Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

Thematic Report

Justice Mislaid

Lost records and lost opportunities

Contents

www.ombudsman.wales
communications@ombudsman-wales.org.uk
@OmbudsmanWales

This report is laid before the National Assembly for Wales under paragraph 15 of Schedule 1 of the Public Services Ombudsman (Wales) Act 2019

Foreword

2019 was an exciting year for my office with the enactment of the new Public Services Ombudsman (Wales) Act ("the Act").

The Act draws on best practice from Ombudsman schemes across the world, providing tools to drive up the standards of complaints handling and improve service delivery. Through the creation and implementation of the Complaints Standards Authority ("CSA"), I can now provide guidance and support, on complaints handling and learning from complaints, to public bodies in Wales. I aim to provide bespoke training for bodies in my jurisdiction which will target areas that require additional support, promote good practice and ensure that, when a complaint is upheld, the lessons are learned and shared. The CSA will also promote a consistent approach to complaint handling and the reporting of complaints performance.

The Act also allows me to conduct 'own initiative' investigations which gives me the opportunity to take a pro-active approach to investigating where I have a reasonable suspicion of maladministration or service failure. Own initiative investigation powers enable me to undertake investigations into potentially systemic maladministrative practice or service failure. This removes the need for a direct complaint to have been made to me. I see these powers as my opportunity to provide a voice for the voiceless, and they will allow me not only to draw attention to significant matters of public interest, but also to affect people's lives by driving 'real time' improvements to service delivery.

It is my intention, however, to continue publishing thematic reports. These reports are based on my analysis of the actual cases investigated by my office. They are a useful way of highlighting and emphasising the key issues being identified by my Investigation and Casework Officers on a daily basis. These reports also provide an opportunity for me to share that information across the public sector and drive wider learning.

This is the fourth thematic report I have published during my time as the Public Services Ombudsman for Wales. My previous thematic reports have focused on 'out of hours' care in Welsh hospitals, effective hospital discharge and on lessons that can be learned from poor complaint handling by all sectors of public service in Wales. The reports have been well received and have resulted in changes to public service delivery. I will continue to support this work through my dedicated Improvement Officers and my new CSA powers.

It has been reassuring to see the impact of my previous thematic reports. However, I am concerned to note that, once again, the number of complaints I am receiving annually is increasing and a significant proportion of those complaints in some way relate to complaint handling.

Lost or inadequate records held by bodies significantly impact upon the thoroughness of complaint investigations and the responses provided. The consequences of this include a prolonged complaints process, a delay in justice and a breakdown in the relationship between the service provider and the service user. These outcomes, and the additional injustice they cause to citizens and service users, are unnecessary and avoidable. Robust information governance and records management on the part of providers of public services in Wales would prevent this additional injustice.

Nick Bennett
Public Services Ombudsman for Wales

Introduction

The responsibility and role of the Ombudsman

The Public Services Ombudsman for Wales has legal powers to examine complaints about public services. He also investigates complaints that members of local government bodies have breached their authority's Code of Conduct. He has a team of people who help him to consider and investigate complaints. He is independent of all government bodies and the service that he provides is impartial and free of charge.

Introduction to Records and Records Management

Records

Records are anything, paper or electronic, containing information. They may include scanned images, photographs, audio/video recordings and digital records. A record will usually contain sufficient personal and sensitive data to identify a person.

Health and Social Care Records

Health and social care records hold confidential, sensitive and personal information. These records are a valuable resource which is essential to the delivery of evidence-based health and social care and enables effective complaint handling. Health and social care records should be contemporaneous and include details of the provider's accountability for clinical and social care decisions. It is a fundamental principle of information governance that public sector bodies, especially those responsible for providing health and social care services, can easily identify, locate and retrieve information relating to their service users.

Records Management

Records management is the procedure for controlling recorded information throughout its life cycle; this includes the process for the secure storage and destruction or permanent preservation of records.

