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PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a complaint against Betsi Cadwaladr University Health Board and Denbighshire County Council

A report by the
Public Services Ombudsman for Wales
Case: 202000661 & 202001667

Contents

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 D and to his late mother as Mrs M. Relevant staff involved are referred to by their posts/designations.

Summary

Mr D complained about the care and treatment that his late mother, Mrs M, received at Glan Clwyd Hospital and Llandudno General Hospital. He complained that:

1. Clinicians failed to adequately investigate and appropriately treat Mrs M's symptoms of abdominal pain, gastro-intestinal upset and weight loss which she developed following bowel surgery.

2. Clinicians failed to accurately assess Mrs M's frail condition and discharged her without appropriate home care support in place. This was subsequently provided by the Council but was inadequate and, within days, Mrs M was readmitted to hospital.

3. The decision to remove Mrs M's nasogastric tube led to further weight-loss and deterioration.

4. A secondary cause of Mrs M's death – an ischaemic bowel - was not identified from scans or investigations conducted during her admissions.

5. The Health Board and the Council failed to coordinate their response to the complaint. The Council's response was received 6 months after the response provided by the Health Board.

The Ombudsman upheld complaint 1. He found that senior physicians at both hospitals (including the Colorectal MDT) failed to identify that Mrs M had developed a post-operative blockage in the small bowel (a small bowel obstruction – SBO). He found that, despite conspicuous radiological and clinical evidence pointing to this, physicians inappropriately excluded a physical cause for Mrs M's symptoms and attributed her weight loss and aversion to eating to a "food phobia". The Ombudsman could not definitively conclude that the failure to identify and treat the SBO meant that Mrs M's death was preventable. This was because it was unclear whether she could have sustained further surgery, given her frail condition and comorbidities. The Ombudsman nevertheless considered this to be an

alarming, systemic misdiagnosis and considered the uncertainty surrounding whether an opportunity to surgically intervene was lost to be, in itself, an injustice to Mrs M and her family.

The Ombudsman upheld complaint 2. He found that the attempt to discharge Mrs M failed due to multiple shortcomings on the part of both the Health Board and the Council in relation to pre-discharge planning and to the post-discharge support Mrs M received.

The Ombudsman did not uphold complaint 3. He found that the nasogastric tube was appropriately managed and was removed at Mrs M's request.

The Ombudsman upheld complaint 4. He found that, although difficult to detect, ischaemia might have been preventable had the clinical suspicion of an SBO been considered and pursued. However, the Ombudsman could not definitively conclude this because direct treatment of ischaemia would have rested on Mrs M being able to sustain surgery. As with complaint 1, the Ombudsman nevertheless considered that the uncertainty surrounding the question of whether an opportunity to conduct surgery was lost, amounted, in its own right, to a serious injustice to the family.

The Ombudsman upheld complaint 5. He found that there were complaint-handing failings on the part of both bodies.

The Ombudsman recommended that:

- Both bodies provide Mr D with fulsome written apologies for the failings identified in this report.

- Both bodies share the report with their respective Equalities Officers to facilitate training on the principles of human rights in the delivery of care.

- Each body makes a redress payment to the family of £250 in recognition of failings in complaint handling.

- The Health Board makes a redress payment of £5,000 to the family in recognition of the distress that the findings of this report will give rise to.

The Ombudsman additionally recommended that the Health Board:

- Demonstrates that the report has been discussed with the physicians involved in Mrs M's care and that the diagnostic failings are reflected upon at their appraisals and revalidation.

- Evidences that these physicians have undergone training/revision in regard to: the diagnosis and treatment of SBOs; the theory and practice of the use of contrast media in CT scans and the clinical contexts in which the threshold for CT investigations should be lowered; the medical management of nutritional needs.

- Demonstrates that the relevant nursing teams referred to in the report have undergone revision/training in respect of the Health Board's Discharge Policy and are reminded of the importance of documenting actions, plans and developments surrounding the discharge process.

Both the Health Board and the Council accepted the findings and conclusions of the report and agreed to implement these recommendations.

The Complaint

1. Mr D complained about the care and treatment that his late mother, Mrs M, received at Glan Clwyd Hospital ("the First Hospital") and Llandudno General Hospital ("the Second Hospital"). He complained that:

- Clinicians failed to adequately investigate and appropriately treat Mrs M's symptoms of abdominal pain, gastro-intestinal upset, persistent nausea and weight loss which she developed following bowel surgery.

- Clinicians failed to accurately assess Mrs M's frail condition and discharged her from the Second Hospital without appropriate home care support in place. The home care support subsequently provided by Denbighshire County Council ("the Council") was inadequate and, within days, Mrs M was readmitted.

- The decision to remove Mrs M's nasogastric ("NG") tube (a tube passed into the stomach via the nose to aid the provision of nutritional support) led to further weight-loss and deterioration.

- A secondary cause of Mrs M's death – an ischaemic bowel (a condition resulting from a reduced blood supply to the intestines) - was not identified from scans or investigations conducted during her admissions to either hospital.

- Betsi Cadwaladr University Health Board ("the Health Board") assured the family that those aspects of the complaint that involved social services would be shared with the Council who would respond separately. The response was received 6 months later but only after Mr D pursued this matter with the Council.

Investigation

2. My Investigator obtained comments and copies of relevant documents from the Health Board and from the Council and these were considered in conjunction with the evidence provided by Mr D. Clinical

advice was obtained from 3 of my Professional Advisers: Dr Misra Budhoo (a Consultant Colorectal & General Surgeon), Ms Annabel van Griethuysen (an Advanced Dietetic Clinical Specialist), and Mrs Jean Hazelwood (a Specialist Practitioner District Nurse). I refer to them throughout the report as, respectively, the Medical Adviser, the Dietician Adviser and the District Nurse ("DN") Adviser.

3. My 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 in this report every detail considered during the investigation, but I am satisfied that nothing of significance has been overlooked.

4. My decision to issue this report as a public interest report under s23 of the Public Services Ombudsman (Wales) Act 2019 ("the Act") reflects the gravity of the identified failings in Mrs M's medical care and treatment. Whilst the findings of the report in relation to the Council's home care provision are also concerning, I accept that, in isolation, they may not have met my public interest report threshold. For this reason, I do not require the Council to give publicity to the report or to otherwise modify its response to it in accordance with my public interest report procedure.

5. Mr D, the Health Board and the Council were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant clinical guidance, policies and procedures

6. Reference is made within this report to the following legislation, clinical guidance and policies:

- The Health Board's Discharge Policy & Protocol (Adults): Acute and Community Hospitals 2018 ("the Discharge Policy").

- The Council's Domiciliary Care Services Standard Operating Procedure ("the SOP").

- The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011; "Putting Things Right" ("PTR") - the process for dealing with complaints about the NHS.

- European Society for Parenteral and Enteral Nutrition (ESPEN) guideline on clinical nutrition and hydration in geriatrics ("the ESPEN Guidance").

