The investigation of a complaint

by Ms D

against Hywel Dda University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201604287

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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 D.

Summary

Ms D complained about the care and treatment that her late father, Mr F, received at Prince Philip Hospital when, on the day that he was due to be discharged following a hip replacement operation, he rapidly deteriorated, suffered a cardiac arrest and, sadly, died. Ms D complained that clinicians were slow to respond to Mr F's deterioration and, consequently, any opportunity there may have been to stabilise his condition was lost. Ms D also complained that clinicians failed to advise the family of Mr F's poor prognosis and subsequently failed to provide the family with a clear explanation of the cause of Mr F's deterioration and death. Finally, Ms D complained that the Health Board's handling of her complaint about these matters was unnecessarily protracted and added to the family's distress.

The Ombudsman, assisted by his Clinical Advisers, upheld Ms D's complaints. He found that an incomplete provisional diagnosis of Mr F's condition was made by two junior doctors who were inadequately supported by senior physicians. The junior doctors failed to identify that Mr F was in cardiac failure. Whilst it was not possible to say that this directly led to Mr F's death (given his comorbidities and poor prognosis), the Ombudsman considered that the uncertainty surrounding this matter amounts to a significant injustice to the family. The Ombudsman also found that, as a result of this initial failing, the family was not accurately advised of Mr F's poor prognosis or, subsequently, of the precise cause of his death. Finally, the Ombudsman found that there were substantial delays in the Health Board responding to the family's complaint. The Ombudsman recommended that:

a) The Health Board provides Ms D with a fulsome written apology for the identified failings, and, in recognition of the distress and injustice caused to the family, makes a payment to them of £2,500 plus £250 for its poor complaint handling.

b) The Health Board produces a detailed, written escalation policy and makes this available to medical and surgical clinicians of all grades at Prince Philip Hospital.

c) The Health Board demonstrates that it has reminded physicians (particularly consultants) working in the Trauma & Orthopaedic Department, of the requirement to conduct and record a daily, documented review of patients in accordance with guidance issued by the Academy of Medical Royal Colleges and by the Royal College of Physicians.

d) The Health Board demonstrates that it has reminded all middle-grade and senior doctors at Prince Philip Hospital of their obligation to adequately support and supervise junior doctors in accordance with General Medical Council and other guidance.

e) The Health Board urgently reviews its pre-operative assessment protocol to ensure that patients with cardiac risk-factors are identified and receive an appropriate, documented, clinical management plan in advance of any surgery.

f) The Health Board demonstrates that it has taken steps to ensure that clinicians at Prince Philip Hospital are made aware of the role of, and means of liaising with, the Medical Emergency Team in responding to critically ill patients.

g) The Health Board reminds Trauma and Orthopaedic Nurses at Prince Philip Hospital that it is good practice to conduct physiological observations on patients on the day of their discharge.

h) The Health Board reminds the Concerns Team of the need to comply with timescales set out in Putting Things Right regulations and to provide explanations to complainants of unforeseen delays in the production of responses.

The Complaint

1. Ms D complained to me about the care and treatment that her late father, Mr F, received at Prince Philip Hospital ("the Hospital") when, on the day that he was due to be discharged following a hip replacement operation, he rapidly deteriorated, suffered a cardiac arrest and, sadly, died.

Ms D complained that:

- Clinicians failed to respond to Mr F's deteriorating condition in an appropriate and timely manner and, consequently, any opportunity there may have been to stabilise his condition and/or to reverse his deterioration was lost.

- Clinicians failed to advise the family of Mr F's poor prognosis.

- The Health Board failed to provide the family with a clear explanation of the cause of Mr F's deterioration and death.

- The Health Board's subsequent handling of her complaint about Mr F's care was unnecessarily protracted and added to the family's distress.

Investigation

2. I obtained comments and copies of relevant documents from Hywel Dda University Health Board ("the Health Board") and considered those in conjunction with the evidence provided by Ms D. Clinical advice was obtained from Dr Richard McGonigle - a Consultant Physician, and from Ms Elizabeth Onslow - a Senior Registered Nurse, both with many years' experience. I refer to them throughout as, respectively, the Medical Adviser and the Nursing Adviser. Whilst I have not exhaustively recorded in this report every detail of the information that the investigation considered, I am satisfied that nothing of significance has been overlooked.

