



Northern Ireland

Public Services

Ombudsman

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

Report Reference: 202002827

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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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Case Reference: 202002827

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 complaint was about the care and treatment the Trust provided to the complainant's late father (the patient) at Altnagelvin Area Hospital (AAH) between 11 June and 25 June 2021. The complainant believed the Trust should have carried out an '*urgent*' scan of the patient's abdomen and a surgical review following his admission to AAH. She questioned why the Trust waited until 17 June to perform surgery on the patient. She said the patient was transferred between five different wards within the hospital and that poor handovers of information between staff on different wards contributed to the patient's untimely death.

The investigation established it was reasonable for the Trust to wait until 15 June to carry out an abdominal scan on the patient. It established that the surgical team's decision to operate on the patient on 17 June was appropriate. It also established that communication between staff on different wards was reasonable and in accordance with the relevant guidance. The investigation found failures in the Trust's handling of the complaint.

I recommended that the Trust provide the complainant with a written apology for the delay in providing her with a response to her complaint.

I extend my deepest condolences to the complainant and her family for the sad loss of her father.

THE COMPLAINT

1. I received a complaint about the actions of the Western Health and Social Care Trust (the Trust) in relation to the care and treatment provided to the complainant's late father (the patient) at Altnagelvin Area Hospital (AAH) between 11 and 25 June 2021.

Background

2. The patient attended AAH's Emergency Department (ED) on 11 June 2021 following a collapse at home. Doctors carried out tests and examinations in the ED and diagnosed the patient as having a urinary tract infection (UTI) and prescribed antibiotics.
3. Doctors transferred the patient to the Acute Medical Unit¹ (AMU) on 12 June. On 13 June doctors diagnosed him with sepsis of unknown origin and prescribed additional antibiotics. The Trust transferred the patient to a general medical ward on 15 June. On the same day clinicians took an abdominal x-ray which showed a possible obstruction in the patient's small bowel. A follow up CT scan² indicated the possibility of gallbladder inflammation/perforation with peritonitis³.
4. On 15 June the surgical team took over the patient's care and moved him to a surgical ward. On 17 June the Trust carried out exploratory surgery on the patient which found he had a necrotic⁴ perforated gallbladder. Following surgery, the Trust transferred the patient to the Intensive Care Unit (ICU). The patient passed sadly away in the ICU on 25 June 2021.

¹ The first point of entry for patients referred to hospital as an acute medical emergency by those requiring admission from the Emergency Department. Its primary role is to provide rapid definitive assessment, investigation and treatment for patients.

² Computed tomography scan: a medical imaging technique used to obtain detailed internal images of the body.

³ Inflammation of peritoneum, the membrane that lines the inner abdominal wall and encloses organs within the abdomen.

⁴ Affected with, characterised by, or producing death of a usually localised area of living tissue.

Issues of complaint

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

Issue 1: Whether the care and treatment the Trust provided to the patient in Altnagelvin Area Hospital between 11 June and 25 June 2021 was reasonable and in accordance with relevant standards?

In particular, this will include consideration of:

- Timeliness of diagnosis;
- Indication for surgery; and
- Communication between clinical staff.

Issue 2: Whether the Trust handled the complaint in accordance with relevant guidance?

INVESTIGATION METHODOLOGY

6. In order 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 complaints process.

Independent Professional Advice Sought

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

- **Consultant in Emergency and Acute internal Medicine:** BSc (Med Sci) MBChB MRCP(UK) MRCP(AIM) FCEM DipIMC PGCert(EM): A dual trained consultant working in emergency and acute internal medicine at a regional trauma centre for over 11 years. Daily practice includes managing poorly patients with complex medical needs. (ED IPA);

- **Deputy Chief Nurse** RN, BSc (Hon) Nursing, MSc (distinction) Health Management. Practicing since 1995. Experience in acute care, intensive care, emergency department and medical and surgical wards(N IPA); and
- **Consultant Upper GI and General Surgeon.** MA, MD, FRCS (Gen). A department head with 14 years' experience. Up to date with recent research and guidelines relevant to this case. (G IPA).
- **Consultant Radiologist** Dr med, MRCP, FRCR A consultant radiologist for 18 years in a specialist cancer centre with a high workload of CT scans and special interest in gastro-intestinal imaging and procedures including the biliary tree and gallbladder (R IPA)

I enclose the clinical advice received at Appendix three to this report.

