Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 201914016

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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 actions of the Southern Health and Social Care Trust (the Trust). The complainants said the Trust failed to properly care for their son, (the patient) after he was admitted for his hip replacement on 27 August 2018. The complainants could not understand how the patient became so sick despite being admitted for a hip replacement which was never done. The complainants were concerned that the patient was able to abscond from the hospital before falling outside the hospital shortly before he passed away after being brought back to his hospital bed.

In order to assist with the consideration of the issue raised in the complaint, advice was obtained from an independent advisor who was a consultant nephrologist. Although the IPA felt that the care provided to the patient was generally to a good standard, the investigation of the complaint identified failures on the part of the Trust in assessing the patient's capacity and mental state. The investigation found that had these assessments been carried out, the patient may have had greater supervision which may have prevented him from absconding from the hospital shortly before he passed away. I also considered the impact that these unfortunate circumstances had on the patient's family, who were understandably distressed.
I recommended the Trust issue an apology in accordance with the 2016 NIPSO guidance on apology for the distress and upset the complainants experienced, as well as the loss of opportunity experienced by the patient as a result of the failings identified within the report.

I also recommended the Trust remind the relevant clinicians involved in the patient's care and treatment of the importance of performing mental capacity assessments and provide evidence that such discussions have taken place within three months of the date of this report.

Finally, I wish to pass my condolences to the complainants and the patient's

extended family over the sudden and unexpected death of the patient. I hope that my report has gone some way to address the complainants' concerns. I hope that by reading my detailed report and the advice obtained the complainants can understand how I have arrived at my conclusions, but I wish to assure them that I have reached them only after the fullest consideration of all the facts of this case.

THE COMPLAINT

1. I received a complaint about the actions of the Southern Health and Social Care Trust (the Trust). The complainants said the Trust did not provide appropriate care and treatment to their son, the patient. The complainants could not understand how the patient died after he was admitted to hospital for a hip replacement. The complainants also expressed concerns regarding how the Trust communicated with the family in explaining how the patient had become so ill and regarding the decision to let the patient go home before he passed away.

Issue(s) of complaint

2. The issue of complaint accepted for investigation was:

   Issue 1: **Was the care and treatment provided to the patient from 3 September 2018 to 16 September 2018 consistent with good medical practice?**

INVESTIGATION METHODOLOGY

3. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the patient's medical records and the care and treatment provided to the patient.

Independent Professional Advice Sought

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

   - A Consultant nephrologist for 20 years, treating inpatient acute kidney injury, in-reach to orthopaedic wards

5. The clinical advice received is enclosed at Appendix two to this report.

6. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'; however how

I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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. I also make reference to relevant regulatory, professional and statutory guidance.

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

   - The Principles of Good Administration
   - The Principles of Good Complaints Handling

8. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgment of those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:

   - National Institute for Health and Care Excellence (NICE): Acute Kidney Injury. Quality Standard [QS76] Published date: 22 December 2014 (NICE Quality Standard)
   - General Medical Council (GMC): Good Medical Practice Domain 3. Communication, partnership and teamwork. (GMC Domain 3)

   Relevant sections of the guidance considered are enclosed at Appendix three to this report.

9. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

10. A draft copy of this report was shared with the complainants and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

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

THE INVESTIGATION

Issue 1: Was the care and treatment provided to the patient from 3 September 2018 to 16 September 2018 consistent with good medical practice?

Detail of Complaint

11. The complainants believed the patient did not receive appropriate care and treatment during his admission. The patient was admitted for a hip replacement on 27 August 2018. The complainants were concerned about how the patient became so sick in hospital. The complainants also believed they were not properly communicated with about the patient being allowed to go home on 16 September 2018.

Evidence Considered

Trust's response to investigation enquiries

12. In its 13 October 2018 response to the Complainants as part of local resolution, the Trust said the patient attended for dialysis on 14 September 2018 *'and was seen and assessed by [a consultant nephrologist] whilst in the renal unit. [The consultant nephrologist] acknowledged [the patient] was keen to go home and advised [the patient] that he required his blood tests repeated the following day (Saturday) and that if his blood results had improved, that he could go home for a few hours on Sunday 16th September 2018.*' The Trust said the nursing staff documented on Sunday 16 September 2018, that '[*the patient] was confused in the early morning period and [was] very anxious to go home. [The patient] had taken a full breakfast and there is a note to say that the nurse tried to reassure him to stay. At 10:00 hours it was noted [the patient] was not on the ward and an immediate search was started on the 5th floor of the hospital site. At this time, records reveal that your [daughter and husband] were contacted informing them that [the patient] had left the ward. The nursing staff also rang [the patient's] mobile and received no reply.'* The Trust believed the patient *'left the ward whilst dressed in his dressing gown and pyjamas before 10:00 hours.*

Up until this point, [the patient] did not indicate to staff that he would leave or not follow medical advice, but he continued to express his wish to go home.

