The investigation of a complaint

by Mr D

against Cwm Taf University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201604327

Contents

Introduction

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

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr D.

Summary

Mr D complained to the Ombudsman about the manner in which the Health Board dealt with his complaint under the NHS complaints procedure about the care his late mother ("Mrs D") received. Mr D was particularly concerned about the length of time it took for the Health Board to respond to him after it had identified that it had breached its duty of care towards his mother and with the response he ultimately received from the Health Board.

The Ombudsman found that the Health Board had taken too long to investigate the matter under the relevant redress arrangements, had misplaced Mrs D's records and failed to inform Mr D, when offering him a full and final settlement, that the clinician whose advice it had relied upon in its response letter to Mr D did not have access to Mrs D's records. The Ombudsman found that the delay in dealing with the redress issue coupled with the lack of transparency in the Health Board's redress response to Mr D amounted to clear maladministration leading, to injustice to Mr D.

The Ombudsman upheld the complaint and recommended that the Health Board:

a) Apologises to Mr D.
b) Provides him with redress of £2000 for the distress he and Mrs D would have experienced as a result of the shortcomings identified.
c) Provides Mr D with redress of £500 for his time and trouble in pursuing the complaint over a prolonged period of time.
d) Provides Mr D with free legal advice and arrange for the joint instruction of an independent clinical adviser to consider whether Mrs D had suffered harm as a result of the shortcoming the Health Board identified.
e) If it was not possible to arrange such an instruction in a timely manner, that Mr D be paid a further £1500 in redress to reflect the lost opportunity to have his mother's care considered appropriately.
f) Ensures that all relevant staff are formally reminded of their duty to be open and transparent, at all times, with patients and their relatives.

The complaint

1. Mr D complained to me that Cwm Taf University Health Board ("the Health Board") had failed to deal in a timely manner with the complaint he made to them about the management of his late mother's care following her admission as an emergency patient to the Royal Glamorgan Hospital ("the Hospital") in November 2012. My original complaint investigation focussed on the delay Mr D experienced in receiving a response from the Health Board. However, following the commencement of the investigation, Mr D received a final response from the Health Board in relation to the care his mother, Mrs D, received. Mr D is dissatisfied with this latest response and complained to me about it. Originally it was not possible for me to consider Mr D's most recently expressed concerns with any degree of confidence, as the Health Board confirmed at the outset of the investigation that Mrs D's records for the time of the incident were missing. However, following the issuing of a draft version of this report the Health Board has located Mrs D's records and has agreed to consider any qualifying liability under the relevant regulations.[1]

Investigation

2. My investigating officer obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mr D. I have not included every detail investigated in this report but I am satisfied that nothing of significance relating to the focus of the original complaint has been overlooked.

3. Both Mr D 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

4. In 2011 the Welsh Government introduced regulations[1] ("the Regulations") setting out how health organisations in Wales should deal with concerns. Regulation 26 sets out the responsibilities of a Health Board if, during the course of investigating a concern, it identifies that

[1] The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. These regulations are known as the "Putting Things Right" ("PTR") process.

a breach of duty of care has occurred and that as a result of that breach, a person is, or may be, eligible for qualifying liability.[2] In such cases the Health Board must produce an interim report which, amongst other matters explains why there is or may be a qualifying liability. It explains the availability of access to legal advice without charge in accordance with the provisions of Regulation 32 and explains the availability of advocacy and support services which may be of assistance. Regulation 32 also sets out that where a Welsh NHS body has determined that a qualifying liability exists, or may exist, a Health Board must also ensure, if a medical expert or experts need to be instructed, that such instruction is carried out jointly by the Health Board and the person who has notified the concern.

5. There are timescales set out for Health Board's to respond to concerns under the Regulations. If, following an investigation under the Regulations, a Health Board considers that there is, or may be, a qualifying liability it must take all reasonable steps to produce an interim report within 30 days of receiving the concern. If it is unable to produce such a report within 30 days, it must send the report within six months, providing the complainant with an explanation for the delay.

Summary of the key events

6. On 9 November **2012** at 7:26pm, Mrs D was admitted to the Hospital's Emergency Department with a reported history of, amongst other problems, respiratory failure, infection, low blood pressure, impaired kidney function and a NEWS[3] score of six, which indicated she was acutely unwell. She had at least two medical reviews the following day but, over the course of that day, she deteriorated and sadly is recorded as having died at 5:15pm.