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs 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

9. In order 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 Principles⁵:

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

10. 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

⁵ These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- British National Formulary (BNF) Piperacillin with tazobactam (undated) (BNF Piperacillin with Tazobactam);
- British National Formulary (BNF) Gentamicin (undated) (BNF Gentamicin);
- The General Medical Council's (GMC) Good Medical Practice, updated April 2014 (the GMC Guidance);
- The National Institute for Health and Care Excellence (NICE) Guidelines:CG50 Acutely ill Adults in hospital - recognising and responding to deterioration July 2007 (NICE CG50);
- The National Institute for Health and Care Excellence (NICE) Guidelines: NG51 Sepsis, recognition, diagnosis and early management September 2017 (NICE NG51);
- The Nursing & Midwifery Council (NMC) The Code – Standards of Conduct, performance and ethics for nurses and midwives, October 2018 (NMC Code);
- Parliamentary and Health Service Ombudsman (PHSO): TIME TO ACT Severe sepsis: rapid diagnosis and treatment saves lives, September 2013 (PHSO, Time to Act);
- Royal College of Physicians (RCP) National Early Warning Score (NEWS)⁶2 Standardising the assessment of acute-illness severity in the NHS, December 2017 (RCP NEWS Guidance);and
- Western Health and Social Care Trust (WHSCT) Policy for Management of Complaints May 2011 (Trust Complaints Policy)

I enclose relevant sections of the guidance considered at Appendix four to this report.

⁶ A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs

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 comment on factual accuracy and the reasonableness of the findings and recommendations. I carefully considered all of the responses I received from the complainant and the Trust and, where appropriate, made changes to the report to reflect these comments.

THE INVESTIGATION

Issue 1: Whether the care and treatment the Trust provided to the patient in Altnagelvin Area Hospital between 11 June and 25 June 2021 was reasonable and in accordance with relevant standards?

Timeliness of diagnosis

Detail of Complaint

13. The complainant said the patient '*ultimately*' died from sepsis. She believed the Trust's '*delay*' in carrying out investigations caused a subsequent delay in clinicians making a definitive diagnosis of a perforated gallbladder. In particular, the Trust's '*failure*' to carry out an '*urgent*' CT scan on 12 June which '*would have*' identified the source of his sepsis. The CT scan of 15 June '*clearly demonstrated*' a perforated gallbladder. The complainant believed the Trust's actions led to the patient's '*avoidable*' death.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following guidance:

- GMC Guidance.

Trust's response to investigation enquiries

15. In relation to the treatment it provided to the patient, the Trust's response comprised largely of statements provided by the consultant responsible for the patient's care in the AMU between 12 and 15 June and the surgeon

responsible for his care in the surgical ward from 15 June.

16. In relation to investigations carried out in the AMU, the consultant stated the following: on 12 June the patient had '*some tenderness*' in the epigastric⁷ region. Otherwise, he found no abnormality. Clinicians continued to give the patient the broad spectrum antibiotic Tazocin⁸, as they believed the '*most likely*' source of his infection was a UTI/aspiration pneumonia⁹. On 13 June, clinicians commenced the patient on the antibiotic Gentamicin¹⁰, '*to cover the source of sepsis*'.
17. The consultant stated a culture taken from the patient's blood tested positive for Klebsiella¹¹. A doctor advised the patient's daughter of the '*source of (the patient's) sepsis*' on 14 June. The patient remained '*unwell*' but '*clinically stable*' and clinicians transferred him to Ward 40 later that day. The Trust did not address the complainant's view that the Trust '*failed*' to carry out an abdominal CT scan until four days after the patient's admission.

Relevant Trust records

18. I carefully considered the patient's clinical records. A summary of the relevant clinical records is enclosed at Appendix five to this report.

Relevant Independent Professional Advice

19. The ED IPA advised the following: the ED doctor's initial review of the patient and subsequent management plan was '*lacklustre*' and '*poorly documented*' with no reference of LFT¹² and lactate¹³ levels recorded. The doctor did not address a number of potential issues which may have led to the patient's

⁷ Relating to the part of the upper abdomen immediately over the stomach.

⁸ An antibiotic used to treat serious bacterial infections such as pneumonia, septicaemia and complicated urinary tract infections.

⁹ A type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs.

¹⁰ An antibiotic used to treat several types of bacterial infections, including, pneumonia, urinary tract infections, and sepsis.

¹¹ A type of bacteria usually found in the gut and airways of humans. Most bacteria can live within the body without causing any harm, but some can go on to cause infection.

