Investigation of a complaint against Western Health and Social Care Trust

Report Reference: 202003197

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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.

TABLE OF CONTENTS

Page

Case Reference: 202003197
Listed Authority: Western Health and Social Care Trust

SUMMARY

I received a complaint about the actions of the Western Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to her father (the patient) in Altnagelvin Hospital on 10 May 2021 when the patient sadly passed away. The complainant submitted the complaint on behalf of her mother, the patient's wife.

The complainant said staff failed to save the ultrasound scan images of the patient's abdominal aortic aneurysm (AAA) and staff inserted a catheter while the patient was dying. The complainant also said monitoring and clinical observations were not carried out appropriately, staff did not administer Diamorphine correctly and did not perform troponin levels and coagulation profiles. The complainant said staff placed a Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR order) without first discussing this with the family, and that the incorrect address was recorded on the order. The complainant was also concerned the Trust failed to perform a computerised tomography (CT) scan, failed to consider sepsis and failed to report the patient's death to the Coroner.

The complaint was also about the Trust's communication with the complainant and her family following the patient's sad passing.

The investigation established there were failures in care and treatment in relation to the following matters:

- the insertion of a catheter shortly before the patient passed away; and
- the failure to save the ultrasound scan images of the patient's AAA.

The investigation also established there were a considerable number of service failures. These included:

- the failure to record accurately the patient's address on the DNACPR order;

- the failure to communicate appropriately with the family on 10 May 2021;
- the failure to document a record of the family's meeting with the treating Consultant Cardiologist (Consultant A) on 18 May 2021; and
- the failure to provide timely and accurate information regarding the family's eligibility to access bereavement services.

The investigation also identified maladministration in relation to the Trust's:

- failure to monitor and respond to the complainant's telephone calls in December 2021; and
- failure to handle appropriately the meeting it arranged with the complainant for 13 May 2022.

I recommended the Trust provides a written apology to the complainant for the injustices caused by the failures I identified in this report. I also made further recommendations for the Trust to address under an evidence-supported action plan to instigate service improvements and to prevent their further reoccurrence of the failings identified.

I wish to convey my heartfelt condolences to the complainant and her family.

I am pleased the Trust accepted my findings and recommendations.

THE COMPLAINT

1. This complaint was about care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) at Altnagelvin Hospital on 10 May 2021. It was also about the Trust's communication with the complainant and her family following the patient's sad passing. The complainant submitted the complaint on behalf of her mother, the patient's wife.

Background

2. On 10 May 2021, the National Ambulance Service[1] transferred the patient from his home in Donegal to Altnagelvin Hospital where he presented at the Catherisation Laboratory (Cath Lab)[2] with a suspected myocardial infarction. On arrival at the Cath Lab at or around 22:10, the patient experienced sudden onset epigastric pain. A Consultant Cardiologist (Consultant A) undertook an ultrasound of the patient's abdomen using a cardiac echocardiogram (ECHO) machine.[3] This confirmed an abdominal aortic aneurysm (AAA)[4] which was leaking.

3. Trust staff discussed the patient's case with the Vascular Surgical Team in the Royal Victoria Hospital, Belfast (RVH)[5] who accepted him for emergency referral. However, the patient's condition rapidly deteriorated and transfer to RVH did not take place. Trust staff determined the patient was terminal with AAA rupture and should commence palliative care. The patient sadly died soon afterwards at 23:36.

---

[1] The Health Service Executive (HSE) National Ambulance Service is the statutory public ambulance service in Ireland.
[2] A cardiac Catherisation Laboratory is an examination room where specialised cardiac investigations and treatment takes place. It is staffed by doctors, nurses, cardiac technicians or physiologists and radiographers.
[3] An echocardiogram is a type of ultrasound scan used to look at the heart and nearby blood vessels.
[4] An abdominal aortic aneurysm (AAA) is a bulge in the main aortic blood vessel. It can be dangerous if not spotted early. There are usually no early symptoms of an AAA. The bulging can lead to tears, bleeding or even a complete rupture of the artery. In the event of a ruptured aneurysm, this is a medical emergency.
[5] The Cardiac (heart surgery) Unit in the Belfast Trust provides different heart surgery procedures for adults and children, including emergency surgery when a thoracic aortic aneurysm bursts. The unit is based at RVH. It is a regional service for patients across Northern Ireland.

Issues of complaint

4. I accepted the following issues of complaint for investigation:

Issue 1: Whether the patient's care and treatment was appropriate and reasonable and in accordance with relevant standards.

Issue 2: Whether the Trust's communication with the family following the patient's passing, was appropriate and reasonable.

INVESTIGATION METHODOLOGY

5. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's communication with the complainant and her family following the patient's death.

Independent Professional Advice Sought

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

    - A Cardiology Consultant with over 30 years' experience of treating patients with acute cardiac problems.

7. 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

8. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman's Principles[6]:

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

9. 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 judgement of those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:

   - The Western Health and Social Care Trust's Urgent ECHO/ Pericardial Tap Protocol, updated January 2022 (the Trust's ECHO Protocol);
   - The Western Health and Social Care Trust – Policy for Management of Complaints, May 2011 (Trust's Complaints Policy);
   - The Western Health and Social Care Trust Compliments and Complaints Annual Report 2021/2022 (The Trust's Complaints Annual Report 2021); and
   - The Department of Health's (DoH) Guidance in relation to the Health and Social Care Complaints Procedure, April 2022 (the DoH's Complaints Procedure).

10. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the Trust's administrative actions. It is not my role to question the merits of a discretionary decision. That is unless my investigation identifies maladministration in the Trust's process of making that decision.

11. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

12. I shared a draft copy of this report with the complainant and the Trust for

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

comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant submitted comments in response. I gave careful consideration to all the comments I received before finalising this report.

THE INVESTIGATION

Issue 1: Whether the patient's care and treatment was appropriate and reasonable and in accordance with relevant standards.

In particular, this will include:

- The placement of the Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR order);
- The timeliness and appropriateness of monitoring and clinical observations;
- The timeliness and appropriateness of catheter tube insertion;
- Administration of Diamorphine;
- ECHO/Ultrasound scan image; and
- The reporting of the patient's death.

Detail of Complaint

13. The complainant was dissatisfied that Trust staff placed a DNACPR order on the patient's medical file without discussing it with the family. She said the family did not want this order in place and staff should have discussed the options regarding it with them. The complainant raised concern too that the incorrect address was placed on the DNACPR order.

