The investigation of a complaint

By Ms C

against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201605326

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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 C.

Summary

Ms C complained about the care her father, Mr D, received when he was admitted to Ysbyty Gwynedd. Ms C complained that Mr D's cause of death had not been accurately recorded. Ms C also complained about the way her complaint was handled and the length of time taken to provide her with a response.

The Ombudsman found that the care and treatment provided to Mr D was not of a reasonable standard. The Health Board did not adequately monitor Mr D's condition and missed a number of opportunities to escalate his care. Had Mr D's care been appropriately escalated his death may have been avoided.

The Ombudsman found that the form submitted to the Coroner by the Health Board did not accurately reflect the cause of Mr D's death. The Ombudsman also found that the complaint was poorly handled, the amount of time taken to deal with the complaint was unreasonable and the final response did not contain the Serious Incident Report the Health Board had said it would provide.

The Ombudsman upheld the complaint and recommended that the Health Board:

a) Undertake a NEWS (National Early Warning Score) audit. This should include a minimum 10% dip sample of the NEWS recorded on the ward in the past three months. If members of staff involved in the recording of NEWS for Mr D are now working in a different area, the audit should also include a sample of their current practice. If anomalies are identified, an action plan should be prepared to put this right.
b) Share this report with the nursing staff involved in this case. Those members of staff should be given training on NEWS and escalation procedures.
c) Ensure that there is a robust handover system in place and that all acutely ill patients undergo a daily review by a registrar (or above), including on weekends and holidays.

d) Share this report with the doctors involved in this case. The doctors should then review the report and medical notes with their appraiser to identify areas where practice could be improved.

e) Discuss this case with the Coroner and based on that discussion undertake an audit (minimum 10% dip sample) of coroner referral forms for the past three months. If inconsistencies or inaccuracies are identified, an action plan should be prepared to address them, this may include introducing a review system or additional training for doctors preparing the forms.

f) The Head of Corporate Governance should review the complaint handling in this case. The review should seek to identify what happened to the Serious Incident Report.

g) Apologise to Ms C and her family for the failings identified in this report. A meeting with the Chief Executive or the Medical and Nursing Director should be offered to Ms C.

h) Make a payment to Ms C of £10,000 in recognition of the distress and uncertainty caused by the clinical failings identified in this report. This payment is also in recognition of the time and trouble taken in pursuing this complaint, due to the complaint handling failings identified in this report.

The complaint

1. Ms C is an employee of Betsi Cadwaladr University Health Board ("the Health Board") and is involved in handling complaints. She complained to me about the care given to her father, Mr D, at YsbytyGwynedd ("the Hospital") which is in the area of the Health Board. She complained that:

I. The care and treatment given to Mr D during his stay at the Hospital was not of a reasonable standard. Ms C said that the Health Board failed to identify and treat the deterioration in his condition; had it done so, the outcome may have been different.

II. The Health Board's complaint response indicates that Mr D died as a result of a cardiac arrest, but this is not indicated on the death certificate, neither is there any reference to sepsis or kidney injury, both of which were diagnosed.

III. The Health Board took an unreasonable amount of time to respond to the complaint. The Health Board said it conducted a Serious Incident Report but failed to provide a copy to Ms C, even though it said in its complaint response that the Serious Incident Report was included.

Investigation

2. I obtained comments and copies of relevant documents, including Mr D's clinical records, from the Health Board and considered those in conjunction with the evidence provided by Ms C. I also obtained advice from two of the Ombudsman's Professional Advisers ("the First Adviser" – Dr Ian Woolhouse is an experienced Consultant in Respiratory and General Medicine and "The Second Adviser" – Gemma Ellis is an experienced Registered Nurse). I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. Both Ms C and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant Guidance

4. The advisers and I have had regard to a number of regulatory and good practice documents in considering this case, including the following:

- The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (also known as “PuttingThings Right” (PTR)

- National Early Warning Score (NEWS); Standardising the assessment of acute-illness severity in the NHS. Report of a Royal College of Physicians (RCP) working party, July 2012

- Acute Kidney Injury: prevention, detection and management. National Institute for Health and Care Excellence (NICE) Guideline [CG169] August 2013

- International Guidelines for management of severe sepsis and septic shock: 2012

- Acutely ill adults in hospital: recognising and responding to deterioration NICE clinical guideline [CG50] 2007.

