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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint against Cardiff and Vale University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201706982

Contents	Page

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 refers to the complainant as Mr A and his late mother as Mrs A.

Summary

Mr A complained that while his mother, Mrs A, was admitted to hospital following a fall in May **2017**, the Health Board failed to adequately assess and treat her symptoms of slurred speech, lethargy and fits, and that it incorrectly administered an antidote for a morphine overdose. He also complained that the Health Board failed to deal with his safeguarding concerns appropriately, particularly in relation to bruising to Mrs A's elbow. He further complained that the Health Board did not deal with his formal complaint reasonably and had failed to provide him with information he had requested.

The Health Board had lost Mrs A's health records for a significant period of her care. However, Mr A had already obtained a copy, which the Ombudsman was able to use to inform his investigation and findings.

The Ombudsman found that the Health Board failed to identify that Mrs A had acute kidney failure from the time she was admitted. In an attempt to control Mrs A's back pain, she was prescribed pain relief at inappropriate levels (in the context of her kidney failure) and, even when she began to decline, this was not reviewed. The failure to monitor Mrs A's medication and kidney function resulted in an acute kidney injury, which was probably preventable but was overlooked and, ultimately, precipitated her death. The prescription of the antidote was appropriate to counter the accumulation of opioid pain killers, which could not be filtered from Mrs A's blood by her damaged kidneys. However, it was prescribed too late, which led to uncertainty about whether it might have had any effect if it had been prescribed sooner.

The Ombudsman accepted the ultimate outcome of the Safeguarding Investigations, which found that bruising to Mrs A's arm had been caused by a manual handling accident when Mrs A was assisted to move up the bed. However, there had been significant delays in the reporting, processing, investigation and management of Mr A's safeguarding concerns. Additionally, the Health Board had failed to process Mr A's complaint in line with its complaints process, Putting Things Right ("PTR"), or keep him updated on progress of the investigation in line with that procedure.

The Health Board had identified, during the course of its own investigation, that Mr A's complaint was not processed correctly, and that communication with him had been poor; it suggested to me that it would offer Mr A £750 in recognition of these failings. Following my investigation, the Health Board agreed to undertake the following actions:

Within one month of the date of this report:

(a) Provide a full and meaningful apology for all the failings identified in this report.

(b) Offer Mr A £750 as suggested by the Health Board for the complaint handling failure.

(c) Offer Mr A £500 for the failure to progress the two Safeguarding Referrals appropriately and £250 for the loss of Mrs A's medical records.

(d) Offer Mr A further financial redress of £4,000, to reflect the failure to assess, diagnose and treat Mrs A's condition and in recognition of the uncertainty as to whether remedial action might have prevented her death, as well as the distress caused to Mr A and his family in the manner of her death.

Within three months of the date of this report:

(e) Undertake a quality improvement project to consider the e-handover system for sharing information about a patient's condition, medication, and any notable changes or deterioration in their presentation when they are moved in a planned move between wards. Where any shortcomings are identified an action plan should be put in place, to address them.

(f) All staff involved in this case should receive training on reporting and handling of injuries sustained during hospital admission, including receiving and processing of both Safeguarding Referrals and complaints raised under PTR and how each should be progressed. This should include guidance on the value of each of those processes, the importance of full and transparent record keeping,

and the consequences of carrying prejudices against patients and their families after any such report or Safeguarding Referral has been made.

(g) All staff involved in complaint handling on this case should be reminded of the role of the Concerns Team, which should ensure that investigations are concluded in a timely manner and that complainants are kept informed, in accordance with PTR.

(h) The Health Board should provide the Ombudsman with evidence that it has adequate arrangements in place for senior medical review on weekends and bank holidays for Geriatric Care.

Within six months of the date of this report:

(i) All doctors involved in this case and any other relevant clinicians should undergo further training, with particular reference to current NICE and professional guidelines, on recognition of sepsis and the risk of AKI, as well as drug dosing and toxicity in elderly patients and those with kidney disease.

(j) All doctors involved in this case should evidence a reasonable level of reflection upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report, including discussion of the matter at their next appraisal. The Health Board's Medical Director should also review the report and consider whether any of the issues raised warrant referral of any relevant clinician to the GMC.

The Complaint

1. Mr A complained about the care that his elderly mother, Mrs A, received from Cardiff and Vale University Health Board ("the Health Board") between 7 and 15 May 2017, specifically that it:

(a) did not adequately assess and treat Mrs A's symptoms of slurred speech, lethargy and fits

(b) incorrectly administered an antidote to Mrs A for a morphine overdose.