It is essential to the operation of organisations such as health boards, local authorities and care homes that they can identify and locate information which is critical to their decision making and the delivery of services. Furthermore, it is imperative that records relating to the health and social care of individuals are managed carefully to ensure there is no risk of loss or inappropriate disclosure:

"Every citizen should feel confident that information about their health is securely safeguarded and shared appropriately when that is in their interest. Everyone working in the health and social care system should see information governance as part of their responsibility." (Dame Fiona Caldicott; Information: To share or not to share? The Information Governance Review; March 2013.)

Introduction

Relevant Legislation and Guidance

All health and social care records are legal public documents according to the Public Records Act 1958 and in accordance with the Government of Wales Act 2006. Consequently, they must comply with legislative requirements. The Data Protection Act and the General Data Protection Regulations ("GDPR"), which came into effect in 2018, have placed an onus on public bodies to ensure that there are sufficient data security measures in place. They state that data should be "processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical and organisational measures."

The Welsh Government has issued non-statutory guidance to health and social care providers in Wales: "Confidentiality: Code of Practice for Health and Social Care in Wales". This provides advice on records management, including information security.

Professional standards championed by regulatory organisations including the General Medical Council, the Nursing and Midwifery Council and Social Care Wales require members to make complete and timely records relevant to their practice and to take all steps to ensure that records are kept securely.

Additionally, there is internal guidance available to NHS Wales providers. Standard 20 of the NHS Wales Governance e-Manual sets out the measures to be implemented to ensure that personal information is protected and kept secure. This makes particular reference to:

- The safe storage and retrieval of health records generally and within clinical areas and offices
- The tracking of records when transferred or required within an organisation and appropriate audit of this
- The return of patient held records when an episode of care is complete
- Splitting of folders and cross referencing of volumes of manual records
- Transportation of health records within and outside of the organisation.

I have also produced guidance to support public service providers with their duty to manage records. My statutory guidance "Principles of Administration and Good Records Management", issued jointly with the Information Commissioner, requires public service providers to ensure that they have effective records management systems in place which allow them to meet their statutory duty, while maintaining and storing records in such a way that they are both retrievable and usable. Systems must also ensure that staff are aware of their record management obligations.

Recent Developments in NHS Record Keeping

For many years, the personal records held by a health or social care provider were completely paper based, placing them at risk of being misplaced, misfiled or lost. Whilst it is pleasing to note that NHS Wales is making progress towards the mammoth task of digitising its records, I am mindful of the Auditor General's findings in his January 2018 report, "Informatics systems in NHS Wales, January 2018", which found that, although NHS Wales' vision for an electronic patient record is clear and key elements are being put in place, there have been significant delays in delivery. Consequently, paper-based records will continue to be used and it remains crucial that service providers continue to maintain and safeguard paper records appropriately.

Analysis

As well as being a legal requirement in health and social care settings, information is collected and retained to ensure that the service provider can take a person-centred approach when dealing with individuals and to ensure that there is continuity of care.

This report reflects complaints made about health and social care service providers in Wales. I have taken a sample of 17 cases from those that I have considered where health and social care records have been mislaid or lost. I have also referred to the key themes that have been identified in those cases.

Compliments and complaints are key for any service provider looking to improve service and build on good practice. In order to fully consider a complaint, the service provider should have access to all relevant information, including contemporaneous records, which are key. This not only allows the body to make a reasonable and informed decision which can be fully explained to the complainant, but also instils confidence in the complainant who will feel that the complaint handling process has been open, transparent and objective. The loss of records detrimentally affects the ability of an organisation to investigate the complaint thoroughly. If a body is unable to reassure the complainant that matters have been dealt with appropriately, the complainant may be left with a degree of suspicion and dissatisfaction. Additionally, the organisation is unable to satisfy itself that the matter was dealt with correctly and may not identify any lessons that should be learnt. Importantly the failings may be repeated, with potentially significant outcomes.

