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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint

by Mr Y

against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201603927

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 ("the Act").

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 Y.

Summary

Mr Y complained about the care his mother, Mrs X, received from Betsi Cadwaladr University Health Board ("the Health Board"). Mrs X was admitted to hospital in 2015. She was very ill and it had been agreed between staff and the family that she was for supportive care only, i.e. palliative care, to improve comfort and quality of life. Mr Y complained that despite this, Mrs X was twice transferred to a different hospital for a CT scan. On the second occasion, there was no bed available for Mrs X when she arrived. She sadly died on a trolley waiting for a bed. Mr Y also complained about the time taken by the Health Board to provide its complaint response and that the response was sent to the wrong address.

The Ombudsman upheld the complaints about clinical care. In light of the plan for supportive care, a CT scan would not have altered the approach to Mrs X's care. Despite that, she was twice unnecessarily transferred many miles to another hospital for a CT scan which did not take place. The Health Board's approach was detrimental to Mrs X's well-being and the manner of her death. The Ombudsman concluded that Mrs X's human rights were likely to have been compromised. Her dignity at the end of her life was not respected and she did not have sufficiently considerate care in her final days. The decisions to transfer her for scans which would not have changed the approach to her care failed to take account of her needs as an individual. They failed also to take account of Mrs X and her family's wider needs as part of family life.

The Ombudsman identified contributory factors including that there was no comprehensive assessment made of Mrs X at her initial admission to A&E, and she was not reviewed by a Consultant for 11 days as no leave cover was in place.

The Ombudsman found that the time taken to investigate and respond to Mr Y's concern (17 months) was unacceptable. He upheld this complaint, although did not find that the response had been sent to the wrong address.

The Health Board accepted the conclusions of the report and agreed to implement the Ombudsman's recommendations that it should:

1. Apologise to Mr Y for the shortcomings in Mrs X's care

2. Provide financial redress to Mr Y of £1,000 in recognition of the distress caused by the failure to provide clear management of Mrs X's care

3. Provide financial redress of £500 in recognition of the time taken to investigate his complaint

4. Refer the report to the Board, and to the Health Board's Equalities and Human Rights team to identify how consideration of human rights can be further embedded into clinical practice

5. Remind medical staff on the wards where Mrs X received care of their professional obligations in terms of ethical and clinical management for end of life care in accordance with guidance issued by the General Medical Council

6. Consider the need for clinicians involved in Mrs X's care to undertake further training in end of life care as part of their continuing professional development

7. Carry out a clinical audit on the wards where Mrs X received care to consider consistency of medical management and decision making

8. Remind medical staff of the requirement to ensure adequate cover arrangements are put in place when taking leave.

The complaint

1. Mr Y complained about the care and treatment his mother, Mrs X received during her admissions to Ysbyty Gwynedd ("the First Hospital") and Llandudno General Hospital ("the Second Hospital") between 20 February and 4 March 2015 when she sadly died. The investigation considered the following concerns:

- Mrs X was transferred to the First Hospital from the Second Hospital[1] for a CT scan on two occasions (24 February and 4 March 2015) despite the family being told that, due to her condition, she should receive supportive care (palliative care given to improve a patient's comfort and quality of life)

- There was no bed available for Mrs X following her transfer to the First Hospital on 4 March 2015 despite her deteriorating condition

- The time taken by Betsi Cadwaladr University Health Board ("the Health Board") to provide its complaint response ("the response")

- The response was sent to the wrong address despite the fact that Mr Y had provided an updated address.

Investigation

2. I obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mr Y. I obtained clinical advice from one of my Professional Advisers, Angela Kannan ("the Adviser"). She is a Consultant Geriatrician with a special interest in Orthogeriatrics and Stroke Medicine. I am satisfied that she is appropriately qualified and experienced to provide me with advice on the matters subject to this complaint. I have taken her advice, which I have summarised below, into account in reaching my conclusions.

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

[1] A distance of about 22 miles.

