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PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a complaint against Cwm Taf Morgannwg University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202001285

Contents

Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

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

Summary

Mr X complained about the care and treatment provided to his wife, Mrs X (who had been diagnosed with cancer 3 months earlier) at Prince Charles Hospital ("the Hospital") Emergency Department ("ED") on 16 and 17 December **2019** when she was admitted with a possible infection. Mr X was concerned that due to staffing levels and the high level of patients at the ED, Mrs X's care may have been compromised. Mr X believed that, had Mrs X received earlier diagnosis and treatment, there was a chance she may not have aspirated (where contents such as food, drink, saliva or vomit enter the lungs and is characterised by coughing, difficulty breathing, and shortness of breath). Mrs X sadly died on 17 December.

The investigation considered whether there was a delay in:

a) Diagnosing the reason for Mrs X's admission.

b) Commencing treatment once a diagnosis had been reached.

c) Administering oxygen when Mrs X's oxygen saturation levels were recorded as low.

d) Responding to Mrs X's breathing difficulties which led to aspiration.

The Ombudsman found that there was a significant delay in diagnosing the reason for Mrs X's admission. Despite a pre-alert call indicating that Mrs X possibly had sepsis (and the failure to recognise the significance of this), the Ombudsman found that the time taken to reach a diagnosis of pneumonia and commence correct treatment was alarming. There was a catalogue of failings that contributed to this delay, including lack of regular monitoring or appropriate escalation when investigation results and monitoring indicated significant clinical deterioration.

Once the diagnosis had been made, correct antibiotic treatment was commenced within the hour. However, Mrs X should have received antibiotic treatment within 1 hour of her admission to the ED, not within 1 hour of the diagnosis. This would have been in line with national clinical

guidance. This had significant consequences for Mrs X. There was a delay of 15 hours before appropriate antibiotic treatment was started.

The Ombudsman considered that, on balance, Mrs X would have survived the admission had she received antibiotics within 1 hour of arrival at the ED. Whilst Mrs X's family accept that her cancer diagnosis meant that she probably had less than a year to live, the identified shortcomings in clinical care meant that Mrs X, Mr X and their family were denied this precious time together. This engaged their Article 8 rights under the Human Rights Act 1998. The Ombudsman also found that there was a considerable delay in administering oxygen and, had Mrs X not encountered delays in diagnosis and treatment, and had she received appropriate monitoring and escalation of abnormal vital signs, it is possible that Mrs X would have been less likely to aspirate. The Ombudsman found that there was a series of failings which contributed overall to a very poor standard of care for Mrs X and denied her the opportunity of spending the little time she had left with her family. The Ombudsman was deeply saddened by this. He upheld all of the complaints.

In addition, the Ombudsman found that there were occasions during Mrs X's admission when there were insufficient numbers of healthcare support workers on duty. Mr X's impression of the ED as having insufficient staffing levels in relation to an exceptionally high number of patients, was supported by the Ombudsman's professional adviser's opinion that the ratio of staff to patients appeared to be unacceptably high. This meant that Mrs X could not be appropriately monitored in the corridor of the ED. This led the Ombudsman to the view that, on balance, the staffing situation at the ED, which was at extreme pressure escalation level, might have, on balance, contributed to the level of poor care Mrs X received. The pressure on the ED department during Mrs X's admission and that fact that she was nursed in the corridor for almost 12 hours also compromised her dignity and impacted on the quality of the family's remaining time with Mrs X.

Finally, whilst the Health Board belatedly carried out a root cause analysis investigation into Mrs X's care; this was not done until after the Ombudsman commenced his investigation. The Health Board's investigation identified the same shortcomings as the Ombudsman's investigation. Had the Health Board carried out this action as soon as it received Mr X's complaint,

this may have resolved the complaint much sooner and provided Mr X with open and honest answers about what happened during Mrs X's admission. As a result of its own investigation, the Health Board prepared an action plan to address the failings it identified. This limited the number of recommendations the Ombudsman made as they would be replicated. The Ombudsman made a number of additional recommendations to ensure that lessons were learnt and to ensure improvement in service delivery for patients. The Health Board accepted the recommendations in full which are to:

a) Provide a fulsome written apology to Mr X for the significant failings in his wife's care and the distress caused to the family which meant that they were denied what little time they had left with Mrs X.

b) Arrange awareness training for all ED staff on the correct use of the NEWS chart and when escalation to the nurse in charge/doctor is required.

c) Arrange training for all ED staff on the recognition and management of suspected sepsis.

d) Carry out an audit of a sample of patient ED records, including NEWS charts at the Hospital ED to ensure that these are being calculated correctly and that staff have escalated appropriately where indicated.

e) Create a standard operating procedure for the management of ASHICE patients (a hospital pre-alert for any patient whose clinical condition suggests special arrangements need to be made by the receiving hospital) within the ED Department.