14. The complainant was also dissatisfied that staff did not record baseline clinical observations or complete NEWS [National Early Warning Score] charts. In addition, the complainant said there were discrepancies in staff's measurement of the patient's heart rate and staff failed to measure his temperature despite noting he was cold. She also said staff should have measured the patient's troponin levels and coagulation profile and they should have considered whether he had sepsis, but they did not do so.

15. In addition, the complainant raised concern that staff inserted a catheter tube into the patient when he was nearing death. The complainant said this timing was *'unethical and inappropriate'* and would have caused the patient pain when

his death was imminent. The complainant also raised concern that the patient was administered '*Diamorphine at the same time as Naloxone'*. The complainant questioned whether the patient had a reaction to the Diamorphine as '*Naloxone reverses opioid induced respiratory depression'*.

16. The complainant also said that the Trust did not save the scan showing the patient's AAA and it failed to report the patient's death to the Coroner.

Evidence Considered

Legislation/Policies/Guidance

17. I considered the following guidance:
    - The Trust's ECHO Protocol.

Trust's response to investigation enquiries

18. The Trust explained the patient presented to the Cath Lab with a presumed myocardial infarction, however the Consultant performed a bedside ultrasound scan which confirmed a 7cm AAA. '*Additional support from medical, surgical and anaesthetic staff was summoned quickly. Referral was made to Vascular Surgical team and the Royal Victoria Hospital (RVH) who accepted [the patient] for a Blue Light Ambulance Transfer should his condition stabilise. Both intravenous fluid and blood were administered to [the patient] but sadly his condition continued to deteriorate'.*

19. The Trust said '*despite attempts at restoring [the patient's] circulating volume, he remained critically unwell and the Consultant [A], the surgical registrar and anaesthetic registrar made a joint decision that [the patient] would not survive transfer to RVH for major vascular surgery. Despite fluid resuscitation, [the patient] did not stabilise and continued to deteriorate. In [the patient's] best interest, a DNAR order was placed. It is documented that this decision was explained to the patient's son'.*

20. In relation to the recording of an incorrect address on the DNAR order, the Trust stated it *'wishes to sincerely apologise'* for this. *'However, all other clinical details were correct'.*

21. In relation to the observations carried out, the Trust advised the NEWS Chart is not used within the Cath Lab. The Trust also said *'Patients in the Cath Lab are monitored continuously… However, while Multi-professional Notes within the Integrated Care Pathway record observations on arrival, no further observations are documented as part of the baseline…. It will be noted to the team of the importance of documenting a full set of baseline observations within the Integrated Care Record'.*

22. In relation to having not carried out troponin levels or a coagulation profiles, the Trust advised there is '*no record of Troponin being taken… [*however] *a coagulation screen was taken but the sample later… clotted and could not therefore be analysed'.* The Trust stated *'these would not have been reported by the hospital laboratory before [the patient's] death and would not have changed his acute management'.* In response to the complainant's concerns the patient had sepsis, the Trust said *'there was no evidence of sepsis'.*

23. Regarding '*discrepancies in the records taken of the patient's heart rate'*, the Trust explained, '*During the period within the Cath Lab [the patient] was rapidly deteriorating therefore it would not have been unusual to have changes in [the patient's] observations including his heart rate at that that time'.*

24. In relation to the catheter insertion, the Trust said this '*was inserted at 23:22 by an FY1 doctor… to assist in monitoring urinary output which is a marker of perfusion of tissues and organs'.*

25. In relation to the complainant's concerns regarding the administration of Diamorphine, the Trust confirmed the records state '*Diamorphine 5mg and Maxlon [sic] 10mg was given at 22:40'.*

26. The Trust explained that while '*the Consultant carried out a bedside ECHO as noted in the records, the images were unfortunately not saved'.* The Trust said further, '*it was the Cardiologist who used the ECHO machine and therefore his responsibility to store the images, which due to the rapid deterioration of the patient he did not do'.*

27. The Trust confirmed the patient's *'diagnosis was secure therefore there was no requirement to refer to the Coroner'.*

Consultant A's response to investigation enquiries

28. Consultant A commented '*When there was a medical decision to issue a DNACPR instructions for [the patient], he was in a moribund state and certainly had no capacity to make an informed choice himself. Therefore the decision was made in his best interests on the basis of futility'*.

Relevant Trust's records

29. The Trust provided the patient's medical records as well as an explanation of the care and treatment the patient received.

Relevant Independent Professional Advice

30. I considered the advice I obtained from the IPA. T

The Complainant's response to the draft investigation report

31. In response to the draft report, the complainant said her *'brother was not told about the DNACPR'* and he did not know the patient's death was imminent. The complainant said she '*did not agree that catheter insertion had no impact'* on the patient. The complainant also reiterated her view that the patient had symptoms of sepsis. The complainant said, '*it concerns me that a lot of the sepsis red flags were present' but 'sepsis wasn't even acknowledged in [the patient's case'.*

Analysis and Findings

The DNACPR order

Decision to place DNACPR order

32. The complainant believed the Trust should not have placed a DNACPR order on the patient's file and said this and other options were not discussed beforehand with the family. On review of the patient's records, I note Consultant A authorised the DNACPR order to be signed at 23:30. I note the medical records at 23.30 document '*rapid deterioration to no recordable BP, No*

peripheral pulses. On call surgeons [discussed with] vascular RVH accepted but never fit for discharge. Joint decision myself [Consultant A], ICS SpR + Surgical CT1 to palliate. Family (son) present. All explained'. I accept the IPA's advice that *'at the time the DNACPR form was signed, the patient was unresponsive. He therefore did not have capacity to make any decisions'.* I note the IPA advised that '*in the event that a patient does not have capacity to make decisions and does not have a lasting power of attorney for health and welfare in place, DNACPR decisions can be made by medical attendants in the patient's best interests'*. I accept this advice. Therefore, I am satisfied that the Trust's decision to place the DNACPR order was appropriate.

33. I note the complainant's concern that the DNACPR order was not discussed with the family. As noted above, the records indicate the patient's *'son and partner'* were the family members who were present at the hospital at the time the DNACPR was placed. I note the complainant confirmed this in response to investigation enquiries. I note both the medical records and the nursing notes document that at the time of its placement, the DNACPR order was explained to the patient's son. While the records do not state the details of that discussion, I am satisfied a discussion did take place. I note the complainant's response to the draft report, in which she said her brother was not told about the DNACPR. While I acknowledge the complainant's view, I note the evidence within the records indicates the DNACPR placement was discussed with him. I am in no doubt that this was a highly stressful time for the family members present and I consider it understandable if recollection of that discussion is not clear. If staff did not discuss in detail the DNACPR or other options with the patient's son, I note the patient died at 23:36, six minutes after the DNACPR order was placed. I note the IPA advised *'whilst it is usually good practice to discuss a DNACPR decision... and other options… with relatives when it is signed, in this case there was no time'*. Based on the documentary evidence within the records I am satisfied the Trust staff did discuss the DNACPR with a family member. I do not uphold this element of the complaint.

