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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Mr A against Abertawe Bro Morgannwg University Health Board

A report by the Public Services Ombudsman for Wales

Case: 201103324

Contents

Introduction

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

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

Summary

Mr A complained that there had been a delay in diagnosing and treating Mrs A's, aortic dissection, and that clinicians had failed to communicate with either of them. Mr A also complained about Abertawe Bro Morgannwg University Health Board's ("the UHB") response to his letter of complaint.

Having reviewed all of the information, I found that unreasonable delays had occurred. Despite being aware of Mrs A's medical history, and Mr A's concerns that she was having a heart attack, Mrs A waited at least 35 minutes before any initial tests were undertaken, including any heart monitoring. Following a further wait Mrs A was examined and referred to a Registrar, where she waited an hour to be seen.

The medical notes suggest that following an examination of Mrs A the clinicians suspected that she had an aortic dissection, although there is no evidence to suggest that this information had been shared with Mr or Mrs A. Due to the serious nature of this illness and the high mortality rate, clinicians would be expected to prioritise the tests to diagnose this condition. However in Mrs A's case the clinicians failed to do this, instead tests were undertaken to "rule in" other more common disorders rather than "rule out" the aortic dissection. Sadly, Mrs A passed away shortly after being diagnosed.

Finally I found that the UHB had failed to respond to Mr A's letter of complaint in accordance with its procedure. I also found that there was no evidence that lessons had been learned and that remedies had been put into place to prevent this occurrence again.

I upheld the complaint and recommended that the UHB should apologise and pay the sum of £5000 to Mr A, and Mrs A's children. I also recommended that relevant staff be reminded of the importance of communication with patients and relatives, and that complaint handlers be reminded of the requirements set out in the UHB's interim complaints policy and procedures. Finally I recommended that the UHB implement a pathway for treating patients presenting to the SAU with suspected aortic dissection.

The complaint

1. Mr A complained that there had been a delay in diagnosing and treating his late partner, Mrs A's, aortic dissection[1], and that the clinicians in Singleton Hospital had failed to adequately communicate a possible diagnosis and treatment plan to him. Mr A also expressed particular concern about Abertawe Bro Morgannwg University Health Board's ("the UHB") response to his letter of complaint dated 2 September 2011.

Investigation

2. My investigator obtained comments and copies of relevant documents from the UHB and considered those in conjunction with the evidence provided by Mr A. I have also taken advice from two of my professional advisers. Adviser 1, Mr Wayne Hamer has been an Emergency Medicine Consultant since 1994 and sees a wide range of acute presentations in a large teaching hospital setting where chest pain is a common presentation and its evaluation and treatment is part of his daily activity. Adviser 2, Mr David Richens has been a consultant cardiac surgeon for the last 20 years and routinely sees and operates on patients with acute aortic dissection. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

3. Both Mr A and the UHB were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant guidelines

4. NICE Clinical Guideline 95: Chest pain of recent onset[2] outlines the pathway used by clinicians for the assessment and diagnosis of recent onset chest pain or discomfort. This guideline refers only to

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[1] The aorta is the main artery of the body supplying oxygenated blood to the circulatory system. It arises (ascends) from the left ventricle of the heart, arches and then descends down through the chest cavity and abdomen where it divides into two arteries that go into the legs. An aortic dissection is a tear or partial tear in the wall of the aorta that allows blood to flow within its layers.

[2] Assessment and diagnosis of recent onset chest pain or discomfort of suspected cardiac origin. Issued March 2010.

where the pain and discomfort is believed to be of cardiac origin. (Appendix 1)

Manchester Triage System

5. The purpose of a triage system is to assess and prioritise the patient based on the patient's clinical need. The Manchester Triage System ("MTS") is widely used in the UK and specifically at Singleton Hospital.