The Complaint

1. Mr X complained about the care and treatment provided to his wife, Mrs X (who had been diagnosed with cancer 3 months earlier) at Prince Charles Hospital ("the Hospital") Emergency Department ("ED") on 16 and 17 December **2019** when she was admitted with a possible infection (she had a temperature and low oxygen saturation levels). Mr X was concerned that due to staffing levels and the high level of patients at the ED, Mrs X's care may have been compromised. The investigation considered whether there was a delay in:

a) Diagnosing the reason for Mrs X's admission.

b) Commencing treatment once a diagnosis had been reached.

c) Administering oxygen when Mrs X's oxygen saturation levels were recorded as low.

d) Responding to Mrs X's breathing difficulties which led to aspiration (where contents such as food, drink, saliva or vomit enter the lungs and is characterised by coughing, difficulty breathing, and shortness of breath).

Mr X believed that, had Mrs X received earlier diagnosis and treatment, there was a chance she may not have aspirated. Mrs X sadly died on 17 December.

Investigation

2. My investigator obtained comments and copies of relevant documents from Cwm Taf Morgannwg University Health Board ("the Health Board"), including an RCA investigation report (a root cause analysis investigation seeks to identify the root cause that led to a serious incident happening) that was started after the commencement of my investigation and the resulting action plan. I considered these in conjunction with the evidence provided by Mr X. Clinical advice was obtained from 2 of my Professional Advisers, Dr Ian Woolhouse, a Respiratory Consultant ("the First Adviser") and Dr Susan Croft, a Consultant in Emergency Medicine ("the Second Adviser").

3. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

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

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

Relevant legislation and guidance

6. The National Institute for Health and Care Excellence "Sepsis: recognition, diagnosis and early management" (2016) ("the NICE Guideline") makes recommendations for adults who have suspected sepsis according to a risk stratification criterion.

7. The British Thoracic Society "BTS Guidelines for the Management of Community Acquired Pneumonia in Adults: update 2009" ("the BTS Guideline").

8. The Human Rights Act 1998 ("the HRA") incorporated the European Convention of Human Rights ("the Convention") into UK law. All public bodies must comply with the HRA. Such rights are set out in the Convention through a series of Articles. It is not my function to make definitive findings about whether a public body has breached an individual's human rights by its actions or inaction. However, I will identify where human rights matters are engaged and comment on a public body's regard for them.

9. Article 8 of the Convention provides a right to respect for one's private and family life. The positive obligation imposed on a public body to respect and promote those rights applies to the way in which health providers exercise their powers and perform their duties. The impact on someone of the failure to provide appropriate medical treatment or care is sufficient to engage Article 8. Article 8 applies not only to the individual but also to their wider family.

10. The Welsh Government has issued statutory guidance on NHS complaints handling. Under the Putting Things Right Guidance ("the PTR Guidance"), Health Bodies are expected to deal with concerns openly and honestly. At the heart of the PTR Guidance is the principle of "investigate once, investigate well".

11. I issued guidance on "Principles of Good Administration and Good Records Management" ("my Guidance"). I expect bodies in my jurisdiction to ensure that when they investigate complaints they do so thoroughly, quickly and impartially (Principle 5 – putting things right). I also expect that bodies learn lessons from complaints to contribute to developing and improving services (Principle 6 – seeking continuous improvement).

The background events

12. Mrs X was diagnosed with cancer of unknown primary origin in September **2019** following a computerised tomography scan (a "CT" scan uses X-rays and a computer to create detailed images of the inside of the body). She was subsequently diagnosed with adenocarcinoma (a type of cancer that forms in the glands) of the lung with extensive metastases (cancer spread) to the bones and liver.

13. On 16 December **2019**, a 999 call was made. When the ambulance arrived, the District Nurse was present; there was concern that Mrs X may have an infection (possibly a urinary tract infection). A pre-alert call was made by paramedics to the Hospital ED at 15:50 as it was felt that Mrs X had possible sepsis (a life-threatening reaction to an infection that can cause organ damage).

14. Mrs X arrived at the ED at 16:04 and was assessed by a junior doctor at 16:20. Mrs X described feeling unwell with lethargy for the previous 3 days. She had no cough, no breathlessness, no vomiting, chest or abdominal pain and no urinary symptoms. The working diagnosis was possible cancer related lethargy, infection and salt imbalance. The plan was for an infection screen, blood tests and a review. Mrs X was referred to the Inpatient Medical team. Mrs X had her first set of observations taken at 18:25. Her NEWS ("National Early Warning Score" – a tool developed to improve detection and response to clinical deterioration in adult patients)

score was documented as 3 (the higher the score means the patient's treatment needs to be escalated).

15. Mrs X was assessed by the Medical team/Medical Admitting Junior Doctor at 22:15 in the Hospital corridor. A diagnosis was made of disease related fatigue/side effects of afatinib (a drug that is used as treatment of advanced or metastatic lung cancer, the side effects include decreased appetite, dehydration, diarrhoea and fever). The plan was for intravenous fluids ("IV" - liquids given to replace water, sugar and salt) overnight, C-reactive protein blood test ("CRP" levels in the blood rise due to inflammation, infection, cancer or major tissue injury) and to encourage oral intake. Her CRP was subsequently recorded as 151 (normal range is 0-5).

