Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against:

- **Northern Ireland Ambulance Service Trust (NIAS);**
- **Belfast Health and Social Care Trust (the Belfast Trust); and**
- **Southern Health and Social Care Trust (the Southern Trust)**

NIPSO Reference: 21053 / 21181 / 21182

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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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Southern Health and Social Care Trust (the Southern Trust)

SUMMARY

I received a complaint about the actions of three listed authorities namely the Northern Ireland Ambulance Service Trust (NIAS), the Belfast Health and Social Care Trust (the Belfast Trust) and the Southern Health and Social Care Trust (the Southern Trust) in relation to each of their actions in the recording and processing of a patients information, and allocation of an incorrect Health and Care (H+C) number). The complainant said that an error was made in the recording of the patient's personal details, which resulted in him being identified as another patient. The complainant said the error ought to have been detected and queried if the patient's treatment was adversely affected by the error. I also considered the actions of the listed authorities when they were each made aware of an error in the allocation of an incorrect H+C number to a patient.

I obtained all relevant information, including the records held by each listed authority in relation to the matter. In the course of the investigation, staff members from the listed authorities were interviewed and meetings were held in relation to changes in procedure. I also obtained clinical advice from a Consultant in Emergency and Critical Care Medicine.

The investigation found that the most likely source of the error was the communication of an incorrect date of birth by NIAS staff to Belfast Trust staff. A NIAS paramedic also incorrectly recorded the patient's son's medications as those of the patient on the NIAS PRF form though this error did not affect the treatment of the patient. The investigation also found the incorrect date of birth should not have resulted in the patient being allocated the wrong H+C number in hospital, as information should have been triangulated and the patients address would not have matched that of the patient's identity he was allocated. The investigation concluded

it was likely that Belfast Trust staff used the incorrect date of birth to allocate the patient's H+C number and did not triangulate the information available. The incorrect patient identification did not affect the care and treatment provided by the Belfast Trust.

The investigation found the mis-identification continued when the patient was transferred to the Southern Trust who also had a responsibility to check that the patient's details were correct. The patient was administered medication in the Southern Trust that he should not have been however I am satisfied that this did not lead to harm and did not affect the patient's prognosis. Overall the investigation found failures in the implementation of procedures which prompted hospital staff to cross reference information to ensure accuracy.

The investigation also found failures in the actions taken by all three listed authorities when the error was made known to them. I found failures in the recording of considerations and actions taken. I concluded that there was a failure to work collaboratively to provide the complainant with a complete and accurate response. This caused frustration and uncertainty to the complainant, regarding the care and treatment provided to her late husband. I consider there was a missed opportunity for all three Trusts to have worked together to have identified the factors that lead to the error and to have taken corrective action through the procedures that are in place for such interface incidents.

I recommended that the Chief Executives of the three listed authorities apologise to the complainant. I also recommended focused training for staff, in particular around the recording of actions taken during Interface investigations.

I am pleased to note that the Chief Executives of the three listed authorities accepted my findings and recommendations.

THE COMPLAINT

1. The complaint concerns the care and treatment provided to the complainant's late husband (the patient). On 11 November 2017, the patient received treatment from Northern Ireland Ambulance Service Trust (NIAS), the Belfast Health and Social Care Trust (the Belfast Trust) and the Southern Health and Social Care Trust (the Southern Trust). The complainant said that an error was made in the recording of the patient's personal details, which resulted in him being identified as another patient. The complainant said that any error in her late husband's details ought to have been detected and queried if his treatment was adversely affected by the error. The complainant complained to NIAS, the Belfast Trust and the Southern Trust. The complainant also complained to my Office regarding NIAS' handling of her complaint. I determined to produce one composite report so that the patient's journey could be fully understood and to provide maximum opportunity for learning.

Background

2. On 11 November 2017, the patient suffered a collapse at home. An ambulance was tasked and the patient required Advanced Life Support (ALS)[1]. The patient was conveyed to the Royal Victoria Hospital (RVH)[2] catheterisation laboratory (cath lab)[3] and was subsequently transferred to Craigavon Area Hospital (CAH)[4] where he sadly passed away on 16 November 2017. Following his passing, it emerged that the incorrect H+C[5] number was allocated to the patient and he was treated as a different patient who had the same name and a similar date of birth. As a result of the error, all investigations carried out on the patient were recorded on the wrong NIECR[6]. This also lead to the Death Certificate being issued on the incorrect patient's record and uncertainty regarding the family's capacity to have a burial. The patient's family uncovered the error when an incorrect past medical history was

[1] Medical procedures for sustaining life including the advanced diagnosis and protocol-driven treatment of a patient in the field such as defibrillation, airway management, and administration of medications.
[2] Hospital within the Belfast Trust
[3] A cath lab is room within a hospital where specialised tests and assessments are carried out on the heart
[4] Southern Health and Social Care Trust (the Southern Trust)
[5] Health and Care Number – uniquely identifies a patient within the healthcare system
[6] Northern Ireland Electronic Care Record - a computer system that health and social care staff can use to get information about your medical history

noted on the Death Certificate. The Southern Trust asked the Coroner's office to intervene so that the patient's burial could proceed.

Issues of complaint

3. The issues of complaint which I accepted for investigation were:

NIAS

Did NIAS follow appropriate policy, procedure and standards in relation to the completion of the Patient Report form (PRF)?

Was NIAS handling of the complaint appropriate and in accordance with relevant policies, procedures and standards?

Was the NIAS investigation of the complainant's concerns, appropriate and in accordance with policy/procedure?

Belfast Trust (BHSCT)

Were BHSCT's actions in relation to registering the patient, appropriate and in accordance with relevant policies, procedures and standards?

Was the BHSCT's investigation of the complainant's concerns, appropriate and in accordance with relevant policies, procedures and standards

Southern Trust (SHSCT)

Were the SHSCT's actions in receiving the patient as a transfer from the BHSCT, appropriate and in accordance with relevant policies, procedures and standards?

Was the patient's treatment affected by an error in retrieving his medical history?

Was the SHSCT's investigation of the complainant's concerns, appropriate and in accordance with relevant policies, procedures and standards?

4. For ease to the reader, the issues raised are considered in this report sequentially, that is, the listed authorities' actions in processing and receiving the patient and any impact on his care and treatment (issues 1, 2 and 3), followed by the listed authorities' consideration of the issues raised when the error was made known (issues 4, 5 and 6). The NIAS handling of the complainant's concerns is considered under issue 7.

INVESTIGATION METHODOLOGY

5. I determined to issue a composite report of the investigation of the complaint in order to provide a clear and complete explanation of the issues raised. I am also mindful of the need to provide a full explanation as to how I reached my conclusions and reflect the patient's journey through the healthcare system. I informed NIAS, the Belfast Trust and the Southern Trust of my determination in this regard on 12 February 2020. This report will therefore encompass the issues of complaint against all three authorities and will be set out under the headings stated in paragraph three.

6. In order to investigate the complaint, the Investigating Officer obtained from NIAS, the Belfast Trust and the Southern Trust, all relevant documentation together with comments on the issues raised by the complainant. This documentation included information relating to the handling of the complaint. The Investigating Officer interviewed a member of NIAS' staff, met with two members of staff from the Belfast Trust and spoke with a member of staff from the Southern Trust.

Independent Professional Advice Sought

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

- Consultant in Emergency and Critical Care Medicine with over 10 years' experience

The clinical advice I received is enclosed in Appendix two to this report.

6. The information and advice which informed my findings and conclusions are included within the body of my report. The IPA provided me with '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. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[7]:

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

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:

- Northern Ireland Ambulance Service (NIAS) 'Policy and Procedures for completion of Patient Report Forms (PRF)', 19 March 2008, ('the PRF Policy');
- Joint Royal Colleges Ambulance Committee (JRCALC) Clinical Guidelines, March 2016, ('the JRCALC guidelines');
- Northern Ireland Ambulance Service 'Policy and Procedures for the Management of Medicines', August 2015, ('the NIAS medicines management policy');
- Belfast Health and Social Care Trust 'Patient Identification Policy within a

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

hospital setting', October 2015 (implemented 2016), ('the 2016 identification policy');

- Nursing and Midwifery Council (NMC) 'The Code: Professional Standards of Practice and behaviour for nurses and midwives', 29 January 2015, ('the NMC Code);
- Southern Health and Social Care Trust 'Policy on Patient/Client Identification', March 2009, ('the 2009 Identification Policy');
- Northern Ireland Ambulance Service Complaints Policy[8], 2 April 2015, ('the NIAS complaints policy');
- Department of Health, Social Services and Public Safety (DoH) 'Complaints in Health and Social Care - Standards and Guidelines for Resolution and Learning', 1 April 2009 ('the HSC Complaints Procedure');
- Health and Social Care Board (HSCB) 'Procedure for the Reporting and Follow up of Serious Adverse Incidents', November 2016, (the SAI procedure), and
- Belfast Health and Social Care Trust 'Procedure for Investigating an Incident' (excluding SAIs)', January 2018, ('the BHSCT AI procedure').

