The investigation of a complaint

by Mrs X

against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201501406

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 Mrs X and her husband as Mr X.

Summary

Mrs X complained about the decision not to immediately treat her husband, Mr X, in the ITU department of Glan Clwyd Hospital ("the Hospital") following his repatriation from Tenerife on 25 February 2014. She believed that, had this been the case, Mr X would have received constant monitoring and any deterioration in his condition would have been identified at the earliest opportunity, which would have given him a better chance of survival. Mrs X said that her husband was not regularly reviewed when on the renal ward. Mrs X also complained that the Health Board lost Mr X's notes for six months.

Mr X suffered with Chronic Renal Failure (a long term condition where the kidneys do not work effectively) and with other medical conditions. He was a patient of the Hospital's dialysis unit and had received dialysis three times a week since around February 2012.

Mr X became ill when on holiday in Tenerife, in February 2014. On 25 February, Mr X was repatriated back to the Hospital. A fax was sent to the Hospital which detailed the treatment Mr X had received in Tenerife.

On arrival at the Hospital, Mr X was transferred to the AMU (Acute Medical Unit) department, before being transferred to the renal ward. He was not attended by a consultant until 26 February.

All of the clinical renal physicians were away from the hospital that day. An ITU Registrar did not attend Mr X until 11.50am, when it was considered that Mr X may have pulmonary oedema (excess fluid in the lungs). At 1.02pm, Mr X suffered a peri-arrest (when a cardiac or respiratory arrest is imminent). The clinical plan was to increase Mr X's blood pressure so that he could have dialysis. At 9.30pm, there was a sudden deterioration in Mr X's condition and he sadly died at 10.00pm. The post mortem noted bronchopneumonia, COPD and damage caused to the kidneys due to diabetes, as the cause of death.

The Health Board carried out a Root Cause Analysis of Mr X's death. This concluded that his death was not avoidable due to his existing medical conditions and that, whilst he should have been admitted to the

ITU department immediately following repatriation, this would not have saved his life. The Ombudsman's advisers found that the renal team should have been involved in Mr X's admission to the hospital, to decide when Mr X needed dialysis. They were concerned that the Consultant Physician did not instigate dialysis. The ITU Registrar also did not instigate any dialysis. Mr X was not admitted to ITU until it was too late.

The Ombudsman concluded that there was a lack of responsibility for Mr X on the part of the Consultant Physician. He was critical of the lack of renal physicians on 26 February.

The Ombudsman also noted delays in care. He said that there was a ten hour gap in observations between 10.45pm on 25 February and 9.20am on 26 February when no observations were taken. There was no attendance by a consultant between 8.00pm on 25 February and 9.00am on 26 February. The Ombudsman was concerned about the Health Board's comments that timings in Mr X's medical records could not be relied upon, due to the practice of writing retrospectively. The most critical episode of delay, however, related to the failure to provide Mr X with dialysis. The Ombudsman found that Mr X's pneumonia would not have improved until he had received dialysis and there was no urgency for this to be done. Mr X did not receive any dialysis until 6.00pm on 26 February.

The Ombudsman was critical of the RCA and its lack of objectivity. There was no mention of fluid overload or heart failure being the major causes of Mr X's death. A further failing is the loss of Mr X's medical records for six months, without proper explanation.

Recommendations:

Renal

a) The Health Board instigates immediate (same day) senior review of renal patient admissions by consultant renal physicians.

b) The Health Board carries out a review of why there was no decision making renal consultant at the Hospital on 26 February, together with an explanation for inpatient responsibilities. A copy of the review

should be forwarded to the Health Board's Medical Director for consideration and any appropriate action be taken within three months of the date of issue of this report. A copy should also be sent to my office within this timeframe.

c) The Health Board reminds all junior doctors and consultants working in emergency and acute medicine of the need to immediately inform renal physicians when a renal patient is admitted. Evidence should be supplied to my office that this has been completed within three months of the date of issue of this report.

d) The Health Board's renal department draws up clear policies for the management of emergency hospital admissions of renal patients within three months of the date of issue of this report.

Governance

a) The Health Board's Chief Executive provides confirmation to my office that the Consultant Nephrologist and the Consultant Physician have reflected upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report. An anonymised copy of the complaint, together with this report and the consultants' reflection on them, should be retained on their appraisal file, which will then be further discussed with their Appraiser and will be retained within the permanent appraisal database. Appropriate training should be supplied to anyone identified to be in need of it within six months of the date of issue of this report. The Health Board should also consider whether any of the issues raised as part of the process of reflection warrant referral of any relevant Consultant to the GMC.

b) The Health Board carries out further investigation as to who was contacted by the air ambulance, the Spanish ITU department and the patient's wife. It should report the outcome of this investigation to my office within three months of the date of issue of this report.

c) The Head of the Health Board's ITU department reviews the delay in the attendance of the ITU Registrar on 26 February at 11.50am and provides a report to the Medical Director for consideration containing their findings and any proposed recommendations within three months of the date of issue of this report. A copy should also be supplied to my office within this timeframe.

d) The Health Board completes the work set out in the RCA regarding its review of the management of repatriated or transferred in patients as a matter of urgency. Should the Health Board decide that a policy is required to best manage repatriated or transferred in patients, that work, in addition to the review of the position, should be completed within six months of the date of issue of this report.

Apology

a) The Health Board's Chief Executive personally apologises to Mrs X for the failings identified in this report, most notably, Mr X's potentially avoidable death, within one month of the date of issue of this report.

Redress

a) In light of Mr X's potentially avoidable death, the Health Board's service failure and the uncertainty caused to the family, it should pay Mrs X the sum of £20,000, within one month of the date of issue of this report. This sum also reflects the distress caused to the family by the manner of Mr X's death, Mrs X's time and trouble in pursuing the complaint and the delayed complaint response.

The complaint

1. Mrs X complained about the decision not to immediately treat her husband, Mr X, in the ITU department of Glan Clwyd Hospital ("the Hospital") following his repatriation from Tenerife on 25 February 2014. She believed that, had this been the case, her husband would have received constant monitoring and any deterioration in his condition would have been identified at the earliest opportunity, which would have given him a better chance of survival. She said that her husband was not regularly reviewed when on the renal ward.

Investigation

2. I obtained copies of Mr X's medical records for the relevant period, together with other documentation from Betsi Cadwaladr University Health Board ("the Health Board") and considered those in conjunction with the evidence provided by Mrs X. I obtained advice from two of the Ombudsman's Professional Advisers ("the First Doctor" and "the Second Doctor"). Following the First Doctor's initial advice, my Investigation Officer interviewed members of staff at the Hospital, accompanied by the First Doctor. The First Doctor, Dr Richard McGonigle, is a Consultant General, Acute and Renal Physician with over twenty years' experience. The Second Doctor is a Consultant Renal Physician and a Regional Doctor for Nephrology. His name is Dr Christopher Dudley. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. Both Mrs X and the Health Board were given the opportunity to see and comment on drafts of this report before the final version was issued.

The background events

Clinical Care

4. Mr X suffered with Chronic Renal Failure (also known as chronic kidney disease, a long term condition where the kidneys do not work effectively) for which he received dialysis three times a week; Chronic Obstructive Pulmonary Disease ("COPD", the collective name for a number of lung

diseases which cause breathing difficulties, mainly due to the narrowing of the airways); type 2 diabetes (a condition where the body does not produce enough insulin to function properly, or the body's cells do not react to insulin); hypothyroidism (when the thyroid gland does not produce enough hormones) and high blood pressure. He was a patient of the dialysis unit in the Hospital and had received dialysis there since approximately February 2012.

5. Mr and Mrs X planned to go on holiday to Tenerife from 1-15 February **2014**. On 27 January 2014, the Hospital's Consultant Nephrologist sent a letter to the company managing Mr X's dialysis abroad to confirm that there were no medical reasons why Mr X could not go on holiday.

6. On 1 February, Mr and Mrs X travelled to Tenerife. On 10 February, Mr X was admitted to Hospital in Tenerife with a lower respiratory tract infection secondary to influenza type A. He spent 14 days in the ITU department. The ITU department found that Mr X had an acute exacerbation of his COPD (a sudden worsening in the airway function of respiratory symptoms in patients with COPD); atrial fibrillation (an irregular and often rapid heart rate that commonly causes poor blood flow to the body), pulmonary oedema (excess fluid in the lungs, which collects in the air sacs in the lungs, making it difficult to breathe); fluid overload; leg haematoma (small collection of blood); bruising and severe anaemia (a deficiency in the number of red blood cells in the body). A CT scan (a scan which reveals the anatomic details of internal organs) identified bilateral pleural effusions (an abnormal amount of fluid around the lung) and an enlarged and congested liver. Pneumonia was not noted.

7. On 24 February, Mr X was due to travel by air ambulance back to the Hospital. In Mr X's medical notes, which were written in Spanish, it was recorded that, whilst in the ITU department in Tenerife, he had been receiving bronchodilators (a medication that makes breathing easier by relaxing the muscles in the lungs and widening the airways), antibiotics, tamiflu (flu medication), corticosteroids (an anti-inflammatory medicine) and diuretics (medication used to help the body get rid of water and salt through the urine). Mr X had been intubated and ventilated for several days to assist with breathing. Diagnoses of pulmonary oedema and leg haematoma were noted on the transfer form. Due to deficiencies with the oxygen supply on the air ambulance, Mr X's repatriation was postponed until the following day.