16. At 01:00 on 17 December Mrs X was noted to be comfortable on the trolley and IV fluids were commenced. Her second set of clinical observations were taken at 01:40 and the third set at 05:05. Further observations were taken 08:15, 11:45, 12:30, 15:30 and 16:15. Her NEWS was between 3 and 7 during this period. Mrs X had a temperature of 38.4C at 05:05.

17. Mrs X was transferred to a room from the corridor at 05:30. Mrs X's oxygen saturations had fallen (79-81%). She was seen by the Medical team; an arterial blood gas sample (a test to measure the oxygen and carbon dioxide levels in the blood) had been taken and advice given to increase oxygen therapy. Mrs X also underwent a nursing assessment at this time.

18. A medical registrar reviewed Mrs X at 06:11. It was noted that she was in type 1 respiratory failure (associated with damage to lung tissue which prevents adequate oxygenation) and the oxygen being administered had been increased. The working diagnoses were possible infection, progression of Mrs X's disease and possible side effects from treatment. The plan was to complete a DNACPR (do not attempt cardiopulmonary resuscitation order), discuss Mrs X with the Oncology (cancer) team, continue with oxygen via mask and prescribe amoxicillin (an antibiotic).

19. A medical consultant review took place at 07:30. It was noted that Mrs X had been unwell for a few days, had a fever, her CRP was raised, and she was hypoxic (a low level of oxygen in the blood). Her chest X-ray

was reviewed, and a right basal consolidation (a pathologic disease process that takes place with certain types of lung infections and can block air flow through your lungs, causing you to feel short of breath or fatigued) was noted. A diagnosis was made of community acquired pneumonia ("CAP" - a breathing condition in which there is an infection of the lung). The plan was to prescribe a further antibiotic (clarithromycin), carry out further investigations, IV fluids, and monitor her CRP. Mrs X was transferred to an ED room and she was assigned to the Chest/Respiratory team. A DNACPR was completed at 07:40.

20. At 15:50 Mrs X was noted to be feeling nauseous. Cyclizine (an anti-sickness medication) was added to her medication and administered by IV. A one-off prescription for hydrocortisone 200mg (a steroid medicine) was administered intravenously at 16:30.

21. At 16:30 Mrs X was noted to be deteriorating. The Respiratory team reviewed Mrs X at approximately 16:36. It was documented that she was drowsy and that she had recently had a repeat chest X-ray which showed new left sided changes. A discussion with Mr X was documented and an agreement made to aim to keep Mrs X comfortable. The records noted that the Respiratory team stayed with Mrs X and the family until she passed away. Mrs X's death was verified at 17:35.

Mr X's evidence

22. Mr X's complaint to the Health Board in January 2020 outlined his impression of the Hospital ED as an "extremely busy" ward with a corridor that was "congested". He said he expected the department to be busy, but he was not prepared for the "chaos" that faced him. He said that all of the cubicles were full, some with multiple patients sitting in them and that both sides of the corridor were lined with patients on trolleys, to the extent that "it was difficult for staff to manoeuvre" and "almost impossible for accompanying relatives to sit". He said the family could not help but think that "if treatment was started earlier that [his wife] wouldn't have died in the department". He raised further concerns with the Health Board about insufficient staffing levels at the ED in relation to the exceptionally high numbers of patients presenting at the department at the time of his wife's admission.

23. In his complaint to me, Mr X said that on 16 December, the District Nurse and an adviser at a cancer unit (where Mrs X had been receiving treatment) decided to call an ambulance to take Mrs X to the Hospital as they thought she had developed an infection. He said Mrs X was admitted to the Hospital ED at 16:00 on 16 December.

24. Mr X said the ED was extremely busy on arrival and Mrs X was initially accommodated on a trolley in the corridor. He said that whilst staff attended to his wife quite quickly on arrival, a diagnosis of pneumonia was not made until 05:30 the following day (17 December), and an antibiotic drip was not administered until 09:30. He said Mrs X's oxygen levels had dropped further by 15:00 when oxygen was administered and increased progressively. He said this caused his wife to vomit and aspirate around 16:00. Mr X said that within 40 minutes of aspiration Mrs X passed away.

25. Mr X said the family recognised that his wife probably had less than a year to live, but they feel that this would not have happened if the ED had been adequately staffed. He said the family had been left totally devastated by Mrs X's death. Mr X said there was an 11-hour delay in diagnosing the cause of his wife's illness and the family found this delay difficult to accept. He said the Health Board delayed in providing treatment to Mrs X, and whilst the Health Board accepted there was a delay in administering treatment, he said it was unable to say if this contributed to the eventual outcome.