Relevant background information and events

5. On **21 December 2014**, Mr D was admitted to the Hospital as an emergency patient. He was suffering with a chest infection and had been prescribed steroids and antibiotics by his GP. Mr D was known to have Chronic Obstructive Airways Disease (COPD - A lung condition

which causes breathing difficulties). He was diagnosed with pneumonia (inflammation of the lungs) and respiratory failure. He had an elevated heart rate and a NEWS[1] score of 8.[2] Mr D was initially cared for in the ambulance and there was a delay in finding Mr D a bed on a ward.

6. Early on 22 December, Mr D was reviewed by a consultant who recommended treatment including broad spectrum antibiotics (an antibiotic which will act against a wide range of bacteria). Mr D's kidney function appeared to be outside the normal range. Mr D was taken to the ward at 1.15pm. On arrival, his NEWS was calculated as 3. At 6.25pm, Mr D's NEWS was recorded as 5, this later reduced to 4. It was reported that Mr D had lost weight recently. Next of kin details were taken for Ms C; it was noted that she worked for the Health Board and her internal extension telephone number was the only telephone number recorded.

7. On 23 December, Mr D's NEWS was calculated on four occasions as 5 early in the morning and as 6 throughout the rest of the day. Mr D was given an assisted wash. Mr D was reviewed by a junior doctor; the notes reflect that Ms C was pleased to hear of Mr D's progress and that discharge plans were being made.

8. On 24 December, Mr D's NEWS was noted as 6 at 3.26am and again at 6.46am. He was given an assisted wash at 12.10pm. Mr D was very anxious. An untimed record in the notes, made by the junior doctor following a ward round by the respiratory consultant, indicated that Mr D's kidney function had deteriorated. The note states "Acute Kidney Injury[3] secondary to Sepsis[4]". "Strict input and output" was noted on the records indicating that the plan was to monitor Mr D's fluid balance. A further

[1] NEWS – National Early Warning Score – system used to establish the degree of illness of a patient using the observations taken e.g. respiratory rate, oxygen level and temperature.
[2] A score of 1-4 prompts assessment by a registered nurse who can decide if monitoring should become more frequent or if escalation of care is needed; a score of 5-6 prompts an urgent review by a clinician, who should consider whether critical care is required and a high score of 7 or more prompts emergency assessment by a clinical care/critical outreach team and would usually lead to high dependency care.
[3] Sudden damage to the kidneys that causes them not to work properly.
[4] A serious complication of an infection when the body's immune system reacts in a way which causes damage to the body.

untimed record notes that Mr D had a poor appetite. A food chart was commenced, but not fully completed. It was again noted that Mr D was anxious and Ms C had raised a concern that Mr D appeared muddled. At 4.15pm, Mr D's NEWS increased to 7.

9. An untimed record, dated 25 December, indicated that Mr D was given prescribed medication. At 4.40am, a nurse was alerted to Mr D due to the alarm on his infusion pump (the pump on the drip used to give Mr D fluids directly into the bloodstream) bleeping. Mr D was found to be unresponsive, having suffered a cardiac arrest. The resuscitation team attended to Mr D, but he died. The cause of death noted in the records was pneumonia and COPD.

10. On **17 February 2015**, Ms C made a complaint to the Health Board about the care and treatment her father received. She returned the consent form required on 3 March. The complaint was identified as a "grade 5"; this is the most serious type of complaint and a Serious Incident Report should be undertaken. On 1 June, Ms C emailed the Health Board, advising it that her niece had been approached on a night out by a member of nursing staff who made inappropriate comments about the case. Ms C was advised by telephone later that day that the issue was a workforce matter and would be addressed. On **4 January 2016**, Ms C asked the Health Board for an update. On 11 January Ms C sought the help of a Community Health Council Complaints Advocate to assist her with the complaints process. On 2 February Ms C was advised the investigation was continuing.

11. On 31 March, a "panel" discussion took place involving a Consultant Anaesthetist, a Doctor of Emergency Medicine, a Patient Flow Manager (an administrative manager with responsibility for providing the status of patients within a hospital), a Consultant Physician and the first Investigation Manager. There were no minutes of the meeting, but basic details of the discussion were noted on the complaint file. On 18 May, the complaint was passed to a second Investigation Manager. On 22 July, the second Investigation Manager emailed the Concerns Team to say that the draft letter was complete and she was trying to finish the Serious Incident Report to go with the letter.