8. Also on 24 February at 9.22am, the Health Board received a fax from the company transporting Mr X. It was marked for the attention of the Consultant Nephrologist, but his name was spelled incorrectly. It noted the date that Mr X had been admitted to hospital in Tenerife and confirmed the treatment that had been provided. It said that the last confirmed dialysis Mr X had received was on Saturday 22 February and said that dialysis was planned for that morning. It was not, however, confirmed that dialysis had taken place that morning. Notes were made after receipt of the fax by the Hospital, but the signature on the fax was illegible and the Health Board was initially unable to confirm who had received it. (The Health Board subsequently confirmed in response to the first draft report that the doctor who made the notes was a speciality doctor in renal medicine).

9. On 25 February, Mr X was repatriated to the Hospital's Acute Medical Admissions department ("AMU"). The admitting doctor is noted to have commenced the initial assessment of Mr X's medical history at 3.50pm and to have concluded it at 4.15pm. Mr X was noted to have been admitted to the AMU department at 4.16pm. It was noted that Mr X usually received dialysis three times a week and had done so since 2012.

10. Mr X was seen by the duty Consultant Physician ("the Consultant Physician") in the AMU. Whilst the entry is timed at 8.00am, the Consultant Physician later confirmed at interview that this should have read 8.00pm. The Consultant Physician noted that Mr X was "well known" to the Consultant Nephrologist. He noted Mr X's clinical condition to be "unwell, drowsy, [high level of fluid retention]". The entry concluded by stating, "let [the Consultant Nephrologist] know re. this admission". The Consultant Physician decided that Mr X was to be transferred to the renal ward.

11. On 25 February at 9.25pm, Mr X was transferred to the renal ward. It was noted by nursing staff that a jug of water had been provided. It was also noted that 600 millilitres of water had been consumed by Mr X during the night.

12. On 26 February at 4.00am, Mr C was given a nebuliser, to assist with breathing.

13. On 26 February at 9.50am, Mr X was attended by the Senior House Officer ("SHO") on the renal ward. The SHO was requested to attend because of Mr X's high NEWS (the National Early Warning Score, a scoring system for monitoring patients in hospital) score, which necessitated urgent medical review. It was noted that Mr X was "drowsy" and was still feeling unwell, "but feels no different from yesterday". That day, the three Consultant Nephrologists and the renal registrar were away from the Hospital undertaking training in the area.

14. Also at 9.50am, it was noted that the SHO discussed Mr X's condition with the Consultant Nephrologist who had advised that the ITU department should be contacted and there should be a referral to the respiratory team. The SHO did so and was told by an ITU Registrar that if non-invasive ventilation ("NIV" the administration of support for breathing without using an artificial airway) was needed, Mr X should be referred and the respiratory team should be contacted. A Respiratory Registrar was contacted and said that they wanted the Consultant Nephrologist's advice regarding whether there should be a referral to the ITU department or for NIV. The SHO then contacted the Consultant Nephrologist again who, "reiterated that [ITU] should review". The SHO passed this information to the ITU department's Senior House Officer.

15. At 11.50am, a Registrar from the ITU department ("the ITU Registrar") attended. Mr X's history was noted and the doctor considered Mr X might have pulmonary oedema. Included in the clinical plan was for Mr X to have "dialysis as planned". The ITU Registrar noted that, "if deteriorates kindly inform. [The Consultant Nephrologist] to kindly speak to ITU consultant if further ITU input required".

16. At around 1.02pm, Mr X suffered a peri-arrest (when a cardiac or respiratory arrest is imminent). He was attended by the ITU Consultant at 2.00pm, having been transferred to the ITU department at 1.39pm. The ITU Consultant said that,

> "Arrived in ITU 'in extremis (at the point of death)'. Unfortunately since this morning when he was haemodynamically stable (stable blood flow) he has rapidly deteriorated and is now obtunded (lethargic) and hypotensive (abnormally low blood pressure)".

17. The clinical plan was that inotropes (drugs that affect the strength of contraction of the heart muscle) would be given so that Mr X's blood pressure would increase and he could have dialysis. He was to have NIV. The Consultant Nephrologist was noted by the ITU Consultant to be in agreement with the plan.

18. At 7.30pm, the Second ITU Consultant attended. It was noted that, Mr X had been admitted to the renal ward on 25 February, where he had been stable overnight. This was without communication with the ITU team, however. Mr X then required "significant support" and the Second ITU Consultant felt that intubation would not be appropriate, should Mr X deteriorate. Mrs X was noted to be upset and concerned that Mr X had not been treated in the ITU department following his repatriation.

19. At 7.45pm, the Consultant Nephrologist attended Mr X. He noted the sudden deterioration in Mr X's condition earlier in the day. He agreed that intubation would not be in Mr X's best interests.

20. At 9.30pm, there was a further sudden deterioration in Mr X's condition. It was clear to the ITU Consultant that Mr X was dying. Mrs X and Mr X's son were in attendance when Mr X sadly died at around 10.00pm.

21. On 28 February, a post mortem was carried out. This noted as the causes of death;

- Bronchopneumonia (inflammation of the lungs due to infection), Cardiorespiratory Failure (combined cardiac and respiratory failure)

- Chronic Obstructive Airways Disease (or COPD, please see paragraph 4), Diabetic Nephropathy (damage to the kidneys caused by diabetes)

- Diabetes Mellitus (diabetes; a chronic disease associated with abnormally high levels of glucose in the blood).

22. The post mortem found bilateral large straw-coloured pleural effusions (fluid which can appear as consolidation on X-ray and be confused with infection) in keeping with terminal congestive cardiac failure; moderate to severe pulmonary oedema (fluid in the lungs) and consolidation (solidification into a firm dense mass particularly where there is pneumonia) in both lungs.

There was also evidence of pus in the airways consistent with bronchitis (an inflammation of the lining of the bronchial tubes) and lower respiratory tract infection (an acute illness, usually with a cough).

Complaints handling

23. On 14 August **2014**, Mrs X wrote to the Health Board to complain about Mr X's treatment. Mrs X asked for an explanation of what had happened, an apology and a review of current procedures.

24. On 13 October, the Health Board wrote to Mrs X to apologise for the delay in responding to her complaint.

25. On 19 January **2015**, the Clinical Governance Nurse sent an email to the Investigations Manager. She said that Mr X's medical notes were missing and were last tracked to the renal unit. A search had been undertaken in the renal unit, but the notes had not been found. On 22 January, an update letter was sent to Mrs X.

26. On 28 January, the Senior Support Officer for the Concerns Team ("the Senior Support Officer") contacted the Investigations Manager to say that the Consultant Nephrologist's office had been checked twice for Mr X's records. The ITU department had also been checked. Two other departments and another Consultant Nephrologist's office ("the Second Consultant Nephrologist") had also been checked. It was suggested that the Consultant Nephrologist be asked to meet with Mrs X as, although the notes would not be available, a meeting might be helpful.

27. On 4 February, Mrs X's Assembly Member wrote to the Health Board's Chief Executive ("the Chief Executive") about the delay in handling the complaint.

28. On 9 February, Mrs X rang the Health Board for an update.

29. On 11 February, the Senior Support Officer emailed the Consultant Nephrologist. She explained that extensive searches had not located Mr X's records, but asked whether he would be prepared to meet with Mrs X on an informal basis. Also on 11 February, Mrs X's AM wrote again to the Chief Executive.

30. On 18 February, Mr X's notes were located in the Assistant Medical Director's office.

31. On 2 March, Mrs X's AM wrote again to the Chief Executive.

32. On 8 April, a root cause analysis ("RCA": a method of problem solving used for identifying the root causes of faults or problems) was conducted, chaired by the Senior Investigations Manager. Present were the Consultant Nephrologist, a Consultant Anaesthetist ("the Consultant Anaethetist"), another Consultant Nephrologist ("the Third Consultant Nephrologist"), the Patient Experience Lead Officer and the Patient Experience Officer. The RCA found,

> "no record of our [ITU department] being contacted prior to Mr [X's] transfer from Tenerife to advise us of his needs. We also cannot identify when contact was made with the Hospital to arrange his admission following [his] arrival back in the United Kingdom, however the on call doctor that day does recall having a conversation with somebody and subsequently arranging a bed to be allocated for Mr [X] in the Acute Medical Unit [AMU].
>
> The review team concluded that in view of Mr [X's] existing serious clinical conditions and the bilateral viral pneumonia...it was...unlikely that earlier admission to the [ITU department]... would have increased his chances of survival".

33. The Health Board, however, accepted that,

> "Mr [X] should have been directly admitted to the [ITU department] for assessment...Following review of Mr [X's] observations the Review Team assessed Mr [X's] condition to be stable and concluded that it was appropriate for him to have been a ward admission because his condition at the time did not warrant him being [admitted] to [ITU]".

34. The Health Board confirmed that the ITU department was not aware of Mr X's admission to the Hospital until they were requested to review him at 9.50am on 26 February.

