Summary

Complaint from Mr B
against
Mayo General Hospital, Health Service Executive

The husband of a 53-year-old woman who died while she was being investigated for deteriorating health complained to my Office about the HSE. His wife had attended her General Practitioner (GP) with shortness of breath and weight loss. The GP referred her to Mayo General Hospital, from where she was sent to Merlin Park Hospital, Galway, for further tests. A test was completed and the test results, which were available immediately and which showed significant abnormality were sent by ordinary post back to Mayo General Hospital. The woman was not told of the significance of the results and was sent home. Four days later, she became unwell at home and died on her way to hospital in an ambulance. Ten days after her tragic death, the GP rang the Hospital Consultant to ask about the results. The Consultant's secretary found the results awaiting attention in the Consultant's postal slot.

The family contacted the Consultant and asked for an explanation of what had happened their wife and mother. Four months later, after several further phone-calls, but having received no explanation from the Consultant, the family made a complaint to Hospital management. During these initial four months, while the Consultant had provided reassurance to the family that he was examining what had happened, his clinic issued the dead woman with an appointment for a further test. Some months on, having received no adequate explanation from Hospital management either, the family complained to my Office. Twelve months after the woman died, the Hospital provided the family with some explanation regarding what had happened to the test results and they extended an apology. Just before the family received the Hospital's response and after I had commenced my examination of the case, an application form for medical card renewal was sent to the deceased.

The case was investigated by my Office and involved interviews with eleven medical and administrative staff. I also sought copies of medical records and requested a number of reports from the HSE.

My investigation ultimately found that there was a serious deficiency in the administrative standards and procedures for reviewing incoming post in Mayo General Hospital, that led to test results, acknowledged to be significantly abnormal, lying unattended for two weeks (and possibly much longer if the GP had not intervened). My investigation also found that the HSE had failed, at a number of levels, to respond effectively to the complaint.

In the course of my investigation, I was very concerned by a conflict of evidence which emerged between Hospital management and administrative staff, and the Consultant responsible for the care of the woman who had died and his personal secretary (non-HSE employee). Hospital staff and management told me that the Consultant's post, except post marked for his private office, was sent to the "Typing Pool", where it was placed in a postal slot for his attention. Hospital staff told me that post often backed-up and they would have to phone the Consultant to remind him to

come and attend to his post. In contrast, the Consultant told me that he had a system in place whereby all post marked with his name was sent to his personal secretary who would open it daily and ensure that any important information was brought to his attention. (The issue of public patient information being handled by a non-employee of the HSE itself raised issues for me and I asked the HSE to address this matter.) When this conflict of evidence with regard to basic but fundamental hospital procedures (the handling of potentially critical patient related information) arose, I once again reverted to the Hospital management and sought clarification on the procedures in place. I was told that the processes and procedures they had previously described were fact for that period in time. Although I was unable to resolve the conflict of evidence that presented, in this particular case, it was undisputed that the test results for the woman who had died were found in the postal slot in the typing pool, ten days after her death, and only then due to the enquiries of her GP.

My investigation uncovered another issue with regard to the communication of test results that concerned me. When the laboratory test was originally completed, the Laboratory Technician, who herself noted some concerning abnormality, brought the results to the attention of a Specialist Registrar. The Specialist Registrar wrote an explanatory note on the results page and that page was sent by ordinary post back to the woman's Consultant. When the GP asked the Consultant's secretary for a copy of the test results, this explanatory note was not included on the fax he received. My investigation later established that the Consultant had asked his secretary to omit this part of the page from the information to be faxed to the GP. No explanation was offered by the Consultant when interviewed as to why an integral part of the test results was not shared with the GP.

It is important to note that there is no evidence whatsoever that the death of this woman would have been prevented had the test results been attended to speedily. As Ombudsman, I am not empowered to examine clinical judgements regarding the diagnosis of an illness or the care and treatment of a person, however, I can and do examine the administrative actions of clinicians. In this regard, I sought expert and independent clinical advice to identify the level of adverse affect caused by the maladministration found. The advice I received said that there would have been no reason to expect this woman's sudden death. Further testing, which would have been indicated following receipt of the laboratory results, would most likely have been scheduled for a date beyond the date on which the woman suddenly died. But, the distress caused to this woman's husband and children, by the knowledge that abnormal results had not been reviewed or acted upon, can be imagined. It was only through my investigation that this expert and independent advice was made available. The family were left for a very long time wondering whether this woman's life could have been saved through timely intervention.

The recommendations from my investigation included the following:-

- Mayo General Hospital and the Respiratory Function Laboratory in Merlin Park Hospital, Galway, complete a comprehensive review of the system for requesting and reporting all respiratory tests (including Lung Function Tests**).** This should incorporate a risk assessment of current procedures to ensure that
    - tests are requested in the most efficient manner possible,
    - all results are reported as efficiently as possible,
    - the Consultant, or medical team, demonstrate that they have received the results and acted on them, as appropriate,
    - tests results which are requested and / or appropriate for a GP's attention are provided in their entirety to the GP in a timely manner,
    - the feasibility of using communication technology be explored to achieve the above and
    - there is regular audit of the system for requesting and reporting test results.

- Mayo General Hospital complete a comprehensive assessment and review of the arrangements by all clinical staff in relation to how post, which may contain patient related information, is actively managed.

- Mayo General Hospital review whether public patient information is being handled by non-HSE employees.

- Mayo General Hospital review its data capture techniques and procedures to ensure that all patient deaths are entered to the Hospital's Information System to ensure that no appointment cards are issued in respect of deceased patients.

- the HSE review complaint handling procedures in Mayo General Hospital to ensure compliance with the Health Act 2004 (Complaints) Regulations 2006

- the HSE make this report available to all staff involved in the care of the deceased and to the National Director of the HSE with responsibility for Care and Quality.

- the HSE makes a "Time and Trouble" ex-gratia payment, on a without prejudice basis, in the sum of €5,000, to the patient's family in recognition of the effort expended by them in the pursuit of their complaint and the unacceptable delay in the examination of their complaint.

This Investigation Report was issued to the CEO of the HSE in December 2009. The Ombudsman is delighted that all her recommendations have now been accepted.

Emily O Reilly, Ombudsman
6 April, 2010