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The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202004800

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

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

Summary

Mr L complained about the care and treatment he received from Betsi Cadwaladr University Health Board ("the Health Board") after he attended the Emergency Department on the advice of his optician.

Complaint 1

Mr L complained that the Health Board failed to, between January and September 2018, promptly and appropriately identify, investigate and treat his carotid artery stenosis (blockage of blood vessels in the neck, restricting the blood flow to the middle of the brain, face and head). The Ombudsman found that the Health Board missed opportunities to consider the possibility of carotid artery stenosis or that Mr L may have suffered a watershed stroke (this occurs when the blood supply to an area is compromised within 2 major vessel systems at the same time).

Consequently, the Health Board failed to carry out carotid artery imaging in January and March 2018. The Ombudsman considered that these missed opportunities amounted to service failures and that they caused injustice to Mr L because he continued to experience debilitating symptoms. The Ombudsman upheld Mr L's complaint.

Complaint 2

Mr L was further concerned that the Health Board failed to provide him with timely care once the stenosis had been identified in September, up to his surgery in November 2018. The Ombudsman identified that the Health Board delayed treating Mr L's carotid artery stenosis and ocular ischemic syndrome (damage to the eye and loss of vision as a result of reduced blood flow), despite him suffering transient ischaemic attacks ("TIA" - temporary disruption to a blood supply in the brain) during and following the imaging.

The Ombudsman noted similar failings in a previous case she investigated against the Health Board that identified shortcomings in neurological assessment to diagnose a TIA. Since that investigation, 2 reports (1 external) were published that were extremely critical of vascular care and treatment at

the Health Board. They contained significant recommendations for improvements in most areas.

It is the Ombudsman's view that serious failings occurred in this complaint, including a complete failure to follow both the original Guideline and the Health Board's own Policy. Mr L now has permanent sight loss and will need life-long treatment to try to manage his ongoing pain, inflammation, and increased pressure as a result of the damage caused to his eye. This constitutes a significant and ongoing injustice. The Ombudsman upheld Mr L's complaint.

Ombudsman's recommendations

The Ombudsman made several recommendations, which the Health Board accepted:

- Provide a meaningful written apology to Mr L for the failings identified in this report.

- Pay Mr L £4750 redress for the failings identified and the resulting impact upon him, and for the significant time and trouble he was put to in pursuing his complaint.

- Remind all relevant staff of the requirement for all patients who may be appropriate for surgery to undergo carotid imaging, in line with the new Guideline.

- Remind all relevant staff of the clinical indications of a watershed stroke (or TIA) and of the importance of considering this possibility when reviewing patients.

- The treating Consultant to reflect on how they can improve their future practice in light of the Ombudsman's findings.

- Review its Policy about treatment to ensure that it is compliant with current guidance and share the revised Policy with staff.

The Complaint

1. Mr L complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to:

a) Between January and September 2018, promptly and appropriately identify, investigate and treat his carotid artery stenosis (blockage of blood vessels in the neck, restricting the blood flow to the middle of the brain, face and head).

b) Provide him with timely care once the stenosis had been identified in September, up to his surgery in November 2018.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mr L. Clinical advice was sought from my Professional Advisers, Mr Samer El-Sherbiny, a Consultant Ophthalmic Surgeon ("the Ophthalmic Adviser"), Dr Les Ala, a Consultant Physician in Acute and General Internal Medicine ("the Acute Care Adviser") and Mr Daryll Baker a Vascular Surgeon ("the Vascular Adviser").

3. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. It is my role as the Ombudsman to determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

4. My office has investigated a previous complaint[1] against the Health Board which identified shortcomings in neurological assessment to diagnose a transient ischaemic attack ("TIA" - temporary disruption to a blood supply in the brain) at Ysbyty Glan Clwyd ("the Hospital"). Since that

[1] Case reference 201903132.

investigation, 2 reports were published, listed below at paragraphs 8 d) and e), that were extremely critical of vascular care and treatment at the Hospital. They contained significant recommendations for improvements in most areas.

5. Following the first report, the Welsh Minister for Health and Social Services announced in May 2022 the extension of targeted intervention arrangements to include vascular services. After the second report, she issued a written statement dated 31 January 2023[2] in which she said the Health Board must "…provide assurance they are addressing or have already addressed, the recommendations within this report as a matter of urgency." I am gravely concerned that the Health Board missed opportunities to identify its failings, having reconsidered this case as recently as July 2022, when it maintained its position.