7. On 12 March **2013,** Mr D complained to the Health Board about his mother's care and treatment. The Health Board formally responded to Mr D on 24 October 2013. In this response, the Health Board accepted that there had been poor monitoring of his mother; there had been poor communication between nursing and medical staff and this had resulted in a failure to

[2] The Regulations define qualifying liability as "a liability in tort owed in respect of, or consequent upon, personal injury or loss arising out of or in connection with breach of a duty of care owed to any person in connection with the diagnosis of illness, or in the care or treatment of any patient."
[3] A National Early Warning System which scores patients against known risk factors and alerts clinical staff to call for a response dependent on the total score. A high NEWS value indicates an ill patient with a value of 7 or more indicating a patient has a high clinical risk.

escalate the deterioration in Mrs D's condition in a timely manner. The Health Board confirmed that measures had been taken as a result of Mrs D's case and that lessons had been learned. The Health Board apologised for the failings identified and acknowledged that these amounted to a breach in its duty of care towards Mrs D. The Health Board also told Mr D that it would be investigating the matter further and asking a Senior Nurse and a Consultant Physician ("the Consultant Physician") to determine whether Mrs D's treatment would have been different had the breaches in the duty of care not occurred.

8. Over the next two years Mr D approached the Health Board on a number of occasions and also pursued the matter through my office because of the Health Board's failure to provide the outcome of the further investigation. My officers were told in February **2015** that the records of the complaint had been overlooked during a 'culling exercise'. Following further contact from this office, one of my officers was given an expectation that the further investigation should be concluded shortly.

9. By September 2015, having heard nothing further from the Health Board, Mr D contacted my office again. Enquiries of the Health Board resulted in confirmation being received in October 2015 that Mr D's concern was being handled by the redress team and that the investigation was ongoing but that it was hoped a decision on whether there was any qualifying liability would be made within two weeks. In correspondence with my office the Health Board agreed to apologise and provide Mr D with financial redress of £250 for the delay in responding. On 15 January **2016** the Health Board's Chief Executive provided Mr D with the redress and assured him that his concern had been taken over by the its Redress/Claims team and that it was ensuring that the investigation was being pursued as a matter of urgency so that a response could be provided without any further unnecessary delay.

10. On 4 March, a Claims Investigation Officer ("the Claims Officer") informed Mr D that she was liaising with a clinical colleague to obtain an opinion about his mother's care.

11. On 16 October, Mr D approached me again having heard nothing further. I commenced the investigation into Mr D's concerns about the manner in which the Health Board had dealt with his concerns on 14 November.

12. On 1 November, a Solicitor ("the Solicitor") from an external Legal Advice Service the Health Board used ("the Legal Service") responded to a request for advice from the Claims Officer. In her response the Solicitor made reference to the view expressed by the Consultant Physician that he believed the delay in transfer, assessment and treatment of Mrs D was detrimental to her condition.

13. On 10 November, the Claims Officer contacted the Health Board's Clinical Director. In response to a query from the Clinical Director, the Claims Officer confirmed that Mrs D's clinical notes were missing and could not be located. The Claims Officer asked the Clinical Director to provide an opinion without benefit of the clinical notes adding "I fully appreciate that it will be a compromised opinion however this would allow the Health Board to value the claim and avoid any further delay and save costs with regard to instructing an independent opinion".

14. On 18 November, the Clinical Director responded to the Claims Officer. He expressed the view that, without the notes relating to the admission, it would be very difficult to give an opinion and that it would also be difficult to get an independent opinion. He said that, in light of the notes not being available he believed the Health Board would have to accept 'some sort of liability'. The Clinical Director concluded, from a review of the available documentation, that the shortcomings that had been identified did not appear to relate directly to Mrs D's death. However, he concluded that, as a result of the shortcomings, it appeared that "harm/unnecessary distress" was caused to Mrs D and her relatives.

15. On 21 November, the Solicitor provided the Claims Officer with a further view. The Solicitor advised the Claims Officer to inform Mrs D's family that they had mislaid the clinical notes for the relevant period. She further advised that the family should also be informed that the Health Board had obtained an opinion from the Clinical Director and that based on the detailed accounts available he was of the view that the failings did not have a bearing on the outcome for Mrs D. The Solicitor concluded by stating that if the family did not accept what the Health Board said about the outcome not being affected, then it would need to proceed with an expert opinion.

16. On 5 December, the Claims Officer wrote to Mr D offering an ex-gratia payment of £650 in full and final settlement of the matter. The Claims Officer conveyed that the Clinical Director 'based on the information available ... concluded that ... the failings identified would not have been the cause of your mother's death'. The Claims Officer made no reference to qualifying liability nor to the fact that Mrs D's clinical notes were missing and that the Clinical Director had not had the benefit of the clinical notes in forming his view.

17. On 18 December, after he had received the Health Board's response, Mr D complained to me about the service the Health Board provided to his mother.

