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The investigation of a complaint against Cwm Taf Morgannwg University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202106392

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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 A. Relevant staff involved are referred to by their posts/designations.

Summary

Mr A complained about the care and treatment his late son, Mr B received at the Princess of Wales Hospital ("the Hospital) between December 2019 and January 2021 when he experienced episodes of bleeding from the navel. Mr B attended at the Emergency Department ("the ED") on 4 occasions: once in December 2019, once in August 2020 and twice on the same day in January 2021. On each occasion he was discharged home. In January 2021, on the day following his discharge, Mr B suffered a further bleed and was taken to the ED where he had to be resuscitated. Mr B sadly died a day later.

The Ombudsman found that the Health Board's "watch and wait" approach was appropriate for Mr B in December 2019 and August 2020. The Health Board's decisions not to refer to liver specialists but to make a referral for consideration of weight loss surgery were clinically appropriate, considering Mr B's best interests.

On 21 January 2021 Mr B attended at the ED on 2 occasions. The Ombudsman found that in respect of the first admission, Mr B should not have been sent home. This was because he had a history of significant bleeding, he was on medication to reduce blood clots, he had mild anaemia, and he also had extremely high blood sugar levels, which would likely have led to admission in its own right. Mr B was discharged home a few hours after his arrival. This decision was clinically inappropriate.

In respect of the second admission on 21 January, the Ombudsman found that Mr B's care should have been escalated to a senior doctor. It is likely that a more senior doctor would have admitted Mr B into hospital. The decision to discharge Mr B for a second time was clinically inappropriate.

Had Mr B been admitted to the Hospital on 21 January 2021, even accepting that he would have been high risk for surgery, his deterioration and death might have been prevented. This represented a failure by the Health Board and caused significant injustice both for Mr B and his family. This aspect of Mr A's complaint was upheld.

By the time Mr B was re-admitted to the ED on 22 January 2021, he was very ill. Emergency surgery at that point would have been futile and would not have been likely to save Mr B's life. The Ombudsman found that the management of Mr B during his final hospital attendance was clinically appropriate.

The Ombudsman made a number of recommendations, which the Health Board accepted. These included:

- An apology to Mr A, and payments to him totalling £5750 for the loss of opportunity for Mr B, and for Mr A having to pursue his complaint.

- To remind all ED doctors of the recommendation by the Royal College of Emergency Medicine to escalate patients making an unscheduled return to the ED, with the same condition within 72 hours of discharge, to a consultant.

- To remind all doctors about interaction with the Coroner, including the importance of providing accurate information. Also, the advisability of discussing a patient with consultant staff and a Medical Examiner following a patient's death.

- To ensure training is provided to all junior doctors in respect of interacting with the Coroner and the Medical Examiner following a patient's death in hospital.

The Complaint

1. The investigation considered Mr A's complaint about the care and treatment his late son, Mr B, received at the Princess of Wales Hospital ("the Hospital"), between December 2019 and January 2021. The investigation focused on the standard of care and treatment provided to Mr B by Cwm Taf Morgannwg University Health Board ("the Health Board") when he experienced episodes of bleeding from the umbilicus (navel) from 1 December 2019 onwards.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mr A. They also obtained evidence from one of my Professional Advisers, Mr Doug Bowley, a consultant General and Colorectal Surgeon ("the Adviser").

3. The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been 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.

4. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

5. 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 guidance

6. Quality in Emergency Care Committee Standard: "Consultant Sign-Off" (Royal College of Emergency Medicine) (2016) ("the RCEM Guidance).

7. Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee Guideline: “Transfusion management of major haemorrhage” (“the Transfusion Guideline”).

8. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. The overriding principle (set out in accompanying Welsh Government Guidance) is that “being open with service users and their representatives when things go wrong in their care is the right thing to do”. This is in addition to any professional duty of candour a healthcare professional will be subject to under their own professional practice regimes, and specifically applies when a healthcare provider is responding to complaints about a service.

The background events

9. On 1 December **2019** Mr B attended at the Hospital Emergency Department (“the ED”) with bleeding from his umbilical (near the belly button) hernia (a hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall). He was subsequently referred to the Surgical Team as an outpatient.

