The investigation of a complaint

by Ms A

against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201504223

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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 Ms A.

Summary

Ms A through her Assembly Member complained to the Ombudsman that the care her father ("Mr M") received post-operatively at Ysbyty Glan Clwyd ("the Hospital") was inadequate, resulting in his death from sepsis. Ms A also complained about the Betsi Cadwaladr University Health Board's ("the Health Board") poor handling of her complaint.

The Ombudsman's investigation found that Mr M had significantly raised CRP[1] levels following surgery. This was a possible indication of a post surgical leak. Mr M's clinical records showed his CRP levels were tested repeatedly, but were not reviewed. The failure to review Mr M's increasingly abnormal CRP levels was a fundamental clinical deficiency, resulting in missed opportunities for earlier intervention. The Ombudsman could not rule out the possibility that, had clinicians intervened sooner, a different outcome for Mr M may have resulted. Ms A's complaint was upheld.

The Ombudsman was critical that it took the Health Board over eight months to reply to Mrs A's complaint. The reply broadly maintained that Mr M's treatment was appropriate. Additionally, he had concerns about the rigour and depth of the Health Board's investigation. He upheld Ms A's complaint.

The Ombudsman recommended that the Health Board should:

(a) provide a fulsome apology to Ms A both for the significant clinical failings and inadequate investigation of her complaint.

(b) pay Ms A the sum of £8,000 for the distress and uncertainty caused by the failings identified. The Health Board should also provide a further payment of £350 to Ms A in recognition of the shortcomings in complaint handling.

(c) ensure that the guidelines issued by the Association of Coloproctology and the Association of Surgeons are brought to the attention of its medical staff highlighting the importance of

[1] A blood test marker for inflammation/infection in the body - the levels increase in response to inflammation/infection present.

recognising that raised CRP levels is a marker that a surgical leak is likely to have occurred.

(d) discuss the contents of the Ombudsman's report at an appropriate consultant forum and at junior doctors' teaching sessions.

(e) as part of a wider learning process, the Ombudsman's report should be shared with the clinical staff within the colorectal team who delivered the care to Mr M.

(f) a copy of the Ombudsman's report should be shared with the Chair of the Health Board and its Patient Safety and Clinical Governance Group.

The complaint

1. Ms A via her Assembly Member ("AM") complained that the care and treatment that her father ("Mr M") received post-operatively at Ysbyty Glan Clwyd ("the Hospital") in September 2014 was inadequate, resulting in his death. She said that her father had not been reviewed by the on-call surgical team despite his deteriorating condition. She added that the concerns that she and her family raised with the nursing staff about her father's deterioration were ignored and not documented. Finally, Ms A complained about the Health Board's poor handling of her complaint.

Investigation

2. Comments and copies of relevant documents were obtained from Betsi Cadwaladr University Health Board ("the Health Board"). These were considered in conjunction with the evidence provided by Ms A. Clinical advice was sought from two of my Professional Advisers, a Consultant Colorectal Surgeon, John F Abercrombie ("the Surgical Adviser") and a Senior Nurse, Liz Onslow ("the Nurse Adviser"), both of whom have extensive experience in the NHS. Their advice was shared with the Health Board for its comments. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. I should add that I and my officers who carry out investigations are impartial and consider (in relation to the matter complained of) the adequacy of the service/treatment provided. What is adequate is based on the circumstances known at the time, rather than the treatment/care that might have been provided with the benefit of hindsight. In considering whether the treatment was reasonable, I do not apply a "gold standard" test to the NHS. Instead, I will seek to establish whether the treatment fell within the bounds of acceptable clinical practice. To uphold a complaint, I must be satisfied that the complainant has been caused injustice as a result of any failing identified during the course of the investigation.

The background events

4. Mr M was diagnosed with bowel cancer in 2014. He was admitted to the Hospital on 15 September for planned surgery to remove the cancer, which was carried out the following day. Post-operatively, he was cared for on the intensive therapy unit ("ITU") and transferred to the enhanced recovery unit a day later where he was reviewed by a senior doctor. A comprehensive entry in the medical records identified that Mr M was complaining of pain and that his oxygen saturation level had fallen. The senior doctor noted that Mr M's C-reactive protein[2] ("CRP") levels on 18 September were noted to be 75 rising from the previous day. The senior doctor reviewed Mr M on two further occasions, when he recorded some improvement in Mr M's oxygen saturations with the administration of pain medication and oxygen. However, on his last review, he noted that Mr M's blood test results still showed high white cell count and CRP levels.