13. The Trust's response stated *'[t]he ward staff then received a phone call from the ED to say that [the patient] had fallen and was in the department. [The patient] had presented to the ED at 9:58 hrs. One of the senior nursing staff had seen [the patient] sitting on the curb outside, she came to his aide and escorted him into the ED for assessment. [The patient] advised the nursing staff in ED that he had signed himself out and wanted to go home.'*

14. The Trust said that while he was in ED, the patient *'informed the medical team that he remembered walking down on a step and losing his footing. [The patient] was noted to be confused to time and date and had blood tests repeated and a CT scan of his brain, which did not show any abnormality. When [the patient] left the ED his clinical observations were completed and he returned to the Male Medical Ward at 11:45 hrs and was advised to rest on top of his bed in his pyjamas and dressing gown. At 12:23 hours, unfortunately [the patient] was found unresponsive and despite all the efforts of the Medical and Nursing teams he did not respond to resuscitation and passed away.'*

15. In its 29 March 2019 response to NIPSO's inquiries, the Trust said the patient "*was admitted, as planned on 27 August 2018. The following morning, [the surgeon] brought him to theatre and aspirated fluid from the collection around his right hip… [the surgeon advised] that when [the patient] was admitted on 27 August 2018, clinicians took routine blood tests, as happens for anyone who is going to theatre. Although he appeared well, [the patient's] blood count was dangerously low. [The patient] went on to develop kidney failure in the next few days. [The patient] was no longer fit to proceed to surgery.'*

16. In relation to the cause of the patient's acute sickness, the Trust said *'[n]either his anemia[2] nor renal failure[3] can be explained by his hip replacements. [The surgeon] has never been involved in a case where raised metal ions in the blood have caused these sorts of problems, and he thinks that it is very*

[2] A state in which haemoglobin in blood is below the reference range
[3] A condition where the kidney reaches advanced state of loss of function.

unlikely. [It was the surgeon's opinion] that [the patient's] hip and acute illness were two unrelated problems. He believes that if [the patient] had not been admitted on a planned basis on 27 August 2018 that he would have presented to hospital feeling very sick within a day or two. He became very sick, very quickly, and his hip replacements became a secondary issue.'

17. In relation to discussions relating to the patient going home, the Trust said 'nursing and clinical notes reveal [the patient] was very anxious to go home. *After Dialysis[4] on 14 September 2018, [a nephrology consultant] documented and agreed that [the patient] could go home for 4 hours on Sunday, if his bloods were stable and he was clinically well. It is clear that [the consultant] did not feel [the patient] was fit for permanent discharge and this is recorded. This arrangement was conveyed from the renal dialysis nursing team to the Male Medical Ward nurses on return from Dialysis… Prior to [the patient's death] he was being managed by [two nephrology consultants]. He had been receiving dialysis for his renal failure and he had haemodialysis on Saturday 15 September 2018.'*

18. Regarding the events on the day of the patient's death, the Trust said a nephrology consultant '*was undertaking a ward round on Sunday morning 16 September 2018… he had planned to review [the patient] to see if he could go home for a few hours as indicated by the nephrology team. He was made aware that [the patient] had been found to have left the ward and that attempts were being made to find him… [the consultant nephrologist] was then informed around 12:30 pm that [the patient] had been returned to the ward following assessment in the Emergency Department and had been found unresponsive and unfortunately had not responded to attempts at cardiopulmonary resuscitation.'*

19. The Trust said the consultant nephrologist '*confirmed [the patient] had been extensively reassessed in the [ED] after his representation and that no abnormality had been identified on his CT scan, ECG and blood tests that would account for his sudden death.'*

[4] A blood purifying treatment given when kidney function is not optimum

Relevant medical records

20. The medical records indicate the patient was electively admitted to Craigavon Area Hospital on 27 August 2018 under orthopaedics. The records indicate that '*on admission patient had severe AKI egfr[5] 5 and oliguric[6], Hb[7] 42.'* The patient had a blood transfusion and hip aspiration on 28 August 2018. By 31 August, the nursing records indicate the patient was *'very confused'* and this was again noted repeatedly in the nursing entries on 1 September 2018 and 2 September 2018.

21. The patient had a CT scan of the brain on 2 September 2018 which showed '*involution… likely due to the long term high alcohol intake.*' The nursing notes document the patient was unsettled and wanted to go home. The nurses noted the patient '*remains confused'* on 3 September 2018 and was '*very confused'* on 4 September 2018.

22. A note at 14:00 on 5 September 2018 noting the patient's '*renal function had plateaued over [the] past 24 hours… no need for dialysis at present*.' On 7 September 2018, the records indicate the patient's '*renal function [was] static at present.'*

23. Overnight on 8 September 2018, the nursing staff '*reported 2 episodes of melena[8] overnight. This [was] since followed by a normal bowel movement x2.'* The patient had a blood transfusion on 9 September 2018 and was noted to have episodes of haematemesis[9]. The records indicate the plan was for the patient to undergo an OGD[10] that evening, however, this was cancelled due to emergencies with other patients.

24. The records reflect the family were updated on 9 September 2018. The note from that conversation states '*family updated (parents and sister) explained; multiorgan involvement – liver including coagulopathy; kidneys – little*

[5] Estimated glomerular filtration rate **–** A test to measure your level of kidney function and determine your stage of kidney disease.
[6] The production of abnormally small amounts of urine.
[7] Haemoglobin
[8] the production of dark sticky faeces containing partly digested blood, as a result of internal bleeding or the swallowing of blood.
[9] Vomiting blood.
[10] Gastroscopy – an examination that allows visualisation of the patients oesophagus

improvement – now bleeding…. For OGD tomorrow if remains stable. Explained he is unwell. Is currently stable but could be unbalanced very easily. Could easily deteriorate and may need ICU. There is a possibility ICU may not be able to help, but not there yet and things are being constantly reviewed. Thankful for opportunity to talk and for update. Upset at how unwell [the patient is] Current plan explained, content with current care. No further questions.'

