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PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a Complaint against Cwm Taf Morgannwg University Health Board and Swansea Bay University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202006310/ 202105931

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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 V.

Summary

Miss V complained about care and treatment provided to her cousin Ms F, by Cwm Taf Morgannwg University Health Board ("Cwm Taf Morgannwg UHB") and Swansea Bay University Health Board ("Swansea Bay UHB"). Specifically, she was concerned that Cwm Taf Morgannwg UHB and Swansea Bay UHB ("the Health Boards") missed opportunities to identify and treat the appendicitis that caused Ms F's ruptured appendix.

The Ombudsman did not uphold the complaint against Swansea Bay UHB because she found that it was unlikely that Ms F had appendicitis during the time she was under Swansea Bay UHB's care.

The Ombudsman upheld the complaint against Cwm Taf Morgannwg UHB. She found that Cwm Taf Morgannwg UHB had missed opportunities to identify and treat Ms F's appendicitis during her attendances at the Ambulatory Emergency Surgical Unit at Princess of Wales Hospital on 17 and 20 July 2020.

The Ombudsman found that there was a failure to suspect appendicitis and admit Ms F to hospital on 17 July, taking into account her severe abdominal pain, unusually low blood pressure and blood test results which indicated the presence of a significant infection. There were also failures to prescribe antibiotics and arrange appropriate and timely investigations, including scans. Instead, Ms F was sent home and told to return for a review and further investigations on 20 July. This was a significant service failure.

The Ombudsman found that, after a scan on 20 July ruled out gallstones as a potential diagnosis, there was a further failure to admit Ms F to hospital for more investigations into the cause of her symptoms. She found that it was not appropriate to send Ms F home on 20 July with advice to return for review and further investigations 2 days later. This was another significant service failure. Sadly, Ms F did not return for further review, and she died at home on 1 August 2020. The Ombudsman found, on the balance of probabilities, that if Cwm Taf Morgannwg UHB had provided appropriate care on 17 or 20 July, Ms F's appendicitis would have been identified and treated, and her death would have been avoided.

The Ombudsman recommended that Cwm Taf Morgannwg UHB should within 1 month of this report:

- Provide a fulsome apology to Miss V and the family for the failures identified in this report and acknowledge that it missed opportunities to take steps which would likely have avoided Ms F's death.

- Support Ms F's family by offering details of solicitors who can provide Ms F's family with confidential, independent legal advice to assess the contents and findings of this report in order that they receive appropriate financial compensation from Cwm Taf Morgannwg UHB, in recognition of the significant injustice caused to the family. Cwm Taf Morgannwg UHB should, within 1 month of the date of this report, ensure that it funds appropriate legal support to the family of Ms F to facilitate this.

- Share a copy of this report with the First and Second Consultants and provide evidence to the Ombudsman that they have reflected on the failings identified and how they can improve their practice in the future.

- Remind all clinicians working in ambulatory settings to be mindful when assessing patients with abdominal pain that a significant proportion of patients do not present with typical appendicitis.

And within **6 months** of this report:

- Share a copy of this report with attendees of a forthcoming meeting of the Surgical Clinical Governance Team and provide evidence that the findings have been considered and discussed.

- Carry out a review of practice and procedure ("the review") within the AESU and its other ambulatory settings to ensure that the failings identified in this report have been appropriately addressed, including (but not limited to) consideration of:

    i. How to ensure appropriate investigations (including CT scanning) are carried out for undiagnosed abdominal pain

where there is evidence of infection/inflammation.

ii. How to ensure that antibiotics are appropriately prescribed where there is evidence of an infection/inflammation.

iii. How to ensure appropriate follow up, including repeat blood tests, and diagnostic work is completed prior to discharge when initial blood tests suggest infection/inflammation.

iv. How to ensure that patients who require more active management than can be provided in the AESU are appropriately escalated.

- 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.

The Ombudsman is pleased to note that in commenting on the draft of her report Cwm Taf Morgannwg UHB accepted and agreed to implement these recommendations.

