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The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202107105 & 202205543

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

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 B.

Summary

Mr B complained about the care and treatment provided by Betsi Cadwaladr University Health Board ("the Health Board") to his wife, Mrs B.

Complaint 1

Mr B complained that the operation to remove Mrs B's appendix was unduly delayed. The Ombudsman's investigation found that after appendicitis was suspected in August 2019, there was no undue delay in arranging appropriate investigations or treatment, including the operation to remove Mrs B's appendix. The Ombudsman did not uphold this complaint.

Complaint 2

Mr B complained that there was a failure to investigate the cause of Mrs B's breathing difficulties in a timely manner. The investigation found that there was a failure to provide Mrs B with the expected level of care after the surgery to remove her appendix. There was a failure to identify the underlying cause of her breathing difficulties and to provide appropriate and timely treatment. There was also a failure to recognise signs that her condition was deteriorating and take appropriate action. The Ombudsman found, on a balance of probabilities, that Mrs B's cardiac arrest and lengthy admission to the Intensive Care Unit would likely have been avoided if she had received appropriate care.

The Ombudsman was concerned that these events had taken a considerable toll on Mrs B's physical and mental wellbeing, which was a very serious injustice to her. Mrs B had been left with health and mobility problems that she would not have expected to have to cope with in her 50s and which may significantly limit her quality of life for years to come. Mr B had also suffered significant injustice through the distress he experienced during his wife's admission and afterwards, in adapting to the need to provide ongoing physical and psychological support to her. The Ombudsman upheld this complaint.

Extended investigation

During the investigation, a concern arose that the Health Board had failed to arrange appropriate follow-up and treatment for Mrs B in response to a scan in September 2017. The Ombudsman used the recently introduced "own initiative" power to extend the investigation to look at the concern, of which Mr and Mrs B had been entirely unaware. The investigation found that, in response to the scan result, the Health Board should have arranged to remove Mrs B's appendix but failed to do so. As a result, there was a missed opportunity to avoid the deterioration in Mrs B's health which occurred after she developed appendicitis in 2019. The Ombudsman upheld this complaint.

The Ombudsman noted that had her office not started an "own initiative" investigation, this significant failing leading to serious injustice to Mr and Mrs B would not have come to light. This demonstrated why the "own initiative" power is needed, in the public interest, and for individuals who come to the Ombudsman.

The Ombudsman's Recommendations

The Ombudsman recommended that within **1 month**, the Health Board should:

a) Apologise to Mr and Mrs B for the failings and associated injustices identified in this report.

b) Make a payment to Mr and Mrs B of £10,000, reflecting the serious injustices arising from the missed CT colonography finding in 2017 and the poor post-operative care in 2019.

c) Share the report with the First and Second Consultants for the purposes of reflection and discussion at their next annual appraisals.

The Ombudsman also recommended that within **2 months** of this report,

d) The Health Board should provide evidence that this report has been discussed at a surgical clinical governance meeting and appropriate learning points shared with relevant clinical teams.

The Complaint

1. Mr B complained about the care and treatment provided by Betsi Cadwaladr University Health Board ("the Health Board") to his wife, Mrs B. Specifically, he complained that:

a) the operation to remove Mrs B's appendix was unduly delayed

b) there was a failure to investigate the cause of Mrs B's breathing difficulties in a timely manner.

2. In response to evidence gathered during this investigation, I used my "own initiative" investigation power under Section 4 of the Public Services Ombudsman (Wales) Act 2019 to extend the investigation to consider, as an additional complaint, a concern that the Health Board failed to arrange appropriate follow-up and treatment for Mrs B in response to the incidental finding (a finding which is not related to the reason for requesting a test) in September 2017. This was a finding of mucocele of the appendix (a rare condition where a mucous-filled cyst develops on the appendix) following a computed tomography colonography ("CT colonography", the use of X-rays and a computer to create an image of the body; in this case the bowel).

Investigation

3. My investigator obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mr B. They also obtained professional advice from one of my professional advisers, Mr Misra Budhoo, an experienced general and colorectal surgeon ("the Adviser"). The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment was appropriate in the situation complained about. It is my role to determine whether the standard of care was appropriate by referring to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

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

What happened

5. In September **2017** Mrs B, who was 50 at the time, was under the care of a consultant colorectal & general surgeon ("the First Consultant") who was investigating symptoms of bleeding and weight loss. Mrs B underwent a CT colonography on 28 September which confirmed that her bowel was normal but included an incidental finding of mucocele of the appendix. The First Consultant reviewed the report but did not refer to or arrange any further action in relation to the incidental finding.