4. Both Mr Y 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 legislation

5. The Human Rights Act 1998 ("HRA") incorporates the rights set out in the European Convention of Human Rights into British law. It requires public authorities to act in compliance with the HRA and to respect and protect human rights. The HRA includes a number of rights set out as a series of Articles. Article 8 is the right to respect for private and family life, home and correspondence, and includes issues such as participation in decisions about treatment.

6. The General Medical Council guidance 'Treatment and care towards the end of life: good practice in decision making'[2] ("the GMC guidance") amongst other things, deals with issues of equalities and human rights for patients entering the last phase of life. It says that 'you must treat patients and those close to them with dignity, respect and compassion, especially when they are facing difficult situations and decisions about care'. It also states that, 'if you are involved in decisions about treatment and care towards the end of life, you must be aware of the Human Rights Act 1998 and its main provisions, as your decisions are likely to engage the basic rights and principles set out in the [HRA] Act'.

7. The concept of 'prudent healthcare' has been developing in the NHS in Wales in recent years supported by Welsh Government. The aim is to provide healthcare that fits the needs and circumstances of patients and avoids wasteful care. One of the key principles is to do only what is needed, no more, no less, and to do no harm.

8. The Welsh Government issued statutory guidance on NHS complaint handling in 2011. Putting Things Right ("PTR") sets out specific actions that health bodies should complete when considering complaints. PTR states that a Health Board should send a response within 30 working days. If it is unable to do so, it should advise the complainant of the reason why and provide the

[2] July 2010.

response within six months. PTR guidance also states that all serious incidents should be subject to a root cause analysis which should include findings, recommendations and associated action plans and learning.

The background events

Clinical background

9. Mrs X was admitted to Accident and Emergency ("A&E") at the First Hospital on **20 February 2015**. Her mobility and oral intake had decreased and she was confused. The plan was to administer intravenous fluids and antibiotics and transfer her to the Second Hospital. Transfer was deferred until the following day due to a delay in medical review.

10. On 23 February, Mrs X was reviewed by a staff grade doctor in Care of the Elderly Medicine ("the Doctor"). On examination, she was drowsy, but could open her eyes to voice and denied any pain. Possible right sided weakness was documented. The plan was for supportive care, antibiotics, intravenous fluids, and although there was a suggestion of a possible CT head scan ("CT"),[3] she was noted to be 'not for escalation'. The Doctor spoke with the family and explained that in view of Mrs X's fragility and history of cancer (she had been diagnosed with bladder cancer in 2014) she was 'for supportive care' and a CT would not change Mrs X's management. The records noted the family agreed with the plan.

11. The Doctor reviewed Mrs X again on 24 February. Her symptoms on examination were suggestive of a new stroke. As the Consultant ("the First Consultant") was on leave, the Doctor discussed his findings with a Medical Registrar ("the Medical Registrar") at the First Hospital and they decided to transfer her to the First Hospital for a CT. On her arrival, the Medical Registrar and Stroke Registrar ("the Stroke Registrar") at the First Hospital agreed that a CT would not change her management and that she was for supportive care. She was transferred back to the Second Hospital without a scan.

12. Between 25 February and 2 March, the plan continued to be for supportive care. Records made on 25 February noted the family's agreement.

[3] A computed tomography (CT) scan uses X-rays to make detailed pictures of parts of the body.

13. On 3 March, Mrs X was reviewed by the First Consultant who noted a possible new stroke. The plan was for a CT, to liaise with the family and that Mrs X was for 'supportive care not for escalation'. A later entry in the records notes a discussion with the son to inform him about the plan for a CT to clarify diagnosis (an appointment was made for 6 March at the First Hospital but did not take place as Mrs X had passed away).

14. On 4 March, Mrs X was seen by a Specialty Doctor in Care of the Elderly ("the Specialty Doctor"). She was noted to be unresponsive with profound left sided weakness. The Specialty Doctor wanted to rule out head injury (new onset stroke) and spoke to a Consultant Physician ("the Second Consultant") at the First Hospital. It was agreed that Mrs X would have a CT and arrangements were made for her to be urgently admitted to the First Hospital by ambulance. The family and site manager at the First Hospital were informed of the transfer. On arrival, Mrs X was taken to the Ward ("Ward A"). There were no beds available and she remained on a trolley in the corridor. Mrs X's breathing deteriorated and she was moved to a side room. Mrs X remained on a trolley and sadly died.