35. The RCA recommended the following action be taken by the Health Board;

- That it reviewed how it managed repatriated or "transferred in" patients from other Hospitals, so that it could ensure an appropriate level of care on arrival at the Hospital and throughout the admission.

- That it raised awareness with frontline staff of arrangements it had with an outside service provider for translating clinical notes for repatriated patients.

36. Also on 8 April, Mrs X and her Community Health Council ("CHC") advocate attended a meeting with the Senior Investigations Manager, the Patient Experience Lead Officer and the Patient Experience Officer in order for them to share the findings of the RCA. The Consultant Nephrologist was unavailable for the meeting, but offered to meet with Mrs X at a later date if she had ongoing concerns.

37. On 20 May, the Senior Investigations Manager wrote to Mrs X's CHC advocate to provide the outcome of the RCA. It was noted that the Consultant Nephrologist had offered to meet with Mrs X to discuss any concerns arising from that correspondence.

Mrs X's evidence

38. In relation to Mr X's general health prior to the holiday, Mrs X said that he "was in good health despite his long term chronic illnesses". He was reasonably active and enjoyed doing housework, cooking and shopping. Mr X used a stairlift as climbing stairs made him breathless.

39. In terms of the RCA, Mrs X said that "there are large voids and inconsistencies in the chronology of events".

40. Mrs X noted the Health Board accepted that Mr X should have been directly admitted to the ITU department. She said there was "very little evidence" that Mr X received regular monitoring and noted that there was a gap in monitoring of almost 11 hours from 10.45pm on 25 February to 9.20am on 26 February. She questioned whether Mr X's observations were

missed and, as a result, his condition deteriorated. Mrs X said that she would have expected that he would have been more closely monitored. She said that the RCA said Mr X had received 4 hourly observations, but the response letter of 19 May said that Mr X received 1-2 hourly observations.

41. Mrs X said that she arrived on the renal ward at around 10.20am on 26 February. She said that nursing staff advised her that they were very concerned about her husband's condition and had contacted the ITU department for urgent review. Mrs X said that, during this time, she did not leave her husband's side and asked nursing staff on several occasions when he would be moved to the ITU department, as she could see him deteriorating.

42. Mrs X noted that the ITU Registrar did not attend until 11.50 am. She described herself as "rather confused as to what was happening as [the ITU Registrar] appeared to leave the ward and I was left alone with my husband who at this point was barely able to speak".

43. Mrs X disputed that her husband had a "sudden deterioration" as he had "dramatically worsened throughout the morning of which the nursing staff were well aware".

44. Mrs X said that she believed that there would have been a different outcome had her husband been directly transferred to the ITU department. She said that,

> "I understand that he had been extremely ill having spent two weeks in the [ITU department] in Tenerife but had been stabilised and considered well enough to survive the lengthy journey back to the UK... He arrived safely only to be admitted to a general ward which I believe lessened his chances of survival".

45. Mrs X said that she carefully considered the offer to meet with the Renal Consultant and key staff to discuss the issues raised. She concluded, however, that she did not think the meeting would offer any further answers above those gained by the RCA.

The Health Board's evidence

46. The Health Board provided additional comments on 3 July 2015. The Health Board said that it does not have a policy concerning the management of repatriated or "transferred in" patients. The work on a review of the management of such patients, due to be undertaken following the RCA, had not been completed due to "operational management changes at each of the three Hospital sites". It added that, "as positions have now been filled we can move on with conducting the review".

47. In respect of the second recommendation from the RCA regarding the translation of clinical notes for repatriated patients, the Health Board said that its intranet site had been redesigned with 'interpretation services' being given a "prominent position in the centre of the screen when staff log into the intranet. By clicking the link staff will be able to access guidance for staff on obtaining verbal interpretation, sign language and translation of written documents".

48. In respect of the misplacing of Mr X's medical records, the Health Board said that it had,

> "Advised all staff of the availability of an e-learning package for good record keeping [and has] recommended [that] all employees...undertake [it] to emphasise the importance of good record keeping and relevant legislation".

Interviews with Health Board staff

The Haemodialysis senior nurse

49. The Haemodialysis senior nurse ("the Nurse") said that there were around 80-90 patients on regular haemodialysis in the Hospital at the time of Mr X's treatment. She said that vacant dialysis spaces are always available for the urgent dialysis of ill patients.

50. The Nurse said that Mr X's general health was normally stable and "quite good". She said that Mr X was always cheerful and independent and walked in and out of the unit unaided for his dialysis sessions.

51. The Nurse said that a diary is kept on the ward of communications and messages. There was a note in the diary on 15 February that Mr X was due back from holiday on 17 February and that he would require dialysis. There was a further note in the diary on 17 February that Mrs X had called to say that Mr X was being treated in the ITU department of a Hospital in Tenerife. There was an additional note on 26 February that Mr X was being treated in the ITU department of the Hospital.

The Sister in charge of the renal ward

52. The Sister in charge of the renal ward ("the Sister") said that at the time Mr X was treated, the ward was accommodating both diabetic and renal patients in 30 beds. The Sister said that she was not trained in haemodialysis and neither are the nurses on the renal ward. Haemodialysis nurses work on the renal dialysis unit only.

53. The Sister said that patients' observations are not normally undertaken until 9.00am. She said that the Consultant Nephrologist carries out ward rounds on Tuesdays and Fridays.

The Consultant Nephrologist

54. The Consultant Nephrologist said that he had sanctioned Mr X's holiday, but the letter of 27 January was slightly inaccurate as it said he had suffered no dialysis related problems. In fact, Mr X had suffered from a similar episode of fluid overload in January 2012 which required ventilation and dialysis on the ITU department for 24 hours before he made a full recovery.

55. The Consultant Nephrologist said that he had not seen the faxed letter addressed to himself on 24 February and was not sure that he recognised the handwritten notes. He confirmed that the Health Board had an informal policy that the duty renal physician should be contacted for renal admissions, with particular emphasis on dialysis and transplant patients, but this did not happen on this occasion

56. The Consultant Nephrologist said that, on 26 February, he was away from the Hospital with the Second and Third Consultant Nephrologists and the renal registrar for the monthly renal meeting. He only became aware of Mr X's admission at 9.45 am. He said that, as Mr X had fluid overload, he advised he should be immediately treated by NIV and dialysis to relieve the pulmonary oedema and that this treatment should be provided in the ITU department. This advice was not, however, followed by the ITU Registrar and the Consultant Nephrologist did not discuss it further with him or his consultant. The Consultant Nephrologist confirmed that it was open to him to have done so and then to have escalated it to the lead intensivist or the Medical Director.

57. The Consultant Nephrologist said that whilst, with hindsight, Mr X should have had dialysis on the morning of 26 February, he rated Mr X's chances of survival at around 20%. This was due to the combination of pulmonary oedema, bronchopneumonia and sepsis (a potentially life threatening complication of an infection) that Mr X was suffering from.

The Second Consultant Nephrologist

58. The Second Consultant Nephrologist said that he does not have responsibility for renal inpatients on the renal ward. He has a general physician role for the AMU and a general Nephrologist role for haemodialysis unit patients and outpatients. Renal patients on the renal ward are divided between the Consultant Nephrologist and the Third Consultant Nephrologist. He said that, whilst he attended the RCA meeting, he was unclear why he was asked to do so, as he was not involved in Mr X's care and did not contribute to the report.

59. The Second Consultant Nephrologist said that, as part of their induction, junior doctors are advised to inform Consultant Nephrologists about renal patient admissions. He said that there was an assumption that consultant acute or general physicians would do the same.

60. The Second Consultant Nephrologist said that there are now acute medicine handovers on AMU at 9.00 pm which usually involve the duty Consultant Physician. He was not, however, clear as to whether he would have raised any concerns about Mr X, had there been such a handover at the time of his care.

The Consultant Physician

61. The Consultant Physician said that he is on call for acute emergency admissions and is a Consultant in health care of the elderly.

62. The Consultant Physician said that, whilst he had seen the chest X-ray in this case, he did not comment on the finding. When asked at interview, the Consultant Physician said that he was not aware of the expectation that he would contact the duty renal physician regarding the admission of any concerning renal patients, particularly haemodialysis or transplant patients. In Mr X's case, he did not contact the renal physician because he was "haemodynamically stable...and although oedematous, the clinical examination, blood tests and chest X-ray taken together did not suggest a need for urgent dialysis that evening".

63. In relation to his involvement in Mr X's care, he said that his ward round took place at 8.00pm on 25 February rather than 8.00am on 26 February, as documented. He was unaware of when Mr X had last had dialysis and was unaware of when the next session was due. Following his decision to move Mr X to the renal ward, the Consultant Physician assumed he would be reviewed early the following morning, at around 8.00am, but was unsure when the rounds took place. He assumed they were daily. The Consultant Physician did not contact the duty Renal Physician, the Consultant Nephrologist or any ITU clinicians, as he did not consider he should do so, given Mr X's clinical presentation at the time. At interview, he said he would not revise that decision with hindsight, although he remained of the view that Mr X was "unwell, drowsy and oedematous" during his ward round.