2. Mr A also complained that the Health Board failed to investigate his safeguarding concerns adequately, particularly in relation to:

(a) bruising on Mrs A's right elbow and upper arm

(b) a suspected head injury

(c) Mr A's concerns that a medication error caused his mother's death.

3. Mr A also raised concerns that the Health Board failed to deal with his complaint appropriately, and to provide him with information he had requested.

Investigation

4. The Health Board was unable to locate the medication charts and medical records for Mrs A between 11 and 15 May. I obtained a full copy of Mrs A's medical records for her period of admission from Mr A.

5. As the Health Board's first response was provided without access to Mrs A's full medical records, I forwarded a copy of the records Mr A provided to the Health Board and asked it to comment further. I considered all of the Health Board's comments alongside the evidence provided by Mr A.

6. I also sought advice from two of the Ombudsman's Clinical Advisers, Dr Angela Kannan a Consultant Geriatrician ("the Consultant Adviser") and Shelley McElvaney, a Senior Nurse ("the Nursing Adviser"). I provided both Advisers with a copy of Mrs A's full medical records, as provided by Mr A. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

7. Both Mr A and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant Policy and Legislation

8. The NHS process for considering concerns about its service is called Putting Things Right ("PTR").[1] Complaints are progressed through PTR by the Health Board's Concerns Team, which should provide a response within six weeks or issue regular updates if it is unable to meet this timescale. Under the Regulations governing PTR, the Health Board has a duty to consider whether any failings identified amounted to a 'qualifying liability in tort'. This is where a person has suffered a personal injury or loss arising from a breach of duty of care that is owed to that person. A breach of duty of care is defined as being where someone has failed to act with the same reasonable care that would be provided by another person in the same circumstances, but also that the failure has caused significant harm.

9. The Health Board is a member of the Cardiff Multi Agency Safeguarding Hub ("MASH").[2] MASH provides an integrated service intended to improve and facilitate collaborative working between the organisations which have responsibility for safeguarding throughout Cardiff, including the Health Board, Local Authority and the Police. It follows the 'Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse' ("the Adult Protection Policy").

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

[2] https://www.cardiffandvalersb.co.uk/2016/11/new-integrated-safeguarding-service/

10. The Adult Protection Policy sets out ten stages that should be followed when an Adult Protection concern is raised, along with relevant timescales. Stages one and two cover the initial concern being raised, and then referral to MASH. Within two days of the initial concern a Strategy Discussion should confirm whether the Adult Protection Policy applies. If so, a Strategy Meeting should decide within seven days whether an investigation is needed, what actions will be taken and in what timescale. The investigation should be completed and reported as soon as possible. A further Strategy Meeting should be held to review it and the outcome should be communicated to the person who raised the concern. The process should be concluded within six weeks.

11. The British National Formulary ("BNF") is a pharmaceutical reference book that contains a wide spectrum of information and advice on drug prescribing and pharmacology, along with specific facts and details about many medicines available on the UK National Health Service (NHS).

The background events

12. Mrs A was living independently at almost 89 years old with a history of recent chest infections and heart failure caused by restricted blood flow to her heart. She had undergone bypass surgery in 2008. On 1 May **2017**, she attended the Emergency Department ("ED"), following a fall at home. X-rays at that time showed no fracture but blood tests indicated the presence of infection and moderate kidney failure. Chest X-rays revealed possible pneumonia and Mrs A was discharged with antibiotics and pain relief.

13. Mrs A was returned to the ED by ambulance on 7 May, with ongoing lower back and hip pain which was radiating down to her knee, affecting her mobility and which could not be controlled by painkillers at home. Blood tests revealed that her kidney function was unchanged, but her heart failure was slightly worse and she now had an irregular heartbeat. Mrs A was admitted to the Acute Assessment Unit ("AAU"), with ongoing prescriptions for blood thinners, as well as paracetamol and ibuprofen. Morphine (a very strong, opioid pain killer) was also prescribed as needed, rather than regularly, to manage her pain control needs as they arose. A referral was made for a Trauma and Orthopaedic ("T&O") Consultant to

provide a second opinion regarding her pain. The T&O Consultant confirmed that pelvic X-rays showed no fracture but noted significant degenerative changes in Mrs A's lower lumbar area, which suggested her pain was related to the joints, muscles and/or tissues in her back, and recommended a referral to Physiotherapy for help with her mobility.