The Health Board's evidence

26. The Health Board formally responded to Mr X's complaint on 13 May 2020. It said that, at a meeting with Mr X and his daughter on 5 March 2020, in response to Mr X's concern that staff at the ED were extremely busy and did not have time to take care of Mrs X, the Health Board apologised; it said this was not a situation it found acceptable. It explained there were a number of sick patients presenting to the ED on the evening of Mrs X's admission. The Health Board confirmed it was recruiting additional staff and had been successful in increasing the number of registered nurses in the ED and across the Health Board as a whole.

27. The Health Board said that due to the treatment Mrs X was receiving for her cancer, the symptoms she presented with could have been due to her underlying cancer progression. Investigations were therefore undertaken to establish the cause of her infection. It acknowledged there was a delay in administering antibiotics once a decision was made to prescribe them. The Health Board apologised for this delay, but it was unable to say whether this contributed to Mrs X's rapid decline.

28. The Health Board said in response to Mr X's concern about a delay in responding to Mrs X's breathing difficulties and when she vomited, that when a person vomits, normally coughing triggers an automatic gag reflex to prevent anything going into the lungs. It said patients who are very ill and weak may be unable to cough. It said that Mrs X was unable to cough as she was in a weakened state, this resulted in liquid going into her lungs (aspiration). Once this has happened, there was no way of removing the liquid from the lungs.

29. It acknowledged there were lessons to be learnt from the care provided to Mrs X and that it would be taking this forward with staff in the ED for shared learning.

30. In responding to my investigation, the Health Board:

- Confirmed that a formal action plan was not written regarding some of the actions identified after its investigation due to the pressures on the service arising from the COVID-19 pandemic.

- Provided a chronology of events which identified that on 16 December 2019 at 16:04 there were only 2 health care support workers ("HCSW") on duty when there should have been 3 and this was the case again at 18:25 and at 01:40 on 17 December.

- Clarified the number of staff on duty during Mrs X's admission and that it had the correct establishment of staff during the admission for the ED Department.

- Said it had no standard operating procedure in place for the management of ASHICE[1] patients within the ED Department, but it was widely recognised that ASHICE patients required immediate transfer to the resuscitation space in the majors area of the ED.

- Confirmed that Welsh Government would be implementing a supported escalation process (a process for managing capacity) as part of the reorganisation of the scheduled (planned) care programme.

- Advised that a nurse staffing review has been undertaken to support the ED Department and an additional senior nurse has been employed. It has also increased the HCSW model to support 5 HCSWs per shift.

- Clarified that a senior post of Flow Manager has been created to support the flow of patients throughout the hospital and to promptly manage and escalate any blockages.

- Confirmed it did not have a policy in place at the time of Mrs X's admission relating to care of patients in the ED corridor. It has subsequently developed a policy to address this which was approved in January 2020 – "Procedure for the Care of Patients in Additional Capacity Areas (Ambulance and Corridors)".

- Clarified that, due to the escalation level the ED Department was in at the time of Mrs X's admission (level 4 – extreme pressure) that 2 ambulances were diverted to another hospital.

31. Following Mr X's complaint, and after I commenced my investigation, the Health Board undertook an RCA investigation, completing its report on 9 March 2021. Its findings included:

- Given the ASHICE call, Mrs X should have been cared for in Resus (an area for the most seriously ill patients), but Resus and major cubicles were full.

[1] An ASHICE message is a hospital pre-alert for any patient whose clinical condition suggests that special arrangements need to be made by the receiving hospital – it stands for Age, Sex (gender), History, Injury/illness, condition, ETA.

- Observations should have been completed on arrival and would have highlighted dehydration plus provided another red flag for sepsis.

- Staffing levels were appropriate for the department with 9 registered nurses and 3 HCSWs on duty.

- Given Mrs X's presenting complaint, it would have been appropriate to have given antibiotics and completed the sepsis 6 (a care bundle to reduce deaths and complications related to sepsis, to be commenced within 1 hour of admission) at 16:20 on 16 December when Mrs X was assessed, especially given the concerns post-cancer treatment and from the cancer treatment centre.

- The Chest X-ray performed at 17:58 was not escalated to the ED Doctor; this delayed the review of the X-ray until Mrs X was reviewed at 22:15. The X-ray confirmed pneumonia and, had it been reviewed, should have led to antibiotics being prescribed significantly earlier.

- A NEWS of 3 at 18:25 should have been escalated to the Nurse in charge; there was no documentation this was done. Given her diagnosis of lung cancer and oxygen levels a month before, Mrs X's NEWS would have been 6, and with oxygen being administered, would have raised it to 8. This would have indicated that she was sick, requiring escalation to the Doctor and outreach review and observations should have been performed every 1-2 hours.

- At 22:15 Mrs X should have been clerked (taking a patient's complete history and examining the patient) in privacy, but there was no space available in the department. There was another delay in prescribing treatment for infection and dehydration.

- There was a delay in administering IV fluids after they were prescribed.