The Senior Investigations Manager

64. The Senior Investigations Manager was unaware of the faxed letter of 24 February. This had not been located at the time that the RCA took place (although it was included within the original notes when examined during my investigation). The Senior Investigations Manager said that, had this document been available at the time of the RCA, it might have affected its outcome.

65. Mr X's medical records were found in the Assistant Medical Director's Office. The records had not been tracked or traced using the Health Board's records tracking system.

66. The Senior Investigations Manager's role in the RCA was to facilitate discussions. The clinical input was mainly provided by the Consultant Nephrologist. Whilst the RCA found that Mr X should have been transferred directly to the ITU department, clinicians remained of the view that even if this had happened, the outcome for Mr X would have been the same due to his pneumonia. The Senior Investigations Manager acknowledged that there was no mention of fluid overload or heart failure in the report. The Senior Investigations Manager also said that she did not feel comfortable with the conclusions reached by the RCA as there appeared to be "some clinical inaccuracies in the report".

67. The Senior Investigations Manager said that the signatory to the RCA letter, the Director of Corporate Services, had not spoken with clinicians before signing the letter. The signatory process includes levels of approval by clinicians and senior Hospital managers. The Director of Corporate Services signs it on behalf of the Chief Executive, once the response has gone through a quality assurance and approval process. The Senior Investigations Manager was unaware of whether there had been any discussion at board level regarding the RCA.

The Second ITU Consultant

68. In respect of the attendance of the ITU Registrar, the Second ITU Consultant acknowledged that the two hour delay was "sub optimal". She said that procedures have since been improved so that more rapid attendance can be provided by the team including medical emergency calls.

69. The Second ITU Consultant said that the ITU department encourages and expects its junior doctors to have discussions with Consultants and that Consultants should, in turn, have discussions between themselves. This is best practice and Consultants "certainly should" be aware of the Hospital's policy on this.

70. The Second ITU Consultant said that, from Mr X's notes, it was clear to her that he was very sick at the time of her consultation. She said that, from a discussion with the Consultant Nephrologist, dialysis was planned for that day which seemed reasonable for a patient with pulmonary oedema. She acknowledged that this would have taken place in another location.

71. The Second ITU Consultant said that the post mortem report identified infection and, in her opinion, this was the most likely cause of death given Mr X's white cell count (a marker of infection) and the appearance of the X-ray. The Second ITU Consultant said that Mr X was hypothermic (abnormally low body temperature), hypotensive (low blood pressure), bradycardic (slow heart rate) and drowsy. These features were symptoms of advanced systemic infection and are generally not features of fluid overload. The ITU department started to address the fluid overload at around 6.00pm on 26 February and the Second ITU Consultant said that she was unsure whether, "in reality" they could have done that any earlier. The NIV was started at 2.00pm which started to help with the pulmonary oedema. If the pulmonary oedema was serious enough, she would expect to see a problem with Mr X's oxygen levels, but this was not the case. She said that,

> "Given that oxygen was not a huge problem...removing that fluid earlier would not actually have made much difference because...clinically, it was probably infection that was more of a problem here".

72. The Second ITU Consultant said that,

> "We would certainly expect that if [a patient] is coming [from an] ITU [department] that he would be put into our ITU [department]. Mr [X's] transfer had not been discussed with [the] ITU [department]...I don't know what happened in this case".

The Executive Medical Director in post at the time

73. The Executive Medical Director ("the Medical Director") said he was surprised by the Consultant Physician's comment at interview that it was not his responsibility to contact the Consultant Nephrologist. He was also surprised by the Consultant Nephrologist's comment that he could not challenge the advice provided by the ITU Registrar.

74. The Medical Director noted that, when Mr X was transferred to the renal ward on 26 February, he was a critically ill patient, yet was managed by a "very junior doctor".

75. In terms of Mr X's clinical presentation, the Medical Director said that he could see a "narrative [that] this [patient's] got pneumonia" in the notes, as opposed to a focus on pulmonary oedema.

76. In relation to how RCAs should be conducted, the Medical Director said that it should be an "objective search for the truth in a safe environment which should not be about apportioning blame but identifying whether there were any failings in care...Improvements should be fed back into the system so that there can be improvements for future patients. I am disappointed that an external look at the RCA was that it was...flimsy."

77. The Medical Director was not aware of the details of the complaint prior to the interview. He said that,

> "What is concerning...is the sense of complacency...and that the threshold of risk and tolerance is at a level which is simply not good enough and the icing on the cake...is that I am...completely unsighted on this case having not been properly briefed...that further reflects poorly on the organisation".

78. The Medical Director said that the complaint raised issues around leadership and responsibility, escalation, adequacy of handovers and governance. He said that,

> "[The Health Board] may have missed the opportunity to intervene in the patient's case. What would be absolutely unforgiveable would be not to take the opportunity to learn these lessons...but [the Health Board] cannot do that if our levels of tolerance are set at the wrong level. [This and the care provided to the patient] is not good enough".

79. In response to my first draft report, the Medical Director said that he,

> "Had not reviewed the case in detail prior to the interview with the Ombudsman; [my] comments were made in response to the narrative given to [me] by the [PSOW's]...First Doctor.
>
> Considering the inaccuracies and challenges within the Ombudsman report these have compromised the exactness of [my] own responses".

80. The Medical Director clarified that the investigation into Mrs X's complaint was undertaken in response to questions raised in her letter; an incident report had not been submitted and it was not a Serious Incident Review.

Professional Advice

The First Doctor

81. In relation to Mr X's repatriation, the First Doctor said that it remained unclear who accepted him at the hospital. The First Doctor said that the condition of the transferred patient is often not known in detail. It would therefore have been sensible for Mr X to be assessed in the Emergency Department before a decision was made as to which department was appropriate for transfer. Mr X was, however, transferred straight to AMU.

82. The First Doctor said that it was not clear when the translation of the Spanish notes was provided. He added, however, that he did not believe the translation or lack of it was particularly important because there was sufficient information available to provide appropriate and effective clinical care.

83. Turning to the input from the clinical teams and the renal team in particular, the First Doctor said that it was most unusual that they were not involved. He said that they should have been involved because an assessment of whether the patient required dialysis would be required on the same day as their transfer and arrival. The dialysis unit, or possibly the ITU department, would have been expected to have communicated with Tenerife. He said that the Consultant Nephrologist should have been aware of the patient's transfer, as should the renal nursing staff. In terms of accepting

responsibility for the patient, given that Mr X was a dialysis patient, this would have been for the duty renal physician. The First Doctor noted that the Health Board, until the issue of the draft report, was unable to clarify who was contacted, which was, "difficult to understand or accept".

84. In relation to the care and treatment provided by AMU, the First Doctor noted that Mr X's condition was described as stable by the admitting doctor. The First Doctor said that, whilst the initial assessment was thorough, the Consultant Physician did not instigate treatment for fluid overload, even though he noted "oedema (fluid overload) +++". He said the assessment, by the Consultant Physician, that Mr X was stable and could be transferred to the renal ward did not take into account that he was fluid overloaded and in need of dialysis. It was unclear as to when the Consultant Physician expected Mr X to be dialysed or when he expected the Consultant Nephrologist to be advised of his patient's admission.

85. The First Doctor referenced relevant guidance (GMC 'Good Medical Practice 2013'), which states that,

> "You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must...share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, when you delegate care or refer patients to other health or social care".

and,

> "When you do not provide your patients' care yourself...or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient".

86. The First Doctor said that there was no evidence that the Consultant Physician had shared all relevant information with the Consultant Nephrologist.

87. In relation to the involvement of the ITU department in Mr X's care, the First Doctor said that he noted the Consultant Nephrologist had requested that they be contacted at 9.50am on 26 February; however, the ITU Registrar did not attend until 11.50am. He questioned what happened in the intervening two hours. At 11.50am, the advice from the ITU Registrar was that the Consultant Nephrologist should speak to the ITU Consultant if further input was required. He said that this advice was, "not constructive or helpful". The First Doctor added that there was no plan at 11.50am to transfer Mr X to the ITU department. This was not instigated until 1.02pm when Mr X suffered a peri-arrest. Mr X then had fluid overload (the circulating volume is excessive, i.e. more than the heart can cope with, which results in heart failure and manifests as pulmonary or peripheral oedema) with pulmonary congestion (an excessive accumulation of fluid in the lungs associated with inflammation).

88. The First Doctor pointed to a number of instances where delays in treatment were apparent. The discussions which took place between general, renal and respiratory physicians resulted in a delayed ITU department review at 11.50am. The review also resulted in delay as the ITU Registrar did not instigate any dialysis treatment. The First Doctor noted that the chest X-ray showed infection and pulmonary oedema which were not treated in a timely manner. He therefore concluded that these delays were detrimental to Mr X's health.

89. The First Doctor went on to specify when appropriate treatment could and should have been given. He said that there should have been a senior renal review to assess Mr X's dialysis requirements on 25 February, and again early on 26 February. He said that the opportunity to escalate Mr X's care was at 8.00pm on 25 February or, more urgently, at 9.00am on 26 February. He said that, "none of these opportunities were taken". Although the First Doctor acknowledged that antibiotics were administered, Mr X was not monitored for his progress, even though he was described, in the medical records, as "unwell". He added that, "even when ITU attended at 11.50am [on 26 February] no active treatment or intervention was advised". He reiterated that Mr X's clinical condition of fluid overload and infection causing respiratory failure was reversible, "with early dialysis and fluid removal".