25. On 10 September 2018, the records document the patient had *'ongoing diarrhoea – 14 bowel movements [in past] 24 hours… no further haematemesis/melena.'* On 10 September, the nursing notes document family in attendance until late and the patient was *"[v]ery unsettled this am. Wanting to go home'.*

26. The patient was transferred to Daisy Hill Hospital on 11 September 2018 and it is noted the patient's *'next of kin was informed.'* His creatinine[11] was 1096. The discharge record from the patient's transfer to Daisy Hill Hospital indicates that after *'initially showing some improvement in urine output, he again became oliguric'.* Transfer documentation stated the patient had '*severe AKI'* [12]when he was admitted on 27 August. The AKI was '*presumed secondary to large Volume GI losses and anemia.*' The reason for the transfer to Daisy Hill Hospital was that he was '*being transferred to renal to start dialysis.'* The transfer documentation also reflected that the patient had an ultrasound *'showing evidence of liver cirrohis'* which was presumed to be '*alcoholic liver disease*.' Before his transfer, on 9 September 2018, the patient had an episode of hematemesis, but had not had any since. Reasons for admission to Daisy Hill was noted to be '[*t]ransferred from CAH for Permicath[13] insertion and to commence Haemodyalysis.'*

27. Records on 14 September 2018 indicate the patient was '*[t]aken over to [Heamodialysis today by mistake. 1 Hour Haemodialysis.*' At 17:00 on 14 September 2018, the consultant nephrologist's records indicate the patient '*appeared confused re being discharged tomorrow. He also wanted to go out*

[11] A test of the waste product produced by a patient's kidneys.
[12] AKI – Acute Kidney Injury
[13] a long, flexible tube (catheter) that is inserted into a vein

overnight. I have explained he is too ill for discharge. He can go out for 4 hours Sunday if labs tomorrow stable and clinically well.' The nursing notes for the night of 14 September 2018 also record that the patient *'appears agitated – wants to go home, seems disorientated at times, not sleeping much, regular reassurance given.'*

28. The medical record of 16 September 2018 notes that the patient '*was mobilizing and seen in the corridor 15.9.18*' and the nursing notes of 15 September 2018 indicate he was '*very unsettled trying to go home +++.*' Overnight on 15 September 2018, it was noted the patient *'appears confused at times.*' On the morning of 16 September 2018, it was again noted that the patient *'remains confused this am.'*

29. The records on 16 September 2018 indicate the patient '*took a good breakfast this am. In good form. Looking to go home ++.'* Thereafter, the records note that at 10:00 am, the patient was *'noted not to be in ward. Hospital checked. No sign of patient. Family contacted…[the patient] phoned his mum to tell her he was in a taxi going to bank machine.' The nurse tried contacting the patient, but did not receive an answer…Consultant, family and police notified'.*

30. The patient was found following an '*unwitnessed fall, eye laceration, found at hospital entrance'* He was taken to the ED and the patient was '*brought to ward at 11:30 am and mobilised into bed himself.'* A CT Scan was carried out that showed no new brain abnormality. After the patient was returned to the ward, observations were noted to be *'stable with no indication of impending cardiac arrest'*. The patient was '*found unresponsive in bed. Cardiac Arrest call 12.28'.*

31. The medical records state*: 'Family informed – Mother/Father/Sister. Condolences offered. Family updated on events and how patient passed away in bed. Likely sudden cardiac event. All questions answered. Family grateful he didn't suffer. [Consultant Nephrologist] arrived to ward and discussed all of the above with family. I left message with Coroner given unexpected suicide/death. Death Cert will not be able to be issued until coroner contacts [the nephrology Consultant].* The nursing notes also state the *'Death Cert*

cannot be issued until confirmation from Coroner. Question whether patient needs Post Mortem.'

NIPSO's Communication with the Coroner's Office.

32. According to the Coroner office, it was informed of the patient's death by the Consultant on 16 September 2018. The Coroner's office also said the consultant nephrologist informed the coroner's office that the patient had been transferred from Craigavon Hospital *'for ongoing dialysis support due to Acute Kidney Injury linked to infected hip. He has been receiving treatment for C-Diff, immunosuppression due to psoriasis, alcohol intake, liver cirrhosis and previous overdoses. According to [the consultant nephrologist, the patient] was stable following dialysis however has left the ward at 10:00 am that morning. He was found an hour later in the grounds of the hospital. He was readmitted to the ward following a CT scan and ECG. There were no abnormalities noted.'*

33. The consultant nephrologist informed the Coroner's office that the patient *'was discovered in cardiac arrest 15 minutes later. CPR was commenced and continued for 20 minutes without success - cause of death MI linked to multiple illnesses, electrolyte disturbances and co- morbidities.'* In relation to the cause of death as listed on the Death Certificate, the Consultant Nephrologist '*suggested cause of death to the Coroner as 1a MI[Myocardial Infarction]; 1b Acute Renal Failure; II Alcoholic Liver Disease. That was accepted by the Coroner and the Death Certificate issued by the doctor.'*

Relevant Independent Professional Advice.