The Complaint

1. Miss V complained about the care and treatment provided to her cousin, Ms F by Cwm Taf Morgannwg University Health Board (“Cwm Taf Morgannwg UHB”) and Swansea Bay University Health Board (“Swansea Bay UHB”). Specifically, she was concerned that Cwm Taf Morgannwg UHB and Swansea Bay UHB (“the Health Boards”) missed opportunities to identify and treat the appendicitis that caused Ms F’s ruptured appendix.

Investigation

2. My Investigator obtained comments and copies of relevant documents from the Health Boards and considered those in conjunction with the evidence provided by Miss V. My Investigator also obtained clinical advice from a professional adviser, Mr Misra Budhoo, a General and Colorectal surgeon with over 20 years of experience (“the Adviser”). My Investigator asked the Adviser to consider whether, without the benefit of hindsight, the care or treatment was appropriate in the situation complained about. I determine whether the standard of care was appropriate by referring to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

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

4. Miss V and the Health Boards were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation

5. The Human Rights Act 1998 (“the HRA”) incorporated the European Convention of Human Rights (“the Convention”) into UK law. Article 8 of the Convention protects a person’s right to respect for their private and family life, home and correspondence. This right can only be lawfully interfered with in order to protect the rights of others. It is accepted that Article 8 can also be viewed in conjunction with other rights, where the threshold is not met to view them in isolation.

6. All public authorities must follow the HRA and respect and protect an individual's human rights. It is not my office's function to make definitive findings about whether or not a public body has breached an individual's human rights by its actions (or inaction). However, when considering whether there has been maladministration or service failure on the part of a public body, I may consider whether public bodies have regard for human rights when they are performing their functions when this is a relevant consideration. Accordingly, I will identify where human rights are engaged and comment when there is evidence that a public body has not had sufficient regard for them.

The background events

7. Ms F lived at home with her son, who is autistic, and who was 21 years old at the time. She had type-1 diabetes (a condition which causes a person's blood sugar to be too high) and a history of gastroparesis (a long-term condition where the stomach cannot empty in the normal way). Symptoms of gastroparesis include vomiting, bloating and abdominal pain. Ms F's gastroparesis was sufficiently severe that she had a percutaneous endoscopic gastrostomy ("PEG" – a plastic tube which is inserted through the abdomen into the stomach) to help her take on food. Ms F had been admitted to hospital many times in recent years.

8. Ms F was seen at the Emergency Department ("ED") at Princess of Wales Hospital ("the First Hospital" - a hospital for which Cwm Taf Morgannwg UHB is responsible) on 24 March **2020** complaining of vomiting and abdominal pain. An ED Doctor noted that her symptoms were caused by a "gastroparesis crisis". Ms F was discharged the same day.

9. On 5 May Ms F was admitted to the First Hospital via the ED with vomiting and increased abdominal pain which was described in the records as being "like her usual pain." It was noted that she had hypoglycaemia (where the level of sugar in your blood drops too low) and had developed an acute kidney injury ("AKI" – where the kidneys suddenly stop working properly) as a result of her diabetes and gastroparesis. Ms F was discharged on 8 May.

10. On 5 July Ms F was admitted to Morriston Hospital ("the Second Hospital" - a hospital for which Swansea Bay UHB is responsible) complaining of frequent vomiting and pain all over her abdomen. A computerised tomography scan ("CT scan" - the use of X-rays and a computer to create an image of the inside of the body) of her abdomen was taken on 6 July and was reported to be normal. Ms F's symptoms were thought to be due to gastroparesis and poor diabetic control. The clinical notes record that Ms F left the hospital unexpectedly on 8 July.