During my review of the complaints made to me since 2017, I have recorded a number of cases where records have been misplaced, misfiled or lost. As a result, there have been occasions when neither the service provider nor my office have been able to fully respond to the complaints made, thus denying the complainant answers to the questions posed and any reassurance that the action taken was appropriate. During the review, I have identified four significant barriers to satisfactory complaint handling caused by misfiled, misplaced or lost records:

- Incorrect information is shared with the complainant
- The service provider is unable to investigate the complaint
- The service provider undertakes an inadequate investigation of the complaint
- I, as Ombudsman, am unable to investigate the complaint.

It has been evident from the complaints that I have received that, despite having guidance, policies and processes available, there are occasions when service providers fail in their statutory duty to safeguard the information in their control.

The case studies selected also illustrate the impact of misplaced or lost records on the complainant's experience of the process. The detrimental effect of the lost records on these people is evident as they are left feeling frustrated and suspicious as their concerns are left unanswered; justice mislaid is justice denied.

I would also add here that, over the years, my office has seen a significant number of cases where complaints have been made about NHS continuing healthcare assessments. I have seen cases where a decision on a person's eligibility for NHS continuing healthcare has been made despite crucial records being mislaid or destroyed by either the social care provider or the Health Board. Again, these failures to maintain such important personal information undermine the decisions made.

Analysis

Analysis of Individual Complaints

To give context to the issues identified in this review I refer below to the experiences of some of the complainants in the sample cases considered. To protect the identities of those complainants, they are referred to by title and alphabetical pseudonyms only, for example, **Mrs A**. I have grouped the sample cases to reflect the various issues I considered.

Incorrect information shared with the complainant

In this section, I refer to the complaints made by Mrs N and Mr W.

When meeting a service provider, particularly in a clinical setting, a service user expects the relevant records to be available. This is not always the case. **Mrs N** attended a meeting with her late father's consultant to discuss the surgical treatment and care he received in the 3 days before his death. Unfortunately, the relevant records were mislaid and the Consultant attended the meeting with records relating to another patient. As a result, the wrong patient's care and treatment were discussed. This added to the distress experienced by **Mrs N** and her family as it reinforced her view that the Health Board had not taken the complaint seriously.

Another example is the case of **Mr W** who had concerns about the accuracy and security of his care and treatment records held by the Health Board. His concern was compounded by the Health Board when, on more than one occasion, it sent him records relating to a different patient. This is worrying, given the Health Board's statutory duties to manage records.

The service provider was unable to investigate the complaint

In this section, I refer to the complaints made by Mr H, Mrs L and Mrs X.

It was of great concern to me that, of the 17 cases identified for this report, over 30% of the complaints were escalated to my office because the body complained about had lost records and was therefore unable to undertake a proper investigation of the complaint.

In the cases of **Mr H** and **Mrs X**, concerns had been raised about the care and treatment their respective parents had received in the period leading up to their deaths. Unfortunately, the records that had been lost were those for the periods in question. What was of greater concern was that these families waited between 3 and 5 months for a complaint response, only to be informed that the records were missing and that it was not possible to fully address the concerns raised.

In the case of **Mrs L**, numerous requests were made to the Health Board for copies of her late mother's medical records. Contrary to the requirements of legislation and guidance to provide copies of records on request, **Mrs L** and her Advocate were informed that the records were unavailable as they were being used to formulate the complaint response. It was not until 3 months later that **Mrs L** was informed the records had, in fact, been lost.

The failure to maintain the records not only undermined the service provider's position but caused the grieving families to experience preventable delays. It drove them to escalate their complaints to me, further delaying any conclusion to their concerns.

Analysis

The service provider undertook an inadequate investigation of complaints

In this section, I refer to the complaints made by Mrs AB, Mrs S and Mr F.

I recognise that many complaints received by service providers and by my office are often multi-faceted. In many of these cases, only some of the records for the period in question are available, allowing only part of the complaint to be addressed. This causes problems because the complainant is left wondering what information has not been included, why that information had been lost and, in some cases, what the service provider might be trying to hide.