6. At 18:16 on 8 August **2019** Mrs B attended the Surgical Same Day Emergency Care unit ("the SDEC") at Ysbyty Glan Clwyd ("the Hospital") complaining of generalised abdominal pain. Sepsis (when the body overreacts to an infection and damages the organs and tissue) was suspected and she was given fluids and antibiotics intravenously ("IV" - given directly into the vein). She was admitted to the Surgical Assessment Unit ("the SAU") at 22:17. A chest and abdomen X-ray was reported to show distended (swollen) loops of small bowel suggestive of a bowel obstruction.

7. Mrs B had a CT abdomen and pelvis scan at 12:15 on 9 August. The report, which was available at 13:39, noted mild inflammation of the appendix consistent with appendicitis (a painful swelling of the appendix). It stated, "…given the findings of the CT colonoscopy [sic] performed in September 2017, I am surprised to see the appendix remains apparent". Mrs B had an appendicectomy (an operation to remove the appendix) at 23:02 that evening.

8. On 11 August a junior doctor noted that Mrs B had generalised abdominal pain and had been vomiting since the previous evening. The junior doctor diagnosed ileus (reduced bowel function, causing a build-up of food material), requested blood tests and an abdominal X-ray, and recommended a nasogastric tube ("NG tube" - a plastic tube which is inserted through the nose and extended to the stomach to deliver food and medicine or remove fluids). On 12 August it was recorded that Mrs B's abdomen was distended and that the NG tube should only be fitted if the vomiting continued. Later that day Mrs B developed shortness of breath and wheezing and was given medication to treat a suspected worsening of her asthma. It was noted that she was not vomiting.

9. A consultant surgeon ("the Second Consultant") reviewed Mrs B on 13 August and noted her mildly swollen abdomen and continued shortness of breath. He requested a chest X-ray and made a referral to the Respiratory Team.

10. At 14:51 on 14 August Mrs B was seen by a respiratory consultant ("the Respiratory Consultant"), who noted that Mrs B may be developing hospital acquired pneumonia (an infection of the lungs) but was concerned that she had a bowel obstruction which was splinting (restricting) her diaphragm (a large muscle running between the chest and the abdomen which plays an important role in breathing). They arranged an urgent CT abdomen and pelvis scan and asked the Second Consultant to review her again. The report of the CT scan noted that Mrs B's small bowel was significantly distended, potentially due to an obstruction or an ileus.

11. On 15 August the Second Consultant reviewed Mrs B, noted the results of the CT scan and that she was feeling better and not in pain. The plan was for continued supportive care.

12. During the evening of 16 August nurses found Mrs B unconscious having suffered a cardiac arrest (when the heart suddenly stops beating). She was given cardiopulmonary resuscitation ("CPR" - emergency treatment to re-start the heart and breathing) which was successful. Mrs B was intubated (where a plastic tube is inserted into a person's throat to help them to breathe) and transferred to the Intensive Care Unit ("the ICU") where she required a ventilator (a machine which helps with breathing).

13. Mrs B remained in the ICU for 33 days. While in the ICU Mrs B was diagnosed with abdominal compartment syndrome (dangerous levels of swelling and pressure in the abdomen which can prevent organs and muscles from getting enough blood and oxygen) and developed multiple organ failure. She had surgery to open her abdomen to relieve the pressure. She required 6 visits to theatre to wash the wound and change dressings before the wound was closed. Mrs B also underwent a tracheostomy (when a cut is made at the front of the neck to insert a plastic tube to help with breathing) on 1 September before she was taken off the ventilator.

14. Mrs B recovered sufficiently to be transferred to a ward on 18 September and discharged home on 30 September.

What Mr B said

15. Mr B said that the Health Board failed to treat Mrs B's appendicitis with sufficient urgency and failed to properly investigate and treat the cause of her breathlessness. He said that he and Mrs B believed that prompt action could have avoided her need for ICU care.