12. On 5 September, Ms C was sent the complaint response. It referred to the terms of reference within the Serious Incident Report which was attached; the Serious Incident Report was not attached. The Health Board acknowledged that there had been a breach of duty of care because it had not undertaken a MUST (Malnutrition Universal Screening Tool used to identify adults at risk of malnutrition) assessment on the day of admission, it had failed to assess fluid and nutrition, it had failed to undertake physiological observations and had incorrectly calculated NEWS and failed to record adequate next of kin details for Mr D. The letter said that these omissions would not have changed the outcome.

The Health Board's evidence

13. The Health Board said that it failed to undertake full observations of Mr D and did not properly calculate NEWS. It said that correct calculations might have resulted in more frequent observations and may have alerted staff to Mr D's deterioration, but would not have reversed the outcome.

14. The Health Board acknowledged that Mr D's NEWS scores had not been correctly calculated, but that, even if they had been calculated correctly, this would not have led to further escalation of his care before his sudden death on 25 December. It also said that people with COPD have persistently higher scores and that the Health Board has introduced new automated NEWS triggers are set specifically for patients admitted with exacerbations of COPD (CREWS[5]). The information provided by the Health Board states that the CREWS system should never be used on patients with pneumonia.

15. The Health Board said that, when the kidney problem was identified (on 24 December), Mr D was started on intravenous fluids[6] but an opportunity to review his antibiotics was missed. However, it said that

[5] Chronic Respiratory Early Warning Score.
[6] Fluids administered directly into the vein.

Mr D had been on suitable antibiotics and that it is unlikely this would have been managed differently if it had been reviewed. The Health Board said that the duty roster for the ward did not indicate significant staffing issues that would have affected nursing care.

16. The Health Board said that, given Mr D's diagnosis, presentation and observations, he would not have been a patient that the Respiratory Team would have expected to have a cardiac arrest but, unfortunately this does sometimes occur in patients for whom there was no prior precipitation or deterioration.

17. The Health Board said that the cardiac arrest was not recorded as the cause of death, as this was a sudden medical event that occurred due to the causes of death (Pneumonia and COPD) recorded on the certificate.

18. The Health Board has confirmed that there was no Serious Incident Report, only a timeline which referenced the notes of the "panel discussion" on 31 March 2016. This had not been provided to the complainant, but was used to inform the complaint response. It apologised for the delay in sending the response to Ms C, citing staff changes as the reason for this. The Health Board said it arranged two meetings with Ms C in September and October 2015 but they were cancelled by Ms C.

19. The Health Board said that it conducted a "fact finding" exercise when it received the additional complaint from Ms C on 1 June 2015 about a breach of confidentiality and the harassment of her niece by a member of staff involved in Mr D's care. It determined that no formal action was necessary. The Health Board provided a copy of its report which showed that the member of staff had been interviewed. The Health Board said it provided feedback on this element of the complaint through the complaints process. The Health Board said no further information was given by Ms C and Ms C's niece did not complain directly to the Health Board.

Professional advice

Clinical Advice

20. The table below shows the recorded NEWS for Mr D and the correct calculations:

Date	22/12			23/12				24/12				
Time	13:40	18:25	21:58	07:06	11:29	16:25	21:58	03:26	06:46	16:15	19:30	21:29
Recorded	3	5	4	5	6	6	6	6	6	7	4	5
Correct	3	9	8	7	9	7	8	8	8	8	8	8

21. The First Adviser, an experienced Consultant in Respiratory and General Medicine, said that scores from 18:25 on 22 December onwards were all 7 or more and should have prompted emergency assessment by a clinical team/critical care outreach team; this would usually result in the patient being transferred to a higher dependency care area, unless a decision had been made that this would not be in the patient's best interests. Even using the incorrectly calculated scores, this should have taken place when Mr D's score reached 7 at 16:15 on 24 December. There are no documented discussions regarding treatment escalation or limitation. Mr D should have been referred to critical care for further treatment, had the score been properly calculated and appropriately actioned. The First Adviser said he did not consider it appropriate for the Health Board to state that correct calculation would not have made any difference beyond informing Mr D's family of his deterioration.

