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

A report by the Public Services Ombudsman for Wales

Case: 201201214

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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 Ms A, and to her partner, the aggrieved, as Mr B.

Summary
Mr B underwent complex bowel surgery in July 2011with a view to managing unpleasant symptoms. He very sadly died six days later. My investigation considered the following complaints:

- the extent and risks of surgery were not fully explained to Mr B;
- there were insufficient investigations and bowel preparation prior to surgery, and the surgery itself was not appropriate; and
- Mr B's partner was not told of the outcome of surgery until he deteriorated.

The Health Board said that there had been a 'long and detailed consent process'. However, there was no evidence of this. I upheld the complaint and found that Mr B was only made fully aware of the extent of the surgery shortly before he was taken to theatre. I concluded that he was not made aware of all the potential risks involved, and that he went into major surgery, which ultimately led to his death, without having been fully informed or being in a position to give proper consent.

My investigation found a divergence of opinion about whether pre-surgery investigations were needed. None were undertaken. However, it was suggested that Mr B's case should have been discussed within a multi-disciplinary team forum prior to surgery, and I asked the Health Board to consider this.

Having carefully considered all the evidence, I concluded that the surgery was too risky for symptom control only, unless Mr B had wished to proceed on a fully informed basis. I found that the surgeon was acting at the limit of his skills in undertaking such complex surgery. I upheld this complaint. Finally, I found that it would have been good practice for Mr B's partner to have been told of his deterioration sooner than she was and I also upheld this complaint.

I made a number of recommendations to the Health Board which it agreed to implement. These included a payment of £5000 to Mr B's partner for the distress caused by the failings identified, and to acknowledge the uncertainty she lives with over whether Mr B might have lived.

The complaint

1. Mr B underwent bowel surgery in July 2011. It was a long and complex operation. Having shown some signs of recovery, he deteriorated and very sadly died six days later.

2. The investigation considered the following complaints:

(a) Consent: that the extent and risks of surgery were not fully explained to Mr B prior to him consenting to it.

(b) Surgery:
   i. there were insufficient investigations and bowel preparation prior to surgery;
   ii. the surgery was not appropriate particularly given the difficulties encountered during previous surgery in 2007.

(c) Information post-surgery: Ms A was not told of the outcome of the surgery until Mr B deteriorated on 29 July 2011.

Investigation

3. My investigator obtained comments and copies of relevant documents, including Mr B's clinical records, from Abertawe Bro Morgannwg University Health Board (the UHB). I considered those in conjunction with the evidence provided by Ms A in writing and at interview with my investigator. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

4. I obtained clinical advice from Miss P Durning, a senior and experienced consultant surgeon. Her report is attached in full at **Appendix 1(a)** with supplementary advice at **Appendix 1(b)**.

Relevant Guidance

5. The Royal College of Surgeons has issued guidance[1] to surgeons which includes:

> Section 4.1 - 'ensure that patients … are given information about the treatment proposed, any alternatives and the main risks, side effects and complications when the decision to operate is made …' and '… record all discussions about consent in the patient's records'

6. The General Medical Council has issued guidance for doctors about patient consent[2]. It includes:

> Paragraph 5(a) - '…The doctor explains the [treatment] options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. …'
>
> Paragraph 32 - 'You must tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood is very small. …' A serious adverse outcome is defined as 'an adverse outcome resulting in death, permanent or long-term physical disability or disfigurement, medium or long-term pain, or admission to hospital; or other outcomes with a long-term or permanent effect in a patient's employment, social or personal life.'

The events and evidence

7. I set out below the key events and evidence relating to Mr B's care and treatment.

August 1997

8. Mr B had surgery for a rectal tumour.

October 2007

9. He had further bowel surgery undertaken by a consultant colorectal and general surgeon, who I will refer to as Mr Y. Mr Y subsequently wrote to Mr B's GP about the difficulties of surgery. He

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[1] 'Good Surgical Practice' The Royal College of Surgeons of England 2008 (this also applies in Wales and Northern Ireland)

[2] 'Consent: patients and doctors making decisions together' General Medical Council 2008

said that it had been an extremely challenging operation and that 'the whole of the pelvis was rock solid with adhesions[3] and excising[4] this would have led to an unacceptable risk of complications for a lifestyle operation'. We do not know if Mr B was aware of the difficulties encountered during this surgery. Ms A has said she was not.

2009/10

10. Mr B subsequently suffered worsening problems with mucus discharge from the rectum. This was noted in scheduled reviews with the colorectal nurse specialist on 8 June 2009, 22 June 2009 and 30 June 2010. The computer record of the 2010 appointment notes 'still having discharge every day. This is greatly affecting [Mr B's] quality of life'. It noted he was fed up of trying things, and that '… the only permanent solution would be for him to have his rectum removed which is a major undertaking with potential complications and he would have to see a consultant to discuss this in depth..'. The handwritten note of the consultation does not include this level of detail. It states 'No problem with stoma. Still having pr [from the rectum] discharge every day. See next year.'

4 November 2010

11. Mr B saw an associate specialist in colorectal and general surgery, who I will refer to as Mr Z, having been referred by the colorectal nurse specialist. Mr Z noted symptoms of rectal discharge leading to social restriction and that Mr B had said he 'cannot go on like that'. Mr Z asked the colorectal nurse specialist to speak to him about the possibility of rectal washouts. He referred him back to Mr Y. His letter to the GP included '… my feeling is the only way to stop this discharge is by removing the rectum which I don't think [Mr Y] will contemplate in a hurry since he has a solid pelvis from previous surgery'.

12. Ms A disagreed that Mr B's symptoms had been unmanageable. She agreed he had had some rectal leakage/discharge. However, she said he was self-caring, he went out, he lived a normal life, and they coped. Ms A said that in comparison to the symptoms he had had for

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[3] an adhesion is a band of scar tissue that may cause tissues or organs to stick together. They commonly form after surgery in the abdomen or pelvis

[4] to cut away

the 10 years before the 2007 surgery, these were the best years of his life. She agreed that he had had a mucus discharge, but said it wasn't continuous. Sometimes he needed to wear pads, but he could sometimes go for 24 hours without any discharge.