16. Mr B said that Mrs B was a shadow of her former self following her admission to the ICU. He said she had been left badly scarred by the operations she underwent and that she found the tracheostomy scar particularly distressing. He said that due to the ICU admission and her loss of appetite since then, she had lost 2 stone in weight and a lot of muscle mass. He said that while she used to enjoy going for walks with her dog, she was now too weak to stand for long periods, struggled to walk more than 50 paces without help and was prone to falls. He said she had trouble with her memory, lacked energy, had lost confidence and rarely left the house. He said that she had needed further operations for hernias caused by the surgeries in the ICU and had recently been admitted for low blood pressure and low potassium, connected to a general decline in her health.

17. Mr B said that he would like the Ombudsman to consider a recommendation of financial redress because of the impact of the admission on Mrs B. He said that she was not the same person since then, and that he now had to look after her, which had a significant impact on both of them.

What the Health Board said

18. In response to this investigation, the Health Board provided a statement submitted during its initial investigation by its former Clinical Lead for General Surgery, a consultant general and gastrointestinal surgeon. They said:

> "…the cause of the cardiac arrest is not clear to me now, and was not clear to the doctors caring for her at the time. However, the splinting of the diaphragm due to a dilated bowel is likely to have been a significant factor."

19. The Health Board also provided a statement by an ICU consultant who was involved for part of Mrs B's care while she was admitted to the ICU. They said:

> "…the abdominal compartment syndrome was in all likelihood the reason that [Mrs B] had the cardiac arrest, as it is a serious condition that has a high mortality. It has many consequences which can include multiorgan failure. The abdominal compartment syndrome would appear to have been caused by appendicitis."

20. During the investigation, the Health Board was provided with a copy of the Adviser's advice (in anonymous format). In response, the Health Board said that it accepted there were failings in Mrs B's care, including a missed opportunity to carry out an appendicectomy in 2017/18 and in some aspects of her post-operative care in 2019. However, it said that there were differences of opinion regarding other aspects of the post-operative care.

21. The Health Board said that the First Consultant's opinion, supported by colleagues within the department of Surgery, was that the finding of an incidental mucocele does not require the removal of the appendix in all cases. It also would not increase the risk of future appendicitis. The Health Board said that its Radiology Department has a flagging system for urgent and immediately life-threatening findings, but that an incidental finding of mucocele would not fall into this category.

22. The Health Board acknowledged that there was no documentation regarding whether elective removal of the appendix was discussed with Mrs B. Therefore, while the treatment may have been reasonable, it would have been best practice to have weighed and documented the treatment options related to the incidental finding. It said that it would ask the First Consultant to reflect on this and discuss it within his next annual appraisal. The case would also be discussed at the Surgical Department Clinical Governance meeting.

23. The Health Board said that its current Clinical Lead for General Surgery was satisfied that, in general, Mrs B's treatment for appendicitis and post-operative care was appropriate and within acceptable time limits. The Clinical Lead for General Surgery said that it was

appropriate and in accordance with the practice at many UK hospitals to manage similar patients without an NG tube, for the first few days after the operation. This did not indicate poor understanding of the use of NG tubes. They said that post-operative ileus is a relatively common finding which often resolves without the need for an NG tube, an intervention which carries risks for the patient. They also said that there was no evidence of an excessive reliance during assessments on the National Early Warning Score ("NEWS" – a system which calculates a score based on observations of a patient's condition; it is used to identify deterioration and trigger senior clinical review).

24. The Clinical Lead for General Surgery acknowledged that Mrs B's post-operative care fell below the required and expected standard in some areas. In particular, not enough attention was paid to the monitoring of Mrs B's serum electrolytes (salts and minerals, such as sodium, potassium, chloride and bicarbonate, which are found in the blood; having too much or too little of these can indicate underlying medical problems). There was also a failure to ensure that an NG tube was inserted as recommended by the Surgical Team after splinting of the diaphragm was identified as a likely cause of Mrs B's shortness of breath. They said that it was possible that one or both of these failures may have contributed to Mrs B's cardiac arrest, although it was unlikely that either was the sole factor.

25. The Health Board said that it was not correct to say that provision of better care would have avoided Mrs B's cardiac arrest; rather it was more appropriate to say that the care failings may, in all likelihood, have contributed to the cardiac arrest; or that a better standard of care might have avoided the cardiac arrest.

