apology** - Write to Mrs A to acknowledge, and apologise for, the clinical and complaint handling failings identified within the report.

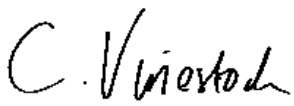
(b) **Financial redress** – Pay Mrs A a nominal sum of £3000, which should benefit her and Ms B's immediate family, in recognition of the distress and uncertainty associated with the possibility that Ms B might have survived if the clinical failings identified within the report had not occurred.

44. The Ombudsman **recommends** that, within three calendar months of the date of this report, the Health Board should:

(c) **Action plan** – Prepare an action plan which details how it will address each of the clinical failings identified within the report and specifies when it will complete these actions. These actions should include the completion of its discharge policy.

(d) **Undertaking** - Give him a formal written undertaking, in which it agrees to complete all of the actions, identified within its action plan, within the time frames that it has specified.

45. The Ombudsman is pleased to note that the Health Board, when commenting on a draft version of this report, has agreed to implement these recommendations.



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