17 November 2010

13. The colorectal nurse specialist recorded telephone contact with Mr B that he would attend the following day with Ms A to teach her how to do rectal irrigation. There is no record of the appointment the following day, and the UHB has reported the loss of some of the computer records (due to a system 'crash'). Ms A has since said that the training on rectal washouts had already taken place by this point and there was no appointment on 18 November.

14. Ms A said that they did the rectal wash outs on a regular basis until the surgery in July 2011. She said the wash outs led to a 'massive improvement'.

26 January 2011

15. Mr B saw Mr Y. In a hand-written note of the consultation, Mr Y recorded: 'terrible trouble [with] mucus discharge. … washouts every 4 [days] not [especially] helpful'. In his subsequent letter to Mr B's GP, Mr Y wrote: '… we have evolved to a situation where [Mr B's] partner needs to irrigate the stump once every 4 days, which is a procedure which neither of them enjoy and every day even with this, he is aware of leaking, foul smelling mucous.' Mr Y also referred to the surgery in 2007 that: 'at the time of theatre, I thought about excising the remnant colon right down into the pelvis and leaving [Mr B] with a short rectal stump, but horrible adhesions prevented me from even doing this'. He went on: 'These cases are always difficult because it is not a fatal condition, but pretty obviously is having such a major impact on [Mr B's] life that I think it is right to offer surgery. The operation is not going to be easy. …[and] clearly is not without its risks. The main problems will be of pelvic bleeding as I know the pelvis is near frozen, but I believe that if I stay close to the bowel wall I can avoid major problems. …''.

16. Ms A attended this consultation with Mr Y and offered her recollection of it. She said that Mr B had explained to Mr Y about the discharge, but that the wash outs were helping, and that he was coping. He had also said that he found the stoma[5] (created during the 2007 operation) too high as it was on his waistline. Mr Y said that if he went ahead with surgery, he would try to re-locate the stoma. He said yes, he thought he could do the surgery. Ms A said she was very surprised at this; she had been sure when they went into the consultation that Mr Y would say no to surgery. She was against surgery and thought it should not have been offered as the only option. Mr B could have continued as he was with the wash outs. Another possible intervention was irrigation to wash out faeces from the stoma, but this wasn't mentioned. The option to do nothing wasn't mentioned.

17. Ms A said she asked Mr Y about the risks of surgery. She described him as a 'man of few words' and he referred only to abscess or infection. He didn't say it was major surgery. Ms A thought that Mr B was taken with the idea of being able to move the stoma. He trusted the professionals, and as he'd had successful surgery before, he thought this would be the same.

18. Ms A said they were told there would be a six month wait for surgery. They saw no-one during that six months except for a routine annual stoma check with the colorectal nurse specialist. At that appointment, Mr B asked about a possible date for surgery. The nurse spoke to Mr Y's secretary to enquire. Ms A had been upset at Mr Y's comment that Mr B had been pushing for surgery. She said he had enquired only once so they could make plans for the summer.

19. Mr Y subsequently wrote an account of the events for the coroner. I attach anonymised extracts from this at **Appendix 2**. He set out his reasons for proceeding to surgery, and said that Mr B was very keen for surgery despite having been told it might not be successful. He considered that surgery was worthwhile despite the difficulties with adhesions encountered during the 2007 surgery. He wrote 'I had worried quite a lot about Mr B's operation over many months …'.

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[5] stoma – a surgically created opening from the intestine to allow removal of faeces

20. At Mr Y's request, the colorectal nurse specialist wrote an e-mail in June 2012 about the events leading to Mr B's decision for surgery. Her note includes:

> 'clinical notes from June 2010 indicate that [Mr B] was having rectal discharge which he found very uncomfortable. From a nursing point of view we tried all conservative measures such as suppositories and rectal wash outs, which [Ms A] undertook. We also discussed colostomy irrigation with [Mr B] on many occasions and he was thinking about this but never actually made the decision to undertake this. [Mr B] felt that his life had become intolerable from his [rectal] discharge and was extremely keen to undergo surgery despite being aware that surgery was a major undertaking. I did make him aware that surgery was a major undertaking …Having known [Mr B] for fifteen years, I do feel I had a fairly close patient-nurse relationship with him … .. I was extremely surprised if not shocked to hear that [Ms A] had felt that he did not have support and adequate counselling prior to surgery. I am aware that [Ms A] herself was always very reluctant for [Mr B] to undergo surgery while [Mr B] was insistent that this is what he wanted….I feel for [Ms A] but in my own mind am confident that [Mr B] felt his symptoms had taken over his life and was determined to undergo surgery despite the risks.'

10 February 2011

21. Ms A said that at the request of the colorectal nurse specialist Mr B attended a day long training seminar as a volunteer. She said this showed he was not restricted by his condition.

1 June 2011

22. The colorectal nurse specialist recorded contact with Mr B – 'no new problems, awaiting date for surgery for re-fashioning, otherwise see next year'.

25 July 2011

23. Mr B was admitted to hospital for surgery the following day. Ms A said she remained with him until about 9.00pm by which time his consent for the operation had not been taken. Mr B phoned her later to say that he had seen the doctor who would be assisting with the operation. He had signed the consent form. The risks recorded on the consent form were:

'bleeding, wound breakdown, post op sepsis[6], HDU/ITU[7] care'.

26 July 2011

24. Ms A said that Mr B phoned her on the morning of the operation. He told her that Mr Y had been to see him, and that it was going to be major all-day surgery. She said he sounded shocked and upset. Ms A said to him not to have the operation, that she would come and pick him up, but he said it had gone too far, they were coming to take him to theatre.