11. On 17 July Ms F saw her GP and reported that she had been experiencing extreme stomach pain for the previous 2 days. The GP noted that the pain was so severe that she could not stand up. Ms F said she felt bloated but was not vomiting as she usually would with gastroparesis. The GP arranged an emergency review at the First Hospital's Ambulatory Emergency Surgical Unit ("the AESU") and wrote a referral letter which stated that Ms F's pain seemed to be localised to the right upper quadrant of her abdomen. The GP suggested that Ms F might be suffering from gastroparesis, a bowel obstruction or biliary colic (pain which typically occurs in the middle to upper right part of the abdomen and is caused by a gallstone blocking the tube which drains bile – a bodily fluid which aids digestion - from the gallbladder to the small intestine).

12. Later that day a Consultant Surgeon ("the First Consultant") assessed Ms F at the AESU. Ms F stated that her pain was "terrible" and "not like my usual." The First Consultant noted that she was not vomiting, her bowels were "ok" and her pain was mostly right-sided above the belly button but affecting the whole abdomen. He observed that Ms F's symptoms did not seem similar to previous episodes. Noting that the pain was very "colicky" and "biliary" (relating to bile or the bile duct), he suspected gallstones were the cause. According to Cwm Taf Morgannwg UHB, the First Consultant noted inflammatory markers (signs of an infection) in Ms F's blood test results but considered these were not unusual for her. Ms F was discharged with a plan to return on 20 July for an ultrasound scan ("USS" - the use of high-frequency sound waves to create an image of the inside of the body) of her abdomen. Ms F had painkillers with her when she was discharged.

13. Ms F returned to the AESU on 20 July where she was reviewed by another Consultant Surgeon ("the Second Consultant"). Ms F reported that she felt much better with no nausea and that her pain had decreased. The USS was reported to be normal, and she was observed to be well on examination. The Second Consultant decided not to carry out further investigations but advised Ms F to return for a review in 2 days' time. He noted that if she was not better by then, a CT scan and further blood tests should be arranged. Ms F did not attend the review appointment and no further follow up was carried out.

14. Sadly, on 1 August, Ms F was found dead at home by her son. The death certificate recorded the main causes of her death as: (a) sepsis (when the immune system overreacts to an infection and starts to damage the body's own tissues and organs), (b) peritonitis (infection of the lining of the abdomen) and (c) ruptured (burst) appendix (the appendix is a small, thin pouch which is connected to the large intestine). A post-mortem (the medical examination of a person's body after they have died) found evidence of severe and chronic (long standing) inflammation with necrosis (death of body tissue) which was "suggestive of a ruptured chronic appendicitis with peritonitis".

The family's evidence

15. Miss V said that the First and Second Consultants at Cwm Taf Morgannwg UHB's AESU missed opportunities to identify signs of appendicitis or a ruptured appendix on 17 and 20 July respectively. She said it was clear from the GP's referral letter on 17 July that Ms F had many of the symptoms of generalised peritonitis. She said that Ms F was sent home from the AESU on 17 July despite being in agonising pain and was told to continue to self-medicate with the painkillers codeine and diazepam. She said that the First Consultant should have shown more concern about the inflammatory markers in Ms F's blood test results.

16. Miss V said that the Second Consultant should not have sent Ms F home on 20 July without carrying out further investigations, given that the USS had excluded a diagnosis of gallstones. She said that Ms F's mother called the AESU on 20 July asking for Ms F to be kept in but was told that her USS was normal and there was no reason to admit her. Miss V said that the painkillers Ms F was taking at the time masked her symptoms and

gave a false impression of her condition. Taking that into account, she said it was not sufficient to rely on Ms F returning in 2 days for a further review. She said that Ms F did not return because the lack of investigations carried out at her visits to the AESU made her feel like she was making the whole situation up and wasting their time.

17. In response to a draft version of this report, Miss V said that she strongly believed that Cwm Taf Morgannwg UHB had breached Ms F's human rights. She said she was deeply concerned by the lack of professionalism shown by clinicians at each of Ms F's visits to the AESU.

18. In her letter of complaint to Swansea Bay UHB, Ms F's mother said she believed that her daughter must have been suffering with appendicitis when she was admitted to the Second Hospital on 4 July. She was concerned that clinicians at the Second Hospital failed to identify that Ms F's abdominal pain was caused by appendicitis.