6. Given this pattern of concerns, as well as the serious issues I have identified in Mr L's complaint, I consider it appropriate to publish this report in the public interest.

7. Both Mr L 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 legislation, guidance and policies

8. Reference is made within this report to the following legislation, clinical guidance and policies:

a) NICE Guideline CG68: National clinical guideline for diagnosis and initial management of acute stroke and TIA, 2008 ("the original Guideline"), was in place at the time of the events in this complaint. It noted that there was no specific clinical characteristic or symptom which would confirm, without doubt, the presence of carotid stenosis. Therefore, carotid imaging was required for all patients who had suffered a confirmed or suspected stroke or TIA and who would be a candidate for endarterectomy (surgery to remove the plaque blocking the blood flow through the arteries). A patient with a blockage of

[2] https://www.gov.wales/written-statement-vascular-services-betsi-cadwaladr-university-health-board-0

more than 70% should undergo surgery within 2 weeks. A patient with a blockage of less than 70% should be treated with medication and given lifestyle advice to reduce their risk of further stoke.

b) NICE Guideline NG128: Stroke and transient ischaemic attacks in over 16s: diagnosis and initial management, 2019, replaced the original Guideline ("the new Guideline"). The recommendations noted above were unchanged.

c) The Health Board's Policy ICP0025 – Management of people who are at risk or have suffered a TIA, 2009 ("the Policy"), states that patients at moderate to high risk of a stroke should undergo carotid imaging (such as an ultrasound or CT scan to investigate the level of blood flow through the carotid arteries) within 1 week. Where the arteries are less than 70% blocked, treatment with medication should be aimed at preventing further deterioration. Where the arteries are more than 70% blocked, surgery should be undertaken within 1 week.

d) Royal College of Surgeons' Report on 44 clinical records relating to vascular surgery on behalf of the Health Board ("the RCS Report"). Review visit: 19 July 2021, report published 20 January 2022. The following was noted:

- The review team considered the care provided to 50 patients selected by the Health Board through a review of records and other supplementary information, but 6 sets of records were missing entirely. The review team further described the majority of the surgical notes and other paperwork as "disorganised, illegible and incomplete."

- The following criticisms were made:

1. concerns regarding the aneurysm patients reviewed in terms of the complications, mortality, prolonged procedures and high volumes of blood transfusion

2. the effectiveness of clinical pathways in providing optimal clinical care in the case of several patients

3. the effectiveness of the Multidisciplinary team ("MDT") in ensuring continuous and optimal patient care

4. several instances were identified of clinical outcomes not being satisfactory

5. Most records showed communication with patients and other health professionals was either of poor quality or not documented at all

- The team also identified instances of good practice, most notably in the category of "behaviours, communication and team working".

- The report concluded with several urgent recommendations to address patient safety risks and a comprehensive list of other recommendations for service improvement. However, the report also stressed that it was an advisory document, and it was for the Health Board to consider the contents and determine subsequent action.

e) The Health Board's Vascular Quality Review Panel Report ("the Panel Report") 25 January 2023.

The following was noted:

- The Panel was formed following the publication of the RCS Report, to scrutinise whether necessary and follow-up aftercare plans were in place for all the clinical records that had been reviewed as part of the RCS Report review, and whether the records contained the information expected.

- The Panel's work was only one aspect of the work taking place across the Health Board's vascular services.

- The Panel identified a lack of recorded evidence around areas such as the understanding of the function and oversight of the responsible clinician, ensuring best practice in decision-making and consent, MDT working, and ensuring a holistic approach to care includes the wider aspects of medical, psychological, and social care.

- Recommendations were made in the following areas: the effectiveness of clinical pathways; clinical governance, including consent and decision-making, accountability, and 6 professional practice areas; person-centred care; team working, including the multi-disciplinary team; complex pain management; palliative care; education and learning; and discharge and necessary and appropriate follow up and aftercare plans.

The background events

9. On 11 January **2018** Mr L, 64, attended the Emergency Department ("ED") at the Hospital on the advice of his optician. He had been experiencing visual problems since before Christmas, including blurred vision, and a headache. On examination, an ED Doctor noted that Mr L also had numbness to the left side of his face and weakness and pins and needles in his left arm. It was recorded that Mr L's brother and father both died of haemorrhagic strokes (when blood from an artery suddenly begins bleeding into the brain).

