Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Western Health and Social Care Trust

NIPSO Reference: 19019

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the care and treatment of a patient by the South West Acute Hospital (SWAH).

My investigation did not find a failure in the care and treatment provided to the patient while he was treated in the Emergency Department on 28 November 2017. I also did not find a failure in his care and treatment provided to him while he was in Ward One of the hospital. I also found that the Trust's instruction provided to the complainant regarding how to access his father's medical records was in accordance with relevant guidelines.

My investigation found maladministration in the Trust's handling of the complaint it received by the patient's son.

I recommended that the Trust apologise to the complainant for the upset, frustration and time and trouble caused to him as a result of the maladministration identified. I also made a recommendation for service improvements related to complaint handling.

THE COMPLAINT

Background

1. I received a complaint regarding the care and treatment provided to the complainant's late father (the patient) by the Western Health and Social Care Trust (the Trust), and in particular about the end of life care and treatment the medical staff provided to his father in the South West Area Hospital on 28 and 29 November 2017. The patient passed away on 29 November 2017.

2. The complainant further complained about the Trust's handling of his complaint. In particular, he said there were delays experienced during the complaints process and in the handling of requests he made. He also complained that the Trust did not appropriately correspond with him regarding meeting minutes.

Issues of complaint

3. The issues of the complainant accepted for investigation were:

   Issue 1: Whether the patient received appropriate end of life care and treatment in South West Acute Hospital following his admission on 28 November 2017; and

   Issue 2: Whether the Trust handled the complaint raised by the complainant in line with its policy or appropriate standards.

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

   - A Consultant of Emergency Medicine for 33 years (E IPA); and
   - A Consultant Physician for 30 years and an accredited geriatrician for 18 years (G IPA).

6. The information and advice which have informed the findings and conclusions are included within the body of this report. The IPA has provided 'advice'; however how this advice has been weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

   The general standards are the Ombudsman's Principles[1]:

   - The Principles of Good Administration
   - The Principles of Good Complaints Handling
   - The Public Services Ombudsmen Principles for Remedy

8. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the Trust staff whose actions are the subject of this complaint.

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

The specific standards relevant to this complaint are:

- The National Institute for Health and Care Excellence's (NICE) British National Formulary: Morphine[2], September 2017 to March 2018 (the BNF);
- The Regional Palliative[3] Medicine Group (RPMG) Northern Ireland's Guidance for the Management of Symptoms in Adults in the Last Days of Life, October 2014 (the RPMG NI guidelines);
- The Western Health and Social Care Trust and South West Acute Hospital's Non-Invasive Ventilation[4] (NIV) Protocol, 2016 (the NIV protocol);
- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC guidelines);
- The Department of Health's (DoH) Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning, April 2009 (the DoH Complaints Procedure);
- The Access to Health Records (Northern Ireland) Order 1993 (the 1993 Order); and
- The Western Health and Social Care Trust's (the Trust) cover letter to accompany the form required to access records of a deceased person/client, May 2018 (guidance for accessing a deceased person's records).

9. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything considered to be relevant and important has been taken into account in reaching the findings.

10. In accordance with the NIPSO process, a draft of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

[2] Medication to help relieve moderate to severe pain. It belongs to a class of drugs known as opioid (narcotic) analgesics.
[3] Care provided to patients who are nearing the end of their life.
[4] The provision of ventilator support through the patient's upper airway using a mask or similar device.

THE INVESTIGATION

Issue 1: Whether the patient received appropriate end of life care and treatment in South West Acute Hospital following his admission on 28 November 2017?

Detail of Complaint

11. The complainant queried if the medication administered to his father was appropriate. He further complained that the family were not informed of the medication administered and the effect it was likely to have on his father. He also complained that a non-invasive ventilation (NIV) mask was kept on his father while in the ED, which prevented him from communicating with his family.

Evidence Considered

Legislation/Policies/Guidance

12. In relation to this element of the complaint, I considered the BNF guidance for the use of morphine. I identified the following relevant extracts:

    i. The BNF details the uses of morphine in palliative care of patients:

    'Dyspnoea[5] at rest in palliative care
    By mouth, for adult:
    Initially 5 mg every 4 hours, to be given in carefully titrated[6] doses...

    Cough in palliative care
    By mouth, for adult:
    Initially 5 mg (2.5mgs intravenously[7]) every 4 hours…

[5] Difficult or laboured breathing.
[6] The process of adjusting the dose of a medication for the maximum benefit without adverse effects.
[7] A therapy that delivers fluids directly into a vein.

Acute pain[8]

By slow intravenous injection, for adult:

Initially 5 mg every 4 hours, adjusted according to response, dose can be adjusted more frequently during titration, reduced dose recommended in frail and elderly patients...

Cautions – for all OPIOIDS[9]:

Adrenocortical insufficiency[10] (reduced dose is recommended); asthma (avoid during an acute attack); convulsive disorders[11]; debilitated[12] patients (reduced dose is recommended) (in adults); diseases of the biliary tract[13]; elderly (reduced dose is recommended) (in adults); hypotension[14]; hypothyroidism[15] (reduced dose is recommended); impaired respiratory function (avoid in chronic obstructive pulmonary disease [COPD][16]); inflammatory bowel disorders; myasthenia gravis[17]; obstructive bowel disorders; prostatic hypertrophy[18] (in adults); shock; urethral stenosis[19] (in adults)...

Side effects for all OPIOIDS: Common or very common

Arrhythmias[20]; confusion; constipation; dizziness; drowsiness; dry mouth; euphoric mood; flushing; hallucination; headache; hyperhidrosis[21]; hypotension (with high doses); miosis[22]; nausea (more common on

[8] Pain of short duration.
[9] Type of medication used mostly to treat moderate to severe pain, coughing and diarrhoea.
[10] A condition in which the adrenal glands do not produce adequate amounts of steroid hormones.
[11] Sudden, violent, irregular movement of the body, caused by involuntary contraction of muscles.
[12] In a very weakened and infirm state.
[13] Refers to the liver, gall bladder and bile ducts.
[14] Low blood pressure.
[15] An underactive thyroid gland.
[16] A group of lung conditions that cause breathing difficulties.
[17] A disease that causes weakness in the skeletal muscles.
[18] An increase in size of skeletal muscle.
[19] A narrowing of the urethra.
[20] An irregular heartbeat.
[21] Excessive sweating.
[22] Shrinking of the pupil of the eye.

initiation); palpitations[23]; respiratory depression[24] (with high doses); skin reactions; urinary retention[25]; vertigo[26]; visual impairment; vomiting (more common on initiation); withdrawal syndrome…

ii. I also considered the RPMG NI guidelines. I identified the following relevant extracts:

'This Guidance includes management of the following symptoms:
Pain
Nausea and vomiting
Dyspnoea
Noisy chest secretions / Death rattle [27]
Agitation when death is imminent

- *Please note that these recommendations should only be used for patients in the last days of life and should not be used outside this context.*
- *They are a GUIDE [emphasis in guidelines], and should be used as such. They may differ from other recommendations but have been chosen to reflect expert opinion, best evidence and safety.*
- *Users are advised to monitor patients carefully for side effects and response to treatment. Responsibility for the use of these recommendations lies with the healthcare professional(s) managing each patient.*
- *Seek specialist advice when necessary, especially in patients with complex needs.*
- ***When prescribing drugs, always start with the lowest dose in the range specified in this guide** [emphasis in guidelines].*
- *For patients with moderate to severe renal[28] or hepatic[29] impairment in the last days of life please seek specialist advice.*

[23] Pounding heartbeat.
[24] A failure of the lungs to exchange carbon dioxide and oxygen.
[25] The inability to completely or partially empty the bladder.
[26] A sensation of spinning dizziness.
[27] Can occur when a dying person is no longer able to swallow or cough.
[28] Relating to kidneys.
[29] Relating to the liver.