5. Mr M was seen on Friday 19 September by the Consultant Colorectal Surgeon who carried out the surgery. The clinical records documented that, on examination, Mr M's observations were stable with no abdominal tenderness. Blood tests showed that Mr M's CRP levels were very markedly elevated to 454. The next day (Saturday), Mr M was seen by a doctor at 12.00pm. He was noted to be comfortable, but had not passed flatus (wind) or opened his bowels. It was planned to carry out further blood tests although there was no evidence that this was done. The records show that on Sunday 21 September his CRP levels had risen to 575. Mr M does not appear to have been reviewed by the medical team.

6. At 12.45am, in the early hours of Monday morning, there was a significant deterioration in Mr M's condition. He was reviewed by a surgical registrar an hour and a half later, and again by a consultant half an hour after that. Mr M underwent emergency surgery for a leak where the two ends of the bowel had been joined (anastomosis leak), but he developed severe sepsis (a potentially fatal complication of infection) and sadly died on Tuesday 23 September.

[2] A blood test marker for inflammation/infection in the body - the levels increase in response to inflammation/infection present

7. Mr M's family complained to the Health Board via their AM on 31 October. I have seen the protracted correspondence between the AM and the Health Board. Local resolution meetings were held to address their concerns and the Health Board carried out a series of investigations into Mr M's care and management following the planned surgery. The investigations did not identify any significant deficiencies in Mr M's treatment. The Health Board's investigation identified that there was a failure to give Mr M fluid resuscitation as well as a failure by the on-call surgical team to undertake a daily routine review on Sunday 21 September. The investigations concluded that, even if these failings had not occurred, Mr M's complications would not have been identified. A complaint response was sent to the family on 9 June 2015. The Health Board explained that there had been a delay in arranging a meeting to discuss the complaint. The family were aware of the personal reasons for that delay.

Ms A's evidence

8. Ms A said the post-operative care her father received was inadequate resulting in his death. She said that the family raised their concerns with nursing staff many times but these were ignored and not documented. Ms A said that had her father been reviewed by the on-call surgical team on 21 September, investigations could possibly have been instigated sooner. The family remained of the view that had Mr M received timely care and treatment he would still have been alive. Ms A said that she and her family have suffered immensely as a result of the Health Board's failings.

Professional advice

The Surgical Adviser

9. The Adviser noted that on 16 September Mr M had keyhole bowel surgery. The Adviser commented that, medically, there were relatively few entries by doctors between Mr M's departure from ITU on 17 September and his critical deterioration on 22 September.

10. The Adviser had two key concerns about Mr M's post-operative care: firstly, there had been a failure to review Mr M's blood results, in particular his CRP, despite plans to do so forming part of Mr M's management plan.

Secondly, there was a failure to escalate Mr M's test results for senior medical review given his abnormally high CRP levels.

11. The Adviser said that the Association of Coloproctology and the Association of Surgeons had issued guidance in 2016 which advocated that CRP levels should be used as a screening tool for anastomotic leaks after surgery. Whilst he noted that this was not available in 2014, he referred to an article published in the British Journal of Surgery in 2013, which highlighted that anastomotic leak was associated with high CRP levels. He noted that Mr M's CRP level was highly abnormal on the fourth post-operative day and higher still on the fifth post-operative day (see paragraphs 4 and 5). He said that this should have served as a trigger for further investigation. The Adviser commented that it was illogical for the team to be monitoring Mr M's inflammatory marker and then failing to act upon such abnormal results. He added that anastomotic leak is the main risk in a patient who has undergone bowel surgery. He said it was probable that Mr M's anastomotic leak would have been detectable on the third or fourth post-operative day, since his high CRP levels were likely to have been caused by the leak.

12. The Adviser said that CRP levels provide an indication that a anastomotic leak might have occurred. He noted that anastomotic leaks can occur without there being any marked physiological effects. He added that radiological imaging would have helped doctors to reach a diagnosis so they could decide about the need for surgical or conservative management of Mr M's care. The Adviser noted that the Health Board had chosen to believe that the anastomotic leak had occurred on the evening of 22 September following his catastrophic collapse and was undetectable before then. The Adviser added that this was not the usual pattern of this illness. He said that patients are often mildly unwell for a few days before becoming profoundly ill. He said that the guidelines referred to above (see paragraph 11) showed that it is often possible to detect such a leak before a patient becomes catastrophically ill. He said that in Mr M's case the rise in CRP levels was a clear indication that an anastomotic leak was a possibility and needed to be excluded.