Complaint background

15. Mr Y complained to the Health Board on **22 March 2015**. In July, internal emails documented that the concern should be subject to a Serious Incident Review ("SIR"). The emails also indicated that the complaints team who would be handling the concern needed to be changed. West Concerns Team had been dealing with the complaint but it had been handed back to the Central Concerns Team when care at the Second Hospital came under its remit.[4] In December, internal emails indicated that it was unclear if the SIR had been held and whether the complaint had been 'lost in the system'. Another internal email in December said there was confusion from the start as to who was managing the incident and that it was unclear which complaints team was taking the lead. The SIR was held in February 2016. A draft complaint response was approved in July.

[4] The Health Board has three concerns teams (West, Central and East) and each one is responsible for investigating complaints about care at specific hospitals.

16. A response to the complaint, together with the SIR report, was sent on 23 August 2016 (the postal address used was the one provided by Mr Y in his initial letter of complaint of 22 March 2015). A Datix[5] entry on 7 September noted that Mr Y had called 'a couple of days ago' to say he had not received the response and he provided a new address which was updated on Datix.

17. The Health Board concluded that Mrs X's care fell below the standard reasonably expected and that there was a breach of duty of care but that this had not caused harm to Mrs X. In summary, the Health Board's findings were that the treatment and care delivered to Mrs X may have changed her management but would not have changed the outcome. An action plan was created to address the shortcomings identified by the SIR.

The Health Board's evidence

18. The Health Board said that not being reviewed by a Consultant from 21 February to 3 March 2015 may have contributed to inconsistent and indecisive care. This may have exposed Mrs X to unnecessary transfers to the First Hospital for a scan on 24 February and 4 March 2015.

19. It explained that Consultants normally arrange leave cover with colleagues. It confirmed however that no cross cover arrangements had been put in place to cover the Consultant's annual leave on this occasion.

20. The Health Board said the site management team had been made aware of Mrs X's urgent transfer at midday on 4 March. It had been difficult to accommodate Mrs X on her arrival due to a challenging situation with patient flow, and the lack of available beds may have been caused by a lack of communication and of organisation. It said the First Hospital had given a detailed briefing to staff on Ward A but this had not been conveyed appropriately to the Ward Manager. Had the Site Management team and Ward Manager known of Mrs X's condition, it said this may have prioritised the availability of a bed or a cubicle.

21. The Health Board said it was unacceptable there was no bed for Mrs X when she arrived on Ward A on 4 March. It said that she was placed on the corridor on Ward A where she remained on the ambulance stretcher with

[5] DATIX is a database used to report and manage all incidents, concerns, claims, risks and requests for information.

ambulance staff staying with her. It said at 1.55pm, Mrs X's breathing deteriorated and she was immediately moved to the treatment room on Ward A to allow her some privacy.

22. At the time of receiving the concern, it said any concerns about the First Hospital were investigated by the West Concerns Team. The allocation of concerns changed a few months later (see paragraph 15). As a result, some confusion was caused about which team would be dealing with Mr Y's concern. It said a joint SIR meeting took place on 3 February 2016.

23. The Health Board said that its records indicate that the response was sent to Mr Y on 23 August 2016. Since it was sent by standard mail (rather than email or recorded delivery) there was no additional evidence they could provide to support this. Mr Y's new address was submitted onto Datix on 7 September 2016. The Health Board said that when a complainant contacts them with new details, these are normally submitted immediately onto Datix.

Mr Y's evidence

24. Mr Y said that Mrs X and the family were put through totally unnecessary trauma in the weeks before her death.

25. Mr Y indicated that when his mother's condition deteriorated she was taken for a scan by blue light ambulance but passed away shortly after arriving near the nurses' station, despite her having been in a side room at the Second Hospital where she was lying peacefully with his sisters present.