10. A Computerised Tomography scan ("CT scan" - the use of X-rays and a computer to create an image of the inside of the body ("the first CT scan") - revealed that he had suffered a stroke (when the blood supply to part of the brain is cut off) in an area between the middle and the back of his brain. This area normally receives blood from 2 major vessel systems, fed by the carotid artery (in the middle) and the basilar artery (at the back). The first CT scan noted that Mr L's stroke appeared to be the result of an arterial blockage in the back of his brain.

11. The next day a Consultant Geriatrician reviewed Mr L, noting that he had visual problems including loss of his left sided field of vision and "mild L[eft] sensory symptoms". The Consultant Geriatrician prescribed

medication to reduce the risk of blood clots and cholesterol build-up and said that Mr L could go home if he wanted to. A Stroke Nurse and a Physiotherapist reviewed Mr L. The Physiotherapist noted that Mr L's field of vision was reduced, he was less visually aware on his left side and his downward gaze was impaired. It was noted that Mr L would prefer to go home; he was advised not to drive and discharged later that day with a plan for him to see Occupational Therapy in 3 days' time.

12. Mr L was reviewed on 1 March by the Consultant Geriatrician, who wrote to Mr L's GP stating that Mr L had made nearly a full recovery and that he had been unable to detect any problems with Mr L's field of vision. He noted that this should be checked with an optician and that, if everything was normal, Mr L could begin driving again.

13. On 26 July Mr L's optician referred him urgently to the Hospital, noting that he had reported blurred disturbance to his vision over the previous week. He was seen on 6 August, when an angiogram (a type of X-ray used to visualise blood vessels) was arranged. On 13 August the results of the angiogram revealed a blocked vein in Mr L's right eye, but there was no indication to suggest that there was any problem with his carotid artery and no changes in his macula (the central part of the retina responsible for detailed vision) that required intervention. An Ophthalmologist planned to review Mr L in a month's time.

14. On 5 September Mr L attended a routine 6 month review in the Stroke Clinic, where a Stroke Nurse noted that he was experiencing intermittent pins and needles down his left arm and the left side of his face. She discussed Mr L's ongoing symptoms with the Consultant Geriatrician and a Doppler scan (a test to estimate the blood flow through blood vessels) of Mr L's carotid arteries was arranged.

15. On 11 September Mr L underwent a Doppler scan of his carotid arteries, which showed extensive carotid stenosis, which was more than 90% blocked on Mr L's right side. It also showed 50% blockage in Mr L's left side. It was noted that, during the test, Mr L suffered a TIA. The next day the Consultant Geriatrician referred Mr L to a Consultant Surgeon.

16. On 17 September Mr L's optician referred him to the Hospital again, urgently, noting that he was experiencing severe pain in his right eye and his vision was blurred. The next day an Ophthalmologist noted that Mr L appeared to have developed ocular ischaemic syndrome (damage to the eye and loss of vision as a result of reduced blood flow). He explained that it was unlikely Mr L would re-gain his vision and therefore planned treatment to keep the eye as comfortable as possible.

17. On 26 September Mr L underwent a second CT scan, which confirmed significant narrowing in his carotid arteries and noted that Mr L's basilar artery was also blocked. The second CT scan also noted that the scarring from Mr L's stroke indicated a "watershed stroke", which occurs when the blood supply to an area is compromised within 2 major vessel systems at the same time. On 28 September Mr L attended the ED following 2 TIAs in 1 evening. It was noted that Mr L was awaiting surgery and he was discharged with advice to await review by the Consultant Surgeon.

18. On 3 October Mr L was seen by the Consultant Surgeon. It was noted that Mr L was continuing to experience recurrent TIAs and required a date for surgery as soon as possible. A plan was made to discuss Mr L at the next multidisciplinary meeting on 17 October. Mr L's surgery took place on 8 November. A review note at the Vascular Clinic, dated 12 December, noted an incidental finding during the surgery of complete occlusion of the right internal carotid artery by a blood clot. The notes also recorded that Mr L had only very partial vision in his right eye and suffered occasional spasmodic pain in the same eye that was very painful.

19. Mr L first complained (with the assistance of an advocate) to the Health Board on 19 June **2019** and following a response dated 3 October with which he was dissatisfied, requested a meeting that took place on 14 January **2020**. The Health Board began an investigation into the miscommunication between the emergency staff and doctors, the outcome of which he received on 28 October.

