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PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a complaint against Cardiff and Vale University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202102028

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

Summary

Miss X complained about the care and treatment her late father, Mr Y, received at University Hospital of Wales ("the Hospital") in March 2020. He went to the Emergency Department ("the ED") but was sent home. Two days later, he was admitted to the Hospital but sadly died a few days later having had emergency surgery.

The Ombudsman investigated whether Cardiff and Vale University Health Board:

- inappropriately discharged Mr Y from the ED
- failed to diagnose a bowel obstruction/strangulated hernia sooner and whether this impacted on his death
- failed to follow the correct do not attempt cardiopulmonary resuscitation process ("DNACPR" - where the heart or breathing stop, and the healthcare team decide not to try to re-start them).

The Ombudsman found that Mr Y was inappropriately discharged from the ED as a result of several shortcomings in the approach to his care. These included a failure to adequately assess his clinical history and new symptoms. The Health Board did not take enough information about Mr Y's bladder symptoms, constipation and new large groin lump. These symptoms pointed to an obstructed hernia which needed treatment, but Mr Y was discharged without adequate assessment. Further assessment and admission at this time might have changed the outcome for him. This complaint was upheld.

Mr Y was admitted to the Hospital 2 days later. The Ombudsman found that his symptoms at this time were typical of a strangulated hernia with bowel obstruction, and this should have been recognised. Failure to do so led to a delay in Mr Y undergoing surgery which meant that his condition got worse. There were missed opportunities to repeat an abdominal X-ray and to carry out a CT scan sooner. The CT scan led to the diagnosis of an obstruction from the hernia. This diagnosis resulted in emergency surgery.

Had Mr Y been appropriately and urgently investigated and diagnosed on the day he was admitted, and undergone surgery sooner, his chances of survival would have been improved.

Mr Y was very ill following surgery, but he was not moved to the Intensive Care Unit (“ICU”). The decision that he would not benefit from this reduced his chances of survival. Had the clinical failings not occurred, and had Mr Y received ICU care following surgery, his deterioration and death might have been prevented. This complaint was upheld.

The Ombudsman was satisfied that the DNACPR decision was clinically justified. There was a record that this was discussed with the family. This complaint was not upheld.

In reaching her findings, the Ombudsman took account of the impact of the COVID-19 pandemic, which was beginning at the time Mr Y was admitted. This was creating extreme pressure for the Hospital staff. Even so, Mr Y was an emergency case and he did not receive the standard of care he should have.

The Ombudsman made a number of recommendations, which the Health Board accepted, including an apology and carrying out a case review to discuss assessment and diagnosis of strangulated hernias.

The Complaint

1. The investigation considered Miss X's complaint about the care and treatment her late father, Mr Y, received at the University Hospital of Wales ("the Hospital") between 23 and 29 March 2020. The investigation focused on whether Cardiff and Vale University Health Board ("the Health Board"):

a) Inappropriately discharged Mr Y on 24 March 2020.

b) Failed to diagnosis a bowel obstruction/strangulated hernia sooner and whether this impacted on the sad outcome.

c) Failed to follow the correct do not attempt cardiopulmonary resuscitation process ("DNACPR" - means that if your heart or breathing stops, the healthcare team will not try to re-start them).

Investigation

2. I obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Miss X. I also obtained advice from one of my Professional Advisers, Misra Budhoo, a consultant general 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 making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

4. In relation to events which occurred at the height of the COVID-19 pandemic, my staff and I carefully consider whether the care delivered was appropriate within this context and take into account the severe pressure on public bodies at the time and the impact on the organisation's ability to balance the demands on its resources, and capacity to provide treatment when reaching a decision about whether the care and treatment was

appropriate. In doing so, I will consider the explanations of the organisations complained about and whether its approach to care and treatment was appropriate at the time.

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

6. Both Miss X 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

7. Third Patient Report of the National Emergency Laparotomy Audit (NELA) (December 2015 - November 2016) ("the NELA Guidance").

8. "Sharing and Involving": A Clinical Policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults in Wales (version 4, 2020) ("the DNACPR Policy").

9. The Health Board confirmed that, for all patients with small bowel obstruction who require emergency surgery, the local emergency laparotomy pathway based on recommendations from NELA will be followed. The Acute Abdominal Pathway Guidance ("the Acute Pathway Guidance ") states that all patients with a predicted mortality of more than 10% in the post-operative period should be admitted to an Intensive Care Unit ("ICU" - a department of a hospital which provides intensive care medicine to patients).

10. My office's "Principles of Good Administration" ("the Guidance") provides a framework for all public service providers to follow in fulfilling their duties.

The background events

11. On 26 December **2019** Mr Y was taken to the Hospital Emergency Department ("the ED") by ambulance following a fall. He had a suspected hip fracture and underwent an operation on 28 December where a dynamic hip screw was used as a fixation for the fracture. He was discharged on 16 January **2020**.

12. On 23 March (the first day of the COVID-19 pandemic restrictions) Mr Y arrived at the Medical Assessment Unit ("MAU" - a short-stay unit) at 22:17 and was assessed at 22:25. He presented with urinary problems (struggling to pass urine) and pain in his lower abdomen. A further review noted that Mr Y was unable to pass urine, had a feeling of fullness and discomfort, had opened his bowels the previous day and had no nausea or vomiting. His daughter was noted to believe he was more confused that day.