26. Mr Y was concerned that his mother passed away in extremely distressing circumstances while waiting in a corridor. He said his mother took one last gasp and his mother and his distraught sisters were ushered into a side room.

27. Mr Y said that no definitive answer has been given to why his terminally ill mother, who had been promised supportive (palliative) care only, was repeatedly and unnecessarily taken on a journey of 45 miles for a scan that never happened. He felt that his concerns had been trivialised by the cavalier way the whole process had been dealt with, from the date his mother was admitted to hospital on 20 February 2015 where she experienced a lack of appropriate care and consideration.

Professional advice

28. The Adviser said that Mrs X should have been reviewed by a Consultant within 14 hours of arrival at A&E[6] and before transfer to another hospital. She said that initial review at A&E did not include the Comprehensive Geriatric Assessment required in patients presenting with decline in cognition and mobility. She said a Consultant would have addressed this oversight and may have concluded that a CT was required before transfer. She indicated that in accordance with guidelines around holistic assessment of frail older people,[7] they may also have considered that Mrs X was entering the last phase of her life and included a capacity assessment, discussion with the family and advance care planning before transfer.

29. The Adviser said that the lack of Consultant review for 11 days (between 21 February and 3 March) led to lack of clarity around Mrs X's diagnosis and management plan and led to indecision and inconsistencies in her treatment. She said a senior decision maker would have recognised that Mrs X was entering the last phase of her life and, with family discussion, would have been able to set priorities for her management. She was of the view that Consultant involvement would not have altered the final outcome but it would have improved the care Mrs X received in the last few weeks of her life.

30. She said the transfers between hospital sites were unnecessary and would have contributed to any delirium, a common condition in frail elderly patients. Whilst there is no specific treatment for this, she said a calm stable environment can help recovery and that changes can exacerbate it. The Adviser did not consider that the decision to arrange investigations to clarify diagnosis, knowing that they would not alter the management or final outcome, was reasonable.

31. The Adviser also noted that the records indicated Mrs X lacked capacity. A mental capacity assessment would therefore be standard practice, particularly where decisions are being made around appropriateness of investigations and hospital transfers. However it appeared that no assessment

[6] This would be in accordance with RCP Acute Care guidelines (Acute Care Toolkits for management of frail elderly people. Royal College of Physicians 2012).
[7] See above guidelines.

had been carried out. Where there is lack of capacity she said clinicians and family act in the patient's best interests using 'overall benefit' as an ethical basis to make decisions and address uncertainties. She said that the management of Mrs X did not provide overall benefit and therefore did not amount to good care.

32. The Adviser said when Mrs X was reviewed on 4 March she had a NEWS of 6[8] and a Glasgow Coma Scale ("GCS") of 5[9] which she said was consistent with her being in a deep coma. She said the decision to arrange a transfer for a CT was not reasonable, would not have altered her management and was not in her best interests. She said that Mrs X's condition had become worse by the time of the ambulance transfer with a NEWS of 9 and GCS of 3 (which she said is the lowest possible). She said a decision could have been made at that point by either medical, nursing or paramedic staff to return her to her bed to die peacefully.

33. In terms of the lack of available beds on Ward A when Mrs X arrived, the Adviser said that bed capacity is a national issue and busy acute services have to provide the best possible care within available resources. That said, she said that it needed an experienced clinician to realise on arrival that Mrs X was in the last few hours of her life and it should have been possible, in those circumstances, to override the usual bed management pathway and find a quiet bed space for Mrs X to die with her family at her side.

34. The Adviser said the SIR was thorough and robust and that the action plan was appropriate and correctly disseminated. She did consider, however, that it should have included recognition of care at end of life in line with relevant guidance (which would include recognition that the patient was approaching the end of life and setting management priorities including dying with dignity).[10]

35. Finally, the Adviser said Mrs X experienced two lengthy journeys despite being a frail, elderly lady who was in the last few days of her life. The management of Mrs X's care in her final few hours of life did not preserve her dignity and fell short of the compassionate care she should have received.

