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PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201900746

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Introduction

This report is issued under s.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 Mr A, and to his late mother as Mrs B.

Summary

Mr A complained about the care that his late mother Mrs B, received at Betsi Cadwaladr University Health Board's ("the Health Board") Glan Clwyd Hospital ("the Hospital"). In particular, he said that when it came to the management and care of his mother's severe rectal prolapse (a rectal prolapse occurs when part of the rectum (back passage) protrudes through the anus), there had been surgical delays by the Colorectal Department going back to 2011. Mr A queried the adequacy of the inpatient medical care provided by a Care of the Elderly Consultant during Mrs B's admission in May 2018 and had concerns about a delayed diagnosis of his mother's terminal ovarian cancer during this admission. Mr A was also dissatisfied with the robustness of the Health Board's complaint response.

The investigation found consistently from 2011 onwards, that in terms of Mrs B's rectal prolapse management, the clinical decision-making and rationale shown by the Colorectal Surgeons was not in keeping with accepted clinical practice. More straightforward surgical rectal prolapse repair options, including less invasive procedures, were discounted in favour of high risk, unconventional and in one case (which would have involved the complete removal of Mrs B's rectum and possibly her anus), extreme treatment options, which would have provided Mrs B with little or no clinical benefit.

Mrs B was initially reluctant to have either a colostomy (where the colon is brought up to the surface of the skin and the bowel opened to form a stoma so the bowel contents can be collected in a stoma bag), or a complete removal of her rectum. As these procedures were the only rectal prolapse treatment options offered to her from 2011 onwards, this was a further factor in the delay.

The Ombudsman was critical of the lack of clinical clarity demonstrated in Mrs B's case. The mixed messages given to Mrs B concerning the benefits of a colostomy meant it was only on the day of the operation, in March 2018, that she was told definitively the procedure would not benefit her prolapse. Mrs B decided not to go ahead with the operation.

As a result of the failings identified, Mrs B had to endure years of indignity on a daily basis as she dealt with her severely symptomatic prolapse and the accompanying bowel and urinary incontinence. Since 2014, Mrs B had been living with dementia. Mr A referred to his mother being effectively housebound for the last 8 years of her life and being unable to take up social opportunities, including those recommended by the Memory Clinic for her dementia, in case she was "caught short" due to her double incontinence. Whilst the Ombudsman does not have the power to make definitive findings about whether there have been human rights breaches, he was clear that Mrs B's human rights in relation to Article 8 (which includes the right to respect for private and family life) were engaged as a result of the failings found. He noted that opportunities for Mrs B to develop and maintain her personal identity through external social interactions/relationships were considerably hampered. The family's relationship with Mrs B and the quality of the time that they spent together were also affected by her rectal prolapse condition and its wider effect, including the uncertainties around Mrs B's treatment and management. The Ombudsman concluded that the indignity of Mrs B's condition and the longstanding physical and mental impact the failings had on her and her family caused significant injustice to Mrs B. This part of Mr A's complaint was upheld.

In relation to Mrs B's last inpatient admission, and whether her ovarian cancer diagnosis could have been made sooner, the Ombudsman was satisfied on the evidence that Mrs B's general management and care was appropriate and her ovarian cancer could not reasonably have been diagnosed earlier than it was. Therefore, this aspect of Mr A's complaint was not upheld.

Finally, the Ombudsman's investigation found that the Health Board's complaint response should have identified the extent of the failings when it came to clinical decision-making by the Colorectal team and Mrs B's delayed rectal prolapse repair. He concluded that the Health Board had missed opportunities to fully learn from Mrs B's case. The Ombudsman considered the distress and added inconvenience of having to make a complaint to the Ombudsman's office caused Mr A and the family an injustice. This part of Mr A's complaint was upheld.

The following recommendations were made to be carried out over a 3 month period:

(a) The Health Board's Chief Executive should apologise to Mr A, on behalf of the family, for the clinical and complaint handling failings identified.

(b) The Health Board should invite Mr A and his sister to engage with an equivalent to the Putting Things Right Redress process via its Legal and Risk Services Team.

(c) The Health Board should review how its Colorectal team carries out rectal prolapse procedures.