What our Adviser said

26. The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment was appropriate in the situation complained about. I determine whether the standard of care was appropriate by referring to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

27. The Adviser said that the incidental finding of mucocele of the appendix on the CT colonography appeared to have been missed at the time. This was an indication for an elective appendicectomy because of the risk of cancer, including a rare form called pseudomyxoma. Conservative management would not have been appropriate because of this risk. The finding should also have prompted a discussion at a cancer Multi-Disciplinary Team ("MDT") meeting. He said there was either a failure by the referring clinician to see the conclusion (which was printed on the second page of the report) or to appreciate the finding of thickened, distended appendix. He said that while it was the responsibility of the First Consultant to take appropriate action, it appeared that there was no "failsafe" system in place to alert the relevant MDT of potential red flag findings on investigations.

28. The Adviser said that the findings of the appendicectomy showed standard features of appendicitis and no signs of a mucocele. In isolation this would have been regarded as a "near miss", worthy of further investigation to find out how it happened. However, it had serious consequences for Mrs B because, had her appendix been removed as it should have been following the CT colonography in 2017, she would not have developed appendicitis later.

29. The Adviser said that Mrs B's presentation in 2019, including dilated loops of bowel, diarrhoea and sudden onset of pain, was not entirely typical of appendicitis. There was, therefore, a reasonable element of doubt on admission regarding the diagnosis of appendicitis and the need for surgery. He said that an acceptable treatment plan was in place for the management of sepsis. Taking this into account, the initial treatment and investigations were reasonable. The timings of the investigations, and of the appendicectomy were also within acceptable limits. He also noted that as Mrs B has a low BMI, it would be expected that her abdomen may not show classic signs of peritonitis (an infection of the inner lining of the stomach which can be associated with appendicitis) given the thinness of her abdominal wall.

30. The Adviser said that the initial radiology carried out before the appendicectomy suggested a generalised abdominal infection causing an ileus. There was evidence at the time of the appendicectomy that the infection was widespread and rapidly increasing. This indicated that

Mrs B's recovery after surgery would be difficult and that a very proactive approach was required. Furthermore, blood tests showed low potassium levels which would also have slowed her recovery. Taking these factors into account, there appeared to have been a failure to provide the expected level of care after the appendicectomy.

31. The Adviser said that the reports of the CT scans on 9 and 14 August showed that the swelling in Mrs B's small bowel was unresolved. He said that splinting of the diaphragm causing shortness of breath was a recognised surgical problem where an ileus or obstruction is causing swelling of the abdomen. However, the available clinical notes suggested a failure to appreciate the underlying abdominal swelling and the fact that Mrs B's condition was worsening due to the splinting of her diaphragm and not because of her asthma. He said that between 11 and 13 August abdominal examinations were cursory or omitted on occasions, which may have contributed to this.

32. The Adviser said that the respiratory referral should have been made sooner. He said that there was a failure to recognise how unwell Mrs B was and that poor documentation of her fluid balance may have contributed to this. However, Mrs B's falling blood oxygenation levels and persistent tachycardia (when the heart beats faster than normal) in the days before her cardiac arrest should have raised concern that her condition was deteriorating. There was a lack of appreciation that failure to decompress the ongoing swelling was likely to lead to respiratory compromise. This was a particular risk for Mrs B because, as a smoker with asthma and a low BMI her respiratory muscles would have been relatively weak. He said that after the Respiratory Consultant raised a concern about splinting of the diaphragm on 14 August, there was a failure to take adequate corrective action.

33. The Adviser said that the clinical assessment on 15 August that Mrs B was improving was not consistent with the documented clinical evidence, including the review by the Respiratory Consultant, the observation chart and the radiological findings. Despite the signs of deterioration, Mrs B was moved to a side room which led to her collapse being unwitnessed. He said that too much emphasis appeared to have been placed on the fact that Mrs B's NEWS was low. In Mrs B's clinical circumstances, the signs that would trigger a rising NEWS, such as low blood pressure or high temperature, would occur at a much later point in her deterioration and in a much worse clinical situation.

34. The Adviser said an NG tube should have been fitted to decompress Mrs B's bowel, but this was not done until after she had a cardiac arrest. It was not correct to work on the basis that an NG tube would only be appropriate if vomiting continued (in fact, it would not be appropriate to fit an NG tube where there was vomiting, but no indication of an underlying cause such as an ileus or obstruction). Action should also have been taken to correct Mrs B's low potassium and oxygenation levels and physiotherapy and mobilisation should have been considered. The Adviser added that these actions would have been consistent with management recommended by the Bowel Obstruction Protocol (2018), which was issued by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

35. The Adviser said that Mrs B's cardiac arrest could have been avoided if the actions outlined above had been taken. Potentially, the need for her to be admitted to the ICU could also have been avoided. He said that the events which affected Mrs B were very uncommon. He had never seen heart failure caused by prolonged splinting of the diaphragm in 20 years of practice.

