The investigation of a complaint by Ms X against Cwm Taf University Health Board

A report by the Public Services Ombudsman for Wales
Case: 201700714

Contents

Introduction

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

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Ms X and her late brother as Mr Y.

Summary

Ms X complained about the care and treatment provided to her late brother, Mr Y, during two admissions to Prince Charles Hospital ("the Hospital") in April 2015. Ms X complained about whether it had been clinically appropriate to discharge Mr Y following his first admission. Ms X was also concerned about the care provided to Mr Y during his second hospital admission and whether any action could have been taken to prevent Mr Y's bowel from perforating and sepsis developing, from which Mr Y sadly did not recover.

The Ombudsman found that the decision to discharge Mr Y following his first admission was reasonable and did not uphold this element of the complaint. During Mr Y's second hospital admission, the Ombudsman found that there were a number of shortcomings in the care and treatment provided which fell well below reasonable standards. The response to Mr Y's deterioration was highly unsatisfactory and sepsis should have been recognised and treated earlier. A severe complication of colitis (dilation of the colon) was not identified promptly which led to the perforation of Mr Y's colon and critical illness. This was a significant failing and clearly Mr Y should have undergone surgery sooner. The Ombudsman found that the delay significantly increased the likelihood of a poor outcome. The shortcomings in the identification and treatment of sepsis also increased the risk to Mr Y. The Health Board agreed with the Ombudsman's finding that Mr Y should have undergone surgery sooner which would have increased the chance of a more positive outcome for Mr Y. The Ombudsman upheld these complaints and recommended that the Health Board:

(a) Write a letter of apology to Ms X for the significant shortcomings in Mr Y's care.

(b) Provide financial redress of £4,500 to Ms X in respect of these shortcomings and the injustice caused to Mr Y in that he did not receive adequate treatment for the suffering he endured. This represents an injustice to Ms X and her family who will now have to live with the uncertainty of knowing that, had Mr Y received adequate treatment, it

would have increased his chances of survival and in recognition of the real uncertainty which remains as to whether the outcome for Mr Y could have been different if Mr Y had undergone surgery sooner.

(c) Ensure that arrangements are in place for patients with severe colitis to be managed via a multidisciplinary approach with involvement and leadership by consultant gastroenterologists and consultant colorectal surgeons.

(d) Provide training for ward staff in communication with family and carers of vulnerable patients with a history of mental illness and of appropriate care pathways for such patients.

(e) Discuss the contents of this report with the Consultant Surgeon to emphasise the importance of providing clear and accurate information to complainants during Health Board investigations.

(f) Carry out an audit to ensure that the management of sepsis by medical staff is in line with national requirements and includes a protocol for escalation and clear care pathways.

(g) Carry out an audit to ensure that there is adequate consultant (physician and surgical) cover for gastroenterology patients at all times.

The Health Board agreed to implement these recommendations.

The Complaint

1. Ms X complained via her Community Health Council about the care and treatment provided to her late brother, Mr Y, during two admissions to Prince Charles Hospital ("the Hospital") in April 2015. Ms X was particularly concerned about

- whether it was clinically appropriate to discharge Mr Y on 14 April following his first admission

- whether the care provided to Mr Y during the second hospital admission was reasonable and appropriate

- whether any action could have been taken to prevent Mr Y's bowel from perforating and sepsis from developing, from which Mr Y sadly did not recover.

Investigation

2. I obtained comments and copies of relevant documents from Cwm Taf University Health Board ("the Health Board") and considered those in conjunction with the evidence provided by Ms X. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

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

4. In investigating this complaint, I took advice from two of my Clinical Advisers, ("the First Adviser" and "the Second Adviser"). The First Adviser, Dr Imroz Salam, is a Consultant Physician with a special interest in Gastroenterology. The Second Adviser, Mr Douglas Bowley, is a General Surgeon who was appointed as a Consultant Colorectal Surgeon in 2005 and is a Member of the Association of Coloproctology of Great Britain and Ireland.