10. On 5 December Mr B experienced a further bleed and was admitted to the Hospital. He was reviewed by a consultant surgeon and tests were carried out, including a Computerised Tomography scan (“CT scan”). The results of the scan were reported to show a fat-containing hernia, with possible portal hypertension (an increase in blood pressure in the portal vein, which carries the blood from the bowel and spleen to the liver and can be the cause of severe gastrointestinal, or other bleeding). Mr B’s liver tests were noted to be normal, and the Consultant Surgeon reviewed the CT scan with a specialist radiologist. Portal hypertension was considered unlikely and he was discharged on 6 December with dressings, a 5 day course of tranexamic acid (medication to treat or prevent excessive blood loss) and a course of antibiotics.

11. On 31 December Mr B was referred for bariatric surgery to the Welsh Institute of Metabolic & Obesity Surgery ("WIMOS") at Morriston Hospital in Swansea. The WIMOS Bariatric Service declined to consider Mr B for surgery as he did not have local access to an Obesity Management Clinic.

12. On 7 January **2020** Mr B was reviewed by the General Surgical Team at an outpatient appointment. It was noted that no further bleeding had occurred, and that Mr B suffered from poorly controlled diabetes and had a high BMI (measure of body fat based on height and weight) of 50. On examination, there were no signs of bleeding, and a small umbilical hernia was felt. The result of the CT scan was noted and a "watch and wait" approach was decided upon, based on the fact that no further bleeding had occurred, and the hernia was small. It was felt that with such a high BMI, surgery was too great a risk for Mr B. He was advised to lose weight and attend at the ED if he experienced further problems.

13. On 10 August Mr B attended the ED with a further bleed from the umbilicus with unknown cause. It was noted to be the first bleed since December 2020 and was not as severe. Mr B said that he managed to settle the bleed by using Surgicel (a dressing to help control bleeding) and 1 dose of tranexamic acid. Surgery was again considered, but the risk for complications was deemed to be too high. Mr B was discharged with further Surgicel for dressing at his GP surgery.

14. On 21 January **2021** Mr B experienced another bleed from the umbilicus and was taken by Mr A to the ED at the Hospital. He was seen by an ED senior doctor ("the First Doctor") at 16:19. Mr B was noted to have experienced bleeding from the site of the hernia at 10:00 and he thought he had lost approximately 2 pints of blood. Mr B was referred to the Surgical Team and was reviewed by a consultant surgeon ("the Second Doctor") at 17:30. The Second Doctor talked to Mr B about surgical treatment. Mr B acknowledged that it would have been very dangerous for him, and in addition, he was unable to lie flat due to his size. As no further bleeding had occurred since arrival at the ED, Mr B was discharged home.

15. At approximately 21:53 on 21 January Mr B was re-admitted to the Hospital by ambulance to the ED, with a further episode of bleeding from the umbilicus. He was seen again by the First Doctor. Blood tests were repeated, and he was referred to the Surgical Team. The Surgical Registrar on call ("the Third Doctor") noted that Mr B looked very comfortable, had no pallor (pale appearance) and was not complaining of abdominal pain. His clinical observations were normal. The impression was that there were no signs of hypovolemic shock (an emergency condition which happens when the body loses too much blood/fluid) or organ hypoperfusion (poor circulation of blood to the body's organs). The bleeding was considered to be a long-term problem, rather than an acute emergency problem. The risk of Mr B contracting COVID-19 whilst in hospital were explained, and the decision made to send Mr B home for ongoing observation and for him to return if further bleeding occurred. Mr B was discharged at approximately 02:20 on 22 January.

16. At approximately 11:30 on 22 January an ambulance was called to Mr B's home. Mr B collapsed following bleeding from the hernia and was taken to the ED at the Hospital. On arrival, he was very unwell and stopped breathing as he was being transferred into the ED. Mr B was seen by a locum consultant general surgeon ("the Fourth Doctor") who examined Mr B but did not identify a large subcutaneous haematoma (an accumulation of blood in the fatty tissue), significant abdominal distention (expansion in the abdomen due to air or fluid) or signs of gastrointestinal bleeding. Exploratory surgery was considered but deemed inappropriate due to the risk. Mr B was transferred to the Intensive Care Unit ("ICU") for ongoing management. Mr B failed to respond to treatment and Mr B sadly died at 11:50 on 23 January.