14. On the morning of 8 May, a nurse noted a bruise to Mrs A's right elbow and recorded that Mrs A said she had knocked her arm when a nurse had moved her up the bed during the night. At 2:00pm the same day, Mrs A's grandson raised a concern with nursing staff about the bruise and the attitude of the staff; he was advised that the bruise had been noted and his concerns would be highlighted. It was documented that the nurse reported the incident to the Ward Manager, but neither Mrs A nor her grandson wanted to speak to the Ward Manager or raise a formal complaint at that time.

15. Later that day, the physiotherapy team attended and noted that Mrs A was unable to tolerate sitting out in her chair or weight bear owing to pain. Tramadol (a strong opioid painkiller) was prescribed as needed, which was increased to a regular dosage the following day. The Occupational Therapy team attended but Mrs A was not considered appropriate for their input as she needed the assistance of two people to mobilise. On 10 May a Consultant ("the First Consultant") noted that Mrs A's pain was not being controlled and she appeared to be in considerable distress as a result, despite the measures previously taken, so the tramadol was changed to gabapentin (a non-opioid, sedative painkiller).

16. On 11 May Mrs A was moved to a T&O ward where a nurse documented that she should be attended by two members of staff 'because of the allegations'. Shortly after arriving on the ward, Mrs A was assessed by a Consultant Neurologist ("the Neurologist"), who noted that her main issue was ongoing pain and immobility, and that X-rays of her spine and hip had revealed advanced degenerative changes, but no fracture. She was observed to have slurred speech, which was initially recorded as 'long-standing' but then corrected to 'since this morning', following clarification from Mr A. The Neurologist noted that Mrs A's language was otherwise normal and there were no signs of any other neurological deficit. In terms of the bruising to Mrs A's right elbow, this was noted to be large but with a good range of movement and no suggestion that there was any

impairment of arterial supply. The Neurologist concluded that there was no evidence Mrs A had any sort of brain injury or disease and diagnosed musculoskeletal pain, recommending a CT scan if her mobility did not improve. Later that day Mrs A was moved to a Geriatric Care ward.

17. On Friday 12 May a CT1 (3rd year of training) doctor assessed Mrs A and planned to continue with pain relief until she was reviewed by a Consultant. Later that day Mrs A's blood pressure decreased, and nurses noted she was not passing urine. However, on 13 May, the notes record that Mrs A was not complaining of pain and was sleeping on and off during the day.

18. On Sunday 14 May Mrs A was noted by nursing staff to be cold with a further decrease in blood pressure and an abnormally low level of oxygen in her blood; as a result, her National Early Warning Score ("NEWS") rose to 4.[3] It was documented that she remained sleepy throughout the day and nurses had to give assistance with feeding; at 6:30pm she was too drowsy to take her medication and her NEWS had risen to 6. As she had still not passed urine, Mrs A was catheterised. At 8.00pm the On-Call Doctor noted that Mrs A had reduced breath sounds and unintentional jerking movements, which had been increasing since the day before. She also appeared unaware of her surroundings and was only briefly responsive to a loud voice. The On-Call Doctor ordered blood tests (the first since Mrs A's admission on 7 May) and prescribed intravenous (directly into the vein) fluids, although there is no evidence they were administered at that time.

19. In the early hours of Monday 15 May nurses documented that the blood test results were returned; they were negative for sepsis but Mrs A remained drowsy, with low blood pressure and body temperature. A CT2 (4th year of training) doctor was called to review Mrs A at 3.45am. He prescribed intravenous fluids and requested close monitoring of fluid intake/output and monitoring for sepsis. Fluids were recorded as administered at 4.15am and 5.15am.

[3] A standard system between 0 (low clinical risk) and 14+ (high clinical risk) used to assess acute illness and improve detection and response to clinical deterioration. It is based on clinical observations including: respiratory rate, oxygen saturations, temperature, blood pressure, pulse rate, level of consciousness. The higher the clinical risk, the more urgent the need for review.