90. The First Doctor referenced the National Confidential Enquiry into Patient Outcome and Death 2005 ("NCEPOD") which identified the primary causes of sub standard care of the acutely unwell in hospital being delayed recognition and institution of inappropriate therapy that culminated in a late referral. Poor communication between acute medical and critical care teams and a lack of awareness by medical consultants of their patients' deteriorating health and subsequent admission to critical care, were identified as aggravating factors, according to NCEPOD.

91. The First Doctor considered whether the treatment provided to Mr X was reasonable and concluded that it was not. He pointed to a number of themes in Mr X's treatment, including a lack of urgency and a "rather inadequate" consultant review at 8.00pm on 25 February. The First Doctor clarified that, at this review, no plan was made, simply a decision to place the patient on a renal ward where he would be seen during the following morning. He reiterated that there was delayed attendance by the ITU department "due to apparent disagreements between clinicians" and he described the advice that was given by the ITU department as neither, "appropriate or adequate". Notably, there was no plan for dialysis.

92. The First Doctor said that,

> "The patient would have had a better chance of survival with earlier intervention and dialysis, and fluid removal, and earlier intensive respiratory support to provide time for the fluid removal to take place. This would have been best provided in [the] ITU [department]".

93. The First Doctor noted that Mr X had to suffer a peri-arrest to instigate a transfer to the ITU department, "when it was becoming too late to initiate effective treatment including dialysis".

94. The First Doctor commented on the loss of Mr X's medical records. He said that,

> "This is most concerning and difficult to understand".

The First Doctor said that,

> "Even without the medical notes it should have been possible for a clinician to meet with the relatives. No individual clinician seems to have accepted responsibility for the patient's care and therefore been prepared to meet with relatives. This should be the responsibility of the consultant renal physician".

95. The First Doctor said that Chief Executives and senior managers of all NHS organisations are personally accountable for records management within their organisation (Records Management NHS Code of Practice Parts 1 and 2, 2006 Department of Health).

96. Finally, the First Doctor commented on the post mortem. He said that this concluded that the cause of Mr X's death was bronchopneumonia and cardiorespiratory failure (please see paragraph 21). He said that the post mortem findings included bilateral large straw-coloured pleural effusions and moderate to severe pulmonary oedema in keeping with terminal congestive cardiac failure (the heart loses its ability to pump blood effectively). The First Doctor noted the evidence of pus in Mr X's airways which was consistent with the combination of chronic bronchitis and lower respiratory infection. The First Doctor said that infection can complicate pulmonary oedema.

97. Following the interviews with Health Board staff, the First Doctor added further comments. The First Doctor said that he agreed with the Medical Director that "clinical complacency" was evident. He said that,

> "Disappointingly, and rather worringly, nothing has been learnt by the involved clinicians suggesting these issues could recur. Both the Consultant Physician and the Consultant Nephrologist demonstrated a lack of leadership".

98. The First Doctor said that there should be an explanation as to why there was no decision making renal clinician on site on 26 February. There should also be clarification of which clinician is responsible for inpatients. He added that the failure by the Consultant Nephrologist to explain the missing faxed letter of 24 February was "deeply concerning".

99. Following the interview with the Consultant Physician, the First Doctor was satisfied that there had been a post-take ward round. However, he considered it to be "inadequate", for the reasons he had previously explained.

100. The First Doctor said that,

> "After extensive review of the medical notes and interviews with the involved clinicians I consider Mr X's death was avoidable. More urgent action was required on the evening of 25 February, and again early in the morning of 26 February to monitor the patient more closely and initiate earlier dialysis as the patient's condition deteriorated during the evening and night of 25 February".

The Health Board's comments on the first draft report

101. In response to the draft report, the Health Board said that it considered there were a "number of inconsistencies" in the first draft report, in respect of which it needed to raise, "a number of issues of challenge and clarification". It supplied a detailed breakdown of those issues and an amended timeline. As part of that breakdown, the Health Board said that, "due to the practice of writing [in medical records] retrospectively, it was not possible for the Health Board or PSOW to say that this was the time the Doctor attended". The Health Board said this doubt applied to a number of entries in Mr X's records.

102. In terms of specific comments on the draft report, the Health Board said that there was no evidence to support an assertion that there was a disagreement between clinicians on 26 February. The Health Board said that, whilst the Renal Consultants and Registrar were all away from the Hospital on 26 February, they remained on a Health Board site. The Health Board said that it considered Mr X's clinical condition to be more complex than that presented by the First Doctor, particularly in relation to his comorbidities (co-occurrence of two or more health problems). Ultimately, Mr X should have been transferred to the ITU department at the Hospital, however, his death, due to bronchopneumonia, was not avoidable.

103. As a result of the comments raised by the Health Board on the first draft report and further consideration of the complaint by my office, I commissioned a second piece of Professional Advice.

Additional Professional Advice

The Second Doctor

104. The Second Doctor was asked to comment on whether there was evidence of pneumonia and pulmonary oedema on Mr X's admission. He said that the admission medical records note that Mr X was coughing, but not short of breath, his temperature was not raised and there was reduced air entry at the bases of both lungs. Mr X had a raised white blood cell count and neutrophil count (a type of white blood cell, which fights infection), compatible with infection. He said that,

> "These together with the chest X-ray findings all suggest the presence of pneumonia either active or resolving".

105. The Second Doctor also noted that when Mr X was reviewed by the Consultant Physician, the treatment plan included restarting antibiotics.

106. In relation to pulmonary oedema, the Second Doctor said that Mr X was fluid overloaded when he was first admitted, he had raised jugular venous pressure (this measurement provides information regarding haemodynamic changes in the right side of the heart), peripheral oedema and right arm oedema (an excessive accumulation of fluid in the tissues). However, Mr X was not short of breath on admission and widespread fine crackles on breathing were not observed. By 9.20am on 26 February, pulmonary oedema had developed, the Second Doctor said. He noted that there was an increase in Mr X's NEWS score to six, as a result of an increase in his respiratory rate to 25 and a fall in oxygen saturation (a lowering of haemoglobin that is saturated with oxygen; oxygen levels below 90% are considered abnormal). The Second Doctor also noted that at 9.50am, Mr X was diagnosed with "heart failure/pulmonary oedema". Blood gasses taken at 10.16am reflected worsening oxygenation, in keeping with the development of pulmonary oedema.

107. The Second Doctor said that, in view of Mr X's condition at the time of his admission,

> "An appropriate treatment plan would have included antibiotic therapy for an ongoing chest infection, haemodialysis/ultrafiltration for fluid overload, appropriate management of blood glucose according to oral intake and careful observation and monitoring on the ITU, HDU or monitored renal bed depending on availability".

108. The Second Doctor was critical of the timing of the observations taken for Mr X during the evening of 25 February and the morning of 26 February. He referenced the NEWS protocol (Standardising the assessment of acute-illness severity in the NHS, Royal College of Physicians, July 2012) and said that Mr X had a NEWS score of 4 on 25 February. This required the nurse in charge to check Mr X in one hour and then document observation frequency, fluid balance, sepsis and the criteria for escalation. He said that he could not find any evidence for either this frequency of observations being taken or the required information being recorded in the medical or nursing notes.

109. The Second Doctor went on to say that it is recommended that patients with an aggregate NEWS score of four undergo clinical monitoring every four-six hours. He said that the observation chart shows that Mr X had clinical monitoring at 4.55pm, 7.10pm, 9.10pm, and 10.45pm on 25 February. The next set of observations is not recorded until 9.20am on 26 February, representing a gap of over 10.5 hours after the last set. He said this was an "excessive delay". At that time, Mr X's NEWS score was six and, although a medical review was requested, hourly monitoring should have been carried out. The next set of observations, however, was not taken until 11.00am, an interval of one hour forty minutes.

110. The Second Doctor made further comments about the lack of timeliness of treatment provided to Mr X. In particular, the Second Doctor commented on care provided by the ITU department. He said that,

> "There seems to have been a general reluctance for the ITU department to get involved in Mr X's care on the morning of 26 February".

111. The Second Doctor made further comments about the timeliness of treatment. He said that whilst the treatment provided on the AMU was appropriate, there should have been an early review of Mr X carried out by a senior member of the renal team, either a specialist registrar or a consultant. The clinician should have decided how urgently Mr X required dialysis and whether he would be best managed in ITU for haemofiltration (a form of renal replacement therapy used in intensive care) or haemodiafiltration (a form of haemodialysis commonly used in ITU departments in patients with cardiovascular instability) if his condition was considered unstable or on the renal ward in a monitored bed.