The background events

5. Mr Y, a 55-year-old man, was admitted to Prince Charles Hospital on 2 April **2015** via the Emergency Department ("ED") with severe abdominal pain. It was noted in the medical records that Mr Y had a year's history of intermittent rectal bleeding and had suffered significant weight loss of two stone in the preceding three weeks. A medical history of depression and previous alcohol misuse was recorded. Mr Y was examined by a junior doctor who noted in the medical records that Mr Y had a possible gastrointestinal bleed (a bleed within the oesophagus, stomach, small intestine, large intestine, or rectum). Mr Y was referred to gastroenterology (medical speciality that investigates and treats problems with the stomach and intestines).

6. On 7 April, Mr Y was reviewed for the first time by a Consultant Gastroenterologist ("the First Consultant Gastroenterologist"). It was noted in the medical records that tests were planned for Mr Y which included a specialised scan and colonoscopy (a procedure that uses a long, narrow, flexible, telescopic camera to look at the lining of the large bowel). A note in the medical records the same day reflected that Ms X was unhappy that nothing had previously been done for Mr Y.

7. On 8 April, Mr Y underwent a specialised scan which showed severe disease with colonic dilation (where the colon is swollen). Mr Y's C-reactive protein ("CRP") level (CRP is produced by the liver and a high concentration of CRP is a sign of inflammation in the body) had increased from the previous day and an urgent surgical review was requested by the First Consultant Gastroenterologist.

8. Mr Y was reviewed by a surgical registrar the same day, who recorded that Mr Y was to be conservatively managed and there was no need for surgical intervention at that time. Medical records show that treatment for acute severe colitis (an inflammatory bowel disease) was started.

9. Mr Y underwent a flexible sigmoidoscopy (a procedure to examine the rectum and lower colon) on 9 April and was found to have a dilated, swollen bowel with an ulcerated lining.

10. On 11 April, Mr Y was further reviewed by a consultant surgeon. It was noted in the medical records that the plan was to continue with medical conservative care and it was considered that no further acute surgical intervention was required.

11. By 12 April Mr Y's CRP had further reduced and the results of an abdominal X-ray were noted in the medical records by a junior doctor as a 'marked improvement in colon diameter'.

12. On 13 April, Mr Y was seen by another consultant gastroenterologist ("the Second Consultant Gastroenterologist") who noted in the medical records that Mr Y, who had previously been administered with intravenous ("IV") steroids (medication used to reduce inflammation which is passed through a tube directly into a vein), was now due to be prescribed with oral steroid medication. Mr Y was also seen by a member of the surgical team.

13. On 14 April, Mr Y was seen by the Second Consultant Gastroenterologist. It was noted in the medical records that the biopsy (small samples of body tissue) results following the colonoscopy were reported as 'minimally active chronic colitis'.

14. Mr Y was discharged on 14 April and it was planned for him to attend the Medical Day Unit ("MDU") for review a few days later.

15. On 17 April, Mr Y was readmitted to hospital having been found outside semi naked and confused, in the early hours of the morning. Mr Y was found to be suffering with hypothermia (reduced body temperature). Cardiac dysrhythmia (abnormal heart rhythm) was identified and a specialised scan of Mr Y's head was found to be normal. The history of recent admission was noted in the medical records. Mr Y was further reviewed by medical staff on 18 and 20 April.

16. On 21 April, medical records show that Mr Y absconded from the hospital ward. Upon his return, Mr Y was reviewed by the Second Consultant Gastroenterologist who noted the possibility of steroid induced psychosis (a mental health problem that causes people to perceive or interpret things differently from those around them caused by treatment with steroid medication). An abdominal examination of Mr Y and an X-ray were undertaken.