Patient currently experiencing pain - no regular analgesia[30] prescribed:

Give stat SC [subcutaneous[31]] PRN[32] dose of Morphine 2mg– 5mg as above and prescribe Morphine 5mg – 10mg as a SC infusion[33] via syringe pump over 24 hours and prescribe Morphine 2mg – 5mg SC 2-4hourly PRN for breakthrough pain (this can be given more frequently with medical discussion and/or palliative care input)…

Opioid conversions…

Oral Morphine to SC [subcutaneous] Morphine:

Formula: Divide total 24 hour dose of Oral Morphine by 2…

Management of dyspnoea:

Intermittent symptoms or distress:

[Patient already taking regular morphine] – Anticipatory prescribing:

Prescribe morphine sulphate PRN at a dose of ¼ to ½ of 4 hourly breakthrough analgesic dose.

Persistent symptoms or distress:

[Patient already taking regular morphine] – Prescribe equivalent doses of morphine sulphate via a syringe pump and titrate to patient's individual needs according to severity of dyspnoea. Prescribe morphine sulphate PRN at a dose of ¼ to ½ of 4 hourly breakthrough analgesic dose.

If patient is breathless AND anxious, consider midazolam[34] 2mg SC PRN and/or adding midazolam 5mg-10mg SC via syringe pump over 24 hours. If able to tolerate oral medications consider using Lorazepam[35] 500 micrograms sublingually[36] 4-6 hourly PRN.

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[30] Medication that relieves pain.
[31] By injection through the skin.
[32] Medication administered when necessary.
[33] A technique whereby fluids are infused into the subcutaneous space via small-gauge needles.
[34] A short acting sleep-inducing active substance.
[35] Medication used to treat anxiety disorders, trouble sleeping and active seizures.
[36] Administration of medication by which substances diffuse into the blood through tissues under the tongue.

Management of Agitation When Death is Imminent

(Assess the patient first to exclude potentially reversible and treatable causes such as pain, drug withdrawal including nicotine, urinary retention or severe constipation)

No symptoms at present:

Prescribe Midazolam 2mg – 5mg SC 4 hourly PRN. If two or more doses required PRN.

Symptoms: Prescribe Midazolam 2mg – 5mg SC and assess response after 30 mins

If effective:-

Prescribe Midazolam 5mg - 10mg via syringe pump over 24 hrs AND continue to give PRN dose as required. Re-assess regularly. If symptoms persist add up to total SC PRN dose over 24 hours to current syringe pump dose (increase breakthrough dose accordingly) If poor response to increasing dose of Midazolam re-assess cause of agitation. Consider prescribing stat dose of Levomepromazine[37] 5mg - 15mg SC. Assess response and if effective add Levomepromazine 10mg - 25mg SC via syringe pump over 24 hrs [sic]'.

iii. I considered the Trust's NIV protocol. I identified the following relevant extracts:
'Indications for NIV
NIV should be considered in all patients with an acute exacerbation of COPD with a persistent respiratory (PaCO2 > 6.0) acidosis[38] (pH < 7.35) despite 60 minutes of maximal medical therapy. This should include controlled O2 therapy, nebulised[39] Salbutamol[40] and Ipratropium[41], Steroids and Antibiotics where indicated.

[37] Medication used for a variety of distressing symptoms in palliative and end-of-life care.
[38] Occurs when the kidneys and lungs can't keep the body's pH in balance.
[39] A machine that changes liquid medicine into a fine mist.
[40] A medication that opens up the medium and large airways in the lungs.
[41] A medication used to dilate (enlarge) airways (bronchi) in the lungs.

Establish Ceiling

It is essential prior to commencing treatment that patients have a management plan & resuscitation decision in the event of failure of NIV…

Set up Guide

1. *Explain the procedure to patient/relative/carer positively and calmly*
2. *Patient should be placed in the semi-recumbent position[42]*
3. *Check the size and seal of the mask & connect supplemental oxygen if required*
4. *Aim target saturations[43] 88- 92%, prescribe oxygen, modify NEWS[44] [National Early Warning Score], monitor SA02[45] continuously*
5. *Turn on machine and set to pressure support mode, IPAP[46] 15 [20 if pH < 7 .25], EPAP[47] 3 [higher if OSA [obstructive sleep apnoea][48]]*
6. *Hold mask to the patient's face for a few moments to allow them to acclimatise, then attach straps*
7. *IPAP should be increased by 2-5 every 10 minutes [over 30 mins] with a target IPAP of 20 - 30 or until patient tolerability has been achieved- record settings & Oxygen in NEWS chart*
8. *Repeat ABGs [arterial blood gas][49] should be performed at 1 hour and 4 hours - record in prescription chart*
9. *Monitor observations every 15 minutes for the first hour, every 30 minutes for the next four hours then further observation frequency as per NEWS [modify scoring/ frequency pending response and escalation decision]*
10. *If clinical condition/ pH not improving/ deterioration at 60 mins consider discussion with anaesthetics team regarding escalation to HDU / ICU if appropriate*

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[42] An upright positioning of the head and torso at an angle of 45 degrees.
[43] Measures how much oxygen the blood is carrying.
[44] A guide to quickly determine the degree of illness of a patient.
[45] Oxygen saturation.
[46] The pressure delivered by the device [NIV] during inhalation.
[47] The pressure applied in between breathing-in events (when the user is breathing out or the diaphragm is stationary).
[48] A condition where the walls of the throat relax and narrow during sleep, interrupting normal breathing.
[49] An ABG test measures the amounts of arterial gases, such as oxygen and carbon dioxide.

Troubleshooting NIV

1. *Hypercapnia*[50] - *Check for mask teak/ over oxygenation*
   - *Consider increasing /PAP/ increasing amount of time on NIV*
2. *Hypoxia*[51] - *Ensure circuit set up correctly*
   - *Consider increasing F102*[52] *[fraction of inspired oxygen] or EPAP*
3. *Poor Compliance* - *Coach / reassure patient*
   - *Ensure supervision (relatives may be helpful)*
   - *Regular mouth care*
   - *Consider nasal mask if appropriate*
   - *Consider sedation only with senior input'.*

iv. I also considered the GMC guidelines. I identified the following relevant extracts:

[Standard] 16: In providing clinical care you must:

a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs
b. provide effective treatments based on the best available evidence
c. take all possible steps to alleviate pain and distress whether or not a cure may be possible…

[Standard] 21: Clinical records should include:

a. relevant clinical findings
b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

[50] A condition of abnormally elevated carbon dioxide levels in the blood.
[51] A condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level.
[52] The fraction of oxygen in the volume being measured.

c. *the information given to patients*
d. *any drugs prescribed or other investigation or treatment*
e. *who is making the record and when…'.*

The Trust's response to investigation enquiries

13. In its response to enquiries, the Trust explained that the patient was initially treated in the ED under the care of a consultant of emergency medicine, on 28 November 2017. He was then transferred to Ward One under the care of a CT1[53] locum. The Trust explained that '*Ward 1 is the Medical & Surgical Assessment Unit in SWAH. It is the first-line destination ward for any acute patients admitted from either Emergency Department (ED) or General Practitioner (GP) referral. This is the standard practice to admit new medical patients to this ward'*. It further explained that '*[The consultant] confirms that the care of [the patient] was transferred to the Medical Team upon his referral. At this stage he was still responsive…and still on NIV in the ED resus. This was the last contact the consultant had with [the patient]'.*

14. In his response to investigation enquiries, the locum explained that '*…from my recollection the patient was conscious and on NIV upon arrival on ward 1. He remained significantly breathless and agitated and not tolerating his NIV mask which was causing him considerable distress. The decisions had been made in the emergency department that unfortunately this gentleman was dying and the priority of care was good palliation. From my recollection of my discussion with the family…I explained that [the patient] was dying, the need for good palliation, the need to remove the NIV mask (which was not of any benefit to him given his critical illness and severe hypoxia and was only causing him undue distress) and that prior to removing the mask I would administer medication to allow him to settle first so that he didn't become more distressed when the mask was removed. From my recollection the family present were in agreement and had no issues with the care management discussed with them. The morphine and midazolam was given on ward 1 due to the above symptoms (the time of administration will be documented on his medicines Kardex[54]) which had a*

[53] Speciality Registrar in core training
[54] Document to record medicines prescribed and administered.

good effect and after 5-10 minutes the patient was much more comfortable, at which point the NIV mask was removed and replaced with a less distressing oxygen mask'.