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Bowel Obstruction Study 2018.

- The Human Rights Act 1998 ("the HRA") and the European Convention on Human Rights ("the ECHR"). Article 8 of the ECHR is enshrined in UK law by the HRA and deals with the right to respect for one's private and family life which encompasses issues of dignity. All public bodies are required to comply with the Act.

- A guide to handling complaints and representations by local authority social services - Welsh Government August 2014 ("the Complaints Guidance").

Relevant background information and events

7. In December **2018** Mrs M (then aged 69) was diagnosed with locally advanced cancer of the colon (where a tumour has infiltrated or adhered to adjacent organs or structures). Her scheduled surgery was expedited, and on 31 January **2019**, surgeons at the First Hospital performed an extended right hemicolectomy (the removal of the right side of the colon) with en-bloc small bowel resection (the removal of part of the small intestine and surrounding tissue). Mrs M suffered an episode of vomiting on 4 February, but otherwise made a satisfactory recovery and was discharged on 8 February.

8. Following discharge, Mrs M began to suffer with low abdominal pain, nausea, vomiting, loss of appetite and episodes of diarrhoea. These symptoms persisted and Mrs M was briefly readmitted to the First Hospital

on 19 and 25 March and on 10 May (she was also seen as an outpatient on 26 April). On each occasion, investigations were inconclusive and Mrs M's condition was treated conservatively. On 19 March a CT scan (a computer enhanced X-ray providing images of the internal organs) identified "loops" in the intestine (a sign associated with an obstruction) and a further scan on 25 March identified thickening of the loops. Clinicians also identified inflammation of the small bowel mesentery (the membrane that attaches the intestines to the abdominal wall) which was treated with antibiotics.

9. On 17 May Mrs M was readmitted to the First Hospital following an intensification of her symptoms. Her loss of appetite and weight were so concerning that an NG tube was introduced. Mrs M's case was discussed at the Colorectal Multi-Disciplinary Team meeting ("the MDT" – a meeting of clinicians from colorectal and related clinical disciplines) and, suspecting that her cancer might have spread, a plan was put in place to conduct exploratory surgery once Mrs M's nutritional status was stabilised (and following her recovery from a chest infection and a lower-limb DVT – a deep vein thrombosis or blood clot).

10. Clinicians at the First Hospital also considered that Mrs M's loss of appetite and aversion to food was not entirely explained by her physical condition and was likely to be partly psychological in nature (a "food phobia"). Mrs M received regular input from dieticians and, in view of her anxious condition, from the Psychiatric Liaison Team (a dedicated psychiatry team involved in the assessment and treatment of patients in general hospitals with mental health problems).

11. Mrs M was subsequently transferred to the Second Hospital (a community hospital) on 10 June for rest and recovery. Although she continued to struggle with appetite and weight-loss, her NG tube was removed at her request and an attempt was made to discharge her on 25 July via referral to the Council's Reablement Team for home care support (reablement teams provide a social care service for the over 65s on a short-term basis to promote greater independence in matters of self-care). Prior to this, Mrs M underwent assessments that appeared to confirm that she was able to self-care (on 11 and 12 June) and to climb stairs (on 14 and 21 June). However, due to her deteriorating condition, together with changes made to her home care provision that left her without

a support package for several days, Mrs M was unable to cope at home and, following the intervention of a psychiatric liaison nurse ("a PLN") and a district nurse, was readmitted to the First Hospital on 3 August.

12. On readmission, Mrs M was anaemic (iron deficient) and had a concerning low blood-albumin level (an indicator of malnourishment). Her NG tube was reintroduced. A CT scan of her abdomen identified excessive fluid in the tissues, but clinicians found "no evidence of bowel obstruction" or of ischaemia. Mrs M's case was discussed by the MDT on 19 August and, in view of her poor nutritional status and frailty, it was agreed that she could not sustain major surgery. Sadly, over the next few days, Mrs M deteriorated and she died on 24 August. A post-mortem subsequently determined that the primary cause of her death was acute peritonitis (inflammation of the membranes of the abdominal wall and organs, typically caused by infection) secondary to small bowel ischaemia.

13. Mr D complained to the Health Board about Mrs M's care by telephone, both during the discharge process (on 16 July) and following her death (on 27 August). He was provided with a formal response on 10 January **2020**. Mr D was unhappy with the response and subsequently approached my office.

Mr D's evidence

14. In his complaint to my office, Mr D described how, following her initial bowel operation, Mrs M suffered with constant abdominal pain, nausea and vomiting and, as a result, developed an aversion to food. Her numerous readmissions to the First Hospital failed to resolve these problems and the family became increasingly concerned that the cause of her deterioration was not being addressed.

15. Mr D said that, following transfer to the Second Hospital, the NG tube was removed but this led to even greater weight-loss, which was alarming, and so it was subsequently reinstated. Mr D said that Mrs M's weight-loss became painful to witness and that she felt "abandoned and helpless". On 10 July Mrs M underwent a mental health review at the family's request as she had told them that she would rather die than continue to suffer any longer.

16. Mr D said that when clinicians at the Second Hospital discussed discharge with Mrs M (who lived alone) she became very distressed as she knew she would not be able to cope. This was underlined when, during a brief pre-discharge visit to her home, Mrs M struggled to climb the stairs and could only descend in a sitting position. This meant she could not easily access the toilet in her upstairs bathroom, and so would have to use a commode on the ground floor. Mr D said that, as Mrs M was "a very proud woman", she felt she had no choice than to go along with the plan. A physiotherapist had assessed her as able to climb stairs on 21 June. However, her discharge was 5 weeks after this, by which time she had significantly deteriorated.

17. Mr D said that Mrs M was in "no fit state" to be discharged on 25 July and that the only support she received was from the PLN who had conducted her mental health review. Mr D said that the PLN contacted social services on behalf of the family in an attempt to obtain additional home care support. When it became clear that there would be a delay in its provision, she arranged for Mrs M's readmission to the First Hospital. Mr D said that the discharge arrangements were completely inadequate but that the family would always be grateful to the PLN for the efforts she made on their behalf.

18. Mr D said that, following Mrs M's readmission, she was considered too frail to sustain surgery. He said that this period was extremely distressing for her and the family. He described how Mrs M was "…unrecognisable. Her hair was falling out, she was leaking fluid from her body and she was covered in bruises and patches of dark colours all over her arms".

19. Finally, Mr D said that (at the time of submitting his complaint) he had heard nothing from the Council, despite being assured that it would respond separately to his concerns about the role of social services in Mrs M's discharge.

The Health Board's evidence

20. In its complaint response letter of 10 January 2020, the Health Board assured Mr D that his concerns about the role of social services in Mrs M's discharge would be shared with the Council who would respond to him directly.