Incorrect address on DNACPR

34. I must record my concern that the wrong address was placed on the patient's DNACPR order. Although I am mindful of the rapidly escalating clinical emergency that was occurring at the time the order was placed, I am critical of this record-keeping error. I am satisfied this constitutes a service failure. Therefore, I uphold this element of the complaint.

35. I note the Trust acknowledged this error in its response to this office's enquiries and said it '*sincerely apologises'* for it. I will refer to this further in my conclusion to this report. I note the patient's date of birth is correctly documented and that the DNACPR order was placed appropriately within the patient's own medical file. Whilst it is important that I highlight this service failure in record-keeping, I am satisfied that it did not impact the standard of care and treatment the patient received. Notwithstanding, I am satisfied this service failure to properly complete the DNACPR order correctly, caused the complainant the injustice of uncertainty as to whether the DNACPR order and the associated process which the Trust followed, related appropriately to the patient.

Timeliness and appropriateness of monitoring and clinical observations

Clinical observations

36. The complainant raised concern that staff did not record baseline clinical observations or complete NEWS charts. I note the Trust advised that NEWS Charts are not used in the Cath Lab and the IPA in her advice confirmed this. I accept the IPA's advice in this regard. I note the complainant's concern that a full set of baseline observations were not completed and observations which were recorded were done so in a disordered manner. I note the complainant also said staff failed to measure the patient's temperature despite noting that he was cold.

37. Having reviewed the available records, I accept the IPA's advice that baseline observations (other than temperature) were recorded in **the clinical records** [my emphasis added]. These included heart rate, blood pressure, respiratory rate, oxygen saturation, and Glasgow COMA Scale score which the IPA advised were *'all appropriately recorded, in a timely way'*. I note the IPA also advised, that in the Cath Lab staff *'are with the patient constantly'* and that in

the patient's case *'this was done'*. Although I note the patient's temperature was not recorded, the IPA advised this *'is unlikely to have had any impact on the patient'* as the patient '*was already moribund with a ruptured aneurysm'*. I accept this advice. Based on this evidence, I am satisfied the Trust's monitoring and observations of the patient were appropriate. I do not uphold this element of the complaint.

Discrepancy in heart rate measurement

38. I note the complainant said there were discrepancies in staff's measuring of the patient's heart rate. On review of the available records, I note the IPA advised that '*the 12 Lead ECG recorded at 22:59 showed a heart rate of 70 beats per minute'* while *'the single ECG recording at 23:06 shows an initial heart rate of about 60 beats per minute, before the heart then slows and stops'*. I accept the IPA's advice that '*the heart rate of 29 was recorded in the notes before an agonal (dying) rhythm was described and that it probably occurred at 23:23, rather than 23:00'*. Although I am critical that this timing therefore appears to be recorded incorrectly, I note the IPA in her advice explained in detail, the work staff undertook to care for the patient while in the Cath Lab, including that staff '*established diagnosis, gave blood and fluid replacement and contacted the vascular service in Belfast* 'and this *'all happened in less than two hours*'.

39. Moreover, I note the IPA advised that staff's care of the patient was *'excellent'* and *'it is not surprising that there may be minor inaccuracies in timing, given the severity of the situation, the amount of work to be done, and the reduced staffing levels'* during out of hours. I accept this advice. Although I consider the heart rate discrepancy was due to an error in the recording of the timing, I am satisfied this was due to the increasing severity of the emergency unfolding as the patient became increasingly unwell. As such, I do not uphold this element of the complaint.

CT scan

40. The complainant raised concern that '*no supporting diagnostic tests were done'*. I note the complainant also said, '*a CT scan should certainly have been taken to confirm the aneurysm*'. I note the IPA advised that '*there was neither*

need nor time to undertake CT scan'. The IPA also confirmed in her advice that no further imaging was required as diagnosis was already made by ultrasound and the patient was dying. I note the IPA advised further, '*a CT scan might have been helpful if vascular surgery was being offered, but the patient was too ill to undergo surgery… and his condition was such that there was no possibility of active treatment other than palliative care'.* I accept the IPA's advice in this regard. Based on the evidence, I am satisfied that no further diagnostic tests including a CT scan needed to be undertaken as the patient's diagnosis was made. Therefore, I do not uphold this element of the complaint.

Troponin and coagulation

41. I note the complainant also raised concern that staff did not do a troponin level blood test or coagulation profile. I note the Trust's response to this Office in which it said that troponin and coagulation profiles *'would not have been reported by the hospital laboratory before [the patient's] death and would not have changed his acute management'.* I also considered the IPA's advice in which she confirmed that while troponin and coagulation were not measured *'neither would have contributed any useful information which might have affected the care of the patient'*. I accept this advice. For the reasons which both the Trust and IPA outlined, I am satisfied that while the troponin and coagulation were not measured, this did not impact the patient's care and treatment. As such, I do not uphold this element of the complaint.

Sepsis consideration

42. I note the complainant's concern that the Trust failed to consider Sepsis despite her view that the patient had symptoms of Sepsis and '*the lab reports demonstrate this'*. I note the complainant reiterated this view in her response to the draft report. However, having carefully reviewed the lab report records, I note the IPA in her advice disagreed. The IPA advised *'the lab reports do not demonstrate sepsis'* and confirmed *'there is nothing clinically to suggest that the patient had sepsis.'* I note the IPA explained that while the patient's '*white cell marker was raised at 17.98 and the c reactive protein was also modestly raised at 26.5'* both of which are a marker of inflammation and infection, these

levels were *'in keeping with major bleeding'*. I accept the IPA's advice. Based on this evidence, I am satisfied that the Trust's actions in relation to sepsis consideration were appropriate. I therefore do not uphold this element of the complaint.

