Investigation Report

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

NIPSO Reference: 17178

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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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

Reporting in the Public Interest

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

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

TABLE OF CONTENTS

EXECUTIVE SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) regarding the care and treatment provided to the complainant's late father at the Royal Victoria Hospital between 28 November 2011 and 15 December 2011.

Issues of Complaint

I accepted the following issues of complaint for investigation:

- **Issue 1: Was the care and treatment provided to the patient appropriate and reasonable?**

- **Issue 2: The Trust's investigation of the complaint about the patient's care and treatment**

Findings and Conclusion

The investigation of the complaint identified a failure in the care and treatment in respect of the following matters:

- Failure to appropriately administer fluids in the period between 7 December 2011 and 13 December 2011;
- Failure to keep the decision of transfer to the High Dependency Unit/ICU under review; and
- Failure to consider a DNACPR order prior to 13 December 2011.

The investigation identified maladministration in respect of the following matters:

- Failure to have an appropriate discussion with the family following a DNACPR order being made;
- Failure to communicate that the patient was no longer a candidate for HDU/ICU;
- Failure to record reasons why the time limit for accepting complaint was extended;
- The designation of the complainant's concerns as an 'enquiry';
- Failure to inform the complainant that her concerns were being treated as an 'enquiry';

- Failure to keep records of telephone calls; and
- Failure to respond to the complainant's concerns in a timely manner.

I have not found a failure in care and treatment or maladministration in respect of:

- The decision not to transfer the patient to HDU or ICU; and
- The decision not to carry out a further independent review of the patient's care and treatment during the complaints process

Recommendations

I recommended:

- The Chief Executive of the Trust provide the complainant with an apology for the failings identified, within one month of the date of my final report; and
- The Trust make a payment of £1500 by way of solatium for the injustice of distress, upset, uncertainty and frustration;

I considered there were a number of lessons to be learned which provide the Trust with an opportunity to improve its service, and to this end I recommended that they:

- Provide training to complaints staff regarding the requirement for record keeping, in particular in relation to telephone calls and where the time limit for accepting complaints is extended;
- Reconsider the practice of deciding to treat certain complaints as 'enquiries', in particular how time is managed and how the decision is communicated to the complainant; and
- Provide training to relevant staff of the content of the joint statement and the human rights based approach.

I am pleased to note that the Trust accepted my findings and recommendations.

THE COMPLAINT

1. The patient was admitted to the Royal Victoria Hospital through its Emergency Department (ED) on 28 November 2011 complaining of a painful right knee. Following an examination, he was admitted for an arthroscopic wash out[1] of his knee to be carried out. He also presented with jaundice and evidence of decompensated alcoholic liver disease and so his care was managed by a Consultant Hepatologist. He sadly passed away at the hospital on 15 December 2011. The patient's daughter complained about the care and treatment provided to him during his time in the hospital. In particular, she complained about the management of his fluids, that a DNACPR Order[2] was put in place, and that he was not transferred to another ward. She also complained about how the Trust dealt with her complaint.

Issues of complaint

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

Issue 1: Was the care and treatment provided to the patient at the hospital appropriate and reasonable?

Issue 2: Did the Trust adequately investigate the complaint?

INVESTIGATION METHODOLOGY

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

[1] A procedure to remove infection using a viewing tube
[2] Do Not Attempt CardioPulmonary Resuscitation Order: this is a patient management tool which reflects a clinical decision taken that CPR is not to be attempted in relation to a particular patient

Independent Professional Advice

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

- A Consultant Hepatologist (HIPA)
- A Registered General Nurse (NIPA)

5. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with 'advice'. However how I have weighed this advice, within the context of this particular investigation, is a matter for my discretion.

Relevant Standards

6. In order to investigate complaints of maladministration and failures in care and treatment I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

The general standards are the Ombudsman's Principles:

- The Principles of Good Administration[3]
- The Principles of Good Complaints Handling
- The Public Services Ombudsmen's Principles for Remedy

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

The clinical and operational standards relevant to this complaint are:

- European Association for the Study of Liver (EASL) clinical practice guidelines on the management of ascites, spontaneous bacterial

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

peritonitis, and hepatorenal syndrome in cirrhosis' (2010) (the EASL guidelines);

- 'Revised consensus recommendations of the International Club of Ascites' contained within an article in the Journal of Hepatology (2015);
- 'Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, Journal of Medical Ethics (2011);
- General Medical Council (GMC) 'Good Medical Practice' (2006);
- 'Treatment and care towards the end of life: good practice in decision making', GMC (2010); and
- The European Society for Clinical Nutrition and Metabolism (ESPEN) Guidelines on Enteral Nutrition: Liver disease (2006) (the ESPEN guidelines).