20. Mr L remained dissatisfied, and on 7 January **2021**, he asked the Health Board to consider his case under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales)

Regulations 2011 (“the Regulations”), with the express purpose of having the potential qualifying liability assessed. The Health Board said the Redress team had confirmed that a full investigation had taken place, with the addition of an external investigation by a Consultant, and it had been concluded that there was no qualifying liability.

21. Mr L brought the first point of his complaint to my office on 20 January 2021. An investigation was started in March, but during the course of the investigation Mr L wished to raise a further concern (see paragraph 1(b) above). He asked that the Health Board consider the additional element of his complaint under the Regulations, which was forwarded to the Health Board on 8 December 2021. The Health Board eventually provided a 2-page response to this further concern on 28 July **2022**. Mr L remained dissatisfied and asked my office to also investigate his additional concern on 26 August 2022.

22. The Investigation Officer sought further professional advice regarding this additional element of the complaint and a copy of all the advice received was sent to the Health Board on 16 January **2023**. The Health Board confirmed Mr L’s case was presented at a Services Governance Meeting on 14 February 2023 and information was shared for the purpose of learning. A copy of the slides from the presentation stated, “We should have identified and treated his carotid disease on nitial admission” (sic). Lessons learned were stated as:

- Re-visit the history to confirm the clinical presentation.
- Think of watershed infarcts (i.e. strokes).
- Low threshold for requesting carotid Dopplers.

Mr L’s evidence

23. Mr L said that his carotid arteries should have been checked when he first had the stroke and that, between September and November, he suffered numerous TIAs. He said that Doppler scans of carotid arteries should be offered to all stroke patients as standard procedure.

24. He said that although his surgery in November was successful, he remained completely blind in his right eye, which has affected his independence and his quality of life. He used to enjoy doing DIY projects and now needs assistance and cannot do all the household tasks he used to manage. He described the effect as “devastating”.

The Health Board’s evidence

25. The Health Board said that Mr L’s stroke did not originate from his carotid artery, although it did originate at the back of his brain, and that the symptoms he was experiencing were consistent with this diagnosis. It acknowledged that Mr L should have received carotid imaging if the ED Doctor had told the Consultant Geriatrician about Mr L’s facial symptoms. Nevertheless, it said that, even if the blocked carotid artery had been identified at the time of Mr L’s stroke, it would not have been addressed because it was asymptomatic and was not the cause of the stroke.

26. The Health Board confirmed that leaflets providing information on strokes and their management were now available in the ED as well as on dedicated stroke wards.

Professional Advice

27. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about.

The Ophthalmic Adviser

The Ophthalmic Adviser said:

28. The assessment of the results of Mr L’s angiogram in August, and the resulting plan of care proposed on 9 August, were appropriate; there was no indication from that appointment that there was any delay in the blood circulation from the arteries feeding Mr L’s eye.

29. A plausible explanation for the results of the angiogram in August was that the body will re-model its arterial blood vessels to attempt to compensate for a blockage.

30. This re-modelling will often successfully allow for blood flow to reach the areas affected by a blockage up to a critical point, which is what Mr L's blood vessels appeared to have done.

31. The carotid artery stenosis caused Mr L's sight loss and if it had been identified – and treated – in January or March it was possible that this could have been prevented. He could not say whether surgery would have been an appropriate option for Mr L.

32. It would not now be possible to reverse Mr L's sight loss; the only treatment available would be to keep the eye comfortable by managing any pain, inflammation, and increased pressure.

The Acute Care Adviser

The Acute Care Adviser said:

33. The clinical assessment on 11 January was appropriate, as was the decision to undertake a CT scan and the treatment prescribed to manage Mr L's condition and risk of further stroke.

34. However, not all of Mr L's symptoms could be fully explained by a stroke in the back of Mr L's brain alone; his left-sided numbness and weakness suggested a potential blockage in the middle of his brain. Furthermore, the area of Mr L's brain that was affected by the stroke normally receives blood supply from vessel systems in both the middle and the back of his brain. On 11 January 2018 the Doctor noted that Mr L had presented with blurring of vision and headache, and tingling in the left arm and some weakness, as well as decreased sensation of the left face, which should have prompted the Clinical team to consider also a right-sided middle cerebral artery blockage (the middle cerebral artery is a branch of the internal carotid artery).