3. Both Ms D and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Background events

4. On 6 May **2014**, Mr F, then aged 79, was admitted to the Hospital's trauma and orthopaedic ward for a scheduled, right, total hip replacement operation. His medical history included chronic kidney disease, type-2 diabetes (controlled by diet), high blood pressure (hypertension) and a mini-stroke event in 2008.[1]

5. Mr F's hip replacement operation was carried out on 6 May without complication by a Consultant Orthopaedic Surgeon ("the Consultant"). The following day, Mr F was eating and drinking well and, whilst he had some difficulty mobilising, was considered to be clinically stable.

6. Mr F was seen by a junior doctor on 7 May who recorded that his right leg was "ok" and who noted a slightly raised level of creatinine (indicative of impaired kidney function). However, medical and nursing records for the 8, 9 and 10 May indicate that Mr F was not seen by a doctor on any of these days. During this time, nurses recorded that his urine output was low and dark in colour and that his blood pressure was low on the 8 and 9 May. It was also recorded that Mr F's surgical wound was oozing non-infected, watery plasma, requiring regular re-dressing. The nursing records indicate that Mr F was seen by a Second Consultant Surgeon on 11 May and by the Consultant on 12 and 13 May. However, neither Consultant recorded their reviews of Mr F.

7. On the morning of 14 May, Mr F was seen by a junior doctor who noted an improvement in his creatinine level and recorded that Mr F was "going home". At 12.00pm and 1.55pm Mr F's wound was assessed and a slight ooze was noted. At 5.00pm nurses recorded that discharge documentation had been completed and that arrangements were in place for Mr F's family to collect him from the Hospital that evening.

8. Shortly after their arrival, the family reported to nurses (at 6.20pm) that Mr F was hot and clammy. His observations were recorded by nurses and indicated a raised temperature and a low blood pressure. A Charge Nurse attended Mr F at 6.30pm and, on advice from the on-call

[1] A mini stroke occurs when part of the brain experiences a temporary lack of blood flow. Unlike a stroke, a mini-stroke doesn't cause permanent disability.

Surgical Doctor ("the First Junior Doctor"), administered oxygen and conducted an ECG.[2] The First Junior Doctor attended Mr F at 7.15pm and recorded his impression that he had symptoms of sepsis,[3] probably caused by an intestinal obstruction. The First Junior Doctor initiated the sepsis protocol[4] and arranged chest and abdominal X-rays when Mr F appeared to vomit faecal fluid.[5] On returning from his abdominal X-ray, Mr F was seen (at 10.00pm) by a junior doctor from the on-call medical team ("the Second Junior Doctor"). The Second Junior Doctor discussed Mr F's symptoms with the Medical Registrar who agreed to review the abdominal X-ray as soon as it was available.

9. Mr F's abdominal X-ray indicated an obstruction. The Medical Registrar advised that, as emergency surgery may be required (and given that there was no on-call surgical team at the Hospital), the on-call Surgical Registrar based in Glangwili Hospital ("the Second Hospital") should be contacted. In a telephone discussion, the Surgical Registrar advised the Second Junior Doctor to arrange for Mr F to have a more detailed abdominal scan (a CT scan) and to aspirate the contents of Mr F's stomach via a naso-gastric tube.[6] This was done at 11.30pm and 200mls of "offensive smelling dark brown liquid" was aspirated. At 11.45pm, Mr F was taken for his CT scan. The Second Junior Doctor then attempted to contact the Surgical Registrar at the Second Hospital again (to request that he review the scan result) but the Surgical Registrar did not respond. The Second Junior Doctor therefore requested that the Medical Registrar review the scan, but he was unable to do so, as he was dealing with another emergency.