20. At 9.30am, following an emergency call for doctor review, Mrs A was found to be unresponsive and her pupils were constricted, meaning that they remained abnormally small under normal lighting conditions. A Consultant ("the Second Consultant") considered the blood tests from the night before and diagnosed acute kidney injury ("AKI"), where sudden damage to the kidneys causes them not to work properly, and probable pneumonia (infection affecting small air sacs within the lungs). Mrs A was prescribed intravenous antibiotics for chest sepsis and naloxone – an emergency antidote to counter possible opioid toxicity (where an excess of opioids causes breathing problems, small pupils and unconsciousness). The first dose of naloxone was administered at 9.35am and the second dose was given at 1:39pm but neither dose had any effect. Sadly, Mrs A continued to deteriorate; she suffered a heart attack and died at 3.18pm. The cause of death was recorded as bronchopneumonia (pneumonia affecting both the lungs and the air passages within the lungs) and severe frailty, secondary to heart disease and an irregular heartbeat.

21. On 19 May an Adult Protection Referral Form ("the First Referral") was completed by the Manager of AAU; it noted an allegation that on 7 May Mrs A was subject to verbal abuse and assault and sustained a bruise on her right elbow. It also noted that no immediate action was taken, despite the initial report being made to nursing staff on 8 May, and that, as the identity of the person allegedly responsible was unknown, all staff who were on duty should provide statements. The First Referral was received by MASH on 23 May 2017. A Safeguarding Nurse began a fact-finding investigation following a Strategy Discussion two days later, to try to establish the identity of the member of staff and ensure that appropriate procedures were followed.

22. On 11 July, Mr A requested and received a hard copy of Mrs A's full medical records from the time of her admission.

23. On 14 July, a meeting was held between the Second Consultant, the Safeguarding Nurse, Mr A and Mr A's son. It was noted that the family was concerned about the bruising on Mrs A's arm, of which they provided pictures, and felt that the nursing staff treated Mrs A as a "troublemaker" because they had raised a complaint. Mr A also suspected his mother had sustained a head injury, either at the same time as the arm bruising or

during her transfer to the T&O ward, and queried whether the naloxone was administered appropriately, given the time difference between the two doses. It was agreed that all of Mr A's concerns would be referred to the Concerns Team and investigated before a further meeting would be held to provide the outcomes. No further Adult Protection Referral was made at this time and no formal complaint was registered under PTR.

24. On 12 September 2017, a Strategy Discussion took place, at which it was decided that the evidence did not meet the threshold to progress the First Referral further because there was no evidence to suggest deliberate harm. The bruising had been documented appropriately when it was raised on 8 May and had been reported by Mrs A as an accident that had occurred during a manual handling procedure.

25. On 15 September, the concerns Mr A raised at the meeting in July were retrospectively logged as a formal complaint under PTR and the Safeguarding Nurse completed a new Adult Protection Referral Form ("the Second Referral"), noting an allegation that Mrs A had sustained a head injury on 11 May. The Second Referral was received by MASH on 19 September but there was no contemporaneous report or evidence of any head injury. The Neurologist was asked to review his assessment of Mrs A; he noted that slurred speech can be a side effect of both opioid and blood-thinning medications and considered that there was no evidence Mrs A had suffered any sort of brain injury or disease.

26. On 23 October Mr A met again with the Health Board and was advised that both the First and the Second Referrals were concluded, with no evidence of deliberate harm or of any head injury to Mrs A. The Health Board accepted, however, that the actions and behaviour of both medical and nursing staff had been "characterised by suspicion and a defensive attitude" and stated that the nursing care Mrs A had received had been poor. Mr A asked to see the Adult Protection decision documents, and it was agreed that he could also receive copies of the timeline of events and the statements gathered during that process. In respect of the naloxone, the Health Board said that Mrs A had not received excessive amounts of morphine, but the antidote was prescribed in a 'hopeful' attempt to reverse her decline. It acknowledged that there was a delay between

the two doses of naloxone but said that this was unlikely to have been clinically significant because her decline was more likely the result of her other conditions. It was agreed that the recording of the meeting would be sent to Mr A on CD, following which a formal complaint response would be issued.

27. On 9 January **2018**, the Health Board wrote to Mr A, apologising for the prolonged delay in providing a response. The letter advised that the Lead Nurse had provided feedback to the nursing staff who cared for Mrs A, and reminded them of the importance of dealing with patients sensitively and compassionately. The letter went on to state that whilst the Health Board was sorry that the standard of care appeared to fall below what was expected, it had identified no breach in its duty of care. On 8 February Mr A escalated his complaint to me. On 25 May copies of the witness statements, gathered during the safeguarding process, were eventually delivered to Mr A.