- At 01:40 Mrs X's NEWS of 4 should have been escalated to the Nurse in charge and the appropriate NEWS of 6 should have led to a doctor being informed; this did not happen. Given the significant hypoxia, oxygen saturations should have been repeated – it did not happen until 05:05.

- A CRP of 151 noted at 02:38 should have raised concern of infection. There was no documentation for when the result was reviewed.

- A NEWS of 7 at 05:00 should have triggered transfer to Resus but there was no space available, and Mrs X remained in the corridor; there was a 3.5-hour delay in repeat oxygen levels being measured.

- Entry on drug chart on 17 December noted as “morning” – as no stat (immediate administration) dose of antibiotics was prescribed or signed for, it was unclear what time antibiotics were eventually given and good practice is to document the initial dose as a stat to aid this issue. Mrs X waited a total of 14 hours from arrival to administration of antibiotics – with any concern for sepsis this should have happened within the “golden hour” of sepsis treatment.

- On 17 December there was no escalation to the Nurse in charge when significant hypoxia was noted and, despite comments in the nursing record of Mrs X being unable to maintain her own airway, there was no documentation of doctors being informed; this should have led to an urgent review due to concerns of low consciousness and significant illness. In addition, the Respiratory team had not been made aware of Mrs X’s situation until 15:50.

- Care and service delivery problems were identified – significantly, there was a delay of at least 12 hours from admission to the department before Mrs X received antibiotics; there was a delay in IV fluid prescription; lack of privacy and dignity provided to Mrs X as she was being care for and examined in the corridor; lack of appropriate recognition of Mrs X’s observations with reviews and observations largely triggered by Mr X; failure to adhere to the sepsis “golden hour”; failure to escalate as per NEWS, and the acuity of department led to fragmented care.

Professional Advice

The First Adviser

32. The Adviser said that when Mrs X was seen on the post-take ward round (where a clinical diagnosis is obtained or revised) at 07:30 on 17 December, by an acute medical consultant, she was noted to have a fever, high white cell count (an increased production of white blood cells can indicate that your body is fighting an infection) plus low oxygen levels. Examination confirmed crackles and bronchial breathing in the right side with a dry tongue. A diagnosis of pneumonia was made (Mrs X had a fever, high CRP, and abnormal Chest X-ray). He said the severity score was 3 (the maximum is 5). He said the plan included adding another antibiotic (clarithromycin) and for Mrs X to be cared for by the Chest/Respiratory team.

33. The Adviser said that at 15:50, Mr X reported that his wife began vomiting, called for help and was supported by a nurse practitioner who contacted the Respiratory team. The Adviser said it was not documented whether Mrs X was formally handed over to the Respiratory team after the post-take ward round, and according to the RCA, the Respiratory team had not been made aware of Mrs X's situation earlier. The Adviser noted that Mrs X was reviewed by a respiratory consultant at 16:36; a respiratory registrar was also present. They noted that Mrs X was very unwell, drowsy and had a high oxygen demand (her oxygen levels were between 70-80% on 15 litres of oxygen). The Adviser said that Mrs X's poor prognosis was communicated to Mr X and that Mrs X's observations were stopped. Antibiotics were continued in case there was an element of reversibility, but other medications were stopped.

34. The Adviser said that in accordance with the Health Board's RCA, patients are formally handed over to a defined team after the post-take ward round and the responsibility of the patient's care then moves to that defined team, and the Respiratory team would have been responsible then for ongoing review. The Adviser said there was a 9-hour delay from the post-take ward round to the respiratory review, however, there was no additional specific treatment the Respiratory team could have offered during this time. The Adviser said the correct diagnosis was made on the post-take ward round and correct treatment was started. He said the main

issue in terms of delay in transferring Mrs X to the Respiratory Ward was not the medical treatment, but that she could not be appropriately monitored in the corridor of the ED.

35. The Adviser said that based on Mrs X's presentation, she should have received broad spectrum antibiotic within 1 hour of arriving in the ED; this would have been compliant with the NICE Guideline. He said Mrs X received her first dose of antibiotics approximately 15 hours after her arrival at hospital. He said the BTS Guideline states that the chance of surviving severe pneumonia with appropriate treatment is 60 - 85%. The Adviser said that on balance, Mrs X would have survived the admission had she received antibiotics within 1 hour of arrival in the ED.

36. The Adviser said the delay in administering antibiotics was due to the severe pressure that the ED was under at the time Mrs X presented. He said the ratio of patients to staff, in his opinion, appeared to be unacceptably high. He noted the Health Board had undertaken a recruitment drive for new staff, which he said was appropriate. In addition, he said the Health Board should consider direct access beds for oncology patients with suspected sepsis.

37. The Adviser concluded that there were delays in:

- Undertaking a full set of observations, included incorrect NEWS recording on 16 December at 18:25 (the correct NEWS should have been 8 not 3).

- Completing a sepsis 6 bundle.

- Reviewing the chest X-ray.