10. On returning to the ward, Mr F stated that he was feeling somewhat better and appeared to stabilise. In view of this, the family left the Hospital and returned home to allow Mr F to rest. The Second Junior Doctor then

[2] An ECG or electrocardiogram is a test that checks for problems with the electrical activity of the heart.
[3] Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs.
[4] The Sepsis Protocol involves administering oxygen, intravenous fluid, and intravenous antibiotics. It also involves conducting a blood culture test (a test to check for bacteria or other microorganisms in the blood), a test for lactic acid in the blood (which increases during heart failure, severe infection or shock) and the monitoring of urine output.
[5] A condition suggestive of a twist in a section of the intestine that has caused a backup of faecal matter all the way to the opening of the stomach.
[6] Nasogastric aspiration is a process involving the insertion of a plastic tube through the nose, past the throat, and down into the stomach. The stomach content can then be suctioned with a syringe.

contacted the Surgical Registrar again, but was told that he did not wish to discuss the CT scan over the telephone and would only do so when the results were formally reported by the Radiologist.

11. At 1.50am on 15 May, the Second Junior Doctor was called back to the ward when nurses recorded an alarming drop in Mr F's blood pressure. However, before arriving on the ward, the Second Junior Doctor received an emergency bleep informing her that Mr F had gone into cardiac arrest. Sadly, attempts to revive Mr F were unsuccessful and he died at 2.20am.[7]

12. Mr F's post mortem report subsequently identified the cause of his death as:

- Cardiac failure
- Myocardial (heart muscle) ischaemia[8]
- Coronary artery atheroma[9]
- Secondary ischaemic bowel changes (which developed as a consequence of impaired cardiac function).

13. On 16 May, Ms D raised a verbal concern about Mr F's care with the Health Board before submitting a formal letter of complaint on 25 June. Mr F's family met with the Consultant and nursing staff on 22 September to discuss the complaint issues ahead of a formal written response. The response, together with an Action Plan,[10] was provided on 13 August 2015 (as a result of Ms D requesting the intervention of my office). Further meetings were held with clinicians on 7 December 2014, 26 February and 19 May 2016. The family complained to me in October 2016.

Ms D's evidence

14. In her initial complaint to the Health Board, Ms D described how, on the day of Mr F's discharge, clinicians had failed to observe that he was clearly unwell and would not have done so if the family had not brought this to their

[7] The records indicate that an attempt was made to contact the family at about 2.00am but they had not yet arrived home at that point.
[8] Ischaemia is a restriction in blood supply to tissues, causing a shortage of oxygen and the 'death' of tissue.
[9] Atheroma: degeneration of the walls of the arteries caused by accumulated fatty deposits leading to restriction of the circulation.
[10] The Action Plan set out measures that would be taken to address the identified failings in nursing care and in record keeping.

attention. Mr F was hot and clammy and his abdomen was distended and painful. Mr F told Ms D that he had not had a bowel movement since his admission on 6 May and the family relayed this to nurses who subsequently admonished Mr F for not informing them of this. Ms D questioned whether the failure of clinicians to detect Mr F's deterioration sooner was based on an assumption that their duty of care ended once he was declared fit for discharge.

15. Ms D described how, following his CT scan, Mr F's condition appeared to stabilise and how, on this basis, the family decided to leave the Hospital and return in the morning. Ms D said that she did this because no one advised her that her father's condition was life-threatening. However, shortly after arriving home Ms D received a telephone call to say that Mr F had rapidly deteriorated and, by the time she returned to the Hospital, he had suffered a cardiac arrest and had died. Ms D complained that she was therefore denied the opportunity of being with her father during his final hours.

16. With regard to the precise cause of Mr F's death, Ms D emphasised that, whilst she inferred from clinicians that a bowel blockage may have created a significant strain on his heart, this was not clearly and explicitly stated in the Health Board's complaint correspondence.

The Health Board's evidence

17. At a meeting with the family, the Consultant stated that, on 14 May, Mr F was considered fit to be discharged home and his medical notes had been subsequently reviewed by the Clinical Director who concluded that, despite shortcomings in Mr F's care, the outcome for him would not have been different. The Consultant also stated that, although Mr F was constipated and this should have been addressed sooner, the CT scan showed that the bowel was not impacted. Thus, Mr F's constipation had no bearing on his ischaemic bowel disease and played no part in his deterioration and death.