The Health Boards' evidence

19. In its response to the original complaint, Cwm Taf Morgannwg UHB said that the concern had been discussed at length in a meeting of the Surgical Clinical Governance Team and that it had been agreed that Ms F had received "the standard care, as the other surgeons would have provided". It said that there was no misdiagnosis because Ms F did not present at the AESU with symptoms suggestive of acute appendicitis or a ruptured appendix. It said that typical symptoms of generalised peritonitis included stabbing intense abdominal pain, abdominal tenderness, bloating and fullness of the abdomen, fever, nausea, vomiting, loss of appetite, diarrhoea, low urine output, thirst, inability to pass stools or gas, fatigue and confusion. It said that the most striking features were severe abdominal pain, the inability to move and feeling sufficiently unwell that urgent medical attention is sought. It said that on 17 July, Ms F had colicky, right upper quadrant pain indicating gallstones and that she did not have constipation or vomiting, but her bowels were loose.

20. Cwm Taf Morgannwg UHB said that Ms F's blood tests indicated raised inflammatory markers but that these were not unusual in her medical history. It said that her pain was improving by 20 July and that she had no nausea or bowel problems. It said that when Ms F did not attend for further

review it was assumed that her symptoms had resolved. It said that this sadly prevented further investigations which might have identified the cause of her symptoms and prolonged her life.

21. In its response to this investigation, Cwm Taf Morgannwg UHB said that the painkillers Ms F was taking might have masked her symptoms but would not have masked the signs of generalised peritonitis. It said that the case had been discussed at the Surgical Governance Meeting and that those in attendance had agreed that appropriate safety netting advice had been given.

22. Cwm Taf Morgannwg UHB provided comments from a Consultant Upper Gastro-Intestinal and General Surgeon working at the First Hospital. He said that peritonitis was an extremely painful condition and it was not clear why Ms F had not returned for review after 48 hours or subsequently. He said that having reviewed the post-mortem report, it was most likely that the perforation of Ms F's appendix happened on the last day of her life.

23. In response to this investigation, Swansea Bay UHB said that during Ms F's admission to the Second Hospital between 5 - 8 July, there was no clinical, radiological or biochemical evidence that she was suffering from acute or chronic appendicitis. It said that Ms F underwent appropriate investigations to identify the cause of her abdominal pain and she was advised that her symptoms were typical of gastroparesis. It said that physical examination confirmed lower abdominal pain but not right sided lower abdominal pain, which would be expected in patients with appendicitis. It said that various blood tests for inflammation/infection were all within the normal range and Ms F's temperature was not elevated, which might also have indicated an infection. It also said that the CT scan on 6 July showed no changes to Ms F's appendix from the previous scan in October 2019, with no inflammatory changes in the fat surrounding the appendix.

Professional advice

24. The Adviser said that Ms F's clinical management at the AESU on 17 July fell below expected standards. The blood test results, combined with a systolic blood pressure reading (which measures the blood pressure

when the heart is beating out) of below 100 indicated a significant infection. In particular, the white blood cell count showed a very high level of neutrophils (a kind of white blood cell), which is often consistent with bacterial infection, and the C-reactive protein (“CRP”) test (which measures levels of a protein associated with inflammation) was also very high. Taken together, these findings should have prompted further investigations including blood gas analysis (a test to check the balances of oxygen and carbon dioxide and of acid and alkali in the blood) and a USS by 18 July at the latest. The USS would have ruled out gallstones which, in turn, should have prompted consideration of a CT scan.

25. The Adviser said that the threshold for considering admission for Ms F should have been low because of her history of diabetes and gastroparesis and the difficulties in diagnosis these presented. In any case the clinical findings, including the severity of Ms F’s pain despite her taking regular pain killers, her highly elevated inflammatory markers and unusually low blood pressure, meant that she met the criteria for admission. He said that, even if the suggested diagnosis of gallstones had been appropriate, the blood results showed that Ms F required more active management than could have been provided in the AESU. He said that Ms F should have been treated with antibiotics from 17 July, and this would likely have changed the course of her condition.