8. I have not included all of the information obtained in the course of the investigation in this report. However, I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

MY INVESTIGATION

Issue 1: Was the care and treatment provided to the patient appropriate and reasonable?

Detail of Complaint

9. The complaint related to the following aspects of the patient's care and treatment:

(i) the management of his fluid;
(ii) that a DNACPR Order was put in place; and
(iii) the failure by the Trust to move him to either a High Dependency Unit (HDU) or Intensive Care Unit (ICU).

I will address each of these areas of concern below.

The Trust's management of fluids

10. I refer to section 5.4 of the EASL guidelines which relates to the management of hepatorenal syndrome (HRS)[4]. I have considered the following extract which is relevant:

'Recommendations - Monitoring: Patients with type 1 HRS should be monitored carefully. Parameters to be monitored include urine output, fluid balance, and arterial pressure, as well as standard vital signs. Ideally central venous pressure should be monitored to help with the management of fluid balance and prevent volume overload…

Drug therapy of type 1 hepatorenal syndrome - Terlipressin[5]…in combination with albumin[6] should be considered the first line therapeutic agent for type 1 HRS

Contraindications to terlipressin therapy include ischemic cardiovascular diseases. Patients on terlipressin should be carefully monitored for…and fluid overload, and treatment modified or stopped accordingly.'

11. As part of investigation enquiries, the 'Revised consensus recommendations of the International Club of Ascites' contained within an article in the Journal of Hepatology (2015) were considered, which state *'We recommend that patients with cirrhosis[7] and ascites[8] with initial … stage 1 [acute kidney injury (AKI)] should be managed as soon as possible with the following measures:*

[4] Medical condition that consists of rapid deterioration in kidney function
[5] Medication for treatment of low blood pressure
[6] Human Albumin Solution – a fluid preparation containing proteins
[7] A condition of the liver arising from long-term damage to its cells
[8] Excess fluid in the peritoneal cavity (the space between the 2 layered membrane that lines the inside of the abdominal wall

12. *1) Review drug chart: review of all medications (including over-the-counter (OTC) drugs), reduction or withdrawal of diuretic therapy, withdrawal of all potentially nephrotoxic[9] drugs…*

    2) Plasma volume expansion in patients with clinically suspected hypovolaemia[10] (with crystalloids or albumin or blood …) according to clinical judgment.

    3) Prompt recognition and early treatment of bacterial infections when diagnosed or strongly suspected.'

13. I refer to the GMC document 'Good Medical Practice' published in 2006 (updated in 2013) which '*describes what is expected of all doctors registered with the GMC*'. Standard 2 (a) states that good clinical care must include '*adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient.'* I refer to standard 1 (b) which states you must '*provide or arrange advice, investigations or treatment where necessary'.* I also refer to Standard 1 (c) of the guidance which states you must *'refer a patient to another practitioner when this serves the patient's needs.* Standard 3 (c) states that '*in providing clinical care you must: provide effective treatments based on the best available evidence.'*

14. The Trust was given an opportunity to comment on the issue of fluid management. They stated *'the Independent expert witness commissioned by the Trust commented that fluid management was appropriate.'* The Trust also referred to a report which was prepared by the Consultant Hepatologist who treated the patient, which was prepared in the context of legal proceedings. I am unable to disclose the contents of that document by virtue of section 47 of the 2016 Act.

15. I have examined the patient's clinical records. I note that he attended the Emergency Department of the Royal Victoria Hospital on 27 November 2011 with the presenting complaint noted as *'knee injury*.'