13. An examination identified a right-sided inguinal hernia,[1] noted as "huge irreducible[2], non-complicated hernia, no signs of inflammation, solid in consistency". Mr Y's care was discussed with a surgical registrar who asked for an X-ray of the abdomen, noting the hernia and questioning a possible intestinal obstruction. The X-ray results noted, marked faecal loading (where stools build up in the last part of the large intestine, often resulting in the inability to pass a stool) but no suggestion of obstruction (a bowel obstruction is a condition in which the bowels cannot work properly due to a narrowing of the bowel) or perforation (a hole or gap in the wall of the small intestine, large intestine or stomach).

14. Mr Y was reviewed by a surgeon on 24 March. The impression was of a longstanding inguinal hernia that was not acute (i.e. an illness that develops quickly). Mr Y was discharged with a follow-up outpatient clinic appointment for hernia management, pain relief and advice to return if he was unwell.

15. On 26 March Mr Y arrived at the MAU at 16:31 following a referral from his GP and was assessed at 16:46. He presented with vomiting for 3 days. He was noted to be usually fit and well, with increased ketones (chemicals that build up when your body starts to burn fat for energy and can indicate that your body needs more insulin). He was noted to have had recent urinary retention and a urinary tract infection ("UTI") and had a history of type 1 diabetes (which causes the level of sugar in the blood to

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[1] A hernia happens when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall. An inguinal hernia is the most common type of hernia and can appear as a swelling or lump in the groin, or as an enlarged scrotum (the pouch containing the testicles). The swelling may be painful.

[2] An irreducible hernia is a hernia that cannot be pushed back, manually through the opening in the abdomen.

become too high and happens when your body cannot produce enough of a hormone called insulin, which controls blood sugar). His pain score on admission was moderate. The plan was to carry out blood tests and to see the Medical Team.

16. A Medical Team review took place at 18:00. Mr Y was reviewed by an FY1 Medical Doctor[3] ("the First Doctor"). His presentation was noted as fatigue, confusion, abdominal pain, nausea and vomiting. His ketones (5.9)[4] were noted to have increased. Mr Y's history was noted as 2 days of feeling very fatigued and weak and generally unwell. He was noted as having lower abdominal pain; a dull ache but sometimes a sharp pain. Mr Y's presentation at MAU 3 days previously with an inguinal hernia was noted but that this pain was different. He was not eating and drinking very much, and he was vomiting a lot and was unable to keep anything down. Polydipsia (excessive thirst) and polyuria (frequent urination) was increased, and Mr Y was noted as having been urinary incontinent on occasions, but that he denied dysuria (pain or discomfort when urinating) and haematuria (blood in the urine). His bowels had opened 2 days previously, but he had no diarrhoea/constipation. His medication history was noted. A clinical examination noted that Mr Y was alert but sleepy, warm, and well perfused (perfusion means the flow of blood or fluid to tissues and organs) with a regular pulse. His lower abdomen was tender. The diagnosis based on increased ketones was possible dehydration, UTI or gastritis (this occurs when the lining of the stomach becomes inflamed after it has been damaged).

17. Mr Y was seen on post-take ward round (a review of the initial history, examination and results and the stage at which further treatment and investigations will be determined) by a consultant in General Medicine, Diabetes and Endocrinology ("the First Consultant") who noted a history of confusion, lower abdominal pain, vomiting, frequent urination and type 1 diabetes. Mr Y was examined and his blood results were reviewed. His X-ray from 24 March was noted in terms of faecal loading. The diagnosis was hyperglycaemia (high blood sugar level) with ketosis (elevated levels of ketone in the blood or urine), dehydration and constipation; he did not

[3] A junior doctor in their second foundation year of training.
[4] Lower than 0.6 is a normal reading and 3 or above means you have a very high risk of diabetic ketoacidosis.

fulfil the criteria for diabetic ketoacidosis ("DKA" - a serious problem that can happen in people with diabetes if their body starts to run out of insulin; when this happens, harmful substances called ketones build up in the body which can be life-threatening if not found and treated quickly). The plan included consideration for computerised tomography head scan ("CT scan" - a scan that uses X-rays and a computer to create detailed images of the inside of the body) if Mr Y's confusion did not resolve.

18. On 27 March Mr Y was reviewed by a consultant in Diabetes and Endocrinology ("the Second Consultant") at 09:30 on the MAU. He was still complaining of abdominal pain and increased confusion. The hernia was noted, and that Mr Y continued to have nausea and vomiting despite taking antiemetics (medication to treat nausea and vomiting). On examination of his abdomen, it was noted that bowel sounds were quiet, there was no pain and that there was a tender hernia. The impression was of possible bowel obstruction and the plan included blood tests, an X-ray and a CT scan of the abdomen/pelvis if Mr Y's bowels did not open that day. An entry at 12:40 noted that clinicians were awaiting the CT scan report and that it looked like Mr Y had an obstruction secondary to hernia. The plan included a surgical review.

19. A surgical review took place by a surgical registrar at 13:30 noting they were asked to see Mr Y regarding an obstructed hernia. The impression was of obstructed hernia, and possible COVID-19 and the plan was for surgery. A consultant colorectal surgeon ("the Third Consultant") operated on Mr Y; she repaired his hernia, and part of his bowel was removed to form an ileostomy (where the small bowel (small intestine) is diverted through an opening in the abdomen).