17. Mr B's death was subsequently referred to HM Coroner ("the Coroner") by the Health Board. There was no post-mortem examination. Before referral to the Coroner, the circumstances of Mr B's death were not discussed with relevant consultants or the Medical Examiner Service ("the ME" - the service provides independent scrutiny of all deaths that occur in Wales that are not referred directly for investigation to the Coroner), although it is noted that there was no legal requirement to refer to the ME at that time (that changed from April this year).

Mr A's evidence

18. Mr A said that, in respect of Mr B's 2 attendances at the ED on 21 January, he felt that Mr B should have received a blood transfusion as he had lost a substantial amount of blood. He was told that this was relayed to hospital staff by the ambulance crew, and they had witnessed there being around half a bucket of blood. He said that despite this, Mr B was still discharged home.

19. Mr A said that as the doctors had not actually seen the volume of blood that Mr B lost that day, the decision to discharge him was incorrect. Mr A said he and his late wife expressed concerns regarding the discharge, but their concerns were dismissed. He remains of the opinion that had Mr B been given a blood transfusion and admitted to the Hospital for monitoring, Mr B would not have died the following day.

20. Mr A raised concerns about the fact that Mr B was not considered or assessed for bariatric surgery.

21. Mr A said that he and his late wife found it extremely frustrating that staff did not speak with them during either of Mr B's admissions. They were very upset that as Mr B was big in size, he was not given proper treatment. They feel that this was used against him. Mr A explained that his wife sadly passed away within a few months of Mr B, and the events had a massive impact on her.

22. Mr A would like the findings of the investigation to be shared with the Health Board to assist with the improvement of its investigation process and for other patients not to experience the same issues as Mr B did.

The Health Board's evidence

23. In response to Mr A's complaint, the Health Board said that Mr B first presented with bleeding from his umbilical hernia on 1 December 2019. Following a further bleed, and admission, on 5 December 2019, a number of tests were undertaken, but no specific diagnosis was established. Mr B

was discharged back into the care of his general practitioner. It said that Mr B was not a robust patient and recognised his morbid obesity as being the underlying reason for his infirmity.

24. The Health Board said that Mr B's hernia was not large and was not symptomatic, apart from the blood loss, which was a very unusual symptom for hernias. In the hope of improving Mr B's health overall, a referral was made to the WIMOS.

25. The Health Board confirmed that Mr B was seen as an outpatient on 9 January 2020. On examination, there were no signs of bleeding, and a small umbilical hernia was felt. The outcome of the appointment was to adopt a "watch and wait" approach. Mr B was considered too high risk for complications from surgery, due to his BMI.

26. Mr B was seen again in August 2020 with a further bleed from the umbilicus. The Health Board said that the appropriateness of surgical intervention for the hernia was re-considered, and the conclusions remained the same.

27. The Health Board confirmed that it was subsequently informed by the WIMOS that it would not be able to progress Mr B's case for consideration for bariatric surgery as he lived outside of the Swansea Bay University Health Board area.

28. In respect of the admissions in January 2021, the Health Board said that Mr B was seen in the ED on 21 January by a senior ED doctor. The ED Doctor arranged for blood tests to be undertaken and referred Mr B to the Surgical Team. Following review by the Surgical Consultant, Mr B was discharged home on the basis that he appeared stable, and no further bleeding had occurred whilst he was in the ED.

29. The Health Board explained that Mr B re-attended at the ED at 21:42 on 21 January, following a further episode of bleeding from the belly button. His vital signs were performed, and his breathing rate was slightly elevated. Blood tests were repeated, and a referral made to the Surgical Team. Mr B was reviewed by the Surgical Registrar who noted that Mr B looked comfortable and was not complaining of abdominal pain. There were no

signs of hypovolemic shock or bleeding. The Health Board confirmed that it believed that Mr B's recurrent bleeding was a long-term problem, and not an acute emergency problem. As surgery was not felt to be in Mr B's interests, and due to the risk of him contracting COVID-19 whilst in the ED, the decision was made to discharge him home for ongoing observation.