[9] Causing toxicity in the kidneys
[10] An abnormally low volume of blood in the circulation

16. I note from the records that he underwent a procedure to *'wash out'* the infection in his knee on 28 November 2011.

17. The evidence contained in his 'Daily Fluid Balance and Prescription Sheets' as well as 'Standard Observation Charts' for each day on which he was a patient in the hospital, records on 3 December 2011 that (following a ward round) *'Plan…IV fluids to supplement oral intake given drowsiness.'* I also note on 9 December 2011 an entry made during a review by a surgical core trainee doctor records *'O/E [on examination] drowsy, appears comfortable, jaundice, dehydrated…'.* On 10 December 2011, the Consultant Hepatologist noted that the patient's presentations were *'urinary Na [sodium] – if ≤ 30 please commence HRS protocol (terlipressin + albumin)'.* An entry made on 11 December 2011 by the Consultant notes the patient was *''jaundice*[11] *+++ / Dry'.*

18. On 13 December 2011 at 9.35 it is noted during a ward round by the Consultant and a second Consultant Hepatologist that the plan for the patient was *'if echo [echocardiogram] show satis CXF [chest xray film] can try albumin and terlipressin'.*

19. On 13 December 2011 at 16.30 it is recorded that *'note echo report…LV [left ventricular] function satisfactory. P* [plan] *commence Albumin and terlipressin'*

20. The HIPA advised on the patient's condition between 28 November 2011 and 2 December 2011. The HIPA advised *'despite treatment for his sepsis*[12] *and fluid resuscitation [the patient's] renal function deteriorated during this period. By December 1st his serum creatinine*[13] *had risen from a baseline of 51 umol/l to 101 umol/l with a rise in serum urea*[14] *from 3.7 mmol/l to 12.3 mmol/l.'*

21. The HIPA advised that the patient's fluid intake and output was measured using fluid balance charts and that use of fluid balance charts was appropriate. The HIPA also

[11] Yellowish pigmentation of the skin due to high bilirubin in the blood. Jaundice is the chief sign of many disorders of the liver
[12] Infection of wound or body tissue
[13] A type of blood test to measure creatinine (waste product usually from muscle activity) in the blood. This test is used to indicate kidney function
[14] A type of blood test to measure urea (waste product) in the blood

advised that *'the records indicate that the clinicians used fluid balance charts in conjunction with laboratory parameters to monitor [the patient's] renal function.'*

22. The HIPA further advised that the patient was not placed on a fluid challenge[15] and stated *'on December 7th when his blood urea rose…no fluid challenge was given, although in the evening, intravenous saline was commenced at a rate of 83 ml/min…the following day a total of 1815 mls of fluid was given intravenously and on December 9th 1281 mls…During the day time of December 11th intravenous fluids were suspended due to no intravenous access but restarted at 22.00 hrs…His serum urea was 30 mmol/l by December 12th. Thus the rate and discontinuous nature of intravenous fluid administration was not appropriate or reasonable in the context of progressive uraemia. Either the rate of intravenous saline should have been increased…or if fluid overload was a concern then a challenge with intravenous 20% human albumin solution.'* The HIPA further advised *'the rationale for no daytime intravenous crystalloid fluids or intravenous 20% HAS [Human Albumin Solution] was not recorded...in a patient with progressive uraemia I would have expected intravenous fluids to continue throughout the day."*

23. The HIPA also advised that '*According to European guidelines from 2010 and 2015[16] and accepted standard practice for acute kidney injury in cirrhosis over the last decade, the initial treatment is to withdraw nephrotoxic drugs (gentamicin* [antibiotic] *stopped), treat any infections (septic arthritis in this case) and plasma volume expansion with appropriate fluids. If renal failure progresses, volume expansion with salt poor human albumin solution…should be instigated with assessment of response at 48hrs (not done in this case).'* The HIPA further advised that the EASL guidelines regarding the monitoring of patients with HRS would apply to a patient with AKI and cirrhosis.

24. The HIPA was asked if the patient's fluid balance had any effect on his renal function. The HIPA advised *'probably yes in conjunction with the initial sepsis from his knee and possible nephrotoxicity from gentamicin therapy.'* The HIPA further advised *'his prognosis was adversely affected by progressive liver failure and sepsis.*

[15] A fluid challenge is a target fluid input/output for any one day
[16] Appendix four refers

However since the liver failure could not specifically be treated…and his sepsis was controlled after his knee was washed out on December 1st, reversal of intravascular[17] fluid depletion would have improved his prognosis.'

25. The HIPA advised *'on December 11th the patient on the ward round was noted to be "dry" but there was a concern that he may have cardiac dysfunction as he had an enlarged heart on chest radiography…'* The HIPA stated that on 13 December 2011 it was decided to *'treat his renal failure with human albumin solution and terlipressin…'* The HIPA advised terlipressin was commenced on 13 December 2011 and HAS was commenced on 14 and 15 December 2011. The patient sadly passed away on 15 December 2011 at 21.55.