35. Because his basilar artery was blocked, Mr L's carotid artery attempted to compensate by supplying blood to the back of his brain as well as the middle, but the narrowing within Mr L's carotid artery meant that this compromised both vessel systems and led to his watershed stroke.

36. Both the Clinical team and the Consultant Geriatrician should have considered the possibility that Mr L had suffered a watershed stroke, and Mr L should have undergone a Doppler scan of his carotid arteries within a week of his admission in January.

37. The Consultant Geriatrician should also have requested carotid imaging on 1 March, because Mr L's symptoms in January still had not been fully investigated and he still had ongoing pins and needles.

38. When Mr L attended the ED on 28 September, he should have been referred immediately to the Vascular Surgery Team for a view on whether his surgery should have been brought forward.

39. If Mr L's carotid artery stenosis had been identified and treated sooner, this might have prevented the deterioration in his right eye and prevented the repeated TIAs that he experienced. It would also have alleviated some of his anxieties and worries.

The Vascular Adviser

The Vascular Adviser said:

40. It was very unlikely that Mr L's carotid artery would have increased from below 70% blocked, to more than 90% blocked between January and September.

41. Mr L was put at increased risk of further stroke by the failure to provide surgery within 2 weeks of his attendance on 11 January.

42. The ocular ischemic syndrome diagnosis on 18 September was a surgical urgency. Before that occurred, Mr L still had some vision.

43. If Mr L had been reviewed by the Vascular Surgery Team on 28 September, he should have been admitted and undergone surgery as soon as possible or, at the latest, within 2 weeks.

44. On 3 October the Consultant Surgeon appropriately identified that Mr L required surgery urgently. However, the delay between the diagnosis of ocular ischemic syndrome and Mr L's ultimate surgery on 8 November resulted in Mr L losing more of his sight.

Analysis and conclusions

45. The advice I have received is very clear, which is why I have set it out in some detail above. This enables me to be relatively brief in what I have to say here. While accepting that advice in full, the findings set out below are my own. I will address each of Mr L's concerns in turn.

a) **Between January and September 2018, the Health Board failed to promptly and appropriately identify, investigate and treat Mr L's carotid artery stenosis (blockage of blood vessels in the neck, restricting the blood flow to the middle of the brain, face and head).**

46. In terms of identification and investigation of the stenosis, the Acute Care Adviser confirmed that Mr L's symptoms were not wholly explained by the Health Board's finding that the stroke originated in the back of his brain. It is unclear whether the Consultant Geriatrician took into account Mr L's facial symptoms and left arm symptom, although they were clearly noted in the medical records by a number of staff and the Consultant Geriatrician himself noted left-sided vision loss and sensory symptoms.

47. Whilst the first CT scan showed that Mr L's stroke occurred in the back of his brain, it was unclear whether this originated solely from the basilar artery or whether the carotid artery was also blocked. It is therefore concerning that the Consultant Geriatrician did not take any action to investigate the possibility of carotid artery stenosis and did not appear to consider the possibility that Mr L had suffered a watershed stroke.

48. The original Guideline confirmed that consideration of carotid imaging was indicated by Mr L's presentation on 11 January and that, depending upon the result, surgery might have been indicated. The Vascular Adviser has confirmed that it was most likely that Mr L's carotid artery was already more than 70% blocked, and that Mr L should have been offered surgery in January. I accept that advice and therefore consider that if Mr L had undergone carotid artery imaging in January, the likelihood is that it would have identified his carotid stenosis.

49. I am also concerned that no carotid imaging was undertaken in March. It does not appear that adequate consideration was given to Mr L's ongoing symptoms because the Consultant Geriatrician's letter, stating Mr L had made a full recovery, was contradicted by the clinic notes on the day, which recorded ongoing pins and needles. This represents another missed opportunity to consider the implications of Mr L's left-sided symptoms and undertake carotid imaging to investigate the possibility of carotid artery stenosis. As it was, it was not until 11 September that, following the actions of the Stroke Nurse, a Doppler scan was finally arranged and this, ultimately, revealed the issue.

50. It is my view that these missed opportunities amounted to service failures, as, finally, recognised by the Health Board on 14 February 2023. These failures gave rise to an injustice to Mr L, due to his continuing to experience debilitating symptoms. I therefore **uphold** this point of complaint.

b) The Health Board failed to provide Mr L with timely care once the stenosis had been identified in September, up to his surgery in November 2018.