30. The Health Board confirmed that Mr B was re-admitted on 22 January following a collapse at home following bleeding from his hernia. Exploratory surgery to identify the cause of the bleeding was considered, but was deemed inappropriate, due to the risk. A CT angiogram (a type of medical test that combines a CT scan with an injection of a special dye to produce pictures of blood vessels and tissues in a part of the body) was arranged. However, the scan could not be performed as Mr B was too large to fit safely through the scanner. As an alternative, an ultrasound scan was performed. No sign of blood collections or recent bleeding could be seen, but the views were limited, and did not enable a diagnosis to be made.

31. The Health Board explained that Mr B remained unwell and was transferred to the ICU for ongoing management. Sadly, Mr B failed to improve, and he died on 23 January 2021.

32. In respect of the decision to adopt a "watch and wait" approach following Mr B's earlier presentations, the Heath Board said that it was satisfied the decision was appropriate.

33. In respect of the decision to discharge Mr B home following his first attendance on 21 January, the Health Board said that this decision was reasonable. Whilst it accepted that, had Mr B remained in hospital, the distress caused to him and the family would have been less, the eventual outcome would most likely have still occurred.

34. The Health Board said that there was a possibility that only the haemorrhage led to Mr B's deterioration, and that haemorrhage would have been stopped at a lower volume had he stayed in hospital. It said that this conceivably could have led to more rapid resuscitation and more time to establish a definitive diagnosis. It said that whether the arrest that occurred could have been avoided was uncertain, but possible, but it was doubtful that the blood loss was the only cause for his deterioration.

35. The Health Board accepted that it was possible that surgery may have been helpful in providing a diagnosis, but it was also possible that it may not have been, with a high likelihood of doing more harm than good. It said that Mr B was already extremely poorly, and the physiological strain of an operation and recovery, in addition to his diabetes and morbid obesity, were such that an operation was more likely to have hastened his death.

36. The Health Board explained that it remained puzzled as to Mr B's rapid and seemingly irreversible decline and that the underlying cause of his death remains unclear. It said that regrettably it had no opportunity to predict or avoid Mr B's death, and that even if Mr B had been in hospital the day before his final admission, that the cause would not have been known nor could his death have been prevented.

Professional Advice

37. The Adviser considered the care and treatment provided to Mr B between December 2019 and January 2021 in respect of the management of the bleeding from his umbilicus.

38. The Adviser said that the management of Mr B's bleeding between December 2019 and August 2020 was clinically appropriate.

- In respect of the finding of possible portal hypertension on the CT scan carried out in December 2019, the Adviser said that he agreed that there was insufficient evidence to warrant a referral to Hepatology for further investigation. The Adviser confirmed that Mr B did not have a high likelihood of portal hypertension and the decision not to refer him for further assessment was appropriate. He said that the decision to refer Mr B for consideration for bariatric surgery was the appropriate decision, considering his best interests.

- In respect of Mr B's 2 attendances at the ED on 21 January 2021, the Adviser said that he does not consider that it was clinically appropriate to have discharged Mr B following either attendance.

- In respect of the first attendance, the Adviser said that at that time, Mr B's blood tests showed mild anaemia, and raised blood sugar of 31.9mmol/L (normal range is 4 to 9mmol/L) but the results were not documented, and there is no evidence to confirm whether the Second Doctor was aware of the results at the time of the clinical consultation. He said that the ambulance crew had documented that Mr B was taking "dual antiplatelet therapy" (blood thinning medication to prevent clots, which increased the risk of bleeding) but again, there is no evidence that the Second Doctor was made aware of this.

39. The Adviser confirmed that Mr B should not have been sent home following his first attendance, for 2 reasons. Firstly, due to his history of significant bleeding whilst on dual antiplatelet therapy and with mild anaemia. Secondly, due to his extremely high blood sugar for which he would expect a referral to acute medicine which likely would have led to admission in its own right.