36. Having been provided with a copy of the Health Board's response to his advice, the Adviser said that it did not alter his opinion on the care provided. He said that the First Consultant's reference to the CT colonography in his letter to the GP as "normal" did not imply that the mucocele was appropriately noted or considered. Instead, it indicated that the finding was considered normal, which it was not. The failure to document consideration of the finding or monitoring was below the expected standards and not simply a failure to meet best practice.

The reasons for what I found

37. In reaching my conclusions I have considered the advice that I have received from the Adviser, which I accept. However, the conclusions reached are my own. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

That the Health Board failed to arrange appropriate follow-up and treatment for Mrs B in response to the incidental finding of mucocele of the appendix

38. Having regard to the Adviser's advice, I find that there was a failure in September 2017 to follow up the incidental finding of mucocele of the appendix on Mrs B's CT colonography. I note that the Health Board accepted that there was a missed opportunity to carry out an appendicectomy, but also indicated that the First Consultant's view, with support from surgical colleagues, was that such a finding would not require removal of the appendix in all cases.

39. The Adviser said that this finding should have triggered a discussion at the relevant cancer MDT meeting, given the cancer risk it posed as set out in paragraph 27 above. I agree with the Adviser that the available evidence indicates that the First Consultant did not consider that the mucocele finding was sufficiently significant to warrant mentioning in the letter to the GP or further discussion with the patient or relevant MDT. I am guided by the Adviser's advice to find that the incidental finding was a clear indication for removal of Mrs B's appendix and that this was missed. Accordingly, I find that the failure to arrange appropriate follow-up was a service failure.

40. While the failure to respond to the finding was a "near miss" in the sense that Mrs B did not develop complications related to the mucocele, the consequences for her were serious. But for this failure, it is likely that Mrs B would have been listed for a routine appendicectomy. On the balance of probabilities, this would have been carried out well before the summer of 2019. If that had happened, Mrs B would not have developed appendicitis requiring an emergency appendicectomy. On that basis, I find that Mrs B was exposed to avoidable risk of developing appendicitis, which itself brought the risk of developing further complications. This was a clear missed opportunity to provide a medical intervention which would have avoided the deterioration in her health which occurred in 2019. This was a serious injustice to Mrs B. I therefore **uphold** this complaint.

41. I note that Mr and Mrs B were entirely unaware of the missed finding on the CT colonography, and the problem was not identified during the Health Board's investigation of the complaint. Had my office not started an "own initiative" investigation to consider this, this significant failing leading

to serious injustice to Mr and Mrs B would otherwise not have come to light. This would not have been possible before the new "own initiative" power was introduced in 2019 and this case demonstrates why it is needed, in the public interest, and for individuals who come to my office.

That the operation to remove Mrs B's appendix was unduly delayed

42. Mr B complained that the appendicectomy was delayed following Mrs B's admission to hospital in August 2019. Mrs B attended the SDEC at 18:16 on 8 August and was given antibiotics for potential sepsis. A CT scan report at 13:39 the next day suggested a diagnosis of mild appendicitis. Mrs B had an appendicectomy just over 9 hours later at 23:02. I note the Adviser's comments that there was a reasonable element of doubt at the time of admission regarding a diagnosis of appendicitis and that Mrs B was treated appropriately for sepsis. On that basis, I am satisfied that there was no undue delay in arranging appropriate investigations or treatment. I find that the appendicectomy was carried out within an acceptable timeframe, taking into account that the initial CT scan did not show evidence of the widespread infection which was discovered at the time of surgery. I **do not uphold** this part of the complaint.

That there was a failure to investigate the cause of Mrs B's breathing difficulties in a timely manner

43. Having regard to the Adviser's advice, I find that there was a failure to provide Mrs B with the expected level of care after her appendicectomy, taking into account that her recovery was likely to be difficult. There were failures to identify the underlying cause of her symptoms, to provide appropriate and timely treatment and to recognise that her condition was deteriorating. These were all service failures.