Timeliness and appropriateness of catheter tube insertion

Catheter tube insertion

43. The complainant raised concern that staff inserted a catheter tube when the patient was nearing death. She said this timing was *'unethical and inappropriate'* and would have caused the patient pain when his death was imminent. The records document that '*23:22 [FY1] catheter inserted using ANT*T'. I note this timing was 14 minutes prior to the patient's death at 23:36 and two minutes after the records document the AAA diagnosis. I note the Trust said this was *'to assist in monitoring urinary output which is a marker of perfusion of tissues and organs'*. However, the IPA pointed out in her advice, that while it is important to measure urinary output in a critically ill patient so that fluid can be given appropriately, *'the patient was dying and it had been accepted by medical staff that nothing more could be done.'* For this reason, I note and accept the IPA's advice that staff's catheter insertion '*was not appropriate'* at this time. Based on this evidence, I am satisfied that it was not appropriate that the Trust inserted a catheter at 23:22. I consider this constitutes a failure in the patient's care and treatment. As a result, I uphold this element of the complaint.

44. I understand fully the complainant's concerns that the catheter insertion could have caused the patient pain prior to his death. I note the complainant reiterates this concern in her response to the draft report. I note the IPA's advice based on her careful examination of the available records, that the patient '*was probably not conscious'* and therefore there was likely *'no impact'* on him. I accept this advice.

45. However, I am satisfied this failure in care and treatment caused the complainant to experience the injustice of upset and uncertainty as the Trust did not properly explain during its internal complaints process, that the patient

did not suffer any impact as a result of the catheter insertion. I consider this in turn caused the complainant the injustice of time and trouble in having to submit this element of the complaint to my Office. I hope the IPA's advice in relation to this matter, provides the complainant and her family with some comfort in knowing that the patient did not experience pain or discomfort from the Trust's actions in this regard.

Administration of Diamorphine

46. The complainant raised concern that the patient was administered '*Diamorphine at the same time as Naloxone'*. I note the complainant questioned whether the patient had a reaction to the Diamorphine as '*Naloxone reverses opioid induced respiratory depression'.* I note the Trust said, *'there is no record that Naloxone was either required or administered'*. I reviewed the available records and found no reference of the patient having been administered Naloxone. I note the records state that at 22:40 the patient was given '*Diamorphine 5mg and Maxolone 10mg'*.

47. I note the IPA advised that this record should have stated 'Maxolon' which she advised '*is commonly given with diamorphine to counteract nausea which may be induced by diamorphine'*. I note too, the Trust said the patient received 'Maxlon [sic] 10mg' at 22:40'. I accept the IPA's advice that the *complainant 'likely mistook 'Maxolone' [sic] for Naxolone'.* In explaining her reasoning, the IPA advised '*the recommended dose of Maxolon is 10mg'*, which I am satisfied is the dose clearly recorded as being administered to the patient at 22:40. Whereas I note the IPA advised that '*the recommended dose of Naloxone is 10 micrograms/kg up to maximum of 2mg in the first instance'*. I accept this advice. Based on this evidence, I am satisfied the patient was not administered Naloxone and the administration of Diamorphine was appropriate. Therefore, I do not uphold this element of the complaint.

Echo/Ultrasound scan image

48. The complainant was dissatisfied the Trust failed to save the ultrasound image of the patient's AAA. In response to this element of the complaint, I note the

Trust confirmed the image *'was unfortunately not saved'*. I accept the IPA's advice that the ultrasound image should have been saved. However, in making this assertion, I note the IPA advised that the Trust's ECHO Protocol states, *'you may be asked…*' and therefore the IPA advised this suggests that *'saving images is optional'*. On review of page three of the Trust's ECHO Protocol I consider this wording as to whether scan images should be saved, to be ambiguous.[7] However, on reading the ECHO Protocol further, I am satisfied there are several prompts in the subsequent instructions which indicate images should be saved. As such, on reading the instructions in full, I consider it is made sufficiently clear within the Trust's ECHO Protocol that saving an ultrasound image is required. Based on this evidence, I am satisfied the Trust should have saved the ultrasound images of the patient's AAA. I consider the Trust's failure to do so, to constitute a failure in care and treatment. Therefore, I uphold this element of the complaint.

49. I am satisfied the Trust's failure to save the ultrasound images, did not impact on the care and treatment the patient received. Notwithstanding, I consider the Trust's failure to save the scan images caused the complainant to experience the injustice of uncertainty and loss of opportunity to see evidence of the patient's AAA which ultimately caused his untimely death.

Reporting the patient's death

50. The complainant raised concern that the Trust ought to have reported the patient's death to the Coroner as his death *'was unexpected'* and occurred *'five days after receiving the Pfizer vaccine'*. I considered the Trust response to this element of the complaint, in which it said reporting the patient's death to the Coroner was not required because '*the diagnosis was secure'*. I also reviewed the list of circumstances listed when a death should be reported to the Coroner in Northern Ireland.[8] Having done so, I accept the IPA's advice that the

[7] Page 3 of the Trust's ECHO Protocol states, *'You may be asked to save images on the echo machine as per the operator- press 'store' to save them individually; At the end of the case, select patient, here you will be prompted to save images'*
[8] https://www.justice-ni.gov.uk/articles/coroners-service-northern-ireland#toc-3)

patient's death did not fulfil any of the criteria listed in order to require being reported to the Coroner.

51. I understand the patient's death was sudden, unexpected and a grave shock for the complainant and her family. I appreciate how a death in such circumstances can naturally leave loved ones with questions. Whilst with this in mind, I am satisfied that the available evidence within the patient's medical records and the IPA's advice, confirms that a medical doctor assessed the patient and diagnosed a leaking AAA which ruptured, and this caused his death. I therefore found no grounds on which the patient's death should have been reported to the Coroner. As a result, I do not uphold this element of the complaint.

52. Overall, for the reasons outlined above, I partly uphold this issue of complaint.

Issue 2: Whether the Trust's communication with the family following the patient's passing, was appropriate and reasonable.

In particular, this will include:

- Communication on the night the patient died;
- Information provided regarding the patient's cause of death;
- Information provided regarding access to bereavement services;
- Responsiveness to family's attempts to contact Consultant A's secretary in December 2021; and
- The meeting with the family which was to be held on 13 May 2022 as part of the Trust's complaints process.

Detail of Complaint

53. The complainant raised various concerns regarding the Trust's communication with the family following the patient's death. The complainant said Consultant A did not come and speak with the family on the night of 10 May 2021 after the patient died. The complainant said, '*this is unusual as most doctors would involve the family after a death has occurred and let them know what happened'*. The complainant also raised concern about '*poor communication'*

the family received from a named nurse (Nurse A) on the night of the patient's death.