¹² LFT (Liver Function Tests) are a group of blood tests which look at how well the liver is functioning

¹³ A Lactate test measures the amount of lactic acid in your blood when oxygen levels are low. The test is used to diagnose lactic acidosis and evaluate various medical conditions

collapse at home. Further there was *'very little'* to support the doctor's diagnosis of a UTI. While these are potential areas for the Trust to *'reflect'* upon they *'did not influence outcome'*. A junior doctor subsequently reviewed the patient at 18.26. The doctor *'collated'* all the investigations undertaken in the ED and performed a *'very thorough'* examination. Which *'len[t] weight'* to his suggested diagnosis of UTI vs aspiration pneumonia¹⁴. The doctor's review was *'excellent'*. While the diagnosis of a UTI was *'tenuous'*, the medical team's management plan of fluids, antibiotics and referral to the AMU was *'appropriate'*.

20. The ED IPA advised that AMU staff conducted a range of tests on 12 June and undertook a *'very thorough'* examination and management plan on 13 June. They commenced the patient on Gentamicin due to high NEWS, elevated CRP and blood test result showing a positive result for gram-negative bacteraemia¹⁵. This was an *'appropriate'* course of action. The patient subsequently tested positive for Klebsiella¹⁶. On 14 June a doctor advised the complainant the patient had *'chest sepsis'*.
21. The ED IPA advised on 15 June clinicians took an x-ray of the patient's abdomen, the results of which *'raised the possibility'* of a small bowel obstruction. The doctor spoke with the surgical team who advised a CT scan of the patient's abdomen. There was *'no indication'* for clinicians to carry this out sooner. This is because the Klebsiella isolated in the patient's blood culture *'could originate'* from the gastrointestinal¹⁷, biliary¹⁸, or urinary tracts.
22. The ED IPA advised the patient's history relating to the events that led up to his admission was *'vague'*. He said that in such cases it was *'challenging'* for clinicians to diagnose a patient with *'certainty'* and sometimes it was *'not possible at all'*. In the patient's case the medical team investigated the patient's

¹⁴ This refers to two potential diagnoses suggested by the patient's symptoms

¹⁵ A common type of bacteria which can cause a range of infections. Escherichia coli, Klebsiella spp. and Pseudomonas aeruginosa are the leading causes of healthcare associated bloodstream infections.

¹⁶ A species of bacteria which can cause a range of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis

¹⁷ The tract or passageway of the digestive system that leads from the mouth to the anus.

¹⁸ The network of organs and vessels that make, store and transfer bile through the body.

symptoms '*appropriately*' and in line with '*best practice*'. Ward staff escalated him to the surgical team once they identified a '*problem*'.

23. The G IPA advised the patient's initial presenting symptoms '*did not include*' abdominal pain. The medical team undertook '*appropriate*' investigations on 15 June when his symptoms indicated an '*abdominal pathology*'. The G IPA said the report of the CT scan taken on 15 June was '*not categorical*'. The patient's diagnosis was '*unclear*' and only became apparent '*at surgery*'. A surgeon would be '*easily*' criticised for relying on their own interpretation of a scan and therefore '*would rely on advice*' from a specialist radiologist.

Complainant's response to the Draft Report

24. The complainant made a number of comments in relation to the findings of the draft report. In response to these comments I obtained additional independent advice from the ED IPA, the G IPA and a Consultant Radiologist (R IPA). I have addressed these in the body of the report where appropriate and necessary.

Analysis and Findings

25. I acknowledge the complainant's belief that the Trust's '*delay*' in carrying out investigations, specifically an abdominal CT scan on 12 June, led to the patient's untimely death. I examined the patient's medical records which document a doctor examined the patient in the ED (time undocumented) and recorded an impression of '*likely uti*'. The doctor prescribed fluids and antibiotics. Clinicians administered the antibiotic Tazocin at 18.00. A junior doctor subsequently examined the patient in the ED at 18.26 and documented a 16-point plan, including investigations and senior review in the morning. The doctor examined the patient's abdomen which he noted was '*SNT*' (soft, non-tender). The doctor's preliminary diagnosis was '*aspiration pneumonia vs UTI*'.
26. In her response to the draft report the complainant asked why staff did not carry out an immediate "*full trauma scan*" in the ED. The ED IPA advised a full body scan was unnecessary unless the patient had experienced a '*major trauma*'. I accept the ED IPA's advice and I am satisfied there was no indication for

clinicians to carry out a *'full trauma scan'*.