There are examples of cases where the service provider has undertaken an inadequate or partial investigation of a complaint. Mrs **AB's** complaint experience could only be described as long and protracted as the Care Home provided only a partial response to her complaint and failed to explain why it had not addressed the outstanding matters she had raised. Only later did it become clear that this was because the records had been lost.

In the cases of **Mrs S** and **Mr F**, the Health Board drafted a response to the complaints, despite the absence of records. In the case of **Mrs S**, the Health Board based its response on the minutes of a meeting between **Mrs S's** family and the Consultant. The content of the meeting appeared to have been based on a recollection of events, not a contemporaneous record of events. Curiously, in the case of **Mr F**, the Health Board produced a formal response not upholding the complaint, undeterred by the fact that in the absence of records they could not properly investigate the complaint.

These cases demonstrate a lack of the openness and transparency essential to good complaint handling.

The Ombudsman was unable to investigate the complaint

My office is one of the final stages in the complaints process (excluding legal options). It is of great concern to me that, of the 17 cases selected, over 70% could not be investigated either in part, or in full, by my office. The complainants in those cases were denied answers, reassurance and justice.

That said, I am mindful that, in some cases, the records were later found, and the concerns were addressed. However, the missing records caused a significant delay to the investigations and the complainant's access to justice.

Analysis

The Impact of Lost Records on the Complainants

The case studies featured in this report illustrate the effect on the complainant or their family when records are lost or misplaced. In particular, the knowledge of the loss of records, and often the inability of the service provider to find key documents, inevitably has a detrimental effect on that individual's experience of the complaint process. This is illustrated in the cases of Ms A, Mr B, Mrs D, Mrs E, Mr F, Mr H, Mrs K, Mrs L, Mr Q, Mrs S, Mr W and Mr CD; it leads to inconvenience, frustration and distress for those concerned.

In many of the examples, the patient records lost or misplaced have related to the period of care immediately before that patient's death. It is therefore understandable that the relatives of those patients who were pursuing a concern relating to the care or treatment provision have, when learning of the loss or misplacement, expressed great concern that their opportunity to obtain answers might have been lost. **Mrs S** said that she felt unable to grieve as answers could not be provided to her concerns. It is unacceptable that many of these complainants have encountered this additional distress at what would already have been a difficult and emotional time.

The discovery that records have been lost has led to many complainants voicing feelings of distrust of the service provider or a loss of faith in the complaints process. **Mr H**, **Mrs L**, **Mr Q**, **Mrs S** and **Mr CD's** experiences were such that they suspected that the Health Boards were deliberately concealing information about the quality of care provided to their loved ones. **Mr Q** and **Mrs S** felt that the loss of records might have been used by the service providers as a deliberate tactic to frustrate their pursuit of these matters. Although the Ombudsman has not found evidence of deliberate action in any of the cases considered, it is understandable that the complainants reacted in this way. It is deeply unfair to complainants that their concerns can never be addressed.

In **Ms A** and **Mrs D's** cases, the Health Board's responses to their complaints suggested that events complained about had not occurred or that their recollections were disputed in some way. Both complainants said they felt insulted by this and felt that they were being called "liars". **Mrs E's** and **Mr Q's** experiences with the Health Boards left them questioning the quality of the investigation of their complaints, again undermining trust in the service provider and the complaints process. Additionally, **Ms A** and **Mr B** were put to the inconvenience of having to supply evidence to enable further investigation by the Ombudsman.

Further, in **Mrs E's** case, she was not told that some of her records were missing. The Health Board was not open and transparent in its dealings with **Mrs E**, and this, coupled with the fact that the missing records related to the concerns she raised, cast doubt on the complaint response received from the Health Board. In **Mr W 's** case, the inclusion of another person's confidential medical records within his own records caused him to question the nature and quality of his treatment. These cases highlight the importance of open and transparent communication when issues of this kind arise. Timely notification of such incidents may be successful in maintaining trust and co-operation while preventing escalation of complaints.