- Handing over care to the Respiratory team.

38. The Adviser said earlier review by the Respiratory team would not have made a material difference but, on balance, Mrs X would have survived the admission had antibiotics been given promptly.

The Second Adviser

39. The Adviser said there were significant delays in providing Mrs X with clinically appropriate treatment, namely:

- Mrs X should have been prescribed and administered IV fluids when the initial bag of fluid from the ambulance was completed or within 1 hour of arriving in ED (by approximately 17:30 on 16 December). The first bag of fluids was administered at 01:00 on 17 December.

- Mrs X should have been prescribed and administered steroids (higher dose oral or IV) within 2 hours of her initial assessment in ED (by approximately 18:30 on 16 December). These were administered at approximately 16:30 on 17 December.

- Mrs X should have been prescribed and administered oxygen on arrival in ED as Mrs X's oxygen levels were low (92%).

- Mrs X had a chest X-ray at 17:58 and the review showed right lower lung shadowing/consolidation. The Adviser said this would have been consistent with a diagnosis of pneumonia although she said it was important to note that she would have expected that Mrs X would have had some pre-admission changes to her right lung on a chest X-ray due to the tumour identified on the CT scan on 17 September. The Adviser said that whilst it was unclear when Mrs X was referred to the Medical team, she was of the view that a doctor review should have taken place sooner (the review was at 22:15), around 18:30, which is when she would have expected the results of the chest X-ray and blood tests to have been available.

- Oxygen was prescribed in Mrs X's medication chart on 16 December, but there was no record of it being administered until after 01:40 on 17 December at which point her oxygen saturations were dangerously low (71%). There was documentation that she was put on oxygen at this point, but no record of the concentration or percentage of oxygen therapy. Low oxygen levels can cause shortness of breath, headache, confusion, and drowsiness. There was a significant delay in administering oxygen.

- The Adviser said that while some of Mrs X's symptoms may have been due to her cancer treatment, she was of the view that there was a delay in reaching the diagnosis of pneumonia and as a result there was a delay in prescribing and administering IV antibiotics. Mrs X's CRP level was very high, and she should have had a senior doctor review of her progress in light of the CRP result and NEWS. The diagnosis was not definitively made until 07:30 on 17 December and IV antibiotics were not administered until approximately 08:00.

- A senior doctor (Medical Registrar) review took place at 06:11 on 17 December. A diagnosis of possible infection was made, and Mrs X was started on oral antibiotics (amoxicillin). The Adviser said the severity of Mrs X's illness was not appreciated. She should have had a CURB65 score (used in hospital to assess mortality risk in adults with pneumonia), which the Adviser said would have been 3 - high risk - and required treatment with IV antibiotics.

- Mrs X should have been monitored more regularly - there was inadequate monitoring of Mrs X's clinical observations and escalation of these. Between 15:47 on 16 December and 16:15 on 17 December, Mrs X's NEWS was between 3 - 7. Her observations were not monitored frequently enough and should have been monitored every 1 - 2 hours. There was no record that these were appropriately escalated to the Nurse in charge and doctor for review.

- The Adviser said there was no information in the medical or nursing records regarding Mrs X's aspiration. She said the nursing records noted at 15:50 that Mrs X was feeling nauseous and was given IV cyclizine for this. The medical records noted at 16:30 that Mrs X was unwell, drowsy and needing more oxygen. Mrs X had another chest X-ray at 16:31 which showed bilateral airspace shadowing which was consistent with having aspirated. The Adviser said aspiration generally occurs in patients who are unwell, weak, drowsy, and unable to protect their airway from vomit by coughing. Mrs X had delayed diagnosis and treatments as well as inadequate monitoring and escalation of abnormal vital signs.

Analysis and conclusions

40. This is a distressing case where the catalogue of failings I have identified, contributed overall to a very poor standard of care for Mrs X, and denied her the opportunity of spending the little time she had left with her family. I am deeply saddened by this, and I wish to convey my heartfelt condolences to Mr X and the family.

41. In reaching my conclusions I have taken account of Mr X's and the Health Board's submissions, alongside the relevant records. I have also been assisted by the advice and explanations of the Advisers. The advice I have received is clear, which is why I have set it out in some detail above. Whilst I accept the advice in full, the findings below are my own.

Was there a delay in diagnosing the reason for Mrs X's admission?

42. Quite simply, yes, and disturbingly so; a delay of 12 hours at a conservative estimate. Given that the Hospital received a pre-alert call indicating that Mrs X possibly had sepsis, the time taken to reach a diagnosis and institute correct treatment was alarming. Even accepting the Second Adviser's advice that there would be an expectation of some pre-admission changes to Mrs X's chest X-ray due to the cancer, the results of the chest X-ray at 17:58 on 16 December were consistent with a diagnosis of pneumonia. I accept the advice that Mrs X should have received a review, at around 18:30, when the results of the chest X-ray and blood tests should have been available. However, Mrs X was not reviewed again until 22:15 and whilst a CRP blood test was requested at this point (it would have been good clinical practice to have requested it on admission), the result was not followed up. Mrs X was not reviewed by a doctor until 06:11 when a diagnosis of infection was made, and oral antibiotics were commenced. I am guided by the advice that the appropriate treatment would have been IV antibiotics and that a CURB65 score, had it been done (and it should have), would have indicated this. A diagnosis of pneumonia was made at 07:30 and IV antibiotics were commenced.