[8] National Early Warning Score (NEWS). A system to assess the deterioration of patients.
[9] Glasgow Coma Scale (GCS). A scoring system used to describe the level of consciousness in a person.
[10] Improving end of life care: professional development for physicians (RCP 2012) and Treatment and Care towards the end of life: good practice in decision making (GMC 2010).

She said that Mrs X would not have suffered as she was in a deep coma. However, she said that she could understand the distress caused to Mrs X's family.

Analysis and conclusions

36. Firstly, I would like to extend my condolences to Mr Y and the family for their loss. In reaching my conclusions I have taken into account the helpful advice which I have set out in detail above.

Clinical care

37. I have identified a range of failings in Mrs X's care. It is of particular concern that each compounds the others. In summary the failings are:

- a missed opportunity to carry out a comprehensive assessment of Mrs X at her initial admission to A&E. It is difficult to establish whether this would have contributed overall to better care in the following weeks, but it seems likely that a lack of Consultant review, for 11 days, resulted in a lack of clarity around diagnosis and management plan

- the decisions to transfer Mrs X for CT investigations twice, knowing they would not alter her management. This was unreasonable, contributed to delirium and exposed Mrs X, a frail elderly lady, to inappropriate care

- despite transferring Mrs X for CT investigations twice, these scans were not undertaken. The first time, because clinicians at the First Hospital agreed that a scan would not change her management and referred her back to the Second Hospital. The second time, because her condition was so poor, she died soon after her arrival at the First Hospital

- decision making was indecisive, inconsistent and not in Mrs X's best interest

- no bed was available following transfer on 4 March and Mrs X died on a trolley

- no mental capacity assessment was carried out.

38. The plan was for Mrs X to receive supportive care. As a CT would not alter her management, it is inexplicable that the decision was made not once, but twice, to transfer her to another hospital for a scan. These were poor decisions, which did not result in a scan on either occasion. On the first occasion, the Medical Registrar and the Stroke Registrar confirmed that Mrs X should be for supportive care and she was returned to the Second Hospital. On the second occasion, she died shortly after arrival. Despite indications on 4 March that Mrs X was in a 'deep coma', a decision was still made to transfer her to the First Hospital for a scan. Clinicians should have been able to recognise that Mrs X was reaching the end of her life and that transferring her 22 miles for a scan which would have made no difference to her care would not have been in her best interests. The Health Board's approach was contradictory and detrimental to Mrs X's well-being and the manner of her death. Although the lack of overall management of her care by a Consultant would not have altered the outcome, it contributed to a lack of clarity about her plan of care which led to two unnecessary transfers for a scan which did not ultimately take place.

39. This was clearly contrary to the principles of prudent healthcare which drives care to fit the needs and circumstances of individual patients.

40. It is also concerning that no cross cover arrangements had been put in place to cover Consultant annual leave.

41. The shortcomings I have identified have contributed to unnecessary distress for Mrs X and her family. This is an enduring injustice for Mr Y and the family. I **uphold** the first complaint.

42. The Health Board recognised that it was unacceptable there was no bed available for Mrs X when she arrived on Ward A. It attributed this in part to the fact that her poor condition had not been communicated to relevant staff. The result was that Mrs X was placed in a ward corridor. Whilst bed capacity is clearly a national issue, it is plain from what the Adviser said that Mrs X's condition suggested she was in the final hours of her life. This should have been recognised and the bed management pathway overridden so that she could spend her final hours in a quiet space with her family. Sadly, this is not what happened. This was a failing, the consequences of which were that

Mrs X's dignity was not maintained, impacting on the quality of the family's remaining time with Mrs X. This represents an injustice for Mrs X and Mr Y. I **uphold** the second complaint.

43. Human rights are underpinned by core values of fairness, respect, equality, dignity and autonomy ("FREDA"). These principles are fundamental to good public service delivery and as the Public Services Ombudsman for Wales, I have a role in promoting the human rights of ordinary people in their dealings with public services in Wales. Central to applying human rights in practical terms is the recognition of a patient as an individual and to deliver care that is appropriate to them and which takes account of their needs and wishes. The GMC guidance has made it clear that clinicians involved in decisions about care and treatment towards the end of life need to ensure that their decisions are compatible with the rights and principles set out in the HRA.