27. The records document the Trust transferred the patient to the AMU at 23.40 on 11 June. A doctor reviewed the patient at 10.55 on 12 June and recorded his *'upper abdo discomfort'*. The doctor recorded *'?UTI'* on the patient's diagnosis/problem list of the ward round summary. The doctor documented a 13-point plan including an abdominal ultrasound. The records document the ultrasound took place on 15 June; clinicians delayed the procedure as the patient was *'too unwell to attend'*. Doctors reviewed the patient on six further occasions between 10.55 on 12 June and 03.10 on 15 June. On 13 June, doctors recorded a diagnosis of *'sepsis ? source'*, following which doctors commenced the patient on the antibiotic Gentamicin. The notes do not record any further issues relating to the patient's abdomen. On 14 June a doctor examined the patient's abdomen at 05.00 and again at 10.10. On both occasions the doctor noted the patient's abdomen was *'SNT'*.
28. The records document that on 15 June at 03.10, a doctor examined the patient and recorded *'Abdo distended, soft'* with *'high pitched'* bowel sounds. The doctor requested an x-ray of the patient's abdomen, which found *'dilated loops of small bowel'* and *'? Obstruction'*. The doctor examined the patient and *'discussed'* the results with a member of the on call surgical team who advised a CT scan of the patient's abdomen. The radiologist who performed the scan queried *'Can this be GB (gallbladder) inflammation/perforation with peritonitis?'* His report concluded *'Inflammatory process with? Peritonitis which maybe due to the gallbladder inflammation/perforation'*.
29. The records document a plan for the consultant surgeon to discuss the CT scan with the radiologist on 15 June. The surgeon requested an ultrasound of the patient's abdomen on the afternoon of 15 June to measure fluid around the liver. On the ward round of the morning of 16 June the doctor recorded a diagnosis of sepsis *'likely intra-abdominal source'*; the notes document the lack of a definitive source of the infection.
30. The records document a rapid deterioration of the patient's clinical condition on 17 June. The surgeon operated on the evening of 17 June and found the

patient had a '*necrotic perforated gallbladder*'.

31. The GMC Guidance requires doctors to '*a) adequately assess the patient's conditions, taking account of their history including the symptoms...; where necessary, examine the patient b) promptly provide or arrange suitable advice, investigations or treatment where necessary c) refer a patient to another practitioner when this serves the patient's needs*'.
32. I note the Trust initially diagnosed the patient with a UTI on 11 June. The ED IPA advised this diagnosis was '*tenuous*' with '*very little*' to support it. The records indicate that clinicians in the AMU questioned this diagnosis on 12 June and undertook investigations to determine the source of infection. The notes document that clinicians carried out an extensive number of investigations to determine the source of the patient's infection between 12 June and 15 June. I accept the IPA's advice that these investigations were '*appropriate*' and in accordance with '*best practice*'.
33. The complainant questioned why the Trust did not carry out an '*urgent*' CT scan on 12 June. I note the ED IPA's advice that there was '*no indication*' for clinicians to carry out a CT scan prior to this as the patient's infection could have originated from several sources within the body. I note further the G IPA's advice that the patient's initial clinical symptoms '*did not include*' abdominal pain. The patient's medical records document '*upper abdo discomfort*' on 12 June. However, I note this was the only occasion before 15 June clinicians found any issue with the patient's abdomen.
34. In subsequent examinations doctors documented the patient's abdomen was '*SNT*'. Doctors arranged for a CT scan on 15 June when they discovered the patient's abdomen was distended and a subsequent x-ray suggested a possible small bowel obstruction. While there is evidence the patient experienced abdominal discomfort on 12 June, there was no indication of any further issues until 15 June. Therefore, on balance I accept the ED IPA's advice there was no indication for a CT scan before 15 June.
35. Following the patient's CT scan of 15 June, the radiologist concluded

'Inflammatory process with? Peritonitis which maybe due to the gallbladder inflammation/perforation'. The complainant believed this scan *'clearly demonstrated'* the patient had a perforated gallbladder. The patient's medical notes record the surgeon's intention to discuss the issue with the radiologist. While the outcome of the discussion is not recorded in the patient's records, it is clear from the Trust's response to this Office that the surgeon did not consider the scan was definitive. I note the G IPA's advice that in interpreting a scan a surgeon would *'rely on advice'* from a specialist radiologist. In her response to the draft report the complainant referred to the patient's medical history and if this would have made the diagnosis *"more likely"*. The G IPA further advised that the patient's diagnosis was *'unclear'* and only became apparent *'at surgery'* as the report was not *'categorical'* and a history of cholecystitis *"does not"* make the rare diagnosis of gall bladder perforation likely". Having considered the medical records it is evident the radiologist did not conclude definitively that the patient had a perforated gallbladder.