15. In response to the complaint that the medication provided to the patient while in the SWAH was not appropriate, the Trust explained that the day '*advised that Midazolam and Morphine are a recognised therapy and are frequently used in end of life care. [The consultant of palliative care] was asked to comment on the medication administered to the patient, and her response was based on the Regional Guidelines on Medication at End of Life which were in use at the time [the RPMG NI guidelines]*'.

16. The Trust was asked to respond to the complaint that the family were not told that a sedative (midazolam) was being administered to their father. The Trust explained that '*it is recorded in the medical notes that there was a discussion with family about the need for Morphine and Midazolam, as the non-invasive ventilation mask (NIV) was adding to their father's distress and that the priority was to keep him comfortable. This was also discussed during the meeting held with the family on 4 January 2018…[The doctor] explained what midazolam was and why it was given i.e. to help settle their father's distress'*.

17. In relation to the complaint that medical staff kept an NIV mask on the patient when he wished to communicate, the Trust said that '[The doctor] *explained at the meeting on 4 January 2018 that their father had been in respiratory arrest and that the NIV mask was used to help his breathing…it was acknowledged that the mask was agitating and distressing him. Medications were given to help ease this discomfort. The NIV mask was then changed to a normal oxygen mask'*.

18. In relation to learnings identified, the Trust explained that the patient' case '*was discussed at the Medical Morbidity and Mortality meeting. While the management of the patient was deemed satisfactory, the following*

recommendations were made: doctors need to be more familiar with use of anticipatory medications in palliative care (result of snapshot audit) – this was discussed with attendees present and is included in induction; and Trust palliative care guidelines need to be more visible on Trust intranet (result of snapshot audit)'.

The Trust's records

19. I carefully considered the patient' clinical records provided by the Trust.

20. The Trust also provided notes of a Medical Morbidity and Mortality Review meeting held on 13 June 2018 at which the patient' care and treatment was discussed. The notes document that the outcome of the review was that the care and treatment provided was 'satisfactory'. The notes also document learning identified as a result of a '*snapshot audit'* conducted following the complaint raised to the Trust. These were '*doctors need to be more familiar with use of anticipatory medications in palliative care'* and '*Trust palliative care guidelines need to be more visible on Trust intranet'*.

21. I also considered advice the Trust obtained from the consultant of palliative care, following the complaint raised. The consultant explained that '*the administration of both morphine and midazolam in the doses used are in accordance with good practice in Palliative and End of Life Care. The convention within palliative care is to administer these drugs subcutaneously, but the main reason for this is custom and practice, in that it represents a route of administration which any patient in whatever medical setting may receive. We would not want patients to have to have painful venepuncture at end of life if no intravenous access was available, but the subcutaneous route can be used for any patient. The guidelines are based on this experience. To me the important point in the story is that the patient was inevitably dying, and the drugs were used to alleviate pain or other distressing symptoms at end of life, which is good practice'*.

22. I further considered minutes of a meeting held by the Trust with the family regarding their concerns (minutes taken by the Trust and as amended by the complainant). The minutes document that the Clinical Lead in Emergency Care informed the family that the patient was '*given 1mg at 23:00 and 1mg at 00:00'*. The minutes document that '*the family were upset at hearing this as they had been told on the phone that their father only received 1mg in total of morphine'*. The family added that '*this decision to give 2mg of morphine should have been discussed with the family prior to it being administered as her father would not have wanted morphine'*. The minutes document that the doctor '*explained that it would not be usual practice to inform family members of the decision to give low dose morphine'* and he apologised for the '*breakdown in communication'*. He then explained that '*this was a very low dose and that the reason for giving this was to make their father more comfortable wearing the tight fitting non-invasive ventilation mask and possibly for pain to his left buttock as documented in the notes…2mgs Morphine given in A&E would not have caused his condition to deteriorate so suddenly and that his deterioration was due to the fact he had three respiratory arrests[55] and was exhausted'*.

23. The minutes document that the family were also informed of the medication administered to their father while he was in Ward One [2.5mg of morphine sulphate and 2.5mg of midazolam]. The minutes further document that '*it was clear that this was an awful shock to the entire family members as they were extremely upset, tearful and angry that their father was given this when they felt he was not agitated in any way and had been told about the sedation'*. They questioned '*why he was given this after he had been given 2mgs morphine in A&E and again advised that they were informed no sedation was used'.* The family added that they were *'certain that these two final doses of Morphine and Midazolam did the damage and was the reason why their father passed away so quickly in the end. They feel that they were robbed of the last few moments of their father's life'*.

[55] A state in which a patient stops breathing but maintains a pulse.

24. The minutes of the meeting document that the doctor '*explained that it [midazolam] was a sedative drug that is used in end of life care and that it is recorded in the notes it was given to help settle their father's distress. However, the family reiterated that their father was in no distress at all and was alert and aware. [A family member] agreed that the locum doctor told them that he was going to change the oxygen mask to a more comfortable (standard) one and told he would be kept comfortable but no mention of a sedative. [It was] again explained that it would not be usual practice to inform family members of what medications are to be administered'*. The minutes also document that the doctor '*tried to assure the family that their father's quick deterioration was due to his critical condition and that as he had fought and survived three respiratory arrests, he was exhausted and it was clear he was not going to survive'*.

25. I considered the response to the complaint which is contained within the complaints file. The consultant stated that '*I believe additional comfort medications were given solely to ease [the patient's] distress. He was markedly hypoxic and tachypnoeic[56], with a respiratory rate 29-37[57]. His pO2 [partial pressure of oxygen] of 5Kpa would have caused him distress, with a sensation of not getting a breath, akin to suffocation'*.

26. I also considered the written responses from the Trust to the family regarding their concerns. The Trust explained that the consultant on call at the time of the patient's passing investigated their concerns regarding their father's care while he was on Ward One. The Trust explained that '*discussions took place with members of your family regarding medication that would be administered to make your father more comfortable. The medical team administered your father additional drugs to alleviate his distress, namely 2.5mgs Midazolam and 2.5mgs Morphine and that additional discussions took place with [the locum doctor] and members of your family as to why this was needed*

[56] Abnormally rapid breathing.
[57] A respiration rate under 12 or over 25 breaths per minute while resting is considered abnormal.

i.e. to help settle his distress. [The doctor] has explained that the use of these drugs are a recognised therapy and are frequently used in end of life care'.

27. The Trust further explained that the doctor *'has reflected on your concern that during your father's last 30 minutes he became quiet and staring. He agrees with [the] opinion that your father would have become unresponsive due to his severe hypoxia as his brain was not getting enough oxygen. [He] also believes that your father was given the additional medications to ease his distress and that the medical staff in the ED [emergency department] and Ward 1 acted appropriately solely to make your father more comfortable'*.

Relevant Independent Professional Advice

28. As part of investigation enquiries, I obtained the advice of a consultant specialising in emergency medicine (E IPA).