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

11. A draft copy of this report was shared with the complainant and the three relevant listed authorities for comment on factual accuracy and the reasonableness of the findings and recommendations.

INVESTIGATION

Issue 1: Did NIAS follow appropriate policy, procedure and standards in relation to the completion of the Patient Report form (PRF)?

Detail of Complaint

12. When the complainant reviewed her late husband's medical records provided to

[8] Paragraph 1.1 states this should be read in conjunction with the HSC Complaints procedure

her by NIAS on 24 October 2018, she found that his date of birth was recorded incorrectly, one digit out on the day (that is, 3 March instead of 2 March). The complainant said that the error was passed to Belfast Trust staff and resulted in an incorrect H+C number being allocated to the patient. The complainant also said that when the paramedics had attended her home she offered her husband's prescription list to the attending paramedics but the offer was declined. She said that some time later, when she was waiting in a PSNI vehicle[9] to take her to the hospital, she was asked to provide her keys to a police officer, and a police officer and a paramedic entered her house for the prescription. It was later determined that the prescription obtained from her house by the paramedic belonged to her son, of the same name as her late husband. The complainant also considered that some of her husband's medication had also been removed. The complainant also said the patient was incorrectly recorded as being a diabetic, but it was correct that he had suffered a silent heart attack 20 years previous. The complainant said her son is diabetic and he was also prescribed Simvastatin[10] at that time.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the PRF policy and noted the following relevant extracts:

'3.7.1 The TOP copy is retained and returned to station for accuracy checks…

3.7.2 The BOTTOM YELLOW copy is handed on to medical staff at the receiving hospital;

…

4. Patient details

…enter the date of birth if known. This is to be completed as well as the age…'

14. I also considered the JRCALC guidelines and noted the following extract:

'Additional information

The patient history can provide a valuable insight into the cause of the current condition. The following may assist in determining the diagnosis:

- *Relatives, carers or friends with knowledge of the patient's history*

[9] The PSNI attended initially to assist with CPR whilst the complainant awaited an ambulance

[10] Simvastatin is a medication used in the treatment of high cholesterol

- *Packets of containers of medication or evidence of administration devices…'*

15. Finally, I considered the NIAS medicines management policy and noted the following extract:
'19. Carriage of patient's drugs in Ambulance Vehicles
When ambulance crews are requested to carry a patient's own medicines, this must be recorded on the PRF under 'management comments'…'

NIAS Response to investigation enquiries
16. NIAS said '*we have not been able to establish where the incorrect medical history originated from. During these call types, it is common for our staff to complete the PRF after they have handed the patient over to the care of the hospital staff. It is possible that given the fraught nature of this call and urgent need to transport [the patient] to hospital for ongoing critical care, that the paperwork was completed at hospital with the medical history being sourced from the ECR system which would be accessed by hospital staff, who may have used the incorrect H&C number. It is not clear how this error could have been made by a NIAS staff member as our staff at present have no way of accessing a patient's H&C number or record.'*

17. NIAS also clarified *'our ambulance crews have no way of accessing a patient's medical history. Normally, this would be obtained by questioning the patient themselves, or provided by family members/carers/other healthcare professional who are present on scene with patients.'* In relation to the issue regarding the prescription, NIAS said '*we were unaware that one of our staff re-entered the house…'*

18. NIAS also stated '*I do not believe that the issue around the incorrect H&C number was related to the actions of any NIAS staff member and therefore I do not believe that there is any learning relevant to this case at this time'.*

19. Finally, NIAS said '*it should be noted that no H&C number was recorded onto the original version of the NIAS Patient Report Form (PRF) as shown…we have been advised that a H&C number was written on the carbon copy which is left with emergency department staff at the time of clinical handover. We would again state*

that our own staff have no direct way of accessing H&C numbers and we therefore submit that the number was written by a member of the hospital team which would explain why it did not appear on the original document…although it is possible that an incorrect date of birth (3rd versus the 2nd of March) which was recorded on our form contributed to this error…we would apologise regardless, although any of these explanations are more likely to arise in the stressful situation of a resuscitation from a cardiac arrest when the crew's focus will be on stabilizing a critically ill patient…'

20. NIAS was asked to clarify the account regarding the H+C number on the hospital copy of the PRF. NIAS referred to a meeting which took place on 12 October 2018 and stated it '*reflects the explanation provided by the Belfast Trust that the incorrect H&C number was incorrectly documented by a member of the cardiology team in the cardiac catheterisation lab. As the meeting notes are presented in a bullet point format they unfortunately do not reflect further context of the discussion…'*

Interviews / statements

21. Following a request made as part of this investigation, NIAS provided a statement from two of the three paramedics who attended to the patient. In a statement dated 29 October 2019, Paramedic A said that on attendance at the patient's home, they '*immediately commenced Advance Life Support…my memory of the details of this event are quite vague as this incident was 2 years ago….[Paramedic C] and I were both in the back of the Ambulance with the patient and monitored him en-route to the RVH arriving at 0010hours. We handed the patient over with a patient report form to the receiving staff…'*

22. In an undated statement, Paramedic B said '*I can recall the call, but not all the details…I do not remember 'declining' the offer of the prescription, but it is entirely possible if this was offered on our arrival it would have been acknowledged, the provider thanked, and suggested that we would get a look at it shortly, given that we had arrived on scene with an active resuscitation ongoing, which we were now conducting. As a crew, we would have arrived into the house with a lot of equipment, and indeed I do remember having to go in and out to the vehicle for more equipment etc. I do not remember 'taking' a prescription, I would never enter premises and take any documentation or otherwise unless the patient had been the only person at the*

location. I have always sought assistance from the family, carers, or whoever was with the patient to assist in tracing the whereabouts of such documents. I would imagine, (sic.) have been given these when requested, although I do not remember returning to the house for any documentation.'

23. As part of the investigation of the complaint, the Investigating Officer interviewed Paramedic C, who confirmed that she had completed the PRF on 12 November 2017. Paramedic C recalled that she travelled in the ambulance with the patient to RVH. She was unable to say when the PRF was completed. Paramedic C referred to the telephone call between NIAS staff and RVH staff and added *'there would not have been very much more information to handover upon arrival'*. Paramedic C was not previously aware of an issue arising from the recording of the patient's date of birth. She explained that relatives are usually the main source of information contained within the PRF, although she does not recall the source of this information in this case. She added when a patient is taken to hospital, the address will also be checked.

24. Paramedic C was also asked about the complainant's account regarding the patient's prescription. Paramedic C said she had no recollection of a discussion about a prescription or of one being handed to her. She reviewed the PRF and said she may have gleaned the medical history from a medication list e.g. '*? high cholesterol'*.

25. The Investigating Officer asked Paramedic C about the possibility of the H+C number being on the hospital copy of the PRF. She stated that as a rule, once the PRF has been split nothing else is added to it. If there was anything to be added in, they would be put back together so that the information is contained on both copies.

Clinical Records

26. I examined the PRF which is enclosed as Appendix three to this report.

27. I note the patient's date of birth is recorded as 3 March (instead of 2 March) and

that his past medical history is incorrectly noted as '*IDDM*[11]'.

NIAS records

28. The Investigating Officer listened to a copy of the '999' emergency call made in respect of the patient. It was noted that the patient's date of birth was not sought or provided in this call.

