Investigation Report

Investigation of a complaint against the South Eastern Health and Social Care Trust

NIPSO Reference: 201916053

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

Case Reference: 201916053

Listed Authority: South Eastern Health & Social Care Trust

SUMMARY

I received a complaint about the care and treatment provided to a patient who needed surgery to remove gallstones that were causing abdominal pain. The patient, the complainant's wife, was admitted to hospital with severe abdominal pain on two occasions, June and then July 2018. On the first occasion, to the complainant's surprise, the patient was sent home after a week *'even though she was still unwell'*. The gallstones were removed on the second occasion. However, within hours of that procedure it was discovered the patient had a perforated bowel, a serious development which sadly led to the patient's death several weeks later. The complainant sought reassurance that the perforated bowel had not been missed or, worse still, caused by a failure in the care and treatment provided to his wife.

The investigation examined the details of the complaint, the Trust's response, clinical records and relevant guidance. I also sought advice from an independent consultant in emergency medicine, a consultant radiologist and a consultant gastroenterologist.

My investigation found that the care and treatment provided to the patient in June was reasonable. In relation to the July hospital admission, I found no evidence that the patient presented with clinical signs and symptoms which should have alerted the medical teams to an impending bowel perforation. Neither did I find evidence that the subsequent procedure to remove the gallstones caused the perforated bowel.

However, I found that record-keeping by the hospital emergency department (July admission) was illegible and scant and fell short of required standards. I was therefore unable to determine the extent to which other possible causes of the patient's abdominal pain were considered in that department. I found no evidence that a radiologist report, produced after the patient presented at hospital, was

discussed which I deemed to be a failure. The report made no reference to impending bowel perforation but it did flag up abnormalities with the patient's bowel. I found that an examination of the patient the day after admission (in July) introduced findings which made the clinical picture less clear regarding the source(s) of abdominal pain. I found this was a potential opportunity to have considered an alternative diagnosis. On balance, I considered it was a failure that those findings were not discussed, at least with the radiologist.

I considered these failures in care and treatment caused the complainant to experience the injustice of uncertainty and anxiety over whether the outcome may have been different had they not occurred; and the injustice to the patient of a loss of opportunity to have the impending bowel perforation diagnosed sooner.

I recommended that the Chief Executive apologised to the complainant in writing for the failures identified. I also recommended that the Trust's ED and Gastroenterology medical teams were fed back the findings of this report to reinforce the importance of adequate record-keeping and discussion between professional colleagues when diagnosing signs and symptoms of abdominal pain. More generally, I recommended the Trust highlighted this unusual case in the ongoing training of medics, including reminding medics of the importance of documenting their attendance and assessment of patients, as well as any examination findings and outcomes.

THE COMPLAINT

1. I received a complaint about the actions of the South Eastern Health & Social Care Trust (the Trust). The complainant said that, in July 2018, his wife (the patient) was found to have a perforated bowel soon after being admitted to hospital with severe abdominal pain. The complainant said he learned that his wife had a perforated bowel a matter of hours after a procedure was carried out to remove known gallstones which were identified during a previous hospital admission in June 2018. Noting this recent history, the complainant was concerned as to whether signs of an impending perforated bowel were missed or, worse still, the eventual perforation was directly caused by the subsequent procedure to remove the gallstones.

Background

2. In April 2018, the patient was diagnosed with stage one lung cancer and was awaiting treatment. The patient was in her eighties and had various other chronic conditions which impacted on her health.

3. On 20 June 2018, the patient was admitted to hospital by emergency ambulance. She had severe abdominal pain on the upper right quadrant of her abdomen. The presence of gallstones was identified.

4. The patient was discharged on 28 June 2018 and scheduled to return as an outpatient on 17 July 2018 to undergo a procedure to remove the gallstones.

5. At 01:18 on 16 July 2018, the patient was taken, by emergency ambulance, to a hospital emergency department (ED). The patient had severe abdominal pain.

6. At 05:40 the patient was transferred from the ED and admitted to medical Ward 6B.

7. On 17 July 2018, the patient underwent an ERCP[1] procedure which resulted in the removal of gallstones by a consultant gastroenterologist.

8. At 09:25 on 18 July 2018, the nurses noted the patient had abdominal pain. Emergency surgery revealed a perforated bowel which I am aware can lead to serious complications even for a young and otherwise healthy patient.

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[1] Endoscopic retrograde cholangiopancreatography, is a procedure to diagnose and treat problems in the liver, gallbladder, bile ducts, and pancreas. It combines X-ray and the use of an endoscope—a long, flexible, lighted tube.

9. Tragically, the patient passed away on 19 August 2018.

Issues of complaint

10. The issues of complaint accepted for investigation were:

    Issue 1: *Whether the care and treatment provided to the patient at hospital between 20 and 28 June 2018 was appropriate and reasonable.*

    Issue 2: *Whether the care and treatment provided to the patient at hospital between 16 July and 19 August 2018 was appropriate and reasonable.*

11. Noting the emphasis of the complainant's concerns, the Investigating Officer clarified with the complainant that the investigation would focus on events up to and including the bowel perforation but would not cover the patient's care and treatment at hospital after the bowel perforation had occurred, for example, the procedure to repair the perforation or the subsequent aftercare.