29. The E IPA advised that the patient suffered three respiratory arrests on '*28 November 2017 whilst the ambulance crew were with him…and in the [ED] at 22.13 and 22.56'*. The E IPA further advised that '*the nursing observations and blood gas results clearly show hypoxia...hypoxia was a result not a cause of [the patient's] respiratory failure. The effects of hypoxia are that the organs of the body do not get the oxygen they need to function and fail. The organs most affected by hypoxia are the brain, the heart, and the liver. If the hypoxia is severe, irreversible damage can begin within four minutes of the onset…coma, seizures, and death may occur in severe cases. In [the patient's] case his hypoxia was severe and he slid into coma and then brain death'*.

30. The E IPA was asked to provide details of the medication administered to the patient while he was in the ED of the SWAH. The E IPA advised that the patient was administered '*hydrocortisone[58] 200 mg (steroid) intravenously at 22:08, ipratropium bromide 500 micrograms (for wheeze) by nebuliser at 22.08, salbutamol 5mg (for wheeze) by nebuliser at 22.08, Tazocin[59] 4.5 g (antibiotic)*

[58] A steroid which works by damping down the body's immune response to reduce pain, itching and swelling.
[59] An antibiotic for the treatment of infection.

intravenously at 22:10, Morphine sulphate 1mg (for pain and distress) intravenously at 23:00 mg and Morphine sulphate 1mg intravenously at 00.00'.

31. In relation to the effect the medications administered while in the ED had on the patient, the E IPA advised that '*ipratropium and salbutamol are both used to relax the airways in asthma and bronchitis, relieving wheeze and improving air entry. Hydrocortisone is used as an anti-inflammatory which damps down the release of chemicals which cause the airways narrowing. Tazocin is a powerful broad spectrum antibiotic recommended for first line use in sepsis…the morphine could be expected to relieve pain, ease coughing and help with difficulty breathing'.*

32. The E IPA was asked if the decision to administer morphine sulphate to the patient while in the ED was reasonable and appropriate. The E IPA advised that '*morphine has a number of uses in palliative care…where the morphine dose is given as an oral formulation, the intravenous dose is half the quantity i.e for 5mg Morphine, the equivalent dose is 2.5mgs intravenously'*. The E IPA referred to the BNF and advised that *'the [BNF's] list of cautions for all opioids includes "respiratory depression (with high doses)" but comments "in the control of pain in terminal illness, the cautions listed should not necessarily be a deterrent to the use of opioid analgesics". From the guidance above, it can be seen that 1mg morphine is a very low dose and would not be expected to cause respiratory depression. The second dose of 1mg would still only bring the combined dose to 2mgs, still below the recommended single dose…I consider that in the doses used, it would be unlikely to have adverse side-effects"*.

33. In relation to the use of the non-invasive ventilation (NIV) mask, rather than an O2 mask, while the patient was in the ED, the E IPA advised that '*they are used for different purposes. The O2 mask simply provides a higher concentration of oxygen in the inspired air. The NIV mask also provides some added air pressure to keep airways open so the oxygen can get into the patient's system better'*. She further advised that '*it was not necessary to keep the NIV mask on the patient constantly…one of the advantages of NIV over invasive ventilation is that it can be removed to eat, drink and speak. However,*

if it is needed the periods of removal should be minimised…it is difficult to talk through a close-fitting mask but the mask is a necessary part of NIV treatment'.

34. In relation to the communication with the family while in the ED, the E IPA advised that '*it is usual practice to inform patients and their relatives, where indicated, of a treatment plan consisting of the kind of care which will be given. It is not required or usual practice to give the details of every drug to be used in this treatment. I am not aware of any specific guidance on this point. In general, though, the issue goes to informed consent on which there is GMC guidance. Where the patient lacks capacity through illness, the doctor can discuss care with those acting for them – informally this could be assumed to be the family. However, the first responsibility remains to act in the best interests of the patient, particularly in an emergency situation when time for detailed discussion is limited. In any event, [the doctor] states that he did in fact mention morphine to the family'*.

35. The E IPA further advised that from the doctor's notes '*he explained that the morphine was to decrease [the patient's] distress. There is no evidence he discussed adverse effects but, as I have outlined above, the dose of morphine was small and appears to have been adjusted for his age and condition. In a palliative patient, the aim is to make the process of dying as comfortable as possible and the family should be kept abreast of the care being given to effect this in general terms. Discussion of the complete range of possible side-effects of morphine would not be appropriate. On balance, I think it unlikely that the morphine given in the [ED] significantly suppressed [his] respiratory function – he had had three respiratory arrests already before the administration of morphine, was not improving despite treatment and was already known to have end-stage respiratory disease'*.

36. The E IPA was asked if the administration of the NIV treatment was discussed with the patient's family. She advised that '…*I would not expect them to be specifically told so. I would expect them to be informed of the general nature of the treatment being given […] and perhaps of the purpose of NIV'*.

37. In relation to the time the patient transferred to Ward One, the E IPA advised that *'it is not clear from the notes available to me. What seems to be the last MEWS[60] [Modified Early Warning Score] score in the ED was timed 00.05 and the written referral to the ward was timed 00.15 so the transfer could be viewed as starting at 00.15'*. She further advised that transferring the patient to Ward One would be *'a more pleasant and restful environment than a resuscitation room and one where it would be easier for the relatives to be with him'*.

38. As part of investigation enquiries, I also obtained the advice of a general consultant physician (G IPA).

39. The G IPA advised that the patient '*had severe community acquired pneumonia[61]. He was being given oxygen via mask. However with the state of his lungs – infection plus perhaps pulmonary oedema[62] - would have contributed to hypoxia (= low oxygen saturation[63]). He was very breathless after the fall. He was saturating at 65% (normal = ~95%) in the ambulance. This improved slightly, with saturation rising only to 80% despite 15 litres/min oxygen given via mask when he got to the hospital. The three episodes of respiratory arrest too would have contributed to his hypoxic state'*. The G IPA was asked if he considered that the respiratory arrests caused the patient to become unresponsive. He advised that it was '*very likely. There is documentation that he had three respiratory arrests which were occasions when he stopped breathing. This would have caused blood levels of oxygen to drop. And when less oxygen reaches the brain through the blood stream, consciousness gets obtunded*[64]'.

40. The G IPA was asked about the medication administered to the patient while he was in Ward One of SWAH. The G IPA advised that the patient's clinical records from 29 November 2017 detail PRN medicines. He further

[60] A simple, physiological score that may allow improvement in the quality and safety of management provided to surgical ward patients.
[61] An acute infection of the lower respiratory tract acquired outside of a health care setting.
[62] A condition caused by excess fluid in the lungs. This fluid collects in the numerous air sacs in the lungs, making it difficult to breathe.
[63] The amount of oxygen being carried by red blood cells.
[64] A more depressed level of consciousness

advised that upon his arrival into Ward One, the patient was '*administered 2.5 mg midazolam intravenously (IV) and morphine sulphate 2.5 mg subcutaneously at 0140 [hours]*'. The G IPA advised that '*the regular drug prescription sheet had no prescription written up. No injectable drugs were prescribed because it is documented that he [the patient] was for palliation and hence regular enoxaparin[65] was crossed off the chart'*. This related to the patient's regular medication that was stopped as he was for palliative care.

41. The G IPA was asked if the decision to administer morphine and midazolam to the patient at this time was reasonable and appropriate. The G IPA advised, '*morphine sulphate was prescribed for breathlessness as provided for in the Regional Palliative Medicine Group NI (RPMG) guidance for adults in the last days of life. Likewise the RPMG guidance recommends using midazolam 2 mg - 5 mg for agitation. Therefore the drugs were given as per the guidelines'*. In relation to the dosages administered, the G IPA advised that '*the RPMG guidance recommends morphine sulphate 2mg - 5 mg for pain and 1 mg - 2 mg morphine for dyspnoea as also 2 mg - 5 mg midazolam for agitation, when death was imminent. I am satisfied that the drugs were correctly used. The dose of morphine sulphate was exceeded by 500 micrograms but this was reasonable given the fact that he had already had morphine sulphate given twice earlier at a dose of 1mg each and still needed more. Hence the additional 500 micrograms was appropriate. Morphine 2.5 mg IV is NOT [his emphasis] an excessive dose'*.