21. The Health Board said that, on the day before her discharge, Mrs M expressed a desire to go home. She reported feeling better psychologically and felt that she would eat better at home. The Health Board said that Mrs M was self-caring with toileting and personal hygiene needs and had been assessed (on 14 and 21 June) as able to mobilise independently and to be able to climb stairs. The Health Board added that a home access visit was conducted by an Occupational Therapist (an OT) on 25 June to assess Mrs M's living conditions (without Mrs M being present). The OT advised that the stair rail be replaced with one that would allow for an easier grip. This was ordered and fitted before Mrs M's discharge. The OT also ordered a perching stool, a commode and a toilet frame (which were delivered on 10 July).

22. The Health Board said that, prior to her discharge, the Ward Manager contacted social services and explained that Mrs M would need additional support due to her psychological condition. It was agreed that a Social Care Practitioner ("the SCP") would meet Mrs M at her home on the afternoon of 25 July to conduct an assessment. The Health Board said that the Ward Manager referred Mrs M to the Reablement Team and, in addition, contacted the PLN who confirmed she would contact Mrs M to arrange a visit.

23. The Health Board said that, on 26 July, the PLN visited Mrs M who was "very upset" as there was, as yet, no package of care in place. The PLN saw that Mrs M could not manage the stairs despite having been assessed as being able to do so. The PLN therefore contacted the SCP who explained that she had discussed the level of support needed with the Reablement Team but, in view of the PLN's concerns, would arrange for twice daily visits to be commenced immediately.

24. The Health Board said that the Reablement Team subsequently withdrew its home care provision and commissioned a care package from a private care agency (which it felt more appropriate to Mrs M's needs). Pending its instigation, the PLN agreed to conduct support visits each Tuesday and Thursday and additionally arranged for a colleague to visit Mrs M on a Monday, Wednesday and Friday. The Health Board said that, however, by Friday 2 August, Mrs M was extremely poorly and the PLN (and a district nurse) arranged for her to be readmitted to the First Hospital the following day.

25. With regard to the family's concern about Mrs M's medical care following her readmission, the Health Board said that Mrs M had abdominal distension (expansion of the abdomen by the build-up of fluid or gas) for which the medical on-call team sought a surgical review. Though an abdominal X-ray showed her bowel to be dilated (due to a build-up of fluid), a subsequent CT scan did not show any bowel obstruction.

26. The Health Board said that NG feeding was recommenced from 8 August and Mrs M was seen multiple times by the PLNs and a consultant psychiatrist (who prescribed medication for anxiety). The Health Board said that the medical team undertook further investigations, including an upper gastro-intestinal endoscopy on 21 August (in which a camera on the end of a flexible tube is passed down the oesophagus) that did not show any abnormalities.

27. The Health Board said that, in response to her deteriorating condition, Mrs M was reviewed by the Medical Emergency Team and by Intensive Care Unit (ICU) clinicians. However, as it was felt that she was unlikely to benefit from escalation to ICU, a decision was made, following discussion with the family, to provide her with end-of-life care. Sadly, Mrs M passed away soon after 18:00 on 24 August.

28. In its communications with my Investigator, the Health Board emphasised that:

- The cause of Mrs M's symptoms, including aversion to food, was not clear and could not be definitively established.

- The MDT decision to conduct further exploratory surgery was based on the suspicion of recurrent malignant disease or perhaps chronic infection.

- Alongside her poor nutritional status, Mrs M developed a chest infection and a DVT during her 17 May admission which precluded major surgery.

- The CT scan of her abdomen conducted on 5 August showed no evidence of bowel obstruction or ischaemia.

- Mrs M's loss of albumin was attributable to Protein Losing Enteropathy (a condition in which albumin leaks into the intestine).

- The NG tube was removed at Mrs M's request. The risks were explained to her, but she was deemed to have mental capacity to make this decision.

- A medical doctor used the term "anorexia" to describe Mrs M's fear of eating. However, this was not a psychiatric diagnosis.

- A copy of Mr D's complaint was sent to the Council on 1 November 2019 with a request that it respond directly to the family.

The Council's Evidence

29. The Council provided Mr D with its outstanding complaint response on 16 July 2020. In its letter the Council apologised for the delay and stated that there had been a miscommunication with the Health Board which failed to provide, as expected, notification that its formal response to the family had been issued.

30. The Council said that Mrs M received support from the Reablement Team for a period following her discharge, though this was discontinued following discussion with her. The SCP attempted to arrange an alternative care package with a care agency, but this service would not have been available until 5 August. The Council said that the service last visited

Mrs M on 30 July - and Mrs M agreed that Reablement was not the type of service she required as she essentially wanted help to empty the commode and for someone to “pop in to keep an eye on her”.

31. In a letter to my Investigator, the Council said that:

- It received a number of assessments completed by hospital staff which indicated that Mrs M was able to mobilise and transfer, as well as climb stairs.

- Mr D was verbally abusive to home care staff which led to an alert being placed on the system advising of the need for double handed calls for staff safety.

- Support was ended on 30 July as there were insufficient staff to deliver the double handed calls and Mrs M “…was not able to engage with the service to a large extent”.

- Mrs M was observed to be preparing meals and drinks. She declined support with personal care.

- It was accepted that there was a gap in service provision between 30 July and 3 August. During this period, Mrs M was not provided with support to empty her commode.

- There appears to have been a considerable difference between what Mrs M felt able to do on the ward, and what she felt able to do at home.

- It accepted that there was a lack of shared responsibility and joint working between the Council and the Health Board.

- The concern Mr D expressed about social services was more in the nature of a comment or query. The Council said that it would have been happy to respond to the matters he raised, but there was a “disconnect” between it and the Health Board. The Council said that the Health Board failed to confirm that its response had been sent to Mr D and that “…the local authority only became aware of [this] when Mr D contacted us in July 2020”.

Professional Advice

Medical Adviser

32. The Medical Adviser began by noting that Mrs M's surgery (on 31 January 2019) was more difficult than normal due to the locally advanced nature of the tumour and the involvement of the small bowel. He said that, following surgery, blood tests identified an abnormally raised CRP level (C-Reactive protein - a marker of inflammation), a raised white blood cell count (WCC - indicating a response to infection) and a low albumin level (indicating a nutritional deficit – although a drop in albumin may also occur in the acute phase of an infection). Mrs M was given antibiotics and her CRP level improved but, 5 days after surgery, she suffered an episode of vomiting. The Medical Adviser said that the last entry in the records before her discharge stated that her CRP had reduced although her WCC had increased.

33. The Medical Adviser said that the development of vomiting (with a rising WCC) 5 days post-surgery, should have led clinicians to consider conducting a further CT scan. He said that, in Mrs M's case, the risk of post-operative complications arising from 2 bowel anastomoses (the sewing or stapling together of the 2 remaining ends of the intestines after a section is removed), some small bowel repair, a rising WCC and a low albumin was significant. As such, these factors should have lowered the threshold to investigate by CT scan, but one was not performed.