34. The IPA was asked to provide a chronology of events surrounding the patient's admission on 27 August 2018. The IPA advised the patient had a history of '*Arthritis associated with the skin condition psoriasis which had had been treated aggressively including steroids and monoclonal antibodies…Right hip replacement which had metal surfaces and was thought to be causing a local and potential systemic reaction aseptic lymphocytic vasculitis-associated lesions (ALVAL), hence the referral to orthopaedics. He had a long history of significant alcohol excess which was stated to have caused alcoholic liver disease (cirrhosis seen on ultrasound).* The IPA advised the patient was

'investigated with endoscopy and colonoscopy in June 2018' after coughing up blood. The IPA also advised the patient's medical history was significant for *'an abnormality of prominent small blood vessels of the bowel (angiodysplasia[14]). He was noted to have lost 2 stones of weight since [Christmas] and had been treated for clostridium difficle (C Diff) as there was evidence of infection at some point (although not necessarily active). Blood tests from April 2018 showed anaemia (Hb 101) and normal kidney function (Creatinine 60). Previously Hb 112 Creatine 93 July 2017. Past history also includes depression and multiple hospital admissions related to overdoses usually with alcohol and painkillers in the context of long-term chronic pain.'*

35. The IPA was asked to provide advice regarding the cause of the patient's kidney failure. In response, the IPA advised *'[t]he cause of the kidney failure is unknown. Kidney function blood test creatinine was normal in April and severe kidney failure on admission. The assumption was that there was dehydration due to the weeks of diarrhoea before admission. Despite intravenous fluids the kidney failure seems to have been established with a working diagnosis of acute tubular necrosis (ATN)… The ultrasound scan showed some changes that can be associated with longer term medical kidney disease (echobright kidneys). This might be supported by tests showing blood and protein leaking out into the urine. Blood tests and ultrasound ruled out certain other conditions (ANCA associated vasculitis and blocked kidneys).*'

36. The IPA explained that ATN *'is where the insult is so bad that the filter units of the kidneys are badly damaged.'* Regarding the treatment options for ATN, the IPA advised *'[t]here is no specific treatment for this and dialysis may be required. In most cases ATN will recover in 2-3 weeks but dialysis may be required in the interim. If recovery does not happen as expected a kidney biopsy may be necessary.'* The IPA was asked whether the patient's kidney failure was related to the collection in his hip. In response, the IPA advised *'[t]his is unknown. The fluid collection around the hip seems to have been due to a reaction to the metal surfaces AVAL. There is no proof from the medical literature of an association with kidney failure. The definitive diagnosis would*

[14] A small vascular malformation of the gut.

have required a kidney biopsy. However, he was never medially fit enough for this invasive test which has risk of significant bleeding.'

37. The IPA was asked whether the cause of the kidney failure should have been diagnosed. The IPA advised *'[t]here is no criticism in a lack of diagnosis of kidney failure. It is not unusual for a patient with multiple medial problems requiring dialysis not to be fit for kidney biopsy. The appropriate investigations were undertaken in context of the medical condition.'*

38. In relation to the treatment that was provided for the patient's kidney failure, the IPA advised *'[t]he kidney failure was noted immediately on the admission blood tests. With the history of diarrhoea and clinical examination suggesting dehydration, he was treated appropriately with intravenous fluids. Investigations ruled out any reversible cause of kidney failure but did not give a definitive diagnosis. During the admission in the first hospital it became clear that the kidney failure was established and dialysis would be required, hence transfer. No other specific treatment for the kidney failure was required at this stage.'* In relation to the treatment that was provided after the patient was transferred, the IPA advised *'[a]fter transfer to Daisy Hill Hospital a central line was inserted to allow large volumes of blood to be circulated outside the body for dialysis. Haemodialysis was undertaken on 11/9/18, 12/9/18, 14/9/18 (one hour only) and 15/9/18. Blood was transfused during the treatments of 11/9/118 and 15/9/18.'*

39. The IPA advised that *'[o]nce it became evident his multiple medical problems were a higher priority that the orthopaedic issue he was transferred to the medical team. After hospital transfer, he was under the renal team in DHH on a medical ward. This was an appropriate progression in view of the medical issues.*'

40. The IPA was asked to advise whether this treatment was appropriate. In response, the IPA advised that *'the treatment provided was consistent with good medical practice.'* The IPA explained the patient '*had intravenous fluids and treatment of other medial issues (diarrhoea, anaemia). Once it was clear*

the kidney failure was not responding he was transferred for dialysis treatment. He received 4 dialysis sessions.'

41. Despite generally being provided with good care, the IPA was critical that *'One dialysis session appears to have been unintended. This is clearly not good practice and suggests a breakdown of communications between the medial/nursing/dialysis teams. However, there is no evidence of harm from the unintended hour of dialysis.'*

42. Although the IPA was generally not critical of the renal treatment provided to the patient, the IPA was critical of the failure to provide a mental state and capacity assessment for the patient. The IPA advised *'[m]y criticism of care during the admission is the lack of formal documentation of mental state and capacity. Capacity is a major issue for a patient described as confused, even intermittently. The basis of legal guidelines is that if someone has capacity, they can make decisions that other people may regard as incorrect. I cannot find any assessment of mental state, such as the quick clinical tool of mini-mental testing or any discussion of capacity.'*

43. In relation to the complications associated with the patient's hip replacement, the IPA advised the patient *'had a rare but major side effect of metal surfaced joint replacement. Redo joint replacement is a significant surgical undertaking and once the extent of his other health problems became apparent it is likely that hip replacement would have never been felt safe.'* The IPA also advised that *'[d]ialysis dependent acute kidney failure is associated with a 50% mortality.'*

44. When the patient left Hospital on 16 September 2018, the IPA advised that the response by the Hospital Staff was appropriate. The IPA advised '*The nursing staff immediately informed the senior doctor, family and police*.' In relation to the cause of the patient's death, the IPA advised that '[*w]ithout a post-mortem it is impossible to prove the cause of death or if there was any association with the fall.*' However, the IPA also advised that *'[a]lthough his death was unexpected, he was in a very poor state of health even before admission. His history of diarrhoea and weight less in the context of alcoholism*

and alcoholic liver disease clearly suggested major health problems independent of his hip problems.'