INVESTIGATION METHODOLOGY

12. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant.

Independent Professional Advice Sought

13. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):
    - ED IPA, MD, MRCP, FRCSEd, FRCEM, FFICM; a consultant in emergency and critical care medicine. The ED IPA is in his second decade in that role and has held roles with responsibility for emergency and medical services in acute hospitals.
    - Radiologist IPA, MRCP, FRCR; a consultant radiologist with 15 years of experience. He was a member of the Study Advisory Group which informed a 2020 national report on the management of acute bowel

obstruction.

- Gastroenterology IPA, MB ChB with Commendation, FRCP; a consultant gastroenterologist with over 10 years of experience in the care of comorbid[2] patients with abdominal pain, including diagnosing and managing complications.

The clinical advice received is enclosed at appendix three to this report.

14. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided '*advice*'; however how this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

15. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

16. The general standards are the Ombudsman's Principles[3]:
    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

17. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

18. The specific standards and guidance relevant to this complaint are:
    - Good Medical Practice - General Medical Council, 2014 (GMC guidance);
    - Abdominal Pain without Shock - Royal College of Emergency Medicine, 2017 (RCEM guidance);

[2] The condition of having two or more diseases at the same time.

[3] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- Royal College of Surgeons Commissioning Guide – Emergency General Surgery (acute abdominal pain), 2014 (RCS guidance); and
- iRefer Guidelines: Making the best use of clinical radiology, Version 8.0.1, The Royal College of Radiologists, 2017 (RCR guidance).

Reference to the guidance is made within the IPA advice enclosed at appendix three to this report.

19. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

20. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: *Whether the care and treatment provided to the patient at hospital between 20 and 28 June 2018 was appropriate and reasonable.*

Detail of Complaint

21. The complainant said he understood his wife was to undergo a procedure to remove gallstones during her time in hospital in June 2018. However, she was discharged on 28 June 2018 *'even though she was still unwell.'* The complainant said his wife was discharged because the bed she was occupying was needed for another patient.

22. Being aware the patient was taking *'oral Morphine[4]'* which is known to cause constipation, the complainant felt that various scans of the patient's abdomen taken in June 2018 (and in July) should have provided early warning of the impending bowel perforation.

23. The complainant said the Trust told him that the patient's bowel was *'perforated by*

[4] www.nhs.uk/medicines/morphine - 'The most common side effects of morphine are constipation, feeling sick and sleepiness.'

hardened faecal matter'. However, in an apparent contradiction the Trust also told him that scans did not identify any *'significant constipation.'*

24. The complainant wondered whether events would have turned out differently if the gallstones had been removed in June 2018.

Evidence Considered

Legislation/Policies/Guidance

25. I considered the following guidance:
    - RCS guidance; and
    - RCR guidance.

Trust's response to investigation enquiries

26. The Trust said:
    'The scans and X-rays were reviewed by Radiology and there were no signs of any impending bowel perforation. The pain caused by gallstones is usually in a different part of the abdomen from that caused by constipation. In addition, [the patient's] liver enzymes were elevated, which points towards a gallstone cause for the pain rather than constipation.'

27. The Trust said:
    '[A] Consultant Radiologist, has reviewed the imaging performed from 20 June 2018 to 18 July 2018 and provides the following response:
    - *Ultrasound abdomen 20/06/2018 - Colon is not normally evaluated by this procedure due to ultrasound being unable to visualise colon adequately.*
    - *CTPA[5] 26/06/2018- Lungs visualised and assessment for pulmonary embolism in pulmonary arteries - colon not included on this type of study.'*

28. The Trust said:
    'We have formally requested a radiology review of all [the patient's] investigations before her perforations. They have confirmed there were no specific features to suggest impending perforation, or other specific cause of

[5] Computed tomography pulmonary angiogram

concern. There was generalised faecal loading, but that is a common finding in older patients.'

Relevant Trust records

29. The following Trust records were considered:
    - Scans taken in June 2018
    - The patient's medical records covering the period 20 to 28 June 2018

Relevant Independent Professional Advice

30. The Gastroenterologist IPA advised:
    '. . . the presenting symptoms at the time included upper abdominal pain, vomiting and abnormal liver function tests. Appropriate imaging was organised as per RCS guidance including ultrasound and then the MRCP[6] scan. The MRCP scan confirmed the presence of obstructing gallstones and it was reasonable to attribute the pain to gallstones rather than the hardened faeces. Indeed there was little evidence to suggest hardened faeces as a strong differential diagnosis[7]. Hence, the diagnosis of gallstones as the cause of the pain appears to be a secure one.'

31. The Gastroenterologist IPA advised:
    'Even if a CT scan[8] had been organised at that first admission, it remains unlikely to have suggested or confirmed that diagnosis, although it may have picked up some degree of constipation. This had already been identified clinically and appropriate treatment started. Consequently, I do not believe that constipation was a significant contributory factor to the causation of the abdominal pain during the June hospital admission.'