(d) The Health Board should share the points of clinical learning from this case at an appropriate colorectal clinical forum.

The Health Board agreed to implement the above recommendations.

The Complaint

1. Mr A complained about the care provided to his late mother Mrs B, by Betsi Cadwaladr University Health Board ("the Health Board") at Glan Clwyd Hospital ("the Hospital"). Specifically, Mr A complained about:

- The Colorectal Department's management and care of Mrs B's severe rectal prolapse (a rectal prolapse occurs when part of the rectum (back passage) protrudes through the anus) which included surgical delays for the period covering 2011 onwards.

- The adequacy of the inpatient medical care provided by a Care of the Elderly Consultant during Mrs B's admission in May 2018. Additionally, Mr A had concerns that there was a delay in diagnosing his mother's terminal ovarian cancer.

- The robustness of the Health Board's complaint response.

Investigation

2. My Investigator obtained comments and copies of relevant documents from the Health Board and these were considered in conjunction with the evidence provided by Mr A. Advice was sought from my Professional Advisers, Mr Misra Budhoo, an experienced General and Colorectal Surgeon as well as Dr Ian Reeves, a Care of the Elderly Consultant who has experience in the area of acute care. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. As Ombudsman, I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. 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 legislation

4. The Human Rights Act 1998 ("HRA") incorporates the rights set out in the European Convention of Human Rights into UK law. It requires public authorities to act in compliance with the HRA and to respect and protect human rights. The HRA includes a number of rights set out as a series of Articles. Article 8 is the right to respect for private and family life, home and correspondence. It includes a person's right to develop their personal identity, forge friendships and other relationships, and to participate in social, cultural and leisure activities. Underpinning human rights are the core values of fairness, respect, equality, dignity and autonomy. These principles are fundamental to good public service delivery.

5. In my role as Ombudsman I consider whether the human rights of people dealing with public services in Wales have been respected and properly considered. Central to applying human rights in practical terms is the recognition of a patient as an individual and the need to deliver care that is appropriate to them and which takes account of their needs and wishes.

6. In relation to human rights, I am not able to make definitive findings about whether a public body has breached an individual's human rights by its actions or inaction as part of my function. However, where, as in this case, there is evidence of service failure which has caused injustice, it is appropriate for me to consider whether a person's human rights may have been compromised as a result.

Relevant background information and events

7. For many years Mrs B had issues with an increasingly severe rectal prolapse. Despite having repair surgery in **2001** and **2007**, Mrs B's prolapse re-occurred.

8. In February **2011** Mrs B was reviewed by a Colorectal Surgeon ("the First Colorectal Surgeon"). A 10-year history of bowel incontinence was documented. She was examined and a weakness of the sphincter (anal muscles) was identified. The First Colorectal Surgeon did not consider that an abdominal rectopexy (a surgical procedure to repair a rectal prolapse where the rectum is put back in its normal position) would

solve Mrs B's bowel incontinence problems. Instead, he felt a de-functioning loop colostomy (where the colon is brought up to the surface of the skin and the bowel opened to form a stoma so the bowel contents can be collected in a stoma bag) might be her only option. As she wished to delay this option at that time, the First Colorectal Surgeon discharged her.

9. Mrs B was referred again by her GP in June 2014 so treatment options could be discussed with the First Colorectal Surgeon. The referral letter mentioned Mrs B's worsening rectal prolapse, frequent bouts of bowel incontinence and rectal bleeding and that:

> "It is really starting to impact on her life now and she feels embarrassed going out in public with frequent soiling and bleeding."

10. A further GP referral letter sent 2 months later said Mrs B had now been diagnosed with a stroke, dementia and chronic kidney disease. The GP added that Mrs B was coming around to the view that a colostomy might be necessary.

11. Mrs B was seen by the First Colorectal Surgeon in October. He still considered a colostomy her only option since he believed that alternative surgery would not address her prolapse. In the letter to the GP about the consultation, the First Colorectal Surgeon said that Mrs B was "now coming round to the idea that this might actually benefit her." The First Colorectal Surgeon felt that even with a less invasive rectal prolapse repair, given her poor sphincter function, Mrs B would probably still be incontinent.