20. At 00:35 on 28 March Mr Y was seen by an Intensive Care consultant due to respiratory failure and shock. Mr Y's comorbidities (multiple physical conditions) and frailty score (6)[5] and general decline over the last 6-12 months and his current physiological dysfunction indicated that critical care would not improve his outcome and that he should be considered for end-of-life care. It was documented that the Intensive Care Consultant had spoken to Miss X and explained Mr Y's deterioration and poor chances of

[5] The Clinical Frailty Scale is a scale used to assess a person's illness, function and cognition with 1 being very fit and 9, terminally ill.

survival and that she understood. The recommendation was for Mr Y to receive ward level care, consideration of transition to end-of-life care, to arrange a family visit and to complete a DNACPR form.

21. At 01:15 Mr Y was seen in relation to prescribing end of life medication. The plan was to contact a surgical doctor ("the Surgical Doctor") to clarify escalation/DNACPR and level of care. The Surgical Doctor discussed Mr Y's condition and DNACPR with the family (the records document that both Miss X and Mrs Y were present for this discussion) and the form was completed at 01:50. A discussion took place at 02:40 about the level of care for Mr Y noting that DNACPR had been appropriately implemented and the family were aware.

22. A discussion took place with the family later that morning about Mr Y's ongoing care and their concern about the approach to Mr Y's treatment. The Third Consultant explained to Mr Y's wife and daughter that he continued to deteriorate post-operatively and when the family questioned why Mr Y was discharged the previous week, she explained this was not entirely clear and that hernias can be misdiagnosed and not as well tolerated by the elderly. Mr Y sadly died on 29 March.

23. A Coroner's inquest concluded that Mr Y died of natural causes with the medical cause of death recorded as multi organ failure, acute kidney injury and strangulated hernia with bowel obstruction.

Miss X's evidence

24. Miss X said her father was admitted to hospital with difficulties urinating and a lump in his abdomen. She said that, at the Coroner's inquest, the Doctors implied that they had told the family about a suspected blocked bowel and that they should return to the MAU if Mr Y was sick or had not opened his bowels. Miss X said they were not told this and had they known there was a bowel issue, they would have taken Mr Y back to the MAU the following day. Miss X said that the Health Board had put the blame on her for ignoring advice to monitor for bowel issues and because she apparently decided to withdraw treatment.

25. Miss X said the Hospital failed to tell the family that Mr Y had deteriorated or that he would undergo an operation. Until they received a call following Mr Y's operation from the Intensive Care Doctor, the family thought Mr Y was being treated for DKA; she said they had no idea her father had a bowel problem.

26. Miss X said that communication with the family was "appalling". She said the Health Board dismissed her complaint and her concerns about her father's treatment and DNACPR process.

27. Miss X said her father was still working the week of his death and the family had no way of preparing for what happened. She said the family had to deal with losing her father, emotional and financial distress and it had impacted on her mental health. She said the family's lives had been destroyed and they still did not have answers. Miss X said she felt the accounts given at the inquest were untrue and she feels guilty that she could have missed something.

28. Miss X would like the Health Board to acknowledge that communication from her father's admission to the Coroner's inquest was not "good enough" and caused the family stress. She would also like the Health Board to accept that the family did not decide to withdraw her father's treatment or place a DNACPR on her father and that the treatment he received was not of the required level. Miss X said that her father was not treated well and that his death could have potentially been avoided.

29. In commenting on a draft version of this report, Miss X said that Mr Y had been complaining of nausea and struggling with hiccups on 23 March. In addition, she recalled that doctors had tried to reduce Mr Y's hernia but were unsuccessful and that a nurse had carried out a bladder scan. She disputed that Mr Y was discharged with pain relief on 24 March or that they were told that Mr Y should return to hospital if he felt unwell.

30. In addition Miss X said that on 26 March, her father was struggling to stay awake and appeared to be losing consciousness mid-sentence and that she was unable to wake him when this happened. She said that the diagnosis, at this point, was not shared with her.

31. Miss X disputed that the DNACPR decision was discussed with her mother. She said her mother is deaf and lip reads, and staff were wearing masks due to COVID-19 so she would not have been able to understand what staff were telling her. Miss X did not dispute that the DNACPR decision was appropriate given the severity of Mr Y's condition, but she disputes that a discussion was had with the family.

The Health Board's evidence

32. In response to Miss X's complaint, the Health Board said that Mr Y was diagnosed with a large right sided inguinal hernia that was not tender, his abdomen was soft and there were no signs of peritonitis (an infection of the inner lining of the tummy) at that time and he was not complaining of nausea. Based on these findings, the Health Board said that it was felt Mr Y was suffering from a long standing, non-acute hernia that did not require any surgical intervention at that time. The Health Board said a hernia repair would usually be undertaken as a planned, elective procedure (i.e., a surgery that is scheduled in advance); only if it was causing further problems such as obstructing or perforating the bowel, would an emergency repair be arranged which was not indicated in Mr Y's case. The plan was for Mr Y to be discharged and to return as an outpatient to discuss a plan to resolve the hernia. It said hospital admission and urgent hernia surgery was not indicated at this admission and that there was no clinical reason for Mr Y to undergo an operation during his admission on 23 March 2020.

33. The Health Board was unable to say when the hernia first appeared, and that when Mr Y was admitted in December 2019 with a broken hip, he would not have been examined in his groin area.

34. The Health Board acknowledged there was poor communication with the family in relation to Mr Y's deterioration and the decision to operate. It said that staff had been reminded of the importance, at all times, of regular communication with families.