32. The Gastroenterologist IPA advised:
    'The patient was on a relatively low dose of oral morphine sulphate 5mg twice a day. There was a mention of the patient being constipated and then having overflow diarrhoea (loose stools related to being constipated.) She was commenced on oral

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[6] Magnetic resonance cholangiopancreatography - a special type of magnetic resonance imaging (MRI) exam that produces detailed images of the hepatobiliary and pancreatic systems, including the liver, gallbladder, bile ducts, pancreas and pancreatic duct.
[7] Differential diagnosis is a process wherein a doctor differentiates between two or more conditions that could be behind a person's symptoms.
[8] A computerized tomography (CT) scan combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside your body. CT scan images provide more-detailed information than plain X-rays do.

lactulose, a type of laxative and that was an appropriate action to reduce the risk of perforated bowel.'

33. The Gastroenterologist IPA advised:
'By the end of June, the patient was making good progress with improvement of her pain symptoms and liver function tests. She was on an antiplatelet drug called clopidogrel (for her coronary heart disease) which increases the risk of bleeding and this needed to be held for 5 days prior to the ERCP. Therefore, it was reasonable to allow her home to await the procedure as an outpatient.'

34. Referring to scans, the Radiologist IPA advised:
'The crucial sign to alert towards bowel obstruction is the dilatation[9] of the bowel upstream and a limit of 10-11cm in the right colon is commonly accepted as a threshold where perforation may occur.
It is important to understand that the imaging does not necessarily represent stand-alone facts, but vitally depends on the clinical context for interpretation.
In some patients a dilated bowel is normal for them, in others it can signify a developing problem. Adequate clinical information is crucial for the correct interpretation.'

[9] The state of being expanded or widened; specifically, the condition of being stretched or enlarged beyond normal dimensions.

35. The Radiologist IPA advised:
'None of the imaging undertaken in June demonstrate constipation or bowel dilatation and the patient did not exhibit any signs of either, in fact [the patient] was documented to have diarrhoea on the first admission. While there may be paradoxical "overflow" diarrhoea in severe constipation, this is ruled out by the normal appearances of the bowel at that time.'

Other information considered

Complainant's response to the draft report

36. The complainant said he was not happy with the Ombudsman's findings in relation to the June hospital admission but he indicated he would accept them. He said he believed that if the gallstones had been removed in June, this may have assisted with earlier identification of the bowel abnormalities that presented in July.

Analysis and Findings

37. I note the patient was taking Morphine medication due to a lung cancer which was diagnosed in April 2018. I note that a common side effect of this medication is constipation. I note that constipation is highlighted by the advisers as a condition which can lead to bowel obstruction / perforation. Whilst it is apparent the patient was constipated at hospital in June 2018, I note the Radiologist IPA did not consider it to be '*severe'* given the normal appearances of the bowel at that time. I accept this advice. I note the Gastroenterologist IPA advised the patient's constipation was treated with lactulose, a laxative which was '*an appropriate action to reduce the risk of perforated bowel.'*

38. I note the Gastroenterologist IPA advised that *'appropriate imaging was organised as per RCS guidance including ultrasound and then the MRCP scan.'* I note the IPA advice referred to several indicators all of which pointed to gallstones and not bowel obstruction / impending perforation as the source of the patient's pain in June 2018:

- the imaging identified gallstones
- bilirubin[10] levels were elevated
- the source of the pain was the right upper quadrant of the abdomen (under the

[10] A compound formed in the liver which can build up if the gallbladder becomes blocked and can't drain properly.

arm)

- dilatation of the bowel was normal.

Given these indicators, I accept the IPAs' advice that the pain manifested in June 2018 was due to gallstones and not impending bowel perforation.

39. Although the patient had been admitted to hospital on 20 June 2018 with severe abdominal pain, I note she was discharged on 28 June without the diagnosed cause of that pain, gallstones, being removed. I note the complainant understood a procedure to remove the patient's gallstones was to be carried out during that hospital stay. The complainant described an apparent abrupt change to plans when the patient was discharged on 28 June shortly after being moved to another ward. I appreciate the potentially unsettling effect and uncertainty such a change to plans can bring, especially where an identified problem has not been resolved and the patient was *'still unwell'.*

40. However, I note the Gastroenterologist IPA advised that the patient's discharge on 28 June 2018 was appropriate given the patient's condition had settled. In particular the severe abdominal pain with which the patient had initially presented was no longer there. I note the IPA also advised of a blood thinning medication, clopidogrel, which had to be stopped in preparation for the ERCP procedure which was then scheduled to remove the gallstones. I note the IPA advised that it was reasonable the patient should return as an outpatient to allow time for the effects of a blood thinning medication to dissipate.

41. I accept the advice of the IPAs which I have highlighted above. I am satisfied the patient was properly cared for during the June 2018 hospital admission and that it was appropriate to discharge the patient without first carrying out the ERCP procedure. I did not find evidence which calls into question the care and treatment provided to the patient in June 2018. I am also satisfied that the medics treating the patient did not miss any obvious signs which should have alerted them to the possibility of a bowel perforation occurring in the coming weeks. I therefore do not uphold this element of the complaint.