12. The First Colorectal Surgeon added that Mrs B had the option of 2 types of colostomies. He considered that the first would completely resolve Mrs B's prolapse and would involve completely removing her rectum and possibly her anus (an abdominal perineal re-section) followed by a permanent colostomy. The second option - a loop colostomy - would not completely resolve Mrs B's rectal prolapse, so she would still have symptoms. As Mrs B wanted to consider the options available, she was to be seen by a specialist colorectal nurse. Once Mrs B had reached a decision she would be listed for surgery.

13. In April **2015** Mrs B was once again referred to the First Colorectal Surgeon's clinic by her GP. The GP noted that although Mrs B, now aged 77, had been firmly against having a colostomy, she had changed her mind as she was having to constantly wear pads due to her rectal bleeding.

14. In January **2016** Mrs B was seen by another Colorectal Surgeon ("the Second Colorectal Surgeon"). In a letter to Mrs B's GP, he noted she had regular bowel movements and did not suffer from bowel incontinence. However, her rectal prolapse was becoming slightly painful and she was having to manually re-insert the prolapse almost every day. The Second Colorectal Surgeon felt a loop colostomy would be the best option for Mrs B, given her poor sphincter function, existing health problems and age. He warned that it would not cure her prolapse completely. He said that his plan was to trial the loop colostomy after Mrs B had been seen by the Urologists about her urinary incontinence. He added that if Mrs B wanted to have her rectum surgically removed, he would refer her back to the First Colorectal Surgeon.

15. In March Mrs B had a urological review. Following further investigations Mrs B's bladder was found to be normal. Mrs B saw the Urologist (in November) who confirmed that the rectal prolapse was the most likely cause of her urinary incontinence.

16. In the intervening period, Mrs B had further colorectal reviews (in September and November) with the First and Second Colorectal Surgeons. Both expressed the view that a loop colostomy would "hopefully" stop Mrs B's prolapse.

17. Mrs B was scheduled to have the colostomy in **2017** but pre-surgical checks identified she had "anaemia" and led to the procedure being delayed for a year.

18. On 19 March **2018**, the day of the re-scheduled colostomy procedure, the Anaesthetist asked the Second Colorectal Surgeon to speak to Mrs B about her expectations concerning the operation, as she was a high risk patient and there were complications associated with it. The records show

that the Second Colorectal Surgeon informed Mrs B that a colostomy would not help her prolapse and she decided not to go ahead with the operation.

19. The family contacted the Hospital and asked for a plan for the management of their mother's rectal prolapse, as her symptoms were affecting her quality of life. On 8 April the Second Colorectal Surgeon requested a second opinion from another Colorectal Surgeon. In the referral letter, the Second Colorectal Surgeon made reference to his long discussions with Mrs B about the risks and benefits of the colostomy, with an improvement in her prolapse not being guaranteed, although it might improve the leakage. He said Mrs B had "really wanted to go ahead with the [colostomy] surgery" but as Mrs B's main symptom on the day of the procedure related to her prolapse, which a colostomy would not cure, this was why she had not gone ahead with the operation.

20. In May, Mrs B was seen in the Hospital's Emergency Department ("the ED") following a fall. The initial plans for her management included a chest and abdominal X-ray. As Mrs B had a surgical review regarding her rectal prolapse the X-ray was not carried out. Given Mrs B's presenting complaint of recurrent falls/collapse, the Surgical Clinician arranged for her to be transferred to the care of the Medical team.

21. Mrs B underwent further inpatient clinical investigations on the Ward. She also saw another Colorectal Surgeon who proposed putting Mrs B forward for less invasive (Delorme's) rectal prolapse repair surgery. Before surgery could be considered, Mrs B's condition deteriorated and she developed an infection and acute kidney injury (where the kidneys stop working properly). A kidney scan arranged by the Care of the Elderly Consultant found no kidney abnormalities.