Mr A's evidence

28. Mr A said that his mother's death was completely unexpected, and the family had been confused as to what led to it. The cause of death ultimately recorded for Mrs A (chest infection and severe frailty, with secondary heart failure) appeared to bear no relation to the condition for which she was admitted to hospital, i.e. severe pain and loss of mobility, and did not list AKI at all. He said that his mother's final days were characterised by losses in consciousness, excruciating pain and fitting, the reasons for which had not been explained because the Health Board had not informed him of, or explained the implications of, the eventual diagnosis, by the Second Consultant, of AKI.

The Health Board's evidence

29. The Health Board said that it had been difficult to balance the need to relieve Mrs A's pain with her other health concerns, including her heart failure. It said that there was no clinical indication to conduct a CT scan or MRI scan given that the initial X-rays had shown no abnormality, and the clinicians involved in her care would have been reassured by her normal NEWS up until 14 May.

30. It acknowledged that there was a delay between clinicians being made aware of Mr A's suspicions that his mother had suffered a head injury in July and the investigation outcome in September. However, it said that the enquiry into the First Referral was still ongoing and the Second Referral was discussed as part of that investigation. The conclusion was that there was no evidence to suggest that deliberate harm, or any head injury, had been caused to Mrs A.

31. The Health Board also said that the meeting held with the family on 14 July was an informal meeting and was therefore outside of the formal complaint process. Nevertheless, in view of the seriousness of the concerns raised, Mr A's complaint should have been progressed formally following the first contact he made with the Health Board. It also acknowledged that, once the complaint was registered and processed under PTR, both the handling of it and communication with the family was poor. It suggested to me that it would offer an apology for these failures and an ex gratia payment of £750 to reflect the additional frustration, confusion and inconvenience caused by this.

32. The Health Board also evidenced that Mrs A's case was discussed at the Health Board's Quality and Safety Meeting on 13 December 2017. Key learning points were identified, including:

- a clinical incident form should be formally completed as soon as any allegation of harm is raised, to ensure a timely and coordinated response
- staff across all ward settings should be cautious of subconsciously (or even consciously) labelling patients and their families as "trouble-makers" because a concern has been raised
- the importance of timely handover of medication changes and follow-up of effects of those changes
- the lack of routine senior medical cover at weekends should be addressed, to ensure a proactive (rather than reactive) approach to monitoring and addressing patients' deterioration.

33. In its supplementary response, the Health Board accepted that, in the context of developing AKI, Mrs A received a significant amount of 'as required' opioid medications and that her outcome might have been different if she had been appropriately monitored and her deterioration had been reviewed by a senior consultant sooner. It said that it intended to discuss Mrs A's case again at another Quality and Safety Meeting, to identify learning points in the management of sepsis and AKI, particularly relating to in-patients during hours outside of routine medical cover, and the importance of appropriate medical handover when patients are transferred between wards and departments.

34. In response to the draft report, the Health Board apologised that, regrettably, Mrs A's family appeared to have been unaware of her significant frailty, which had increased following her recent fall. It also clarified that death certificates often do not include the reason for a patient's admission; only the cause of death at the time they died.

Professional Advice

35. The Nursing Adviser said that:

- Nursing staff assessed Mrs A's pain on a daily basis and in line with national guidance. It was noted that the pain relief prescribed was not managing Mrs A's pain, which was therefore appropriately escalated to a doctor on 8, 9, 10 and 12 May.
- Mrs A was initially independently eating, drinking and mobilising to the toilet. Although it was noted that Mrs A's urine output had reduced over the 12 and 13 May, there was no instruction (from a doctor) or documented reason for nursing staff to monitor Mrs A's fluid more closely until she was catheterised on 14 May, at which point the relevant documentation was completed appropriately.
- Mrs A's NEWS was between 1 and 3 from the time of her admission until the morning of 14 May, when it rose to 4 briefly then improved back to 0. Throughout this time Mrs A was appropriately monitored every four hours. When, on the afternoon of 14 May, Mrs A's NEWS rose to 4 and then to 6, the on-call doctor was contacted. This was appropriate and in line with national guidance.

- The prescription for naloxone clearly indicated it was to be given as a single, one-off dose at 9.30am, and it was administered five minutes later. A further, single dose was written up and administered at 1.39pm, which appeared to have been following a telephone conversation with a doctor and in accordance with their instruction.