22. The First Adviser said Mr D's kidney function was mildly deranged when he was admitted to hospital and there are no baseline results recorded. He said that given that Mr D's baseline was not known and given the severity of his presenting illness, the kidney function test should have been repeated on 23 December. This may have identified worsening kidney injury sooner. The next blood test result for Mr D was on 24 December and this confirmed worsening kidney injury. Further, the First Adviser said that the failure to properly monitor fluid intake and urine output (which has been acknowledged by the Health Board) resulted in a missed opportunity to identify and treat the worsening kidney injury.

23. The First Adviser said that Mr D met the sepsis guideline criteria on admission, but there is nothing in the notes to confirm the presence of sepsis until 24 December (three days later). The First Adviser was unable to confirm if there were any markers of severe sepsis present, as there were no recorded urine output or lactate measurements.[7] The First Adviser said there was opportunity to recognise and treat the kidney injury and sepsis earlier. He said that Mr D's respiratory failure was recognised and appropriately treated.

24. The First Adviser said that the deterioration in Mr D's kidney function was noted on 24 December (no time was noted). The correct NEWS was 8 and the threshold for severe sepsis was met, but this was not formally documented in the notes. Mr D should have been referred to a critical care outreach team and a sepsis bundle[8] should have been implemented. The First Adviser said that Mr D was already on broad spectrum antibiotics for the pneumonia, but it is standard practice, when patients have deteriorated on current therapy, to discuss further escalation of antibiotics with the microbiology team. As this was not done and there were no blood culture results, it is difficult to predict what the microbiologist would have advised, but it would be standard practice to escalate the antibiotics.

25. The Adviser said that the deterioration in Mr D's kidney function, taken together with the persistently high NEWS, should have signalled that Mr D's treatment needed to be escalated and it is expected Mr D would have been transferred to a high dependency unit. Had Mr D been given appropriate treatment and care his further deterioration and cardiac arrest, which resulted in his death, might have been avoided.

26. The First Adviser said the "Death reported to coroner referral form", requests an account of the admission, to include details of surgery, procedures and pre-existing conditions. In addition to the information regarding prior asbestos exposure, the form should have included that Mr D was admitted with pneumonia, COPD and respiratory failure and that he experienced an unexpected cardiac arrest.

[7] A measurement which indicates when cells are not receiving enough oxygen.
[8] A bundle of medical therapies designed to reduce the mortality of patients with sepsis.

27. In response to the Health Board's statement that Mr B's scores were not unusual for a patient with COPD and the Health Board's new automated NEWS score triggers are set specifically for patients admitted with exacerbations of COPD, the First Adviser said that , although it is true to say that COPD patients may have a higher score if they are on long term oxygen, this patient's correct scores were all 7 or above (apart from the first) and national guidance clearly states that this should trigger an outreach team review. COPD patients should not be excluded from this.

Nursing Advice

28. The Second Adviser said that Mr D would have been at risk of kidney injury in view of his co-morbidities.[9] A standard fluid chart should have been commenced on admission and a standard nutritional assessment should have taken place, given that it is documented that Mr D had a recent history of weight loss. The Second Adviser said that, of the twelve sets of observations carried out during his time on the ward, only two had correct NEWS calculations. Mr D's needs were not adequately assessed.

29. The Second Adviser said that, from 23 to 24 December, Mr D's NEWS were consistently between 6 and 8. In this range, observations should be carried out every one to two hours and there is no evidence that this was the case. There is also no evidence of staff escalating concerns so that a prompt review could have taken place by a senior clinician. A NEWS above 3 with a suspicion of infection, should have prompted a suspicion of sepsis and a sepsis bundle should have commenced. There is no evidence this occurred.

30. The Second Adviser said that, had NEWS been correctly calculated, care should have been escalated. She said that Mr D should have been reviewed by a senior doctor within 30 minutes of scoring more than 6 and an appropriate management plan put in place. Mr D had only four sets of observations on 23 December and five sets on 24 December. The Second Adviser said there seemed to be a failure to understand how acutely ill Mr D was.

[9] One or more medical conditions existing simultaneously, but independently of another condition.