18. In the Health Board's formal complaint response letter of 13 August 2015, the Chief Executive (the CEO) noted that, whilst nurses did not conduct a final set of observations before Mr F's discharge, his wound was assessed at 1.55pm and, at that time, there was no indication

that he was unwell. With regard to whether the family was properly advised as to Mr F's poor prognosis, the CEO said that nurses would have advised the family to stay if they had felt that Mr F was seriously ill. He observed that the ECG conducted on 14 May appeared normal and that, in any event, an ECG does not show if a person has heart failure. The Health Board confirmed that an ECG was not conducted at Mr F's pre-operative clinic appointment.

19. The Health Board stated that it does not have a written escalation policy for medical staff to seek advice from senior colleagues and that escalation is achieved by nursing staff expressing concerns (usually identified by a raised NEWS[11] score) to a junior doctor who may then escalate to the Registrar and on to the relevant Consultant. Referral to the Critical Care Unit is achieved via discussion with the duty Medical Middle Grade Doctor. The Health Board also confirmed that it does not have a policy governing the frequency of patient reviews, but operates in accordance with 'Good Surgical Practice' guidance issued by the Royal College of Surgeons. That is, each patient should be reviewed daily by a senior physician/surgeon and a member of the on-call team at weekends.

20. The CEO said that the approach taken by medical and surgical clinicians was appropriate and, whilst consideration was given to transferring Mr F to the Second Hospital for emergency surgical intervention, the on-call Surgical Registrar wanted to have the CT report from the Radiologist before initiating this. If the diagnosis had been made prior to Mr F's deterioration, it is likely he would have been a candidate for emergency surgery. However, based on his numerous medical conditions, the CEO said it was unlikely, on the balance of probabilities, that Mr F would have survived such surgery. With regard to Mr F's medical records and the absence of entries made by clinicians, the CEO agreed that this was unacceptable and apologised to the family. The CEO also apologised for the delay in the Health Board's provision of its formal response and offered Ms D an ex-gratia payment of £250 in recognition of her time and trouble, but Ms D declined to accept this offer.

[11] NEWS: National Early Warning Score: A system in which a numerical score is allocated to measurements of respiratory rate, oxygen saturation, temperature, blood pressure, pulse rate and level of consciousness. The subsequent level of clinical response required is based on the aggregated score. A raised score (above 5) usually indicates the need to increase the frequency of monitoring to half-hourly.

21. At a further meeting on 19 June 2016, a Consultant General Surgeon said that the cause of Mr F's death was an ischaemic bowel and that, sadly, death was inevitable. He added that it was clear that Mr F had significant heart disease, but the extent of this may not have been obvious. He agreed that it would have been more appropriate for Mr F to have been cared for on a ward for acutely unwell patients, rather than an orthopaedic ward.

22. In its communications with my office, the Health Board stated that the protracted nature of its handling of the family's complaint under PTR[12] was partly attributable to the need to consult with the Health Board's solicitor as a result of a clinical negligence claim being submitted by Mr F's family in December 2014. However, the claim was withdrawn following the Health Board's issuing of its formal complaint response on 13 August 2015.

Professional advice

Medical

23. The Medical Adviser began by considering whether clinicians recognised and appropriately responded to Mr F's deteriorating condition. He said that, whilst Mr F's deterioration was recognised, an incorrect provisional diagnosis (of sepsis and/or possible intestinal obstruction) was made without adequate senior medical support. Mr F's actual condition of cardiac failure was never considered. Consequently, the ensuing clinical management plan was not appropriate for Mr F's condition.

24. The Medical Adviser noted that, contrary to established guidelines[13], there were no medical record entries made by clinicians between 8 and 12 May. Whilst nurses recorded that Mr F was seen by Consultants on 11, 12 and 13 May, the Consultants did not record their reviews or any decisions made about Mr F's clinical care. On 14 May, an untimed entry made by a junior doctor acknowledged that Mr F was to be discharged, but, again, there is no evidence that Mr F was examined or reviewed at this time.