In all the stories included above, the complainants were so dissatisfied with the complaint responses that they decided to pursue their complaints with the Ombudsman. It is therefore understandable that the Ombudsman's inability to independently consider matters further because of a loss of records, as in **Mr F**, **Mr H** and **Mrs K's** cases, was met with deep feelings of disappointment and concern.

Future Considerations & Recommendations

It is encouraging to note that some of the Health Boards identified during this review have undertaken to audit and review their processes. NHS Wales' plans to digitise patient records should reduce the incidence of records being lost, but, given the potentially lengthy delay before patient records are fully digitised, the following recommendations are made to all service providers in Wales:

1. Effective Records Management Policies and Processes

Service providers should review and update their records management policies and processes to ensure that there are clear directions on the storage, access (for both clinical needs and for complaints/legal use) and transfer of records. These processes should also include an effective means of tracking the "real time" location of physical records.

2. Robust Training

Service providers should ensure that all staff handling information have received appropriate training which takes into account statutory duties as well as guidance provided by Welsh Government, regulators and any relevant internal policies. This will increase awareness of requirements and confidence that processes are being followed.

3. Clear and detailed search and reporting procedure for use when records are misplaced or lost.

The mechanism for reporting misfiled, mislaid or lost records as soon as they are identified should be reviewed. This should include a clear and methodical search process to ensure that mislaid records may be found in a timely and effective manner.

Consideration should also be given to introducing an "amnesty" for the anonymous return of patient records in situations where a thorough search in line with procedures has been unable to locate the missing documents and/or where deliberate concealment is suspected.

Future Considerations & Recommendations

4. Communication

Commonly the discovery that records have been misplaced or lost is made by complaint handlers. Service providers should therefore consider reviewing their processes for notifying complainants that records are not available, in addition to arrangements to consider the need to notify the Information Commissioner. Service providers should ensure that complainants are made aware of the position, including the impact on the ability to respond to the complaint, as soon as is practicable, in order to dispel any suspicion or concern that the records are being deliberately concealed and to avoid delay.

Where a service provider takes a view that, despite the misplaced or lost records, it is possible to respond to the complaint or aspects of it, the decision letter should provide a clear rationale for the decision outlining any additional evidence that was considered and the analysis of it. Where missing records mean that the service provider's version of events is unsupported by documentary evidence, particular care should be taken to ensure that findings are fair and balanced.

5. Effective Governance

Boards or committees responsible for governance should take steps to ensure that lessons are learned from incidents of lost or misplaced records. They should:

a) Receive regular reports on incidents of lost or misplaced records

b) Satisfy themselves that measures have been agreed for prevention of recurrence, and that any learning is utilised more widely across the organisation

c) Satisfy themselves that the agreed measures are actually in place

d) Identify and tackle endemic issues

e) Ensure that appropriate consideration has been given in each case as to whether a self-referral to the Information Commissioner for Wales should be completed.

Appendix 1

Case Studies

The sample cases considered in the review are generally ones that have been investigated or concluded by way of early resolution or settlement. Matters are concluded by early resolution or settlement if, following assessment, it is considered that there is other action that might be taken by the organisation which could quickly resolve the complaint. Not all of the cases referenced below are referred to in the report however they are further examples of lost records causing a detrimental impact on the complaint investigation. I have also included some cases which, at the time of drafting this report, were still under investigation.

Ms A's Story

Ms A complained about her discharge from hospital following the birth of her baby and the postnatal care and treatment that she had received in early February 2017.

During the course of the investigation, a request was made for Ms A's medical records. The Health Board advised the Ombudsman that it had been unable to locate Ms A's postnatal pathway records (which included the daily postnatal examinations). Furthermore, the only evidence the Health Board held relating to Ms A's attendance at the Hospital, and her subsequent treatment with antibiotic medication, was a copy of a prescription from that date held in the Hospital Pharmacy. There was no record of her subsequent attendance at the Hospital, or of her being turned away by clinicians.

Whilst the investigation found that Ms A's care, treatment and subsequent discharge from hospital had been in line with relevant guidance, it also found that there had been a missed opportunity to identify a medical complication at an earlier outpatient appointment. With respect to the missing records, the Ombudsman expressed concern about the detrimental impact this had on his investigation as well as the upset and inconvenience it had caused Ms A.