26. The Adviser said that it was appropriate and a priority to provide pain relief for patients with abdominal pain, and that there was no evidence that this “masks” the diagnosis.

27. The Adviser said that management of Ms F at the AESU on 20 July also fell below clinically acceptable standards. He said that whilst the Second Consultant documented that Ms F “felt better”, this was a subjective comment. He noted that there was no record of any observations of Ms F’s temperature, pulse, respiratory rate or blood pressure. There was a diagram with shading appearing to suggest pain on the right side of the abdomen but no record of any associated comments or pain scores. The suspected diagnosis of gallstones had been ruled out, on the basis of the normal USS, but there was no recorded explanation for the ongoing abdominal pain in the context of the previous abnormal blood results and low blood pressure. He said that given that Ms F’s observations and findings remained unexplained, the

blood tests should have been repeated and a repeat CT scan should also have been considered. He said that a review of the available information should have led to consideration of alternative reasons for the apparent infection, including possible appendicitis.

28. The Adviser said that Cwm Taf Morgannwg UHB's explanation that the care was appropriate because Ms F did not present with typical appendicitis was inadequate. He said that it was known that a significant proportion of patients do not present with typical appendicitis. He said that acute abdominal pain was a common indicator of appendicitis and that where any right sided or generalised abdominal pain is present, appendicitis must be considered as a potential diagnosis. He said that on balance, there was sufficient evidence at the time to consider appendicitis. Although it was reasonable to consider a diagnosis of gallstones, this would have been excluded sooner if the USS had been carried out on 17 or 18 July.

29. The Adviser said that it was unlikely that Ms F was suffering from appendicitis during the earlier hospital admissions. Ms F's CRP results had only been mildly elevated prior to 17 July and a CT scan on 6 July was reported as normal. He said that the post-mortem report was lacking in detail in relation to the abdominal findings, but it supported the conclusion that Ms F was suffering from appendicitis or a similar infection within the abdomen from 17 July. This diagnosis was missed. He said that the failure to complete adequate diagnostic work contributed to Ms F's death from sepsis. On that basis, he said that Ms F's death was avoidable.

30. The Adviser said he was surprised that Cwm Taf Morgannwg UHB's investigation had not identified any learning points or recommendations despite clear indications that the management was not sufficient on either 17 or 20 July. He said that death from appendicitis was uncommon, but that death from undiagnosed appendicitis following discharge was even less common. He said that Cwm Taf Morgannwg UHB should review:

- The role of CT scanning for undiagnosed abdominal pain where there is evidence of infection, especially in ambulatory settings.

- The practice of follow up in the AESU when initial blood tests are abnormal to require repeat tests.

- The discharge criteria for the AESU when there is evidence that an infection is present.

Analysis and conclusions

31. In reaching my conclusions, I must consider whether there were failings on the part of the Health Boards and if so, whether those failings caused an injustice to Ms F or her family. In so doing, I have considered whether the actions of the Health Boards met appropriate standards rather than best possible practice. I have also been assisted by the Adviser's advice, which I accept in full, but the conclusions reached are my own.

32. Miss V complained that Swansea Bay UHB missed opportunities to identify and treat Ms F's appendicitis during her admission to the Second Hospital between 5 and 8 July. I **do not uphold** this complaint. In reaching this finding, I am guided by the clinical advice I have received that it was unlikely that Ms F was suffering from appendicitis at this time. The Adviser said that Ms F's blood test results and lack of a high temperature suggested that she did not have a significant infection. Furthermore, if Ms F had been suffering from appendicitis at the time, it is likely that it would have been revealed on the CT scan on 6 July, but this was reported to be normal. On that basis, Miss V and her family can be reassured that the care provided by Swansea Bay UHB would not have contributed in any way to Ms F's death.

33. Miss V complained that Cwm Taf Morgannwg UHB missed opportunities to identify and treat Ms F's appendicitis during her attendances at the AESU. **I uphold** this complaint.