36. The Consultant Adviser said that:

- It was clear from the blood results on 1 May and 7 May that Mrs A's kidneys were not working properly when she was admitted. The Health Board should have monitored Mrs A's kidneys and renal function closely throughout her admission, with regular blood tests and closely balanced fluid intake and output. This did not happen, which reflected a failure on the part of the Health Board to recognise that Mrs A was already at high risk of AKI. Without appropriate kidney function and blood test results it was difficult to say at what point Mrs A's AKI occurred, but her death might have been preventable if the Health Board had recognised this and monitored her kidneys accordingly.

- It was likely that Mrs A's renal function was further deteriorating gradually over days. The medication she was prescribed and given was inappropriate in the context of her reduced renal function, notwithstanding that clinicians were clearly trying to manage Mrs A's severe and unexplained pain. Opiates can accumulate in the blood and cause drowsiness and reduced blood flow and they can impact on breathing and passing urine, all of which can increase the risk of AKI. All the different pain relief medications Mrs A was prescribed throughout her admission should be used with caution in patients with kidney failure and stopped or adjusted if renal function decreases. However, there was no evidence that this was considered, and Mrs A's pain relief was increased to inappropriate levels as her pain escalated.

- The gabapentin, which was started on the 10 May, was prescribed at three times the safe starting dose based on Mrs A's last known kidney function test (7 May), in the context of her age, renal function

and the other opioid medications she had been prescribed.[4] Furthermore, very clear guidance should have been recorded in the notes, with instructions to closely monitor Mrs A's neurological function, level of consciousness, breathing and kidneys so that the gabapentin could be stopped at any sign of deterioration. It was likely that this drug, along with the morphine she had been given, caused Mrs A's newly slurred speech on 11 May and this should have been considered by the Neurology Consultant. There were also other early warning signs from the 11 May when Mrs A's mobility reduced, and she was noted to be drinking very little; this could have been a result of the gabapentin making her drowsier and more lethargic. The failure to review Mrs A's medication and to investigate her renal function at this point was serious because it represented a missed opportunity to stop or reduce the drugs which were, in all likelihood, seriously harming her kidneys.

- Usually, with prompt treatment to increase the blood flow to the kidneys and facilitate rehydration, kidneys can recover from AKI. However, this did not occur for Mrs A who, by 12 May, was presenting with clear signs of deterioration, including reduced blood pressure and being unable to pass urine or sit upright. The CT1 doctor who assessed Mrs A following her transfer to the Geriatric Ward carried out a detailed assessment, but it appeared he did so without any sort of handover from the previous team. As a result, he failed to appreciate the significance of the deterioration in Mrs A's condition and, again, missed an opportunity to investigate her renal function and review her medication accordingly.

- There was no evidence to suggest that Mrs A had suffered any head trauma or injury. The jerking movements Mrs A experienced, noted from 13 May, were probably myoclonic (quick, involuntary muscle jerks which are usually caused by muscle contractions) and were likely to have developed as a symptom of her AKI or toxicity from the medications.

[4] For patients with Mrs A's presentation, the BNF recommends a starting dose of 100 mg three times a day, increasing to 300 mg three times a day. Mrs A's was started on 300 mg, three times a day.

- Only around half of patients with sepsis would have bacteria in their blood because it could be confined to the infected area and still make the patient critically ill. Given the rate of Mrs A's deterioration, the reducing level of oxygen in her blood and the reduced breath sounds identified by the On-Call Doctor, it was likely that her chest infection was emerging or established on the morning of 14 May. By then, Mrs A was meeting the high-risk criteria for sepsis. However, her condition was not promptly or appropriately assessed and treated, and this failure was compounded by the fact that there was no routine Consultant available over the weekend. Mrs A should have been given fluids and antibiotics immediately and then closely monitored in case the treatment caused her heart failure to worsen, but these were not administered until 17 hours later. Having said that, the blood tests taken on 14 May were negative for sepsis and without positive blood cultures it was not certain whether or not sepsis was a factor in Mrs A's decline.

- The naloxone was appropriately prescribed to counter the effects of the accumulation of opioid pain relief Mrs A had received. However, it should have been prescribed and administered on the evening of 14 May, when Mrs A's condition rapidly deteriorated. If it had been, it might have improved her level of consciousness, blood pressure and breathing. Naloxone is eliminated from the bloodstream very quickly and therefore sometimes needs to be given very frequently, or even continuously, to maintain the effect but the separate doses given to Mrs A were each large enough to have been effective. Its lack of effect suggested that opioid toxicity was not singularly the cause of Mrs A's deterioration, which was probably also attributable to her AKI, gabapentin toxicity and possibly also sepsis. As a result, it was not likely that either the delay in prescribing it, or the time between the two doses on 15 May, made any clinical difference to the outcome for Mrs A.