What Mr D said

18. In his most recent complaint submission to me, Mr D expressed his frustration at what he considered to be the Health Board's intransigence in dealing with his concerns and its failure to provide him with a full report of the events surrounding his mother's clinical care at the Hospital. Mr D referred to the Health Board's letter of January 2016, which indicated that progress was being made with the investigation. Mr D also pointed out the delay in the Health Board addressing the issues raised by his mother's care and queried the Health Board's reluctance to explore shortcomings in its quality of care and raised concern about the possible impact on other patients.

19. Following the Health Board's response of 5 December, Mr D raised concerns about the procedures and administrative tools the Health Board utilised which prioritised patients according to their time of arrival within the department and not on clinical need.

20. During the course of the investigation, my investigating officer met with Mr D to discuss his concerns. Mr D confirmed to the investigator that, whilst he was aware that there were shortcomings in the clinical records, he was not aware that his mother's clinical records for final admission were missing. He was content for this issue to be considered as part of the investigation.

What the Health Board said

21. In its response to my enquiries the Health Board accepted that its letter of 24 October 2013 under Regulation 26 of the Regulations did not contain the standard paragraph setting out the right to free legal advice and instruction of medical opinion in accordance with Regulation 32 of the Regulations.

22. The Health Board also explained that, following the transfer of the case to the Redress Team in October 2015, opinions were sought from a number of staff internally and outstanding responses were chased in January and March 2016. One of the responses it received in November 2015 was from the Consultant Physician who expressed the opinion that, whilst he was not a medico-legal expert, 'the delay in transfer, assessment and treatment was detrimental to [Mrs D's] condition'. In July 2016, the Redress Team endeavoured to secure opinion from a number of clinical specialists without success. The Health Board, in responding to me on 20 December, confirmed that Mrs D's medical records had been missing for 'some time'. It did not elaborate at the time, however, about any actions it had taken to locate the records in question or to investigate how they were lost. The Health Board did explain however that the original complaint file was also misplaced and that as a result it was re-constructed, based on various sources of information that were available.

23. The Health Board also said that, since this complaint was received in 2013, there have been a number of changes in its processes, including an escalation of outstanding cases, weekly workload meetings and full reviews of every open case on a monthly basis to ensure the investigation of complaints and redress cases are not unnecessarily delayed.

The Health Board's response to a draft version of this report

24. A draft version of this report was shared with the Health Board on 30 May 2017 and, on 22 June the Ombudsman received its formal response. The Health Board also later confirmed that Mrs D's medical records had been located. The Health Board said that it accepted the content of the draft report and its recommendations. It also outlined a

number of actions it had taken both in terms of complaint handling and redress during 2015 and 2016. These included:

- A full review of all open redress cases was undertaken between 6 and 20 July 2016.

- Action was identified to progress and conclude cases.

- A review meeting was held on 16 August 2016, where improvements to the process were identified.

- A further review of cases was undertaken on 5 October 2016, when further processes were implemented.

25. The Health Board has confirmed that there is now a clear process in place for handling redress cases, again including an escalation process and monthly meeting for an in-depth consideration of cases. The Health Board said that an action plan was developed following an internal audit of Complaints in the Autumn of 2015, which was repeated in September 2016. The Health Board said that the 2016 audit provided a reasonable level of assurance.

26. The Health Board has also confirmed that, following the issuing of the draft report, it took a number of other actions including:

- An individual detailed case discussion with the claims officer on 5 June 2017.

- A 'Fresh Eyes' review of the case by the Head of Patient Experience on 6 June 2017.

- A team meeting was arranged for 16 June 2017, with the majority of staff involved in this case to discuss process and reiterate the new systems and processes introduced in late 2016. This meeting was also attended by one of my Investigation and Improvement officers.

- Closer monitoring of Redress cases is to be undertaken including weekly one to one meetings with case handlers and their line managers.

Analysis and conclusions

27. I wish to emphasise from the outset that the focus of my investigation has been solely the manner in which the Health Board dealt with Mr D's complaint. I also appreciate the fact that the Health Board has already sought to explain the delay in responding to Mr D's concerns between October 2013 and November 2015 and has apologised to him for that delay, including providing an ex-gratia payment of £250. However, the events since October 2013 are all relevant in terms of my consideration of the overall complaint/redress process and will form part of my assessment of the Health Board's overall handling of this matter.