25. Ms A said Mr Y later told her that he had had a full discussion with Mr B that morning. Ms A pointed out that while Mr Y had had six months to think about the surgery, Mr B had had only half an hour on the morning.

26. The surgery took about 9½ hours. It was problematic and ultimately unsuccessful. Mr Y wrote a detailed note of surgery. Under the heading 'Indications' he wrote about the mucus discharge and that all conservative measures had failed. He wrote 'lengthy counselling but decided [on] proctectomy[8]'. The note shows that a vascular surgeon attended theatre at 6.20pm to advise. This note has been carefully considered by the Ombudsman's clinical adviser as part of her review.

Late 26 July 2011 and after

27. Mr B was taken to ITU. He showed some signs of recovery but deteriorated on 29 July. He underwent further surgery that evening but never recovered and died on 1 August.

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[6] colloquially known as blood poisoning

[7] High Dependency Unit / Intensive Therapy Unit

[8] surgical removal of the rectum

28. Ms A said that on the day of surgery, ITU staff phoned her at about 9.00pm to tell her that Mr B had just been brought up after surgery. She was told he had had long surgery, was comfortable, but would be intubated[9] overnight. Ms A said she phoned several times while Mr B was in ITU. She was given no information about the operation. On Wednesday evening (27th), she was told that there were complications; his oxygen levels were low and there were concerns about his blood pressure. She visited Mr B on Thursday (28th). Mr B asked her 'am I dying'? But Ms A said no; she thought he was in the process of recovery. Ms A said she later found out that when she saw Mr B that day, he knew the operation had been a failure as Mr Y had spoken to him. However, she remained unaware of what had happened during surgery; no-one had told her.

29. On Friday morning (29th), Ms A saw the ITU consultant who told her that Mr B was critically ill and that the surgery had gone wrong – the biggest part of the day had been spent repairing damage done, and the proctectomy had not been done.

August 2011and after

30. Ms A met with Mr Y and the colorectal nurse specialist. (I have not seen a note of this meeting.) Ms A said that Mr Y explained why the operation had gone wrong. He had cut into the bowel on the first incision. He had opted to remove that portion of the intestine as it was impossible to repair. He then started with the proctectomy but discovered that the rectum had turned into a solid mass. They called a vascular surgeon to have a look, and they agreed that the proctectomy would not be possible. Mr Y was asked about bowel preparation prior to surgery. Mr Y said he never did this as research had shown it made no difference. Ms A asked why no pre-operative scans had been done.

31. Ms A complained to the UHB on 14 August 2011. In her letter, about Mr B's symptoms, she wrote '[the mucus discharge] caused discomfort and embarrassment he was very self-conscious'. She went on 'He went into hospital without any health problems, he just wanted a bit of comfort.'

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[9] insertion of a tube to assist with breathing

32. The UHB sought the view of Mr Y and replied on 9 November. The covering letter said 'The investigation has concluded that [Mr Y] fully discussed the risks and benefits of proctectomy with [Mr B] and [Mr B] was keen to undergo the surgery.' Under the heading 'Contributory factors' the report included 'The operation and risks were fully discussed with [Mr B] and it is documented in the notes that all possible outcomes were discussed, apart from the risk of dying. However [Mr Y] did not feel that it was sufficiently likely in this case.'

33. Under the heading 'Root Causes', the report included '[Mr Y] thought long and hard about whether to proceed, but [Mr B] was very keen to go ahead, this was demonstrated by the fact [Mr B] was in regular contact about when the operation would be done.' However, in an e-mail on 3 November, the Clinical Director for Surgical Specialities had written 'I am truly not happy with the management of this case by [Mr Y].'

Summary of professional advice

34. My Adviser's views are set out at Appendices 1(a) and 1(b). In summary, her views are that:

- the surgery was extremely difficult, but proctectomy was the only surgical solution for Mr B's on-going symptoms;
- it would have been appropriate for Mr Y to seek a colleague's opinion before proceeding to surgery;
- there is no evidence of detailed pre-operative discussion with Mr B, and the risks associated with the surgery, including death, should have been emphasised to him. The other risks included multiple enterotomies[10], bowel resection, short bowel syndrome, haemorrhage, peritonitis, damage to the mesentery and subsequent bowel ischemia, fistula formation, infection, septicaemia, hernia formation, all relative to the actual abdominal procedure. There were also systemic risks of anaesthetic, including DVT, chest infection, pulmonary emboli, and relative risk of death;

[10] holes in the bowel

- the surgery was not essential, and there was no sign of cancer although Mr Y has suggested this as a reason for persevering with a colectomy[11];
- a second opinion should have been sought earlier during the surgery, and the surgery could have been stopped sooner in the face of the problems encountered; and
- the surgery could possibly have been approached through the perineum with less risk.

Additional comments from the UHB

35. My investigator sent the clinical advice at Appendix 1(a) to the UHB to consider. In response, Mr Y commented that his clinic letter of 26 January 2011 evidenced the 'long and detailed consent process'. Also, that the doctor who took Mr B's consent (on 25 July) spoke at length to him about it, and Mr Y had reminded Mr B of the 'potential difficulties' on the morning of surgery. Mr Y acknowledged that with the benefit of hindsight it would have been sensible to have included death on the consent form. He had not recognised there was a significant risk of death which was an error. However, this was a 'quality of life' operation and he had attempted it on the basis that if problems arose he would withdraw and preserve life.

36. Mr Y said that a colectomy was performed as there were too many injuries and repairs to leave the colon there. Further, if Mr B were to develop a cancer, future operations would be near impossible. Mr Y maintained that he had made the best clinical choices on the day. He said that 'no colorectal surgeon would have contemplated a perineal approach for this operation' as suggested by my Adviser.