51. Turning to the treatment of Mr L's carotid artery stenosis, I note that Mr L was, eventually, referred urgently to the Consultant Surgeon following the Doppler scan that occurred on 11 September. However, given that Mr L suffered a TIA during that test, there was a missed opportunity for Mr L to be seen and considered for surgery within 2 weeks (as per the original Guideline). The Health Board's Policy (see paragraph 8c above) advocates undertaking surgery within 1 week. Just 6 days later Mr L was diagnosed with ocular ischemic syndrome, which the Vascular Adviser has confirmed required urgent surgical treatment. By the time Mr L was seen

again in the ED on 28 September, he was also reporting multiple TIAs. I am therefore concerned that no appropriate input was requested from the Vascular Surgery Team, and Mr L was discharged with advice to simply await an appointment with the Consultant Surgeon.

52. Mr L was ultimately seen by the Vascular Surgeon 5 days later and was listed for urgent surgery but, again, the original Guideline was not followed, and neither was the Policy. Mr L's surgery did not take place until 6 weeks after his hospital attendance on 28 September.

53. As a result of the repeated missed opportunities to identify and treat Mr L's carotid artery stenosis, Mr L suffered multiple TIAs, ongoing discomfort, and blurred vision. Despite the serious consequences of ocular ischemic syndrome, and the irreversible nature of the effects, there still appeared to be no sense of urgency to offer treatment. It is clear that serious failings occurred here and a complete failure to follow both the original Guideline and the Health Board's own Policy.

54. As a result, Mr L has been left with permanent sight loss and life-long treatment to try to manage his ongoing pain, inflammation, and increased pressure as a result of the damage caused to his eye. This constitutes a significant and ongoing injustice to Mr L. I therefore **uphold** this point of complaint.

55. Before I conclude this report with my recommendations to the Health Board, I must invite it to review its complaint handling and responses in light of the NHS Wales Duty of Candour which was introduced in April 2023.[3] In the future, I hope to see the Health Board respond openly and honestly to complaints, in order to save other patients from experiencing the same difficult complaint journey due to its failure to identify deficiencies. I cannot fail to be shocked by the fact that it took the Health Board until February 2023 (see paragraph 50), during this investigation (after I had shared a draft of my Advisers' views), before it recognised any failings in Mr L's case. This is despite his having first put the complaint to the Health Board in June 2019.

[3] Introduced via the Health and Social Care (Quality and Engagement) (Wales) Act 2020

56. Finally, I have learnt of a recent review by Health Inspectorate Wales (HIW),[4] which leads on matters of the quality and safety of patient care in Wales. I see that HIW considers some significant headway has been made by the Health Board in acting upon recommendations made by the RCS Report, which I referred to above, such that it felt able to de-escalate the vascular service from a designation of one of serious concern and requiring significant improvement. While there still remains work to be done, I wish to record that I am pleased that the Health Board is making good progress so that events such as in this case might in future be avoided.

Recommendations

57. I **recommend** that, within **1 month** of the date of this report, the Health Board should:

a) Provide a meaningful written apology to Mr L for the failings identified in this report.

b) Offer Mr L financial redress in the sum of £4000 reflecting the serious failings I have found and the resulting and lasting significant impact upon him. To further offer Mr L redress of £750 for the significant time and trouble he has been put to in pursuing his complaint to fully gain answers to his concerns.

c) Remind all relevant staff of the requirement for all patients who may be appropriate for surgery to undergo carotid imaging, in line with the new Guideline.

d) Remind all relevant staff of the clinical indications of a watershed stroke (or TIA) and of the importance of considering this possibility when reviewing patients.

[4] Vascular Services in North Wales are de-escalated as a service requiring significant improvement by HIW | Healthcare Inspectorate Wales published 29 June 2023

58. I **recommend** that, within **6 months** of the date of this report, the Health Board should:

e) Ensure that the Consultant Geriatrician considers my findings and reflects on how he can improve his future practice as part of his regular supervision.

f) Review its Policy ICP0025 (given its age) to ensure that it remains compliant with current policy and practice, including the new Guideline, and then share the revised Policy with all appropriate staff.

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

Michelle Morris 19 October 2023
Ombwdsmon Gwasanaethau Cyhoeddus/Public Services Ombudsman

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