35. In response to the family's concern about not consulting with them before the DNACPR decision was made, the Health Board said that when Mr Y was still in the Recovery Unit following his operation, the Anaesthetist

asked for a review by the ITU Doctor due Mr Y's poorly condition. It said the ITU Doctor felt that due to Mr Y's other medical conditions and considering the severity of his illness at that time, he would not have benefited from a transfer to ITU, and it was documented that the ITU Doctor spoke to the family and explained the situation. It said the DNACPR form was signed at 01:50 on 27 March by the Surgical Doctor and the form stated it was discussed with Mr Y's wife. The Health Board apologised if the clinical decisions made were not clearly explained to the family at the time.

36. The Health Board said that on 26 March, Mr Y was seen by the First Consultant who noted that Mr Y was haemodynamically stable (stable blood flow) with some tenderness in the lower abdomen. The review of the X-ray from 2 days previously noted marked faecal loading and no signs of intestinal obstruction or bowel perforation. The clinical impression was of hyperglycaemia (high blood glucose), ketosis, dehydration and constipation. The plan was for insulin, fluids, anti-sickness medication, laxatives and a CT head scan if Mr Y's confusion did not settle.

37. The Health Board said Mr Y was reviewed by the Second Consultant on 27 March. Her impression was faecal impaction, but she wanted to rule out intestinal obstruction. A CT abdomen scan later that morning showed a small bowel obstruction, and the Surgical Team were contacted at that point. The Health Board said the First Consultant did not consider the need for an abdominal CT scan during his review as there were no features of intestinal obstruction. In addition, Mr Y's lactate blood test was only mildly raised (it said this is usually very high when oxygen supply to the gut is compromised) and the recent X-ray showed marked constipation with no features of intestinal obstruction or bowel perforation.

38. Following Mr Y's operation, the Health Board said that due to his poorly condition (very low blood pressure and difficulty maintaining oxygen levels), the Anaesthetist asked for a review by an ITU doctor who felt that, due to Mr Y's other medical conditions, he would not benefit from being transferred to the ITU.

39. In commenting on a draft version of this report, the Health Board said that the Coroner's inquest and outcome concluded that Mr Y died of natural causes.

40. In addition, the Health Board explained that Mr Y presented during the first week of lockdown. It said the situation in hospitals was very difficult and every aspect of patient care was being re-evaluated and re-organised. It said that ED services were aiming to send people home if at all possible as the risk of contracting COVID-19 in a hospital setting was known to be substantial and the mortality risk, during the first COVID-19 wave for patients with comorbidities increased for hospitalised patients with COVID-19. The Health Board explained that any patient with a temperature or respiratory symptoms was deemed to have suspected COVID-19 (at that time it said there was no test available). It said Mr Y fell into this category when he was referred to surgeons on 27 March 2020, and this, along with the delay in addressing his hernia and the possibility of bowel strangulation meant he was deemed high risk for surgery.

41. The Health Board said that surgical theatres and ITU were being re-configured, and staff were being trained in techniques to reduce the possibility of COVID-19 transmission, and at that time, it was unclear how much demand there would be for ITU support.

42. The Health Board explained the Third Consultant had a discussion with Mr Y pre-operatively to explain that if he did not have an operation, he was 100% likely to die. It said, if he did have an operation, there was still a significant chance that he would die, particularly if the bowel was ischaemic as suspected. It said Mr Y was able to give consent to surgery on the grounds that he had no other option, and it was his only chance. Although no ITU bed was available, it said if there had been any reasonable prospect of improvement, Mr Y could have been ventilated and given inotropes (medicine that alters the force or strength of the heartbeat) in the recovery area. However, it said Mr Y's condition worsened during the operation, such that his vital organs were less well functioning and did not improve despite removing the ischaemic bowel. It said it was sadly not unexpected that Mr Y deteriorated and passed away over the next couple of days.

43. The Health Board said that Miss X was noted in Mr Y's records as the next of kin. Regarding the timings of the DNACPR discussion with the family, it said that Mr Y's clinical records documented, at 00:35 on 28 March 2020, that the Intensive Care Consultant had spoken to Miss X and that she was told about her father's deterioration and that he was

unlikely to survive and that she understood. At 01:15, it said the clinical notes documented a review, that the Surgical Doctor was contacted to clarify escalation and DNACPR position and that a discussion took place with Mr Y about DNACPR and the seriousness of his condition. The Health Board said Miss X and Mrs Y were noted as present during this discussion and that the DNACPR form was completed after this.

44. The Health Board said that whilst it was now reported that Mrs Y was deaf, there was no mention of this previously and Miss X was documented as the next of kin and was present when the discussions took place. The Health Board apologised if Miss X and Mrs Y did not understand the discussions in relation to DNACPR and acknowledged that this was a distressing time for them. Had they been aware of any communication difficulties, it said that consideration would have been made in relation to these at the time. It said that the DNACPR decision is a clinical decision; however, the decision was discussed with Mr Y, Miss X and Mrs Y as documented in Mr Y's records.

Professional Advice

45. The Adviser considered Mr Y's admission between 22 and 24 March and whether discharge was appropriate. The Adviser explained that Mr Y was admitted as an emergency on 22 March with difficulty passing urine. During this admission, Mr Y had difficulty but no pain on passing water, he had no nausea or vomiting, he had lower abdominal and bilateral loin pain, a large lump was noticed by Mr Y in his right groin, he had pain in his groin and back when straining to open his bowels and these were all new onset symptoms. On examination of Mr Y's abdomen, he was noted to have a solid irreducible "non complicated" inguinal hernia, which was not tender. An abdominal X-ray showed no signs of obstruction, and the conclusion was a long-standing hernia and to discharge Mr Y with advice to return if he had any problems.