6. Under MTS a patient is assessed then allocated a priority and should be seen within the corresponding timeframe:

• 1	Immediate	Red	0 minutes
• 2	Very Urgent	Orange	Within 10 minutes
• 3	Urgent	Yellow	Within 1 hour
• 4	Standard	Green	Within 2 hours
• 5	Non-Urgent	Blue	Within 4 hours

GMC Guidance

7. The GMC guidance outlines the measures that should be taken to ensure good clinical care, good communication and the inclusion and support of relatives, carers and partners. (Appendix 2)

The UHB's Interim Complaints Policy and Procedure

8. This states that complaints will be acknowledged within 2 working days and a complete response issued within 20 working days of receipt of the complaint. Where the investigation will take longer than 20 working days, the Complaints Handler will inform the complainant accordingly with a realistic indication of when the investigation will be completed and an explanation for the delay. (Appendix 3)

The background events

9. Between 7:45 – 8:00pm on 27 June 2011 Mrs A presented at Singleton Hospital complaining of excruciating back and stomach pain. She was attended by a nurse and taken to the Surgical and Medical Assessment Unit ("SAU"). Mr A advised staff that Mrs A had previously suffered from angina[3] and kidney problems, and expressed his concern

that she was having a heart attack. At 8:35pm blood tests and an ECG[4] were performed on Mrs A.

10. At 9:00pm Mrs A was seen by the Senior House Officer ("SHO") who noted that Mrs A's blood pressure was 256/124 and 159/129, and referred to both a systolic murmur[5], and oedema[6]. The SHO also noted "?biliary colic[7]", pancreatitis[8] and "?dissection". The SHO planned a number of tests for Mrs A including chest and abdominal x-rays and blood tests. Mrs A was then referred to the Specialist Registrar ("the Registrar") for a review. There is no evidence in the notes to suggest that the SHO had discussed the working diagnosis, the results of the ECG or what investigations were planned with Mr or Mrs A.

11. At 9:10pm Mrs A was prescribed intravenous paracetamol for the pain, however it was not very effective and the pain escalated. Mr A requested further help from the nurses, and Mrs A was then prescribed morphine which helped with the pain for a short time.

12. At 10:00pm Mrs A was seen by the Registrar, Mr A advised him of Mrs A's symptoms and medical history. The Registrar examined Mrs A noting a possible biliary colic, pancreatitis and aortic dissection. The Registrar proposed similar tests to those suggested by the SHO.

13. At approximately 11.30pm Mrs A was scheduled to have an x-ray. However this was cancelled as a more urgent case had been prioritised. Mrs A was subsequently x-rayed at 11:51pm.

14. Mr A left the Hospital at 12:00 midnight following an agreement that he could contact the Hospital hourly for an update. At that point no differential diagnosis had been communicated to him or Mrs A and no treatment started.

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[3] A heart condition that is caused by a restriction in the blood supply to the muscles of the heart.
[4] Electrocardiogram – this test records the rhythm and electrical activity of your heart.
[5] This is a vibration that occurs at a variable duration and can be heard with the help of a stethoscope. A systolic murmur can be heard at the beginning of the first heart beat and ends after the sound of the second heartbeat. The noise is the result of a disordered flow of blood through the ventricles.
[6] Fluid retention in the body.
[7] This is caused when a gallstone temporarily blocks the bile duct.
[8] This is inflammation of the pancreas.

15. It is noted that at 1:00am the Registrar made additional notes stating that Mrs A had a possible aortic dissection and that she needed a scan that night. The Registrar also noted that the radiographer at the Hospital was not trained and that Mrs A may have to be moved to Morriston Hospital.

16. At 2:00am the Registrar noted that the chest x-ray showed a widened mediastinum[9] with unfolded aorta[10] and planned an urgent CT[11] scan of Mrs A's chest and aorta. The Registrar also planned to move Mrs A to the High Dependency Unit with the aim of lowering her dystolic blood pressure[12]. Mrs A was given a CT scan at 2:25am.

17. At 3:15 the Registrar confirmed that Mrs A had an aortic dissection from the root of the aorta.

18. At 3:25 Mrs A was moved to the High Dependency Unit where she suffered a cardiac arrest. Despite attempts to resuscitate her, Mrs A passed away.

19. At 3:30am Mr A was asked to return to the Hospital where he was told that Mrs A had died. The death certificate recorded the cause of death as aortic dissection with chronic renal failure as a contributory factor.