37. However, the Clinical Director for Surgical Specialities at the time viewed my Adviser's report as balanced. The consent process as set out by Mr Y had not been documented. He said that prior to surgery he would have undertaken sigmoidoscopy[12] and scans to establish operability, and would have first discussed the surgery within a colorectal multi-disciplinary forum. He would have approached the

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[11] surgical removal of the colon

[12] a procedure where a doctor looks into the rectum and lower colon using an instrument called a sigmoidoscope

surgery from the perineum to avoid some of the problems Mr Y encountered. He added that many experienced surgeons would have abandoned the procedure at an earlier stage.

38. Having seen a draft version of this report, Mr Y wrote to me expressing regret if he had appeared defensive or resistant to my findings. He explained that he had learned lessons for his future practice about obtaining consent from patients and about the need for caution. He remained of the view that he could not have stopped the surgery sooner without unacceptable risk to the patient, and that a perineal approach to surgery was not appropriate.

Analysis and conclusions

39. In reaching my findings I have taken account of all the evidence, including the views of Ms A and Mr Y (including his views on the draft version of this report), and I have been guided by the views of my Adviser.

Consent: that the extent and risks of surgery were not fully explained prior to Mr B giving his consent to it.

40. There is significant disagreement about the level of information provided to Mr B about the surgery. According to Ms A, he understood it to be a fairly straightforward operation with just the 'normal' risks of infection. Mr B had previously had successful surgery and it is reasonable to assume that this would have encouraged him to have an optimistic view of further surgery.

41. Mr Y has said that there was a 'long and detailed consent process'. The only record of consent was the consent form itself. The risks included on the form are very limited. Mr Y has acknowledged that he had not recognised death as a possible risk of the surgery. The colorectal nurse specialist has written that she had made Mr B aware that surgery was a major undertaking but that he was determined to undergo surgery despite the risks. She does not identify those risks. The colorectal nurse specialist wrote this almost a year after Mr B's death, having made no similar contemporaneous record.

42. Mr Y has pointed to the fact that Mr B was pressing for surgery by contacting his secretary for a date. I am not persuaded by this. There are no records to support this, and Ms A has offered an entirely reasonable explanation for the one enquiry he did make.

43. There were limited opportunities for Mr B to discuss the surgery as he had only one consultation with Mr Y prior to his admission. Ms A was present at that consultation and reports that Mr Y gave very little information about the extent of the surgery or the risks. Mr B had a routine appointment with the colorectal nurse specialist, but nothing of note was recorded. Mr B gave his written consent on the evening prior to surgery, but Ms A's account is that it was not until the following morning that Mr B understood the magnitude of the surgery he had agreed to.

44. I conclude that Mr B was only made fully aware of the extent of the surgery shortly before he was taken to the theatre. I also conclude that he was not made aware of all the potential risks involved. Given that Mr Y had worried 'quite a lot' about the operation over many months, it is deeply concerning to me that Mr B did not know exactly what he was consenting to. Mr B went into major surgery, which ultimately led to his death, without having been fully informed or being in a position to give proper consent. That is a major injustice. I **uphold** this complaint.

Surgery:

i. **there were insufficient investigations and bowel preparation prior to surgery; and**
ii. **the surgery was not appropriate particularly given the difficulties encountered during previous surgery in 2007.**

45. Ms A complained about the absence of investigative scans or x-rays prior to the decision for surgery. She also questioned what bowel preparation was done and was concerned about Mr Y's claim that bowel preparation was not necessary. The Adviser has confirmed Mr Y's view that no bowel preparation was required prior to surgery.

46. There is divergence of opinion about whether pre-surgery investigations were needed. Mr Y did not undertake any. My Adviser

has said that they were not necessary. However, the Clinical Director for Surgical Specialties at the time has said he would have undertaken a scan and sigmoidoscopy. The Clinical Director has also commented that he would have discussed the case within a colorectal multi-disciplinary team forum prior to surgery. My Adviser agrees that a second opinion should have been sought. While I **do not uphold** this part of the complaint as put, it seems to me that Mr Y should reflect upon the views of more experienced clinicians.

47. I now turn to the matter of whether the surgery was appropriate. Ms A believes the operation was simply too risky especially as it was for symptom control only. There is disagreement about the severity of Mr B's symptoms and his ability to cope with them. Ms A has agreed that he did suffer with rectal discharge but she said that it was manageable, especially in comparison to the severity of his symptoms prior to the 2007 surgery. However, Mr Y, Mr Z and the colorectal nurse specialist have each separately documented that he was suffering badly with unpleasant symptoms.

48. My Adviser has confirmed that the surgery was the only solution to his symptoms. (Of course, the option remained of continuing with non-surgical management of symptoms.) The decisions facing Mr Y were first, whether the symptoms were so bad as to merit surgery, and second whether the surgery was feasible. Mr Y has explained that he believed Mr B's symptoms were affecting the quality of his life. He has said that he gave the matter very careful thought before concluding that surgery was a reasonable and viable proposition. In his letter to the coroner, Mr Y has said that, with hindsight, the decision to operate was potentially a poor one.

49. An important factor in Mr Y's decision to operate would have been the knowledge from the 2007 surgery. He has described the operation as extremely challenging, and at that time wrote that excising the adhesions in the pelvis gave rise to an unacceptable level of risk. Given that the adhesions would not have improved, I do not know why Mr Y changed his mind about this. He has also acknowledged that he did not identify death as a possible outcome. In fact, a number of risks listed by

the adviser do not seem to have been identified by Mr Y or by the doctor who took Mr B's consent.

50. Mr Y approached the surgery through the abdomen. I understand that he did this in order to achieve Mr B's wish of re-siting the colostomy. However, in my view, re-siting the colostomy would have been a bonus, secondary to safe proctetomy. My Adviser and the Clinical Director at the time have commented that Mr Y could have considered approaching this surgery through the perineum. This would have carried less risk. I am concerned that Mr Y has been dismissive of this view, he has said that 'no colorectal surgeon would have contemplated a perineal approach'. My concern is that there is no evidence that Mr Y even considered or evaluated a perineal approach as an option, particularly given that the primary aim of the surgery was not to move the stoma. Both doctors also agree that the surgery should have been stopped at an earlier stage.