46. The Adviser said there was a failure to adequately assess both the history and new onset symptoms, which he said pointed to an acute obstructed hernia. He said that there was no recorded previous history of difficulty in passing urine, no assessment of bowel symptoms but a reliance on the X-ray to state that Mr Y was constipated.

47. The Adviser noted that of significance was a history obtained from Mr Y that he had "only noticed lump today" in his right groin; he said that this was described as a "hard lump" in MAU and "soft" by a surgical doctor. The Adviser said neither clinician assessed for cough impulse (a manual method of detecting hernias) nor attempted to reduce the hernia (where the contents can be returned through the fascial defect (a band of connective tissue) back into the abdominal cavity without surgical intervention). The Adviser said there was an over reliance on the abdominal X-ray to show bowel obstruction in a relatively acute situation; he said it took many hours for distension and symptoms to develop. He said there was too much reliance placed on the abdominal X-ray to diagnose the absence of acute small bowel obstruction from an acute obstructing hernia; he said signs of vomiting, bowel distension and significant pain usually comes later (12-24 hours).

48. The Adviser said the hernia was "incorrectly" described as "uncomplicated"; he said it was at best irreducible or incarcerated (he said this was a complicated hernia). The Adviser said the case should have been treated as an acute inguinal hernia and given the overall picture, should have been assessed further. The Adviser noted that Mr Y had difficulty in passing water which was acutely related to straining and a new lump in the groin; this could be an acute hernia where part of the bladder is trapped in the hernia. There was no record of the volume of urine passed in MAU or an assessment of residual urine that may have revealed urine retention. In addition, given that Mr Y could not recall the presence of a large lump in his groin, the Adviser said it was unsafe to diagnose a long-standing hernia; he said there was a dissociation from the history to examination, leading to a conclusion of long-standing hernia (he said this overrode Mr Y's statement that the hernia was not noted before). He said no attempts were made to assess Mr Y's cough impulse in the hernia or its reducibility; a lack of cough impulse in an acute hernia is a clue that the hernia may be obstructed as well as incarcerated.

49. The Adviser said that Mr Y's recent symptoms and recent development of a large lump in the groin area were indications that he had an acute hernia, which appeared to have been developing when straining; he said lower abdominal pain and urinary symptoms with a new onset groin lump can be a presentation of an acute obstructed hernia due to the

anatomical vicinity of the bladder. He said the lack of history taking in relation to bladder symptoms, constipation, the new large groin lump (which was not adequately assessed) provided an ill-informed basis for a diagnosis of long-standing hernia and in the Adviser's opinion was suggestive of an assessment that was below an acceptable clinical standard. He said an abdominal X-ray was not a reliable predictor of bowel obstruction and on balance, Mr Y had an acute inguinal hernia that was incarcerated with early obstruction.

50. The Adviser said that Mr Y should have received a more adequate assessment in view of his acute symptoms (bladder pain, new lump, raised white blood cell count), consideration should have been given to a CT scan as well as admission. The Adviser's view was that admission and further assessment would "likely have had a significant impact on the outcome" and that Mr Y was discharged without an adequate explanation of his symptoms.

51. In considering whether there was a failure to diagnose a bowel obstruction/strangulated hernia, the Adviser said that on 26 March, Mr Y's symptoms were noted as urine retention, a history of confusion, frequency of urine, lower abdominal pain and vomiting and he was seen by the Medical Team. An examination showed lower abdominal tenderness and blood tests showed a high urea level (raised urea levels are associated with dehydration, renal failure and chronic cardiac failure). Mr Y's previous X-ray was reviewed showing "faecal loading". A provisional diagnosis was made of possible UTI or gastritis with dehydration and constipation. The plan included IV fluids and a CT head scan if Mr Y continued to be confused.

52. The Adviser said that the presenting features of abdominal pain, vomiting, and constipation were consistent with a diagnosis of intestinal obstruction and the history of a new onset hernia, and the recent admission made the case for this. The Adviser said that a surgical referral on 26 March could have been made and "the outcome may have been different". In addition, he said there was a missed opportunity to repeat an abdominal X-ray and carry out a CT scan.

53. The Adviser noted that on 27 March, Mr Y continued to complain about lower abdominal pain and his presentation with hernia, faecal loading and increased ketones was noted and that Mr Y was vomiting and could not keep anything down. An examination of his abdomen noted a mildly tender hernia, and a comment was made about an obstruction with a plan to consider a CT scan if Mr Y's bowels did not open. Later that day, a CT scan showed an obstruction from the hernia, and Mr Y was booked for surgery; the impression was of an obstructing inguinal hernia (the Adviser said the indication was that this was more advanced and should have been treated as "strangulated", "loss of blood supply" indicating an emergency situation existed).

54. The Adviser said that Mr Y's history, including vomiting, abdominal pain, new hernia, constipation, ketosis in a diabetic were all typical symptoms of bowel obstruction. He said it was not until the day after his admission (27 March) that clinicians appreciated that Mr Y had a bowel obstruction secondary to an inguinal hernia. He said there was a failure to review Mr Y's recent records on 23 March and to note the history and the hernia. The Adviser said the abdominal X-ray was reviewed but no comment was made on the presence of an inguinal hernia which only appeared to have been noticed and examined on 27 March, and on this occasion, it was described as tender. The Adviser said that, at this stage the most likely diagnosis was a strangulated hernia with bowel obstruction. He said that, had it been appreciated that this was an obstructed and possibly strangulated hernia for at least 3 days, emergency surgery (within 6-12 hours of admission) would have been indicated. He said a delay to surgery for over 24 hours was detrimental in a patient who was already frail and compromised by an acute illness.