22. On 31 May following a complaint from Mrs B of lower abdominal pain, Mrs B was noted to have a distended abdomen (there had been no reference to her having a swollen abdomen or any abdominal pain in any of the clinical entries before this date). An urgent abdominal and pelvic CT scan suggested that Mrs B had malignant ascites (an abnormal build-up of fluid in the abdomen which contains cancer cells) and metastatic ovarian cancer. This was discussed with Mrs B's daughter and follow-up tests

arranged to confirm the diagnosis. In light of Mrs B's terminal diagnosis her management became palliative care only. Sadly, Mrs B died on 6 June.

23. Mr A and his sister subsequently complained about their mother's rectal prolapse management and care as well as her last period of inpatient care. In its complaint response, the Health Board acknowledged long waits between colorectal outpatient appointments with some of the delays and "confusion" caused by consultant surgeons being on sick leave and Mrs B's care being transferred to other consultants. The response referred to Mrs B having "misunderstood" and thought the colostomy would cure her prolapse, despite being told previously it would only relieve some of her symptoms. The Health Board said that clinically it was not clear how much Mrs B would have benefited from any of the proposed surgical procedures. It added that a colostomy was a high-risk procedure.

24. The Health Board referred to areas where Mrs B's colorectal management and care could have been better and to measures it intended to take to prevent a re-occurrence. These included patients only seeing 1 consultant where possible to improve continuity of care and more robust handovers when patients transfer between consultants. It concluded that whilst there had been a breach of its duty of care regarding Mrs B's colorectal care, with some delays for outpatient appointments, and "some confusion" regarding which consultant was leading on her care, the breach of duty had not caused Mrs B harm as her treatment plan was being managed according to her wishes at that time.

Mr A's evidence

25. Mr A said that there was no misunderstanding on the part of the family and their mother about the nature of the colostomy treatment being offered. They were aware of the nature of the surgery and what it would offer but were given no alternatives and left with little option but to trust the Surgeons involved. He added that having waited so long for surgery, only to be sent home on the day of the scheduled operation, had severely affected his mother's morale, particularly as there was no management plan in place going forward. Mr A expressed disappointment that the

concerns they had raised previously about the benefits of the proposed surgery had not been taken seriously and that no alternative treatments had been considered.

26. Mr A said that the delays meant his mother was effectively housebound for the last 8 years of her life. She was in too much pain and too worried about "being caught short" due to her double incontinence to risk going to social activities such as the cinema or a pensioner's social group recommended by the Memory Clinic. She only went to GP and hospital appointments and occasional trips to the local supermarket because she knew that she could use a toilet if necessary. Mr A referred to the impact the situation had on his mother's physical and mental health, which the family believed had caused an escalation of her dementia. Mr A said that the uncertainty around her treatment, coupled with travelling from his home to look after his mother and taking her to, and attending her medical appointments, had also affected his and his other family members' mental health. Part of the outcome that Mr A and his sister wanted was an acknowledgement by the Health Board that as well as breaching the duty of care it owed towards their mother, it had caused harm to her and the family.

27. Mr A said that in terms of his mother's inpatient admission, he believed the Care of the Elderly Consultant had failed to spot the seriousness of his mother's condition. He added that her distended abdomen, which was present on her admission to the Ward, as well as her abdominal pain, warranted further investigations, including an abdominal scan and he questioned why the scan had not taken place. He added that as a family they would have spent the remaining time left to their mother differently if they had known she had ovarian cancer in the few weeks before she died.

The Health Board's evidence

28. My Colorectal Adviser's clinical concerns (see paragraphs 35 - 42 below) were shared with the Health Board, which in turn asked 1 of its experienced Colorectal Consultants ("the Third Colorectal Consultant") who had not been involved in Mrs B's care to review the care provided. The Health Board said that the Third Colorectal Consultant acknowledged problems with the handover of care between consultants and the delays in

making decisions. However, he highlighted the management challenges that cases such as Mrs B's posed and referred to the lack of available evidence both at the time of her treatment and now as to the best way to manage both her incontinence and prolapse.

29. The Health Board said it was agreeable to implementing the recommendation that it review the practice of dealing with patients who have these kinds of issues. The Health Board added that as pelvic floor surgery is complex, teams need to work together to make the best possible plans for such patients.