13. The Adviser noted that Mr M was reviewed by a surgical doctor at 12.45am on 22 September. At this point, Mr M was profoundly unwell with observations consistent with sepsis. The surgical doctor correctly surmised an anastomotic leak as the likely cause. The prescription chart did not show

that Mr M received fluid resuscitation (where fluid is administered to counter the abnormal effects of sepsis on the circulation) and/or antibiotics before a more senior doctor reviewed him at 2.15am. He noted that Mr M was reviewed by a consultant half an hour later. The Adviser added that early administration of antibiotics with fluid resuscitation and rapid action to deal with the source of the sepsis are the cornerstones of effective management. The medical records did not show that these basic steps were undertaken. He added however, that it is improbable that Mr M would have survived even had best practice been followed at this time.

14. The Adviser noted that Mr M had been placed on an early recovery after surgery pathway. He said therefore the expectation would have been that Mr M would be discharged from hospital within a few days of his operation. The Adviser said that Mr M had not made sufficient progress for discharge to have been considered. The Adviser noted Mr M's family's assertion that they told ward staff that they felt he was becoming less well. The Adviser said that the failure to progress, along with the concerns of his family, might have triggered further investigation notwithstanding the CRP abnormalities already described.

15. The Adviser concluded that, had Mr M's anastomotic leak been detected on the 19, 20, or 21 September, before he became so catastrophically unwell, on the balance of probability his life could have been saved. He added that the fact that Mr M had vomited black fluid on 21 September should have been reported to medical staff. He said that this can be a sign of bleeding in the stomach and would have alerted clinicians to the fact that Mr M was not recovering as smoothly as they had hoped.

The Nursing Adviser

16. The Adviser noted that, on 19 September, Mr M's oxygen saturation levels had decreased and his National Early Warning Score ("NEWS" - a tool used to assess a patient and alert the clinical team to any medical deterioration and triggering a timely clinical response) increased. She added that according to the Royal College of Physicians' guidance, such decreasing oxygen levels require a registered nurse to urgently inform the medical team caring for the patient. This did not occur. That said, the Adviser was not critical of this because the nurse correctly checked Mr M's observations within

ten minutes, by which time his oxygen saturation levels had increased, reducing the overall NEWS score. She noted that the score remained at four throughout the day.

17. The Adviser noted an entry at 7.00pm on 21 September, that Mr M had vomited, and that it was dark in colour. The time when vomiting occurred was not recorded, and a fluid intake/output chart was not commenced until 1.00am the following morning (22 September). The Adviser said that black vomit is usually caused by bleeding in the upper gastrointestinal tract, and even if observations were within normal parameters, as they were in Mr M's situation, it should still have triggered a request for medical review.
She noted that a nursing entry in the records documented "medics to review tonight". However, there was no indication that a request for medical review was made at the time the vomiting occurred.

18. On 22 September, Mr M experienced an episode of acute rectal bleeding. Nursing staff appropriately escalated their concerns and he was seen and reviewed by a surgical doctor at 12.45am, and later by a consultant surgeon. Mr M agreed to emergency surgery, following which he was transferred to ITU. Mr M's family were contacted and informed of the events. However, when the family arrived at the Hospital, Mr M had been taken to theatre. Nursing records show that the family was aware of Mr M's poor condition and that they had spoken with the Consultant. On the morning of 23 September, nursing records noted that Mr M's daughters visited him overnight and were updated about his deterioration in the early morning. It was noted that the nursing staff were awaiting a consultant decision.

19. The Adviser noted that there were some issues with record keeping which the Health Board had taken reasonable steps to address and that there was evidence of communication with the family. The Adviser noted Ms A had stated that she raised concerns with nursing staff about her father's deterioration, but these had been ignored and not documented. The Adviser added that, when considered overall, nursing staff did respond appropriately and escalate concerns about signs of acute deterioration in Mr M's condition post-surgery.

The Health Board's evidence

20. My investigator shared the professional advice with the Health Board. The Health Board said that Mr M's observations (pulse, temperature and blood pressure) showed that the perforation occurred on the Sunday evening (21 September). It added that Mr M's raised CRP levels were probably a marker that a perforation was likely to have occurred. The Health Board said that it would monitor and take note of raised CRP levels in patients who had undergone bowel surgery and bring these results to the attention of senior doctors. The Health Board said that at the time it did not have a functioning clinical portal available throughout the Hospital. A portal is now available and allows consultants to check blood test results for patients under their care from anywhere in the Hospital.