42. The G IPA was also asked to provide advice regarding the method of administration of the medications. He advised that '*the guidance does recommend subcutaneous administration. Morphine was given subcutaneously and midazolam was administered intravenously. The routes used are perfectly interchangeable and appropriate in the situation that [the patient] was in. The two routes subcutaneous and intravenous can be interchangeably used without deleterious[66] / unintended consequences'*. The G IPA advised that these medications were administered to the patient at this time to '*[relieve]*

[65] Medication used to prevent and treat deep vein thrombosis and pulmonary embolism following surgery.
[66] Causing harm or damage.

anxiety/distress/palliation. It is standard practice to use these drugs at the end of life. And both these drugs are recommended for use for these reasons in the RPMG NI guidance'.

43. In relation to how these medications would have affected the patient, the G IPA advised that '*it had been determined that [the patient] was dying, in a terminal state and it had already been explained to the family that he was for palliation as there was no hope of recovery. The family were informed that he was poorly. Administration of these drugs in the dosage used and the route used would have made him less distressed and anxious and allowed him to have a peaceful death, free of breathlessness or distress. Having a good death and not suffering terminal distress due to breathlessness and the anxiety that causes was in his interests and in keeping with good practice'*.

44. The G IPA was asked if the medications administered would have caused the patient to become unresponsive. He advised that '*morphine would serve to allay the anxiety and breathlessness that [he] was suffering from. Midazolam would have reduced the agitation that occurs at the end of life. Both morphine and midazolam have sedating properties and would cause the patient to become unresponsive. It would therefore not be unexpected that sedation would therefore occur when morphine and midazolam were used. He had previously been given two doses of morphine sulphate intravenously at 2300 hrs and again an hour later, at 00:00 hrs. The second dose was required because the first dose was not sufficient when he was in ED [emergency department]*'.

45. The G IPA advised that the notes document that the patient was '*unresponsive on arrival'* to Ward One and that he was wearing a NIV mask. He further advised that the NIV mask was removed while the patient was in Ward One at 0140 hours. The G IPA advised that this action was reasonable. He advised, '*by that time [the patient] was agonal*[67] *and NIV (non-invasive ventilation) was no longer appropriate. Switching to high flow oxygen was the*

[67] Struggling to breathe or gasping.

correct decision as it makes for easier breathing. The decision is correctly documented. It was in keeping with good medical practice'.

46. In relation to the communication between the clinical staff and the patient's family, the G IPA advised that '*the records show that at 2350 hrs detailed discussion was had with family, explaining the seriousness and severity of [the patient's] illness. The locum Medical CT1 has written, "I explained that I believe the priority is to keep him comfortable. They are all in agreement with this… We agreed we would switch the NIV [non-invasive ventilation] mask normal oxygen mask following midazolam/morphine to help settle his distress." The explanation had already been given when he was in ED and it has been so documented. The Ward One nurse has timed her notes at 0140 hrs on 29/11/17. There would be no reason for the information to be repeated on arrival on Ward One that he was to be given morphine and midazolam'*.

47. The G IPA was asked if the clinical team ought to have informed the family of the medication to be administered to the patient. He advised that '*the RPMG NI guidance does not require that information be given to family prior to palliative care medicines being administered. However, [the doctor] had explained to the family that morphine and midazolam were to be used and this is clearly documented. That is good practice and it has been done correctly'*. The G IPA further advised that '*it had been explained that he [the patient] was unlikely to survive the night. Family were made aware that [he] was dying and that the team would only strive to keep him comfortable to enable him to have a good death. That would entail using morphine and midazolam to relieve his breathlessness and terminal agitation. Communication with the family was entirely adequate…the purpose of giving him morphine and midazolam was to relieve distress and to keep him comfortable, allowing him to pass away peacefully. Family were told that he was less distressed on a small amount of morphine'*.

48. In summary, the G IPA advised that '*communication with the family is recorded clearly. Medical record keeping has been good with entries being dated and timed, in order to understand the time frame of events. This case exemplifies good terminal care and overall good medical practice'*.

Analysis and Findings

Emergency Department: Medication

49. The complainant said that the medication administered to his father was not appropriate. I note from the clinical records that the patient was first administered morphine sulphate (1mg IV) while he was in the ED at 23:00. He was administered another 1mg (IV) at 00:00 for '*pain and distress'*.

50. I note that the clinical records state that the patient was very ill and was for palliative care. I further note that both the RPMG NI guidelines and the BNF recommend prescribing morphine sulphate for patients in palliative care. I note that the BNF guidelines recommend a dosage of 2.5mg (IV) for those patients. I also note that Standard 16 of the GMC Guidelines states that in providing care and treatment, the medical professional is to '*take all possible steps to alleviate pain and distress whether or not a cure may be possible*'. Having considered the guidelines, I accept the E IPA's advice that '*morphine has a number of uses in palliative care*' and '*the morphine could be expected to relieve pain, ease coughing and help with difficulty breathing'*. I also accept the E IPA's advice that '*the aim is to make the process of dying as comfortable as possible'* and '*the first responsibility remains to act in the best interests of the patient'*. I understand that this was a very difficult time for the patient's family. However, I consider that the decision to prescribe and administer morphine sulphate to the patient while in the ED was to alleviate his pain and distress, which was in his best interests. I also consider that the decision to administer this medication was reasonable, appropriate and in accordance with recognised guidelines. **Therefore, I do not uphold this element of the complaint.**

Emergency Department: Use of NIV mask

51. The complainant said that clinical staff did not remove the NIV mask when his father '*clearly wished to communicate*'. I note that the NIV treatment was administered while the patient was in the ED to assist with his breathing. I further note that during his discussion with the family at 23:48, the doctor informed them that the NIV would be continued for comfort as their father was '*less distressed'* on it.

52. In relation to the complaint that the medical team kept the NIV mask on the patient, I note the E IPA's advice that '*it was not necessary to keep the NIV mask on the patient constantly…one of the advantages of NIV over invasive ventilation is that it can be removed to eat, drink and speak'.* However, I also note the Trust's response that the patient was in '*respiratory arrest'* and the '*NIV mask was used to help his breathing'*. Having considered the patient's records and relevant guidance, I accept the E IPA's advice that '*if it [the NIV mask] is needed the periods of removal should be minimised…the mask is a necessary part of NIV treatment'*. I note that at this time, the patient was very ill and the NIV treatment was required to assist with his breathing. I consider that the clinical team's decision to keep the NIV mask on the patient as much as possible during his time in the ED was reasonable, appropriate and in accordance with relevant guidelines. **Therefore, I do not uphold this element of the complaint.**

Emergency Department: Communication with the family

53. The complainant said that his family in attendance at the hospital were not informed of the type or dosage of medication administered to his father. I note that the patient's clinical records document that at 23:48 on 28 November 2017, the doctor '*explained [the] severity of the illness'* and informed the family that '*escalation beyond current treatment would be futile'*. I note that the records also document that he informed the family that the medical team would continue administering NIV to the patient '*for comfort'* along with a '*small amount of morphine'*.