51. In reaching a view, I have to put myself into the position Mr Y faced at the time, and discount what we have learned with hindsight. In doing so, I cannot help but lean to the conclusion that the surgical option, with all the potential difficulties known to Mr Y who had conducted the 2007 surgery, was too risky for symptom control only, unless Mr B himself had wished to proceed on a fully informed basis. My Adviser has explained how complex the surgery was and has said that she would have advised Mr Y against it.

52. I acknowledge Mr Y's good intentions in aiming for a good result for Mr B. He clearly also thought carefully about the operation and thought it was achievable. However, I think that he was acting at the limit of his skills. On balance, I conclude that the operation bore too many risks, that Mr Y could have sought the view of colleagues beforehand, and could have considered approaching the surgery in a different and potentially safer way. I therefore **uphold** this complaint.

Information post-surgery – Ms A complains she was not told of the outcome of the surgery until Mr B deteriorated on 29 July 2011.

53. There is no disagreement here. Ms A was not told that the surgery had been unsuccessful until the ITU doctor explained this to her on 29 July. It would have been good practice for Ms A to have to been told before this, and I therefore **uphold** this complaint. However, I accept Mr Y's contention that given Mr B's initial signs of recovery he intended to explain later what had happened at surgery.

Other issues

54. In responding to my Adviser's written opinion, the UHB presented me with two opposing views, those of Mr Y and of the Clinical Director. That is not acceptable. It was incumbent on the UHB to determine and present me with its organisational view on the matter, along with any remedial action it intended. The UHB has shirked its responsibility to tackle potentially difficult issues. I expect, in future, to receive corporate and senior responses to matters which I and my staff raise.

55. I was concerned to note Mr Y's resistant and defensive attitude to my investigation and to my Adviser's views, until the time I issued my report in its draft format. I would have expected him to have demonstrated at an earlier stage what he had learned from his experience of undertaking this surgery and from the views of more experienced clinicians. Mr Y seemed disinclined to believe he had anything to learn. In light of that, I initially decided to send a copy of this report to the GMC (the body which regulates doctors). However, in light of the recent comments made by Mr Y, I have decided that he has demonstrated some acceptance of, and learning from, the key parts of my findings, and I therefore have some assurance that his future clinical practice will be safer.

Recommendations

56. I **recommend** that within one month of the date of the final version of this report the UHB:

(a) offers Ms A a fulsome apology for the failings I have identified in this report;

(b) pays Ms A the sum of £5,000 for the distress caused by the failings identified, and to acknowledge the uncertainty she lives with over whether Mr B might have lived;

(c) reminds Mr Y of the importance of the consent process, of the need to identify and discuss all the relevant risks, and to document the consent process.

(d) arranges for Mr Y to consider the issues raised in this case and the learning points that arise. Personnel matters are not within my jurisdiction, but, for example, Mr Y could complete a piece of reflective writing with regard to the learning points from this case and discuss this with his appraiser. The competed appraisal documentation might identify learning and development objectives which arise and how they could be met, and whether Mr Y should restrict his practice in the future. The UHB could also consider whether Mr Y should operate jointly with another consultant surgeon for an agreed percentage and type of case, taking account of the issues raised in this case.

57. 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 28 March 2013

Appendix 1(a)

Clinical Adviser's Name and Qualifications:
Miss P Durning, BSc, MBCHB, FRCS, MD

Relevance of qualifications and/or experience to clinical aspects of this case:
I am P Durning, a consultant general surgeon with many years experience of colonic surgery and its complications. I am confident to advise on this case.

Conflict of Interest (clarification of any links with Body or clinicians complained about):
I have no conflict of interest.

Documentation Reviewed
I have read the complaint, the medical records provided, the Health Board files and response, and the statement by Mr Y. I am also in receipt of the Ombudsman's case file.

Background and Chronology
Mr B had surgery for a low rectal tumour in August 1999 with reconstruction surgery at that time. In October 2007 he was referred back to the Abertawe Bro Morgannwg University Health Board where he saw Mr Y, Consultant Surgeon. Following surgery he had suffered with increasing degrees of urgency and faecal incontinence. He had reached a stage where his life was difficult to live because of these symptoms and it was felt that, although surgery would be difficult, he could be helped by excision of the rectum and formation of a colostomy. On 26/7/11 Mr B underwent a laparotomy with a view to excision of the rectum and repositioning of a colostomy but unfortunately this operation proved very difficult and despite going to the ITU he died on 1/8/11.

Ms A (Mr B's partner) has complained to the Health Board about many aspects of his care and management but remains dissatisfied by the response and has referred her complaint to the Ombudsman.

Chronology

19/8/97 Pre-operative radiotherapy for a low rectal carcinoma followed by low anterior resection with an anastamosis[13] 2cms above the dentate line[14] and formation of a defunctioning ileostomy[15].

30/8/97 Discharge, no post-operative complications.

27/10/07 Laparotomy[16] and division of adhesions and a formation of an end colostomy. Mr B had struggled and tried every conceivable conservative manoeuvre to control his faecal incontinence. It was beginning to have a "gigantic impact" on his life. At operation adhesions were noted to be excessive. He made a good recovery following this surgery and continued on follow up.

8/6/09 Appointment with the stoma care nurse for follow up, records "difficulty with rectal discharge".

4/11/10 Offensive rectal discharge and bleeding per rectum. Rectal examination and sigmoidoscopy performed. No evidence of recurrent tumour.