Issue 2: *Whether the care and treatment provided to the patient at hospital between 16 July and 19 August 2018 was appropriate and reasonable.*

Detail of Complaint

42. The complainant said the Trust told him the patient's bowel was perforated by hardened faecal matter but the radiology report *'did not show significant constipation'.* The complainant said this was contradictory and he asked the Trust to provide clarification. The Trust advised the complainant that the perforation was caused by constipation and the term '*significant'* used by the radiologist was a clinical term meaning nothing had been noted that required follow up. The complainant said this did not reassure him.

43. The complainant said:
'Given the scans and MRI which was carried out, should these not have provided early warning signs of the impending bowel perforation?'

44. The complainant was concerned that the patient's known gallstones history and the planned arrangements that were in place to remove them, in some way masked the impending bowel perforation. Or, worse still, the procedure to remove the gallstones was itself the cause of the bowel perforation.

Evidence Considered

Legislation/Policies/Guidance

45. I considered the following guidance:
    - RCEM guidance;
    - GMC guidance;
    - RCS guidance; and
    - RCR guidance.

Trust's response to investigation enquiries

46. The Trust said:

'We can confirm that the terminology "significant constipation" refers to constipation that was likely to cause an obstruction, perforation or required follow up. I am sorry for the lack of clarity. The conclusion from Radiology is that there was no way of predicting that [the patient] would have suffered a perforation due to constipation based on the scans and X-rays that were done.'

47. The Trust said:

'The scans and X-rays were reviewed by Radiology and there were no signs of any impending bowel perforation. The pain caused by gallstones is usually in a different part of the abdomen from that caused by constipation. In addition, [the patient's] liver enzymes were elevated, which points towards a gallstone cause for the pain rather than constipation. The perforation was unrelated to the procedure to remove her gallstones, as it was very far away from where the gallstones were removed.'

48. The Trust said:

'[A] Consultant Radiologist, has reviewed the imaging performed from 20 June 2018 to 18 July 2018 and provides the following response:

- *Chest X-ray 16/07/2018 -No pneumoperitoneum[11].*
- *Abdominal X-ray 16/07/2018-"Unusual gas pattern in the ascending colon. Inflammatory bowel disease should be considered. Further assessment would be of value".*
  Non-specific changes within the ascending colon as outlined. Generalised faecal loading is present, however, this is not an uncommon finding in the elderly population. No colonic obstruction.
- *Abdominal X-ray 18/07/2018 - Pneumoperitoneum consistent with bowel perforation.*
- *In summary, there was no radiological indication of an impending stercoral sigmoid perforation[12] on the examinations performed prior to the diagnostic chest X-ray on 18/07/2018.'*

[11] The presence of air or gas in the abdominal cavity.
[12] Perforation or rupture of the last section of the bowel by its internal contents, such as hardened faeces.

Relevant Trust records

49. The following Trust records were considered:
    - Scans taken during the period 16 to 18 July 2018
    - The patient's medical records covering the period 16 to 18 July 2018

Relevant Independent Professional Advice

50. The ED IPA advised:

    'From my review of the documentation, I have found gaps in the record keeping pertaining to [the patients'] attendance at the emergency department on the 16th July 2018.

    There appears to be a bias in assessment and decision making based on the appointment for an ERCP that the patient had later that day. This is by both the emergency department and medical department clinicians.

    Despite these shortcomings I think the correct primary diagnosis of cholecystitis[13] was made. Appropriate treatment and care was provided to [the patient] by the administration of painkillers, antibiotics and referral for admission.

    Other causes of abdominal pain were of course possible but the collation of symptoms, signs and tests at the time of presentation point towards cholecystitis rather than anything else. The findings of serial abdominal examinations over the first four hours of her attendance supported this.

    There were not enough abnormal findings, either individually or collectively, to warrant further tests in the emergency department.'

51. The Radiologist IPA advised:

    'The crucial sign to alert towards bowel obstruction is the dilatation of the bowel upstream and a limit of 10-11cm in the right colon is commonly accepted as a threshold where perforation may occur.

    It is important to understand that the imaging does not necessarily represent stand-alone facts, but vitally depends on the clinical context for interpretation.

    In some patients a dilated bowel is normal for them, in others it can signify a developing problem. Adequate clinical information is crucial for the correct

[13] Inflammation of the gallbladder, usually due to a blockage caused by a gallstone.

interpretation.'

52. Referring to the radiology report produced on 16 July 2018, the Radiologist IPA advised:
    'While there is no direct reference to constipation or bowel obstruction, the report correctly flags up abnormalities relating to the large bowel and not to gall stones and raises the possibility of an alternative pathology.'
    'It is a reasonable assumption that a discussion between the admitting staff and the on-call radiologist would have resulted in a CT scan of the abdomen to investigate further, as suggested by the radiology report.'

53. The Radiologist IPA advised:
    'The appearances of the bowel on the films from 16/7/18 are equivocal and were called in the formal report as "unusual". Whether any importance needed to be attached to this would have been dictated by the clinical picture.
    The key is not so much the findings on the film, but whether the patient's pain and history pointed towards bowel obstruction.'

54. The Radiologist IPA advised:
    'In summary, a second pathology was missed due to pursuing the management of a pre-existing condition. Mitigating factors were a complex scenario of multiple pathologies and a therapeutic procedure scheduled the day after the emergency admission.
    Several biochemical and clinical pointers can be identified in retrospect, which in combination with the abdominal x-ray and its report could have alerted to the alternate diagnosis. Key is the clinical assessment, the diagnostic imaging plays a secondary role to this.'