20. On 2 September 2011 Mr A complained to the UHB. Mr A's complaints related to the diagnosis, treatment plan and lack of urgency in responding to Mrs A's condition.

21. The Investigations and Redress Officer acknowledged Mr A's complaint on 8 September 2011 and informed him that they "will normally let you have a reply within 30 working days of receiving your concerns".

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[9] This is the part of the chest cavity that contains the heart.
[10] A slight lengthening of the section of the aorta in the chest cavity resulting some distortion or twisting.
[11] This is a computerised tomography scan that uses x-rays and a computer to create detailed images of the inside of the body.
[12] The minimum pressure in the arteries between beats when the heart relaxes to fill with blood.

22. During the course of the investigation the Registrar completed a report on the management of Mrs A's condition. He concluded that:

> "there was not a lack of appreciation of the seriousness of [Mrs A's] condition. Acute aortic dissection is a rare presentation that must be evaluated in a systematic manner. The diagnosis is often not immediately apparent & for this reason many doctors were asked to attend [Mrs A] during the night to confirm the diagnosis. Neither was there a lack of urgency in this case. [The Registrar] was contacted as an emergency overnight. Having arranged for urgent discussion with the radiologist and asked that preparations be made for an emergency scan, [the Registrar] attended [Mrs A] at the Hospital. This allowed [the Registrar] to decide on further management, ensure investigations were conducted urgently and that appropriate treatment was initiated. Regrettably despite our best efforts and use of all resources available to us we were overtaken by the severity of [Mrs A's] condition and sadly were unable to save her life…."

23. On 21 October 2011, Mr A was informed that there was to be a delay in providing a full response to his complaint. The letter did not include any explanation for the delay, nor was he given an estimated date for the response.

24. The Director of Primary, Community & Mental Health Services ("the Director") in conjunction with the Registrar responded to Mr A in full on 22 November 2011. In her response, the Director said that there was an indication that the initial working diagnosis had included pancreatitis, biliary colic and aortic dissection, and that the doctor conducting that initial assessment had requested a review by a more senior registrar to help formulate an exact diagnosis. It was recognised that it was usual practice to inform patients and relatives of the ongoing differential diagnosis and management being considered, and that that had not happened in this case.

25. With regard to the diagnosis of aortic dissection, the Director said that making the distinction between a heart attack and aortic dissection at the initial assessment stage, could be "challenging". She added that

consideration was not only given to a heart attack, but that disorders of the gall bladder, bile duct and pancreas were also considered as well as the possibility of the less common aortic dissection.

26. The Director said that as the investigations had resulted in the exclusion of the other conditions, the diagnosis of aortic dissection became more likely. The initial treatment for acute aortic dissection is the lowering of blood pressure, however rapid blood pressure reduction can be hazardous and is usually initiated on the intensive care unit under close surveillance. The clinicians treating Mrs A also considered initiating intravenous beta blockers[13] but this was ruled out because the last time this type of treatment had been used on Mrs A it had resulted in chest tightness. It was therefore decided to establish the diagnosis of aortic dissection before starting treatment on the intensive care unit.

27. The Director said that Mrs A had needed a CT scan of the chest and aorta, and arrangements were made to conduct the test overnight. Some consideration was given to whether Mrs A should have been transferred to Morriston Hospital, particularly as the test was not routinely performed in Singleton Hospital and that this may have resulted in a delay in performing the scan.

28. The Director said that Mrs A had an extensive dissection of the aorta which extended from the heart to beyond the renal arteries and involved the ascending and descending aorta. The diagnosis needed to be confirmed before starting treatment in the intensive treatment unit where careful titration[14] and supervision were needed.

29. Mr A complained to this office on 31 January 2012.

Mr A's evidence

30. Mr A said that despite being in Hospital between 6:45 hours and 8 hours no attempt had been made to treat Mrs A's condition.

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[13] This medication mainly works on the heart muscles where it reduces the amount of work the heart does.

[14] This process is used to determine the correct dosage of medication.