55. In addition, he noted that there was a failure to appreciate that Mr Y was now significantly dehydrated; he said there was poor documentation, monitoring and management of a dehydrated patient. He said the fluid balance records were inadequate for a dehydrated patient and the amount of fluids prescribed were not reflective of attempts to correct this but standard prescribed fluids. By the 27 March, Mr Y's urea had climbed further despite being given IV fluids which was most likely due to inadequate rehydration. In addition, there was no regular monitoring of urine output given Mr Y's severe dehydration (he was not catheterised to

monitor his urine output) and no NG tube (a nasogastric tube) was inserted initially, despite the history of persistent vomiting. The Adviser said there was a lack of appreciation of the need for an NG tube in a persistently vomiting patient, secondary to bowel obstruction and an NG tube was only considered if Mr Y "continued" to vomit. The Adviser said that, had it been appreciated on admission that the persistent vomiting was caused by a bowel obstruction secondary to an inguinal hernia, an NG tube could have been inserted to decompress the bowel.

56. Early in the evening on 27 March, the Adviser said Mr Y was dehydrated, his respiratory rate had climbed, and he required oxygen; Mr Y was very seriously ill. He said that as a frail patient, Mr Y's deterioration would have significantly reduced his chances of survival from surgery. The Adviser noted that Mr Y's mortality was calculated to be in the region of 16% before surgery; he said the NELA Guidance recommends ITU care for mortality over 5%. However, the recommendation was that Mr Y would not benefit from ITU care and that he should be on a supportive care pathway and managed on the ward. Mr Y required 10L oxygen to maintain his oxygen saturations (indicates the amount of oxygen travelling through the body; a normal oxygen saturation is usually between 95 - 100%). He said this decision further reduced Mr Y's chances of survival significantly to very low.

57. The Adviser was of the view that a period of supportive care in the 24-48 hours after surgery could "possibly have made a difference" in that Mr Y was already at high risk and fitted the criteria of needing ITU post operative care. He said without ITU post operative care and the anticipated deterioration from surgery, the likelihood of survival was poor. The Adviser said that NELA recommendation for ITU care was not considered because it was felt that Mr Y would not benefit. He said if this was anticipated, it made surgery futile as without ITU support, surgery in a very high-risk patient becomes sub-optimal. The Adviser said the discussion on ITU care should have taken place before surgery; given the poor clinical condition before surgery and the expected deterioration after surgery, the Adviser said Mr Y's case could have been considered more carefully. However, the Adviser could not find any reference in Mr Y's notes that a decision on ITU had been taken at the time when surgery was considered. He said that not providing a "trial of ITU" was effectively accepting that surgery was

essentially pointless. The Adviser concluded, without evidence of ITU consideration pre-operatively that the NELA Guidance and the Acute Pathway Guidance (which observes the NELA Guidance) was not followed.

58. The Adviser said that despite the missed opportunity to diagnose on 23 March, if Mr Y had been urgently investigated and diagnosed on 26 March, rehydrated and had surgery and subsequent ITU care "his chances of survival would have been significantly improved". He said a 24 hour "untreated delay led to deterioration followed by surgery, and with no ITU care in a high mortality case, also inadequately rehydrated, was likely contributory to his demise".

59. In terms of the DNACPR decision, the Adviser stated that Mr Y was possibly not able to make a decision regarding DNACPR. He noted that it was recorded earlier that Mr Y wanted to be resuscitated and it was discussed with his wife. The Adviser's view was that the clinical decision for DNACPR based on high mortality, frailty and likelihood of poor outlook if resuscitation was successful, meant the decision was appropriate and the criteria that Mr Y would not benefit from CPR was also appropriate.

60. I asked the Adviser to consider the case further in light of Miss X's and the Health Board's comments on the draft report. The Adviser confirmed that in providing his advice, he had taken into account the context of the pandemic and the impact of COVID-19 on healthcare provision, especially as Mr Y was admitted on the first day of the first lockdown. He reiterated that Mr Y was an emergency care patient and as such, any consideration of conservative management must consider risks and benefits. However, he said there was no reference to this in Mr Y's records. He said an obstructed hernia is an emergency, and the issue was that it was not fully appreciated that the hernia was a significant concern. He said this was an urgent case and Mr Y was not evaluated adequately and diagnosed as having an obstructed hernia.

61. The Adviser said that the re-configuration of ITU in light of COVID-19 as a reason for not admitting Mr Y may well be reasonable, but in Mr Y's case there was no reference of recognising the expected need for ITU or that he could not be admitted to ITU. In addition, he said this was at the

start of the re-configuration of ITU and in his clinical experience, emergency surgical cases in need of ITU were not being denied a bed because ITU was full of COVID-19 cases. The Adviser said the seriousness of not admitting Mr Y to ITU demanded that a rational explanation was documented as to the reasons why. Whilst elective surgery may have been cancelled if ITU admission was indicated, he did not consider it was appropriate that emergency cases were being refused ITU care due to potential need for COVID-19 cases.