The Health Board agreed the recommendations made. In addition, the Health Board advised that a review was being undertaken into the storage and tracking of records to prevent future record loss incidents.

Mr B's story

Mr B complained about the care and treatment his mother, Mrs C, received during her admission to hospital in May 2017. Mr B also complained about the Health Board's management of his concerns, including those about safeguarding. (Safeguarding is concerned with protecting those at risk of abuse/harm (adult at risk) from suffering abuse or neglect).

During the investigation, a request was made for Mrs C's medical records and the relevant safeguarding documents. The Health Board advised the Ombudsman that it had been unable to locate the records for the period 7 – 15 May 2017. Fortunately, Mr B had previously obtained a copy of the records and agreed to share them with the Ombudsman for the purpose of this investigation.

Appendix 1

The investigation identified failings in the care and treatment Mrs C had received, as well as significant delays in the reporting, processing, investigation and management of Mr B's safeguarding concerns. Finally, the investigation found that the Health Board had failed to address Mr B's concerns in accordance with its complaints process.

The Health Board agreed the recommendations made, including reviewing its procedures for sharing information and the provision of training on safeguarding.

Mrs D's story

Mrs D complained about the care and treatment she had received during and after an angiogram[1]. Specifically, Mrs D complained about the pain and bleeding she experienced and her subsequent development of deep vein thrombosis (a blood clot that develops within a deep vein in the body).

The Ombudsman started an investigation into the complaints raised by Mrs D. However, it was not possible to complete the investigation because the Health Board had mislaid records relating to the angiogram.

Since the Ombudsman was prevented from undertaking a full investigation of the complaint, the matter was settled. As part of the settlement, the Health Board agreed that it would continue its search for the missing records. The notes were subsequently located.

Mrs E's story

Mrs E complained about the care and treatment she received following the removal of a cyst from her neck.

During the investigation a request was made for Mrs E's medical records. The Health Board advised the Ombudsman that records from the Ear, Nose and Throat, Dermatology, Speech & Language Therapy and Emergency Departments for an 18-month period were missing. Whilst most of the records were located some months later, the Ear, Nose and Throat Department records for a 5-month period could not be found.

The investigation found that the care, treatment and subsequent discharge of Mrs E had been in line with acceptable practice. However, in the absence of any records to the contrary, the Ombudsman found that it was unlikely that Mrs E had been given the appropriate information and advice to ensure she fully understood the risks associated with the surgery.

The Health Board agreed the recommendations made, including apologising to Mrs E for the loss of her records.

[1]A type of X-ray that uses a special dye injected into the blood stream to check the health of the blood vessels and how the blood runs through them.

Appendix 1

Mr F's story

Mr F complained about the care and treatment his mother, Mrs G, received during a surgical procedure to remove a skin cancer, and the subsequent care she received at a community hospital.

In response to the Ombudsman's request for Mrs G's medical records, the Health Board confirmed that the community hospital records had been mislaid. The Health Board also confirmed that the records had not been available when it had responded to Mr F's complaint, concluding that there was no evidence of a breach of duty.

Since the Ombudsman was prevented from undertaking a full investigation of the community hospital element of the complaint, that part of the complaint was settled. The settlement included the Health Board's agreement to continue its search for the missing records. The Health Board also said that it would introduce a process that would prevent such a loss happening again.

Mr H's story

Mr H complained that the Health Board had mislaid the medical records of his late mother, Mrs J. Mr H said that, as a result, the Health Board had not been able to fully respond to his complaint about the care and treatment that she had received during her admission to the Surgical Ward in the hours prior to her death.

In response to the Ombudsman's request for Mrs J's medical records, the Health Board said that those relating to Mrs J's admission to the Surgical Ward had been mislaid.

The absence of the records in this matter prevented the Ombudsman from undertaking a meaningful investigation of the complaint. The matter was settled and the Health Board agreed to apologise to Mr H.