17. The same day, surgical opinion was provided by a junior surgical doctor who noted an abnormal X-ray and identified Mr Y as having tachycardia (an abnormally rapid heart beat) with a mildly distended and tender abdomen. Frequent diarrhoea was also noted. The junior surgical doctor noted in the medical records that Mr Y was suffering with uncontrolled Inflammatory Bowel Disease, but his bowel was not clinically obstructed and that he would discuss Mr Y with a surgical registrar.

18. Mr Y was reviewed by a surgical registrar during the late afternoon of 22 April, who noted that Mr Y's abdomen was distended. No change in the management of Mr Y was recommended. It was documented that there was no current surgical issue, but the surgical team was to be contacted if the circumstances changed.

19. On 23 April Mr Y was referred to the mental health team. Mr Y was reviewed by the Second Consultant Gastroenterologist and commenced on ciclosporin (a medication that reduces the activity of the immune system). A reference to 'possible sepsis' (a potentially life-threatening complication of an infection or injury) was noted in the medical records.

20. Mr Y was reviewed on 24 April and it was noted that he remained unchanged. Mr Y was also reviewed by a further surgical registrar and a repeat abdominal X-ray was requested.

21. On 25 April, Mr Y became critically unwell. Sepsis was further considered during the afternoon and the plan was to increase IV fluids and arrange for a surgical review. Mr Y was seen by a surgical registrar later in the afternoon who noted Mr Y's abdomen as being tender and a deterioration from the previous day was recorded. There was reference to a possible bowel perforation and that Mr Y was likely to require a laparotomy (a surgical incision into the abdominal cavity to examine the abdominal organs to achieve a diagnosis and treat the problem/s identified).

22. A discussion took place with the on-call Consultant Surgeon and it was decided to conduct a specialised scan to rule out a perforation. It was later identified that Mr Y's bowel had perforated and he was operated on by the on-call Consultant Surgeon.

23. Mr Y was managed in the Intensive Care Unit following his surgery; however, he developed multi organ failure and sadly died on 27 April.

The Health Board's response to Ms X's complaint

24. Ms X complained to the Health Board about Mr Y's care on 8 May 2015. Two meetings were arranged with Ms X, her sister and Health Board representatives on 4 August and 11 September in an effort to answer the family's concerns. Ms X remained dissatisfied and contacted a Community Health Council Advocate who wrote to the Health Board, on 20 April **2016**, with their outstanding concerns. A response was received from the Health Board on 25 July. The Advocate initially wrote a letter of complaint on behalf of Ms X to my office on 2 November; however, the complaint was rejected as premature as the Health Board had not provided a response under the "Putting Things Right" regulations (guidance on complaints handling issued by Welsh Government). On 17 March **2017**, the HB provided a further written response, but Ms X felt that it did not answer any of her outstanding concerns. The Advocate wrote to my office again on 4 May 2017, and an investigation was commenced on 21 June 2017.

Ms X's evidence

25. Ms X said that Mr Y should not have been discharged from the Hospital so quickly following his first admission. She was of the view that there was insufficient evidence that Mr Y's enlarged bowel and suspected colitis had subsided. Ms X said that her brother remained unwell and was concerned about his weight loss and pain. The family was also worried about Mr Y's behaviour and described him as being "unnaturally hyper".

26. Ms X was also concerned that the family was not made aware of the possible side effects of the steroid medication that Mr Y had been given.

27. Ms X complained that, three days following his discharge, Mr Y was found confused and half undressed, sleeping in bushes some miles from home. She noted that he was readmitted with suspected hypothermia which added to his clinical problems.

28. Ms X said staff were made aware on a number of occasions that Mr Y had a history of alcohol/mental health issues and was vulnerable and added that this did not appear to be recognised or followed up. She noted occasions when Mr Y had left the ward and hospital grounds unnoticed and in inappropriate clothing.

29. Ms X said that not enough was done during the last week of Mr Y's life. She said that more attention should have been paid to Mr Y's presentation and the concerns of the family. Ms X said her brother was in pain and deteriorating. The family believes that Mr Y's perforated bowel should and could have been avoided if he had been operated on sooner.