43. Mrs X's CRP level, NEWS and chest X-ray results should have prompted a senior doctor review. The fact that Mrs X's observations/NEWS were not regularly monitored or escalated appropriately is a matter of concern and will have contributed to the delay in diagnosis. Taking into

account the advice, I am satisfied that there was a significant delay in diagnosing Mrs X's pneumonia. This was a serious service failure which caused Mrs X a substantial injustice as she should have received antibiotic treatment much sooner. I **uphold** this complaint.

Was there a delay in commencing treatment once a diagnosis had been reached?

44. Once the diagnosis of pneumonia had been made at 07:30 on 17 December, the correct antibiotic treatment was commenced within half an hour. Whilst I have highlighted my concerns about the delayed diagnosis above, what is of considerable concern to me is that Mrs X should have received antibiotic treatment within 1 hour of her admission to the Hospital ED, not within 1 hour of the pneumonia diagnosis. This would have been in line with the NICE Guideline. In addition, paramedics had made a pre-alert call to the Hospital ED due to concerns that Mrs X may have had sepsis, yet this did not result in appropriate and timely treatment. The failure to complete a sepsis 6 bundle and institute correct antibiotic treatment early in Mrs X's admission had significant consequences. The advice I have received is unequivocal; there was a delay of 15 hours before the appropriate antibiotic treatment was started. The First Adviser is clear that, on balance, Mrs X would have survived this admission had she received antibiotics within 1 hour of arrival at the Hospital ED; this is consistent with advice in the BTS Guideline. The standard of proof I apply when considering clinical care is the balance of probabilities, and on this basis, I am satisfied that Mrs X's death during this admission was avoidable.

45. Whilst it is not for me to determine whether there was a breach of Mrs X's and Mr X's human rights, given that on balance, she would have survived this admission but for the serious clinical shortcomings, it is important I comment on it in this case. Whilst the family accept that Mrs X's cancer diagnosis meant that she probably had less than a year to live, the identified shortcomings in clinical care meant that Mrs X, Mr X and the rest of the family were denied this precious time together. This in my view, engages both Mrs X and Mr X's Article 8 rights. In addition, while I accept that ED Departments are under increasing pressure, the fact that Mrs X was nursed in the corridor for almost 12 hours meant that her dignity was compromised/not respected (as recognised by the Health Board's

RCA) and this impacted on the quality of the family's remaining time with her, given the sad outcome.

46. The failure to institute antibiotics within 1 hour of admission was a serious service failure and the consequent injustice to Mr X and the family is immeasurable. Not only did Mrs X not receive the appropriate treatment, failure to do so had a fatal outcome. I **uphold** this complaint.

Was there a delay in administering oxygen when Mrs X's oxygen saturation levels were recorded as low?

47. Mrs X's oxygen level on admission to the ED was 92%. However, whilst oxygen was prescribed on her medication chart on 16 December, it was not administered until after 01:40 on 17 December at which point, Mrs X's oxygen level was dangerously low at 71%. According to the advice, low oxygen levels can cause shortness of breath, headache, confusion, and drowsiness. Given Mrs X's oxygen levels, she should have been administered oxygen much sooner than she was; there was a considerable delay. This was a service failure which caused Mrs X an injustice as earlier oxygen therapy may have improved her breathlessness and drowsiness. It follows that this may have reduced the chance of aspiration, albeit I cannot be certain. I **uphold** this complaint.

Was there a delay in responding to Mrs X's breathing difficulties which led to aspiration?

48. The Second Adviser was unable to identify information in Mrs X's records regarding aspiration. She did note however, that when Mrs X was feeling nauseous at 15:50 on 17 December, she was administered cyclizine and at 16:30, Mrs X was noted to be unwell, drowsy, and required more oxygen. A chest X-ray at 16:31 showed shadowing consistent with aspiration, so I accept Mr X's evidence that Mrs X did aspirate. Had Mrs X not encountered delays in diagnosis and treatment (including antibiotics and oxygen therapy), and had she received appropriate monitoring and escalation of abnormal vital signs, I am guided by the advice that it is possible that Mrs X would have been less likely to aspirate.