45. The IPA was asked to comment on the communication with the patient's family regarding the possibility of the patient being let home for several hours. The IPA advised that the patient '*was clearly very motivated to go home. This is noted several times in the nursing notes. However, this is in the context of intermittent confusion and alcohol withdrawal. There is mention that periods of confusion may have pre-dated the admission…Under these circumstances the clinical team has a dilemma of agreeing to the stated patient preferences and the requirement for patient safety. Keeping him on board with treatment by suggesting a period at home is a reasonable proposal.'*

46. Given the patient's confusion and condition, the IPA advised that he *'would have expected more communication with the family under these circumstances to ensure a safe trip, with family escorts, and the expectation that he would return to hospital.*

47. In conclusion, the IPA advised that *'[t]he sequence of events of disappearing from the ward, suffering a fall and then sudden death was clearly unexpected. However, with the benefit of hindsight his death was, unfortunately, quite likely before discharge from hospital. Without a post-mortem it is impossible to prove the cause of death or if there was any association with the fall. The preceding medical history makes it clear that this gentleman had a number of potentially life limiting medical issues before admission. His alcoholism and alcoholic liver disease was a major issue. He had lost a significant amount of weight and had gastrointestinal bleeding which continued through the admission. He had a very rare complication of hip replacement surgery which would have required major surgical revision of his hip joint had he been fit enough to withstand this. His psoriasis required powerful immunosuppressive medication which rendered him at risk of other problems.'*

48. The IPA advised that *'[a]t the time of admission, he was in established kidney failure and had severe anaemia. He had diarrhoea throughout his admission despite appropriate investigation and management. Unfortunately, his life*

expectancy was significantly limited even prior to admission. Dialysis dependent acute kidney injury has a mortality rate up to 50% and with the benefit of hindsight it is, unfortunately, not unexpected that he did not survive the hospital admission.'

49. In general, the IPA advised *'[a]lthough there are aspects of less than ideal care during the admission the medical and nursing care seems to have generally been of a high standard throughout…. [the patient] had timely diagnosis, investigations and treatment of the various medical conditions. The notes demonstrate caring and high-quality nursing care. The major issue is the response to his confusion. It is difficult from the notes to gauge how severe this was, as many people live with an element of brain impairment are able to stay in hospital and be discharged safely. His fixation about going home should have alerted staff to his flight risk and/or risk of not coming back from a home visit. A more robust assessment of mental capacity and instigation mental state may have resulted in closer supervision (one to one nursing or "specialing") which might have prevented the absconding episode. However, the message from the medical staff was that a home visit on the Sunday was appropriate which suggests lack of concern about flight risk. There is no clear evidence that the unplanned departure from the ward and the fall actually caused his death. The only proof would be a post-mortem which the family clearly wanted to avoid, hence the consultant helpfully discussing with the coroner and issuing a death certificate as requested.'*

Analysis and Findings

50. I carefully considered this complaint. As part of my analysis, I considered whether the patient was provided with appropriate treatment. In particular, I considered whether the cause of the patient's illness could have been diagnosed and whether the patient's acute kidney injury was appropriately managed. I also considered whether the patient's mental state was appropriately assessed and managed, and whether appropriate conversations were held with the patient's family about the patient's plan of care. In particular, I considered whether the patient's family were kept informed about the patient's mental state and discussions around allowing the patient to leave

the hospital. I also considered whether the information recorded on the Death Certificate was appropriate and reasonable.

Was the patient provided with appropriate treatment?

51. In considering this element of the complaint, I had regard to the medical records from the patient's admission, when it became clear the patient was very unwell, up until his death on 16 September 2018. I considered the medical notes and nursing notes. I note the records indicate the patient had an acute kidney Injury on admission. Although this initially improved, I note that his '*renal function had plateaued'* by 5 September 2018. The records reflect that discussions were held with the renal team about whether the patient should be given dialysis. On 7 September, it was noted there was '*no need for dialysis at present' and the patient's 'renal function [was] static at present.'*

52. I note the records indicate the patient's condition deteriorated and he was transferred to Daisy Hill Hospital on 11 September to receive Haemodialysis. The records show the patient received dialysis on 11 September 2018, 12 September, 2018,14 September 2018 (one hour only) and 15 September2018. Blood was transfused during the treatments of 11 and 15 September 2018. The records indicate that the dialysis treatment on 14 September 2018 was given by mistake.

53. I also considered the Trust's responses to enquiries related to the treatment provided to the patient. In particular, I considered the Trust's statements that when the patient was admitted, '*[a]lthough he appeared well, [the patient's] blood count was dangerously low. [The patient] went on to develop kidney failure in the next few days. [The patient] was no longer fit to proceed to surgery.'*

54. I note that in relation to the cause of the patient's renal failure and anemia, the Trust said neither of these *'can be explained by his hip replacements. [The surgeon] has never been involved in a case where raise metal ions in the blood have caused these sorts of problems, and he thinks that it is very unlikely.'* I considered the Trust's position that the *'hip and acute illness were two unrelated problems.'*

55. I considered the IPA advice in relation to the cause of the patient's acute kidney injury. The IPA advised *'[t]he cause of the kidney failure is unknown.'* The IPA explained that *although '[k]idney function blood test creatinine was normal in April' the patient had 'severe kidney failure on admission. Despite intravenous fluids the kidney failure seems to have been established with a working diagnosis of acute tubular necrosis (ATN)… The ultrasound scan showed some changes that can be associated with longer term medical kidney disease (echobright kidneys).'*