The Health Board's evidence

30. The Health Board said that appropriate tests and investigations had been diligently carried out by the staff who cared for Mr Y. It said that two meetings had taken place with senior Health Board staff and members of Mr Y's family, during which staff present had provided Ms X and her sister with full and detailed explanations of the care and treatment Mr Y received, along with the rationale for any decisions made.

31. The Health Board noted that Mr Y had been treated for colitis in the first instance with medication and said that surgery would be a last resort. It added that most people do not need surgical intervention. The Health Board stated that, on Mr Y's first admission, after receiving medication, his CRP levels showed an improvement which was an indication that he did not need surgery at that time.

32. In relation to his discharge from the Hospital on 14 April, the Second Consultant Gastroenterologist said that Mr Y had responded clinically very well to the treatment for the flare up of presumed ulcerative colitis (a condition where the bowel and the rectum become inflamed). She said that Mr Y's IV steroids had been changed to oral steroids the day before his discharge, and he had been monitored on the Ward for

24 hours. Mr Y had informed them he felt better, therefore he had been discharged home to continue the medication and was due to be reviewed at the MDU a few days later to assess how he was doing.

33. In respect of the second admission, the Health Board noted that Mr Y's bowel did not burst until the 25 April. A Consultant Surgeon advised that the blood tests and X-rays carried out in the days prior to Mr Y's death had shown that he was improving while he was receiving IV ciclosporin (used for ulcerative colitis that has not responded to other medication). It was therefore decided to continue with conservative treatment.

34. In its response to my investigation, the Health Board provided further comments from the Consultant Surgeon who had subsequently reviewed Mr Y's abdominal X-ray from 21 April. The Consultant Surgeon noted in retrospect that it showed signs of colonic perforation. He said that the X-ray indicated that there was free intra peritoneal gas (abnormal presence of air or other gas) which meant that the bowel had perforated at the time of the X-ray which was taken on 21 April. The Consultant Surgeon added that it was a subtle finding and the X-ray was quite difficult to interpret. He apologised for not having picked this up earlier, and said that he now thought that Mr Y would have warranted surgery earlier than 25 April. He added that this might not have changed the end result, but at least Mr Y would have had surgery earlier and might have had a better outcome.

Professional Advice

Consultant Gastroenterologist Adviser ("the First Adviser")

35. The First Adviser said that a working diagnosis of 'ulcerative colitis with recent flare up' had been given during Mr Y's first admission. The First Adviser said that Mr Y was discharged on 14 April after he had clinically responded very well to the treatment provided to him. He said that the Second Consultant Gastroenterologist had undertaken ward rounds on 13 and 14 April and adequately reviewed Mr Y's clinical state. He added that the Second Consultant Gastroenterologist had taken account of Mr Y's own self report and the improvements in the CRP levels in his blood results in making the discharge decision.

36. The First Adviser also noted that Mr Y had been seen by a surgical consultant who was of the view that no surgical intervention was required at that time. The First Adviser added that a specialist nurse had reviewed Mr Y and provided him with more information on his condition.

37. The First Adviser was of the overall view that the care and treatment that Mr Y received during his first admission was appropriate and that it was reasonable for Mr Y to have been discharged from hospital at that time.

38. The First Adviser said that the steroid medication Mr Y had been prescribed during his first admission could certainly have caused or contributed to Mr Y's confused and disorientated behaviour. The First Adviser said it appeared Mr Y suffered an acute episode of psychosis and noted that it is a well-recognised side effect of high dose steroid therapy. The First Adviser explained that the medication can sometimes lead to psychosis irrespective of whether an individual has a history of mental illness or not.

39. The First Adviser noted that, during Mr Y's first admission, his history of depression had been noted, but it was not documented that Mr Y had previously been under the care of the psychiatric team. The First Adviser was of the view that further consideration of Mr Y's mental health status should have been given during the first admission. The First Adviser also said that earlier referral to the mental health team should have taken place during Mr Y's second hospital admission.