26. The HIPA was asked to clarify how fluid balance was related to the patient's kidney failure. The HIPA advised *'serum urea is a surrogate measure of renal function. Serum creatinine (a better indication of renal function) was not measured because severe jaundice interferes with the biochemical test for serum creatinine.'* The HIPA provided a chart showing daily fluid input plotted against renal function. The HIPA further stated *'relatively low fluid intake would be a contributor [to kidney failure] but as stated earlier not the sole cause of progressive renal failure.'*

27. The Trust was given an opportunity to comment on the HIPA advice. In response, the Trust stated *'[The Consultant] feels it is…unreasonable that literature published following the death of the patient should be considered…'* The Trust also commented *'whilst there is understandable attention being given to fluid balance, [the Consultant] feels it is important this should be viewed in the context of the progressive liver failure the patient was suffering. By 4th December [the patient] had progressive jaundice, hepatic encephalopathy[18] and persistent coagulopathy[19]…there has been much literature and debate worldwide as to whether severely ill patients should be given excessive volumes of supplementary fluids or not (the terminology used is "run wet" or "run dry"). There are many publications supporting both approaches and the issue continues to be the subject of debate. It*

[17] Associated with blood vessels
[18] Any disorder affecting the brain
[19] A condition that affects the way the blood clots

is however important that fluid management is tailored to each individual patient and [the Consultant] would take the opportunity to point out a chest x-ray report that appears to have been overlooked in the IPA report…taken on 29th November and reported on 30th November reads "Even allowing for technique the heart appears enlarged and pulmonary vascular congestion consistent with cardiac failure"…to be clear [the patient] had excessive fluid within the tissue of his lungs and the radiology report indicated he had an enlarged heart. In [the Consultant's] opinion, further fluid challenges would have been high risk.'

28. The Trust further commented that *'the cause of renal failure was multi-factorial however if dehydration was the predominant cause, the urinary sodium level checked on 10th December would have been expected to have been significantly supressed...'*

29. Finally, the Trust stated *'Human Albumin solution was not used as a standard of care in the RVH liver unit for fluid resuscitation in 2011…the 2010 guideline quoted by the IPA recommended use of albumin in cirrhotic[20] patients with concurrent ascites. [The patient] first developed only a tiny skiff of ascites detected by ultrasound only on 7th December…'*

30. The HIPA was provided with the Trust's comments and asked to advise further on the issues raised by it. The HIPA stated *'with regard to the treatment of acute kidney injury in liver disease, guideline references from 2010 & 2015 were used but these were simply revision of guidance from 2007'.*

31. The HIPA also referred to 2007 guidance provided by the International Ascites Club and stated *'thus in 2011 most hepatologists in the context of acute kidney injury in a patient with liver disease would ensure adequate circulating volume with human albumin solution (or if dehydrated appropriate crystalloids) and then a trial of terlipressin. Indeed, terlipressin and human albumin solution infusion was commenced later in this gentleman's admission.'* The HIPA also stated that they *'had noted the gentleman's abnormal chest radiology but also his normal*

[20] Suffering from cirrhosis

echocardiogram, which perhaps calls into question whether he had pulmonary congestion…I thus find it difficult to explain why [the patient] was not given a therapeutic dose of intravenous 20% human albumin solution on the basis of…guidelines from 2007, declining renal function and clinical assessment of dehydration.'

32. The HIPA was also asked to comment on the statement that it was not the policy of the hospital liver unit to use HAS at the time of the patient's care and treatment. The HIPA stated *'I note that small doses of [HAS] were eventually given in the terminal phase of [the patient's] case on December 14-15th even those [sic.] this was not policy according to response from the Belfast Trust. In summary, I accept the relative controversy regarding the use of human albumin solution in acute kidney injury associated decompensated the liver disease in 2011. However, I believe on balance that an early trial of intravenous [HAS] when [the patient's] renal function started to deteriorate after December 7th 2011 would be accepted good medical practice at the time, despite the caveat's in the Belfast Trust response.'*

33. Finally, I note the HIPA stated that he agreed with the Trust's assertion that the patient was *'not a candidate for liver transplantation ultimately death was probable, even with earlier treatment of his renal failure.'*

34. As part of the investigation, I sought advice on the standard of nursing care from a nursing IPA (NIPA). The NIPA was asked to advise on the role of nursing staff in the management of the patient's fluid. The NIPA advised *'nursing staff monitored fluid intake and output by documenting on fluid balance chart. This included oral, intravenous and nasogastric feed intake… documentation of all fluid intake/output was documented to a reasonable standard.'*

Response to draft investigation report

35. On 12 April 2018, I issued my draft investigation report to both the complainant and the Trust for comment on factual accuracy. The comments submitted by both were taken into account as part of my final consideration of the complaint.