[12] PTR: Putting Things Right: The NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011.
[13] For example, GMC Good Medical Practice 2013 (19-21).

25. The Medical Adviser was unable to identify any evidence that Mr F's condition deteriorated before 14 May. He observed that Mr F's NEWS scores were stable and satisfactory post-operatively, but added that it is possible (though not confirmed) that Mr F may have been developing cardiac problems before this. He added that, if this were the case, the intravenous fluids administered on 14 May would have worsened Mr F's cardiac failure.

26. With regard to whether the family was advised of Mr F's poor prognosis, the Medical Adviser stressed that the diagnosis was unclear and that the junior doctors appeared to be struggling to manage Mr F without adequate support.[14] Consequently, as far as the Medical Adviser could ascertain, the family was not accurately advised of the seriousness of Mr F's condition.

27. The Medical Adviser stated that it should not have been left to two junior doctors to manage Mr F's deteriorating condition without better support. The Critical Care Outreach Team (or, in this case, the Hospital's equivalent Medical Emergency Team – MET)[15] should have been contacted, together with the responsible Consultant. Also, the Medical and Surgical Registrars should have been in attendance. The Medical Adviser considered that it was not appropriate for the Surgical Registrar to insist on a CT scan result before considering Mr F's transfer. Rather, he should have referred Mr F to the MET.

28. The Medical Adviser said that whilst, initially, sepsis and/or intestinal obstruction was suspected, it appears that, even after the post-mortem result was available, the Health Board's statements about the cause of Mr F's death only refer to intestinal ischaemia. Cardiac failure and ischaemic heart disease were never explicitly discussed in the explanations given to the family about what caused Mr F's deterioration and death.

[14] Contrary to GMC Good Medical Practice 2013 (40).
[15] In its response to the draft report, the Health Board explained that it does not currently have a Critical Outreach Team but that it operates a Medical Emergency Team (MET), whose role is to respond to patients with a rapidly deteriorating clinical condition.

29. The Medical Adviser added that:

- A chest X-ray and ECG were not performed before surgery. This was a failing in a hypertensive patient with type-2 diabetes and a history of mini-stroke.

- The ECG conducted on 14 May recorded changes or waves suggestive of cardiac ischaemia; it did not appear 'normal' as stated by the Health Board.

- The Health Board stated that it does not have a written escalation policy, but a recommendation that emerged from the Health Board's investigation (referred to in the CEO's letter of 13 August 2015) stated that a written escalation procedure would be developed for dealing with acutely ill patients within the Hospital.

30. The Medical Adviser concluded by stating that, whilst it is not possible to say that Mr F's death was avoidable (in view of his comorbidities[16] and poor prognosis), the identified failings, taken together, raise doubts about the Health Board's suggestion that Mr F's death was inevitable.

Nursing

31. The Nursing Adviser began by noting that, throughout Mr F's admission, his physiological observations were appropriately recorded using the NEWS system. On the basis of these recordings, there was no indication that Mr F was deteriorating before the 14 May. However, contrary to established good practice, no physiological observations were recorded on the morning of Mr F's discharge. The Nursing Adviser said that, once recognised, nursing staff responded appropriately to Mr F's deterioration and promptly escalated his condition to the surgical doctor on call.

32. The Nursing Adviser said that the Health Board's formal response of 13 August 2015 was thorough and identified a number of failings in nursing care and in maintaining nursing records. In her view, the actions taken to address these failings (as these are outlined in the Health Board's action plan) were entirely reasonable.

[16] That is, his range of accompanying illnesses and medical conditions.

33. With regard to whether nurses omitted the opportunity to advise the family of Mr F's poor prognosis, the Nursing Adviser said that, whilst there is no evidence that the family were contacted by nursing staff, it would appear, from the complaint correspondence, that family members were present at the time of Mr F's initial deterioration. Results of the CT scan and planned interventions should have been discussed with the family by medical staff.