26/1/11 Operation - laparotomy, proctectomy[17] and mucosectomy[18] with intersphincter dissection, revision of colostomy ?ileostomy was agreed. Referral for preassessment, "no adverse co-morbidities and note that this gentleman had suffered from Gullain-Barre Syndrome which is a cardiac irregularity on two occasions in the past".

25/7/11 Consent taken for operation noted above by the Associate Specialist. Risks and complications noted include bleeding, wound

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[13] Surgical connection

[14] The border between the rectum and anus

[15] Where the ileostomy is designed not to function for a temporary period

[16] A large incision through the abdominal wall

[17] Surgical removal of the rectum

[18] Surgical removal of the mucosa, the innermost layer of the colon

breakdown, post-operative sepsis, HDU/ITU. The anaesthetic chart records the operation started at 9:30 hrs and did not conclude until 19:30 hrs. It also records that during the course of the operation, six litres of crystalloid fluid was transfused and three units of blood. Immediate post-operatively haemoglobin was 14.6. The operation note records lengthy counselling.

26/7/11 The operation note shows x4 enterotomies in small bowel before entering peritoneal cavity. Multiple enterotomies repaired throughout but one badly damaged section of small bowel was excised and anastomosed[19] with its mesentery[20]. Decided to do total colectomy ?reason,?metachronous tumour[21]. After completion of the total colectomy attempts to enter the pelvis to proceed with rectal excision record "pelvis concrete". A vascular surgeon was asked for assistance and conjoint decision not to proceed with further surgery was made. An endileostomy was performed, peritoneal cavity was washed out and a generalised persistent ooze was noted. Drainage tubes were inserted and the patient was transferred to the Intensive Care Unit.

28/7/11 The patient was extubated.

29/7/11 Supraventricular tachycardia[22] noted. Resuscitation in place, blood gases show lactic acidosis[23].

> '10:45hrs significant deterioration, exploratory laparotomy performed, small bowel perforation identified at site of previous enterotomy. Washout ++ and closure.'

30/7/11 Further concerns as to potential ischaemic bowel. Family informed of poor prognosis.

31/7/11 Further deterioration but further surgery not indicated.

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[19] joined together

[20] small bowel mesentery anchors the small intestines to the back of the abdominal wall. Blood vessels, nerves, and lymphatics branch through the mesentery to supply the intestine

[21] this would mean a second deposit of cancer appearing at another time in the future

[22] rapid heart rate

[23] lactic acidosis is when lactic acid builds ups in the bloodstream faster than it can be removed. Lactic acid is produced when oxygen levels in the body drop

1/8/11 ITU doctor spoke to the family at 08:00hrs.
09:30hrs: patient certified dead. Post mortem report:

Death certificate:
1a. multi organ failure
1b. peritonitis.
1c. elective proctectomy.

(This is not strictly correct in that the operation did not proceed to an elective proctectomy.)

Questions and Responses
In answer to the investigator's questions:

1. *What were the risks of surgery, especially given knowledge from the 2007 surgery?*
The main risks of the procedure Mr B embarked on were adhesions leading to peri-operative perforation of the bowel referred to by Mr Y as multiple enterotomies, more simply holes in the bowel, bowel resection, short bowel syndrome, haemorrhage, peritonitis, damage to the mesentery and subsequent bowel ischemia, fistula formation, infection, septicaemia, hernia formation, all relative to the actual abdominal procedure. There were also systemic problems re anaesthetic, DVT, chest infection, pulmonary emboli, and relative risk of death.

2. *What information should Mr B have had to make an informed decision?*
Given that the surgeon was aware of the magnitude of adhesion formation, all of the above including death should have been included in a discussion of consent.

3. *Do the records contain an adequate level of information about what Mr B was told?*
I find no record in the case note of a pre-operative discussion with Mr Y and Mr B. The consent form simply refers to bleeding, wound breakdown, and sepsis, ?ITU/HDU.

4. *Was the timing of taking his consent appropriate? Who should have done it?*

When Mr Y agreed to perform surgery on Mr B I would have expected that the operation was explained in graphic detail, almost over-emphasising the potential side effects or problems. It was appropriate for his assistant who was experienced in GI[24] surgery and had knowledge of Mr Y's technique, to take consent and answer any further questions Mr B might have. I would have expected that the surgeon had explained to him in outpatients some of the above, if not all of the above complications prior to accepting him for surgery. Mr Y says that the colorectal nurse was with him in some of the discussions.

5. *Would additional clinical investigations have aided the decision-making process?*

No. The decision to operate was on the basis that the discharge from the colorectal stump was such that his quality of life was significantly impaired and it was Mr B's decision to proceed on a quality of life basis that was the indication for surgery, not the possibly of further recurrent cancer.

6. *What bowel preparation was undertaken? Was this appropriate and effective?*

I do not think that any particular bowel preparation was undertaken or indeed relevant.

7. *Was surgery appropriate particularly (a) in light of the experience of surgery in 2007 and (b) for symptom control?*

The only surgery to help in this situation was the proctectomy. It might have been feasible to do a perineal dissection of the rectum to good effect without transgressing the peritoneal cavity at all. This could have led to sinus formation[25] and perianal sepsis but these would have been lesser side effects than the abdominal procedure which was undertaken. Mr B had already had the bowel transsected and a colostomy performed during which many dense adhesions were encountered. Mr B also wanted the colostomy resited and I think this is why Mr Y adopted the

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[24] gastro-intestinal

[25] wound sinus is a late infectious complication from a deep chronic abscess that can occur after apparently normal healing

approach he did but once the operation had started the adhesions were significantly worse.

8. *Was the operation performed to a reasonable standard?*
The clinical operative scenario he was faced with is one of the most difficult. Each step seems to cause more problems. I am still very unsure why Mr Y proceeded to do a total colectomy. It would seem from the operation note he justified it by his question of metachronous carcinoma. This would mean a second deposit of cancer appearing at another time in the future. The histology, however, did not show any sign of cancer in the colon. There was perforation of the splenic-flexure but the time and extension of the procedure to do this seemed unnecessary to me. I cannot see what positive effect removing the colon would have in preventing small bowel obstruction which was also referred to as a possible reason for doing this in Mr Y's statement.