29. NIAS provided a copy of minutes taken at a meeting which occurred on 12 October 2018 between NIAS and the Belfast Trust. The minutes contain the following references to the patient's case:

' *- NIAS - name and address correct but wife gave DOB and it was out by one day. She was distressed.*

- Mistake occurred at cath lab by a clinical physiologist who is now on Mat leave (patient intubated, family not present)

-As no ICU bed in BT [Belfast Trust], the patient was nursed in emergency theatres. Long chat with family but identity not checked'

Southern Trust records

30. In response to investigation enquiries, the Southern Trust said '…*there was a list of medication with the name of [the patient] which included diabetic medication. The Trust believes this list of medication had come from [the patient]'s home. Later this was identified to be that of [the patient]'s son…this error was identified by the Intensive Care Unit Staff on the Saturday morning'. The family were contacted via telephone to confirm this.*[12]*'*

Independent Professional Advice

31. The IPA was asked to review the medication administered by NIAS staff in view of the correct medical history of the patient. The IPA said *'none of the drugs administered at the time of the cardiac arrest had an adverse impact on the patient's prognosis'* and added *'from the ambulance sheet record I cannot find any indication that any clinical decisions were altered as a result of the incorrect medical history or medication list.'*

[11] Insulin Dependent Diabetes Mellitus

[12] The actions of the Southern Trust in relation to the prescription will be considered under issue six

32. The IPA was asked about the handover between NIAS and Belfast Trust staff. The IPA referred to the PPCI activation sheet[13] and also said *'there is no specific evidence of an additional verbal handover or of the form being received. If a copy was in the BHSCT notes (it is in the bundle) that would indicate the incorrect personal information documented on it was provided to hospital staff.'*

PSNI Records

33. As part of the investigation of the complaint, the Investigating Officer obtained the PSNI Command and Control documentation in relation to its attendance at the complainant's home. The PSNI documentation does not make reference to the patient's prescription.

Analysis and Findings

34. I note the complainant's concern about the incorrect recording of her late husband's details on the NIAS PRF. The investigation uncovered that NIAS first recorded the patient's date of birth on the PRF. I note the patient's date of birth was incorrectly recorded. The NIAS staff member (Paramedic C) was unable to recall the source of the incorrect information, and one possibility could have been the complainant. Although the patient's date of birth was incorrectly recorded, the investigation found no deviation from the PRF policy and therefore I make no finding in respect of NIAS actions in relation to this. I accept NIAS' account that staff are dependent on others for the information contained within the PRF. I am also mindful of the extreme stress faced by all those present at the scene, not least the complainant herself, which may have affected the accuracy of the information provided[14].

35. The PRF policy reflects that a carbon copy of the PRF is provided to the receiving hospital. The investigation was informed that in this case, the carbon copy also contained the patient's H+C number. NIAS outlined that staff do not have access to the H+C computer system. The investigation found no evidence that the

[13] See paragraphs 44 and 47

[14] It is also noted that the complainant said that she provided an incorrect date of birth to the Belfast Trust (see paragraph 38)

recording of the H+C number was made by NIAS staff. The actions of Belfast Trust staff in this regard will be considered under issue two. I therefore **do not uphold** this element of the complaint.

36. I also note the complainant's account regarding her husband's prescription. The JRCALC guidelines recognise current medication as being a source of information regarding the cause of a patient's presentation. I also note the NIAS medicines management policy indicates if a patient's actual medication is conveyed to hospital, this should be recorded on the PRF. I note there is no such indication in respect of a patient's (paper) prescription. The paramedics who attended the scene did not recall any discussion in respect of the patient's prescription. However I also note their statements are dated almost two years after the event. There was no record of removing the prescription on the PRF. I also note the PSNI records make no reference to the prescription. Further, the investigation did not uncover evidence of the patient's son's prescription being removed by NIAS staff. However I note that the patient's son's prescription was found within his medical records by staff in CAH, and Paramedic C informed the investigation that she may have used a medication list to ascertain the patient's (incorrect) past medical history.

37. I acknowledge the complainant's clear recollection of the events regarding the prescription. I also note the medication list on the PRF contains medication prescribed to the patient's son, and that this list may have informed the (incorrect) past medical history recorded on the PRF. In the absence of another explanation for the account provided by the Southern Trust of the presence of the son's prescription in CAH records, I find it is most likely that it was provided by NIAS staff in the manner outlined by the complainant. The investigation did not uncover policy or guidance related to this specific issue. I therefore make no finding in relation to this element of the complaint. I make an observation that NIAS should consider how this issue could feed into its next review of the PRF policy. I accept the IPA's advice and I am satisfied that the issue of the prescription had no bearing on the care and treatment afforded to the patient by NIAS. I trust this provides some reassurance to the complainant.

Issue 2: Were BHSCT's actions in relation to registering the patient, appropriate and in accordance with relevant policies, procedures and standards?

Detail of complaint

38. The complainant said that details were provided to Belfast Trust nursing staff to assist in identifying her husband such as the name of his GP, his GP's telephone number and his H+C number. She said that she mistakenly provided the incorrect date of birth[15] to RVH staff but later phoned the hospital to rectify this and also provided his National Insurance Number. Her late husband under went a PPCI[16] procedure and was subsequently transferred to the Intensive Care Unit (ICU) of RVH.

Evidence considered

Legislation/policy/guidance

39. I considered the 2016 identification policy and note the following relevant extracts:

'4.1…Whenever possible, the patient should be asked to read the details on the identity band and confirm correctness prior to placement of same. If this is not possible, the patient details on the identity band should be checked

4.2 The core identifiers that uniquely identify a patient when used in combination and which must be present on the identity band are: Last Name, First Name, Date of Birth, H+C number and Hospital Number…'

40. I also considered the NMC code which requires nursing staff to

'10 Keep clear and accurate records relevant to your practice

[15] It was noted to be the same incorrect date of birth recorded on the NIAS PRF

[16] Primary percutaneous coronary intervention - is a procedure used to treat the narrowed coronary arteries of the heart

This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice. To achieve this, you must:
…10.2 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…'

Response to investigation enquiries

41. The Belfast Trust said the complainant '*has been advised that the first error in respect of [the patient]'s identification occurred when the incorrect date of birth was listed on the Northern Ireland Ambulance Service (NIAS) paperwork issued to the Belfast Trust. This paperwork, containing the error, was then used by the Cardiology Cath Lab team. The service recognised this as an error on their part as staff did not cross reference the patient name, date of birth and address before attributing the [H&C number]…from the moment the wrong H&C number was attributed, this followed the patient through his journey in the Belfast Trust (including the Cardiology Cath Lab and the Theatre departments). The theatre team do not recall any events or conversations that would have made them query [the patient]'s ID and thus the same H&C number followed through when [the patient] left Belfast to be managed within the Southern Health and Social Care Trust. The normal procedure, if there is any query with a patient's details, is to check with the Index Department in the Trust and to correct any errors immediately.'*

42. The Trust stated '*there were two patients in the Royal Victoria hospital with the [same surname] between 11/11/2017 and 12/11/2017. The team can also confirm there was only one [name of patient] treated in the Royal Victoria Hospital during this period of time'.*

43. The Belfast Trust was asked about the information recorded on the 'PPCI activation sheet' by a Senior Cardiology Nurse. Staff stated *'the activation sheet is a tool to ensure information handed over on the telephone is documented; this is the first document created on the RVH site in reference to the patient episode…the first time the wrong H&C was computerised was in the Cath Lab through the*

Cardiovascular Information System (CVIS)[17] *to document the patient's procedure in the Cath Lab.'*

Discussion with Belfast Trust staff

44. As part of the investigation, the Investigating Officer held a meeting with two members of Trust staff with operational knowledge regarding the process of registering patients. The staff outlined that the process has changed since the occurrence of the error related to this complaint. Referring to the previous process, staff stated that when a patient was a potential for transfer to the RVH Cath Lab, a phone call was made by NIAS staff to the Senior Cardiology Nurse who was based in Ward 5D in RVH. The co-ordinator would record the details of the call on a 'PPCI activation sheet' which was completed by hand. The staff said that if an ECG was shared with Belfast Trust for consideration, it contained only a name. Staff said when the decision was made to accept the patient, the PPCI activation sheet was placed in a localised file/binder which was created and taken to the Cath Lab to await the patient. The NIAS PRF was also placed inside this file when handed over by NIAS staff.

45. The Belfast Trust staff outlined its new patient identification protocol, adopted since the error in this case arose. At the point of accepting the patient, Belfast Trust staff are now prompted to ask if the patient can confirm their own identity. If the patient cannot, the 'unidentified patient protocol'[18] is enacted and temporary identification number is allocated to them to enable emergency treatments to proceed. This is followed up with the allocation of the patient's correct H+C number when confirmed and cross-checked.

Clinical records

46. The clinical records provided by the Belfast Trust were examined. The records reflect that on arrival, the patient was unconscious and underwent a PPCI procedure in the cath lab and was transferred to the ICU within RVH. Due to bed pressures, arrangements were made to transfer the patient to the ICU within CAH.

[17] Cardio Vascular Information System – the computer system adopted by cardiac services in Northern Ireland
[18] BHSCT 'Management of Unidentified Patients' (2019)

47. The records contain a document entitled 'Activation of Primary PCI Service' (the PPCI activation sheet), a pro-forma which was completed by hand by the Senior Cardiology Nurse. The patient's incorrect date of birth, H+C number and past medical history is noted on the PPCI activation sheet.