34. Ms F had a longstanding history of gastroparesis which caused her significant abdominal pain and discomfort which had required several hospital admissions in previous months, including the admission to the Second Hospital just 2 weeks before the first attendance at the AESU. However, the First Consultant noted on 17 July that Ms F was in "terrible pain" and that her symptoms did not seem similar to previous episodes. Whilst the Adviser said that it was reasonable to consider gallstones as a potential diagnosis, he said that the clinical findings should have prompted a plan for more active clinical management than would have been possible within the AESU. Ms F should have been admitted to hospital, on the basis

of the severity of her pain, combined with unusually low blood pressure and blood test results which indicated the presence of a significant infection. The Adviser noted that blood tests from previous admissions had shown only mildly raised inflammatory markers.

35. I am guided by the Adviser's evidence to find that Ms F should have been started on antibiotics on 17 July and additional investigations should have been carried out. Whilst it was appropriate to arrange a USS, this should have been planned for the following day at the latest. Blood gas analysis should have been arranged and, following the USS, a CT scan should also have been carried out. The failure to admit Ms F for further investigations on 17 July was a significant service failure.

36. Ms F returned to the AESU on 20 July for further review. The Second Consultant recorded that she said she felt "much better" and that the USS was normal. He asked Ms F to return for a further review on 22 July and noted that a CT scan and repeat blood tests could be considered if she was not better by then. I am guided by the Adviser's evidence to find that this approach was not within the range of acceptable clinical practice. The USS had excluded gallstones as a diagnosis, but there was no recorded attempt to consider alternative diagnoses which might have explained the cause of Ms F's abnormal blood test results and abdominal pain. It was not clinically justified to rely on Ms F's subjective assessment of her pain as an indicator that the, as yet unexplained, problem was resolving. The failure to keep Ms F at the hospital pending further investigations, including a CT scan and blood tests, was another significant service failure.

37. I accept the Adviser's evidence that Ms F's symptoms and clinical findings from 17 July should have prompted consideration of potential appendicitis taking into account that she had severe abdominal pain and that a significant number of patients with appendicitis do not present with typical symptoms. There is no recorded evidence that appendicitis was even considered as a potential diagnosis either on 17 or 20 July. This was a significant service failure because consideration of appendicitis may well have prompted the necessary investigations.

38. I am guided by the Adviser's evidence to find that it was likely that Ms F was suffering from appendicitis (or a clinically similar infection within the abdomen) from 17 July. On that basis, I consider that Cwm Taf Morgannwg UHB missed opportunities on 17 and 20 July to identify the problem and provide appropriate treatment. Having regard to the Adviser's evidence, I find on the balance of probabilities that if Cwm Taf Morgannwg UHB had provided appropriate care and treatment to Ms F, her death would have been avoided. The resulting injustice to Ms F and her family could not have been more serious. The manner of Ms F's death and discovery by her son must have been a source of great distress to her son and Ms F's family.

39. It is extremely unfortunate that Ms F did not return to the AESU after 2 days as advised by Second Consultant on 20 July. If she had, the plan was for her to have a CT scan which would on balance, have been likely to lead to identification and successful treatment of the infection. The fact that Ms F did not return was clearly a significant contributory factor in her death. However, Miss V's evidence suggests that Ms F felt, based on her experience of the care provided at the AESU, that a further attendance would have been of little benefit. If that was the case, she was sadly mistaken, but the evidence that insufficient investigations were carried out on 17 and 20 July goes some way to explaining how she might have formed this view. In any event, the offer of safety netting advice does not take away from the failings identified above. If the appropriate investigations had been carried out, it is likely that Ms F would have received appropriate treatment in hospital or at home and there would have been no need to rely on her returning at a later date.

40. I am mindful that it will be particularly distressing to Ms F's mother to learn about the missed opportunities identified above, because it appears that she was so concerned about her daughter on 20 July that she called the Second Hospital to ask for her to be admitted. She said that she was told that this was not necessary because of the normal USS. Having regard to the Adviser's evidence, it is clear that her concerns should have been taken more seriously.