44. Where I find evidence of service failure which has caused injustice, it is appropriate for me to consider whether a person's human rights may have been engaged and/or compromised as a result. I conclude that, in this case, Mrs X's human rights are likely to have been compromised. Her dignity was not respected and she was not afforded sufficiently considerate care or compassion in her final days. The decisions to transfer her 22 miles for a scan which would not have changed the approach to her care - especially the second at a time when the family described Mrs X as peaceful - failed to take account of her needs as an individual. They failed also to take account of Mrs X and her family's wider needs as part of family life.

45. It is therefore apparent that Mrs X's human rights under Article 8 were engaged as a consequence of the failings I have identified; this is to the extent that her right to dignity at the end of her life was compromised by poor and inconsistent decision-making which also failed to take into account the GMC guidance. There was an impact also on the human rights of her family who wanted their mother to die in a peaceful and dignified way. This is a serious finding.

Complaint handling

46. Mr Y received a response to his complaint 17 months after it was initially submitted. Whilst it was appropriate and in accordance with PTR to carry out the SIR, given the events giving rise to Mr Y's concern, there was a clear lack of ownership of the complaint which delayed its progression. Changes to the way concerns were allocated should not have led to the misunderstanding that ensued about which concerns team was responsible for investigating the concern/carrying out the SIR. Whilst it is a matter for the Health Board how it structures its concerns teams, this should not result in complaints getting 'lost in the system'. This is poor management which has resulted in poor complaints handling. As a result, both the SIR and the subsequent complaint response were excessively delayed and well outside the timescales set out in PTR guidance. This amounts to maladministration. Given the distressing circumstances that led to Mr Y's complaint, the time taken by the Health Board to investigate and respond to his concern was unacceptable, contrary to guidance and represents an injustice to Mr Y. I **uphold** this complaint.

47. Mr Y said that the complaint response was sent to the wrong address despite him updating the Health Board with an alternative. The response was sent on or around 23 August 2016 to the address provided by Mr Y in his complaint letter. The first reference to a change of address was a Datix entry on 7 September 2016 (which noted Mr Y had called a 'couple of days' before this date). Whilst I would urge the Health Board to ensure that staff are reminded of the importance of updating Datix as soon as possible, I do not consider that it was an administrative failing on the part of the Health Board to send its response to the address provided by Mr Y in his complaint letter as, at that time, it was not aware of a change of address. I **do not uphold** this complaint.

48. Finally, as a result of the SIR, the Health Board carried out a number of actions to address identified failings. This limits the recommendations I make below.

Recommendations

49. I **recommend** that the Health Board should, within six weeks of the date of this report:

(a) Apologise to Mr Y for the shortcomings in Mrs X's care

(b) Provide financial redress to Mr Y of £1,000 in recognition of the distress caused by the failure to provide clear management of Mrs X's care which led to unnecessary transfers and compromised Mrs X's dignity

(c) Provide financial redress to Mr Y of £500 in recognition of the time taken to investigate his complaint

I **recommend** that the Health Board should, within three months of the date of this report:

(d) Refer this report to (i) the Board and (ii) the Health Board's Equalities and Human Rights team to identify how consideration of human rights can be further embedded into clinical practice

(e) (i)Remind medical staff on the wards where Mrs X received care of their professional obligation in terms of ethical and clinical management for end of life care in accordance with the GMC guidance and;

(ii)Consider the need for clinicians involved in Mrs X's care to undertake further training in end of life care as part of their continuing professional development

(f) Carry out a clinical audit, to include a review of medical notes of a sample of patients on the wards where Mrs X received care to consider consistency of medical management and decision making, and share its findings with the Ombudsman. If the audit identifies inconsistent management, the Health Board should take action to address this

(g) Remind medical staff of the requirement to ensure that adequate cross cover arrangements are put in place when taking leave

(h) Provide documentary evidence to show that the recommendations have been carried out within the stipulated timescales.

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

Nick Bennett
Ombudsman 16 August 2017

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