21. The Health Board said that it had learnt the importance of regular ward rounds by an experienced doctor on weekends to try to identify deteriorating patients early. It added that recognition and responding to acutely ill patients and the use of the sepsis care pathway were its key priorities. It said that regular audits had shown that both these areas were improving.

Analysis and conclusions

22. I would firstly like to offer to Ms A and her family my sincere condolences. It is clear from Ms A's correspondence and my investigator's conversations with her how deeply these events have affected her and her family and I recognise that they will find much of the detail in this report distressing. That said, I am conscious that the family have been left with uncertainty surrounding the quality of Mr M's post-operative care.

23. In reaching my conclusions, I have considered carefully all of the information before me, including the reports I have received from my Professional Advisers, whose advice I accept. However, the conclusions reached are my own.

24. The Surgical Adviser highlighted that raised CRP levels are a screening tool used to identify a potential anastomotic leak following bowel surgery. It appears from Mr M's clinical records that repeated blood tests were carried out to measure Mr M's CRP levels, but the results were not reviewed, resulting in missed opportunities for earlier intervention. In my view, the

significant clinical deficiency in this case was the failure to recognise and then monitor Mr M's increasingly abnormal CRP levels. The Health Board itself acknowledged that Mr M was not reviewed on the Sunday. Furthermore, when Mr M became seriously ill on 22 September, there was no system in place to ensure prompt intervention in the form of antibiotics and fluid resuscitation while more senior clinician review was awaited.

25. I am of the view that the clinical shortcomings in this case were fundamental, and to that extent, unacceptable. My role is in part to consider outcomes based on the balance of probability. I am mindful that any surgery carries a degree of risk. However, I cannot rule out the possibility that, had clinicians intervened sooner, this could have led to a very different outcome for Mr M, who eventually succumbed to sepsis. I therefore **uphold** the complaint about the post-operative care and treatment provided to Mr M. The Health Board's service failure caused a significant injustice to Ms A and her family as they will never know whether Mr M's life could have been saved and they will always know that opportunities were missed. To reflect this injustice I am therefore recommending financial redress. I would like to stress that this is in no way to be seen as compensation for the family's loss, but rather to reflect the injustice to Ms A.

26. Turning to the Health Board's complaint handling, the Health Board has throughout the course of the lengthy complaints process, maintained that broadly, Mr M's treatment was appropriate. I am concerned that the Health Board failed to identify the extent of the failings found by my Advisers, which suggests that its own review of Mr M's care lacked sufficient depth and rigour. In reviewing the care of a patient following the submission of a complaint, it is vital that a robust investigation is undertaken, which includes the ability to retrospectively assess the standard of care delivered in an objective manner. I am disappointed that the Health Board's own consideration of Ms A's complaint fell significantly short of what I regard as acceptable. Furthermore, the Health Board, from receipt of Ms A's initial letter of complaint, took in excess of eight months to produce its formal response. In my view, the complexity of Mr M's case meant that some delay in the Health Board providing a response was inevitable. However, I consider eight months to be unreasonable. In view of the shortcomings in complaint handling identified by my investigation, I also **uphold** this aspect of Ms A's complaint. I am recommending financial redress to reflect Ms A's time and trouble in pursuing the complaint.

Recommendations

27. I **recommend** that:

Within **one** month:

(a) The Health Board provides a fulsome apology to Ms A both for the significant clinical failings I have identified and for the inadequate investigation of her complaint.

(b) The Health Board pays Ms A the sum of £8,000 for the distress and uncertainty caused by the failings identified. The Health Board should also provide a further payment of £350 to Ms A in recognition of the shortcomings in complaint handling.

Within **two** months:

(c) The Health Board should ensure that the guidelines issued by the Association of Coloproctology and the Association of Surgeons are brought to the attention of its medical staff highlighting the importance of recognising that raised CRP levels is a marker that an anastomotic leak was likely to have occurred.

(d) The Health Board should discuss the contents of this report at an appropriate consultant forum and at junior doctors' teaching sessions.

(e) As part of a wider learning process, this report should be shared with the clinical staff within the colorectal team who delivered the care to Mr M.

(f) A copy of this report should be shared with the Chair of the Health Board and its Patient Safety and Clinical Governance Group.

28. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Nick Bennett Date 19 October 2016
Ombudsman

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