Analysis and conclusions

37. In reaching my conclusions I have considered the opinions of the both the Nursing Adviser and the Consultant Adviser, which I accept in full. The clear and detailed advice I have received allows me to be relatively brief in my conclusions which, whilst informed by the comments of the Advisers, are my own.

38. It is clear from the comments of the Consultant Adviser that the Health Board missed a number of opportunities to identify the underlying cause of Mrs A's slurred speech, lethargy and the myoclonic jerks she experienced. It would appear that there was a complete and continued failure to appreciate the seriousness of these symptoms, or to recognise the underlying causes. I am very concerned that Mrs A was prescribed pain relief at inappropriate levels (in the context of her extant kidney failure) from the beginning, including an excessive amount of gabapentin with no safety checks, and that even when she began to decline this was not reviewed. It seems the Neurologist noted that the medication Mrs A was prescribed can cause slurred speech but, significantly, failed to adequately consider the implications of it. The possibility of gabapentin toxicity, accumulation of opioids and AKI were repeatedly overlooked and, as a result, went unaddressed until it was too late. I recognise that there may be challenges, compounded in this instance by the number of times Mrs A was transferred between wards and departments, in ensuring that each clinical assessment takes full account of a patient's current presentation, long term health trends and recent history. Nevertheless, clear and detailed hand-over information should have enabled the next clinician to have a good idea of the clinical picture prior to their assessment and to ensure that evidence of deterioration in Mrs A's condition, demonstrated by the increase in these symptoms, was identified. That did not happen. As a result, Mrs A became more and more unwell until she died. I **uphold** this element of the complaint.

39. I accept the Consultant Adviser's comments that the prescription of naloxone was appropriate to counter the effects of opioid toxicity, caused by the accumulation of tramadol and morphine which could not be filtered by Mrs A's damaged kidneys. However, notwithstanding that the delay between the two doses of naloxone was of little clinical significance, I

cannot conclude that it was administered correctly; given Mrs A's condition on the 14 May, it should have been given at least 14 hours earlier than it was prescribed. It is far from clear that earlier administration would have had better effect, given the Adviser's opinion that its inefficacy the following day was probably due to her additional and underlying AKI and/or gabapentin toxicity. Nevertheless, the uncertainty on this point, along with the associated failure to diagnose and treat the underlying cause, suggests the possibility that Mrs A's death might have been avoided had appropriate action been taken sooner. Consequently, I **uphold** this element of the complaint.

40. I acknowledge that, initially, both Mrs A and Mr A's son said that they did not want to 'make a fuss' about the bruising to her arm; nevertheless, I believe that, in the circumstances, it should have been considered formally. An incident form should have been completed the day it was reported, and a Strategy Discussion should have considered whether the First Referral was necessary within 2 days. Furthermore, the investigation was not concluded until 16 weeks after it was received by MASH. I cannot say why there is no contemporaneous record available from when the bruise was caused to Mrs A's elbow, but I accept that it appears from what Mrs A said that it was an accident rather than deliberate harm. Whilst the outcome of the investigation is encouraging, I am also particularly concerned that, despite the delay in completing the First Referral, the allegation appears to have influenced the relationship between Mrs A and the staff involved in her care, as was acknowledged by the Health Board at the meeting in October. This was inappropriate; it represents a serious service failure and could represent a wider culture which may prevent patients from raising a concern for fear that doing so would negatively impact upon the level of care subsequently provided. Reporting a complaint and action taken should be seen as a positive act in that it assists organisational learning. Although I am pleased that the Health Board has already highlighted this as an important learning point, I **uphold** this element of the complaint.

41. I accept that the possible head injury was discussed during the meeting in July and considered alongside the First Referral. I am not convinced it was unreasonable for the Health Board to consider both referrals at the same time, given that the first was still ongoing, although I concede that this led to confusion for Mrs A's family. It is not clear why there was an extended delay in completing the Second Referral, but again I am reassured that both the elbow bruising and the possibility of a head injury were, eventually, assessed fully. I am not persuaded that there was any evidence that Mrs A had suffered a head injury, although I recognise that the symptoms her family observed might, to them, have appeared to be similar to symptoms of concussion. Nevertheless, there were clearly delays in the reporting, processing, investigating and managing of both the First and Second Referrals and therefore I **uphold** this element of the complaint.