Mrs K's story

Mrs K complained about the care and treatment her late husband, Mr K, received during the period leading to his death. In particular, Mrs K expressed concerns about the clinician's failed attempts to insert a catheter into Mr K's vein.

During the investigation, the Ombudsman requested Mr K's medical records. The Health Board advised the Ombudsman that it was unable to locate the hospital records for the period of care in question. The Health Board confirmed that the records had been available when responding to the complaint, and for the inquest into Mr K's death, but had since been mislaid.

Since the absence of the hospital records prevented the Ombudsman from completing his investigation of Mrs K's complaint, the complaint was settled. As part of the settlement, the Health Board agreed to continue its search for the missing records and introduce a process that would prevent such a loss reoccurring.

Appendix 1

Mrs L's story

Mrs L complained that the Health Board had mislaid the medical records of her late mother, Mrs M. As a result, it had not been able to fully respond to her complaint about the care and treatment that Mrs M had received in the period leading up to her death.

In response to queries made by the Ombudsman, the Health Board confirmed that the records relating to the last two weeks of Mrs M's life had been mislaid. The Health Board said that it was looking for the records and would respond to the complaint once they had been located. The complaint was referred back to the Health Board to give it an opportunity to locate the records and respond to Mrs L's complaint.

Mrs N's story

Mrs N complained that the Health Board had mislaid the medical records of her late father, Mr P. Mrs N said that the missing records prohibited the Health Board from fully responding to her concerns about the surgery and post-operative care Mr P received in the three days before he died.

In response to queries made by the Ombudsman, the Health Board confirmed that the surgical and medical records relating to the last days of Mr P's life had been mislaid. The Health Board said that it would continue its search for the documents and review its processes. The matter was settled and the Health Board agreed that it would expedite the investigation of Mrs N's concerns, should the records be found.

Mr Q's story

Mr Q complained about the care and treatment his late grandmother, Mrs R, received following surgery to remove part of her bowel. Mr Q also complained that, post-surgery, Mrs R contracted two hospital-acquired infections and, sadly, died.

In its response to Mr Q's complaint, the Health Board explained that some of Mrs R's medical and nursing records had been mislaid. The Health Board acknowledged that, given the absence of these records, it had been unable to adequately respond to the complaint. The Health Board informed Mr Q that it was undertaking an extensive search to locate the records.

In response to queries made by the Ombudsman, the Health Board agreed to write to Mr Q providing a formal response to his complaint.

Appendix 1

Mrs S's story

Mrs S complained that the Health Board had failed to fully respond to the concerns that had been raised about the care and treatment her mother, Mrs T, received. Mrs S also complained that the Health Board failed to provide a copy of Mrs T's medical records.

In response to queries made by the Ombudsman, the Health Board confirmed that Mrs T's medical records had been mislaid. The Health Board said that, despite the absence of the records, it had drafted a response to Mrs S's concerns based on the minutes of Mrs T's family's meeting with the Consultant. The Health Board also confirmed that it would continue its search for the records.

The Health Board agreed to settle the complaint and provide Mrs S with a fulsome response to her concerns.

Mrs S remained dissatisfied with the outcome of the Health Board's investigation and submitted a further complaint to the Ombudsman. Specifically, Mrs S expressed concerns about the Health Board's complaint handling.

The Ombudsman asked the Health Board to confirm whether it had located the missing medical records. The Health Board confirmed that they had not yet been found.

Mrs U's story

Mrs U complained about the care and treatment her late Mother, Mrs V, received in the period leading up to her death. This included the decision to undertake a liver biopsy[2] without fully explaining the risks, and the failure to identify other co-morbidities[3] such as metastatic disease[4] and a displaced fracture[5].

During the investigation a request was made for Mrs V's medical records. Whilst the records provided by the Health Board were partially complete, those for the period 26 April to 9 May 2018 (the date Mrs V died) were missing. The Health Board agreed to continue looking for the records and they were found approximately two months later.