54. The complainant also raised concern regarding information Consultant A provided to the family during a meeting on 18 May 2021[9]. The complainant said Consultant A informed the family '*the patient died from a ruptured AAA, but he did not have a heart attack and possibly did have a blood clot also'*. However, the complainant said when she subsequently received the patient's death certificate, it stated *'myocardial infarction'* as a cause of death. The complainant said she considered this meeting indicated the Trust was not transparent with the family about the patient's cause of death. The complainant also said this meeting indicated the Trust was not sure of the confirmed cause of death. The complainant also said Consultant A told her at the meeting on 18 May 2021, staff '*were not prepared'* for the patient's case but also *'there was no learning to be achieved from it'.*

55. The complainant also said the Trust gave incorrect information to the family about their eligibility to access bereavement services. The complainant was also dissatisfied with the Trust's responsiveness in December 2021, when she attempted unsuccessfully to arrange a meeting with Consultant A. The complainant said she was eventually told Consultant A had left the Trust.

56. In addition, the complainant raised concern about how the Trust handled a meeting which was supposed to take place on 13 May 2022. The complainant said she booked time off work and flights home from England to attend the meeting, but the Trust cancelled the meeting at the last minute on 11 May 2022.

Evidence Considered

Legislation/Policies/Guidance

57. I considered the following policies and guidance:

- The Trust's Complaints Policy;

[9] The complainant explained she arranged this meeting with Consultant A to have the opportunity to discuss what happened the patient as Consultant A did not speak to them on the night of the patient's death.

- The Trust's Complaints Annual Report 2021; and
- The DoH'S Complaints Procedure.

The Trust's response to investigation enquiries

58. In relation to Consultant A's communication with the family after the patient died, the Trust referred this Office to its written response to the complainant dated 15 August 2022, '*in which the Consultant [A]…offered his apologies. He was sorry to learn that the family felt that communication had been poor despite a meeting being held on 18 May 2021 with the family'*.

59. In relation to the complainant's concerns about *'poor communication'* from Nurse A on the night the patient passed away, the Trust said *'[Nurse A] wishes to apologise if she came across as abrupt as this was not her intention'*.

60. Regarding the information Consultant A provided at the meeting on 18 May 2021, the Trust confirmed *'a meeting took place on 18 May 2021. Unfortunately, the complaints department was not aware of this meeting and a note taker was not present. We apologise for any confusion around this and lack of detail regarding discussion'.*

61. In relation to the Trust having said staff '*were not prepared for it'*, the Trust explained the patient *'presented to the Cath Lab with a presumed myocardial infarction. The Cath Lab primary PCI [Primary Percutaneous Coronary Intervention] pathway[10] for myocardial infarction is designed to rapidly assess and treat patients presenting directly with a heart attack. Out of hours, the Consultant Cardiologist is the only medically qualified person in the Cath Lab team and the Cath staff are trained in the assessment and management of acute cardiac emergencies only. It is not expected that a patient with a leaking abdominal aneurysm (AAA) presents directly from paramedics to this service. Hence why staff were not prepared for it'*.

62. The Trust explained the patient *'had ECG changes due to probable underlying*

[10] Primary Percutaneous Coronary Intervention is a procedure used to treat the narrowed coronary arteries of the heart and angina in patients.

undiagnosed coronary heart disease. This was as a result of his primary presenting pathology of a leaking and then ruptured abdominal aortic aneurysm. This can, if associated with elevation in cardiac troponin, be classed as a type 2 myocardial infarction and may have contributed to his death but was not the cause of death'.

63. The Trust also said '*The Medical Certificate of Cause of Death notes Ruptured Abdominal Aortic Aneurysm as the disease or condition leading to death. Myocardial Infarction was noted as an antecedent*[11] *cause. We apologise if there was any lack of clarity regarding this'*.

64. In relation to the family's eligibility to access bereavement services, the Trust explained Nurse B to whom the complainant spoke briefly about this, was not aware at the time of the discussion that this was a cross border service. The Trust confirmed that it now offered the family support from the hospital's Bereavement Councillor, and the Trust *'can arrange input from the Bereavement Service should this be required'.*

65. In relation to the complainant having made several attempts to contact Consultant A's secretary in December 2021, the Trust advised that '*due to the passage of time, the consultant's secretary unfortunately cannot recall this matter. If attempts were made by the family that went unanswered then the Trust apologises unreservedly'.* The Trust also said, *'All telephone calls should be monitored and responded to…'.*

66. In relation to the Trust's last-minute cancellation of a meeting arranged with the family, the Trust said it had telephone contact with the family *'in and around April 2022'* during which it set *'a provisional date for an informal meeting'* for 13 May 2022. The Trust said it later *'received written correspondence from the family dated 4 May 2022 which confirmed that they wished to commence a formal complaints process and wanted an investigation. On 9 May 2022 the Trust received from the family a list of 24 questions which would take time to investigate'*. The Trust said it informed the family on 11 May 2022 that the

[11] An antecedent cause of death is the condition(s) that led to or precipitated the immediate cause of death as recorded on a death certificate.

meeting would not now proceed, and its Complaints Officer also spoke to the complainant on 12 May 2022 to apologise for this.

67. In relation to the inconvenience the meeting's cancellation caused the complainant, the Trust said it *'regrets any disturbances to plans that were made and apologises… However, in order to make any meeting worthwhile, issues did need to be investigated beforehand with adequate time to do so'*.

Relevant Trust records

68. I completed a review of the Trust's complaints file as well as documentation I received from the Trust and the complainant in relation to the organisation of the meeting which was to be held on 13 May 2022.

Relevant Independent Professional Advice

69. In relation to the complainant's concern that the Cardiologist did not speak to her mother on the night of the patient's death, the IPA advised the '*patient died late at night. It would have been good practice for the consultant to speak to the family soon after the death, if the family were in the hospital… At night, staffing levels are reduced, and the consultant [Consultant A] may have had other patients to see… The notes suggest that another doctor, probably a registrar, spoke to the family at around the time of the death'*.

70. In relation to the patient's cause of death, the IPA advised this was *'caused by rupture of the aortic aneurysm, with fatal bleeding'.*

71. In relation to whether the patient also had a myocardial infarction, the IPA advised *'the diagnosis of an acute myocardial infarction was appropriate and reasonable in the circumstances'*. The IPA advised further, that *'it was appropriate to document myocardial infarction as a secondary cause of death… it is strongly suggested by the ECG recorded in hospital'*.

72. I asked the IPA whether she found any evidence the Trust was not transparent with the family about the patient's cause of death. In response, the IPA advised *'no'*.