36. In her response to the draft report the complainant questioned the radiologist's interpretation of the scan. I sought additional advice from the R IPA who advised the findings within the CT scan correctly identified the diagnosis as an inflamed gallbladder. He further advised it *"cannot"* be said with certainty whether the gall bladder had perforated or not at this point and the interpretation in the report was *"accurate"* and reported *"clearly"* by the radiologist. I accept the R IPA and G IPA's advice in relation to this issue.
37. In summary, having initially diagnosed the patient as having a UTI, the Trust carried out a range of investigations to determine the source of his sepsis infection. The patient's abdomen was distended on 15 June and an x-ray suggested a possible obstruction in the small bowel. A subsequent CT scan indicated the possibility of a perforated gallbladder. Ward staff asked surgeons to take over the patient's care. The CT scan was not definitive, and surgeons only confirmed the patient had a perforated gallbladder during surgery on 17 June. I considered the patient's medical records, the relevant guidance and the advice of the ED IPA and G IPA and I am satisfied:

- Staff in the AMU carried out appropriate investigations to determine the source of the patient's infection from 12 June;
- The Trust prescribed appropriate antibiotics to treat the patient's infection;
- Ward staff referred the patient for a CT scan at the appropriate time as there was no indication for an '*urgent*' CT scan on 12 June; and
- The CT scan of 15 June did not '*clearly*' demonstrate the patient had a perforated gallbladder.

38. I note the ED IPA's advice that the Trust's initial examination of the patient following his presentation to the ED was '*lacklustre*' and '*poorly documented*'. The ED IPA also advised clinicians' diagnosis of a UTI had '*little*' to support it. Nevertheless, these areas '*did not influence* (the patient's) *outcome*' and the subsequent care the Trust provided was in line with '*best practice*'. Therefore, I do not uphold this element of the complaint. However, I ask that the Trust reflects on the ED IPA's comments in relation to the initial examination of the patient.

Observation

39. I note the ED IPA's advice regarding the failure of ED clinicians to record LFT and lactate levels. The ED IPA advised that while the Trust '*should*' have carried out these tests, ultimately it did not have a detrimental impact on the patient's health on this occasion. As such I do not consider the patient sustained an injustice as result. However I would expect the Trust to remind ED staff of the importance of carrying out basic investigations when assessing gravely ill patients in the ED.

Indication for surgery

Detail of Complaint

40. The complainant believed the Trust did not refer the patient for surgery in a timely fashion. The Trust did not operate on the patient until six days after his admission. She was '*genuinely perplexed*' as to 'what went on' in the period between 15 June and 17 June. By the time Trust operated on the patient he was not '*well enough to withstand same*'. She also questioned the Trust's

decision to fast the patient for two days before surgery.

Evidence Considered

Legislation/Policies/Guidance

41. I considered the following guidance:
- GMC Guidance; and
 - Good Surgical Practice.

Trust's response to investigation enquiries

42. The Trust stated the following: there was '*no indication*' for surgery on 15 June. On 16 June, the patient's bloods were '*better*' and he had '*improved clinically*'. On 17 June the surgeon decided to proceed with surgery when the patient deteriorated '*even though*' his diagnosis was '*not clear*'. In relation to its decision to fast the patient, the Trust stated this was because it had not '*excluded*' small bowel obstruction and because he was fasting for surgery.

Relevant Independent Professional Advice

43. The ED IPA advised there was '*no indication*' for clinicians in the AMU to seek a surgical review as there was '*no suggestion*' the patient had a '*problem*' which required surgical input.
44. The G IPA advised the following: it was '*not clear*' from the medical records why the surgical team decided to delay surgery. However, its '*actions*' were '*clear*'. The G IPA advised that on the afternoon of 15 June, the consultant surgeon requested an ultrasound guided aspiration of the patient's abdominal fluid¹⁹. The '*likely*' purpose of this was an attempt to clarify if gall bladder perforation was the source of the fluid. If the fluid extracted was bile, then it would '*indeed*' indicate the patient had a perforated gallbladder. This action '*supports*' the need for '*clarity*' in relation to clinicians' '*uncertainty*' about the patient's diagnosis. The patient was '*generally an unfit man*' with several comorbidities, thus the Trust's decision making around the '*need*' for, and '*timing*' of surgery was '*very important*'. The G IPA advised that in relation to the Trust's actions,

¹⁹ A procedure to remove extra fluid from the abdomen.

the *'sequence of events'* made *'sense'* and was *'reasonable'*.

45. The G IPA further advised that in relation to the patient's fitness to undergo surgery, his condition *'appeared to improve'* on 16 June. His *'chart observations'* did *'not show'* a deterioration in his clinical condition until 17 June. The Trust decided to fast the patient from 15 June to carry out the CT scan, the ultrasound scan and ultimately for surgery. Each of these events required the patient to fast to ensure *'optimal outcomes'*. The patient *'may have'* been allowed to eat and drink in between investigations and surgery.