40. In respect of the second attendance, the Adviser said that in June 2016, the RCEM identified a high-risk group of patients who should be reviewed by a consultant in Emergency Medicine before they are discharged from the ED. The patient groups included "Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge".

41. According to the RCEM Guidance, Mr B should have been escalated to a consultant during his second presentation. The Adviser said that a review by a consultant would likely have led to the decision to admit Mr B.

42. In respect of the decision not to perform a blood transfusion on 21 January, the Adviser said that he does not consider that a blood transfusion would have been appropriate when he was seen by the Second Doctor. However, he considered that it was likely that had Mr B been kept in hospital when he re-presented for a second time, then the indication for a blood transfusion would have been identified.

43. The Adviser confirmed that the care and treatment provided to Mr B following his admission on 22 January was clinically appropriate. He said that the decision-making was appropriate, and the Clinical Team had

sufficient information to make a definitive management decision. The Adviser confirmed that emergency surgery at that point would likely have been futile and would not have altered the final outcome.

44. Following Mr B's death, the Adviser said that he considered the referral to the Coroner to be appropriate, as a death should be referred where the cause is unknown. The Adviser said that the circumstances of Mr B's death were relayed to the Coroner hastily and inappropriately, and without adequate supervision by the Consultants engaged with his care.

45. When considering whether a death was avoidable, the Royal College of Physicians advocates using a scale:

- Score 1 Definitely avoidable.
- Score 2 Strong evidence of avoidability.
- Score 3 Probably avoidable (more than 50:50).
- Score 4 Possibly avoidable, but not very likely (less than 50:50).
- Score 5 Slight evidence of avoidability.
- Score 6 Definitely not avoidable.

46. The Adviser said that using this scale, he considers that, accepting that Mr B would have been high risk for surgery at any time, Mr B's death was probably avoidable, meaning there was a greater than 50:50 chance of survival.

Analysis and conclusions

47. In reaching my conclusions, I must consider whether there were failings on the part of the Health Board and if so, whether those failings caused an injustice to Mr B or his family. In doing so, I have considered whether the actions of the Health Board met appropriate standards rather than best possible practice. I have had regard to the advice I have received, which I accept. However, the conclusions reached are my own.

48. I would like to extend my sincerest condolences to Mr A and his family for the sad loss of Mr B.

49. I accept the advice that I have received that the management of Mr B's bleeding from the umbilical hernia between December 2019 and August 2020 was clinically appropriate. I accept that the Health Board's decisions to adopt a "watch and wait" approach and to refer Mr B for consideration for bariatric surgery were appropriate. The actions of the WIMOS (managed by Swansea Bay University Health Board) in declining Mr B for bariatric surgery, have not been considered as part of my investigation. This particular element of Mr A's complaint is therefore **not upheld**.

50. I accept the advice that I have received that the management of Mr B's care and treatment during his 2 attendances at the ED on 21 January 2021, and in particular the decision to discharge him on both occasions, fell below an adequate clinical standard and that there were several shortcomings in the approach to Mr B's care:

51. There was a failure during the first admission to admit Mr B to the Hospital, despite his history of significant bleeding whilst on dual antiplatelet therapy and with mild anaemia and also due to his extremely high blood sugar levels.

52. There was a failure to record the results of Mr B's blood tests in the medical records, and consequently it is likely that the surgical clinician who reviewed Mr B during the first admission, was unaware of the results of his blood tests.

53. When Mr B attended for a second time, there was a failure to escalate him for review by a consultant, which I consider would likely have resulted in Mr B being admitted to Hospital for treatment.

54. Taking into account the above, I am satisfied that these shortcomings represent significant service failure. It is additionally concerning to note from the Adviser's comments that, on the balance of probabilities, the outcome might have been different for Mr B had he been admitted to hospital on 21 January 2021.