40. The First Adviser added that any involvement of the mental health team at either admission would not have changed the sad outcome for Mr Y in any way. The First Adviser raised concerns about communication with family members and said that this appeared to be inadequate at times.

Consultant Colorectal Surgeon Adviser ("the Second Adviser")

41. The Second Adviser explained that the aim of medical treatment in ulcerative colitis is to induce remission of the inflammation in the lining of the bowel and the default treatment is IV corticosteroids (type of steroid

used to reduce inflammation). The Second Adviser said that full remission (when the symptoms have gone) should be achieved before starting the tapering of steroids, as rapid recurrence of symptoms may ensue. He added that, if steroids do not induce remission, there are other medical therapies that can be tried (such as ciclosporin). The Second Adviser added that, when medical therapy does not work, or if complications ensue, surgical treatment is necessary.

42. The Second Adviser added that it can be difficult to identify which patients require surgery. The Second Adviser said that, in addition, NICE guidelines (National Institute for Health and Care Excellence guidance, advice and information services for health, public health and social care professionals for ulcerative colitis (2013)) note that doctors must be aware that there may be an increased likelihood of surgery being needed for people with any of the following: stool frequency of more than 8 per day, pyrexia (fever), tachycardia, an abdominal X-ray showing colonic dilation, low albumin (protein in the blood), low haemoglobin (the molecule in red blood cells that carries oxygen), high platelet count (small cell-like structures in the blood which are important for blood clotting. A high platelet count may be a symptom of an underlying condition) or high CRP levels.

43. The Second Adviser also pointed out that NICE guidelines suggest that consideration be given to adding IV ciclosporin to IV corticosteroids or to consider undertaking surgery for people who have little or no improvement within 72 hours of starting IV corticosteroids, or whose symptoms worsen at any time despite corticosteroid treatment.

44. In respect of the second admission, the Second Adviser said there was a significant delay before Mr Y was reviewed by the Second Consultant Gastroenterologist. He added that recognition that Mr Y was experiencing a flare up of the severe colitis was slow and unsatisfactory.

45. The Second Adviser said it was reasonable that steroids were not re-started but he was concerned that there had been a delay in starting the administration of ciclosporin. However, the Second Adviser said that the treatment was reasonable for Mr Y who had severe acute colitis and had developed complications in using steroid therapy.

46. The Second Adviser was also concerned that there was no record of a discussion by the junior surgical doctor with the senior doctor as planned on 21 April. He said that this was unsatisfactory, particularly as abnormal physical signs had been documented suggestive of colon distension and there had been abnormalities on the X-ray. He was also concerned about the surgical response on 22 April. The Second Adviser said that despite the identified concerns, vital signs and blood tests were not documented and the written opinion was 'no current surgical issue'. The Second Adviser said, in his view, this was an inappropriate response.

47. The Second Adviser also said that multidisciplinary management of severe colitis should be at consultant level. The Second Adviser was concerned that a consultant colorectal surgeon was not involved until 25 April. He said that medical staff should have involved a consultant surgeon much earlier and that this was a significant failing. In the Second Adviser's view, this contributed to the delay in recognising Mr Y's problems and significant deterioration.

48. The Second Adviser concluded that there was an unnecessary delay in recognising a severe complication of colitis which led to the perforation of Mr Y's colon and his critical illness.

49. The Second Adviser was critical of the clinical response on the morning of 25 April. He noted that a junior doctor saw Mr Y as his NEWS score was assessed as 8 (National Early Warning Score, an early warning scoring system used to identify patients who need urgent attention. A score of between 6 and 8 means that the patient is likely to deteriorate rapidly). The Second Adviser was concerned that Mr Y's abdomen was not examined at that time and there was no record of escalation to a more experienced doctor. The Second Adviser was of the view that sepsis should have been diagnosed during the morning and was concerned that appropriate treatment for sepsis was not carried out in a timely manner. He noted that antibiotic therapy had not been started until the late evening.