31. The Second Adviser said that there is no evidence that Mr D received appropriate levels of nutrition and hydration; when a fluid balance chart was commenced on 24 December with the words “strict input and output” on it, there was no record of any output. Further, the Second Adviser said there is no documentation to suggest that there was any discussion with a renal registrar about Mr D’s kidney injury. The Second Adviser said there was no indication that correct treatment for a kidney injury was given to Mr D or that there was an attempt to identify the cause. If the reason why there is no record of output is because there wasn’t any, this could have been due to a blockage in the urinary system and should have prompted a referral. The Second Adviser also said it is not possible to tell from the records whether Mr D’s hygiene needs were properly met.

32. The Second Adviser said that a contact number for Ms C is recorded but this was an internal extension number and this was not appropriate, as it would not allow for contact outside of working hours. There is no documentation of contact details on the nursing admission record. The Second Adviser also said that there are three references to Ms C in the records, including “Dr to speak to daughter” with no record of why, or what was communicated and, on the night Mr D died, there is reference to attempting to call Ms C but no record of the communication that actually took place.

33. The Second Adviser said that, overall, Mr D received substandard care throughout his stay in the Hospital.

Analysis and conclusions

34. Ms C complained that the care and treatment given to Mr D during his stay at the Hospital was not of a reasonable standard and the Health Board failed to identify and treat the deterioration in his condition. I **uphold** this complaint.

35. The Health Board missed opportunities to identify a worsening kidney injury and sepsis by failing to test Mr D’s kidney function, failing to properly monitor fluid input/output, failing to accurately record Mr D’s observations, failing to reconsider Mr D’s antibiotic cover, failing to

implement a sepsis bundle, failing to take an adequate number of observations and failing, within the appropriate times, to treat or identify the cause of the worsening kidney injury and failing to escalate concerns, even when they were identified.

36. The Health Board said it would not have expected Mr D to have a cardiac arrest but, unfortunately it does sometimes occur in patients for which there was no prior deterioration. Such a response is disingenuous as it does not take into account the significant deterioration which occurred while Mr D was in the Hospital.

37. The First Adviser said the Health Board missed a number of opportunities to take action which may have prevented Mr D's further deterioration and cardiac arrest. Ms C and her family will always be left with the uncertainty of knowing that, were it not for the failings identified, on the balance of probabilities, Mr D's death could have been avoided. The distress arising from this is significant and an enduring injustice to the family.

38. The Health Board said in both the complaint response and in response to a direct question from this office that, had it correctly calculated the NEWS, care would not have been escalated. This is clearly incongruous with the views of both Advisers and indicates an unwillingness to acknowledge the seriousness of that failing.

39. I am also concerned that the Health Board has indicated it has decided to alter the triggers for patients with COPD and use the CREWS system. I referred this point to the First Adviser. He said national guidance clearly states that a NEWS above 6 should trigger an outreach team review; COPD patients should not be excluded from this. In any event, this response is not relevant to this case and appears to further deflect attention from this serious issue. The information provided by the Health Board clearly indicates that the CREWS system should never be used for patients with pneumonia; Mr D was diagnosed with pneumonia on admission.

40. I would also add that communication with Ms C and her family was poor. The Health Board did not take an appropriate contact number for Mr D's family. I also find that there is no reference within the notes to discussions with the family about how gravely ill Mr D was. Consequently, Mr D's death was a shock to his family that they had not been prepared for. This caused additional, unnecessary distress which caused further injustice for Ms C and the family.

41. Ms C complained that the Health Board did not accurately record Mr D's death. I **uphold** this complaint. The form submitted to the Coroner did not accurately reflect that Mr D had been admitted to hospital with pneumonia, COPD and respiratory failure, that he had subsequently contracted sepsis and that he experienced an unexpected cardiac arrest. The failure to accurately reflect the reasons why Mr D died caused further distress to the family.

42. I now turn to the Health Board's handling of Ms C's complaint, I **uphold** this complaint. I conclude that the standard of the handling of Ms C's complaint fell far below what could be considered acceptable. The Health Board took one year and seven months to issue a complaint response. The PTR guidance says that a robust investigation should be completed and learning identified within 60 working days (approximately three months). This response took 16 months more than the guidance indicates, during which there were limited updates to the complainant which is poor practice. The Health Board said that two meetings with Ms C were arranged, but cancelled, by her, in September and October, the Health Board did not provide evidence to support this and the statement is disputed by Ms C. Further the reason given for the delay was "due to staff changes"; I find this statement to be disingenuous. There was one relevant staff change during the life of the complaint and this took place one year and three months after the complaint was received.