44. The findings of the initial radiology and the appendicectomy showed that Mrs B had a widespread and rapidly increasing abdominal infection which was causing an ileus. CT scans on 9 and 14 August showed that Mrs B had unresolved swelling in her small bowel. The Adviser said that, in this context, there was a failure to appreciate that Mrs B's breathing difficulties were potentially due to splinting of the diaphragm which was a recognised surgical problem caused by swelling of the abdomen. Instead, worsening asthma was wrongly suspected, and the respiratory referral

was delayed. I was concerned that the apparent lack of an appropriate abdominal examination between 11 and 13 August may have contributed to this.

45. Having regard to the Adviser's advice, I find that there was a failure by clinicians to appreciate that without swift action, the swelling in Mrs B's abdomen was likely to lead to increasing breathing difficulties and that she was particularly vulnerable to this risk. There was a failure to take appropriate corrective action which should have included the use of the NG tube to decompress Mrs B's bowel. I note that while the Health Board said that it was appropriate not to fit an NG tube when the ileus was first detected, a tube should have been fitted in response to the Surgical Team's recommendation. Even after the Respiratory Consultant raised concerns about splinting of the diaphragm on 14 August and asked for further review, there was a failure to take appropriate, proactive action.

46. The Health Board has acknowledged that there was a failure to monitor Mrs B's electrolyte levels. I share the Adviser's concerns that further signs that Mrs B's condition was deteriorating, including tachycardia and falling blood oxygenation levels were missed and that poor documentation of her fluid balance may also have contributed to this.

47. Taking into account the Adviser's advice, I find that, on a balance of probabilities, Mrs B's cardiac arrest is likely to have been avoided if appropriate, proactive steps had been taken to address the swelling in her abdomen. This finding considers that there were a number of factors which contributed to her cardiac arrest and that the relative role of each factor cannot be known with certainty. I note that the Health Board said that the care failings "may, in all likelihood" have contributed to the cardiac arrest. I consider that the finding that it was more likely than not that Mrs B would not have had a cardiac arrest but for the poor care, is consistent with this statement and the statement provided by the ICU Consultant (see paragraph 19), as well as my Adviser's advice.

48. The failure to appreciate Mrs B's deterioration also led to her being moved to a side room where she had the cardiac arrest unwitnessed. Given that CPR was provided successfully, the delay in responding had no clinical impact, but the circumstances of her collapse caused Mr B avoidable additional distress and concern.

49. I find that, on a balance of probabilities, appropriate care would have avoided Mrs B's admission to the ICU and the need for multiple surgical procedures including a tracheostomy. Thankfully Mrs B survived, but her stay in the ICU has clearly taken a considerable toll on her physical and mental wellbeing. She has been left with health and mobility problems that she would not have expected to have to cope with in her 50s and which may significantly limit her quality of life for years to come. These are very serious injustices to her. The period after Mrs B's cardiac arrest must have been extremely distressing to Mr B, given how unwell Mrs B became. Since then, he has had to adjust to a new role providing ongoing physical and psychological support to his wife which he, too, would not have expected to be providing to her, at this level, when she is in her 50s. These are significant injustices to him also.

50. In order to achieve appropriate redress for Mr and Mrs B, I am recommending that the Health Board makes a significant payment to them. This is to reflect the exceptional nature of the injustices I have identified above, and in particular the serious impact on Mrs B's quality of life, taking into account her age at the time of the events complained about. It also reflects that the Health Board missed 2 separate opportunities to spare Mrs B the suffering she has experienced.

What the Health Board should do to put things right

51. I **recommend** that within **1 month** of this report, the Health Board should:

a) Apologise to Mr and Mrs B for the failings and associated injustices identified in this report.

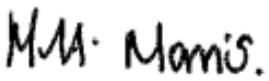
b) Make a payment to Mr and Mrs B of £10,000, reflecting the serious injustices arising from the missed CT colonography finding in 2017 and the poor post-operative care in 2019.

c) Share the report with the First and Second Consultants for the purposes of reflection and discussion at their next annual appraisals.

52. I **recommend** that within **2 months** of this report, the Health Board should:

d) Provide evidence that this report has been discussed at a surgical clinical governance meeting and appropriate learning points shared with relevant clinical teams.

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



Michelle Morris 31 August 2023
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