50. The Second Adviser noted that the necessary operation was eventually undertaken in an appropriate manner. He added that, in his view, the laparotomy and colectomy should have been carried out on, or shortly after, 21 April. Although the Second Adviser could not state that

Mr Y would have survived the surgery at that time, he was of the view that it would certainly have significantly increased the chance of a more positive outcome for Mr Y.

Comments of the Second Consultant Gastroenterologist on a draft of this report

51. The Second Consultant Gastroenterologist said that she clearly documented Mr Y's history of mental illness during his second admission. She said that she noted that Mr Y was known to the mental health team in the past, but had been discharged by them a few years previously and was being treated for anxiety and depression by his General Practitioner only. She added that all conversations with the family members were clearly documented in the medical notes during both hospital admissions.

52. The Second Consultant Gastroenterologist said that Mr Y's second hospital admission was over a weekend and that she reviewed him on the Monday morning. She said that the Health Board does not operate a 24/7 gastroenterology consultant cover. The Health Board's Clinical Director advised that this situation is not different from other units in Wales.

53. The Second Consultant Gastroenterologist said that she had asked for a consultant surgeon to review Mr Y as is their standard practice. She said that, as consultants, they carry out daily ward rounds and leave clear plans if a patient is staying in hospital over the weekend. She said that they write a referral to a speciality and give them telephone reminders to see the patients on their consultant's ward round.

54. The Second Consultant Gastroenterologist said that, if there is an admission of an acute colitic patient under their care, the standard practice is for daily consultant ward rounds to be conducted, a review by an inflammatory bowel disease ("IBD") nurse and early involvement of colorectal surgeons. She said that they hold two weekly IBD multi-disciplinary team meetings to discuss complicated patients and therefore, these arrangements are already in place at the Hospital. The Second Consultant Gastroenterologist said that, as a result of this case, from now on she will telephone the Consultant Colorectal Surgeon in charge to remind them to see patients personally.

55. The Second Consultant Gastroenterologist said that it was not possible to have adequate consultant cover for gastroenterology patients at all times, as there were only three consultants available. She said that the Health Board was in the process of reviewing staffing levels in gastroenterology for out of hours cover.

Analysis and conclusions

56. Ms X was concerned from the outset that Mr Y might have been inappropriately discharged from hospital following his first admission. Having considered the clinical advice I am of the view that this discharge was reasonable. Mr Y had been appropriately diagnosed with acute colitis, reviewed by the relevant clinicians, received treatment and it was clear that his condition had improved.

57. On balance, **I do not uphold** the complaint concerning the discharge of Mr Y on 14 April. However, even at this stage, further attention could have been given to Mr Y's mental health status, alongside improved communication with the family. There also appeared to be a delay in Mr Y being referred to gastroenterology and the Health Board should review this matter (see paragraph 67(g) below).

58. Unfortunately, although there was a prompt response to treatment during Mr Y's first admission, it is possible in hindsight that the clinical presentation and sigmoidoscopy/biopsies may have given a false picture and that Mr Y's colitis may not have fully resolved.

59. Mr Y was readmitted to hospital a few days following the first discharge after being found partly clothed, having become confused and hypothermic. Mr Y had experienced a rare, but recognised, complication of steroid therapy which, unfortunately, could not have been predicted.

60. During this second admission, I am of the view that the care and treatment fell well below reasonable standards. The shortcomings included:

- Steroid psychosis was not identified promptly and this caused additional worry and risk for Mr Y and his family

- Recognition that Mr Y was experiencing a flare up of the severe colitis was slow and there was an unnecessary delay in re-referral to the appropriate specialists

- Opportunities were missed on 21 and 22 April (when surgical staff become involved) to recognise the seriousness of Mr Y's condition

- A delay in Mr Y starting on new medication without adequate multi-disciplinary review and an explicit review of his abdominal X-ray

- A delay in involving a consultant surgeon (until 25 April)

- The response to Mr Y's deterioration was highly unsatisfactory and sepsis should have been recognised and treated earlier.