36. In response to my draft investigation report, the complainant stated that as she was previously a member of staff on Ward 6D, she witnessed the administration of HAS *'to many patients'*.

37. The Trust sought a meeting following the issue of my draft report. This meeting took place on 30 April 2018 in my offices. Present was myself, the Director of Investigations and the Investigating Officer. The Trust was represented by a number of staff including the patient's Consultant, a Consultant Hepatologist and the Medical Director. At this meeting, the Trust raised concerns about my findings in relation to the clinical judgment exercised by the Consultant Hepatologist. The Trust was asked to put its comments on the draft report into writing and I received these on 14 May 2018. The Trust stated that it considered the clinical judgment of the patient's care and treatment to be a matter of opinion and that it felt the clinicians involved provided care which was in the patient's best interests. The Trust stated that it disputed that he was suffering from HRS, and suggested the renal failure was 'multifactorial'. Further, the Trust stated *'the HIPA's report suggested that the previous sepsis (from the patient's knee) was under control and that the (sic.) [patient] was not septic in the period between December 7th and 13th…'* The Trust referred to an assessment carried out on 7 December 2011 and stated this '*recorded that there was a new source of infection in the form of cellulitis of the right lower leg…infection was therefore not controlled'.*

38. The Trust also referred to the HIPA's advice in relation to pulmonary congestion and stated *'the team were working with the information available to them at the time, which included a chest x-ray report from a consultant radiologist confirming pulmonary congestion following fluid challenge earlier in the admission, and reduced oxygen saturations of 93% on the morning of December 7th…indeed [the patient] required supplementary oxygen therapy on both December 7th and 8th for low oxygen saturation levels…'*

39. The Trust further stated *'it is clear that fluid balance was actively being considered on a daily basis and that all the clinicians caring for [the patient] had concerns about [his] ability to cope with additional fluid'* and added *'…the care afforded to [the patient], including his fluid administration, was deliberately and carefully*

commissioned by the clinical team rather than through omission or neglect to consider additional fluid..'

40. The Trust also referred me to the findings of a GMC enquiry into the Consultant's practice, which stated *'…any lack of appropriate fluid replacement was a lesser contribution to the patient's kidney failure and would not be attributable to inappropriate practice'* and requested that I seek clarity from the HIPA regarding whether he still considers the standard of care fell below that outlined in 'Good Medical Practice'.

41. Following receipt of the comments received by both the complainant and the Trust, the HIPA was asked to provide further advice in relation to the issues raised.

42. The additional advice obtained from the HIPA was shared with the Trust and it was given an opportunity to comment on the advice received. In its response dated 19 June 2018, The Trust stated *'we continue to contest however the IPA's opinion that [the patient] should have been administered a fluid challenge on the grounds that he "tolerated a large fluid challenge on 29-30th November". As per our previously provided evidence in the medical notes, [the patient] did not tolerate that fluid challenge; rather he exhibited subsequent desaturation with evidence of pulmonary congestion on a chest x-ray.'*

43. In this response, the Trust also stated that it was concerned that the HIPA agrees with the GMC decision, however *'in direct contrast…your IPA has re-iterated their view that the care has failed to meet the standards of Good medical practice, 2006…'* The Trust further stated *'[the Consultant and his colleagues remain very clear that all the available evidence was carefully considered when making decisions regarding [the patient's] treatment. Specifically, amongst other factors, they considered the following:*

- *The background context of a failing liver with very poor prognosis*
- *Grossly oedematous[21] patient*

[21] Having excessive accumulation of fluid

- *Fluid balance records confirming a positive fluid balance throughout the length of admission*
- *Poor tolerance of initial fluid challenge with subsequent desaturation and chest x-ray confirming pulmonary vascular congestion*
- *Ongoing infection (initially knee sepsis, later cellulitis)'*