56. I note the IPA also advised that it was '*unknown*' whether the patient's renal issues were related to the patient's hip. However, I note the IPA's advice that *'[t]he fluid collection around the hip seems to have been due to a reaction to the metal surfaces ALVAL.'* I also note the IPA agreed with the Trust in so far as to say *'[t]here is no proof from the medical literature of an association with kidney failure.'* I note the IPA advised that '*definitive diagnosis would have required a kidney biopsy. However, he was never medially fit enough for this invasive test which has risk of significant bleeding.'*

57. The IPA was asked whether the cause of the kidney failure should have been diagnosed. The IPA advised '[t*]he kidney failure was noted immediately on the admission blood tests…'[t]here is no criticism in a lack of diagnosis of kidney failure. It is not unusual for a patient with multiple medial problems requiring dialysis not to be fit for kidney biopsy. The appropriate investigations were undertaken in context of the medical condition.'* In relation to the applicable NICE Guidelines, the IPA advised *'the treatment of kidney failure is within the NICE Quality Standard. This includes early recognition, investigation which included ultrasound scanning, referral to kidney specialists and eventually dialysis treatment.'*

58. I considered the IPA's advice about the treatment provided for the patient's kidney failure. In particular, I note the IPA advised '*[w]ith the history of diarrhoea and clinical examination suggesting dehydration, he was treated appropriately with intravenous fluids. Investigations ruled out any reversible cause of kidney failure but did not give a definitive diagnosis. During the admission in the first hospital it became clear that the kidney failure was established and dialysis*

would be required, hence transfer. No other specific treatment for the kidney failure was required at this stage…'[o]nce it became evident his multiple medical problems were a higher priority than the orthopaedic issue he was transferred to the medical team. After hospital transfer, he was under the renal team in DHH on a medical ward. This was an appropriate progression in view of the medical issues

59. I note the IPA advised that after the patient was transferred to Daisy Hill Hospital, '*a central line was inserted to allow large volumes of blood to be circulated outside the body for dialysis. Haemodialysis was undertaken on 11/9/18, 12/9/18, 14/9/18 (one hour only) and 15/9/18. Blood was transfused during the treatments of 11/9/118 and 15/9/18.'*

60. After explaining the treatment provided to the patient, the IPA advised that *'the treatment provided was consistent with good medical practice…[o]nce it was clear the kidney failure was not responding he was transferred for dialysis treatment. He received 4 dialysis sessions.'* Despite generally being provided with good care, the IPA was critical that *'[o]ne dialysis session appears to have been unintended. This is clearly not good practice and suggests a breakdown of communications between the medial/nursing/dialysis teams. However, there is no evidence of harm from the unintended hour of dialysis.'* I note the IPA also advised *'[d]ialysis dependent acute kidney injury has a mortality rate up to 50% and with the benefit of hindsight it is, unfortunately, not unexpected that he did not survive the hospital admission.'*

61. I also considered the IPA's advice relating the Trust's staff's response to the patient unexpectedly leaving the hospital on 16 September 2018. The IPA advised '*The nursing staff immediately informed the senior doctor, family and police.*' I consider that the Trust's staff appropriately responded to the patient's unexpected departure from the hospital.

62. I accept the IPA's advice that *'[a]lthough there are aspects of less than ideal care during the admission the medical [in regards to the patient's extra session of dialysis] and nursing care seems to have generally been of a high standard throughout.'* Although there was clearly a breakdown in communication that lead

to the patient receiving an additional unintended hour of dialysis, I accept the IPA's advice that overall, the patient received *'timely diagnosis, investigations and treatment of the various medical conditions. The notes demonstrate caring and high-quality nursing care.'* Accordingly I find that the care and treatment provided to the patient was reasonable and I do not uphold this element of the complaint.

Was the patient's mental state appropriately assessed and managed and were appropriate conversations held with the patient's family about the patient's plan of care?

63. In addition to considering the care and treatment that was provided to the patient, I also considered whether the patient's capacity was properly assessed and whether the family were properly communicated with during his admission. I consider these elements are linked because the appropriate level of communication with the patient's family would depend on patient's mental state and capacity.

64. In considering this element of the complaint, I had regard to the complainants' concerns about how they were kept informed about the patient's condition and discussions about whether the patient would be able to be temporarily allowed to go home for a few hours. In particular, I considered the patient's mental state during this admission and whether his family should have been involved in these discussions.

65. I considered the medical records related to the patient's mental state. The records repeatedly documented the patient was confused and agitated throughout his admission. It appears the patient even underwent a CT Scan on 2 September 2018 because of this confusion. After the transfer to Daisy Hill Hospital, the patient was noted to be confused and agitated and eager to get home. In particular, I note the nursing records for the night of 14 September 2018 state the patient *'appears agitated –wants to go home, seems disorientated at times, not sleeping much, regular reassurance given.'* Again, on 15 September 2018 the records state the patient was '*very unsettled trying to go home +++.*' Overnight on September 15 2018, it was also noted the patient

'*appears confused at times'*, which was again noted on the morning of 16 September 2018.