Analysis and Findings

46. The complainant said the patient deteriorated over the six days he remained in AAH. She said the Trust had no *'medical reason'* or *'justification'* to delay surgery for the patient for this length of time. In addition, in her response to the draft report the complainant said the family spoke with two surgeons who advised the patient was very ill and would require surgery. I have been unable to find any record of this conversation in the patient's notes. In making a decision on the appropriateness of the treatment the Trust provided to the patient I am reliant on the information contained in the medical records and whilst I acknowledge the complainant's concern I can find no evidence of this conversation in the notes. I acknowledge the complainant's strongly held view on this issue, however, I am satisfied, on the evidence available, there was no indication for a CT scan before 15 June. In addition, I note and accept the ED IPA's advice there was *'no suggestion'* the patient required surgical input while he was in the AMU. As such I am satisfied there was no indication for surgery before 15 June. Therefore, I have only considered the Trust's actions between 15 and 17 June in relation to this matter.
47. I examined the patient's clinical records which document the consultant surgeon requested an ultrasound *'Guided aspiration abdomen'* at 16.14 on 15 June. The report documented a *'small collection of blood stained fluid obtained'*. In his statement to this office the consultant surgeon refers to the procedure. He stated that he requested the scan after discussing the results of the CT scan with the radiologist who *'mentioned'* inflammation and fluid. There

is no detailed rationale for why he did this in the medical records, however I note the G IPA's suggestion of the surgeon's possible reasons for requesting the procedure. The Trust transferred the patient to the surgical ward at approximately 19.30 on 15 June. On the ward round of 16 June, the surgeon documented the patient's NEWS had dropped to two from six the previous day. The patient reported feeling '*better*' than he had that morning.

48. In her response to the draft report the complainant believed the Trust should have ruled out its initial potential diagnosis of a bowel obstruction earlier as the patient had regular bowel movements from admission. In relation to this, the R IPA advised the CT scan demonstrated free fluid and dilation of the small bowel which "*mimics the signs of bowel obstruction*"
49. On 17 June, the patient's NEWS had risen to seven and he was exhibiting '*intermittent confusion*'. His abdomen was '*grossly distended*'. The surgeon referred the patient for an MRI²⁰ scan at 11.30. At 12.46 the consultant documented a working diagnosis of '*biliary sepsis*'. He noted that as the patient's bowel was moving his symptoms were '*unlikely*' due to a small bowel obstruction. The patient consented to surgery at 16.15 and the surgeon operated on him later that evening.
50. The GMC Guidance requires doctors to '*prescribe drugs or treatment...only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*' and to '*provide effective treatments based on the best available evidence*'. In addition, Good Surgical Practice requires surgeons to '*ensure that patients are treated according to the priority of their clinical need*' and to consider carefully '*the risks and benefits of surgical intervention*'.
51. The G IPA advised that the surgical team did not document its reasons for delaying surgery in the patient's records. However, its actions between 15 and 17 June were '*clear*'. The G IPA explained the surgical team undertook

²⁰ Magnetic resonance imaging: a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body

additional investigations to determine if the patient had a perforated gallbladder as the results of the CT scan were uncertain. He also advised the patient's clinical condition appeared to improve on 16 June. The patient deteriorated again on 17 June at which point the Trust operated on him. I note the G IPA's advice that the patient had several comorbidities and therefore the Trust's decision around the '*need*' for and '*timing*' of surgery was '*very important*'. He concluded that in relation to the Trust's actions, the '*sequence of events*' between 15 and 17 June made '*sense*' and was '*reasonable*'. I accept the G IPA's advice.

52. The Trust moved the patient to the Intensive Care Unit (ICU) after surgery. The patient remained there until 25 June when he sadly passed away. It is evident from the medical records that the patient was critically ill when the surgeon operated on him. I acknowledge the complainant's belief that the Trust's '*delay*' in progressing the patient to surgery led to his death. However, the patient's medical records document that medical staff did not consider the CT scan definitively showed a perforated gall bladder and they continued to investigate the source of his symptoms. The records also show an improvement in the patient's clinical condition on 16 June, before he deteriorated the following day. Having considered the medical records, the relevant guidance and the G IPA's advice I am satisfied the Trust's decision to wait until 17 June to operate on the patient was reasonable. Therefore, I do not uphold this element of the complaint.