Mr W's story

Mr W complained that the Health Board had failed to maintain accurate and complete records reflecting the care and treatment he had received. Mr W said that, having requested a copy of his records from the Health Board, he was provided with records relating to another patient. This happened on more than one occasion.

[2] Examination of tissue removed from a living body to discover the presence, cause, or extent of a disease.

[3] A medical condition that co-occurs with another.

[4] The development of a secondary malignant growth away from the primary site of a cancer.

[5] A fracture in which two ends of the broken bone are separated from one another.

Appendix 1

Mrs X's story

Mrs X complained about the nursing care her late father, Mr Y, received during the period leading up to his death. This included concerns about the management of Mr Y's nasogastric[6] tube, the administration of medication and pressure sore management[7]. Mrs X also complained about the way the Health Board had managed her complaint.

The Health Board responded to Mrs X stating that it had been unable to investigate her complaint adequately because it had been unable to locate Mr Y's nursing records and risk assessments.

During the investigation, the Ombudsman asked the Health Board to confirm whether it had located the missing records. The Health Board confirmed that they had not yet been found.

Mrs Z's story

Mrs Z complained about the nursing care and treatment she received for an infection in her shoulder joint.

During the investigation a request was made for Mrs Z's medical records. The records provided by the Health Board were partially complete; there were essential records missing from the fracture clinic and physiotherapy department. The Health Board agreed to continue looking for the records and they were found approximately 4 months later.

Mrs AB's story

Mrs AB complained about the care and treatment her late husband, Mr AB, received during his admission to a Care Home.

During the investigation a request was made for Mr AB's care home records. The records provided were partially complete. The Care Home confirmed that the records had been missing for some time, and that this might have had an impact on its previous investigations into Mrs AB's complaint.

Mr CD's story

Mr CD complained about the care and treatment his late wife, Mrs CD, received in relation to poor communication, delayed treatment and poor pain management.

In response to an investigation started by the Ombudsman, the Health Board confirmed that, despite referring to the content of the medical records when responding to Mr CD's complaint, the records did not contain a contemporaneous record of the discussions with the clinicians. The Health Board agreed to apologise to Mr CD and provide an explanation for the poor record keeping.

[6]A tube passed through the nose and into the stomach to aid the provision of nutritional support.

[7]Management and treatment of pressure sores. Pressure sores are an injury that affects areas of the skin and underlying tissue.

Appendix 2

Legislation

Public Records Act 1958 (as amended by the Government of Wales Act 2006)

Access to Medical Records Act 1990

Regulation

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011

General Data Protection Regulations 2018

Guidance

Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011. Version 3 (November 2013)

NHS Wales: Governance e-manual Standard 20

www.wales.nhs.uk/governance-emanual/standard-20-records-management

The Confidentiality Code of Practice for Health & Social Care in Wales. Version 8.8 (August 2005)

Nursing and Midwifery Council: The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates Paragraph 10

www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

General Medical Council: Ethical Guidance for Doctors Paragraph 52 & 58

www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people/keeping-records

Welsh Assembly Government: Confidentiality: Code of Practice for Health and Social Care in Wales. Welsh Assembly Government Guidance on Sharing Information and Confidentiality (August 2005)

www.wales.nhs.uk>sites3>documents>codeofpractice

Public Services Ombudsman for Wales: Principles for Good Administration and Good Records Management (February 2016)

www.ombudsman.wales/wp-content/uploads/2018/03/Principles-of-Good-Administration-and-Good-Records-Management-Final-2016-1.pdf

Appendix 2

Reports

Auditor General for Wales: Informatics systems in NHS Wales (January 2018)

www.audit.wales/system/files/publications/NHS_-Informatics-2018%20-%20English.pdf

Dame Fiona Caldicott: Information: To share or not to share?
The Information Governance Review (March 2013).

assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

Online resources

Information Governance: Online Support for NHS Providers

British Medical Association: Priorities for Health: Protecting and Safeguarding Patient Information – Online toolkit

www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records


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