34. In conclusion, the Nursing Adviser noted that, as nursing observations were not taken or recorded on the morning of discharge, there is no way of knowing if deterioration could have been detected earlier. Also, nursing staff should have escalated concerns about Mr F's report of not having a bowel movement for seven days. However, this failing did not have a causal link to his subsequent acute deterioration.

Analysis and conclusions

35. In reaching my conclusions, I have been assisted by the advice and explanations of both Advisers, which I accept in full. The investigation has considered four complaint elements and I will address each of them in turn:

Clinicians failed to respond to Mr F's deteriorating condition in an appropriate and timely manner and, consequently, any opportunity there may have been to stabilise his condition and/or to reverse his deterioration was lost.

36. I concur with the Medical Adviser that, whilst clinicians promptly instigated a clinical management plan in response to Mr F's deteriorating condition on the evening of 14 May 2014, the plan was based on an erroneous provisional diagnosis of sepsis/intestinal obstruction and was therefore not appropriate for Mr F's condition. As such, the opportunity to respond to (and to possibly stabilise) Mr F's cardiac failure was lost.

37. I also agree that critical decisions surrounding the diagnosis and treatment of Mr F's condition should not have been left to two junior doctors who, as their attempts to escalate their concerns demonstrate, were clearly in need of the support and experience of senior clinicians. It is especially

concerning that neither the Medical nor the Surgical Registrar thought to alert the MET or the Duty Consultant to Mr F's deteriorating condition (or to instruct the junior doctors to do this).

38. It is additionally concerning that:

- The Medical Registrar based in the Hospital did not attend Mr F.
- The Surgical Registrar inappropriately insisted on receiving a radiologist's report of the CT scan before considering Mr F's transfer.
- The ECG was not reviewed by a senior clinician who may have identified changes suggestive of cardiac ischaemia.
- The intravenous fluids administered on 14 May might have worsened Mr F's cardiac failure.
- Nurses failed to record Mr F's observations on the day of his discharge.

39. I also note the Medical Adviser's view that, although Mr F's medical history placed him at high risk for ischaemic heart disease, he did not have an ECG or chest X-ray at the pre-operative assessment stage or at any time prior to surgery. Further, it appears that whilst there is no obvious evidence of Mr F deteriorating before 14 May, the available records consist of scant, post-operative nursing notes which are (understandably) mainly concerned with Mr F's wound care and mobilisation. Given that Mr F was not seen by any doctor for three days after his surgery and that the Consultants who saw Mr F did not record their reviews or any decisions made about his care, the records are almost entirely devoid of relevant clinical information that might have alerted physicians to the need to consider Mr F's cardiac health.

40. In conclusion, I consider these failings to be serious, and, taken together, create uncertainty around the question of whether Mr F's death was, as the Health Board suggested, inevitable. Whilst, ultimately, this matter cannot be definitively determined (in view of Mr F's co-morbidities and poor prognosis), for Ms D and her family there will always be an element of doubt surrounding this. I am therefore of the view that the

distress and uncertainty arising from this element of doubt is, in itself, a significant injustice to the family which, had Mr F's care been of a higher standard, could have been avoided. I therefore **uphold** this complaint.

Clinicians failed to advise the family of Mr Fs' poor prognosis

41. I acknowledge that the family's decision to leave the Hospital at around 1.30am on 15 May (in order to allow Mr F to rest), was based on the fact that Mr F, on his return from undergoing his CT scan (and following further aspiration of his stomach contents), told the family and clinicians that he was feeling somewhat better and appeared to have stabilised.

42. However, it remains the case that the incorrect provisional diagnosis, together with the failure to escalate Mr F to the MET, conveyed the impression to the family that, although Mr F required intervention to clear an intestinal blockage, his condition was not immediately life-threatening. There was, therefore, a significant failure to accurately advise the family about his diagnosis and prognosis. The consequence of this failure was that the family were not at Mr F's side when he died. This will remain for the family a source of distress and anguish. I therefore **uphold** this complaint.