Analysis and Findings

Communication with family on the night the patient died

Consultant A

73. The complainant raised concern that Consultant A did not speak to the family soon after the patient's death to explain what happened. I understand the family's disappointment regarding this matter. I note the IPA advised *'It would have been good practice'* for Consultant A to speak to the family soon after the death. However, I am mindful that the IPA also advised, that due the '*reduced staffing levels at night'* Consultant A likely had other patients to see. I accept this advice. Whilst it is unfortunate Consultant A did not speak with the family soon after the patient's death, I note the records document '*reg spoke to daughters'* and therefore another doctor did speak with family members following the patient's passing. I note the IPA advice confirmed this. I note Consultant A met with the family one week later, on 18 May 2021, to discuss the patient's cause of death and to answer any queries the family had. I do not therefore uphold this element of the complaint.

Nurse A

74. *The complainant* also raised concern with Nurse A's communication with her sister upon her arrival at the hospital on 10 May 2021, shortly after the patient passed away. The complainant explained that when her sister requested information from Nurse A *'about what happened and regarding the patient's last words'*, Nurse A '*abruptly told her to ask her brother as she had already explained all to him'.* The complainant said, *'this was not a nice way to be spoken to having lost a big part of your life'.* I consider this response to the patient's family to be inappropriate in the circumstances. It is my expectation that staff demonstrate appropriate communication skills and apply an understanding of what is important to family members following the death of a loved one. I am satisfied the Trust's communication in this instance constitutes a service failure. I therefore uphold this element of the complaint. I note the Trust in its response to investigation enquiries, said it wishes to apologise for this communication with the family. I will refer to this further in my conclusion to this report.

75. As a consequence of this service failure, I am satisfied that the complainant and her family experienced the injustice of upset that their request for information was not treated with the appropriate sensitivity and helpfulness during what was a particularly very sad time for them.

Information regarding the patient's cause of death

Meeting on 18 May 2021

76. I note the complainant raised concern about the information she said Consultant A provided the family at their meeting with him on 18 May 2021. The information related to the patient's cause of death and whether the patient also died from a myocardial infarction and possibly had a blood clot. I note the complainant said Consultant A told the family during the meeting that the patient did not have a myocardial infarction, but this was documented as a cause of death on the patient's death certificate. I note the complainant said this led her to believe the Trust has not been transparent with the family and is not sure of the patient's confirmed cause of death. The complainant also raised concern that during this meeting Consultant A provided conflicting information, by stating 'staff *were not prepared for the event'* yet also confirming *'there was no learning to be achieved from it'.*

77. I note the Trust confirmed there is no documented record of this meeting discussion. In the absence of any record of the discussion that took place, I am unable to conclude on matters relating to the information Consultant A did or did not provide during this meeting. I am critical of the Trust's failure to take notes of the meeting on 18 May 2021 between Consultant A, the complainant and her family. I acknowledge this meeting was not part of a complaints process, and the family requested it to understand better what happened the patient. However, good record keeping is a key tenet of good administrative practice. Having a contemporaneous record of a discussion means that those involved are clear at the time or later about what took place. While I do not make a conclusion regarding what was discussed at the meeting on 18 May 2021, I consider the Trust failed to document a record of what was discussed at

this meeting. I am satisfied this constitutes a service failure. I therefore partly uphold this element of the complaint.

78. As a consequence of this service failure, I am satisfied that the complainant and her family sustained the injustice of uncertainty as to what was discussed during the meeting on 18 May 2021 and the loss of opportunity to receive clarity on her queries surrounding these matters. As a result, I am satisfied the complainant also sustained the injustice of time and trouble in having to complain about this matter to both the Trust and this Office.

Transparency regarding cause of death

79. I note the complainant considers the Trust has not been transparent regarding the patient's cause of death. On review of the available records, I found no evidence to support this. I note the IPA in her advice agreed that there is no indication to suggest the Trust has not been transparent regarding the confirmed cause of death or that the Trust is unsure of this. While I am unable to conclude on matters relating to what was discussed at the meeting on 18 May 2021, I am satisfied that the Trust in its response to the complaint dated 22 August 2022 provided clarification that the patient died from a ruptured aortic aneurysm. I note the IPA also confirmed in her advice this was the cause of death. In relation to whether the patient had a myocardial infarction I note the Trust in its response to the complainant, explained the clinical reasoning for believing the patient may have also had a myocardial infarction *'which may have contributed to his death but was not the cause of it'.*

80. On review of the patient's death certificate, I note the cause of death is documented as *'(a) Ruptured abdominal aneurysm (b) Myocardial infarction'*. In response to investigation enquiries, the Trust advised that myocardial infarction '*was an antecedent cause'* of death. I note the IPA in her advice agreed that '*the diagnosis of an acute myocardial infarction was appropriate and reasonable in the circumstances'*. In explaining her reasoning, I note the IPA advised this is supported by the patient's ECG recorded on arrival at the Cath Lab, which *'showed ST wave changes consistent with an ST elevation myocardial infarction'*. On this basis, I accept the IPA's advice that *'it was*

appropriate to document myocardial infarction as a secondary cause of death…' I found no evidence to support the complainant's concern the Trust was either unsure of the patient's cause of death or failed to be transparent with the family in relation to it. I therefore do not uphold this element of the complaint.

Information provided regarding access to bereavement services

81. I note the complainant was dissatisfied that following the patient's death, Nurse B incorrectly informed her that the family could not access Cruse[12] bereavement service. I note the Trust said Nurse B to whom the complainant spoke about this, was not aware at the time of the discussion that this was a cross border service. I note the complainant also raised concern that the Trust did not clarify the family's eligibility to access to this service until the Trust issued its response to her complaint in August 2022. I am satisfied the Trust failed to provide the complainant with accurate information in a timely manner regarding this matter. Principle Two of Good Administration requires public bodies to be *'customer focused'*, by '*ensuring people can access services easily'* and by *'dealing with people helpfully…'*. By failing to provide correct information to the complainant and to rectify this in a timely manner, I consider the Trust failed to adhere to Principle Two. I am satisfied this constitutes maladministration. I therefore uphold this element of the complaint.

Responsiveness to family's attempts to contact Consultant A's secretary in December 2021

82. I note the complainant said she made several unsuccessful attempts to contact Consultant A's secretary by telephone in December 2021, to arrange a meeting with him. I note the complainant said she did not receive answers to her calls until late December 2021 when a '*stand-in secretary'* answered her call and advised the secretary was on sick leave and that Consultant A was due to leave the Trust. I note the complainant said the *'stand-in secretary'* advised she would pass a message to Consultant A's secretary, but the complainant said she did not hear anything further.