66. I also considered the medical records relating to discussions with the patient about potentially being allowed to leave the hospital for a few hours. In particular, I considered the consultant nephrologist's 14 September 2018 note indicating the patient '*appeared confused re being discharged tomorrow. He also wanted to go out overnight. I have explained he is too ill for discharge. He can go out for 4 hours Sunday if labs tomorrow stable and clinically well*.' The nursing notes for the night of 14 September 2018 also record that the patient *'appears agitated –wants to go home, seems disorientated at times, not sleeping much, regular reassurance given'.* I also considered the records that the patient '*was mobilizing and seen in the corridor 15.9.18'* and the nursing notes of 15 September 2018 indicate he was '*very unsettled trying to go home +++.'* I note that although there are records detailing discussions with the family about the patient's condition, there are no recorded discussions with the family either about the patient's confusion, or the possibility of the patient being allowed to temporarily leave the hospital for a few hours.

67. I considered the IPA's advice about the patient's mental state and the Hospital staff's communication with the patient's family. I note that although the IPA was not critical of general medical and nursing care provided to the patient, the IPA was critical of the failure to carry out mental state and capacity assessments on the patient. In particular, I note that the IPA's *'criticism of care during the admission is the lack of formal documentation of mental state and capacity.*' In particular, the IPA advised that *'[c]apacity is a major issue for a patient described as confused, even intermittently...I cannot find any assessment of mental state, such as the quick clinical tool of mini-mental testing or any discussion of capacity.'*

68. I also considered the IPA's advice regarding communication with the patient's family about the possibility of the patient being let home for several hours. The IPA advised that the patient *'was clearly very motivated to go home. This is noted several times in the nursing notes. However, this is in the context of intermittent confusion and alcohol withdrawal.'* I note the IPA also advised that,

in his opinion, '*the major issue is the response to his confusion. It is difficult from the notes to gauge how severe this was, as many people live with an element of brain impairment are able to stay in hospital and be discharged safely [and] [t]here is mention that periods of confusion may have pre-dated the admission.'*

69. I considered the Trust's statement that up until the time the patient absconded from the Ward on 16 September 2018, he *'did not indicate to staff that he would leave or not follow medical advice, but he continued to express his wish to go home.*' However, having considered the multiple entries in the record indicating the patient's significant confusion and increasing insistence on going home, I accept the IPA's advice that the patient's *'fixation about going home should have alerted staff to his flight risk and/or risk of not coming back from a home visit. A more robust assessment of mental capacity and instigation mental state may have resulted in closer supervision (one to one nursing or "specialling") which might have prevented the absconding episode.'*

70. I also accept the IPA's advice that '*the clinical team has a dilemma of agreeing to the stated patient preferences and the requirement for patient safety. Keeping him on board with treatment by suggesting a period at home is a reasonable proposal.'* Accordingly I accept that considering allowing the patient some time at home, if he was stable, was appropriate. However, I also accept the IPA's advice that *'I would have expected more communication with the family under these circumstances to ensure a safe trip, with family escorts, and the expectation that he would return to hospital.'*

71. Accordingly, I find that the Trust failed to properly carry out a mental health or capacity assessment on the patient, and failed to properly communicate with the complainants about the plan to possibly allow the patient to go home for a few hours. I consider this constitutes a failure in care and treatment. I therefore uphold this element of the complaint. I will consider the injustice at paragraph 82.

Was the information recorded on the Death Certificate appropriate and reasonable?

72. In considering this element of the complaint, I had regard to the events on 16 September 2018 surrounding the patient's death and the communication with

the Coroner's office. I note the medical and nursing records reflect that at around 10.00, the patient was *'noted not to be in ward. Hospital checked. No sign of patient. Family contacted…[the patient] phoned his mum to tell her he was in a taxi going to bank machine.' The nurse tried contacting the patient, but did not receive an answer…Consultant, family and police notified'.*

73. The patient was found following an '*unwitnessed fall, eye laceration, found at hospital entrance'* He was taken to the ED and the patient was '*brought to ward at 11:30 am and mobilized into bed himself.'* A CT Scan was carried out that showed no new brain abnormality. After the patient was returned to the ward, observations were noted to be *'stable with no indication of impending cardiac arrest'*. The patient was '*found unresponsive in bed. Cardiac Arrest call 12.28'.*

74. Following the patient's death, the records document that a death certificate '*will not be able to be issued until coroner contacts [the nephrology consultant].* The nursing notes also document the *'Death Cert cannot be issued until confirmation from Coroner. Question whether patient needs Post Mortem.'*

75. I note that the Coroner's Office confirmed the consultant Nephrologist spoke with its staff in relation to the cause of death before issuing a death certificate. The Coroner's office stated the consultant nephrologist informed the coroner's office that the patient had been transferred from Craigavon Hospital *'for ongoing dialysis support due to Acute Kidney Injury linked to infected hip. He has been receiving treatment for C-Diff, immunosuppression due to psoriasis, alcohol intake, liver cirrhosis and previous overdoses. According to [the consultant nephrologist, the patient] was stable following dialysis however has left the ward at 10:00 am that morning. He was found an hour later in the grounds of the hospital. He was readmitted to the ward following a CT scan and ECG. There were no abnormalities noted.'*

76. The consultant nephrologist informed the Coroner's office that the patient *'was discovered in cardiac arrest 15 minutes later [after being returned to the ward]. CPR was commenced and continued for 20 minutes without success - cause of death MI (Myocardial Infaction) linked to multiple illnesses, electrolyte disturbances and co- morbidities.'* In relation to the cause of death as listed on

the Death Certificate, the consultant nephrologist '*suggested cause of death to the Coroner as 1a MI; 1b Acute Renal Failure; II Alcoholic Liver Disease. That was accepted by the Coroner and the Death Certificate issued by the doctor.'*