34. The Medical Adviser noted that Mrs M re-presented to the First Hospital on 19 March with wave-like abdominal pain, vomiting and inability to tolerate food. Her CRP was again elevated (though no explanation for this was recorded) and a CT scan showed dilated loops of small bowel. The Medical Adviser was clear that these features, together with her other presenting symptoms, were consistent with a small bowel obstruction ("an SBO" - a blockage in the small intestine). However, an entry made in the records on the following day stated that Mrs M had no further pain and that, if fit, she could be discharged home.

35. Mrs M was readmitted on 25 March with increasing abdominal pain (in 30-minute waves). The Medical Adviser said that a CT scan was performed and it was recorded that there was "no significant bowel pathology". However, the scan report identified "thickening of two small bowel loops" (in addition to the persistent dilatation identified in previous images). The plan was to continue with 5 days of antibiotics. The Medical Adviser noted that an entry in the records on 1 April said that Mrs M had reported feeling much better and, as this was the last recorded entry, was presumably discharged. It appears that Mrs M was then seen as an outpatient on 26 April. A Consultant Colorectal Surgeon recorded that Mrs M's "apparent pain" was "…due to her not eating sufficient amounts". A dietician referral was completed, and a plan recorded to see Mrs M in 6 weeks.

36. The Medical Adviser said that the next entry related to Mrs M's 10 May admission, when she presented with intermittent pain and tenderness on the right side of her abdomen. He noted that her CRP was again raised and her albumin very low. Abdominal X-rays showed a dilated small bowel. The Medical Adviser said that these X-rays (and a further CT scan) showed dilated loops of small bowel and featured "laddering" (where small bowel loops appear to be stacked on top of each other). He said that this finding indicated an SBO that was either incomplete (where there are loose motions) or complete (where there is no bowel motion). However, the following day it was again documented that Mrs M was feeling better and could be discharged.

37. The Medical Adviser said that Mrs M was readmitted on 17 May (her substantive admission) with dull abdominal pain, vomiting and poor intake of food. She was described as weak and frail and was diagnosed with possible recurrent malignancy, severe hypoalbuminaemia (very low albumin) and frailty.

38. The Medical Adviser said that Mrs M had multiple admissions for essentially the same problem. The medical notes consistently recorded colicky abdominal pain, vomiting and diarrhoea and often recorded rapid improvement when tenderness in the lower abdomen subsided. On each occasion, Mrs M presented with an elevated CRP and a slowly dropping albumin level. The Medical Adviser said that, whilst investigation reports

were never definitive, the scans consistently identified dilatation of the small bowel and subsequent scans indicated a progressive thickening of the bowel (while showing no evidence of a recurrence of bowel cancer). The Medical Adviser said that these factors, taken together, were strongly indicative of a chronic, incomplete SBO. As such, consideration could and should have been given to further investigation and/or treatment.

39. The Medical Adviser said that Mrs M's apparent food phobia was not, therefore, of psychological origin but was a response to the pain that she suffered after eating. This, in turn, explained her poor dietary intake. The Medical Adviser said that, despite the multidisciplinary approach to Mrs M's care, it appeared that the plan for treatment was led by the "conclusive exclusion of a surgical cause for her symptoms" and that "…overall, the [medical] management represents a failure to critically review, conclude and pursue this diagnosis [of SBO], despite the clear indications pointing to it".

40. With regard to whether this diagnostic failure implied that an opportunity for surgical intervention was missed, the Medical Adviser said that he could not answer this definitively. He explained that, even if the SBO had been identified, it would not have been unreasonable for clinicians to have initially attempted to manage Mrs M's condition conservatively (in keeping with established practice). Additionally, given that this approach met with some limited success (insofar as Mrs M's symptoms appeared to settle during her March admissions), it was not unreasonable that urgent surgical intervention was not initially considered appropriate. The Medical Adviser said that, subsequently, by the time it became clear that Mrs M's condition was not resolving (by, approximately, her second readmission in late March), her nutritional status was compromised and it was unlikely that she would have been considered a candidate for surgery without significant improvement of her condition. The Medical Adviser said that, by May, Mrs M's deterioration and the additional complications of a chest infection and a DVT precluded surgery. The Medical Adviser stressed that surgical intervention would only have taken place under optimal conditions and it was not possible to definitively state that such conditions existed at any time during Mrs M's admissions. As such, he could not say with certainty that an opportunity to conduct surgery was lost.

41. The Medical Adviser said that this uncertainty did not alter the fact that "…three admissions within a short timeframe should have prompted further investigations and possibly definitive treatment". He noted that none of the scans conducted employed oral contrast or dye (taken either as a drink or intravenously) to help with diagnosis (as recommended by NCEPOD), and that further investigation via a CT-PET scan (a more discriminating scan used in the detection of cancer) might have been considered. This scan would have shown potential sites of abnormality and might have pointed towards other causes of Mrs M's symptoms. The Medical Adviser added that Mrs M's poor absorption was attributable to her SBO and not, as stated by the Health Board, to Protein Losing Enteropathy.

42. With regard to Mrs M developing ischaemia (identified at post-mortem), the Medical Adviser said that this is always a possibility with SBOs but is difficult to detect with non-contrast CT scans. He noted that the post-mortem made mention of a "complex mass of bowel with ischaemia". This suggested chronic obstruction eventually leading to ischaemia and perforation (and thus to peritonitis). The Medical Adviser said that "…the ischaemia here is likely an acute event leading to perforation and a natural consequence of matted bowel and obstruction…actual ischaemia could not have been detected earlier but might have been potentially preventable had the clinical suspicion of incomplete SBO with recurrent symptoms been considered". He stressed however, that prevention of ischaemia in Mrs M's case would have rested on her suitability for SBO surgery which (as outlined above) could not be said definitively (in retrospect) to have been possible.

43. The Medical Adviser said that, in view of Mrs M's initial complex surgery, he would have expected a formal plan to have been recorded to ensure improvement after her discharge. He said that the day-of-discharge documentation always appeared abruptly, despite Mrs M's regular returns to hospital, and the records did not contain any discharge summaries. He said that Mrs M's admissions continually included a history of vomiting (with episodes of vomiting in hospital) but there was no objective review of volumes or of the content of the vomitus. He also considered that reliance on dietician input alone was not reasonable since the Consultant is ultimately responsible for the care of the patient. He said that it is difficult

to see from the records that Mrs M's nutritional difficulties were treated with great concern. Albumin levels below 10 are uncommon and did not seem to trigger any level of anxiety regarding diagnosis.

44. In conclusion, the Medical Adviser emphasised that:

- Most of Mrs M's nutritional deterioration was unsurprising. That an organic cause for it was not conclusively excluded before considering psychiatric reasons was a missed opportunity. Clinicians appeared to act with "tunnel vision".

- Very little consideration seems to have been given to the possibility of providing parenteral nutrition (nutrition via a vein, that would by-pass the stomach). Mrs M's nutritional deterioration required more than NG feeding.

- Discharging Mrs M repeatedly without fully addressing her problems (and hoping her appetite would return) was not acceptable.