44. Following a request for additional evidence to support the concerns of fluid overload, the Trust stated *'I would like to clarify in our previous correspondence we highlighted that [the patient] was suffering from pulmonary congestion…the chest x-ray report of November 30th stated "even allowing for technique, the heart appears enlarged and there is pulmonary vascular congestions consistent with cardiac failure"… [He] had clinical signs of oxygen desaturation on December 7th and 8th indicating a limited ability to transfer or carry oxygen…given the low oxygen saturations, a further chest x-ray was taken on December 7th and the report for this stated: "allowing for altered technique there is no progressive changes seen since the last examination". A further chest x-ray was taken the following day on December 8th and the report stated "marked air space changes are also present in the lower zones". Air space changes can be due to ongoing fluid congestion within the lung bases…nonetheless, given the concerns about pulmonary congestion a cardiac echogram was performed. The formal report of this test was not available until December 13th. The exclusion of cardiac dysfunction did not in itself exclude the presence of pulmonary congestion as there are many other possible causes…'*

45. Given the content of the Trust's response, it was shared with the HIPA and he was asked to provide additional advice in relation to its contents, in particular the Trust's statement that the patient was 'a grossly oedematous patient'.

Analysis and Findings

46. The complainant raised concerns about the management of fluid balance of her late father when he was a patient at the Royal Victoria Hospital between 27 November 2011 and 15 December 2011.

47. From an examination of the records, he initially presented with difficulties arising from septic arthritis in his knee. However, during his admission, he was diagnosed with decompensated liver disease and the treatment of this condition was the focus of the care and treatment afforded to him. I accept the advice of the HIPA that the patient's renal function also deteriorated following his admission.

48. The investigation did not find evidence that the patient was placed on a fluid challenge. The HIPA has confirmed this, and this is also evident from an examination of his clinical records. However, I note his fluid input and output was recorded using daily 'fluid balance charts'. I accept the advice of the NIPA that the monitoring of the fluid balance was carried out by nursing staff to a reasonable standard. I also accept the advice of the HIPA that it was appropriate to have used 'daily fluid balance charts' in this case.

49. I have carefully considered the HIPA and the Trust's comments. However I accept the advice of the HIPA that there is a concern about a lack of fluid intake in the period from 7 December 2011. I note that HIPA stated that the patient's fluid provision was not appropriate or reasonable in the circumstances and that the Trust ought to have either increased the volume of intravenous saline or put him on a fluid challenge with HAS.

50. As stated previously, I have taken into consideration the comments of the Trust in response to the HIPA's advice, in particular in relation to the 'risk' of fluid overload. I have also taken into consideration the published guidance at the time in relation to the management of patients with kidney injuries in the context of the patient's primary ailment. I have considered the Trust's comment that HAS was not used as a standard of care in the Royal Victoria Hospital liver unit at the time of the patient's treatment. However there is reference to HAS in the clinical records and the HIPA's advice was that it was administered to the patient late in his treatment. The patient's records and my investigation has not disclosed a reason why HAS could not have been administered earlier, when the records show that it was administered on 13 December 2011.

51. I have taken into account the GMC 'Good Medical Practice' guidelines in relation to the standard of care required of medical practitioners. In accepting a complaint for investigation, the GMC, as opposed to the legislation under which I operate, focuses on serious, significant concerns which may call into question a doctor's fitness to practice. In reaching its findings the GMC considers if a doctors current fitness to practice is impaired by his action or inaction, to a degree which would justify action being taken on an individual's registration as a doctor. Its role is not to examine whether a patient's care and treatment following failures in clinical care require a remedy, its role is to make a finding on the doctor's fitness to practice as a doctor. I make findings on maladministration and make no judgements on an individual doctor's fitness to practice, nor is it my role to discipline a doctor.

52. I have carefully considered the Trust's responses to my draft investigation report. Firstly, I accept that the patient's care and treatment depended very much on the clinical judgment and opinion of the clinicians treating him. I also accept that the management of his fluid was difficult and had associated risks and complications. I acknowledge that the patient was a very ill man.

53. I have considered and weighted all the evidence available to me, including the Trust and the Consultant Hepatologist's comments, the HIPA advice I received and the complainant's comments.