28. It is clear from the evidence that I have seen that, after the Health Board acknowledged a breach in its duty of care to Mrs D, it failed to issue Mr D with an appropriate interim report in line with Regulation 26. Whilst I appreciate that many elements of response were in keeping with this Regulation, the Health Board failed to offer Mr D the opportunity to receive legal support free of charge and failed to alert him to the opportunity to jointly instruct an expert clinician to obtain an opinion about the care his mother received. This failing not only meant that Mr D lost the opportunity to have an independent consideration of any harm or suffering his mother may have experienced, but he also lost the opportunity to have suitable support in formulating instructions for such independent advice. Neither I nor the Health Board can say what conclusion any independent advice would have reached. It also seems to me that the Health Board's apparent loss of Mrs D's medical records at the time and the delays that this entailed will also inevitably make the task of establishing any harm caused to Mrs D inherently more difficult. The failure to provide Mr D with the opportunity for support and independent consideration of the potential harm that the Health Board's breach of its duty of care towards his mother, is maladministration, which has led to a clear injustice to Mr D in terms of his lost opportunity. Accordingly, **I uphold** this aspect of the complaint.

29. I turn now to the matter of Mrs D's clinical notes being misplaced. The notes appear to have been available to the Health Board when it prepared its response to Mr D of 24 October 2013. However, following the commencement of my enquiries and for some time before this, it is evident that the clinical notes had been unavailable. The Health Board also formally acknowledged in December 2016 that the clinical notes 'have been missing for some time'. I can see no evidence that the Health Board

conveyed this loss to Mr D. A careful examination of the Health Board's internal files has failed to identify any acknowledgement that the clinical records had been misplaced until this was queried by the Clinical Director in November 2016. I am astonished that the Health Board, when writing to Mr D on 5 December 2016, failed to acknowledge that the 'information available' that led the Clinical Director to conclude that the failings it previously identified would not have been the cause of Mrs D's death, did not include her clinical records. It seems to me that this was a crass attempt to secure Mr D's agreement to a full and final settlement in relation to the matter, without revealing the untenable basis for the proposal.

30. At best the Health Board's actions suggest a lack of transparency, at worst, an attempt to mislead. Given that the Health Board was already aware of the view of the Consultant Physician who had a more direct involvement with the patient and her records, I am more inclined towards the latter motivation. This approach on the part of the Health Board seems to me to have the potential to undermine the faith that patients should have in the putting things right process. This is as clear-cut an example of maladministration as I have encountered and, in conjunction with the previous example of maladministration I identified, clearly constitutes an injustice to Mr D. Specifically this injustice involves a prolonged delay in receiving answers to the concerns he raised over many years. I mentioned in paragraph 24 above that, in recent weeks, Mrs D's records have been located. In view of this latest development, there is at least an outside chance that, even at this late stage, it may be possible for Mr D to receive a robust explanation about the effect the acknowledged shortcomings in care had on his mother. However, I would not be surprised if, at this late stage, it transpires that it may not be possible to provide such an assessment. It is inevitable that the manner in which the Health Board dealt with the redress element of his complaint has the potential to instil lasting doubt about the reliability of any future correspondence Mr D receives from the Health Board. In view of all of the above, I **uphold** this aspect of the complaint.

Recommendations

31. I **recommend** that:

(a) Within one month, in view of the manner in which the Health Board denied Mr D the opportunity to have legal support and the ability to jointly instruct clinical advice to determine any harm his mother suffered, the Health Board should provide a fulsome apology to Mr D for the failings identified in this report.

(b) Within one month, in view of the fact that Mrs D's clinical records are now available, the Health Board should ensure that Mr D is given the opportunity to access to legal advice without charge in accordance with the provisions of Regulation 32 of the Regulations and ensure that a medical expert is instructed jointly by the Health Board and Mr B. Regardless of the outcome of any consideration of harm under the Putting Things Right redress process the Health Board should provide Mr with redress of £2000 to reflect the acknowledged distress caused to Mrs D and Mr D.

(c) If recommendation (b) cannot be achieved in a timely manner[4] the Health Board should provide Mr D with additional redress (over and above that referred to in recommendation (b)) of £1500 for the fact that Mrs D's clinical records which confirmed a breach of the Health Board's duty of care were unavailable. This figure is based on the likelihood that if I had been able to investigate the clinical aspects of this complaint, and being mindful of the views of the Consultant Physician[5] and of the Clinical Director[6] that it appeared that harm had been caused, I consider it likely that I would have upheld the complaint and recommended redress at the level set out in paragraphs (b) and (c).

[4] In my view, given the period of time that has already elapsed, three months to arrange for joint instruction of a clinical adviser is sufficient
[5] Paragraph 22
[6] Paragraph 14

(d) Within one month, the Health Board should provide financial redress of £500 for Mr D's time and trouble pursuing the complaint, recognising that this was exacerbated by the failure to disclose to Mr D that it did not have his mother's clinical records for the episode in question when responding on 5 December 2016.

(e) Within one month, the Health Board should, if it has not done so already, ensure that all relevant staff are formally reminded of their duty to be open and transparent at all times with patients and their relatives.

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

Nick Bennett 17 July 2017
Ombudsman

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

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