55. The advice I have received is very clear that opportunities to treat Mr B were lost in this regard. Mr A will find this advice upsetting given his concerns that Mr B's death could potentially have been avoided. I am satisfied that the clinical shortcomings in Mr B's care and management represent a serious service failure and that, as a result, Mr A and his family have been caused a significant injustice. This is because we cannot discount the possibility that had Mr A not been discharged, the cause of his bleeding could have been diagnosed and treated. That loss of opportunity in itself represents a service failure and a grave injustice in the circumstances. I therefore **uphold** this element of the complaint.

56. I accept the advice I have received that the care and treatment provided to Mr B following his admission on 22 January 2021 was clinically appropriate. I consider that the Health Board's decision making at this time was appropriate, and that emergency surgery at that time would not likely have changed the outcome for Mr B. This particular element of Mr A's complaint is therefore **not upheld**.

57. I have considered the role of the Health Board in respect of its actions after Mr B's death and the process it followed when making the referral to the Coroner. In consideration of the Health Board's management of the events following Mr B's death, and in particular its referral to the Coroner, I am satisfied that there was a failure to ensure that sufficient and accurate information was provided to the Coroner to support their decision-making. There was a failure also, by those clinical staff who made the referral, to consult senior colleagues who had been directly involved in Mr B's care, or to consult the ME, prior to making the referral. Had the referral been more comprehensive, it may have led to a decision for a post-mortem, or a full Coroner's hearing. As a consequence, Mr A has been denied the opportunity to fully understand what caused his son's death and I consider that this represents a significant injustice to him.

58. I am sharing my report with the Healthcare Inspectorate Wales, whose role it is to independently assess the quality, safety, and effectiveness of healthcare services, so that it is aware of my findings on this case and the recommendations made to the Health Board.

59. I am also sharing my report with HM Coroner for South Wales Central, to highlight the Health Board's failure to provide his office with sufficient and accurate information about Mr B.

60. I note that in addition to the distress caused to Mr A in him experiencing the loss of his son, it has also been a source of frustration to Mr A in having to pursue his complaint with me because the Health Board's own investigation lacked both rigour and candour. An anonymised copy of the Adviser's comments was provided to the Health Board prior to this report being issued, and only at that point did it accept the failings identified. It is regrettable that it has taken until this point for the Heath Board to recognise the failings.

61. Finally, therefore, I must invite the Health Board to review its complaint handling and approach to responses to service users. Whilst not in force at the time of the response here, it was well known that the NHS Wales Duty of Candour would be implemented. The response to Mr A here fell well short of what this duty promotes and is intended to achieve (see paragraph 8). The Health Board needs to ensure that in future it responds openly and honestly to complaints, and that clinicians involved in formulating/feeding into the response also reflect on both the duty, and their own professional standards obligations when doing so.

Recommendations

62. I **recommend** that the Health Board, within **1 month** of the date of the final report:

a) Provides Mr A with a fulsome apology for the failings identified in this report. The apology should make reference to the clinical failings and the impact of these on Mr B's outcome.

b) Offers Mr A redress of £5000 in light of the loss of opportunity afforded to Mr B. To further offer Mr A redress of £750 for the significant time and trouble he has been put to in pursuing this complaint to gain answers to his concerns.

63. I **recommend** that the Health Board, within **3 months** of the date of the final report:

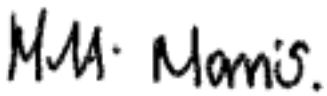
c) Reminds all doctors working in acute care of the Royal College of Emergency Medicine recommendation to escalate patients making an unscheduled return to the ED with the same condition within 72 hours of discharge, to a consultant.

d) Reminds all doctors about interacting with the Coroner, and the importance of providing accurate information and the advisability of discussing the patient with consultant staff and a Medical Examiner following the death of a patient in hospital.

e) Ensures that training is provided to all junior doctors in respect of interacting with the Coroner and ME following the death of a patient in hospital.

f) Shares this report with the Departmental Morbidity and Mortality meeting, particularly highlighting the lack of clarity around dual antiplatelet therapy and the abnormal blood results, which were potentially not acknowledged by the Consultant Surgeon following Mr B's first attendance at the ED on 21 January 2021.

64. I am pleased to note that in commenting on the draft of this report **Cwm Taf Morgannwg University Health Board** has agreed to implement these recommendations.



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