55. The Gastroenterologist IPA advised:
    '. . . the ERCP was unlikely to have directly caused the perforation. It may have indirectly contributed to the perforation by the necessary air insufflation which may have expedited the presentation of the perforated bowel. However, this was not a deficiency of care but rather an unintended complication as part of a necessary medical procedure and does not imply any error in carrying out the ERCP.'

56. The Gastroenterologist IPA advised:

‘The pain was documented initially as being in the right upper quadrant which would be consistent with gallstones and it was associated with vomiting. Having already had a similar presentation recently it was, on balance, reasonable to assume the readmission was related to the gallstones. There was a documented entry later in the stay (17/07) by an SHO (Senior House Officer) that mentioned upper and left iliac fossa (lower) abdominal pain as well as diffuse tenderness of the abdomen. With the benefit of hindsight, it is possible that the changing nature of the pain was a reflection of progressive pathology in the sigmoid colon[14]. There was abdominal auscultation[15] for bowel sounds which were reported as scanty, a non-specific finding. However, on balance, it remains reasonable and within the acceptable range of practice (based on professional experience) to have assumed the pain was related to the gallstones and proceed with the ERCP as planned. The ERCP took place later that day and did remove gallstones from the common bile duct.’

57. The Gastroenterologist IPA advised:

‘. . . [the patient’s] initial readmission pain documented [on 16 July 2018] appeared similar, there were no significant concerning signs when assessed apart from the morning of the procedure but the assessment did not conclusively point to an alternative pathology due to the difficulty making such a judgement with clinical examination alone.. She underwent X-Ray imaging which did not suggest new pathology, though the tests requested did have limitations. As discussed the AXR[16] did highlight large bowel abnormality but it was not specific. The only investigation that would have confirmed the diagnosis would have been a CT scan of the abdomen. As discussed, without the benefit of hindsight, there were no strong indications for a CT scan prior to the ERCP.’

Other information considered

Trust’s response to the draft report

58. The Trust said the patient *‘was reviewed by an ST6*[17] *Gastroenterology Doctor*

[14] The last section of the bowel.
[15] The action of listening for sounds within the body using a stethoscope.
[16] Abdominal x-ray
[17] A doctor in their 6th year of specialist training.

between 04:15 and 04:45 on 16 July 2018 whilst in the Emergency Department (ED). The abdominal X-ray image, which was available on PACS[18], was viewed on 16 July 2018 by an ST4[19] ED doctor at 02:47 and by the ST6 Gastroenterology Doctor at 04:37. The radiology report was not available at this time.'

59. The Trust said *'the Consultant Radiologist report of the abdominal X-ray was not available until 17:34 on 16 July 2018.'* The Trust said *'the abdominal X-ray report of 16 July 2018, whilst indicating an abnormal gas pattern, was non-specific and given the patient was clinically stable, it would not have alerted a physician to an impending abdominal problem.'*

60. The Trust said *'when examined by the SHO at noon on 17 July 2018, there was a new Left Iliac Fossa (LIF) pain in the patient with severe constipation. Had the SHO considered it necessary to escalate the new LIF pain, albeit non-specific, to a senior doctor, a routine CT scan may have been considered. However, there are no strong indications from this examination that a CT would have been requested to be undertaken prior to the planned ERCP procedure.'*

61. The Trust quoted from the Gastroenterolgist IPA conclusion that this was '*a very unusual and unfortunate case of a very rare cause of bowel perforation [stercoral peforation] co-existing with a pre-existing abdominal condition. The care was reasonable and there is no evidence to suggest that an omission in care led to a missed opportunity to have made an earlier diagnosis of the stercoral perforation.'* The Trust agreed with this and said that *'consideration of a different or supplementary diagnosis on 17 July 2018 is difficult to determine without bias from the benefit of hindsight.'*

Analysis and Findings

Patient in the ED – 16 July 2018

62. I note the patient arrived in the ED in the early hours, 01:28 on Monday 16 July 2018. The ED record indicates the patient presented with severe abdominal pain which she had been experiencing since 18:00 the previous evening. The patient

[18] Picture Archiving Communications System - all radiology examinations performed are now stored and reported digitally on computers. The PACS system is accessed by both Radiology staff and clinicians outwith Radiology.

[19] A doctor in their 4th year of specialist training.

was feeling sick, had vomited twice and had a fever. There is a diagram in the notes, drawn by an ED doctor, which identified the source of the pain as the right upper quadrant of the abdomen. I note the ED IPA advised*: 'The documentation of the history and examination support the problem being gall bladder related rather than large bowel related.'* The IPA advised there was no pain in the left lower quadrant where the bowel perforation is now known to have occurred. I accept this advice.

63. I did not find any direct evidence of whether the patient was asked about bowel habits or constipation while being examined in the ED. However, at 02:01, I note that a chest x-ray and an abdominal x-ray were requested by the ED. The reason for the request was recorded as *'?perf ?obstruction'*. I note that *'?perf'* is listed in the differential diagnosis. I am satisfied these facts are confirmation that perforation / obstruction of the bowel was among the possibilities considered by the ED as the potential cause of the patient's severe abdominal pain.