77. I also considered the IPA's advice relating to how the Trust staff responded to the patient's unexpected departure from the hospital. The IPA advised '*[t]he nursing staff immediately informed the senior doctor, family and police.*' In relation to the cause of the patient's death, the IPA advised that '[*w]ithout a post-mortem it is impossible to prove the cause of death or if there was any association with the fall.*' However, the IPA also advised that *'[a]lthough his death was unexpected, he was in a very poor state of health even before admission. His history of diarrhoea and weight less in the context of alcoholism and alcoholic liver disease clearly suggested major health problems independent of his hip problems… There is no clear evidence that the unplanned departure from the ward and the fall actually caused his death. The only proof would be a post-mortem which the family clearly wanted to avoid, hence the consultant helpfully discussing with the coroner and issuing a death certificate as requested.'*

78. I also considered the IPA's advice that *'[t]he sequence of events of disappearing from the ward, suffering a fall and then sudden death was clearly unexpected. However, with the benefit of hindsight his death was, unfortunately, quite likely before discharge from hospital. Without a post-mortem it is impossible to prove the cause of death or if there was any association with the fall. The preceding medical history makes it clear that this gentleman had a number of potentially life limiting medical issues before admission. His alcoholism and alcoholic liver disease was a major issue. He had lost a significant amount of weight and had gastrointestinal bleeding which continued through the admission… Unfortunately, his life expectancy was significantly limited even prior to admission. Dialysis dependent acute kidney injury has a mortality rate up to 50% and with the benefit of hindsight it is, unfortunately, not unexpected that he did not survive the hospital admission.'*

79. Having considered the IPA advice regarding the cause of the patient's death and the communication with the Coroner's office on the part of the consultant

nephrologist, I accept the IPA's advice that *[t]he only proof [of the patient's death] would be a post-mortem which the family clearly wanted to avoid, hence the consultant helpfully discussing with the coroner and issuing a death certificate as requested.'* Accordingly, I consider the Trust's staff properly discussed the cause of death with the Coroner's Office and the information contained within the Death Certificate was reasonable.

80. I have not identified any note within the medical records which documents the conversation between the Coroner's office and the Consultant Nephrologist. Although the Coroner's office have informed me that a discussion took place and indicated they were satisfied with the explanation provided as to the patient's death, I would have expected to see a note of this conversation within the chart and I am critical that no such appears to have been made.

Injustice suffered by the Complainants.

81. I considered whether the failings I identified caused an injustice to the complainants and the patient. I found that the Trust failed to recognise that the patient required an assessment of his capacity and mental health and that the patient's family, including the complainants, should have been consulted regarding the possibility of the patient being let out of hospital for a few hours. I note the complainants were extremely distressed when their son called after he had left the hospital due to his confusion. The patient spoke with his mother while he was in a taxi leaving the hospital and the complainants knew that he should not have been allowed to leave as he was very sick at this time. I considered the IPA's advice that *[a] more robust assessment of mental capacity and mental state may have resulted in closer supervision (one to one nursing or "specialling") which might have prevented the absconding episode.'* In turn, this would have prevented the distress and anxiety caused to the complainants when they found out the patient had absconded from the hospital.

82. Accordingly, I consider the complainants sustained the injustice of distress and upset. This is because an assessment of the patient's mental health and capacity may have resulted in steps being taken which would have prevented him leaving the hospital on the morning of 16 September 2018. I also consider the patient sustained the loss of opportunity to have closer supervision and

family support, however it is unknown whether this would have prevented him from leaving the hospital on 16 September 2018.

CONCLUSION

83. I received a complaint about the Trust's actions in caring for the patient from 3 September 2018 to 16 September 2018. The complainants raised concerns about how the patient was cared for and how he became so sick during his admission.

84. I investigated the complaint and while I found in general the care and treatment of the patient was in accordance with good medical practice I found a failure in care and treatment in relation to the following matters:

(i) The Trust staff failed to assess the patient's mental health and capacity during his admission, and failed to communicate with the family about the possibility of the patient being allowed to leave the hospital temporarily.

85. I am satisfied that the failure in care and treatment I identified caused the complainants to experience the injustice of distress and upset. I am also satisfied that the injustice identified caused the patient to experience the injustice of loss of opportunity.

Recommendations

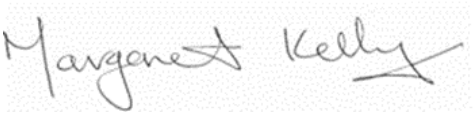
86. I recommend that the Trust provides the complainants with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failure identified within this report and should be issued within **one month** of the date of this report).

87. I further recommend that the Trust review the findings within this report about the assessment of the patient's capacity and communication with families to identify if there are areas for improvement.

88. The Trust should also remind the relevant clinicians involved in the patient's care and treatment of the importance of performing mental capacity assessments and

provide evidence that such discussions have taken place within three months of the date of this report.

89. Finally, I wish to pass my condolences to the complainants. Throughout my examination of this complaint I fully recognise the pain and trauma experienced by the complainants and the patient's extended family over the sudden and unexpected death of the patient. The effects of losing a much loved son in such circumstances is still very evident in the correspondence I have received and it has been clear from my reading of the medical and nursing notes how much the family were involved in his care and the love and devotion they had and demonstrated towards the patient. I hope that my report has gone some way to address the complainants' concerns. I wish to assure the complainants that I have reached my conclusions only after the fullest consideration of all the facts of this case.



Margaret Kelly. **2 September 2021**
Ombudsman

Appendix 1

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.