- Whilst it was not possible to say with any certainty that Mrs M, at any point, was capable of sustaining a further surgical intervention, the missed SBO diagnosis made this possibility progressively more remote as her condition deteriorated and the underlying cause of her inability to absorb nourishment was not addressed.

- Finally, Mrs M was always unlikely to improve in a community hospital. She required further investigation, parenteral nutrition, and a definitive management plan.

Dietician Adviser

45. The Dietician Adviser noted that, following initial referral, the dietetic team offered Mrs M a "food first" approach (as opposed to alternative forms of nutrition). The Dietician Adviser said this was based on Mrs M's preferences and was an appropriate line of treatment (supported by the ESPEN Guidance) which reflected a patient-centred approach.

46. The Dietician Adviser said that (post-discharge) follow-up appointments were arranged by the dietetic team and Mrs M had ongoing monitoring in the community which was appropriate. The dietetic team also appear to have liaised with the wider MDT in respect of the underlying causes of Mrs M's reluctance to eat, including concerns about her mental health.

47. The Dietician Adviser said that, subsequently, Mrs M was unable to meet her nutritional requirements orally and dieticians recommended NG feeding. Mrs M appeared to tolerate the NG tube, along with small amounts of oral intake, and was regularly reviewed throughout May and early June. However, she subsequently appeared to disengage with artificial / NG tube feeding and requested the tube be removed prior to her discharge. The Dietician Adviser said that, on readmission, the dieticians appropriately reintroduced NG tube feeding when it was clear that Mrs M continued to struggle with eating.

48. With regard to Mr D's complaint that the NG tube should not have been removed before discharge, the Dietician Adviser stressed that its removal was carried out at the request of Mrs M who had the mental capacity to make that decision. The notes also indicated that Mrs M was reporting that she was managing oral intake better (she was receiving home-prepared food). Having said this, the Dietician Adviser felt that Mrs M might have been communicating differently with staff and family.

49. With regard to the suggestion that Mrs M's loss of appetite amounted to anorexia, the Dietician Adviser said that Mrs M had no prior history of this condition or dealings with mental health services. She said that the term "anorexia" in clinical practice is generally used to describe someone with no appetite and should not be confused with the clinical diagnosis of anorexia nervosa, which requires specialist eating disorder input and is very different. The Dietician Adviser noted that Mrs M did, however, have difficulties with her mental health, including fear of food and eating. Due to this, the dieticians did include mental health service referrals at frequent points during their reviews.

50. In conclusion, the Dietician Adviser said that, overall, the dietetic treatment provided to Mrs M was appropriate, evidence based, and patient focussed. Moreover, the advice and plans put in place, in regard to supporting oral intake and NG feeding, were consistent with ESPEN guidance.

District Nurse (DN) Adviser

51. The DN Adviser began by noting the Health Board's statement that the Council was informed of the plan to discharge Mrs M in a telephone call from the Ward Manager to the SCP (a call that was not recorded in the nursing notes). The SCP and a Social Care OT subsequently visited Mrs M at home on the afternoon of 25 July to assess her needs and produce a care plan. A referral to the Reablement Team was made by the SCP and this was expedited following a home visit by the PLN the following day. Two (retrospective) referrals were subsequently received from the Second Hospital, dated 26 and 31 July. It was agreed that Mrs M would receive 2 (30 minute) visits a day for assistance with preparing breakfast and an evening meal. It was also agreed that home-care staff would empty Mrs M's commode and assist her in having a daily wash or shower. The DN Adviser noted the OT's assessment and actions (see paragraph 21).

52. The DN Adviser said that the communication between the Health Board and the Council in advance of Mrs M's discharge was fragmented, confusing, lacking in clarity and at times contradictory. There appeared to be no expectation / advance consideration on the part of Health Board clinicians that Mrs M would require a home care package (other than "additional support" due to her psychological condition). There was also a consistent failure to adequately record any consideration this matter was given. The DN Adviser said that, overall, clinicians showed little awareness of numerous elements of the Health Board's Discharge Policy – primarily those relating to communication and recording (e.g., sections 1.2-1.9, 5.51, 5.6.11 and 6.5.2). The DN Adviser said that Mrs M's discharge was not a complex one and that during the weeks she was in the Second Hospital a package could have been prepared to meet her care needs (though this would not have precluded the possibility of the discharge failing).

53. The DN Adviser said that only a passing reference to Mrs M's discharge was recorded by the MDT (on 22 July). She said that, in view of the number of emergency admissions in Mrs M's case, together with the fact that the surgical team were considering further exploratory surgery, she would have expected an MDT to gather and consider all of the relevant information and to identify and put in place what was required for her package of care. She added that there was no documented record of the family being involved at any point with the discharge plan.

54. The DN Adviser said that the care plan prepared by the SCP did not reflect Mrs M's needs as she expressed them in the pre-discharge "What Matters Conversation" (the WMC). This is the stage at which the patient/client's preferences, desires and goals are recorded[1] and did not appear to comply with the standards set out in the SOP (with its emphasis on tailoring services to the client's needs). The DN Adviser noted that the WMC had clearly recorded Mrs M's concern that she was not able to fully wash herself or to cook due to her inability to stand for any length of time. It also referred to how she found transferring to and from the sofa difficult and to how unsteady she was in climbing and descending the stairs.

55. The DN Adviser said that, despite this, the "action required" parts of the care plan enjoined staff to "prompt" Mrs M to perform self-care and mobilisation activities. This appeared to disregard her need for help with these tasks. The DN Adviser said that Mrs M required home care visits to assist her, not prompt her.

56. The DN Adviser said that the care package provided did not address Mrs M's anxiety relating to food, and Reablement staff failed to document oral intake of diet or fluids. Equally, no record was made of any encouragement given to Mrs M to wash or shower. The DN Adviser said that the 1-page, 5-point care plan was wholly inadequate. Moreover, Mrs M did not appear to know what she could expect from her package or from the staff attending to her.

[1] As stipulated by the Social Services and Well-being (Wales) Act 2014).

57. The DN Adviser said that, with regard to the Reablement Team's decision to withdraw its service, the rationale for this was nowhere made clear. Whilst it was understood from the SOP that Reablement offered a "…personalised approach whereby the individual using the service sets their own goals and is supported to achieve them…", there was no recorded discussion of such goals and/or of what, precisely, made Mrs M's situation inappropriate for Reablement intervention. The DN Adviser noted that, according to the SOP, the service can provide "…assistance with washing, showering, bathing, getting up, retiring to bed, toileting, emptying commodes, preparation of meals, diet and fluid intake" and that this precisely reflected the assistance that Mrs M required. The DN Adviser also noted that reference was made by the Council to Mrs M's son having been abusive to Reablement staff who, for safety reasons, subsequently attended Mrs M's home in pairs. However, the DN Adviser could find no documented account of this incident in the daily records or elsewhere.