54. I note that the record of this discussion with the family does not document that he informed them of the specific dose of morphine administered to their father. I also note that the Trust advised the family during their meeting in January 2018 that '*it would not be usual practice to inform family members of the decision to give low dose morphine'*. I further note that the E IPA also advised that *'it is not required or usual practice to give the details of every drug to be used in this treatment'* and that '*the first responsibility remains to act in the best interests of the patient, particularly in an emergency situation when time for detailed discussion is limited'.* I consider that it was for the doctor, as the

medical professional, to use his knowledge and experience to determine which treatment was in the patient's best interests. I do not consider that it was necessary to inform the family of the dosages of the medication administered to their father at that time. I am satisfied that the information provided to the family was reasonable, appropriate and in accordance with relevant guidelines. **Therefore, I do not uphold this element of the complaint.**

55. The complainant also said that his family were not informed of the effect the medication administered would have on his father. I note that a discussion about the possible effects of the medication was not recorded in the patient's notes. I considered the medications administered to the patient by the ED staff. I note the E IPA's advice that the level of morphine administered to the patient while in the ED (2mg IV) was within the dose recommended by the BNF (2.5mg IV). I also note the E IPA's advice that the dosages of morphine administered '*would be unlikely to have adverse side-effects'*.

56. I note from the patient's clinical records that he was very unwell at the time he entered the ED on 28 November 2017. I consider that given the critical situation, the doctor's primary responsibility would have been the patient's care and treatment. Therefore, I accept that he had to prioritise the information he shared with the patient's family at that critical time. I accept the E IPA's advice that '*it is not required or usual practice to give the details of every drug to be used in this treatment…discussion of the complete range of possible side-effects of morphine would not be appropriate*'. I also accept the E IPA's advice that '*the first responsibility remains to act in the best interests of the patient, particularly in an emergency situation when time for detailed discussion is limited'*. Given that the dosages of morphine administered were unlikely to have adverse side effects, and that they were administered to the patient in an emergency situation, I do not consider it was necessary for the doctor to discuss the possible effects of the medication with the family. **I do not uphold this element of the complaint.**

Ward One: Medication

57. The complainant said that the medication administered to his father while

on Ward One was not appropriate. I note from the clinical records that the patient was transferred to Ward One between 00:15 and 01:00 on 29 November 2017. I also note from the clinical records that the doctor administered 2.5mg of morphine sulphate subcutaneously and 2.5mg of midazolam IV at 01:40 to the patient on 29 November 2017.

58. I note that the RPMG NI guidelines recommend prescribing 2mg to 5mg of midazolam for the '*management of agitation when death is imminent'*. I further note that these guidelines also recommend prescribing 2mg to 5mg of morphine sulphate for pain and 1mg to 2mg morphine for dyspnoea. Having carefully considered the RPMG NI guidelines, I accept the G IPA's advice that *'the dose of morphine sulphate was exceeded by 500 micrograms [a total of 2.5mg] but this was reasonable given the fact that he had already had morphine sulphate given twice earlier at a dose of 1 mg each and still needed more*'.

59. I note that the doctor administered midazolam to the patient intravenously. I also note that the RPMG NI guidelines recommend that midazolam is administered subcutaneously. I further note the consultant of palliative care's statement to the Trust, which explains that '*the convention within palliative care is to administer these drugs subcutaneously, but the main reason for this is custom and practice, in that it represents a route of administration which any patient in whatever medical setting may receive. We would not want patients to have to have painful venepuncture at end of life if no intravenous access was available, but the subcutaneous route can be used for any patient'.* Having considered the RPMG NI guidelines and the consultant's statement, I accept the G IPA's advice that *'the routes used are perfectly interchangeable and appropriate in the situation that [the patient] was in'.*

60. The complainant said that his father became unresponsive following administration of this medication and his family were therefore unable to say their goodbyes. I note that there is some dispute over when the patient became unresponsive and the cause of this. I note the consultant's view in his response to the complaint, which states that the patient was '*markedly*

hypoxic and tachypnoeic, with a respiratory rate 29-37'. I further note the E IPA's advice that '*hypoxia was severe and he slid into coma and then brain death'*. I also note the G IPA's advice that '*it would…not be unexpected that sedation would…occur when morphine and midazolam were used'*. However, I note that the G IPA also advised that experiencing three respiratory arrests and his hypoxic state were '*very likely'* to have caused the patient to become unresponsive.

61. In his response to a draft copy of this report, the complainant explained that the view that his father suffered from hypoxia is '*conjecture*' and he maintained that the medication caused him to become unresponsive. I have carefully considered the clinical records, the views of the clinicians and those of the E IPA and the G IPA in reaching my finding. I note that the clinical records document the patient's medical observations, including his respiratory rate, and that he experienced three respiratory arrests prior to his transfer to Ward One. I consider that the consultant took an informed view based on the clinical observations taken of the patient during his time in the SWAH. I also note that both the E IPA and G IPA agreed with his view based on the records available. Therefore, on the balance of probabilities, I accept both the consultant's and the IPA's views that the patient's hypoxic state caused him to become unresponsive.

62. I note Standard 16 of the GMC Guidelines, which states that in providing care and treatment, the medical professional is to '*take all possible steps to alleviate pain and distress whether or not a cure may be possible'*. I again understand how difficult the situation was for the patient's family. However, I consider that the decision to prescribe and administer morphine sulphate and midazolam to the patient while in Ward One was to alleviate his pain and distress, which was in his best interests. I also consider that the medications as prescribed and administered to the patient while in Ward One was reasonable, appropriate and in accordance with recognised guidelines.

Therefore, I do not uphold this element of the complaint.

Ward One: Communication with family

63. The complainant said that his family were not informed of the medications administered to their father [morphine sulphate and midazolam]. I note that the clinical records document that the doctor informed the family that '*the NIV mask isn't helping him and is only adding to his distress. We agreed we would switch the NIV to [a] normal O2 mask following midazolam/morphine to help settle his distress'*. I note that in his response to a draft copy of this report, the complainant disagreed that his family were informed that their father would be administered morphine and midazolam. In the absence of any additional evidence relating to this discussion, I am unable to conclude whether or not the doctor informed the family that this medication was to be administered to the patient while he was in Ward One.

64. I note that the record of the doctor's discussion with the family does not document that he informed them of the specific dose of morphine and midazolam administered to their father. I further note that the G IPA advised that *'the RPMG NI guidance does not require that information be given to family prior to palliative care medicines being administered'.* I consider that it was for the doctor, as the medical professional, to use his knowledge and experience to determine which treatment was in the patient's best interests. I do not consider that it was necessary to inform the family of the dosages of the medication administered to their father at that time.

65. The complainant also said that his family were not informed of the effect the medication administered [morphine and midazolam] would have on his father while he was in Ward One. I note that the doctor provided a detailed record of his discussion with the family. However, I also note that this record does not detail that possible side effects of the medication were discussed. I would have expected that if possible effects of the medication were discussed, this would have been recorded.

66. I note that there was no longer an urgency to treat the patient while he was in Ward One as the focus moved to palliation. Therefore, I consider that the medical staff would have had more of an opportunity to communicate with the

family than when in the ED. While I accept it likely that the patient's hypoxic state caused him to become unresponsive, I consider that providing some insight into how the medication was likely to affect their father would have ensured that the family were fully prepared for any changes in his presentation. However, I accept that communicating this was unlikely to impact the patient's ability to communicate with his family at that stage.

Issue 2: Whether the Trust handled the complaint in line with its policy or appropriate standards.

Detail of Complaint

67. The complainant said there were delays in the Trust's handling of his complaint and that he did not receive minutes of a meeting held between the family and the Trust in January 2018 until March 2018. Furthermore, he complained that he did not receive acceptance of the amendments he made to these minutes. He also said that he did not receive a copy of the 'process of investigation' he requested from the Trust. He further complained that the Trust passed the responsibility of accessing his father's clinical records to him, and that he did not receive a copy of his complaints file despite his request to the Trust.