Communication between clinical staff

Detail of Complaint

53. The complainant said the patient was placed '*in no fewer*' than five wards during his time in AAH. She said there appeared to be '*no clear handover*' between staff on different wards. She said this was not just '*frustrating*' for the family but was '*critical*' to the patient's care and treatment. She believed the lack of '*continuity and consistency*' between staff led to '*fatal consequences*' for the patient'.

Evidence Considered

Legislation/Policies/Guidance

54. I considered the following

- GMC Guidance
- NMC Code

Trust's response to investigation enquiries

55. The Trust stated to this Office it was '*standard practice*' for nurses to handover a patient's details upon transfer to another ward. In its response to the complainant, it stated nurses in the AMU '*would have...given*' a '*full nursing handover*' to staff on the General Medical ward upon the patient's transfer there. In relation to communication between doctors, the surgeon '*confirm[ed]*' medical staff passed the patient's '*information*' on to the relevant staff when the patient transferred between wards.

Relevant Independent Professional Advice

N IPA

56. The N IPA advised the following: the handover between the ED and the AMU was '*very good*' and nurses followed this with a '*thorough*' assessment on the ward. The handover between the AMU and the General Medical ward was also '*good*'; nurses were '*clear*' with the medical plan and completed a '*full*' nursing assessment. The nursing records document that nurses on the General Medical Ward contacted nurses on the Surgical Ward and '*handed over*'. Overall, the documentation in the nursing records is '*succinct*' and '*clear*' and handovers between nursing staff were of '*high quality*'.

ED IPA

57. The ED IPA highlighted the poor record keeping by the doctor who initially assessed the patient in the ED on 11 June. He noted that the doctor who subsequently examined the patient later in the ED carried out an '*excellent*' review which was thoroughly documented. The ED IPA advised that as a result the initial poor documentation did not impact the patient's care. The ED IPA did not raise any concerns in relation to the communication between doctors in the AMU and the General Medical Ward.

Analysis and Findings

58. I examined the patient's nursing records which document nurses completed a Pre-Transfer Handover of Patient form between the AMU and the General Medical Ward. Nurses do not appear to have completed this document when the Trust transferred the patient to the Surgical Ward on 15 June, however, the notes document '*handover given*' while the patient was waiting for a bed to become available. The Surgical Ward nursing notes clearly document nurses' awareness of the patient's clinical condition and potential diagnoses.
59. The NMC Code requires nurses to '*maintain effective communication with colleagues*', and to '*identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*'

N IPA

60. The N IPA did not raise any concerns about the handovers nursing staff provided to colleagues when the Trust transferred the patient between wards. She described nurses' communication as '*very good*' and '*clear*' and advised handovers were of a '*high quality*' overall. I accept this advice. Having considered the nursing records, the relevant guidance and the N IPA's advice, I am satisfied that communication between nursing staff was reasonable and appropriate.

ED IPA

61. The IPA did not raise any concerns in relation to the communication between doctors between the ED and the General Medical Ward.
62. The GMC Guidance requires doctors to '*share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty*'.
63. In relation to communication between doctors on the General Medical Ward and the Surgical team, I note surgeons were already involved in the patient's

care and treatment and provided advice to ward staff before his transfer to the Surgical Ward on 15 June. Therefore, I do not consider that there was any requirement for a formal handover between doctors in this instance.

64. I acknowledge the complainant's concern about the number of wards the patient passed through during his admission to AAH. However, having examined the medical records, I am satisfied these transfers were necessary given the patient's clinical pathway.
65. In summary, having considered the clinical records, the relevant guidance and the IPAs' advice I am satisfied there was reasonable and appropriate communication between clinicians during the patient's stay in AAH. Therefore, I do not uphold this element of the complaint.

Issue 2: Whether the Trust handled the complaint in accordance with relevant guidance?

Detail of Complaint

66. The complainant said the Trust's response to her complaint was '*vague, inaccurate*' and did not address her queries '*in full*' meaning it was '*entirely unacceptable*'.

Evidence Considered

Legislation/Policies/Guidance

67. I considered the following:
- Trust Complaints policy

Trust's response to investigation enquiries

68. The Trust stated it was '*sorry*' if the complainant felt its response did not address all her issues. It offered her the option of a meeting, but she did not '*get back in touch*'.