48. The clinical notes do not record any discussions between the family and nursing or other staff regarding the patient's identity.

Independent Professional Advice

49. The IPA was asked to review the medications administered to the patient in RVH, in light of his correct past medical history. The IPA advised that the patient's blood glucose was recorded as high and he was administered insulin on two occasions in RVH. The IPA also advised *'none of the drugs used to treat [the patient during or following his cardiac arrest would have had an adverse interaction with his usual medications. None of the treatment provided or drugs used to treat [the patient] during or following his cardiac arrest would have had an adverse impact on his prognosis.'*

Response to draft investigation report

50. In response to the draft investigation report, the complainant provided a detailed account of an exchange between herself and two staff nurses who were on duty on 11 November 2018. The complaint said she recalled one of the staff nurses saying '*I have two [name of patient]'s; one in [town] and one in [town patient lived]*'. The complainant said the other staff nurse lived near the complainant.

Analysis and findings

51. I note at the outset that the incorrect date of birth and past medical history recorded by NIAS, was communicated to the Belfast Trust through the PRF. I also note that an incorrect date of birth was recorded on the PPCI activation sheet. The source of this information was the telephone call between NIAS staff and the Belfast Trust Senior Cardiology Nurse.

52. I also note at the time, the 2016 identification policy was relevant. It required staff to check that the patient's details matched, that is the correct name, date of

birth and address were all attributable to the same patient / H+C number on the NIECR. On the balance of probabilities, it is most likely that the incorrect H+C number was appointed during or after the telephone call recorded on the PPCI activation sheet. The investigation found no evidence of compliance with the 2016 identification policy, as the required check would have identified the anomaly in the details. Notably, the 2016 identification policy, relied heavily on the accuracy of information being provided by the patient or family member. The First Principle of Good Administration requires public bodies to 'get it right' by '*acting in accordance with the public body's policy and guidance'*. I am satisfied that this standard was not met in this case and I find the failure to comply with the 2016 identification policy amounts to maladministration. I therefore **uphold** this element of the complaint. I find this failure particularly concerning given the potential for serious harm to a patient who may have been administered incorrect medication.

53. However, the complainant's account indicates that staff treating the patient were aware of at least the potential for error. I acknowledge the candour of the complainant in stating she provided incorrect information in the first instance, but later rectified this in a telephone call. The investigation did not uncover evidence that the telephone call was made. However, I found no reason to disbelieve the complainant's account in this instance. I also note that Belfast Trust staff did not recall the exchange regarding two patients, as outlined by the complainant. Similarly, I found no reason to disbelieve the complainant's account. The investigation did not uncover recording of concern for potential error, or of the information provided and clarified by the complainant. I take account of the short period of time the patient was in RVH, and the limited opportunity for recording. However, I am also mindful of the provisions within the NMC Code. I consider it a failing that staff in the Belfast Trust did not record or action the telephone call from the complainant providing rectification of her husband's details. I find that this failing constitutes maladministration.

54. I note and accept the advice of the IPA and find that the failure of Belfast Trust staff to identify the error and resolve it had no bearing on the patient's prognosis. The investigation also uncovered that the other patient (whose H+C number had

been appointed to this patient) was not being treated in RVH at the time. I trust this provides reassurance to the complainant.

55. I am pleased to note that as a direct result of this complaint, the Belfast Trust has reformed its procedure regarding the registration of incapacitated[19] patients. I consider that the previous arrangement relied too heavily on information often sourced at the scene of distressing and anxious incidents.

Issue 3: Were the SHSCT's actions in receiving the patient as a transfer from the BHSCT, appropriate and in accordance with relevant policies, procedures and standards?

Detail of complaint

56. The complainant said that when her husband was a patient in CAH, nursing staff '*continually checked with family members'* the patient's name, address, date of birth and if he was diabetic. When she found the error had continued to CAH, the complainant was concerned that staff did not take action despite being provided with the correct personal details and medical history. She was also concerned that the patient's treatment was adversely affected by the error.

Evidence considered

Legislation/policy/guidance

57. I considered the 2009 Identification Policy and in particular noted the following relevant extracts:

'It is essential that all staff acknowledge and accept that the management and monitoring of patient/client identification is a key component of their role and is an ongoing process rather than an activity which takes place only at initial contact.

…

Appendix 1

2.0 First contact

Ensuring that the Trust secures the correct patient and client identification information begins at first contact. It is the responsibility of all staff, i.e., clinical and

[19] That is, unable to confirm their identity / details due to intubation or loss of consciousness

administrative, at the first contact to elicit the correct information from the patient/client and to detail the information on an appropriate health or social care record. Any anomalies or identification queries highlighted in relation patient/client details should be reconciled and clearly recorded.

3.0 Subsequent contacts
At subsequent contacts, e.g., at in-patient or out-patient facility or unit, it is the responsibility of the admitting staff to ensure the patient/client information recorded at first contact remains correct. If there are changes to the patient/client's biographical details these should be clearly and unambiguously recorded in the health or social care record.

3.1 Where a patient or client requires to be admitted to an in-patient facility or unit the admitting health care professional is responsible for ensuring that a patient/client identification wristband is applied. The patient/client must be advised as to the safety importance of wearing an identification wristband during his/her in-patient stay. The identification wristband must include the following information and must be written clearly in ballpoint pen: -

- *Patient/Client Name*
- *Date of birth*
- *Hospital number*
- *Gender*
- *Ward/Department'*

58. Paragraph 10 of the NMC Code is also relevant to this issue of complaint.

Response to investigation enquiries

59. In its response to the complainant on 4 January 2019, the Southern Trust said the Consultant Anesthetist (ICU) '*had sought an opinion from [Consultant Endocrinologist] with regards to the incorrect administration of Thyroxine. [Consultant Endocrinologist] confirmed that the administration of this drug would not have had any effect on your husband as it takes a significant amount of time to build up therapeutic levels of this drugs in your husband (sic.) system.'*

60. In response to enquiries made, the Southern Trust said '*at the time of admission to Craigavon Area Hospital there was never any doubt about the identity of [the patient]. The information within the medical notes and from Northern Ireland Electronic Care Record informed the Trust that [the patient] did have diabetes. There was further "evidence" to support this in that there was a list of medication with the name of [the patient] which included diabetic medication…'*

61. The Southern Trust also confirmed that the error '*only came to light after [the patient] had died.*' In respect of the care and treatment provided to the patient, the Southern Trust said '*insulin was administered as a matter of routine…it was emphasized to the family that insulin was given to [the patient] as part of normal Intensive Care Unit management and not in response to the wrong medical history.'*

62. The Southern Trust further stated '*the distress caused by the wrong death certification is especially regrettable'*

Discussion with Southern Trust staff

63. As part of the investigation of the complaint, the Investigating Officer had a telephone discussion with the Ward Sister in CAH ICU.

64. The Ward Sister advised that the stickers that arrived with the patient already had his H+C number on them. She said that as the patient was transferred from another hospital it was assumed that the patient transferred had the correct given identity. The Ward Sister advised there was a list of medications given by the Belfast Trust and this was later found to belong to the patient's son.

65. The Ward Sister also emphasised the change in process as a result of this complaint, specifically that there is a positive 'tick box' process followed in terms of identifying patients.

Clinical records

66. The patient's clinical records were analysed. It was noted that the records make no reference to the patient's son's prescription. It was also noted that the various

ICU records made by clinical and nursing staff, make reference to the patient being an insulin dependent diabetic.

Other Southern Trust records

67. The Southern Trust provided a 'Safety & Quality Learning letter' dated March 2018 (the learning letter). It referred to the patient as Patient A and referred to the other patient (with same name and similar date of birth) as Patient B, stating: '*Patient A received Patient B's medication in error, based on the incorrect medical history. This error did not result in any clinical harm or affect the eventual outcome for this patient.'*

68. The learning letter also stated '*this letter is being issued to highlight the importance of both checking and recording the correct patient identifiers on admission, transfer to a ward, department or to another other (sic.) hospital or healthcare facility…'*

69. I also note the Southern Trust issued a response to the complaint on 4 January 2019. The response referred to the patient's admittance to CAH and stated *'the staff at that time had no reason to question your husband's identity due to the HCN having been already established'.*

Relevant Independent Professional Advice

70. The IPA was asked to advise on the medications administered to the patient in CAH. The IPA provided a list of these and the reason for administration. The IPA identified that levothyroxine was administered to the patient and this is a treatment to regulate thyroid function levels.