31. Mr A said the possible diagnosis and planned treatments had not been discussed with either him or Mrs A. He added that whilst in the Hospital Mrs A was attached to an ECG, however as he had not been informed of the results he assumed that there was no evidence to suggest a diagnosis of a heart attack.

Abertawe Bro Morgannwg University Health Board's evidence

32. With respect to the concerns about the decision to prioritise the x-ray of another patient over Mrs A the UHB said that:

> "in the case of [Mrs A] it was considered that [Mrs A] was unwell from the time of arrival. As stated in [the doctor's] report dated 20th September 2011 the differential diagnosis was wide. Acute aortic dissection was a part of that differential as documented by the SHO who initially saw [Mrs A], although other more common diagnoses were considered more likely.
>
> The delay between arrival and the initial x-ray being performed will have been a consequence of ongoing assessment by the nursing staff, junior and more senior doctors who were attempting to stabilise [Mrs A] and control her pain. The x-ray department will also have needed to accommodate other patients who were being treated in the department at the same time."

33. The UHB also confirmed that the steps taken by the doctor in this matter were in line with the NICE guidance for the management of chest pain (see paragraph 5). The UHB added that once a diagnosis of thoracic aortic dissection is made the cardiothoracic surgeon on call gets involved directly and he manages it.

Professional advice

34. My Professional Adviser in Emergency Medicine (Adviser 1) said that the delay between Mrs A's arrival and her undertaking an ECG was not reasonable. Following her examination, Mrs A should have been categorised as orange for triage purposes and seen by a doctor within 10 minutes of her arrival, not the 60 minutes she had waited.

35. Adviser 1 noted that the SHO examining Mrs A recorded a good clinical history and examination, and actively looked for physical signs associated with aortic dissection, such as differential blood pressure in both arms and delays in the peripheral pulses[15]. Adviser 1 said that the SHO recognised a marked difference in the blood pressure in Mrs A's arms and noted that the probable difference was that of "?biliary colic, pancreatitis or aortic dissection". Adviser 1 said that the aortic dissection should have been ruled out as soon as practically possible, given that it was life threatening, and until that had happened Mrs A's elevated blood pressure should have been treated. Adviser 1 said that a failure to do this had resulted in an unacceptable standard of care. Adviser 1 recognised that it was beyond the expertise of a SHO to deliver the required standard of care and noted that the Registrar was contacted as soon as possible.

36. Adviser 1 said that Mrs A did not see the Registrar until 10:00pm, which introduced a significant delay. Adviser 1 recognised that the Registrar took a good history and performed a "good examination", which included a note that there was an early diastolic murmur [16]which is common in proximal aortic dissection[17]. Adviser 1 said that at that point an ECHO[18] should have been requested to rule out aortic dissection. Adviser 1 said that had an ECHO been performed the clinical presentation would have been abnormal and Mrs A would have been considered for transfer to Morriston Hospital for an investigation and treatment, and that that may have resulted in a different outcome.

37. Adviser 1 said that there was a delay in treating Mrs A's condition, and that the priority should have been to "rule out" the diagnosis of aortic dissection as soon as the possibility was raised, particularly as it was a life threatening condition, not wait for the blood test to "rule in" other conditions such as biliary colic or pancreatitis.

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[15] Sites used for measuring the patient's pulse rate e.g. legs.

[16] This is a noise caused by turbulence of blood flow during ventricle relaxation.

[17] Proximal aortic dissection relates to the ascending aorta.

[18] An echocardiogram is an ultrasound scan of the heart. The scan produces accurate pictures of the heart muscle, the heart chambers, and structures within the heart such as the valves.

38. With respect to the clinician's communication with Mr A, Adviser 1 noted that the only communication with Mr A noted in the clinical notes was after Mrs A had died. Adviser 1 said that there was no documentation before this indicating that aortic dissection, which is known to have a high mortality rate even when diagnosed early, was discussed with Mr or Mrs A.

39. With respect to the UHB's response to the clinical issues in Mr A's complaint, Adviser 1 said that the Registrar had failed to acknowledge the delay in assessing Mrs A, who had "presented with typical feature of aortic dissection". Additionally the Registrar had "not recognised that the process to rule out aortic dissection was incorrect and should have been done much more urgently".