43. Further, it is clear from the letter from the Health Board, dated 5 September 2016 and from the email of 22 July 2016, that it was intended that a Serious Incident Report would be included with the response. The Health Board has been unable to give a clear reason why this was not done. It gave a legitimate expectation to Ms C that it did not fulfil. Accordingly, I conclude that Ms C has been put to unnecessary and

avoidable time and trouble in pursuing this complaint and this constitutes an injustice to her. The protracted nature of the complaints process and the lack of transparency about what happened to the Serious Incident Report served only to aggravate the situation and the distress felt by Ms C.

44. At no point has Ms C used her position in the Health Board to seek a higher standard of service when using the complaint process, but it cannot go unsaid that, even though Ms C understands the complaint process (she handles complaints as part of her job), 11 months after making her complaint she became so frustrated by the lack of progress that she sought the assistance of an advocate. This is of great concern for members of the public, with no knowledge of the system, wishing to use the service.

45. The Health Board has already assured me that it has taken steps to reduce delays in complaint handling since these events occurred. I am aware that it will take some time to see the effect of changes that have been implemented, but it is an issue that I will continue to monitor.

46. I have considered the "fact finding report" from the Health Board which arose from the additional complaint made by Ms C on the 1 June 2015. It is my view that the action taken to address this element of Ms C's complaint was woefully inadequate. The member of staff provided a version of events which substantially differed to that of the complainant, yet no action was taken to investigate further; witness details were not noted, the credibility of the statements made by the member of staff were not questioned and no further information was sought from the complainant or her niece. That the Health Board did not receive the complaint from Ms C's niece directly is irrelevant and I was not provided with evidence that this matter was reported back to the complainant as part of the complaints process as claimed by the Health Board.

47. Ms C was advised that this element of her complaint was a staff matter which would be dealt with. I am of the view that this approach was taken because Ms C was also a member of staff and it was expected she would accept this explanation. Whilst it is accepted that

the details of any action taken against the member of staff involved should not be disclosed, Ms C should have been provided with an outcome to this element of the complaint. Regrettably, I consider that too much time has now passed for a worthwhile investigation of this incident to take place.

Recommendations

48. I **recommend** that, within three months of the final report date, the Health Board should:

a) Undertake a NEWS audit. This should include a minimum 10% dip sample of the NEWS recorded on the ward in the past three months. If members of staff involved in the recording of NEWS for Mr D are now working in a different area, the audit should also include a sample of their current practice. If anomalies are identified, an action plan should be prepared to put this right.

b) Share this report with the nursing staff involved in this case. Those members of staff should be given training on NEWS and escalation procedures.

c) Ensure that there is a robust handover system in place and that all acutely ill patients undergo a daily review by a registrar (or above), including on weekends and holidays.

d) Share this report with the doctors involved in this case. The doctors should then review the report and medical notes with their appraiser to identify areas where practice could be improved.

e) Discuss this case with the Coroner and based on that discussion undertake an audit (minimum 10% dip sample) of coroner referral forms for the past three months. If inconsistencies or inaccuracies are identified, an action plan should be prepared to address them, this may include introducing a review system or additional training for doctors preparing the forms.

f) The Head of Corporate Governance should review the complaint handling in this case. The review should seek to identify what happened to the Serious Incident Report.

I **recommend** that, within one month of the final report date, the Health Board should

g) Apologise to Ms C and her family for the failings identified in this report. A meeting with the Chief Executive or the Medical and Nursing Director should be offered to Ms C.

h) Make a payment to Ms C of £10,000 in recognition of the distress and uncertainty caused by the clinical failings identified in this report. This payment is also in recognition of the time and trouble taken in pursuing this complaint, due to the complaint handling failings identified in this report.

49. I am pleased to note that in commenting on the draft of this report **Betsi Cadwaladr University Health Board** has agreed to implement these recommendations.

Nick Bennett 19 September 2017
Ombudsman

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
Email: ask@ombudsman-wales.org.uk
Follow us on Twitter: @OmbudsmanWales