71. The IPA further advised *'none of the drugs used to treat [the patient] during or following his cardiac arrest would have had an adverse interaction with his usual medications', and 'none of the treatment provided or drugs used to treat [the patient] during or following his cardiac arrest would have had an adverse impact on his prognosis'.*

Response to draft investigation report

72. In response to the sharing of the draft investigation report, the complainant said she wished to emphasise the number of occasions she and her family members were asked by CAH staff, if her husband was diabetic. The complainant said she cannot understand why the error was not detected then. The complainant also cited interactions with two clinicians from CAH which she said presented an opportunity to uncover the error.

Analysis and findings

73. I note that the patient was received by CAH on the morning of 12 November 2017. The clinical records reflect at that time, the patient's family had not yet arrived to the hospital and as the patient was intubated, staff were unable to verify his identity. I also note a staff member spoken to as part of the investigation stated that there was an assumption that as the patient was transferred from another hospital, the correct patient and identity were presented. The 2009 Identification Policy does not specify what action should be taken by staff if a patient is unable to verify his own personal details. However, it would seem reasonable to expect staff to verify these with the patient's next of kin at the earliest opportunity. The investigation found no evidence of attempted compliance with the 2009 Identification Policy, which notably refers to an ongoing duty on staff to ensure correct identity. The First Principle of Good Administration requires public bodies to 'get it right' by '*acting in accordance with the public body's policy and guidance'*. I am satisfied that this standard was not met in this case and I find the failure to comply with the 2009 identification policy amounts to maladministration. I therefore **uphold** this element of the complaint.

74. I note the complainant's account that staff in CAH checked with family members about the patient's identity. She emphasised this in her response to the draft investigation report. However, there is no reference within the clinical or nursing records of there being even a potential issue about the patient's identity. I also note the Southern Trust stated that the patient's son's prescription was found within the patient's notes and this supported the (incorrect) NIECR that the patient was diabetic. Further, there is no record made by staff in CAH, of the telephone call on 12

November 2017, informing the family of the presence of the son's prescription, as stated by the Southern Trust. The investigation found no evidence to counter the account provided by the complainant. I considered this in light of the provisions within the NMC Code. I find the failure to record the information provided by the family (that the patient was not diabetic) or note that the son's prescription was found within the notes, is contrary to the NMC Code and constitutes maladministration. Given the information now available, the failure presented as a lost opportunity to identify the error sooner. In the absence of another reasonable explanation, I conclude that the patient was administrated levothyroxine due to the error in identity. However, I note and accept the advice of the IPA that the medication administered by the Southern Trust had no bearing on his prognosis.

Injustice

75. I am satisfied that as a result of the failings I have identified, the complainant sustained the injustice of frustration, uncertainty regarding her late husband's care and treatment, and loss of opportunity to rectify the error at an earlier stage.

Issue 4: Was the NIAS investigation of the complainant's concerns, appropriate and in accordance with policy/procedure?

Detail of complaint

76. The complainant said that NIAS made no contact with her during the investigation. The investigation also considered NIAS' decision not to carry out its own investigation of the events occurring on 11 and 12 November 2017.

Legislation/Policies/Guidance

77. I considered the SAI procedure, the relevant extracts of which are contained in Appendix five of this report.

NIAS Response to investigation enquiries

78. NIAS stated that it had '*not previously dealt with this matter under [its] complaints process…on the 20 February 2018, NIAS received an Interface Incident*

Notification[20] from the Health and Social Care Board (HSCB)[21] advising that the Southern Trust had notified them of the above serious incident and were seeking clarification on whether NIAS would also be submitted (sic.) an SAI around the matter. We responded to the HSCB on the 18 April 2018 confirming that we would not be initiating our own SAI investigation but would contribute to the SAI process already initiated by the Southern Trust…given the amount of investigation that was already underway by the Southern Trust at that time, we were of the view that it would be unproductive to initiate a separate parallel process but did offer our support and input to the Southern Trust's ongoing investigation.'

79. NIAS also said '*I accept that communication with [the complainant] has neither been timely nor sufficient and I would apologise for this. However as shown… a letter of advice was issued and a meeting was offered.'*

80. NIAS was asked to provide further information regarding the support and input offered to the Southern Trust. NIAS said its Risk Manager '*offered support and input through the following communications:*

- *An email communication on 21 February 2018 to [Southern Health and Social Care Trust Governance Coordinator] requesting information regarding documentation in order to provide information to support the Serious Adverse Incident review;*
- *E mail communications on 27th February 2018 & 05 March 2018 to [Governance Coordinator] in relation to review and feedback regarding the learning letter drafted by the Southern Health and Social Care Trust.'*

NIAS Records

81. The records in respect of all three listed authorities were analysed and a chronology of was prepared and is contained at Appendix four to this report.

82. I was provided with the HSC Interface Incident Notification Form (the Interface Notification Form) (undated) which NIAS states it received on 20 February 2018. The Interface Notification Form states *'the SHSCT are sharing this as an interface*

[20] See paragraph 80
[21] The role of the HSCB in SAIs is explained in Appendix five

incident with NIAS and the BHSCT for investigation. I would be grateful if you would share your findings with the SHSCT as we plan to meet with the family in the near future.'

83. I was also provided with an email exchange between the HSCB and NIAS, following from when the Interface Notification Form was sent on 20 February 2018. I note an email from HSCB to NIAS sought a response by 27 February 2018. I note the HSCB sent a reminder email to NIAS on 5 March 2018, 5 April 2018 and 17 April 2018. On this date, NIAS responded stating *'…given the amount of investigation already undertaken by the Southern Trust I doubt if it would be productive to initiate a parallel process but we have already spoken to the Southern Trust Lead to offer our support and input.'*

84. Further, I was provided with an email exchange between NIAS and the SHSCT, the first of which is an email from NIAS on 21 February 2018 seeking further information. I also note that the SHSCT shared with NIAS a draft 'learning letter' for staff, which was approved by NIAS on 5 March 2018.

Analysis and Findings

85. The investigation established that NIAS was first made aware of this case when it received the Interface Notification Form from the HSCB on 20 February 2018. I note the purpose of the Interface Notification Form is to inform other HSC bodies of involvement in an incident, but also to allow staff to decide if an SAI investigation is required. I note on this occasion, NIAS decided that it would not initiate an SAI investigation. The HSCB was notified of the decision by email on 17 April 2018 and a reason for the decision was given. The investigation did not uncover why the response to the HSCB was delayed, requiring numerous follow up emails. I make an observation to NIAS to consider reinforcing to staff the importance of responding to such notifications promptly.

86. Apart from this email, the investigation found no other evidence of NIAS' consideration of whether to report the issue as an SAI. I also considered the reason cited by NIAS to HSCB for not reporting the issue as an SAI. I note that the reason provided is not within the considerations of the SAI procedure. The First Principle of

Good Administration, 'getting it right' requires public bodies to take *'reasonable decisions, based on all relevant considerations'*. The Third Principle of Good Administration, 'being open and accountable' requires public bodies to state the criteria for decision making and give reasons for decisions. I am satisfied that these standards were not met in this case. I cannot be satisfied that all relevant considerations were taken into account, and due to the failure to record considerations, I cannot conclude that the decision not to instigate an SAI, was reasonable. I consider the failure constitutes maladministration. I therefore **uphold** this element of the complaint. As a result of this failure, I am satisfied the complainant sustained the injustice of uncertainty.

87. I also note NIAS' position that it would contribute and did offer support and input to the Southern Trust investigation of the issue, in default of initiating its own SAI investigation. I note an email exchange between NIAS and the Southern Trust following its receipt of the Interface Notification Form. The correspondence was reviewed and found no evidence of contribution, support or input into the Southern Trust investigation. I note NIAS firstly asked the Southern Trust to share documentation on which incorrect information was shared. I also note that it indicated to the Southern Trust, agreement with a proposed learning letter which was shared. NIAS staff were not asked for statements in relation to their involvement, until the commencement of the investigation by my Office. The Interface Notification Form refers to continued uncertainty regarding what happened and I consider it would have been reasonable for NIAS to, at least, inform the relevant staff of the issue and record their accounts. The passage of time before doing so, meant that uncertainty remained and the opportunity was lost. Indeed, the continued lack of clarity regarding what occurred remains as evidenced in NIAS response to investigation enquiries[22]. I find that the failure on NIAS to carry out any investigation, contributed to the uncertainty which persists.