112. The Second Doctor detailed the contact between the ITU Registrar, the Consultant Nephrologist and the Respiratory Registrar. He noted that, "at least 5 telephone calls were required over this time whilst the SHO tried to get help with the further management of a deteriorating patient". He said that whilst it was difficult to know from the medical records, exactly when the ITU Registrar was contacted, it was clear that he attended at 11.50am, two hours after the first entry in the notes that recorded a deterioration. The Second Doctor also said that Mr X's "sudden deterioration" was noted at 12.10pm and there was, therefore, a delay of around two and a half hours,

> "between the identification that the patient was deteriorating and the arrest call...an opportunity to intervene and stabilise the patient was missed".

113. The Second Doctor was also critical of the involvement of the ITU Registrar. He said that,

> "The ITU Registrar either failed to recognise that the patient's condition had deteriorated following their assessment at 11.50am ([his] NEWS had progressively increased to 9 at 11.20am) despite concluding that the patient had pulmonary oedema...or had decided that escalation of care was not indicated. There was no significant attempt to intervene".

114. The Second Doctor said that,

> "Mr X should have been treated with haemodialysis immediately after the...assessment at 9.50am"

and,

> "By the time the ITU Registrar had seen [Mr X] at 11.50am he should have either been transferred to the ITU for urgent haemofiltration or, if Mr X's outlook had been considered hopeless, then a decision should have been made to keep him comfortable and allow him to die peacefully".

115. The Second Doctor went on to say that, had Mr X received treatment, initially, in the ITU department, he could have been offered haemofiltration or haemodiafiltration to remove excessive salt and water as well as metabolic waste products (the products of metabolic activity which are excreted and exhaled). The Second Doctor confirmed that, even if Mr X,

> "Had [not] been immediately commenced on this treatment then he would have received careful monitoring of his fluid balance with early intervention with non-invasive ventilation and haemofiltration/haemodiafiltration at the first sign of respiratory deterioration".

116. The Second Doctor was also critical that all Consultant Nephrologists and the Renal Registrar were away from the Hospital at the same time on 26 February. He noted that the SHO who diagnosed "heart failure/pulmonary oedema" at 9.50am on 26 February,

> "struggled to obtain help from senior colleagues making at least 5 telephone calls whilst [being] passed from one more senior clinician to another and back again...I suspect more timely assistance would have been offered [to a renal registrar or consultant]".

He added,

> "A renal [registrar] or consultant would have recognised the need for immediate dialysis and this intervention would have occurred more promptly".

117. The Second Doctor referenced the GMC's Guidance, "Good Medical Practice (2013 Domain 3 paragraph 38)", which states that, "patient safety may be affected if there is not enough medical cover" and (paragraph 40), "you must make sure that all staff you manage have appropriate supervision".

118. The Second Doctor said that,

> "Mr X's condition deteriorated in large part because of the development of pulmonary oedema. On the morning of 26 February...the timely provision of haemodialysis on the renal unit or haemofiltration on the ITU [department], would have resolved his pulmonary oedema and may have prevented his peri-arrest and subsequent death. Even after he had "arrested" and had been transferred to the ITU at 1.02pm, haemofiltration was not initiated until 6.00pm. Mr X died at 10.50pm. Therefore Mr X's death was potentially avoidable. Whether his death was avoidable "on the balance of probabilities" is difficult to know. A patient of his age and with his co-morbidities who has spent twelve days with respiratory failure requiring ventilation on an ITU with pneumonia complicating Influenza A (a severe manifestation of influenza, a respiratory illness caused by a virus) has a relatively poor prognosis".

119. The Second Doctor concluded that,

> "On admission [Mr X] had signs of ongoing pneumonia and fluid overload and was appropriately treated with antibiotics. The recommended frequency of observations according to his NEWS score was not followed when he was transferred to [the renal ward]. He developed pulmonary oedema. Appropriately trained renal medical staff (Specialist Registrar and Consultant Nephrologists) were apparently absent from the hospital and there was a delay in providing haemodialysis on the renal unit. There was a further failure to recognise and respond appropriately to the deterioration in his condition and in transferring him to the ITU for haemofiltration until after he had suffered a "peri-arrest". After transfer to ITU there was a further delay in providing haemofiltration. These delays contributed to his death".

The First Doctor

120. The First Doctor said that the Consultant Physician noted that Mr X was unwell and "oedematous +++", upon his transfer from the AMU department. The First Doctor clarified that he considered the treatment on AMU was inadequate because the renal team was not contacted, the importance of Mr X's oedema was not appreciated and regular observations were not arranged. He added that the poor care provided to Mr X was on the part of the Consultant Physician. He was also critical of the fact that there was a lack of renal doctors on the hospital site, the behaviour of the ITU registrar and the delayed transfer to ITU.

121. The First Doctor said that he fully appreciated that Mr X's condition rapidly deteriorated when he reached ITU. He said that he considered the issue for the Health Board was the delay in Mr X reaching ITU.

The Health Board's comments on the second draft report

122. In response to the second draft report, the Health Board supplied a print out from the Patient Administration System ("PAS"). This showed that Mr X was admitted to AMU at 4.16pm on 25 February and that he was transferred to Ward 9 at 9.25pm. It also showed that Mr X was admitted to ITU at 1.39pm on 26 February.

123. The Health Board accepted recommendations a-d under the heading 'renal' and b-e under the heading 'governance'. It said that it acknowledged,

> "...that there were service failures in the care of Mr X and apologises for the distress the delay in responding to Mrs X's complaint has caused. The Health Board does not accept that Mr X's death was potentially avoidable or avoidable and therefore believes that the sum should be a reasonable consolatory payment for our service failures at a time of distress to Mrs X".

The Health Board clarified that it was unable to accept recommendation headed 'governance' a, and under 'redress', a.

124. When commenting on a second draft of this report, whilst the Health Board accepted some of my recommendations, it said that it had commissioned an opinion from an independent Consultant Intensivist ("the Consultant Intensivist"). A copy of Mr X's notes had been supplied to the Consultant Intensivist and he had been asked to provide an "overview" of the care on the basis of Mrs X's complaint – had Mr X been transferred to ITU following repatriation, he would have survived. In response to the Health Board's request for his opinion, the Consultant Intensivist confirmed that his understanding of the synopsis of the care was, "whether the patient should have been admitted to ICU earlier". The Consultant Intensivist was not supplied with copies of the opinions of my professional advisers or copies of my draft reports.

125. The Consultant Intensivist said that Mr X should have been admitted to ITU on his admission to the Hospital. He should also have received Meropenem (an antibiotic that fights bacteria) from 25 February. The Consultant Intensivist, however, said that it was unclear what impact the admission to ITU and the use of Meropenem would have had on Mr X's outcome.

126. The Consultant Intensivist said that Mr X received less observations and a lower level of nursing care than he should have. He noted that, had Mr X been admitted to ITU, he would have received very close observations and 1:1 or 1:2 nursing. However, he was admitted to a ward. The Consultant Intensivist confirmed that there were no documented observations between 10.45pm on 25 February and 9.20am on 26 February. There was no clinical review following the observations at 10.45pm and indeed, there was no review until 9.20am, when there had been a further worsening of Mr X's observations.

127. The Consultant Intensivist said,

> "The only way [this] could have worsened [Mr X's] outcome, is if they [led] to altered or missed treatment. I have not identified any specific therapy he did not receive as a result of this reduced monitoring".

128. The Consultant Intensivist was also critical of the type of antibiotic used to treat Mr X. He said that Mr X should have received Meropenem, as it is a broader spectrum antibiotic, used to treat bacteria "selected out" by an earlier course of antibiotics. He noted that Meropenem was provided to Mr X, but not until 2.00pm on 26 February.

129. The Consultant Intensivist said that,

> "The combination of [Mr X's] background health and precedent I[T]U admission meant [his] risk of death when admitted to [the] Hospital was greatly increased".

He added that the combination of hospital acquired pneumonia and pulmonary oedema had a significant mortality, even with prior good health.

130. The Consultant Intensivist used the Acute Physiology and Chronic Health Evaluation (APACHE 2; a severity-of-disease classification system) model and the Intensive Care National Audit and Research Centre (ICNARC) case mix programme (an audit of patient outcomes from critical care units in the UK) to predict Mr X's mortality. He took data from Mr X's initial deterioration on the evening of 25 February and gained the results of 59% mortality (APACHE 2 system) and 68% (ICNARC system).

131. The Consultant Intensivist concluded,

> "On the balance of probabilities I would not have expected [Mr X] to survive this illness, irrespective of treatment".

132. As part of its comments on the second draft report, the Health Board also supplied comments from the Consultant Physician, the Second ITU Consultant, the Senior Investigations Manager and the Consultant Anaesthetist. The Consultant Physician said that he realised he had made "several assumptions" regarding Mr X's care. He said that, had he known that there was to be no senior renal cover the following day, he would have "made every effort" to tell the renal team about Mr X's admission, or would have discussed the case with the on-call renal physician. He would also have informed the dialysis unit of Mr X's admission the following morning. He said,

> "I now realise that making assumptions was wrong and since this incident I have learnt the lessons and I have reviewed my hand-over practice".