58. The DN Adviser said that there was no documented explanation for why the Reablement Team felt unable to continue to support Mrs M for the brief period before the private care agency took over her home care. This decision appeared to have been taken with little regard to Mrs M's frail condition (as emphasised by the PLN) and, moreover, sat uneasily with the statement in the SOP that "...if it is agreed that a change is required, we will work with the individual to try to ensure the transfer is done in the best possible way".

59. With regard to the home assessment conducted by the OT, the DN Adviser could find no reference to the problem of where Mrs M would sleep (given her difficulties with climbing stairs). She added that, whilst Mrs M had undergone a stair-assessment in the Second Hospital, this took place some weeks before the discharge and entailed climbing only 3 or 4 steps in a highly supervised environment. Negotiating a full flight of stairs, however, can be very different. Moreover, Mrs M's difficulty with climbing stairs became clear during a pre-discharge home visit in which she had struggled to climb and descend the stairs. There was no evidence that this was inputted into Mrs M's care plan.

60. In conclusion, the DN Adviser emphasised that:

- There was a concerning failure by clinicians at the Second Hospital to adhere to the Health Board's Discharge Policy.

- Assessments repeatedly described Mrs M as self-caring. However, this was at odds with the contents of her WMC.

- Assessments of Mrs M's physical capacities may have been out of date by the time she was actually discharged.

- The Reablement Team's care plan was inadequate.

- The decision of the Reablement Team to withdraw its support provision was not adequately explained.

- Without the voluntary assistance of the PLN, Mrs M would have had no professional support at all.

- Whilst the Council acknowledged that it had not considered how Mrs M would manage to empty her commode, there was no recognition of the severe difficulty this created or of how it might have compromised her dignity and added to her anxieties. This was a particularly acute problem for her, given that she was suffering with a long-term gastro-intestinal upset. The Council's complaint response letter to the family neither mentioned nor apologised for this failing.

Mr D's comments on a draft version of this report

61. Mr D said that, during each of Mrs M's admissions, clinicians spoke of anorexia as a diagnosis and that this caused his mother "endless confusion and anxiety". Mrs M was continuously told that her only problem was lack of food intake. This led her to make determined efforts to eat "…but each time she ended up in worse pain". Mr D said that, in desperation, Mrs M even discussed with mental health clinicians the possibility of undergoing Electroconvulsive Therapy (ECT - a procedure in which small electric currents are passed through the brain causing changes to brain chemistry that can reverse symptoms of certain mental health

conditions). Mr D added that this procedure might have gone ahead had Mrs M not been deemed too weak to undergo it. He said this reflected her desperation to get well and the extent to which she had come to believe that her problems were "all in her mind". Mr D said that the family still find this matter distressing some 2 years on.

62. With regard to the Council stating that Mr D was, on one occasion, "verbally abusive" to a member of the Reablement Team, Mr D said that this was an unfair description of an incident which was taken out of context. He said that, on 29 July 2019, he visited his mother and found her extremely distressed after learning that her support visits had been withdrawn by the Council. Mr D said that, feeling angry and upset, he telephoned the Council and demanded to speak to the SCP. As this was not possible, he insisted that the SCP call him back in due course. However, this did not happen. Mr D said "…I was not subsequently told my behaviour was unacceptable or that it prompted double-handed calls". Mr D said that he was angry on that occasion but not abusive and that the Council has "…used this incident without justification".

63. Finally, Mr D said that family members are still haunted by the memories of Mrs M's acute physical and mental suffering. He said that one of the hardest parts of dealing with their loss is the memory of how their mother was made to believe that her mental health was the main contributing factor to her deterioration.

Analysis and conclusions

64. In considering Mr D's complaint and in reaching my findings, I have had regard to the advice that I have received from my Advisers, although the conclusions reached are my own. The investigation has considered 5 complaint elements and I will address each of them in turn:

1. That clinicians failed to adequately investigate and appropriately treat Mrs M's symptoms

65. I concur with the Medical Adviser that overall, Mrs M's medical management represented a failure to "...critically review, conclude and pursue a diagnosis of SBO, despite the clear indications pointing to it".

This process began (in January 2019) with a failure to recognise the extent of the risk of post-surgical complication that Mrs M was exposed to and with a failure to have recorded a formal plan to ensure improvement after discharge. This was followed by a failure to lower the threshold for CT investigation of her post-surgical symptoms. Subsequently, there appears to have been an abiding, systemic failure during each of Mrs M's 4 readmissions to:

- Identify the signs of an SBO from X-rays and CT scans (including signs such as progressively thickening loops and laddering that can point to obstruction).

- Relate Mrs M's other symptoms to the radiological evidence (her abdominal pain on eating, her nausea, vomiting and diarrhoea), along with the failure to note the easing of these symptoms in response to a reduction of solid food intake and an increase in liquid food supplements.

- Respond to / investigate Mrs M's elevated CRP and WCC levels and her significantly low albumin level (which was incorrectly considered to be attributable to Protein Losing Enteropathy).

- Consider the use of contrast in CT scans (in accordance with clinical guidance) that might have confirmed an SBO or signs of ischaemia and/or consider conducting a CT-PET scan (to exclude the possibility of Mrs M's cancer returning).

- Consider parenteral nutrition and devise a definitive management plan (as opposed to discharging her without addressing her problems in the hope that her appetite would return).

66. I also concur with the Medical Adviser that Mrs M's apparent food phobia was not of psychological origin but was a response to the pain that she suffered after eating – especially attempts at solid food. As such, whilst Mrs M's general anxiety was addressed by the psychiatric team, the idea that this was linked to a food phobia (i.e., to an "irrational" fear of food) was incorrect. As Mr D observed in his comments on the draft report, the impact of this error on Mrs M was profound.

67. It is additionally concerning to note from the Medical Adviser's comments, reproduced in some detail above, that:

- Clinicians acted with "tunnel vision" in the way that they conclusively excluded a surgical cause for Mrs M's symptoms.

- Mrs M's discharges appear to have been organised abruptly without consideration of the repeating admission-discharge pattern and without documenting any formal follow-up plan (either in medical records or in discharge-summaries).

- Mrs M's uncommonly low albumin level did not trigger any particular level of concern regarding diagnosis.

68. I am satisfied that, for the reasons I have outlined above, clinicians failed to adequately investigate Mrs M's symptoms and consequently failed to diagnose her condition of an incomplete SBO. Whilst any such diagnostic failing is a matter of concern, in this case it is additionally concerning to note that the presence of the SBO was supported by conspicuous clinical evidence. I would add that the records provided by the Health Board suggest that the failure to identify the incomplete SBO (from the CT scan evidence) was systemic in nature. That is, the "conspicuous clinical evidence" was apparently missed by a significant number of senior physicians involved in Mrs M's care (including a Consultant Colorectal Surgeon, a Consultant Surgeon, a Consultant Physician, a Consultant in Elderly Care and the Colorectal MDT as a whole). I consider the widespread nature of this failing to be, in its own right, alarming, given my Adviser's view that the signs of an SBO were so evident. I also consider that this systemic failing constitutes a disquieting injustice to Mrs M and her family (and, in view of the implications for patient safety, has led me to forward a copy of this report, at draft stage, to Health Inspectorate Wales).