64. Noting the ED IPA advice about the location of the abdominal pain with which the patient presented (right upper quadrant of the abdomen) I am satisfied ED clinicians did not suspect an obstruction / perforation of the bowel to be the cause of the pain. Nonetheless I am satisfied it was covered as part of the differential diagnosis. Referring to the abdominal x-ray request, I note the ED IPA advised: *'The test requested appears to be of a "routine" nature.'* I accept this advice.

65. I note the Trust's comments on the draft report which advised that 'the Consultant Radiologist report of the abdominal X-ray was not available until 17.34 on 16 July 2018.' I am therefore satisfied that those who treated the patient in the ED did not see the radiologist's report of the abdominal X-ray.

66. I note the patient was examined by a Gastroenterology doctor between 04:15 and 04.45 whilst still in the ED. The medic's grade is not clear from the medical admission notes, however the Trust's response to the draft report confirmed the grade to be ST6. (I have further considered the legibility of the record below under the heading *Record keeping - Gastroenterology*). The record shows the clinical examination identified pain in the right upper quadrant of the abdomen, similar to the ED doctor's findings. I note the Gastroenterologist IPA advised: *'The pain was*

documented initially as being in the right upper quadrant which would be consistent with gallstones'. I note the patient was subsequently admitted to Ward 6B.

Record-keeping in the ED

67. Although the ED IPA advised that ED clinicians made a correct diagnosis, I note the IPA highlighted a problem with record-keeping. GMC guidance states that a doctor's work should be recorded *'clearly, accurately and legibly'.* Referring to section 21 of the guidance, I note the IPA advised: *'The ED note keeping on the attendance on 16th July 2018 is not of an acceptable standard. It lacks relevant clinical findings, decisions and actions.'* I accept this advice.

68. I consider good record-keeping affords protection to clinicians involved in providing patient care by providing a clear record of their actions and the treatment provided. I consider a failure in maintaining accurate and contemporaneous records impedes the thorough, independent assessment of care provided to patients. I consider the patient's medical notes in ED fell below the required standard and this constitutes a service failure. I am satisfied this failure caused the complainant the injustice of uncertainty over whether the differential diagnosis list was adequately considered. I therefore uphold this element of the complainant

69. I note the ED IPA referred to an apparent *'bias'* towards gallstones in the decision-making in view of the ERCP that ED clinicians knew was scheduled for 17 July. Perhaps if there had been adequate recording of the clinical findings, decisions and actions taken by ED clinicians may have prevented this adverse analysis. I did not find sufficient evidence to make a definitive finding on whether ED clinicians were inappropriately influenced in their diagnosis by the patient's recent history and planned treatment. However, noting the ED IPA advice, I am satisfied '*the collation of symptoms, signs and tests at the time of presentation point towards cholecystitis rather than anything else.*'

Patient in Ward 6B - 16 July 2018

70. I note the Gastroenterologist IPA advised that *'constipation is part of the differential diagnosis of abdominal pain'.* However, I did not find any reference to the patient's bowel habits or constipation among the record made by medics in Ward 6B on 16 July 2018. I note the Gastroenterologist IPA advised that *'hardened faeces or*

constipation is a very common finding especially in elderly patients.' Perhaps this fact may explain why the matter of constipation did not feature prominently within the medical notes.

71. In contrast, I note that a Staff Nurse in Ward 6B referenced that the patient was constipated and recorded *'constipation from morphine'* as a possible cause of the pain. I note the Radiologist IPA advised that the nurse considered the correct conclusion and this should be *'cited as an example of good practice.'* I accept this advice, though I acknowledge the nurse was not a member of the medical team.

72. Whilst the source of the pain at that time was consistent with gallstones, I note the Radiologist IPA advised that referral to the patient's bowel habits is a *'fundamental component of an assessment of a patient with severe abdominal pain.'* The investigating officer raised this with the Gastroenterologist IPA who advised that constipation was *'in effect checked for by default when the abdominal X-Ray was ordered'.* I am prepared to accept this advice on the basis that the reason for the abdominal x-ray request, *'?Perf ?obstruction',* was related to the bowel.

73. I note the Gastroenterologist IPA advised that *'perforation caused by hardened faeces (stercoral perforation) is a very rare and unusual complication.'* Although the patient was constipated when admitted to hospital on 16 July 2018, I note the Gastroenterologist IPA advised that the signs and symptoms with which she presented supported the initial diagnosis that the abdominal pain was related to the known gallstones. I note this advice is consistent with that of the ED IPA. Both IPAs advised that the ED and Gastroenterology clinicians had reached appropriate conclusions based on the patient's presentation. I accept this advice. I am satisfied the possibility that the patient would suffer a perforated bowel caused by hardened faeces was not apparent from the various clinical examinations that the patient underwent on 16 July 2018.

74. I note the Radiologist IPA advised that '*the clinical assessment'* is *'key'* and*, 'the diagnostic imaging plays a secondary role to this.'* Nonetheless, I consider it to be relevant that a specific request to check for perforation / bowel obstruction was made to a radiologist and his report on the diagnostic imaging did not find an obstruction or a perforation of the bowel. The Radiologist IPA advised that the radiology report gave no indication of an impending bowel perforation. I accept this advice.