9. *Should Mr Y have stopped the surgery at any earlier point?*
It is very easy to say yes in answer to this question but having embarked on the procedure there is often no exit other than completion which would be safe. The first cut actually made a hole in the small bowel.

10. *Should information about the unsuccessful outcome have been shared more promptly with Ms A?*
It would have been better to inform Ms A about the complexity of the procedure as soon as possible after the patient went to ITU.

11. *Does the content of the investigation report appear thorough and evidence-based?*
The investigation report seems to be based solely on Mr Y's statement. Statements from the colorectal nurse, anaesthetist and surgical assistant were not included.

Comments
Perineal dissection of the rectum, which I have referred to above, refers to removal of the back passage from outside and closing the skin over the hole. It is very easy to be critical after the event in such a difficult surgical case. I am sure that the surgeon wishes that he had not taken this case on. There was no evidence of recurrent or metastatic

malignancy which would have made surgery mandatory. I think that from the surgeon's statement I would have stopped the procedure. I can see no reason to plough on to do a total colectomy. He did ask for help from the vascular surgeon before proceeding with the pelvic resection and was advised to stop. I have found no evidence in the notes of detailed pre-operative discussion but the statement refers to discussions in the presence of the nurse specialist but without documentary evidence I cannot comment further.

Appendix 1(b)

Additional Clinical Advice

Response to Mr Y's comments

The clinic letter to which Mr Y refers (of the clinic appointment on 26 January 2011) is a medical and very technical letter to the general practitioner, not documentary evidence of what was said to the patient. He seems to assume because he, the surgeon, knew the patient's history well, that the patient understood what was involved. He may feel that everything that needed to be said was said, but there is no documentary evidence of this.

He stated in his response that the reasons he took out the colon was because he felt he had breached the mesentery which would mean he had damaged the blood supply to the colon and that if he were to allow the bowel function to be maintained through the colon it may add back pressure to the many repairs he had performed in the small bowel. The use of an ileostomy is the preferred option these days because of such considerations regarding the fluid content of the bowel at the level of the ileum and the pressure scenarios. He's obviously giving 3 reasons why his judgement call to extend surgery by removing the colon was necessary. However, I simply raise the point that there were options with regard to the colonic resection as conceded by Mr Y.

The Clinical Director at the time has understood the tenor of my response [Appendix 1(a)], which was not *per se* criticism but has questions for the surgeon to reflect on with regard to 1) the consent documentation in relation to good surgical practice and 2) were other procedures possible or necessary during such a difficult procedure and were other options open to the surgeon. I suggested perineal proctectomy as one possibility. I had no way of assessing the feasibility of this procedure, or the length of the colon. The Clinical Director quite rightly suggests other investigations could have been done pre-operatively and again, quite rightly, notes that this type of procedure may well have been more difficult because the patient had previously had surgery then small bowel loops could have been fixed in the pelvis, which indeed they were. I would agree with the Clinical Director that this operation was done for quality of life issues. Mr Y knew that this was

going to be an extremely difficult procedure. I personally would have tried to dissuade him and it would have been very appropriate to take a second opinion before proceeding to surgery as suggested by the Clinical Director. I also feel that he should have requested a second opinion much sooner in the operation.

I agree that his was indeed a unique case and a very difficult surgical procedure. Having made a hole in the bowel on entry into the abdomen the die was cast to deal with at least the small bowel adhesions and closure of any bowel damage. I believe that a more experienced surgeon would have asked for help sooner or abandoned the procedure.

Appendix 2

Extracts from Mr Y's statement to the coroner

1. …

2. [In 2007] the main problem for Mr B was urge and incontinence. Obviously this was difficult to live with. I explained to Mr B at the time that I felt that surgery would be difficult, but that we could perform a colostomy … .

3. This operation was technically demanding. Following [the] operation 10 years previously, Mr B had developed terrible adhesions. ... Overall this operation … was somewhat technically unsatisfying but I am pleased to say that afterwards proved to have been a success and Mr B was certainly glad to have a colostomy, rather than his incontinence and urge problems.

4. Mr B was under the radar of our colorectal specialist nurses … and we became aware that he was still getting nasty symptoms associated with his rectal stump. I was surprised by this because long rectal stumps, as I had been forced to leave in the operation of 2007, seldom give bad symptoms but this was not the case for Mr B and despite my best efforts in 2007 I did wonder whether we had rendered the rectal stump somewhat ischaemic. The majority of Mr B's symptoms were associated with forming copious mucous. Over time mucous inspissates, which means it becomes solid and putty like and [Mr Z], my Associate Specialist colleague, found copious inspissated mucous when he sigmoidoscoped the rectal stump in November 2010. He handed this over to our colorectal specialist nurses and hoped that irrigation of the stump might again improve Mr B's quality of life but unfortunately despite their intervention he went on to have persisting problems with horrible offensive mucous discharge of which he had no meaningful control and got to the point where he was unhappy when he left the house, and somewhat fearful so to do. We naturally encouraged him to keep active and with the help of his caring partner, [Ms A], managed to cope reasonably.

5. [Mr Z] referred [Mr B] back to consider “proctectomy”. This would be removing what was the neorectal stump and hope that this improved his quality of life. Mr B was very enthusiastic to take this course of action despite being told initially by Mr Z and then subsequently by myself that such a surgical undertaking was not without risk and it would be difficult to guarantee that even this major undertaking would solve his problem. ... I had thought long and hard about whether this operation would be technically achievable bearing in mind what I had found 4 years previously. … I felt that there was a reasonable chance that I would be able to effect haemostatically safe [not causing bleeding] dissection close to the wall of the bowel and remove all of the offending stump. Also, it would have given us the opportunity to move Mr B’s original colostomy, which had necessarily been placed rather higher than I had hoped would be possible in 2007.