42. It is no surprise to me that Mr A was confused about the prescription of naloxone, and whether it caused, or contributed to, his mother's death. The Health Board's response to this point was ambiguous and did not accurately, or adequately, explain what had happened. It appears that the Health Board focused on attempting to reassure Mr A that the naloxone was not responsible for Mrs A's death and failed to explore or explain the other medications she had been prescribed. Whilst I recognise that, in doing so, the Health Board was attempting to reassure Mr A and respond to the specific concerns he was raising, I consider that it should have reviewed the complaint, and the care provided to Mrs A, as a whole rather than becoming preoccupied with singular points in isolation. Moreover, I do not consider this to be mitigated by the Health Board's difficulties investigating because it lost the medical records which is, in and of itself, a service failure. Ultimately, Mr A had no option but to escalate his concerns to me because he had not received an adequate response and it was only after I acquired his copy of the medical records, and passed them on to the Health Board, that the true picture of Mrs A's decline became clear. I **uphold** this element of the complaint.

43. There were a number of failures on the part of the Health Board in respect of its handling of Mr A's complaints. It was not wrong for it to hold an informal meeting with Mr A in July, but once it became clear that this would not resolve the matter it should have been escalated. All of Mr A's

concerns should have been referred to the Concerns Team and considered under PTR, as had been agreed. Even once this happened, however, communication with Mr A was poor and disjointed and he was not provided with the information relating to the First or Second Referral in a timely manner. Furthermore, were it not for the fact that Mr A had already obtained a copy of the records before they went missing, and could provide them to me, I would have been unable to conduct this investigation. Whilst I am reassured that the Health Board, in its response, has acknowledged these shortcomings and made a suggestion for redress, it seems to me that the failure to escalate Mr A's concerns promptly, through the proper channels, and inadequate communication contributed to a loss of trust in the Health Board and fuelled Mr A's concerns that the Health Board was attempting to "cover up" what had happened. Consequently, I **uphold** this element of the complaint.

Recommendations

44. I recommend that within **one month** of the date of this report the Health Board should:

(a) Provide a full and meaningful apology for all the failings identified in this report

(b) Offer Mr A £750 as suggested by the Health Board for the complaint handling failures

(c) Offer Mr A £500 for the failure to progress the two Safeguarding Referrals appropriately and £250 for the loss of Mrs A's medical records

(d) Offer Mr A further financial redress of £4,000, to reflect the failure to assess, diagnose and treat Mrs A's condition and in recognition of the uncertainty as to whether remedial action might have prevented her death, as well as the distress caused to Mr A and his family in the manner of her death.

45. I also recommend that within **three months** of the date of this report:

(e) The Health Board should undertake a quality improvement project to consider the e-handover system for sharing information about a patient's condition, medication, and any notable changes or deterioration in their presentation when they are moved in a planned move between wards. Where any shortcomings are identified an action plan should be put in place, to address them

(f) All staff involved in this case should receive training on reporting and handling of injuries sustained during hospital admission, including receiving and processing of both Safeguarding Referrals and complaints raised under PTR and how each should be progressed. This should include guidance on the value of each of those processes, the importance of full and transparent record keeping, and the consequences of carrying prejudices against patients and their families after any such report or Safeguarding Referral has been made

(g) All staff involved in complaint handling on this case should be reminded of the role of the Concerns Team, which should ensure that investigations are concluded in a timely manner and that complainants are kept informed, in accordance with PTR

(h) The Health Board should provide the Ombudsman with evidence that it has adequate arrangements in place for senior medical review on weekends and bank holidays for Geriatric Care.

46. I further recommend that within **six months** of the date of this report:

(i) All doctors involved in this case and any other relevant clinicians should undergo further training, with particular reference to current NICE and professional guidelines, on recognition of sepsis and the risk of AKI, as well as drug dosing and toxicity in elderly patients and those with kidney disease

(j) All doctors involved in this case should evidence a reasonable level of reflection upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report, including discussion of the matter at their next appraisal. The Health Board's Medical Director should also review the report and consider whether any of the issues raised warrant referral of any relevant clinician to the GMC.

47. I am pleased to note that in commenting on the draft of this report **Cardiff and Vale University Health Board** has agreed to implement these recommendations.

Nick Bennett 8 January 2019
Ombudsman

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