75. However, the Radiologist IPA advised that the report did flag up an *'abnormal gas pattern'* in the patient's bowel which he considered should have prompted a follow-up discussion. This advice is reinforced by his further advice that '*Several biochemical and clinical pointers can be identified in retrospect, which in combination with the abdominal x-ray and its report could have alerted to the alternate diagnosis.'* I have listed the following examples from his report:
    - the level of bilirubin[20] was normal
    - the level of white blood cells was normal[21]
    - the radiographs taken on 16 July 2018 indicated *'recent development of moderate dilatation of most of the large bowel.'*

76. The record indicates the patient was seen by medics later that day at 15:30. I note

[20] A substance found in the blood, high levels of which can be a sign of a blockage in the gallbladder which prevents it draining properly.
[21] The white blood cell count would be likely to be above normal in a patient with an inflamed gallbladder.

the consultant and an SHO signed the record. I note the patient was '*asleep'*. The record contained no new information.

77. Noting the Trust's response to the draft report, I accept the radiology report was not available until 17.34 on 16 July 2018. However, when it was produced, I found no evidence that the radiology report was considered by clinicians in Ward 6B as part of the differential diagnoses. Although the report gave no indication of any impending trauma, I accept the Radiologist IPA advice that a conversation should at least have taken place between the specialities. I consider the responsibility lay with the medics who had access both to the clinical findings and to the radiology report.

78. In the absence of any record to the contrary, I conclude that a conversation between the specialities did not occur. I find this was a failure in care and treatment which caused the complainant the injustice of frustration and anxiety over whether such a conversation would have led to a different outcome; and the injustice to the patient of a loss of opportunity to have the impending bowel perforation diagnosed sooner. I therefore uphold this element of the complaint.

Record keeping - Gastroenterology

79. I note the Radiologist IPA had difficulty reading the medical records. He advised: *'Unfortunately annotations on the presenting symptoms in the medical admission notes . . . are not very legible, there is a word that might say "Diarrhoea" but it is illegible. Equally the documentation on the abdominal examination is illegible . . . at a guess saying "mildly tender RUQ (right upper quadrant)".'*

80. This is an unfortunate finding given the importance to the complainant of establishing the facts in hindsight. If the word '*diarrhoea'* was recorded by the clinician, I appreciate its potential significance, though I note the Gastroenterologist IPA did advise that *'overflow diarrhoea'* can occur even when a patient is constipated.

81. I note the GMC guidance[22] requires doctors to record their work legibly. I consider

[22] Section 21

it is vital that records are legible since they are an important means of scrutinising processes retrospectively to resolve complaints and monitor the operation of systems. I therefore consider this is a service failure.

Patient in Ward 6B – 17 July 2018

82. I note the Gastroenterologist IPA advised of *'the possible change in symptoms and signs noted on the morning of the ERCP on 17/07/18.'* The IPA advised:
'The patient was assessed by SHO in the morning . . . who noted she was drowsy, with diffuse abdominal pain but mostly in the LIF (left iliac fossa[23]). A fever the previous night was documented.'

83. I note the Gastroenterologist IPA advised:
'. . . with the benefit of hindsight it is possible that the cause of pain and clinical deterioration at this stage related to impending bowel perforation.'
'. . . the clinical assessment prior to ERCP was a potential opportunity to have considered an alternative diagnosis.'

84. However, considering the information that was available to the SHO on 17 July 2018, I note the Gastroenterologist IPA advised:
    - *'. . . it must be borne in mind that abdominal pain can be non-specific in its presentation, severity and location.'*
    - *'clinical assessment had not detected an abnormality convincingly pointing to a different location.'*
    - *'there was abdominal auscultation[24] for bowel sounds which were reported as scanty, a non-specific finding.'*
    - *'the AXR did highlight large bowel abnormality but it was not specific'*
    - symptoms of impending bowel perforation *'could include severe uncontrollable lower abdominal pain or abdominal distension[25].'*

85. I note the IPA advice cast doubt over whether the patient's signs and symptoms at that point were convincing enough to cause the SHO to consider a different diagnosis. I note the Gastroenterologist IPA advised:

[23] The lower left quadrant of the abdomen (where the perforation occurred).
[24] The action of listening to sounds from the heart, lungs, or other organs, typically with a stethoscope, as a part of medical diagnosis. (I note the Radiologist IPA did not find this reference to auscultation within the patient's medical records.)
[25] Swelling, expansion, enlargement

'On balance, it remains reasonable and within the acceptable range of practice (based on professional experience) to have assumed the pain was related to the gallstones and proceed with the ERCP as planned.'
I accept this advice. Nonetheless, I consider that the signs and symptoms manifest in the patient at noon on 17 July did present a potential opportunity for an alternative (or a supplementary) diagnosis to be considered.

86. I note the Gastroenterologist IPA advised the investigating officer that *'SHOs are fully qualified doctors and a senior review would not be mandated.'* I accept this advice. However, given the radiologist's report had signalled abnormality in the bowel the day before, I consider the SHO's findings reinforced the need for discussion, at least with the radiologist. Again, I did not find any evidence of such a discussion in the record and I therefore consider that it did not occur.