133. As part of its comments on the second draft report, the Health Board supplied additional comments from clinicians. The Consultant Physician commented on the antibiotics prescribed for Mr X following his review of the patient on AMU. He said that the Health Board's policy guidelines in early 2014 suggested use of intravenous tazocin (an antibiotic used to treat bacterial infections) as first line or intravenous cefuroxime (used to treat bacterial infections) as an alternative in patients were severe hospital acquired pneumonia. As Mr X had end stage renal failure, the Consultant Physician said that he chose tazocin. He also prescribed clarithromicin (used to treat bacterial infections, including those that affect the skin and respiratory system), given that Mr X had been abroad and may have acquired foreign organisms.

134. The Second ITU Consultant commented on the post mortem. She said that the post mortem stated that there were "findings in keeping with...florid respiratory tract infection" and provided further detail. The Second ITU Consultant said that the assertion by the First Doctor that the pneumonia would not improve while the patient had fluid overload, was factually incorrect. She said that fluid overload and infection are separate entitles, with separate treatments which act independently of each other.

135. The Second ITU Consultant said that her clinical involvement in the matters complained about came some hours after the events examined by the investigation. She confirmed that she would actively participate in any further investigation or other process the Health Board found necessary following the publication of the report.

136. The Senior Investigations Manager said that she believed her interview had been taken out of context. She said that her interview was not planned and when it was carried out, she had just returned from annual leave and was asked to attend the interview without time to prepare or re-read the report. Therefore, when the Senior Investigations Manager was presented, by the First Doctor, with his version of events, it can be seen how she would have said that she would not be comfortable if there were clinical inaccuracies in the RCA. The Senior Investigations Manager said that she stood by the explanation she had supplied following receipt of the first draft report.

137. The Senior Investigations Manager said that she was unaware of the missing fax of 24 February 2014 detailing the treatment Mr X had received abroad until she was presented with it at the interview with my Investigation Officer. She said that she had reflected on the matter and could only assume that the fax was not filed in the envelope until after the RCA meeting and before the request from my office was received. The Senior Investigations Manager noted that the words "file please" were written on the fax so it was possible that the fax was awaiting filing and had not made it onto the file, at the time of the RCA. She said that the faxed letter would have informed the investigation. Finally, in respect of the RCA, the Senior Investigations Manager said that the document itself was not signed by any member of the Health Board but the response to the complaint was signed by a Director following appropriate approvals. There was a copy of the RCA included with the complaint response. The scope of the meeting with Mrs X was to answer any questions raised in her complaint letter.

138. The Consultant Anaesthetist said that he was concerned by my decision not to obtain external critical care opinion. He said that the Second Doctor was another renal physician, whom he said had,

> "overlooked important information regarding this gentleman's rapidly progressive multiple organ dysfunction following his admission to intensive care".

139. The Consultant Anaesthetist said that neither the First nor Second Doctors recognised that by the time of Mr X's admission to the ITU department, he had developed features of septic shock, the management of which was more complex than simple fluid removal. He said that the Second Doctor failed to recognise the need to start respiratory and circulatory support before dialysis and inappropriately considered this prioritisation to be a failing. The Consultant Anaesthetist noted my view that earlier fluid removal was highly likely to have saved Mr X's life. He said that he was unsure as to whether this statement reflected the views of the Second Doctor, who said that it was difficult to know whether his death was avoidable on the balance of probabilities.

140. The Consultant Anaesthetist said that my report contained disproportionate focus on Mr X's fluid overload and overstated the benefit of dialysis. He said that he considered the report to be "grossly compromised" by the lack of specialist critical care input.

The First Doctor's comments on the Consultant Intensivist's report

141. The First Doctor noted the Consultant Intensivist's comments regarding Mr X's pneumonia. He said that Mr X did not have pneumonia in Spain; there was no evidence of it on the CT scan.

142. The First Doctor noted that the Consultant Intensivist was critical of the antibiotics used; he said that they were the wrong type. Further comments on this issue were sent by the Health Board. The First Doctor also noted the Consultant Intensivist's view that Mr X had pulmonary oedema shortly after he arrived back in the UK. Finally, the First Doctor referred to the mortality prediction carried out by the Consultant Intensivist. He said that,

> "A predictive mortality rate of over 50% does not preclude an avoidable death".

Mrs X's comments on the second draft report

143. Mrs X said that she was concerned that the Health Board had said that the Consultant Nephrologists and the Renal Registrar remained on a Health Board site, even though they were forty miles away at another hospital. She was also concerned about the Health Board's approach to timings in the medical records.

144. Mrs X said that she was pleased to see that this report recognised the impact that the matters complained about had on the family, in prolonging the distress by having to "keep on reliving" the events that led to Mr X's death.

145. Finally, Mrs X commented on the proposed financial redress. She said that the amount proposed was "life-changing" for her and her family. She said that she was pleased that there would be justice for Mr X,

> "as no-one deserves to go through what he went through, especially when he fought so hard to get back to the UK to be cared for by Doctors who knew him".

The Health Board's comments on the proposed final report

146. The Health Board said that there were a number of areas where, through its own investigation process, it had already identified areas of concerns where improvements were required (particularly the management of repatriated patients and aspects of communication, ownership and handover between clinical teams). It said that it had "moved forward" with these issues in advance of the final report being produced.

147. The Health Board concluded,

> "Difficult clinical decisions were made at various stages in the care of Mr X based on his complex presentation and multiple morbidities. There remains a difference in clinical opinion between different specialisms... However, the Health Board accepts all the recommendations contained within the report".

Mrs X's comments on the proposed final report

148. Mrs X said that,

> "The issue here for the Health Board is that my husband should have gone to Intensive Care on admission which has already been agreed, but as they had already failed in that respect, there was then the lack of regular monitoring and significant delay in ITU attending my husband when requested and then no apparent action being taken by the attending Doctor. It was very obvious that my husband was rapidly deteriorating on the ward... It took a peri-arrest for any action to be taken, when he was eventually admitted to ITU."

149. Mrs X said that she considered it crucial that the fax sent from Tenerife on 24 February was not acted upon and that Mr X received delayed and ineffective treatment from the ITU Registrar. Mrs X said that the delay in Mr X reaching ITU meant that he did not receive the treatment he needed.

Analysis and conclusions

Responsibility

150. Mr X was a dialysis patient and had been for approximately two years. He would therefore have been well known to the Consultant Nephrologist. The Consultant Nephrologist had provided a letter to confirm that he was fit to travel. The company managing Mr X's transfer sent a fax on 24 February addressed to the Consultant Nephrologist which detailed his condition and details of the planned transfer. The Consultant Nephrologist said that he had never seen the fax and was unaware of Mr X's proposed transfer, although there was a note in the haemodialysis diary that he was being treated in Hospital in Tenerife and would not return for dialysis as planned. Three Consultant Nephrologists and the only Renal Registrar were all away from the Hospital on a course on 26 February. The Consultant Nephrologist attended Mr X once during his admission to Hospital, at 7.45pm on 26 February.

151. The Health Board has said that the Consultant Nephrologists and the Renal Registrar were "on site" on 26 February, although they were actually on another site, forty miles away. The lack of accessible renal physicians has been criticised by both of my professional advisers. I agree that, had renal physicians been more accessible during Mr X's period of care, swifter and more appropriate treatment would have been instigated, i.e. dialysis.

152. The Consultant Physician at AMU noted Mr X was a renal patient. The Consultant Physician did not see it as his responsibility to advise the Consultant Nephrologist that his patient had been admitted so did not advise him. He also did not advise the ITU department of Mr X's admission. The Consultant Physician was, however, the responsible clinician when records show that Mr X was transferred to the renal department on 25 February. This is a failing and in contravention of the GMC Guidance outlined at paragraph 84. The Consultant Physician has also accepted that he made a number of assumptions regarding when Mr X would be attended to and receive treatment, which he should not have done. I welcome these admissions, however, I do not consider that they go far enough.

153. It is clear that there was inadequate consultant supervision of the ITU Registrar. I have already highlighted that it seems he took two hours to attend Mr X and when he did attend, he missed an opportunity to instigate appropriate treatment, i.e. dialysis. There is no evidence to suggest that he discussed Mr X's care and treatment with an ITU Consultant. He should also have discussed his opinion and plan with the referring doctor. The Second ITU Consultant has suggested that he should have done and would have been aware that he should have done. These failings suggest there was inappropriate consultant supervision of the ITU Registrar and amount to a failing.

154. The Consultant Nephrologist, as the responsible and senior physician, could and should have challenged the ITU Registrar's decision not to admit Mr X to the ITU department in the morning of 26 February. Ultimately, he said at interview that Mr X should have had dialysis in the ITU department early in the morning of 26 February. The Consultant Nephrologist was well aware of the lines of communication and his opportunities to challenge the ITU Registrar's decision. The Health Board has said that the Consultant Nephrologist agreed a plan for care with the ITU Consultant, however, this was documented at 2.00pm, following the peri-arrest, and was too little, too late. The Consultant Nephrologist has failed to provide a plausible explanation for his failure to challenge the ITU Registrar's decision in the morning of 26 February and I can only then take the view that it was due to a failure to take responsibility for Mr X. This is a failing.

155. A further failing is the Consultant Nephrologist's instruction to the SHO to contact the ITU department. Mr X was the Consultant Nephrologist's patient and was in a bed on the renal ward. What ensued was an exchange between the Consultant Nephrologist and the ITU Consultant via the SHO which wasted valuable time. The Second Doctor has described this as a "[missed] opportunity to intervene and stabilise the patient". This was a failing.