61. It is clear that a severe complication of colitis (dilation of the colon) was not identified promptly and this led to the perforation of Mr Y's colon and critical illness. This was a significant failing and clearly Mr Y should have undergone surgery sooner. Although the surgery would have been the same, taking account of clinical advice, the delay significantly increased the likelihood of a poor outcome. The shortcomings in the identification and treatment of sepsis also increased the risk to Mr Y.

62. An earlier referral to the mental health team was also indicated for Mr Y during the second admission, but this would not have made any difference to the overall outcome. It has also already been recognised by the Health Board that communication with family members could have been improved.

63. These significant concerns represent a service failure and an injustice to Ms X and her family as they will be left with the uncertainty of not knowing whether the outcome for Mr Y may have been different, had more appropriate action been taken in respect of Mr Y's care. **I uphold** fully Ms X's complaint about the care and treatment provided during Mr Y's second admission

64. I now turn to Ms X's concern of whether any action could have been taken to avoid Mr Y's bowel from perforating and sepsis from developing. The Health Board has acknowledged that an abdominal

X-ray of 21 April showed that Mr Y's bowel had perforated at that time and that Mr Y would have warranted surgery earlier than 25 April. This is supported by the Second Adviser who is clear that Mr Y should have undergone surgery on, or shortly after, 21 April. Even though it is not possible to determine whether Mr Y would have survived the surgery had it been undertaken sooner, it would have increased the chance of a more positive outcome for Mr Y.

65. The knowledge that Mr Y did not receive adequate treatment for the suffering he endured represents an injustice to Ms X and her family who will now have to live with the uncertainty of knowing that, had Mr Y received adequate treatment, it would have increased his chances of survival. I am recommending a redress payment in paragraph 67 below, to go some way towards remedying the injustice caused to Mr Y, Ms X and her family. I also acknowledge the stress for Ms X in having to pursue her complaint through my office in order to receive answers to her concerns. **I uphold** this element of the complaint.

66. I am concerned that the Health Board did not identify failings earlier which would have avoided the need for Ms X to bring her complaint to me at a very difficult time. It was not until I commenced my investigation that the Consultant Surgeon reviewed the medical records and noted that Mr Y should have undergone surgery earlier. This is the type of poor complaint handling which I highlighted in my recent thematic report 'Ending Groundhog Day: Lessons in Poor Complaint Handling'. I will therefore make a recommendation regarding this below.

Recommendations

67. I **recommend** that the Health Board should:

Within **one** month:

(a) Write a letter of apology to Ms X for the significant shortcomings in Mr Y's care

(b) Provide financial redress of £4,500 to Ms X in respect of these shortcomings and the injustice caused to Mr Y and Ms X, and in

recognition of the real uncertainty which remains as to whether the outcome for Mr Y could have been different if Mr Y had undergone surgery sooner.

Within **three** months:

(c) Ensure that arrangements are in place for patients with severe colitis to be managed via a multidisciplinary approach with involvement and leadership by consultant gastroenterologists and consultant colorectal surgeons

(d) Provide training for ward staff in communication with family and carers of vulnerable patients with a history of mental illness and of appropriate care pathways for such patients

(e) Discuss the contents of this report with the Consultant Surgeon to emphasise the importance of providing clear and accurate information to complainants during Health Board investigations.

Within **six** months:

(f) Carry out an audit to ensure that the management of sepsis by medical staff is in line with national requirements and includes a protocol for escalation and clear care pathways

(g) Carry out an audit to ensure that there is adequate consultant (physician and surgical) cover for gastroenterology patients at all times.

68. 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 22 May 2018
Ombudsman

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