Evidence Considered

Legislation/Policies/Guidance

68. In relation to this element of the complaint, the DoH's Complaints Procedure was considered. The following relevant extracts were identified:

    i. *3.25 …Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must not be adversarial and must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be*

able to seek advice from the Complaints Manager/ senior person, wherever necessary, about the conduct or findings of the investigation. Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be advised of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales. All those involved should be kept informed of progress throughout…

3.37 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements.

3.38 A full investigation of a complaint should normally be completed within 20 working days…

3.40 …Where meetings do take place they should be recorded and that record shared with the complainant for comment…

STANDARD 5: INVESTIGATION OF COMPLAINTS
All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.
STANDARD 6: RESPONDING TO COMPLAINTS
All complaints will be responded to as promptly as possible and all issues raised will be addressed…
Criteria:

1. *The timescales for acknowledging and responding to complaints are in line with statutory requirements;*

2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress…'

ii. I also considered The Access to Health Records (Northern Ireland) Order, 1993 (the 1993 Order). I identified the following relevant extracts:

'Right of access to health records

5.—(1) An application for access to a health record, or to any part of a health record, may be made to the holder of the record by any of the following, namely—

…(e)where the patient has died, the patient's personal representative and any person who may have a claim arising out of the patient's death…'.

iii. I also considered the Trust's guidance for accessing a deceased person's records. I identified the following relevant extracts:

'The law in relation to access to a deceased person's health and social care records is the Access to Health Records (Northern Ireland) Order 1993. This legislation provides that an application for a deceased's records may be made by the legally appointed personal representative of the deceased and by any person who may have a legal claim arising out of the patient's death. Access may also only be given to limited information related to such a claim.

Due to a duty of confidentiality that remains after death, we need to validate your request and your entitlement to access the personal information of the deceased'.

The Trust's response to investigation enquiries

69. In its response to enquiries, the Trust explained that it met with the family on 4 January 2018 regarding their concerns. It explained that the '*response letter, dated 18 June 2018, [detailed] why the notes were not provided until 12 March 2018. They were not typed until 5 February and*

approval did not take place until 28 February, due to leave and other work commitments. [The doctor] then suggested some amendments to the notes. The notes were amended and sent to [the complainant]. I acknowledge that this is an unacceptable delay'.

70. The Trust further explained that '*the Complaints Officer dealing with this case no longer works in the Complaints Department, however, on review of the casefile, it is noted that the Complaints Officer informed the complainant by email on 4 January 2018, that she would be able to provide "a letter with all that was discussed at today's meeting". The Complainant was informed that the Trust's Chief Executive would sign this letter. Based on this, the notes from the meeting would be enclosed with this response letter when it was issued. However, [the complainant] made contact with the Complaints Officer on 1 February 2018, for a copy of these notes which was actioned immediately. The notes were typed and issued on 5 February 2018 to those in attendance at the meeting and their approval was requested'*.

71. The Trust also explained that '*the Trust's response letter, dated 18 June 2018, provided an explanation that due to leave and other work commitments the minutes of the meeting were delayed. [The doctor] advises that he received the minutes via email for his review on 5 February 2018 and replied via email accordingly on 28 February 2018. For the period 5 - 28 February 2018, [he] was not at work due to a combination of days off and annual leave for all but 4 days i.e. 6 February 2018, 19 - 20 February 2018 and 27 February 2018. [He] advises that it was unfortunate that he was unable to attend to this matter on those dates due to other competing clinical and non-clinical commitments'*. The Trust was asked if the complainant was notified of the delay in the provision of the minutes. It explained that '*email communication was provided to [the complainant] to inform him of the delay in providing a response, however, there was no specific reference to the delay regarding the approval of the minutes'*.

72. The Trust was asked to respond to the complaint that the complainant did not receive acceptance of the amendments he made to the minutes of this meeting.

The Trust explained that '*the notes were taken by the Complaints Manager. The draft notes were reviewed by a clinician for accuracy before sharing with the family. In the response of 18th June 2018 it was acknowledged that [the complainant's] amendments are held on file'*. The Trust was asked if it considered the amendments to the minutes prior to issuing the response to his complaint on 11 April 2018. It explained that '*unfortunately, on review of the Complaints File, there is no evidence to support that [the] amendments to the notes were considered prior to the response being issued on 11 April 2018'*.

73. The Trust further explained that the complaints department sent the complainant revised minutes to the doctor for his review. This was followed up by an email on 22 May 2018 asking if he agreed the amendments made by the complainant. His response states that he had '*not had an opportunity to review the minutes of the meeting prepared by [the Trust] alongside the minutes of the meeting prepared by [the complainant]….I am not prepared to indicate that minutes of the meeting prepared by [the complainant] have been "agreed*"'.

74. In relation to the delay in responding to the complaint, the Trust acknowledged '*there was a delay in responding to the complainant in writing'*. The Trust explained that '*you will note various communications the Complaints Officer had with the complainant in respect of the delays. I note that, on 27 February 2018, [the] Complaints Manager, provided an overview to [the complainant] by email of the work that was being done and what information staff were still waiting on from the investigation team. It is accepted that no actual timescale was given however and [the Complaints Manager] wishes to offer her apology for this'*.

75. The Trust was asked to respond to the complaint that the complainant did not receive a copy of the process of investigation that he requested. The Trust explained that '*the issues raised were shared with relevant staff for investigation and comment. It is unclear what is being referred to as the 'process for investigation'*. The Trust was referred to an email sent by the complainant on 4 April 2018. In his email, the complainant requested '*a sequential*

account of what process has been employed to conduct this investigation – when it started, who has been interviewed and when it will be concluded. Additionally, the outcome of each stage'. The Trust explained that '*it is noted that although a direct reply to this email is not evidenced in the casefile, some of [the] answers to these questions are within the Trust response dated 11 April 2018. The Complaints Manager wishes to apologise to [the complainant] that he was not provided with this information at the time of his request'*.

76. The Trust was also asked to respond to the complaint that it passed the responsibility of accessing the complainant's father's clinical records to him. The Trust explained that '*in the letter dated 18 June 2018 details were provided on how to request their father's notes…'* The Trust further explained that the '*Information Governance Manager, advises that the law in relation to access to a deceased person's records is the Access to Health Records (Northern Ireland) Order 1993. This legislation provides that an application for a deceased's records may be made by the personal representative of the deceased and by any person who may have a claim arising out of the patient's death. An Application Form is available on the Trust website or on request from the Information Governance (IG) department and all such requests are processed through our central IG office based in Omagh. [The Information Governance Manager] can confirm that upon checking the records they did not receive or process any request for records relating to [the patient]'*.

77. In relation to the complaint that the Trust did not respond to his request for a copy of his complaints file, it explained that '*this request was actioned by the Complaints Manager on 5 March 2018 requesting information from the Information Governance Department. The casefile does not evidence that the Complaints File was ever issued to the complainant. Unfortunately, [the Complaints Manager] went off on sick leave on 18 March 2019 and this may have contributed to a breakdown in communication regarding this matter. The Complaints Manager apologises to [the complainant] for not updating him regarding his request or providing this information'*.

The Trust's records

78. I carefully considered the records relating to the complaint provided by the Trust.

79. I considered the Trust's response to the complaint, dated 11 April 2018. The letter stated that the Trust wished to '*apologise for the extensive delay in providing my response, however, I understand [the] Complaints Officer has informed you of the reason for this'*.

80. I also considered the Trust's second response to the complainant sent on 18 June 2018. The letter stated '*in relation to the notes of the meeting not being received until 12 March 2018, the minutes were not typed until 5 February due to leave and other work commitments. They were then sent to [the doctor] for approval that same day, however, due to work commitments he was unable to review these until 28 February. [He] had made some changes to the notes and after these were completed they were sent to you'*. It also stated, '*with regard to your concerns relating to your own re-written version of the meeting, I can confirm that these have been saved in your file'*.