156. The most critical episodes of delay relate to Mr X's dialysis. I agree with the First Doctor that Mr X's main clinical issue was fluid overload. Whilst the post mortem also notes pneumonia, the First Doctor has confirmed that this would not improve while Mr X had fluid overload. I agree.

157. The Second Doctor has also confirmed that the main reason for Mr X's clinical deterioration was the development of pulmonary oedema. When Mr X was admitted, the Consultant Physician was unaware of when his dialysis was due. Throughout Mr X's care, there was no evidence of urgency for dialysis treatment and when, eventually, dialysis was started at 6.00pm on 26 February, it was, sadly, too late. The First Doctor has said that opportunities were missed to provide dialysis in the evening of 25 February and, at the latest, early in the morning of 26 February, as has the Second Doctor. I agree there was a possibility that had these opportunities been taken, Mr X's life could have been saved. This amounts to a serious failing on the part of the Health Board.

158. I particularly note the comments of the Health Board in response to the draft report that, whilst haemodialysis for Mr X's fluid overload would not have been inappropriate treatment, later deterioration meant that this was not a viable option. This reinforces my view that significant opportunities were missed, early in the period of care, to provide Mr X with the dialysis that he so urgently needed. It also accords with what I have said that, when dialysis was finally carried out, it was, sadly, too little, too late.

159. I am critical of the over ten hour gap between 10.45pm on 25 February and 9.20am on 26 February, when no observations were taken. Also, there is no evidence to suggest that Mr X was attended by a clinician between 8.00pm on 25 February and 9.00am on 26 February, which, for a patient who, at that time, had an NEWS score of 6, is concerning. I agree with Mrs X that there is no evidence that Mr X's observations were taken four hourly at least until his arrival at the ITU department between 1.00-2.00pm on 26 February. Mr X's records confirm nursing attendance on arrival at AMU, on arrival at the renal ward and at 12.10pm on 26 February. There was further delay at 9.50am on 26 February when the SHO was passed between the Consultant Nephrologist and the ITU department. It appears that the ITU Registrar did not then attend for two hours after he was called and when he arrived, he failed to effect dialysis treatment for Mr X. All of these instances highlight delays and ineffectual treatment and amount to failings on the part of the Health Board.

160. I would also, at this point, comment on the Health Board's assertion that, due to the practice of writing retrospectively, most, if not all, records of times of consultations in Mr X's medical records cannot be relied upon. I do not accept this. Relevant guidance on this matter (GMC 'Good Medical Practice 2013'), states that,

> "Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards".

161. Whilst there is established practice of writing records retrospectively, when this is done, records must be marked accordingly. If this is not the case, records will be taken at face value and the consultation or discussion in question will be considered to have taken place at the time recorded.

Communication between departments

162. It is evident that communication between the departments in the Hospital was very poor. The ITU department, and more particularly the renal department, should have been aware of Mr X's repatriation, particularly as the Health Board has confirmed, in response to the first draft report, that a renal clinician received the faxed letter from the company transporting Mr X back to the Hospital. In all probability, Mr X would have been transferred directly to the ITU department had they been aware and different treatment, notably NIV and dialysis, would have resulted. This lack of effective communication must be a failing.

Governance

163. The Medical Director has said that the RCA should have been "an objective search for the truth", but this could not have been the case if the person managing the process could not challenge clinical conclusions. Not only that, but a highly relevant document (the fax of 24 February 2014 detailing the treatment Mr X had received abroad) which "may" have altered the outcome was not available, despite it being clearly available and easy to find during this investigation. I note the First Doctor's concerns that, again,

despite the claim to objectivity, there is no mention of fluid overload or heart failure being the major causes of Mr X's death. The view of the Second Doctor clearly reinforces the view of the First Doctor, that delays in the provision of haemodialysis contributed to the death of Mr X.

164. It is also concerning that a member of senior staff within the Health Board was prepared to put their name to a letter detailing the outcome of the RCA without, apparently, having discussed the matter with clinicians personally or having considered the matter fully at senior level albeit that this appears to have been in accordance with the Health Board's usual practice at the time. I conclude that the RCA conducted by the Health Board was not fit for purpose and amounts to a failing.

165. A further failing is the Health Board's failure to find Mr X's medical records. As the First Doctor has pointed out, the Health Board's senior staff are directly accountable for the records of their patients. It is most concerning that there has been no proper explanation or accountability for the incident.

166. Whilst the misplaced records were said to be the reason why the Consultant Nephrologist did not offer a meeting with Mrs X at an early stage, the Medical Director confirmed that this could and should have been offered. Whilst the Consultant Nephrologist did offer a meeting, this followed his failure to attend the meeting with Mrs X on 8 April held to discuss the RCA and was made only on the basis that she had "ongoing" concerns that she wished to discuss. Mrs X declined this meeting. In any event, failure to offer this meeting at any early stage, despite the suggestion of the complaints team, is a failing.

Injustice

167. Ultimately, I agree with Mrs X that Mr X should have been admitted to the Hospital's ITU department. I note that the Health Board, too, accepts this. Mr X should have received more frequent monitoring and would have done so in the ITU department. The ITU department should have attended more promptly when called on 26 February and should have instigated treatment, including dialysis. Mr X should also, most importantly, have received earlier dialysis, which he would have done, on the balance of probabilities, had he been transferred directly to the ITU department. I agree with the First Doctor and the Second Doctor that earlier fluid removal was an essential factor in

Mr X's treatment programme and as this was missed his death was potentially avoidable. Having survived two weeks in ITU in Tenerife and the journey home where Mrs X was confident that Mr X would receive appropriate treatment at a facility where he was well known as a patient, Mrs X and the family will never know for certain whether Mr X's life could have been saved and will always have to live with the uncertainty of knowing that had the opportunities for treatment been taken his life could potentially have been saved. This is a significant injustice. Mrs X and the family have also had to deal with the impact that Mr X's death has had, at a time when it was not expected.

168. Further injustice was caused to Mrs X as a result of the Health Board's handling of the complaint. Mr X's records were lost for six months and it took around eight months for Mrs X to receive a complaint response. The fact that the Health Board did not accept failings in the care it provided to Mr X at an early stage, with the exception of the transfer to the Hospital's ITU department, meant that Mrs X has been put to the time and trouble of referring the complaint to my office. The Health Board's handling of the matter has also prolonged the distress caused to Mrs X in reliving the events leading to Mr X's death.

Recommendations

169. I **recommend** that:

Renal

a) The Health Board instigates immediate (same day) senior review of renal patient admissions by consultant renal physicians.

b) The Health Board carries out a review of why there was no decision making renal clinician at the Hospital on 26 February, together with an explanation for inpatient responsibilities. A copy of the review should be forwarded to the Health Board's Medical Director for consideration and any appropriate action be taken within three months of the date of issue of this report. A copy should also be sent to my office within this timeframe.

c) The Health Board reminds all junior doctors and consultants working in emergency and acute medicine of the need to immediately inform renal physicians when a renal patient is admitted. Evidence should be supplied to my office that this has been completed within three months of the date of issue of this report.

d) The Health Board's renal department draws up clear policies for the management of emergency Hospital admissions of renal patients within three months of the date of issue of this report.

Governance

a) The Health Board's Chief Executive provides confirmation to my office that the Consultant Nephrologist and the Consultant Physician have reflected upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report. An anonymised copy of the complaint, together with this report and the consultants' reflection on them, should be retained on their appraisal file, which will then be further discussed with their Appraiser and will be retained within the permanent appraisal database. Appropriate training should be supplied to anyone identified to be in need of it within six months of the date of issue of this report. The Health Board should also consider whether any of the issues raised as part of the process of reflection warrant referral of any relevant Consultant to the GMC.

b) The Health Board carries out further investigation as to who was contacted by the air ambulance, the Spanish ITU department and the patient's wife. It should report the outcome of this investigation to my office within three months of the date of issue of this report.

c) The Head of the Health Board's ITU department reviews the delay in the attendance of the ITU Registrar on 26 February at 11.50am and provides a report to the Medical Director for consideration containing their findings and any proposed recommendations within three months of the date of issue of this report. A copy should also be supplied to my office within this timeframe.

d) The Health Board completes the work set out in the RCA regarding its review of the management of repatriated or transferred in patients as a matter of urgency. Should the Health Board decide that a policy is required to best manage repatriated or transferred in patients, that work, in addition to the review of the position, should be completed within six months of the date of issue of this report.

Apology

a) The Health Board's Chief Executive personally apologises to Mrs X for the failings identified in this report, most notably, Mr X's potentially avoidable death, within one month of the date of issue of this report.

Redress

a) In light of Mr X's potentially avoidable death, the Health Board's service failure and the uncertainty caused to the family, it should pay Mrs X the sum of £20,000, within one month of the date of issue of this report. This sum also reflects the distress caused to the family by the manner of Mr X's death, Mrs X's time and trouble in pursuing the complaint and the delayed complaint response.

Nick Bennett 31 August 2016
Ombudsman

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