69. I have also carefully considered whether this diagnostic failing implies that Mrs M's deterioration and death might have been prevented. With regard to this, I have been guided by the Medical Adviser's view that it is not possible to say with any certainty that Mrs M, at any point (after approximately late February), was capable of sustaining surgical

intervention. As such, I cannot conclude with certainty that this failing led, directly or indirectly, to Mrs M's death. It is important to note that every surgery carries an element of risk. Mrs M had already undergone complex surgery in January, so her surgical risk was greater if she were to undergo another significant procedure.

70. Having said this, I nevertheless consider that the uncertainty surrounding this question will remain for the family an enduring source of distress and anguish and, to that extent, I regard it as a significant and disturbing injustice. I am also of the view that the diagnostic failure indirectly caused Mrs M avoidable physical and psychological suffering that was undoubtedly deepened and lengthened by her multiple admissions; by the suggestion/suspicion that her cancer had spread; by the attempt that was made to discharge her in late July (and the burdens of self-care that were inappropriately placed on her by this process); by the suggestion that she was suffering from a mental health disorder (and the ramifications of this as emphasised by Mr D in his comments on the draft report); and by the incomplete understanding of Mrs M's condition that informed the approach to her of all of the clinicians and carers she encountered. Collectively (as well as individually), these failings impacted upon Mrs M's human rights in terms of not only dignity but her quality of life. There was also an impact on the wider family's rights in terms of their witnessing her debilitating decline (as described by Mr D). Whilst it is not for me to make findings of a breach of human rights, even where I might consider there may have been one, the serious events here call into question whether proper regard was given to them in Mrs M's case.

71. On the basis of all these considerations, I **uphold** this element of the complaint.

2. Mrs M's discharge from the Second Hospital

72. I concur with the DN Adviser that communications between the Health Board and the Council in advance of Mrs M's discharge were "fragmented, confusing, lacking in clarity and at times contradictory". Whilst this may largely reflect inadequate record-keeping, such records as

there are suggest there was a concerning failure to observe and comply with (at least) all of the sections of the Discharge Policy listed by the DN Adviser.

73. I also accept the DN Adviser's view that the pre-discharge assessments that were conducted and documented (by OTs and physiotherapists) did not address the problem of where Mrs M would sleep and included a stair-assessment that took place some 5 weeks before the discharge. As such, the assessment did not accurately reflect Mrs M's condition and ability on discharge itself.

74. Additionally, it appears that:

- No specific home care support package had been arranged in advance for Mrs M or discussed in advance by the MDT.

- The referral to the Reablement Team was made by the SCP and OT, not by the Health Board. The Health Board's referrals to the Council were made retrospectively.

- The involvement of the PLN in Mrs M's discharge was not anticipated or planned. Her assessment of Mrs M's abilities and needs (and the extent of the support she would require for them to be met) was conducted on the day following Mrs M's discharge and contradicted assessments that had concluded that she was self-caring, able to mobilise and to climb stairs.

75. I agree that, for the reasons given by the DN Adviser, the care plan prepared by the SCP was inadequate and did not reflect Mrs M's needs as she expressed them in the WMC (and/or as assessed by the PLN). I also agree that the care plan did not address Mrs M's anxiety relating to food and that Reablement staff did not document oral intake of diet or fluids. I am also concerned to note that:

- The rationale for the Reablement Team's decision to withdraw its service was not made clear anywhere. Whilst reference was made by the Council to Mrs M "not engaging" with the Service, this was not clarified or elaborated on.

- The Council's contention that Mr D was "abusive" was not recorded and, as Mr D emphasised in his comments on the draft report, he was not informed that his behaviour had been interpreted as such (or that it had resulted in carers conducting double-handed visits).

- The Reablement Team failed to provide Mrs M with assistance with a range of tasks explicitly specified in its SOP as being within its remit to provide.

- There was no recorded discussion of goals or outcomes that Mrs M wished to / was expected to achieve.

- No explanation was offered as to why the Reablement Team felt unable to continue to support Mrs M for the brief period before the private care agency took over her home care.

- Without the voluntary assistance of the PLN, Mrs M would have had no professional support at all.

- There was no recognition of the difficulty that Mrs M would have encountered in using and emptying her commode following the withdrawal of the Reablement Team. This would have directly impacted on her personal dignity and her human rights.

76. In summary, I am of the view that there were numerous, significant failings and deficiencies (of planning, care-management and recording) before, during and after Mrs M's discharge (on the part of both the Health Board and the Council). The failure of the Health Board to conduct the discharge in accordance with its Discharge Policy was compounded by the failure to coherently document relevant processes, discussions and decisions as these occurred. The significant failings in the home care support that Mrs M received from the Council exposed her to risk (in failing to address her care needs and in leaving her without any appropriate source of support); added to her (and her family's) already heightened anxiety; and created an acute problem around her toileting needs which compromised her dignity and placed an improper and unfair burden on

those in contact with her (friends, family and the PLN) to assist her with this and other matters. I reiterate my comments above in terms of the impact on both Mrs M's and her wider family's human rights.

77. Whilst I accept Mr D's comment (echoed by the Council and the Advisers) that Mrs M was "a proud woman" who found it difficult both to admit that she had incapacities and to accept the assistance of others in personal/intimate tasks, I do not accept that this problem was adequately considered and/or addressed as it might have been had her family been appropriately involved in her discharge. I am of the view that had Mrs M's discharge been properly considered by the MDT in conjunction with her, with the Council and with family members, then a far more accurate picture of her care needs would have emerged and an appropriate means of meeting them might have been arranged.

78. In conclusion, I consider these failings, taken together, undermined any possibility of Mrs M's discharge from the Second Hospital succeeding and, therefore, of being of any benefit to her at a time when she was suffering from a debilitating and unresolved illness. In my view, this amounts to a significant injustice to her and to her family and, consequently, I **uphold** this element of the complaint.

3. That clinicians should not have removed Mrs M's NG tube

79. I concur with the Dietician Adviser that, on the basis of the available records:

- The removal of the tube (in advance of discharge) was done at Mrs M's request. The risks of this were explained to her but Mrs M had the capacity to make this decision.

- At the time, Mrs M reported that her management of oral intake was improving and was likely to improve further with home-prepared food.

- Whilst dieticians (along with other clinicians involved in Mrs M's care) were not fully appraised of the precise cause of Mrs M's aversion to food (i.e., the presence of an SBO), the care and

treatment offered was appropriate to the clinical circumstances and clinical goals as these were understood and formulated at the time.

- The NG tube was appropriately reintroduced following Mrs M's readmission. Its use was accurately documented.