88. The complainant was concerned that NIAS did not contact her during its investigation and this investigation uncovered that the reason for this was due to NIAS not having taken any action after being made aware of the issue. I consider it

[22] Paragraph 16 refers

would have been good practice for NIAS to contact the complainant, confirming that the Interface Notification was received and its intention to contribute to the Southern Trust investigation. The Third Principle of Good Administration, 'being open and accountable' requires public bodies to take '*responsibility for its actions'*. I consider the failure to take any action following receipt of the Interface Notification Form, was a failure to meet this standard and constitutes maladministration. I am satisfied that as a result, the complainant now suffers the injustice of frustration regarding the NIAS process.

Issue 5: Was the BHSCT's investigation of the complainant's concerns, appropriate and in accordance with relevant policies, procedures and standards

Detail of complaint

89. The complainant said that she remained concerned that the Interface investigation was 'flawed'. She also said she was not made aware of communication between Trusts in an attempt to provide a robust response to her concerns and when the PCC requested a copy of the investigation report and interview notes carried out in Theatre Recovery, she was advised that interviews were not carried out but a discussion had taken place with staff.

Evidence considered

Legislation/policy/guidance

90. I considered the BHSCT AI procedure and in particular noted the following relevant extracts:

'1.0 LEVEL OF INVESTIGATION REQUIRED

The grading of an incident by severity and risk will determine the requirements for investigating that incident. All incidents will therefore be graded according to severity (actual harm/impact) and risk…

Depending on the grade of incident an appropriate level of investigation should be carried out. All levels of investigation require some degree of evidence gathering…

3.1 Record keeping

…a thorough record of all the investigation activity should be recorded in the appropriate field in Datixweb[23] or added as an attachment to the incident record…

3.2 Communicating with an involving patients / service users / families / carers

…the accountable person should ensure the appropriate level of involvement of patient / service user / family / carer throughout the investigation'

Response to investigation enquiries

91. The Belfast Trust confirmed *'this issue was not investigated under the Belfast Trust's complaint policy but as an interface incident investigation. The final response regarding the interface incident to [the patient] has been issued on 29 October 2019'*.

92. In response to the complainant's concern about staff interviews, the Belfast Trust said '*the Theatre Sister confirmed she had advised the PCC, that having spoken with all of the nursing team on duty, none of the staff could recollect a conversation with [the complainant] regarding her husband's date of birth. One staff member who was working in a different area, but who stopped to make the relatives tea, did recall saying to [the complainant] that she lived in the same general area but does not recall anything regarding a query over wrong details given…the Theatre Sister and Lead Nurse can both confirm that all the nurses listed in [the patient]'s Theatre care pathway were spoken to and no one could recall discussing the above details with [the complainant]'*

93. In its response to investigation enquiries, the Belfast Trust provided a chronology of the 'Adverse Incident Investigation'. I note reference to the Cardiology Manager (CM) seeking updates on 'staff interviews' on 8 November 2018 and further entries relating to this on 9 and 15 November 2018.

Belfast Trust records

94. The records in respect of all three listed authorities were analysed and a chronology of was prepared and is contained at Appendix four to this report.

[23] Belfast Trust computer system

95. The Belfast Trust provided a copy of a letter it sent to the HSCB on 7 March 2018 in response to the Interface Incident Notification. The letter stated '*I note this incident happened on 11th November 2017 and SHSCT should be asked why it is reporting it now, 3 months after the event'*. The letter also indicated that the Belfast Trust did not intend to report the event as an SAI or to undertake further SEA[24] as this *'is unlikely to establish any further learning other than that already identified by SHSCT'.*

96. The Belfast Trust also provided a telephone record of a call between the complainant and the ICC on 7 September 2018.

97. I note the correspondence from the Belfast Trust to the complainant dated 26 September 2018. The correspondence referred to the telephone call on 7 September 2018 and stated '…*I then detailed the Cardiac Cath Lab internal investigation and highlighted the actions we took as a collective team.*
1. Reinforced the three-point check policy with my team to ensure all patients' name, date of birth and address match with the documentation provided by the Ambulance services
2. If the team are unable to confirm the three-point check they must ring the Trust's Emergency Index to generate a unique patient identification number…
I have linked in with a colleague in the Theatre Recovery Unit to investigate further the interactions between your family and the nursing staff surrounding your husband's health records.' The correspondence also referred to a second telephone call between the Belfast Trust and the complainant on 26 September 2018.

98. I note in its correspondence to the complainant dated 29 October 2019, the Belfast Trust said the matter was investigated under its Adverse Incident procedure and outlined that the investigation was led by the CM who '*held two separate meetings with her staff to discuss your concerns. At these meetings, no staff could recall discussing [the patient]'s identity with the family…after [ICC] spoke with you in*

[24] Significant Event Audit – a level 1 review under the SAI procedure

September 2018 and heard your account of 12 November 2017, she again went back to her staff to see if anyone recalled speaking with you or a family member…'

99. The Belfast Trust provided a document entitled 'Interface Incident Investigation' which related to meetings on 10 and 14 August 2018. The record noted *'NIAS Flimsy had the wrong date of birth listed, which was used to attribute the CVIS patient record the night of [the patient]'s PPCI…there was still a discrepancy with the address in terms of the three point check'*. Under the heading 'What has been changed?' I note *'…the updated local unidentified patient protocol is up in the lab that is used for PPCI. All staff are aware of how to activate this pathway…'*

Southern Trust records

100. I note within the records provided by the Southern Trust, the Belfast Trust replied by email to the Interface Notification on 5 March 2018. The email stated *'we would wish to thank SHSCT for drawing the matter to our attention. This has enabled the Directorate to correct the records on their CVIS[25] system…'* I note that Southern Trust staff replied seeking confirmation of agreement with the learning letter on 9, 15 and 22 March 2018. I also note the Belfast Trust replied on 23 March 2018 stating the learning letter was shared with staff and on 28 March 2018 issued a further reply with suggested amendments to the learning letter.

Response to draft investigation report

101. In response to the sharing of the draft investigation report, the Belfast Trust said that its meeting with Cath Lab staff in August 2018 was arranged when 'the family took issue with the BHSCT response which was highlighted to the BHSCT in an email on 03/08/2018 and led the BHSCT to reopen the investigation.' The Trust also referred to the period of inaction between 26 September and 29 October 2019 and said '*this was due to the delayed reconciliation of the paper notes.'*

Analysis and findings

102. The investigation was informed that the Belfast Trust investigated the concerns under its AI procedure. I note from the records that the Belfast Trust were first made

aware of the issue when the Southern Trust shared the proposed learning letter on 5 February 2018. This was followed by the sharing of the Interface Notification Form on 20 February 2018. I also note the Belfast Trust notified both the HSCB and the Southern Trust of its decision not to initiate an SAI investigation and noted its reason for this. However, the investigation did not uncover evidence of Belfast Trust's consideration of this issue, in particular what factors were considered in reaching this decision. The First Principle of Good Administration, 'getting it right' requires public bodies to take *'reasonable decisions, based on all relevant considerations'*. The Third Principle of Good Administration, 'being open and accountable' requires public bodies to state criteria for decision making and give reasons for decisions. I am satisfied that these standards were not met in this case. I consider the failure constitutes maladministration. As a consequence I cannot be satisfied that all relevant considerations were taken into account, and due to the failure to record considerations, I cannot conclude that the decision was reasonable. As a result of this failure, I am satisfied the complainant sustained the injustice of uncertainty.

103. I also note that Belfast Trust decided to consider the issue under its AI procedure. The investigation did not uncover evidence of when this decision was taken and the reasons for it. I note an email to the Southern Trust dated 27 April 2018, wherein the Belfast Trust indicated it would have 'no findings' to share with the complainant. I note the first action taken by the Belfast Trust was in August 2018 when a meeting of cath lab staff took place. I note the Belfast Trust said this was following an indication that the family took issue with the previous response issued. The investigation did not uncover evidence of this email or reveal any steps taken by the Belfast Trust in the period between April 2018 and August 2018 or why an AI investigation was not commenced in February 2018 when it was first notified. Further, the investigation did not uncover a 'grading' of the investigation, as required by the BHSCT AI procedure. I consider that the failure to record reasons for the decision to initiate an AI investigation, and failure to grade the investigation is contrary to the BHSCT AI procedure. The First Principle of Good Administration, 'getting it right', requires public bodies to act in accordance with its policy and guidance. I am satisfied that this standard was not met and the failure constitutes maladministration. I am satisfied that as a result of this failure, the complainant sustained the injustice of uncertainty.