62. The Adviser said in response to the Health Board's comments that Mr Y was 100% likely to die if he did not have surgery, that this was not in question. However, he said to operate and not provide the most optimal care is effectively reducing the chance of survival, and the NELA audit and recommendations have demonstrated this. He reiterated the fact that there was no further assessment after surgery to aid decision-making in relation to Mr Y's post operative care.

63. The Adviser said the role of the Coroner in Mr Y's case did not detract from the management of the patient. He said a verdict of "natural causes" does not infer the clinical management was optimal. He said it remained that on Mr Y's first visit, he had an irreducible hernia. He said an X-ray to rule out obstruction was inadequate in a newly diagnosed obstructed hernia. He said it remained that this was a missed opportunity for treatment.

Analysis and conclusions

64. 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 Y or his family. In doing so, I have considered whether the actions of the Health Board met appropriate standards rather than best possible practice, taking into account the COVID-19 context. I have had regard to the advice I have received, which I accept. However, the conclusions reached are my own.

65. I would like to extend my sincerest condolences to Miss X and her family for the sad loss of Mr Y.

a) The Health Board inappropriately discharged Mr Y on 24 March 2020

66. I accept the advice I have received that Mr Y's management/assessment during this admission (22 - 24 March 2020) fell below an adequate clinical standard and that there were several shortcomings in the approach to Mr Y's care:

- There was a failure to adequately assess the history and the new onset symptoms (difficulty passing water, lower abdominal and bilateral loin pain in Mr Y's groin and back when straining to open his bowels) which the Adviser said pointed to an acute obstructed hernia.

- Clinicians did not assess for a cough impulse and did not attempt to reduce the hernia. The Adviser said a lack of cough impulse in an acute hernia is a clue that a hernia may be obstructed and incarcerated.

- Whilst the abdominal X-ray showed no signs of obstruction and was interpreted as Mr Y being constipated, there was an over-reliance on the abdominal X-ray to diagnose the absence of an acute small bowel obstruction from an acute obstructing hernia. The Adviser said that signs of vomiting, bowel distension and significant pain usually come later (12-24 hours later) and that an abdominal X-ray was not a reliable predictor of bowel obstruction.

- Of significance, was a history obtained from Mr Y that he had only noticed the lump in his right groin on admission and therefore given that Mr Y could not recall the presence of a large lump in his groin, the Adviser said it was "unsafe to diagnose a long-standing hernia"; there was a dissociation between the history given by Mr Y and the clinical finding.

- Despite noting that Mr Y had difficulty in passing water, there was no record of the volume of urine passed or an assessment of residual urine which may have revealed urine retention. The Adviser indicated that difficulty passing water, acutely related to straining

and the new lump in the groin suggested an acute hernia; lower abdominal pain, urinary symptoms with new onset groin lump can be a presentation of an acute obstructed hernia and the lack of history taking in relation to Mr Y's bladder symptoms, his constipation and a new large groin lump (which the Adviser said was not adequately assessed) indicated, in the Adviser's view, that the assessment was below an acceptable standard. Mr Y should have been admitted for further assessment, including consideration of a CT scan.

67. Taking into account the above, I am satisfied that these shortcomings represent a serious service failure. I accept the advice that Mr Y's presentation was of an acute incarcerated inguinal hernia and that admission and further assessment would "likely have had a significant impact on the outcome" for Mr Y. Consequently, Mr Y suffered a significant injustice as he should have been admitted to hospital and there is an enduring injustice to Miss X and the family given that the failure to admit Mr Y to hospital, on balance, might have affected the sad outcome. However, Mr Y was discharged without adequate assessment of his symptoms. I **uphold** this complaint.

b) The Health Board failed to diagnosis a bowel obstruction/strangulated hernia sooner and whether this impacted on the sad outcome

68. The advice I have received is very clear that opportunities to treat Mr Y were lost in this regard. Miss X and her family will find this advice upsetting given their concerns that Mr Y's death could have potentially been avoided.

69. I agree with my Adviser that:

- Mr Y's symptoms on admission were typical symptoms of strangulated hernia with bowel obstruction (vomiting, abdominal pain, new hernia, constipation, ketosis in a diabetic in addition to the recent admission). This should have been recognised, as well as the fact that, as it may have been a strangulated hernia for at least 3 days, emergency surgery (within 6-12 hours of admission) was indicated; there was a delay of over 24 hours before Mr Y underwent surgery which was detrimental given that Mr Y was frail, and his condition

was compromised as a result of the delay. By 27 March, Mr Y was dehydrated, required oxygen, his respiratory rate had climbed, and he was seriously ill.

- There was a missed opportunity to repeat the abdominal X-ray and carry out a CT scan sooner; a CT scan was not considered until the day after admission (on 26 March) and only if Mr Y's bowels did not open. The CT scan carried out later on 27 March showed an obstruction from the hernia which led to emergency surgery.

- There was a failure to grasp that Mr Y was significantly dehydrated and the documentation, monitoring and management of this was below an acceptable standard - the fluid balance records were inadequate for a dehydrated patient, there was no regular monitoring of urine output, urea levels had increased despite IV fluids being given and the amount of prescribed fluids were "not reflective of attempts to correct" but were the standard prescribed fluids.

- Despite Mr Y's history of persistent vomiting, there was a lack of appreciation of the need for an NG tube for a patient with vomiting secondary to a bowel obstruction; an NG was noted to be considered only if Mr Y continued to vomit. If it had been understood that the persistent vomiting was caused by a bowel obstruction secondary to an inguinal hernia, an NG tube could have been inserted to decompress the bowel.