80. For these reasons, I **do not uphold** this element of Mr D's complaint.

4. That clinicians failed to identify ischaemia of the bowel

81. I accept the Medical Adviser's view that, although difficult to detect, ischaemia of the bowel is associated with SBOs. I also accept his view that the problem of detecting ischaemia might have been aided by performing a contrast CT scan which would have highlighted the quality of blood supply to the bowel. However, I have seen nothing to suggest that this option (or the option of conducting a CT-PET scan) was considered.

82. I also accept the Medical Adviser's view that "…actual ischaemia could not have been detected earlier but might have been potentially preventable had the clinical suspicion of incomplete SBO with recurrent symptoms been considered". As this suspicion was not considered, I **uphold** this element of Mr D's complaint. However, with regard to the implication that this failing led to Mrs M's death, I am again unable to definitively conclude this. This is because I accept the Medical Adviser's view that prevention and/or direct treatment of ischaemia in Mrs M's case would have ultimately rested on her ability to sustain surgery. As outlined above, this cannot be said (in retrospect) to have been definitively possible, and I am not able to consider matters with the benefit of hindsight, knowing the eventual outcome. Nevertheless, I am satisfied that, whilst it cannot be said with certainty that Mrs M's death could have been prevented, it is clear that in failing to pursue the clinical suspicion of an SBO, opportunities to intervene were lost. These opportunities may or may not have included the option of surgical intervention, but in keeping with my earlier comments, I regard the uncertainty surrounding this question as an avoidable injustice to Mrs M and her family.

5. Complaint handling

83. The Council's delay in responding to the family's complaint appears to have been due to a communication failure between the Health Board and the Council. The Health Board says it provided the Council with details of Mr D's complaint and expected it to respond directly. It appears that the Council thought that the Health Board would inform it when its complaint response was ready, and that the Council's response would then be issued as a supplement to it. However, the Council said that the Health Board failed to confirm that its response had been sent to Mr D whereas the Health Board expected and thought that the Council would respond independently.

84. Given that there was no clear agreement on issuing a joint response, it was not unreasonable in my view that the bodies sought to produce separate, though interrelated, responses. However, I would note that the Complaints Guidance advocates that local authorities should work collaboratively with health boards and, unless there is good reason not to do so, co-ordinate their investigations and responses with other public bodies. Whilst I am not critical of the decision to issue separate responses if it was considered better to do so, I am critical of the fact that:

- The complaint was received by the Health Board in July (and added to in August) but the Council was not informed that it contained a concern directed against it before 1 November (thus making the co-ordination of a joint response impossible).

- The issuing of the complaint response on 10 January 2020 (with its explicit reference to the Council's pending response) should have prompted the Health Board's Concerns Team to share the letter with the Council or at least to notify the Council's Complaints Officer that the letter had been issued.

- The Health Board's failure to confirm that its response had been sent to Mr D did not, even by July 2020, prompt the Council to query this matter with the Health Board.

85. I consider that these failings (on the part of both bodies) avoidably delayed the provision of the Council's response to Mr D and obliged him to pursue the matter at what was a difficult time for the family. The inconvenience to him entailed by this extended his complaint, added to his distress and frustration and made it more likely that he would escalate his complaint to me. I consider this was an injustice to Mr D and, consequently, I **uphold** this element of the complaint.

86. Finally, I consider that the level of financial redress I am recommending in paragraph 87(b) appropriately reflects the distressing impact that the report's findings will have on the family. In recommending this sum, I have additionally been guided by the limited options for redress that are available to me, given that Mrs M has now passed away.

Recommendations

87. I **recommend** that, within **1 month** of this report being issued the **Health Board**:

a) Provides Mr D with a fulsome written apology for the clinical, care and communication failings identified in this report. This apology should make reference to diagnostic, discharge and complaint handling failings and to the protracted distress and suffering that Mrs M endured as a result of them and which her family will continue to endure on the basis of this report's findings.

b) Makes a payment to Mr D of £5,000 in recognition of this distress and a further £250 in recognition of the inconvenience and trouble to which he was put in pursuing a complaint about these matters to me.

88. I further **recommend** that, within **3 months** of this report being issued, the **Health Board** confirms to me:

c) That this report has been shared with the Clinical Director(s) responsible for the relevant Surgical and Medical physicians involved in Mrs M's care (along with lead physicians in the

Colorectal MDT) and that its findings have been reflected upon and directly discussed with those physicians (where possible) including at those physicians' appraisals and revalidation.

d) That steps have been taken to ensure that these physicians undergo training/revision in regard to:

- The diagnosis, care and treatment of SBOs (with reference to the NCEPOD Bowel Obstruction Study 2018 or other appropriate clinical guidance).

- The theory and practice of the use of contrast media in CT scans and the clinical contexts in which the threshold for CT investigations should be lowered.

e) That these physicians are able to reflect on the poor (medical) management of Mrs M's nutritional needs and on the need to ensure that somatic explanations for loss of appetite are considered before resorting to psychological explanations.

f) That this report has been shared with the relevant Director of Nursing at the Second Hospital and that its findings have been reflected upon and directly discussed with those nurses involved in Mrs M's discharge (where possible).

g) That the relevant nursing team has revised / reflected on the planning, assessment (of capabilities) and communication elements of the Health Board's Discharge Policy (i.e. communication with social care professionals and family members); and that the nursing team has been reminded of the importance of documenting actions, plans and developments surrounding the discharge process.

h) That this report has been shared with the Health Board's Equalities Officer to facilitate training to relevant staff involved in Mrs M's care on the principles of human rights in the delivery of care.

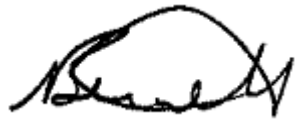
89. I **recommend** that, within **1 month** of this this report being issued **the Council**:

i) Provides Mr D with a fulsome written apology for the care, discharge communication and complaint handling failings identified in this report. This apology should make reference to the inadequacy of the care plan that was prepared for Mrs M, for the poor recording of her dietary, self-care and mobilisation problems and for how the withdrawal of the Reablement Service left her without appropriate professional support. It should also refer to how the withdrawal of assistance she required in using a commode compromised her dignity.

j) Shares this report with its Equalities Officer so that the Reablement Service can receive training on the principles of human rights in the delivery of services.

k) Makes a payment of £250 to Mr D in recognition of the failure to respond to his complaint until prompted by him to do so, and in recognition of the inconvenience and trouble to which he was put in pursuing a complaint about this to me.

90. I am pleased to note that in commenting on the draft of this report **the Health Board** and **the Council** have accepted its findings and have agreed to implement these recommendations.



Nick Bennett 21 July 2021
Ombwdsmon/Ombudsman

ENDNOTE

This document constitutes a report under s.23 of the Public Services Ombudsman (Wales) Act 2019 and is issued under the delegated authority of the Ombudsman.

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
Email: ask@ombudsman-wales.org.uk
Follow us on Twitter: @OmbudsmanWales