40. Finally Adviser 1 said that:

> "it is very unlikely that the trust has a clinical pathway for patients presenting to the SAU with ?aortic dissection. This is a significant risk for the trust as such presentations are common, even though the diagnosis of aortic dissection is rare."

(His report has been reproduced in full at Appendix 4)

41. My second Professional Adviser, a consultant cardiac surgeon (Adviser 2), also considered Mr A's complaint. He concurred with the comments made by Adviser 1. (His report has been reproduced in full at Appendix 5)

42. Both advisers said that had Mrs A been seen by a cardio-thoracic surgeon before her cardiac arrest at 3:30am her chances of survival would have been far greater. Adviser 2 stated that:

> "Survival depends on early diagnosis and surgical intervention. Survival after early emergency surgery is 80%. Survival without surgical intervention is less than 10%. All patients with acute aortic dissection involving the ascending aorta (as here) should have surgical treatment as soon as possible."

Comments on the draft report

43. In its response to the draft report the LHB said that Mrs A presented to Singleton Hospital, which unlike Morriston Hospital, was a District General Hospital with no accident and emergency services and cardiac centre. The LHB said that access to diagnostics were not as readily accessible out of hours at Singleton Hospital as it would have been at Morriston Hospital and there certainly was no out of hours electrocardiography provision. The LHB said had Mrs A's attendance been the result of a 999 call she would certainly been referred to Morriston Hospital.

44. The LHB also said that Mrs A's case had been discussed with the specialist at Morriston Hospital, and it was advised that a local CT scan be undertaken prior to transfer, which was usual management in this type of case. The LHB said that the alternative to such action would be cardiac surgeons being inundated with possible aortic dissections that were due to other pathology.

45. The LHB said that given the circumstances a correct diagnosis was made. However it recognised that some of its systems may not have been sufficiently swift.

46. The LHB has also considered a way of moving forward and improving services which included:

- A robust triage system with a prioritisation for patients attending with chest pain.
- Having an established pathway if a suspected aortic dissection presents again at Singleton Hospital.
- As part of its "Changing for the Better Agenda", consider how acute services will be delivered.

47. My Advisers have had an opportunity to consider the LHB's comments, and their advice has not altered. Adviser 1 said that the service improvements suggested by the LHB should have been in place before Mr A's complaint. Adviser 1 also said that the LHB's response implied that Mrs A would have been triaged to Morriston not Singleton

Hospital had she contacted the 999 service. He added that until the improved services are in place at Singleton Hospital, the LHB should put a system in place redirecting patients to Morriston Hospital when they present with similar symptoms. Adviser 1 concluded that although the number of aortic dissections diagnosed at Singleton Hospital is small, the number of patients presenting with the possibility of such a diagnosis, based on history alone, is significantly more and the LHB should ensure that the right patient get to the right hospital in a timely manner.

Analysis and conclusions

48. Mr A complained that there had been a delay in diagnosing and treating Mrs A's condition. Having considered the information available it is clear that delays did occur whilst Mrs A was at Singleton Hospital. When Mrs A first presented to the Hospital Mr A informed the staff of her medical history and his concerns that she was having a heart attack, yet despite this information being available, Mrs A waited at least 35 minutes before any initial tests were undertaken, including any monitoring of the heart.

49. Adviser 1 has stated that Mrs A's presentation should have resulted in her been categorised as Orange under the MTS and seen within 10 minutes, however, she had to wait at least one hour before she was seen by a doctor. Whilst I accept that the 10 minute timeframe is considered to be the "gold standard" and not always realistically achievable, a one hour wait was unacceptable in the circumstances.

50. I note that the SHO contacted the Registrar following his initial investigations and examinations. However Mrs A's medical notes show that she had to wait a further hour before she was seen by the Registrar. Adviser 1 has stated that that this was a "significant delay".