87. I note that section 16(d) of the GMC guidance states:
'In providing clinical care you must consult colleagues where appropriate.'

88. I consider this a failure in care and treatment. I am satisfied this caused the injustice of frustration and anxiety to the complainant over whether events would have developed any differently if the SHO's findings had been discussed; and the injustice to the patient of a loss of opportunity to have the impending bowel perforation diagnosed sooner. I therefore uphold this element of the complaint.

89. My decision is finely balanced. In particular I acknowledge that the clinical picture is clearer only with the benefit of hindsight. I accept the Gastroenterologist IPA advice that it is by no means certain that discussion with a more senior member of the team would have led to a different course of action. I hope this provides some assurance to the complainant.

90. I note that the ERCP procedure was carried out later by the consultant gastroenterologist. The records show that it proceeded routinely and without incident. However, I note the patient's condition did not improve afterwards. I note the patient continued to have abdominal pain, now more pronounced in the lower abdomen.

91. I note the Gastroenterologist IPA advised that perforation of the bowel can occur

during an ERCP procedure. I note that, at the time, clinicians considered whether this was a possible explanation for the patient's difficulties. However, the location of the bowel perforation was different to that of the ERCP procedure. I note the IPA advised:

'The site of perforation was in the sigmoid colon[26] very distally in the GI tract[27]. The ERCP procedure is performed in the proximal GI tract in the small bowel. Therefore, the ERCP was unlikely to have directly caused the perforation.'

I accept this advice and I am satisfied the ERCP procedure did not directly cause the bowel perforation.

92. I note the IPA further advised the ERCP procedure involved the insufflation of air into the abdominal cavity. The IPA speculated as to whether this necessary part of the ERCP procedure may have inadvertently expedited the perforation. I note he advised:

    'It may have indirectly contributed to the perforation by the necessary air insufflation which may have expedited the presentation of the perforated bowel. However, this was not a deficiency of care but rather an unintended complication as part of a necessary medical procedure and does not imply any error in carrying out the ERCP.'

    I accept this advice.

93. I note the patient's abdominal pain continued and worsened in the lower abdomen. I note this led to emergency surgery the following day and the discovery of the bowel perforation. I am aware that perforation of the bowel is a very serious problem and although clinicians acted to repair the bowel, the patient deteriorated in the days that followed. I am very sorry to learn that the patient died several weeks later on 19 August 2018. I appreciate how such a tragic outcome reinforces for the complainant the importance of knowing as much about events as possible and whether his wife was cared for as she should have been.

CONCLUSION

94. I received a complaint about the care and treatment provided to the complainant's wife when she developed abdominal pain in the summer of 2018 and sought help

[26] The last section of the bowel.

[27] Gastro-intestinal tract - the tract from the mouth to the anus which includes all the organs of the digestive system

from the Trust. The complainant said his wife was sent home from an initial hospital admission in June 2018 despite remaining unwell following a diagnosis of gallstones. The patient presented to hospital in the early hours of 16 July 2018, again with abdominal pain. Gallstones were removed by ERCP. However, the patient remained unwell and it was then discovered she had a perforated bowel. The complainant sought assurance that his wife had been cared for appropriately. He feared the pain from gallstones had masked an impending bowel perforation, or, the ERCP procedure had caused the bowel peroration.

95. I found the care and treatment in the ED on 16 July 2018 was reasonable. However, I found that record keeping in the ED fell short of the required standard which I considered was a failure that caused the complainant the injustice of uncertainty and anxiety over whether the outcome for the patient may have been different had the failure not occurred.

96. I found the care and treatment in Ward 6B to be inadequate because there was no record that clinicians had considered a radiologist report which highlighted abnormality in the patient's bowel. I also found no evidence that an examination of the patient on 17 July 2018 (before the ERCP procedure) had been discussed with a more senior member of the team. The examination had revealed a possible change to the patient's abdominal pain and may have been an opportunity to identify an impending bowel perforation.

97. I am satisfied these failures in care and treatment caused the complainant to experience the injustice of uncertainty and anxiety over whether the outcome may have been different had they not occurred. I therefore partially uphold the complaint.

Recommendations

98. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified (within **one month** of the date of this report).

99. I further recommend the Trust provides evidence that the findings of this report have been fed back to relevant staff in a supportive manner that encourages

learning, including reference to what that learning is (for example a record of a meeting with staff or feedback given at one to one sessions). The following areas should be covered:

- The importance of work being recorded clearly, accurately and legibly and in accordance with section 21 of the GMC guidance.
- The importance of consulting colleagues where appropriate in accordance with section 16(d) of the GMC guidance.

100. More generally, for service improvement and to prevent future recurrence, I recommend the Trust highlights this unusual case concerning the diagnosis of stercoral bowel perforation in the ongoing training of medics. The Trust should also remind medics of the importance of documenting their attendance and assessment of patients, as well as any examination findings and outcomes.

101. I recommend that the Trust implements an action plan to incorporate these recommendations and provides me with an update within six months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

MARGARET KELLY
Ombudsman **17 January 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.