54. I consider the appropriate clinical course would have been for the patient to have been treated with HAS on 7 December 2011. I do not accept the Trust's assertion that it would have been inappropriate to do so given the risk of pulmonary congestion. I accept the additional advice of the HIPA that a trial of HAS for a period of 48 hours to assess improvement or otherwise would have been appropriate. I also accept the advice of the HIPA that the patient's clinical records do not support the Trust's assertion that he was already displaying symptoms of fluid overload. Further, I accept the HIPA's advice that the clinical records do not support the Trust's assertion that he was a *'grossly oedematous patient'*.

55. I therefore consider there was a failing in the patient's care relating to fluid management. I also consider the care failed to meet the GMC guidelines. **Given this**

failure in care and treatment provided to him, I uphold this element of the complaint. However, I do not consider this failing to be a 'fitness to practice' issue that would necessitate my referring the relevant clinicians to the GMC. The HIPA commented that the overall standard of care and treatment was 'good'. I believe there is learning in this particularly complex case for the clinicians, the Trust and other HSC bodies on the issue of fluid management. I note that the Trust accept the learning in this case.

56. In relation to the consequences of this failure in care and treatment, I note the advice of the HIPA that *'reversal of intravascular fluid depletion would have improved his prognosis.'* I also note the advice that it was *'probable'* that the patient's fluid balance had an effect on his renal function. The HIPA advised that unfortunately given his complex presentation however, his death was unavoidable. This was reiterated by the HIPA following comments made by the Trust in response to the draft report. I accept this advice and conclude that appropriate fluid administration in the patient's case may have prolonged his life for a time, but it would not have avoided his death.

57. I am satisfied that as a result of the failing, the patient experienced the injustice of loss of opportunity to have received appropriate fluid administration. I am also satisfied that the complainant experienced the injustice of distress and upset at her father's quickly deteriorating prognosis and the time and trouble in pursuing this complaint.

The DNAR Order

58. In relation to this issue, I have considered *'Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing'*. The joint statement was published in the Journal of Medical Ethics in 2001. The following extracts from this statement are relevant to my investigation of this case: *'These guidelines should, therefore, be viewed as a framework providing basic principles within which local policies on CPR attempts may be formulated…'*

59. At section 3 of the joint statement entitled 'Essential aspects of decision making' it states:

'…ideally, decisions about whether to attempt to resuscitate a particular patient are made in advance as part of overall care planning for that patient, and, as such, are discussed with the patient along with other aspects of future care…'

This section also states that a DNACPR order *'should be made only after the appropriate consultation and consideration of all relevant aspects of the patient's condition. These include:*

- *the likely clinical outcome, including the likelihood of successfully restarting the patient's heart and breathing, and the overall benefit achieved from a successful resuscitation;*
- *the patient's known, or all ascertainable, wishes; and*
- *the patient's human rights, including the right to life and the right to be free from degrading treatment.*

The views of all members of the medical and nursing team, including those involved in the patient's primary and secondary care and, with due regard to patient confidentiality, people close to the patient, are valuable in forming the decision…'

60. At section 5.1 the statement outlines *'any discussions about whether to attempt CPR, and any anticipatory decisions, should be documented, signed and dated in the patient's record.'* Further, at section 6 it states *'relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision making but they cannot insist on treatment or non-treatment.* Also at section 8 it states: *'…it is good practice to involve people close to patients in decisions…it is important to be clear that the information sought from people close to patients is to help ascertain what the patient would have wanted in these circumstances, as opposed to what those consulted would like for the patient or what they would want for themselves if they were in the same situation…The European Court of Human Rights has taken the view that parents have a right under Article 8 of the European Convention to be involved in important decisions concerning their children. By analogy, it is arguable that excluding the family of incompetent patients also breaches this right unless the patient previously instructed it.'*

61. At section 11 the statement records that *'the overall responsibility for decisions about CPR and DNAR orders rests with the consultant or GP in charge of the patient's care.'*

62. The joint statement at section 12 entitled 'Recording and communicating decisions' notes *'communication of decisions to the patient and people close to the patient is also a part of this process…unless the patient refuses, decisions should also be communicated to the patient's family and others close to the patient. The usual rules of confidentiality apply.'*

63. In the context of this element of the complaint, I also considered 'Treatment and care towards the end of life: good practice in decision making'. This guidance was published by the GMC in July 2010 as part of GMC good practice. At paragraph 136 it states *'if a patient lacks capacity, you should inform any legal proxy and others close to the patient about the DNACPR decision and the reasons for it.'*