81. In relation to the complainant's request for his father's clinical records, the letter stated, '*in order to comply with Trust policy, all written requests for access to patient records should be forwarded to the [Information Governance Office]*'.

Analysis and Findings

82. I note that the complainant raised his complaint with the Trust on 13 December 2017. However, the complaint process was initiated following the complainant's meeting with the Trust on 4 January 2018. I note that the Trust did not forward its initial response to the complainant until 16 April 2018 (in a letter dated 11 April 2018). This was 70 working days after the family's meeting with the Trust.

83. I note that the DoH Complaints Procedures states that *'a full investigation of a complaint should normally be completed within 20 working days'*. I have carefully considered the records contained within the complaints file. I note that

the Trust took steps to actively investigate the complaint, which involved a number of medical personnel. However, I do not consider that those involved in the investigation demonstrated sufficient urgency to respond to the complaint. I accept that it may not always be possible for the Trust to fully respond to a complainant within the stated 20 day timeframe. However, I do not consider that the complaint was complex or multifaceted.
Therefore, I consider that the time taken to respond to the complainant's complaint was unacceptable.

84. I note that the Trust accepted the extensive delay and explained that it provided updates to the complainant throughout the process. I have considered the complaints file and note that the Trust corresponded with the complainant at regular intervals during the investigation. However, I also note that the Trust did not initiate this correspondence. Rather, the correspondence followed requests for updates from the complainant.

85. The complainant said that he did not receive the minutes of the meeting held in January 2018 until 12 March 2018. I have considered the Trust's response to this element of the complaint. I note that the minutes of the meeting were not typed until 5 February 2018. I am unable to establish an explanation for this delay. I note that the provision of the minutes was delayed further due to the doctor's leave from work during the month of February 2018.

86. The Trust acknowledged that it did not inform the complainant that the provision of the minutes would be delayed despite his requests for a copy to be forwarded to him. Furthermore, I also note that the Trust did not provide the complainant with an apology nor an explanation for the delay. I am unable to establish an explanation for this omission.

87. The complainant also said that the Trust did not inform him whether or not it accepted the amendments he made to the minutes. I note that the Trust informed the complainant that his amendments were held on file.

88. I have considered the correspondence relating to this element of the

complaint. I am unable to find any evidence that the amended version of the minutes written by the complainant was forwarded to the doctor for his review prior to 22 May 2018. I note that the Trust acknowledged that there is no evidence to suggest that relevant personnel considered the complainant's revised version prior to issuing its response on 11 April 2018. I am unable to establish an explanation for this failing. I consider that the Trust ought to have considered the complainant's revised minutes of the meeting to ensure that the Trust did not omit any pertinent details discussed in his version. I consider that by not reviewing the complainant's version of the minutes, there was a risk that not all relevant points raised at the meeting in January 2018 were considered as part of the investigation.

89. I note that the Trust accepted that whilst it informed the complainant that its response to his complaint would be delayed, it did not advise him when it expected to provide him with an outcome. I note that the DoH Complaints Procedure states that '*as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales'.* I consider that the Trust ought to have recognised the extent of the investigation and anticipated that an extension to the target timescale was required. Furthermore, the Trust ought to have advised the complainant of the reason for the delay and a revised timescale in accordance with the DoH Complaints Procedure.

90. I have also considered the complaint about the Trust's handling of the complainant'request for a copy of the file relating to his complaint. I note that the complainant initially requested the file by email on 1 February 2018. This was followed up by an email to the Complaints Manager sent on 27 February 2018. I note that the Trust sought advice from the IGO on 5 March 2018 regarding the request. I further note that the Trust received advice from the IGO the same day. However, the records do not contain a subsequent response to the complainant following receipt of this advice.

91. I have also considered the complaint about the Trust's handling of the

complainant's request for a copy of the 'process of investigation'. I note that on 4 April 2018, the complainant requested '*a sequential account of what process has been employed to conduct this investigation – when it started, who has been interviewed and when it will be concluded. Additionally, the outcome of each stage'*. The records provided by the Trust do not include a direct response to this request.

92. In relation to both requests made by the complainant, it is not my role to comment on whether or not there was a breach of Data Protection legislation. However, I do note that in accordance with the legislation, the Trust was required to respond to the complainant's requests within 40 days. There is no dispute that the requests were not responded to by the Trust. Whilst I have noted the Trust's explanation, I find it unacceptable that the Trust did not directly respond to these requests. It is clear that the Trust did not provide the complainant with a level of service which he was entitled to expect.

93. In relation to the complaint that the Trust passed the responsibility of accessing his father's clinical records to him, I note the Trust's email to the complainant sent on 5 February 2018. This referred the complainant to its Information and Governance Office (IGO) for advice. I also note the correspondence sent to the complainant on 18 June 2018, which again advised the complainant to forward his request to the IGO. The Trust's guidance for accessing a deceased person's records requires the person making the request to complete the relevant form and provide evidence of their right to access the records. The notes add that *'due to a common law duty of confidentiality that remains after death, the Trust needs to validate your request and your entitlement to access the personal information of the deceased'*. I consider that the Trust's decision to refer the complainant to the IGO was necessary for it to comply with the 1993 Order and its own guidance. **Therefore, I do not uphold this element of the the complaint.**

94. Although I have not upheld all of the complainant' concerns regarding the Trust's handling of his complaint, I have identified a number of significant failings. I have identified excessive delay by the Trust in completion of its

investigation. Furthermore, I have identified that when it became known that the process would be delayed, the Trust failed to inform the complainant of a revised timescale for completion. I have also identified that the Trust did not consider the complainant's amended minutes prior to responding to his complaint. In addition, I identified that the Trust did not respond to requests made to it by the complainant.

95. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with '*complainants promptly and sensitively, bearing in mind their individual circumstances*'. Furthermore, the Fourth Principle of Good Complaint Handling, 'acting fairly and proportionately' requires bodies to ensure that '*complaints are investigated thoroughly and fairly to establish the facts of the case'*. I consider that the Trust failed to act in accordance with these Principles in its handling of the complainant' complaint. I am satisfied that this constitutes maladministration. As a consequence, I am satisfied that the maladministration identified caused the complainant to experience the injustice of frustration and uncertainty. Furthermore, I am satisfied that it also caused the complainant the time and trouble by bringing his complaint to this office.

CONCLUSION

96. The complainant submitted a complaint to this office about the care and treatment his father, the patient, received on 28 and 29 November 2917 in the SWAH. He also complained about the Trust's handling of his subsequent complaint.

97. The investigation of the complaint did not find a failure in the care and treatment provided to the patient while he was treated in either the ED or Ward One of the SWAH on 28 and 29 November 2017. It also did not find any failures in the medical staff's communication with the patient's family.

98. In relation to complaint handling, the investigation found that the Trust's

instruction provided to the complainant regarding how to access his father's medical records was in accordance with relevant guidelines.

99. The investigation did find maladministration in relation to the Trust's handling of the complaint process.

100. I am satisfied that the maladministration identified caused the patient the injustice of frustration and uncertainty, and time and trouble by bringing his complaint to this office.

Recommendations

101. I recommend within **one** month of the date of this report:

i. The Trust provide the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused to him as a result of the maladministration identified;

ii. The Trust discusses the findings of this report with the clinicians involved in the patient' care; and

iii. The Trust's Chief Executive reminds staff charged with the responsibility of investigating complaints of the need to provide a response within a reasonable timeframe to enable the Trust to meet the target timeframe set out in relevant guidance.

PAUL MCFADDEN **March 2020**
Acting Ombudsman

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being Customer focused

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

Being open and accountable

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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