Analysis and Findings

69. In her original complaint to the Trust the complainant asked 16 questions in relation to the care and treatment it provided to the patient between 11 and 17 June 2021. I examined the Trust's response to the complainant dated 4 May 2022. The Trust answered all the complainant's questions. I also examined the patient's clinical records which appear to be consistent with the Trust's answers to the complainant.
70. The Third Principle of Good Complaint Handling 'Being Open and Honest' requires public bodies to provide '*honest evidence-based explanations and giving reasons for decisions*'. While the Trust's decision making around the patient's care is not always explicitly laid out in the medical records, I consider the Trust made a genuine attempt to explain the reasons for its actions in its response to the complainant. The complainant also considered the Trust's response to be '*vague*'. I acknowledge the complainant's view; however, I note the Trust offered to meet the complainant if she required '*further clarity*'. During a conversation with the Investigating Officer the complainant said that she did not think that meeting with the Trust would '*achieve anything*'. I consider that in addressing her complaint the Trust offered to provide additional information to the complainant if she required it. Therefore, I am satisfied the Trust's handling of the complaint in relation to the issues referred to above was reasonable.
71. However, I note the complainant first submitted her complaint on 25 August 2021. According to records provided by the Trust, it sent the complainant holding letters on 28 September 2021, 1 December 2021 and 11 January 2022. Each of these letters stated that it would be unable to provide a response to her complaint within 20 working days. Each letter further stated this was because the complaints officer was waiting for '*information*' or a '*response*' from the investigation officer. Each of the letters also asked for the complainant's '*patience and understanding during these challenging times.*' The Trust provided its final response on 4 May 2022, almost nine months after the complainant submitted her complaint.
72. I refer to the Trust Complaints policy which states '*complaints must be*

investigated and the person making the complaint issued with a written response from the Trust within 20 working days. A holding letter will be issued, if necessary, explaining that the response will be delayed and providing a reason for the delay. Any additional delays should be notified to complaints/ staff to allow them to keep the person making the complaint informed of progress. Any delay in issuing the written response should not normally exceed an additional 20 working days.'

73. In the event of a delay when responding to a complaint, I note the Trust's Complaints policy requires it to send a holding letter to the complainant '*providing a reason for the delay*'. In each of the holding letters it sent to the complainant the Trust stated there was a delay because it was awaiting information or a response from the investigation officer. While I consider this was a reasonable explanation to give on the first occasion it wrote to the complainant, it had not provided any further context to, or explanation for the delay when it sent its third holding letter on 11 January 2022. This was over 19 weeks after it first received the complaint. Further there is no record of it contacting the complainant between 11 January 2022 and 4 May 2022: a period of over 16 weeks.
74. In total it was 36 weeks before the Trust provided the complainant with a response to her complaint. I acknowledge the pressures the Trust faced during the pandemic. I accept it was unlikely under the circumstances at that time that the Trust could provide a response to a complex and multi-faceted complaint within 20 days. However, I consider that 36 weeks delay in responding to the complaint was disproportionate and wholly unacceptable. In my view this was further compounded by the failure of the Trust to provide the complainant with an explanation for the delay or a realistic timeframe to expect a response by.
75. The First Principle of Good Complaint Handling, '*getting it right*', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned*'. In addition, the Second Principle of Good Complaint Handling, '*being customer focused*', requires bodies to deal with '*complainants promptly and sensitively, bearing in mind their individual circumstances*'. I consider that the failure to respond to the complainant in a timely manner and

to provide her with a reasonable explanation for the delay constitutes maladministration.

76. Consequently, I am satisfied that the maladministration identified caused the complainant to sustain the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office. Therefore, I uphold this issue of the complaint.

CONCLUSION

77. The complainant raised concerns about the care and treatment the Trust provided to her father, the patient. The complainant also had concerns about the Trust's handling of her complaint.

Issue One

78. I concluded the care and treatment the Trust provided to the patient in AAH between 11 June 2021 and 17 June 2021 was appropriate, reasonable and in accordance with relevant standards, guidance and practice. I find no failings resulting in injustice to the patient or the complainant, therefore I do not uphold this issue of complaint. However, I hope that our careful consideration of this complaint and the findings that the care and treatment were appropriate provide some reassurance to the complainant.

Issue Two

79. The investigation established maladministration in relation to the following matters:
- Failure to respond to the complainant in a timely manner; and
 - The failure to provide the complainant with a reasonable explanation for the delay.
80. I am satisfied the maladministration identified caused the complainant and her family the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office.

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

Recommendations

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

83. I further recommend for service improvement and to prevent future recurrence that:

- The Trust reminds all staff involved in complaints handling of the importance of meeting response times and where this is not possible to update the complainant, and provide fulsome explanations for the delay.

84. I am pleased to note the Trust accepted my recommendations.

MARGARET Kelly
Ombudsman

August 2024

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing 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.

2. 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 where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. 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.

4. 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 and actions 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

5. 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.

6. 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 learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.