The First Colorectal Surgeon

30. The First Colorectal Surgeon retired from the Health Board in 2019. He said that he was very sorry that Mrs B had had to endure her rectal prolapse for so long prior to her eventual death. He also referred to the complexity of Mrs B's case and the management difficulties this presented. He accepted that removal of the rectum and possibly the anus was not usual treatment and a very rare option for a rectal prolapse. However, looking at Mrs B's rectal prolapse history and significant chronic health conditions in 2014 he felt that if she were to have had a leak following an abdominal rectopexy it was unlikely that she would have survived. He thought that ideally, she needed one procedure which dealt with both her rectal prolapse and the bowel incontinence. A colostomy would also be much easier for her carers to look after than dealing with bowel incontinence.

31. The First Colorectal Surgeon pointed to organisational issues within the Colorectal Department. He also felt there were issues concerning resources for pelvic floor services, which meant that a pelvic floor multi-disciplinary team was not in place. The First Colorectal Surgeon said that he understood this problem was not unique to the Health Board.

32. The First Colorectal Surgeon added that, in retrospect, perhaps he could and should have dealt with Mrs B's rectal prolapse in 2011 or 2014 with an abdominal rectopexy and then accepted and dealt with her almost certain bowel incontinence later. However, he said that his decision-making had been based on what he thought was in her best interest.

The Care of the Elderly Consultant

33. The Care of the Elderly Consultant said that his apology in the Health Board's complaint response related to the family's distress as they felt the Hospital had missed their mother's ovarian cancer diagnosis during her admission.

34. The Care of the Elderly Consultant also said he now made additional efforts to ensure that when communicating with families they understood the situation and the explanations offered with further clarification being given if needed.

Professional Advice

Colorectal Adviser

35. My Adviser was critical of the length of time Mrs B was left without having operative treatment for her rectal prolapse. He said Mrs B should have been offered rectal prolapse surgery in 2011 as this was not a complex case.

36. He identified that the clinical decision-making was unusual and would not be regarded as normal standard colorectal practice for treating a rectal prolapse. My Adviser noted that apart from the second opinion during Mrs B's last inpatient admission that she should be offered a repeat of the surgical rectal prolapse repair (the Delorme's procedure) that she had in 2001 and 2007, the recommendation between 2011 and 2018 was primarily around Mrs B having a colostomy. My Adviser was clear that it was not standard clinical practice to offer a colostomy as a preference for prolapse surgery. Setting aside the clinical issues, on a practical level, for a patient like Mrs B, who was frail, suffered from dementia and had mobility problems, managing a stoma could have been problematic and would generally not be offered unless it was absolutely necessary. Moreover, my Adviser said that any treatment should be based on a patient's needs and not whether a colostomy might make it easier for a carer to manage a patient's bowel incontinence.

37. My Adviser referred to inconsistencies in the First Colorectal Surgeon's comments, since on the one hand part of his clinical rationale for Mrs B not having abdominal rectopexy was her poor health and complications affecting her survival, and yet he was prepared to consider far riskier procedures for Mrs B. My Adviser said that it was uncommon to offer complete removal of the rectum for a rectal prolapse (see paragraph 12) since it carries too high a rate of morbidity and is unnecessary. He considered that it is generally not seen as a clinically appropriate option for rectal prolapse repair.

38. My Adviser said that in 2011 Mrs B could have been offered another Delorme's or an Altemeier's rectal repair, which are both surgical rectal prolapse repair procedures which are approached from the tail end. The Adviser's view was that it would equally have been reasonable, given the 2 failed Delorme's procedures, to have offered abdominal surgery to place the rectum back in its original position (an abdominal rectopexy). My Adviser noted that the First and the Second Colorectal Surgeons appeared to have been significantly concerned about the potential risk of incontinence after the repair. However, rectal prolapse patients often have weaker muscles and a degree of incontinence before surgery and this can either improve, remain the same or worsen after surgery. He said that in any event, if necessary, this can be managed post-surgery.

39. My Adviser also referred to mixed messages being given about the de-functioning colostomy procedure with one clinical letter stating that it would help Mrs B's prolapse by "hitching the bowel" so reducing the risk of prolapsing and helping the incontinence, while another indicated that the colostomy carried "no guarantee" of success but would "hopefully stop [Mrs B's] incontinence and prolapse".