70. These shortcomings represent a significant service failure. It is additionally concerning to note from the Adviser's comments, reproduced in some detail above that, on the balance of probabilities, that the outcome might have been different for Mr Y if:

- Mr Y had been urgently investigated and diagnosed on 26 March, rehydrated and undergone surgery and post-operative ITU care. The Adviser said, "his chances of survival would have been significantly improved" and the 24-hour delay in treatment "led to deterioration followed by surgery and with no ITU care in a high mortality case also inadequately rehydrated was likely contributory to his demise".

- By 27 March, Mr Y was seriously ill which would have "significantly reduced his chances of survival from surgery".

- A surgical referral had been made on 26 March the Adviser said that "the outcome may have been different".

- Mr Y had received post operative ITU care; the decision that Mr Y would not benefit from ITU care reduced his chances of survival to "very low" and that a period of supportive ITU care post-surgery could "possibly have made a difference". Taking into account the NELA Guidance, Mr Y satisfied the criteria for post-surgical ITU care. I note the advice that the NELA Guidance for ITU care was not considered as Mr Y would not benefit from ITU care and that if this was anticipated "it made surgery futile" as without ITU care "surgery in a very high-risk patient becomes sub-optimal". The Health Board failed to consider the NELA Guidance and its own Acute Pathway Guidance.

71. In reaching my decision on this complaint, I have taken account of the impact of the COVID-19 pandemic on the ability of the Health Board to deliver services and how the pandemic influenced decision-making around use of resources, demand on service and the capacity to deliver services. Mr Y was first admitted to hospital on the first day of the first lockdown. This was a profoundly difficult time for the Health Board when patient care decisions were being re-evaluated and re-organised to ensure patient safety during the very early days of the pandemic when events were unfolding at a rapid pace and when Health Board staff were working under extreme pressure. However, Mr Y was an emergency case and I agree with the Adviser that to operate and then not provide the most optimal care reduced Mr Y's chances of survival. Even taking into account the re-configuration of ITU units in anticipation of demand from COVID-19 admissions, Mr Y satisfied the criteria for post-surgical ITU care.

72. Taking all of these factors into account, I am guided by the Adviser's evidence that Mr Y was likely to be suffering from strangulated hernia and bowel obstruction and that the Health Board missed opportunities to identify this sooner and to provide appropriate treatment earlier than

27 March 2020. Whilst I have therefore very carefully considered the challenging circumstances in which the care was delivered, the failings I have identified do in my view, amount to service failure for the reasons set out in this report. I am saddened to conclude that, had these clinical failings not occurred and had Mr Y received ITU care following surgery, his deterioration and death, on balance, might have been prevented. This is a grave injustice and will be an enduring source of distress to Mr Y's family. I **uphold** this complaint.

c) The Health Board failed to follow the correct DNACPR process

73. The DNACPR process relates to the discussion and documentation not to initiate CPR in the event of a future cardiac arrest and anticipated dying event. Whenever clinically possible, all patients should be offered the opportunity of support from a close individual for the DNACPR discussion, and their views should be clearly recognised. That said, in reaching such decisions, if the Clinical Team is as clinically certain as possible that attempting CPR would not re-establish effective circulation and maintain breathing, then CPR need not be attempted. Even if CPR might possibly restore circulation and breathing, the benefits of prolonging life must be balanced against the risk of harm, pain and discomfort to the patient.

74. Ultimately, the DNACPR is a medical decision, but a discussion should take place with the patient/those close to them (unless the offer of such a discussion is declined) and they should be involved in the process so that they are able to express their views, in line with the requirements of the DNACPR Policy. The medical records clearly document that, on 28 March, the Surgical Doctor discussed Mr Y's condition and DNACPR decision with his family. I am guided by the advice that, in view of Mr Y's condition at that time, the decision for DNACPR was clinically appropriate and in line with the DNACPR Policy; Mr Y would not have benefited from CPR. I **do not uphold** this complaint.

75. Whilst the Health Board accepted that communication with Mr Y's family was poor, I am concerned that its investigation failed to identify that there were several missed opportunities to treat Mr Y and that there were therefore failings in the care provided to Mr Y as identified by my Adviser. The Guidance is clear that "putting things right" is a key principle of good

administration which includes investigating complaints thoroughly and acknowledging when things did not go right. I am disappointed that the Health Board's own investigation of the complaint did not identify these failings. This may have identified actions to remedy these failings sooner, rather than the family having to pursue their complaint through my office and the additional time and distress this has caused them. This calls into question the robustness of the Health Board's investigation.

Recommendations

76. I **recommend** that the Health Board, within **6 weeks** of the date of this report:

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

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

b) Should review this case in a mortality meeting to discuss how the diagnosis of strangulated inguinal hernias and acute hernias causing obstruction are cases that can be missed due to inadequate assessment, and produce an action plan based on the outcomes of the review and share this with my office and any clinical department for which the findings may be relevant.

c) Shares this report with the Clinical Director responsible for the relevant clinicians involved in Mr Y's care and that its findings are reflected upon (including in relation to NELA Guidance and the Acute Pathway Guidance and the need to consider ITU care for patients with mortality over 5%) and directly discussed with those physicians (where possible) including at those physicians' appraisals and re-validation.

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

Michelle Morris 6 January 2023
Ombwdsmon Gwasanaethau Cyhoeddus/Public Services 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