49. I am also concerned to note that despite a decision to refer Mrs X to the Respiratory team for care at 07:30 on 17 December, there was a 9-hour delay before they became involved in Mrs X's care. It is unclear whether the Respiratory team had been made aware of Mrs X's clinical situation before 16:36, when the first respiratory review took place. The First Adviser said that there was no additional specific treatment the Respiratory team could have offered during this time. However, in his opinion, the main issue in the delay of transferring Mrs X to the Respiratory Ward was that she could not be appropriately monitored in the corridor of the ED. Given Mr X's impression of the ED on Mrs X's admission and the fact that the RCA identified the impact of the acuity of staff on Mrs X's care, I accept that Mrs X's care was compromised due to being nursed in the corridor in an over-capacity ED department. I **uphold** this complaint.

Other relevant matters

50. Following the commencement of my investigation, the Health Board decided to carry out an RCA investigation into Mrs X's care. It was still appropriate and proportionate for me to continue my investigation as the Health Board had already had the opportunity to respond to Mr X's concerns. The Health Board's report identified a number of failings in care, as also identified by my investigation, and it developed an action plan to address the shortcomings in care. Had the Health Board taken this action when it originally investigated this complaint, it is possible that the complaint would have been resolved much sooner for Mr X and the family.

51. The Health Board should reflect on its complaints handling approach. It should not wait for my office to become involved before deciding to carry out a more thorough investigation. Had the Health Board investigated Mr X's complaint in accordance with the principles of the PTR Guidance and my Guidance, it would have identified the serious shortcomings much sooner and would have been able to take action to learn lessons from Mrs X's care much earlier. This prolonged the complaints procedure significantly for Mr X and the family which will have been distressing, and potentially unnecessary. I am disappointed that it did not take the opportunity to carry out a thorough investigation of Mr X's concerns when he first approached the Health Board.

52. I also feel it is appropriate for me to comment on the staffing situation at the time of Mrs X's admission and about the failure to appreciate the significance of the pre-alert call. The Health Board told me that the ED had the correct establishment of staff during Mrs X's admission. This is contrary to the chronology of events it compiled and shared with me which identified that there were occasions during Mrs X's admission when there were insufficient numbers of HCSW on duty. This contradictory information, Mr X's impression of the Hospital ED as having insufficient staffing levels in relation to an exceptionally high number of patients, and the First Adviser's opinion that the ratio of staff to patients appeared to be unacceptably high meant that Mrs X could not be appropriately monitored in the corridor of the Hospital ED. This leads me to the view that, on balance, the staffing situation at the ED, which was at extreme pressure escalation level, may have, on balance, contributed to the level of poor care Mrs X received. I am pleased to note that the Health Board has addressed this situation including recruitment of a further senior nurse, increased its baseline of HCSW for each shift from 3 to 5 and created a post of Flow Manager to better manage patient flow.

53. In terms of the pre-alert call, it was clear that the threshold of concern that Mrs X may be suffering with sepsis had been triggered even before her admission and this was identified by a district nurse and trained ambulance crew. Advice had also been sought from the cancer centre treating Mrs X who are especially alert to sepsis in their patients. While space may not have been immediately available for Mrs X, the failure to recognise the significance of this pre-alert is concerning. The Health Board confirmed it had no standard operating procedure in place for the management of ASHICE patients within the ED. Had there been such a process, (given the finding I have already made that if Mrs X had received antibiotics sooner), and if the pre-alert had been acted upon, Mrs X would have received appropriate treatment on arrival at the ED. Therefore, on balance, she might have survived this admission. This is certainly something that the Health Board needs to review and develop to improve service delivery and patient care on the ED.

Recommendations

54. Based on the action plan the Health Board has put in place, this limits the number of recommendations I am proposing to make, as they would be replicated. However, where action has not been completed, I have included these, in addition to my own recommendation to ensure that this action is implemented. Whilst I cannot alter the outcome for Mr X and his family, I can provide him with reassurance that lessons are learnt and that the Health Board will take action to improve its service delivery to prevent a sad and avoidable death in future. I would normally have made a recommendation for financial redress, in recognition of the seriousness of the failings identified and the ultimate impact of these on Mrs X, Mr X and the family. However, I have taken into account the fact that Mr X's complaint was made to seek an understanding of what happened during his wife's admission and answers, and to get an independent appraisal of the circumstances that led to his wife's death.

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

a) Provides a fulsome written apology to Mr X for the significant failings in his wife's care and the distress caused to the family which meant that they were denied what little time they had left with Mrs X.

56. I recommend that, within **2 months** of the date of this report the Health Board:

b) Arranges awareness training for all ED staff on the correct use of the NEWS chart and when escalation to the Nurse in charge/Doctor is required.

c) Arranges training for all ED staff on the recognition and management of suspected sepsis.

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

d) Carries out an audit of a sample of patient ED records, including NEWS charts at the Hospital ED to ensure that these are being

calculated correctly and that staff have escalated appropriately where indicated.

e) Creates a standard operating procedure for the management of ASHICE patients within the ED Department.

58. I am pleased to note that in commenting on the draft of this report **Cwm Taf Morgannwg University Health Board** has agreed to implement these recommendations.

Nick Bennett 12 July 2021
Ombwdsmon/Ombudsman

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