51. I also note that despite both the SHO and Registrar making reference in Mrs A's notes to a possible aortic dissection, both planned for Mrs A to undertake an x-ray rather than an ECHO. Whilst in Mrs A's case the damage was significant enough to be visible on an x-ray, this is not a reliable means of identifying an aortic dissection. Furthermore Mrs

A's x-ray was postponed by approximately 20 minutes whilst another patient was prioritised. It was not until 1:00am that the Registrar recognised that Mrs A needed a scan. This however led to further delay because there was some concern over the capabilities of the on call radiographer and whether Mrs A should be moved to Morriston Hospital. Mrs A received her scan at Singleton Hospital at 2:25am over five hours after aortic dissection was initially considered a possible diagnosis.

52. Aortic dissection is a life threatening illness with a high mortality rate. Once identified as a possible diagnosis the clinicians should prioritise the tests accordingly. Having reviewed the evidence it appears that in Mrs A's case the clinicians failed to prioritise the relevant tests for aortic dissection and instead undertook a number of tests in an attempt to "rule in" other more common disorders such as biliary colic.

53. With respect to Mr A's concern about the treatment Mrs A received for her condition, there is no evidence that she received any treatment for her condition, because unfortunately she passed away shortly after being diagnosed with an aortic dissection. My Advisers both stated that Mrs A's chances of survival would have greatly increased had the appropriate scans been undertaken and had she been transferred to the Cardiothoracic Centre.

54. Mr A also complained that the clinicians failed to adequately communicate a possible diagnosis and treatment plan to him. Having reviewed Mrs A's medical notes there is only one reference to a discussion with Mr A, and that was after Mrs A passed away. Therefore, Mr A left the Hospital without being informed of the potentially serious and life threatening condition affecting Mrs A, and despite the Registrar having some indication of Mrs A's condition at 2:00am and diagnosing Mrs A's aortic dissection at 3:15am, Mr A was not contacted by the Hospital until 3.30am after Mrs A had passed away. Furthermore, there is no evidence that Mrs A was informed of the potentially life threatening nature of her condition after Mr A had left the Hospital, this removed her opportunity to contact Mr A or a member of her family for support. In its

letter dated 22 November 2011 the UHB stated that it was usual practice to keep patients and relatives informed of the ongoing differential diagnosis and management, and recognised that that had not occurred in Mrs A's case.

55. Finally Mr A complained about the UHB's response to his letter of complaint dated 2 September 2011. Having reviewed the letters I note that the letter of acknowledgement incorrectly refers to a response date of 30 working days, not the 20 working days outlined in the UHB's complaints interim policy and procedure (see paragraph 9). If the amended date was intentional, then there was no explanation why the investigation was expected to take longer.

56. The letter to Mr A dated 21 October 2011 was sent 30 working days after his complaint was received. Good practice would suggest that Mr A be informed of the delay soon as it became apparent, and not wait until the original issue date for the final response. Furthermore, the complaints policy states that where there is to be a delay the letter should include an explanation for the extended timescale and an indication of when the investigation would be completed. This information was not included in the letter.

57. In her letter dated 22 November 2011 the Director accepted that there had been a failure to adequately communicate with Mr A and apologised. However she failed to recognise the delay in assessing Mrs A, and that the decision to "rule in" other conditions rather that "rule out" aortic dissection was incorrect. Finally there was no attempt to reassure Mr A that lessons had been learned and that remedies had been put into place to prevent this occurrence again.

58. Having considered all of the information available to me including the advice provided by my Professional Advisers, which I accept in full, I **uphold** Mr A's complaint.

Recommendations

59. I recommend that within one month of the date of this report, the UHB should:

- Provide Mr A with an apology letter from the Chief Executive for the failings that have been identified in this report.
- Pay to Mr A and Mrs A's children the sum of £5000 in recognition of the distress and injustice arising from the service failure identified in this report.
- Remind the relevant staff of the importance of communication with patients and relatives.
- Remind the relevant complaint handlers of the requirements set out in the UHB's interim complaints policy and procedures.

60. Within three months of the date of this report:

- implement a pathway for treating patients presenting to the SAU with suspected aortic dissection.

61. I am pleased to note that in commenting on the draft of this report the Abertawe Bro Morgannwg University Health Board has agreed to implement these recommendations.

Peter Tyndall
Ombudsman Date 12 February 2013