[12] Cruse bereavement service is an organisation which provides support to those who are bereaved.

83. I note the Trust's response to this Office in which it stated that while Consultant A's secretary does not recall these events due to the passage of time, '*All telephone calls should be monitored and responded to'*. I have no reason to doubt the complainant's account of these events. I consider the Trust failed to monitor and respond to the complainant's request to have Consultant A's secretary contact her back when she called in December 2021.

84. Principle Two of Good Administration requires public bodies to '*ensure people can access services easily'* and requires they '*deal with people helpfully [and] promptly…'* By failing to be responsive to the complainant's attempts in December 2021 to contact Consultant A's secretary, I consider the Trust failed to adhere to Principle Two. I am satisfied that this failure constitutes maladministration. I therefore uphold this element of the complaint.

85. As a consequence of this maladministration, I am satisfied the complainant experienced the injustice of frustration and loss of opportunity to arrange a meeting with Consultant A before he ceased working for the Trust.

The meeting with the family which was to be held on 13 May 2022 as part of the Trust's complaints process

86. The complainant raised concern about the Trust's '*severe communication issues'* in its handling of a meeting she arranged with the Trust which was due to take place on 13 May 2022. I note the complainant explained, in March 2022 and April 2022 she corresponded with Consultant B (a Consultant Cardiologist, who was not involved in treating the patient) and a Service Manager, who both offered to meet the complainant and family to discuss the care and treatment the patient received. Having examined the available evidence, I note on 1 March 2022 the complainant sent Consultant B a list of 25 detailed queries on behalf of her family relating to the patient's care on 10 May 2021. I note the evidence indicates Consultant B sent an email to the complainant on 14 March 2022 in which he offered to meet her and the family *'to discuss your concerns and questions'*. I examined further email correspondence between the complainant and Consultant B in relation to having that meeting arranged.

87. I note the complainant explained that on 27 April 2022 she, Consultant B and the Service Manager, agreed the meeting date of 13 May 2022. Having reviewed the Trust's Complaints Policy, I am satisfied that the complainant had thereby initiated the '*informal stage'* of the complaints procedure and that her concerns were being managed as part of informal resolution. I note the complainant said that upon agreeing this date on 27 April 2022, she immediately booked time off work and flights home from England where she lived, to attend the meeting. I note the complainant provided this Office with her flight booking confirmation in support of this element of her complaint and evidence of having made telephone calls to Consultant B on that date. The complainant also said she was advised that a letter would be sent to her mother's house confirming the time and venue for the meeting, but she did not receive this. I have no reason to doubt this information from the complainant. I note the complainant provided a screen grab of a text message she sent to the Service Manager on 11 May 2022 in which she referred to the agreed meeting and was seeking the letter that was to be sent to her with details of the meeting venue and time.

88. The complainant said when she did not receive a response to her attempts to get confirmation of the venue and time, she contacted the Complaints Officer. The complainant raised her dissatisfaction that upon doing so, the Trust cancelled the meeting *'at the last minute'* on 11 May 2022. In response to investigation enquiries, I note the Trust said it cancelled the meeting because the family '*confirmed that they wished to commence a formal complaints process and wanted an investigation'.* On review of the available evidence, I note the complainant sent an email to a Complaints Officer on 9 May 2022 stating, *'my mum wishes to go down the formal complaints route please'*. I note a completed complaints form was also attached to that email.

89. In addition, I note the email dated 9 May 2022 included 25 detailed issues regarding the patient's care and treatment which the family wished to be investigated. The Trust referred to these detailed questions in its response to this Office. I note the Trust said it also cancelled the meeting because these 25

detailed questions required to be investigated. However, I note that in providing these questions to the Complaints Officer in her email on 9 May 2022, the complainant stated clearly '*here is a list of questions which I emailed to [Consultant B] on the 1 March 2022'.*

90. Based on the available evidence referenced above, I am satisfied the complainant sent these issues to Consultant B on 1 March 2022, and it was on this basis Consultant B offered to meet with the complainant on 13 May 2022. I am therefore critical that the Trust proposed and then agreed to meet with the complainant to discuss these issues, only to later cancel the meeting because the Trust later deemed the issues to require further detailed investigation.

91. I consider the Trust's actions in this regard to indicate a lack of effective communication between the front-line service staff seeking to deal with the concerns via early resolution, and the Complaints Team. While, for the reasons I explain later in this report, I am satisfied the Complaints Team were aware of the complainant's correspondence with Consultant B and the Service Manager about seeking to meet to discuss her queries, I am not satisfied that the appropriate information was shared between these two departments in relation to the content of the concerns being raised.

92. Having reviewed the Trust's Compliments and Complaints Annual Report 2021, I note it identifies that *'informal complaints'* require '*a more robust process for accurate recording'* and are under reported on the Trust Datix system. In my view the Trust did not demonstrate a joined-up approach between the front-line service staff and Complaints Team by failing to discuss the content of the concerns the complainant was raising. I note 3.17 of the DOH Complaints Guidance states that '*where possible*, *all complaints should be registered and discussed with the Complaints Manager in order to identify those that can been resolved immediately, those that require formal investigation'.* I consider had this happened, the Trust would have identified in a more timely manner, if early *'informal'* resolution was the most suitable approach to take in seeking to address the complainant's concerns.

93. In response to this Office the Trust also stated it cancelled the meeting because the complainant stated *'she wished to commence a formal complaints process'*. I examined the email evidence the complainant provided to this office. In particular, I considered an email the Complaints Officer sent to the complainant on 28 April 2022 which I am satisfied confirmed the Complaints Team was aware a meeting was arranged between Consultant B, the Service Manager and complainant to discuss the family's queries regarding the patient's care. I note the email states '[*I] want to* share the [complaints] processes with you'. The email states further, *'Informal Process – Local resolution directly with service. This has initially begun in that service have offered you a meeting to discuss the information that you and your mother require...* ***as explained the Formal process remains open to you at any time before, during or after this meeting at local level'*** *[Trust's emphasis].* Based on this evidence, I consider the Complaints Officer informed the complainant that the meeting she arranged on 13 May 2022 would still proceed in the event the complainant decided to proceed to the '*formal process'* before the meeting takes place.