The Health Board failed to provide the family with a clear explanation of the cause of Mr F's deterioration and death

43. I agree with the Medical Adviser that the Health Board's references to the cause of Mr F's death throughout the complaint process were narrowly focussed on his ischaemic bowel disease and made no comment on its failure to identify and respond to his cardiac deterioration. Moreover, the Consultant General Surgeon explicitly stated that the cause of death was an ischaemic bowel and that, sadly, death was inevitable. He added that it was clear that Mr F had significant heart disease but "the extent of this may not have been obvious".

44. I am therefore of the view that, whilst there is no evidence to suggest that there was any intention on the part of clinicians to mislead the family on this point, the Health Board has nowhere acknowledged the incorrect provisional diagnosis and its implications, or that the family was misinformed

on this matter (albeit inadvertently). Consequently, it failed to provide the family with a clear explanation of the cause of Mr F's deterioration and death. As such, I **uphold** this complaint.

The Health Board's subsequent handling of Ms D's complaint about Mr F's care was unnecessarily protracted and added to the family's distress

45. I have carefully considered the sequence of events in the Health Board's handling of Ms D's complaint and, having done so, I accept that the complaint handling process was, in part, prolonged by the family's decision to seek a number of meetings with clinicians before and after receiving the Health Board's formal response to the complaint. The Health Board also suggested that the production of its formal complaint response was delayed by the family's submission of a potential clinical negligence claim in December 2014. However, whilst I accept that this development required the Health Board to obtain legal advice, I have seen no evidence to suggest that this process led to any deferral or suspension of the PTR process, or that any reference was made to the claim in communications with the family during the life of the complaint.

46. In any event, it took the Health Board more than 13 months to compile and issue its formal response to the complaint and, moreover, this would have been longer had Ms D not requested my office to intervene on her behalf (in July 2015) to obtain a response. It is also the case that, whilst the Health Board apologised for exceeding the PTR timescale (and offered the family an ex-gratia payment of £250 in recognition of the trouble to which they were put), it did not provide the family with any satisfactory explanation for the delay.

47. In conclusion, I consider that the protracted nature of the Health Board's complaint handling in this case would have significantly prolonged the family's distress. I therefore **uphold** this complaint.

Recommendations

48. I **recommend** that, within **one month** of the final version of this report being issued:

a) The Health Board provides Ms D with a fulsome written apology for the failings set out in this report, and, in recognition of the distress and injustice to the family that has been identified, makes a payment to them of £2,500 plus £250 for its poor complaint handling.

I further **recommend** that, within **three months** of the final report being issued:

b) The Health Board produces a detailed, written escalation policy and makes this available to medical and surgical clinicians of all grades at Prince Philip Hospital.

c) The Health Board demonstrates that it has reminded physicians (particularly consultants) working in the Trauma & Orthopaedic Department, of the requirement to conduct and record a daily, documented review of patients in accordance with guidance issued by the Academy of Medical Royal Colleges and by the Royal College of Physicians.[17]

d) The Health Board demonstrates that it has reminded all middle-grade and senior doctors at Prince Philip Hospital of their obligation to adequately support and supervise junior doctors in accordance with GMC and other guidance.

e) The Health Board urgently reviews its pre-operative assessment protocol to ensure that patients with cardiac risk-factors are identified and receive an appropriate, documented, clinical management plan in advance of any surgery.

[17] Respectively: 'Seven Day Consultant Present Care' (December 2012) and 'Report of the Future Hospital Commission' (2013).

f) The Health Board demonstrates that it has taken steps to ensure that clinicians at Prince Philip Hospital are made aware of the role of, and means of liaising with, the Medical Emergency Team in responding to critically ill patients.

g) The Health Board reminds Trauma and Orthopaedic Nurses at Prince Philip Hospital that it is good practice to conduct physiological observations on patients on the day of their discharge.

h) The Health Board reminds the Concerns Team of the need to comply with timescales set out in PTR regulations and to provide explanations to complainants of unforeseen delays in the production of responses.

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

Nick Bennett 10 October 2017
Ombudsman

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
Email: ask@ombudsman-wales.org.uk
Follow us on Twitter: @OmbudsmanWales