40. My Adviser noted that when Mrs B was finally pre-assessed for surgery in March 2017 she was noted to be "anaemic". However, my Adviser pointed out that Mrs B's haemoglobin blood count (11.5) was just within what would be regarded as acceptable limits for surgery. Again, my Adviser referred to an unusual approach whereby Mrs B was referred back to her GP to provide treatment for her "anaemia" by prescribing iron supplements rather than the anaemia being investigated. He said this was again unfortunate and added to the delay.

41. In summary, my Adviser was critical that for various reasons Mrs B had to manage her rectal prolapse for over 7 years without respite until her death. The main reason for this appeared to be down to the decision to offer stoma surgery which Mrs B was rightly uncertain about. The options of a stoma or removal of the rectum were very unusual and not recommended approaches to provide treatment or symptom relief for a rectal prolapse, even when there has been a recurrence of a prolapse, which is not uncommon. He added that it was also unusual for a clinician to be reluctant to repair a prolapse based on the potential risk of incontinence. My Adviser was critical that too much emphasis seemed to have been placed on this as an issue, rather than the concerns Mrs B had around her symptomatic prolapse, particularly as the urological review had identified her prolapse as the cause of her urinary incontinence. He said that the main focus should have been on the prolapse itself rather than the risk of incontinence, or any already present degree of incontinence.

42. My Adviser recommended that the Health Board consider and review how rectal prolapse repair was managed in its Colorectal Department.

The Care of the Elderly Consultant Adviser

43. My Adviser said there was evidence in the records that Mrs B's abdomen was examined at the time of her admission, but no abnormal findings were noted.

44. The Adviser noted that the ED records did list an abdominal X-ray as part of Mrs B's investigations, but this was prior to the surgical review, and there were no specific clinical findings that meant an X-ray should have been carried out. My Adviser said that he was not sure why the Doctor had suggested an abdominal X-ray. My Adviser added that an X-ray is a relatively insensitive investigation for conditions such as ovarian cancer, and he had significant doubt that even if it had been performed, it would have allowed a diagnosis to be made at that stage.

45. My Adviser noted that despite being seen and reviewed by clinicians, including the Surgical team who were planning to operate on her rectal prolapse, none of these encounters led to any suspicion that an underlying malignancy was present before the CT scan on 31 May.

46. Overall, my Adviser was of the view that Mrs B's ovarian cancer could not have been reasonably diagnosed any earlier than it was. He also considered that broadly Mrs B's care on the Ward was reasonable and in keeping with accepted clinical practice.

Analysis and conclusions

47. In considering Mr A's complaint and reaching my findings I have had regard to the advice that I have received from my Advisers, although the conclusions I have reached are my own. As I have set out their advice in some detail above, this enables me to be relatively brief when explaining my findings here.

The management of Mrs B's rectal prolapse

48. It is clear from the records that Mrs B was initially not keen to go ahead with a colostomy and some of the delay evident in this case reflects this. I am also mindful that from 2011, a colostomy was the only treatment option offered to her, other than a complete removal of her rectum. I have concerns that over the years both Colorectal Surgeons gave mixed clinical messages during their consultations with Mrs B which held out the possibility that a colostomy might provide some relief for her rectal prolapse symptoms. It was not until March 2018, on the day of the procedure, that it was made explicit by the Second Colorectal Surgeon that the colostomy would provide no benefit regarding Mrs B's prolapse after the Anaesthetist raised clinical concerns about the procedure and Mrs B's expectations. As a result, Mrs B decided not to go ahead with the procedure. I consider the lack of clinical clarity evident in this case was also a key factor in the delay.

49. I am satisfied, in terms of Mrs B's rectal prolapse management, that consistently from 2011 onwards the clinical decision-making and rationale displayed in this case by the Colorectal Surgeons was not in keeping with accepted clinical practice. Despite a range of surgical rectal repair procedures (including less invasive options) being available to address Mrs B's recurrent prolapse, these were discounted in favour of high risk, unconventional and, in the case of the abdominal perineal re-section (which involved complete removal of the rectum and possibly more), extreme

treatment options, which would have had little or no clinical benefit for Mrs B. A second opinion, obtained in May 2018, took a more traditional clinical approach to rectal prolapse surgery. It is unfortunate that by that point Mrs B's deteriorating health while an inpatient and subsequent terminal cancer diagnosis meant she was not able to undergo the surgery.