94. 3.9 of the DoH Complaints Guidance provides that complainants *'should be given the opportunity to understand all possible options available in seeking complaint resolution*'. In this case, I consider the Trust failed to provide clear, appropriate and timely information to the complainant regarding whether she could still proceed with the meeting on 13 May 2022 if she submitted a complaint via the formal process of the Trust's Complaints Procedure. I also consider, as previously stated above, the available evidence indicates that while the Complaints Officer was aware that a meeting was arranged with Cardiologist B, to discuss the '*informal complaint'*, the details of that complaint were not made known to the Complaints Team at that time.

95. I am satisfied that the available evidence referenced above, demonstrates that the Complaints Officer was aware of the complainant's scheduled meeting on 13 May 2022 and the complainant's eagerness that this meeting should go ahead. 3.15 of the DoH Complaints Guidance provides that '*complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered*'. I note too,

page four of the Trust's Complaint's Policy provides that '*openness and accessibility'* is a Policy Principle whereby *'flexible options for pursuing a complaint'* are offered. In my view, the Trust could have shown flexibility to pause the formal process of its Complaints Procedure, to allow the meeting between the complainant and Consultant B to take place. While I accept that not all of the complainant's concerns may have been suitable for informal resolution, I consider a meeting could have provided an opportunity for the complainant to obtain clarity and understanding in relation to at least some of her queries.

96. For the reasons outlined above, I am satisfied the Trust's decision to cancel the meeting arranged for the 13 May 2022 for the reasons it stated, was not appropriate. I am also satisfied that the Trust's communication with the complainant, regarding her eligibility to submit a formal complaint *'before, during or after this meeting'* on 13 May 2022, was confusing and unclear.

97. Principle One of Good Complaint Handling is *'getting it right'* which requires public bodies to '*signpost to the next stage of the complaints procedure in the right way and at the right time'*. Principle Two 'getting it right' requires public bodies to be '*customer-focused'* by '*responding flexibly'* and '*dealing with complainants promptly and sensitively*'. Based on the available evidence, I am not satisfied the Trust identified appropriately and in a timely manner, the issues the complainant was raising should proceed to the 'formal' investigation stage of its Complaints Policy.

98. In addition, Principle Three of Good Administration '*being open and accountable'* requires public bodies to '*be open and clear about policies and procedures and ensuring information, and any advice provided is clear, accurate and complete'*. For the reasons outlined above, I consider the Trust failed to adhere to these principles in relation to the meeting arranged for 13 May 2022. I am satisfied this constitutes maladministration. I therefore uphold this element of the complaint.

99. As a consequence of the Trust's maladministration, I am satisfied the complainant experienced the injustice of financial loss, upset and frustration at having flown home and prepared to have a meeting with Consultant B. I consider the complainant also sustained the injustice of loss of opportunity to have met Consultant B to gain clarity on some of the queries she had regarding the patient's care and treatment. As a result, I am satisfied this injustice in turn, caused the complainant to experience the injustice of time and trouble in bringing her complaint regarding this matter to my Office.

100. Overall, for the reasons outlined above, I partly uphold this issue of complaint.

CONCLUSION

101. I received a complaint about the care and treatment the Trust provided to the patient at Altnagelvin Hospital on 10 May 2021. It was also about the Trust's communication with the complainant and her family following the patient's sad passing.

102. I upheld the elements of the complaint in relation to the Trust's catheter insertion and failure to save the ECHO scan images of the patient's AAA, for the reasons outlined in this report. I consider these constitute failures in the patient's care and treatment.

103. I also upheld elements of the complaint in relation to the Trust's failure: to communicate appropriately with the family following their request for information immediately following the patient's death; to record notes of the meeting held on 18 May 2021; to accurately record the patient's address on the DNACPR order; to provide accurate information to the complainant about her family's eligibility to access bereavement services.

104. I also upheld the elements of the complaint in relation to the Trust's failure to monitor and respond to the complainant's phone calls in December 2021; and its failure to appropriately handle the meeting arranged for 13 May 2022. I consider these failures to be maladministration.

105. I recognise the failures identified in this report caused the complainant to experience the injustice of uncertainty and the loss of opportunity to receive clarity on matters discussed during the meeting with Consultant A on 18 May 2021 and to see the scan images of the patient's AAA; upset and frustration that the family's request for information from Nurse A on 10 May 2021 was not treated with sensitivity and helpfulness; frustration and loss of opportunity to arrange a further meeting with Consultant A before he ceased working for Trust; loss of opportunity to have met Consultant B to gain clarity on the queries the complainant had regarding the patient's care and treatment; financial loss, upset and frustration at having flown home to attend the meeting on 13 May 2022; and time and trouble in having to bring the complaint to this Office.

106. For the reasons outlined in this report, my investigation did not find failures in relation the Trust's: decision to place the DNACPR order; monitoring and observations of the patient including in particular, the measurement of the patient's heart rate; failure to perform troponin levels or coagulation profile; sepsis consideration or failure to perform a CT scan; administration of diamorphine; decision not to report the patient's death to the Coroner; and regarding its transparency about the patient's cause of death. I also did not uphold the element of the complaint relating to Consultant's A's failure to speak to the family on the night of the patient's sad passing.

107. For the reasons outlined above, I partly uphold the complaint.

108. I offer through this report my heartfelt condolences to the complainant for the loss of her father.

Recommendations

109. I recommend the Trust provides to the complainant within one month of this report, a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified in this report.

110. To prevent future reoccurrence, I further recommend that the findings of this report are shared with:

(i) Relevant staff within the Complaints Team so that they are reminded of the importance of ensuring appropriate communication between Complaints Officers and front-line service staff who are undertaking informal complaint resolution;

(ii) Relevant nursing staff so that they are reminded of the importance of ensuring appropriate communication with family members of patients who have passed away;

(iii) Relevant staff so that they are reminded of the importance of ensuring that telephone calls are appropriately monitored and responded to particularly during periods of staff absence; and

(iv) Clinical staff within the Cath Lab to highlight the need to save ultrasound images when undertaking an emergency cardiac ECHO and on identifying an AAA and to highlight the findings regarding the timing of a catheter insertion.

111. I recommend the Trust provides full recompense to the complainant for the costs she incurred unnecessarily in booking flights to attend the meeting on 13 May 2022. This should be to the value of £31.00.

112. For service improvement, I also recommend that the Trust implements a review of its ECHO Protocol in light of the IPA's advice regarding the clarity of its wording in relation to the need to save scan images.

113. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six** months of the date of this final report. The Trust should support its action plan with evidence to confirm it took appropriate action.

MARGARET KELLY
Ombudsman **February 2024**

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.