41. As noted in paragraph 6, it is not my role as Ombudsman to make definitive findings about whether or not a public body has breached an individual's human rights. It is relevant to note however, that the circumstances of the complaint may have engaged the Article 8 rights of

Ms F and her family to respect for their private and family life. It is likely that Ms F's final days at home would have been severely blighted by the pain and suffering caused by her undiagnosed appendicitis/infection. As noted above, the discovery of Ms F's body by her son, who is autistic, within the family home, must have been extremely traumatic for him and would also have had a significant negative impact on the wider family.

42. Having regard to the evidence of failings identified by the Adviser, I am concerned that Cwm Taf Morgannwg UHB's investigation of Miss V's complaint did not find any failings in the care provided to Ms F on 17 or 20 July, despite the fact that the case was discussed "at length" at a Surgical Clinical Governance meeting. On the contrary, the view at the meeting was that Ms F had received "the standard treatment, as the other surgeons would have provided". It is disappointing that Cwm Taf Morgannwg UHB appears to have missed clear opportunities during the complaint response process to identify failings at an earlier stage and avoid the need for Miss V to complain to me. These concerns call into question the robustness of Cwm Taf Morgannwg UHB's review of care in response to this complaint and highlights the need for the learnings identified by this report to be shared widely within its surgical team.

Recommendations

43. I **recommend** that Cwm Taf Morgannwg UHB should, within **1 month** of this report:

a) Provide a fulsome apology to Miss V and the family for the failures identified in this report and acknowledge that it missed opportunities to take steps which would likely have avoided Ms F's death.

b) Support Ms F's family by offering details of solicitors who can provide Ms F's family with confidential, independent legal advice to assess the contents and findings of this report in order that they receive appropriate financial compensation from Cwm Taf Morgannwg UHB, in recognition of the significant injustice caused to the family. Cwm Taf Morgannwg UHB should, within 1 month of the date of this report, ensure that it funds appropriate legal support to the family of Ms F to facilitate this.

c) Share a copy of this report with the First and Second Consultants and provide evidence to the Ombudsman that they have reflected on the failings identified and how they can improve their practice in the future.

d) Remind all clinicians working in ambulatory settings to be mindful when assessing patients with abdominal pain that a significant proportion of patients do not present with typical appendicitis.

44. I recommend that Cwm Taf Morgannwg UHB should, within **6 months** of this report:

e) Share a copy of this report with attendees of a forthcoming meeting of the Surgical Clinical Governance Team and provide evidence that the findings have been considered and discussed.

f) Carry out a review of practice and procedure ("the review") within the AESU and its other ambulatory settings to ensure that the failings identified in this report have been appropriately addressed, including (but not limited to) consideration of:

   i. How to ensure appropriate investigations (including CT scanning) are carried out for undiagnosed abdominal pain where there is evidence of infection/inflammation.

   ii. How to ensure that antibiotics are appropriately prescribed where there is evidence of an infection/inflammation.

   iii. How to ensure appropriate follow up, including repeat blood tests, and diagnostic work is completed prior to discharge when initial blood tests suggest infection/inflammation.

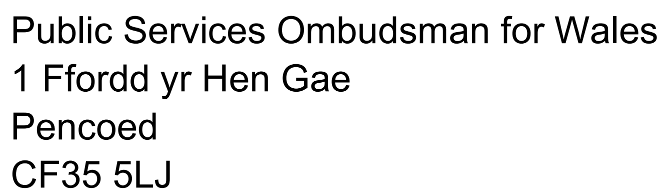
   iv. How to ensure that patients who require more active management than can be provided in the AESU are appropriately escalated.

g) 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.

45. I am pleased to note that in commenting on the draft of this report **Cwm Taf Morgannwg UHB** accepted and agreed to implement these recommendations.

MM. Morris.

Michelle Morris 5 July 2022
Ombwdsmon/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