50. I am satisfied that as a result of the clinical failings identified by my investigation, Mrs B was not offered rectal prolapse repair surgery in 2011 which may well have alleviated her severe symptomatic prolapse and addressed her bowel and urinary incontinence. Instead, Mrs B had to suffer the daily ongoing indignity that her condition caused her over a protracted period of time. This had a significant impact on her both physically and mentally. Mr A has referred to the fact that his mother was effectively housebound for the last 8 years of her life and was not able to take up social opportunities including those recommended by the Memory Clinic for her dementia. Additionally, he has referred to the impact on the family. It is evident that Mrs B's human rights under Article 8 were engaged as a result of the failings I have identified. In particular, opportunities to develop and maintain her personal identity through external social interactions/relationships were considerably hampered, at a time when Mrs B was living with dementia. This led, the family believe, to the effects of her dementia accelerating, although I am unable to say whether that was in fact the case. The family's relationship with Mrs B and the quality of the time that they spent together were also affected by her rectal prolapse condition and its wider effect, a situation which was worsened by the uncertainties around her treatment and management.

51. I conclude that Mrs B suffered an injustice as a result of the service failings identified. The indignity of Mrs B's condition and the longstanding physical and mental impact the failings had on her and her family for a considerable period of time caused significant injustice to Mrs B. Given the service failings and injustice identified I **uphold** this part of Mr A's complaint.

The diagnosis of Mrs B's ovarian cancer

52. Mr A raised concerns about Mrs B's last inpatient admission and especially whether her advanced ovarian cancer diagnosis could have been made earlier. On the evidence I have considered I am satisfied that

Mrs B's general management and care was reasonable and her ovarian cancer could not reasonably have been diagnosed any sooner than it was. Although the ED notes referred to a plan for Mrs B to have an abdominal X-ray, there were no symptoms or clinical issues that would have warranted this. Even if an abdominal X-ray had been carried out, it is unlikely that this would have identified the build-up of malignant fluid in her abdomen or the presence of ovarian cancer. I therefore **do not uphold** this part of Mr A's complaint.

The handling of Mr A's complaint

53. I consider that the Health Board's complaint response should have identified the extent of the failings when it came to clinical decision-making by the Colorectal team and Mrs B's delayed rectal prolapse repair. I am concerned that too much emphasis seems to have been placed on Mrs B wanting the colostomy because she misunderstood what a colostomy would achieve regarding her prolapse. In fact, the clinical records paint a more complex picture (see paragraphs 39 and 48) which the investigation did not fully recognise. As a result, the Health Board missed opportunities to fully learn from Mrs B's case. I consider that the distress and added inconvenience of having to make a complaint to the Ombudsman's office caused Mr A and the family an injustice. I therefore also **uphold** this part of Mr A's complaint.

54. It is right that when, as here, I see evidence of excessive delays in offering appropriate treatment, coupled with poor clinical decision-making, management and care, which is not isolated to a single clinician within a colorectal department, I bring this to the attention of the public and health providers. I have issued this report as a public report because it reflects my ongoing commitment to drive forward improvements when it comes to health care providers within my jurisdiction, to ensure that the wider lessons are learnt from Mrs B's case and to stop other lives being similarly blighted.

Recommendations

55. I **recommend** that the Health Board carry out the following:

a) The Chief Executive should apologise to Mr A, on behalf of the family, for the clinical and complaint handling failings I have identified.

b) Invite Mr A and his sister to engage with an equivalent to the Putting Things Right Redress process via its Legal and Risk Services Team.

c) Review how its Colorectal team carries out rectal prolapse procedures.

d) Share the points of clinical learning from this case at an appropriate colorectal clinical forum.

56. The Health Board should carry out recommendations (a) and (b) within **1 month** of this report with recommendation (d) being carried out within **2 months** and recommendation (c) within **3 months** of the date of this report.

57. 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 16 February 2021
Ombwdsmon/Ombudsman

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