104. I also note that when the decision was taken to commence an investigation, certain actions were taken and recorded by the Trust. One of the actions was a telephone call between the ICC and the complainant, of which a note was made. However, I also note the letter to the complainant from the Belfast Trust dated 26 September 2018 makes reference to a further telephone call on the same date. The investigation did not uncover a corresponding note in relation to this telephone call. Therefore, I was unable to determine the importance of any information shared in that telephone call. Further, I note within the 'chronology of Adverse Incident Investigation, the Belfast Trust outlined steps taken by the ICC such as seeking updates on staff interviews, and reference to discussions with staff. The investigation did not uncover evidence of these actions. When the complainant sought evidence of these, they were not available. As a result, the complainant lost faith in the investigative process. The importance of record keeping in the investigative context is outlined in the BHSCT AI procedure and also in the Third Principle of Good Administration 'being open and accountable'. I therefore find the failure to take a full and appropriate record of the actions taken in the AI investigation, constitutes maladministration. I am satisfied that as a result of this failure, the complainant sustained the injustice of uncertainty regarding the investigative process.

105. Finally, I note the Belfast Trust issued a final response to the complainant on 29 October 2019 which constituted the 'outcome' of its AI investigation. I found no evidence of actions taken by Belfast Trust staff in the period from 26 September 2018 (letter from ICC) and 29 October 2019. I note in response to the draft investigation report, the Trust said this was due to a delay in reconciliation of the paper notes. I was unable to establish a record or evidence of this. The Second Principle of Good Administration, 'being customer focused' requires public bodies to '*deal with people helpfully, promptly and sensitively, bearing in mind their individual circumstances'*. I am satisfied that this standard was not met given the unreasonable delay in the Belfast Trust issuing its final response to the complainant, and the failure constitutes maladministration. I am satisfied that as a result of this failure, the complaint sustained the injustice of frustration, which added to the uncertainty already experienced by her in relation to the Belfast Trust investigation. I therefore **uphold** this element of the complaint.

Issue 6: Was the SHSCT's investigation of the complainant's concerns, appropriate and in accordance with relevant policies, procedures and standards?

Detail of complaint

106. In respect of the Southern Trust, the complainant again said that she was concerned the Interface Investigation was 'flawed' as the reference number identified the wrong Trust. She also said the family were not made aware of communication between Trusts in an attempt to provide a robust response.

Evidence considered

Legislation/policy/guidance

107. The extracts from the SAI procedure Appendix five are also relevant to this issue of complaint.

Response to investigation enquiries

108. The Southern Trust said '*at the outset the Southern Trust would like acknowledged that the case…was never recorded as an SAI but was forwarded to the Health and Social Care Board as an interface incident with the Belfast Health and Social Care Trust. The Belfast Health and Social Care Trust were to review this as an SAI.'*

109. The Southern Trust also said that staff '*met with the family on 17th November 2017 to inform the family of the error and met again with the family on 7 December 2017.* The Trust further stated *'a letter summarising the progress was sent to [the complainant] (dated 13th June 2018). This had been requested by [patient's son] after a telephone update.'*

Southern Trust records

110. The records in respect of all three listed authorities were analysed and a chronology of was prepared and is contained at Appendix four to this report.

111. The Southern Trust provided a copy of a letter the ICU Consultant sent to the complainant on 13 June 2018[26]. I note the letter stated '*The Southern Trust has investigated the incident and has forwarded the information to the Belfast Trust to continue the investigation. [BHSCT Governance staff member] is the manager in the Belfast Trust who is continuing to investigate this incident. He has agreed to contact you in due course with the findings of their investigation….'*

112. I also note the Southern Trust issued a response to the complaint on 4 January 2019. The response said *'…unfortunately due to a failing during the admission process of your husband to the Royal Victoria Hospital and subsequent transfer to Craigavon Area Hospital, significant flaws in the system have been identified. I have attached the Learning letter from the investigation which shows the flaws and learning from this incident…'*

Clinical Records

113. I note within the clinical records, a note of the meetings which took place between Southern Trust staff, and the complainant and her family on 17 November 2017 and 7 December 2017.

114. I note the record of the meeting on 17 November 2017 stated '*I have reassured [complainant] we are going to investigate how this mistake was made…'*

115. I also note the record of the meeting on 7 December 2017 stated '*…they had a lot of questions around [unclear] meds listed in both ED and NIAS records – I had no explanations for this but said it would try to answer these questions…'*

Response to draft investigation report

116. In response to the sharing of the draft investigation report, the complainant said when her son first contacted CAH regarding the error identified when registering the death, he was made to feel that he was being accused of telling lies about his father's condition.

[26] It is noted that the letter refers to an unrelated Trust in the Incident reference number, referred to by the complainant

Analysis and findings

117. I note the Southern Trust was the first of the three authorities to become aware of an issue with the patient's H+C number. I note that clinical staff treating the patient met with the family on two occasions in 2017 (17 November and 7 December) to discuss what had happened and any impact on the patient's care. I also note the next action taken by the Southern Trust was the sharing of the proposed learning letter with the Belfast Trust on 5 February 2017. The investigation did not uncover what, if any, actions were taken in that intervening period that would account for the delay in sharing the Interface Notification. The SAI Procedure outlines the requirement to act '*in a timely manner'* in relation to incidents involving other HSC bodies. I find that the Southern Trust's failure to act promptly in this regard, is contrary to the SAI procedure and constitutes maladministration. I am satisfied that as a result of this failing, the complainant sustained a loss of opportunity in having the issue considered more expeditiously by all three authorities involved. I also make an observation that the lack of a date on the Interface Notification Form made reconciling the chronology across all three listed authorities, more difficult.

118. I note the complainant was provided with an expectation of an investigation during the meeting on 7 December 2017. I further note that a letter was issued to her on 13 June 2018, to provide an update on the investigation. In this letter, the complainant was informed that the Southern Trust forwarded the information to the Belfast Trust 'to continue the investigation'. I note from the records provided by the Southern Trust that the Belfast Trust informed staff on 27 April 2018 that it would not have any further findings. I also note the Southern Trust issued its final response to the complainant on 4 January 2019. In this response, the Southern Trust said the failing occurred in the admissions process in the RVH. The investigation was unable to uncover the source of this information, as there is no evidence of Southern Trust discussing the detail of the incident with either the Belfast Trust or NIAS. The Third Principle of Good Administration, 'being open and accountable' requires public bodies to be *'open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.'* I am satisfied that this standard was not met by the Southern Trust in its communication with the complainant, due to the inaccurate information outlined above. I find that this

failure to provide accurate information to the complainant, constitutes maladministration. I am satisfied that as a result of this, the complainant sustained the injustice of frustration due to receiving conflicting information. I therefore **uphold** this element of the complaint.

Injustice

119. I *am satisfied that as a result of the failings I have identified, the complainant sustained the injustice of uncertainty regarding the investigation, and frustration.*

Interaction between the three listed authorities (Issues 4, 5 and 6)

120. My consideration of the accuracy of the information provided to the complainant prompted me to consider the interaction between the three listed authorities involved in this complaint and the information shared. I was disappointed to find the limited communication between the three authorities. The investigation found little evidence of a collaborative approach to the concerns raised. I acknowledge that a meeting took place between NIAS and the Belfast Trust some 11 months after the error became apparent. Further, the investigation found no evidence of any of the three authorities 'leading' the investigation or response as envisaged by the SAI procedure. As a result, each listed authority acted independently in responding to the concerns, with each taking its own decision as outlined in this report. I also found that each listed authority focused heavily on the learning to be gained from the complainant's experience. Whilst this is undoubtedly extremely important, the complainant was also concerned with how the error was made, a concern which prompted her bringing a complaint to my Office. An example of this is in NIAS' response to investigation enquiries that there was no further learning from NIAS' perspective[27].

121. The failure of the three listed authorities to work collectively in investigating what occurred on 11 and 12 November 2017 and why, left the complainant with unanswered questions. She was required to correspond with each listed authority separately and even then, the communication from the listed authorities was poor[28]. My investigation found that the focus on the complainant's distressing experience, at

[27] Paragraph 18 refers
[28] See points on accuracy and timeliness

the heart of this case, was lost in the ineffective workings of the three authorities. I found no evidence of a consistent approach of openness and honesty as outlined by SAI Procedure. I also found the lack of collective engagement with the complainant from the three authorities involved in the investigation, was contrary to the SAI Procedure. Notably, the complainant was not informed of the structure of the investigation undertaken and there was inadequate communication with the complainant about processes and timescales. The Second Principle of Good Administration requires public bodies to be 'customer focused' by '*responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers'*. I find that each of the listed authorities failed to meet this standard and the failure constitutes maladministration.