6. I had worried quite a lot about Mr B’s operation over many months and he had phoned my secretary a few times wondering when this operation could be performed. He had also been in touch with our colorectal specialist nurses asking the same question.

7. Eventually I had the opportunity to operate and had left myself the full day to do this operation, anticipating that it would be challenging. I … counselled Mr B on the morning of his surgery about what I felt might be the difficulty of his procedure. Never did I anticipate that he would end up dying. The reason that I did not think that it was likely that he would die was because I was deliberately planning to steer well clear of danger and do no form of radical excision. This was purely a functional operation designed to improve quality of life.

8. Mr B accepted that the operation would be difficult and that he might end up with an ileostomy if I had felt it was appropriate to remove the colon … .

9. …

10. Mr B had an entirely standard surgical approach to his problem in that we re-opened the midline laparotomy incision. … we were especially cautious when we used the scalpel to enter the abdominal

cavity. The very first cut that we made (you have to start somewhere) entered the lumen of the small bowel. This was unwelcome in the extreme and both [the Surgical Assistant] and myself recognised that we were in for a challenging day. The operation which Mr B endured lasted 9½ hours. It took many hours simply to re-establish a peritoneal cavity. The adhesions, as feared, but even worse than expected, were dense and surgically unforgiving. During the attempts to free the small bowel from the pelvis a number of holes were made in the small bowel and most of these were repaired primarily. Some of the holes just involved the muscle coat and some were full thickness into the lumen of the bowel. In one area the small bowel was damaged to such a degree that I had to respect it and performed a primary anastomosis.

11. [The Surgical Assistant] and myself discussed what we felt was the correct way to proceed, bearing in mind that the bowel had been multiply damaged and we elected to perform a colectomy. The principal reason to do this was that we needed to ensure that the small bowel would not be obstructed post op. Obstruction of the bowel can cause pressure to build on any of the suture repairs that we had made or even the anastomosis and these could have leaked and led to Mr B's deterioration. We removed the colon and planned for ileostomy as we had talked about with Mr B during the consent process. The colon has now been returned from the histopathology department and unsurprisingly shows no pathological changes. In addition this was a convenient way of resiting the stoma, which was the secondary purpose of the operation.

12. Eventually (more than 6 hours into the operation) we had freed the bowel completely from the pelvis and only at this stage did we discover that there was no sign of a rectal stump. This was extremely surprising to me bearing in mind that I myself had done the operation in 2007 and the stump had been long. Really the only explanation for this is that fibrosis, inflammation and probably ischaemia led to the stump contracting and forming dense inflammatory tissue within the pelvis. I could find no dissection plane at all to offer a route into the pelvis.

13. At this stage I became anxious that if I "ploughed on" and found myself in the wrong plane, whilst trying to dissect the neorectal stump free that I could have caused a vascular injury … . Bleeding from the internal iliac vein can be very difficult to control and particularly in this case when the pelvis was effectively frozen bleeding would have been fatal. I asked for … a Consultant Vascular Surgeon … to attend the operating theatre and he … joined me in the operating room and agreed that it was unsafe to attempt to complete the operation and perform the proctectomy as we had promised Mr B. …

14. With a heavy heart we decided to finish the operation and sorted out haemostasis and checked that all of the repairs in the small bowel were intact. We also made every effort to ensure that there were no kinks or remaining adhesions which could have obstructed the small bowel in the days following surgery.

15. He was returned to the ITU and initially made a good recovery. I was able to discuss the operative findings with Mr B [who] … seemed to understand what we discussed. In subsequent discussions with [Ms A] …, I have been criticised for not having this discussion with her and I have apologized for this, but there was no way that we could have anticipated that he would die and normally these discussions would have taken place at a later date.

16. On the 3rd post operative night Mr B became unstable and had multiple episodes of supraventricular tachycardia. … After a few hours we realised that there must have been a cause within the abdomen and he was returned to the operating theatre.

17. In the operating theatre I discovered that he had biliary peritonitis. One of the small enterotomy repairs had given way. I could see that the knot was intact but it had cut through. The reason for this appeared to be that, despite our best efforts, Mr B's bowel had become obstructed. The obstruction was between the anastomosis and the ileostomy and again seemed to be adhesive. To have had obstruction from an adhesion so soon after an operation is virtually unheard of. I was as pleased as I

could be to see that there appeared to be no technical reason for this. We repaired the hole in the small bowel and the abdominal cavity was washed out with copious water washout until dry and clear. …

18. Mr B was returned to the ITU and at this time we were still hopeful that he may recover from this second insult. Unfortunately over the weekend despite throwing every possible intervention Mr B's way … [he] never recovered consciousness and finally died around 0930hrs on Monday 1st August 2011.

19. I believe that after the decision had been made to operate on Mr B that everything in our power was done in order to get him through. I do not believe that we made any poor decisions, except perhaps to operate in the first place and this could only be known with the benefit of hindsight. Everything was done with Mr B's safety and survival in mind and I am afraid that this has to go down as one of those cases where surgery was genuinely impossible and the insult of trying to perform that surgery was unsurvivable.

20. I am very saddened by this case and spoke with … [Ms A] on 17.08.2011 to explain what happened. For this discussion I was accompanied by [the] colorectal specialist nurse and [Ms A] had a nursing advocate of her own. Both were extremely helpful. She had many concerns, most particularly regarding the decision to operate in the first place. Quite reasonably she intimated that if Mr B had been told that there was a significant risk of death, he would have walked away without surgery. She may be correct in this and I do admit that I did not tell [Mr B] that he had a high likelihood for death, because I did not think that this was true at the time. I did have to remind [Ms A] that [Mr B] himself did pursue us in order to go through with his operation and not the other way around.

17 August 2011