Issue 7: Was NIAS handling of the complaint appropriate and in accordance with relevant policies, procedures and standards?

Detail of complaint

122. The complainant said she experienced difficulties in making contact with NIAS about her complaint as staff didn't respond, and there was a delay in acknowledging her complaint.

Evidence considered

Legislation/Policies/Guidance

NIAS complaints policy

123. I considered the NIAS complaints policy. In particular I noted the following relevant extracts:

'Objectives

1.10 *to ensure responses to complaints are timely whilst being comprehensive, accurate and open with an emphasis on early resolution of the complaint;*

…

1.13 *to ensure all complaints are dealt with in accordance with the Procedure…'*

124. I also considered the HSC complaints procedure and noted the following relevant extracts:

*'**2.1** A complaint is "an expression of dissatisfaction that requires a response". Complainants may not always use the word "complaint".*

…

***3.17** A complaint should be acknowledged in writing within 2 working days of receipt*

…

***3.19** It is good practice for the acknowledgement to be conciliatory, and indicate that a full response will be provided within 20 working days*

…

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

NIAS Response to investigation enquiries

125. NIAS stated '*I can advise that we were contacted on 14 August 2018 by the Patient and Client Council (PCC) who were acting on behalf of [the complainant] in relation to the late [patient]. We wrote to [the complainant] directly on the 17 October 2018, to provide some information around the investigation process and to advise that we had received a request for her late husband's clinical notes. On 25 October 2018, we provided a copy of [the patient]'s patient report form (PRF) and a copy of the call incident log as requested. We were contacted again by the PCC on the 7 November 2018 regarding a further request for information which we responded to on 5 March 2019. We also offered to meet [the complainant] at this point.'*

126. NIAS offered an apology for the poor communication that the complainant received.

NIAS Complaints Records

127. I considered the case chronology contained at Appendix four of this report.

128. I note on 14 August 2018, the PCC sent an email to NIAS on the instruction of the complainant and requested NIAS provide information in relation to three issues, one of which was '*what action NIAS has or intends to take in relation to this incident*'. The letter also sought disclosure of the 999 call transcript and a copy of the PRF.

129. I also note NIAS sent a letter to the complainant directly on 17 October 2018. This letter contains an apology *'for not providing a response to outstanding matter in a timelier manner'* and stated '*I can advise that the interface incident is being investigated by the Southern Trust along with the Health and Social Care Board. NIAS have been cooperating with this investigation by providing support and advice'*.
130. Finally, I note the complainant was provided with copies of the documents requested on 25 October 2018[29].

Analysis and Findings

131. I note the complainant was dissatisfied with the response she received from NIAS when she 'made a formal complaint'. However, I also note that NIAS did not treat the complainant's initial contact on 14 August 2018 as a complaint and no complaints investigation was initiated.

132. I considered the NIAS complaints policy and the HSC complaints procedure. I conclude that the PCC email did not contain an expression of dissatisfaction and therefore the decision not to consider the email under the complaints policy, was correct. However, the investigation is aware that at that time (August 2018), NIAS was aware via the Interface procedure[30] of the distressing outcome for the complainant and her family due to the error made. Notwithstanding that the NIAS complaints procedure was not invoked.

133. Finally, I considered the content of the communication between NIAS and the complainant. I note in the letter to the complainant dated 17 October 2018, NIAS informed the complainant that the interface incident was being investigated by the Southern Trust and NIAS were providing support and advice in relation to this. The correspondence highlighted again the lack of collaborative working between the three listed authorities involved. I am aware from the records that the Southern Trust informed the complainant on 13 June 2018 that the complaint had been 'forwarded' to the Belfast Trust. Further, the investigation did not uncover evidence of NIAS

[29] The investigation did not consider NIAS actions in respect of the complainant's requests for information. Such matters are within the jurisdiction of the Information Commissioner's Office
[30] Considered under issue four

providing support and advice to the investigation, with the exception of approving the proposed learning letter.

134. The Second Principle of Good Administration, 'Being Customer Focused', requires public bodies to deal with complainants '*helpfully, promptly and sensitively, bearing in mind their individual circumstances'.* The Third Principle of Good Administration, 'being open and accountable' requires public bodies to '*information and any advice provided is clear, accurate and complete'*. In consideration of the two month timeframe to respond to the complainant's request, and the explanation provided to the complainant in the response, I am satisfied that these standards were not met by NIAS. I find that the failure to provide a clear and accurate response may have misled the complainant. I find that these failures constitute maladministration. I am satisfied that as a result of these failings, the complainant suffered the injustice of frustration and uncertainty. I note the complainant also said that making contact with NIAS was difficult. I therefore **uphold** this element of the complaint.

CONCLUSION

135. I received a complaint about the actions of NIAS, the Belfast Trust and the Southern Trust in relation to actions taken in the recording of the patient's personal details and subsequent allocation of his H+C number. This was an extremely distressing incident for the patient's family coming to light as it did when they were preparing for the patients funeral. While in this particular case the error did not lead to harm to the patient and did not affect his prognosis if it were repeated for another patient that may not be the case. This is not to diminish the clear concern of the complainant about the impact the error may have had on the patient. I was shocked by the lack of co-ordination in investigating this incident and the misinformation provided to the complainant. This incident required agreement between the three organisations as to who would take the lead in investigating the incident and for the other two organisations to co-operate with and assist that investigation. I did not find that to be the case. I also consider there to have been a delay in achieving the learning from this serious incident. The lack of clear records of decisions and the

reasons for them made this investigation much more difficult than it should have been and was clearly not in accordance with relevant standards.

136. I found maladministration in relation to the following matters:

NIAS

- Failure to record consideration of whether to report matter as an SAI (paragraph 86);
- Failure to act following receipt of Interface Notification Form (paragraph 88);
- Failure to respond promptly to the complainant's request dated 14 August 2018 (paragraph 130), and
- Failure to provide accurate and clear information to the complainant (paragraph 130).

Belfast Trust

- Failure to check the patient's identity in accordance with the 2016 patient identification policy (paragraph 52);
- Failure to record information provided by the complainant in clarification of the patient's information (paragraph 53);
- Failure to record consideration of whether to report matter as an SAI (paragraph 102);
- Failure to record reasons for the decision to initiate an AI investigation, and failure to grade the investigation (paragraph 103);
- Failure to make a record of all actions taken in the AI investigation (paragraph 104), and
- Delay in issuing a final response to complainant (paragraph 105).

Southern Trust

- Failure to check the patient's identity in accordance with the 2009 Identification Policy (paragraph 73);
- Failure to record information provided by the family about the patient's past medical history (paragraph 74);
- Failure to share the Interface Notification Form in a timely manner (paragraph

117), and

- Failure to provide accurate information to the complainant (paragraph 118).

137. I also found that all three listed authorities failed to carry out a co-ordinated investigation and response to the complainant.

138. I am satisfied that the maladministration I identified caused the complainant to experience the injustice of uncertainty, frustration and loss of opportunity.

139. I also made a number of observations in my consideration of this complaint:

- NIAS should consider how the issue of removing patient's prescriptions could feed into its next review of the PRF policy
- NIAS to consider reinforcing to staff the importance of responding to Interface Notifications promptly
- Southern Trust to be mindful of including the date on interface notification forms

Recommendations

140. I make the following recommendations:

- The Chief Executives of NIAS, the Belfast Trust and the Southern Trust, provide the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the maladministration/failures identified (within **one month** of the date of my final report)

- The Belfast Trust (cath lab) and the Southern Trust (ICU) carry out a random audit of patient records within the last 2 years. The audit should consider if there is evidence of implementation of new measures in place in demonstrating correlation between the patients name, date of birth and address.

- NIAS, the Belfast Trust and the Southern Trust provide focused training to relevant staff regarding the importance of record keeping in the context of SAIs

and in particular Interface reporting. Staff should also be reminded of the important role played by patients and their families in this context.

141. I recommend that the listed authorities implement an action plan to incorporate these recommendations and should provide me with an update within **six months** of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self declaration forms which indicate that staff have read and understood any related policies).

142. I note the opportunity for learning identified by the IPA. I would ask the Southern Trust to reflect the role of the pharmacist within the ICU team in drug reconciliation, as part of the patient identification process.

143. Given the lack of co-ordination in this case and the failure to properly and fully investigate the issues that lead to the error and the missed opportunities to identify these I intend to provide a copy of this report to the HSCB which has a regional role in SAIs. This is to ensure it is aware of the issue and involved in considering how best issues identified can be addressed

MARGARET KELLY
Ombudsman **February 2021**

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.