64. In response to investigation enquiries, the Trust stated *'the DNACPR order was placed during a joint ward round with the Consultant's colleague. There was a lengthy discussion with family members around this subject documented in the patient's notes the following day.'* The Trust further clarified that *'[The Consultant] explained [the patient's] ongoing deterioration with decompensating cirrhosis and renal failure and encephalopathy…'*

65. The Trust also stated *'a DNACPR form was not completed, as they were not used as a standard form of care in the unit at that time. They have since been introduced.'*

66. The Trust also commented that *'there was not a Trust Policy for DNACPR at the time of [the patient's] care and treatment in 2011. The Trust DNACPR policy was developed and implemented by the Trust in 2014.'*

67. I have examined the clinical records in relation to the patient's case and note the following extracts which are relevant to this issue:

'Discussion [with] daughter and [consultant] 8/12/11 11:45
Clinical condition updated – remains v.unwell progress static. Appears more settled today. Explained concerned about size of heart – echo
NG tube to be changed to feeding tube
Sepsis improving clinically
…
Closely monitoring renal function if deteriorates ?cardiac ?hepatorenal – will need early urinary sodium
[Daughter] aware that her dad is v.unwell'

'13/12/11 09:35 WR (Ward Round) [Consultant Hepatologist]…
P [Plan] *Prognosis remains poor…not suitable for ICU, not for resus in event of cardiac arrest, to discuss above with daughter'*

'14/12/11 Consultant
I have had a lengthy discussion with daughter …, other daughter and step sister. I have explained ongoing deterioration with decomp cirrhosis and renal failure and encephalopathy. Sepsis currently under control and bowels now starting to function. Prognosis extremely poor. I have explained HDU/ICU care is not going to change outcome due to decompensated liver disease. I have also indicated dialysis does not alter prognosis in such circumstances. [Signature]'.

68. The HIPA reviewed the patient's medical notes in relation to this issue and advised *'a decision to not proceed to escalation of care or resuscitation in the event of a cardiopulmonary arrest was made on December 13th at 09:35 hr on the ward round. A discussion regarding escalation of care by [Consultant] with .. daughter on December 14th.'*

69. The HIPA was asked if he considered that it was appropriate and reasonable to place a DNACPR order on the patient. The HIPA advised that it was, as CPR was unlikely to be successful and thus futile. The HIPA also advised that it was appropriate for the Consultant and another Consultant Hepatologist to have decided on the DNACPR Order, and that one or other of these clinicians could have singularly made the DNACPR Order.

70. The HIPA advised that in 2011, it was appropriate that a DNACPR Order was made without the completion of a form[22].

71. The HIPA also advised that *'no formal assessment of capacity was made in the notes but it is clear that he had a variable degree of cognitive impairment through out [sic.] his hospital stay…thus on the basis of the review of the case notes I am of the opinion that [the patient] did not have capacity to make decisions regarding resuscitation.'* The HIPA clarified that in 2011, a patient's consent was not required for a DNACPR Order to be made.

72. The HIPA referred to the clinical record dated 14 December 2011 and stated *'the decision regarding the DNACPR was not noted in this discussion on December 14th, although in view of [the patient's] poor prognosis, the futility of escalation of care to HDU/ITU and the use of dialysis were explicitly discussed. Thus the note is not reflective of an appropriate discussion of DNACPR...'* The HIPA referred to guidance from 2001 and stated '*I am of the opinion that it would have been appropriate and reasonable to discuss the DNACPR decision with [the patient's] daughter…'* The HIPA further advised that the note of the discussion does not reflect that his relatives were informed of the DNACPR Order. The HIPA clarified that there was *'no requirement to discuss DNACPR order prior to placement with patient/relatives in 2011.'*

73. The HIPA was referred to the Trust's response on this issue which stated there was no DNACPR policy in place at the time. The HIPA was asked if there was any published guidance in relation to the issue of DNACPR. The HIPA advised *'the major professional advice regarding decisions relating to cardiopulmonary resuscitation is from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing'.*

74. The HIPA concluded that *'the correct decision was made as CPR in this case would have been futile and in my opinion in the best interests of the patient. However the*

[22] Following advice from the BMA, forms are now used when DNACPR Orders are made.

decision was not in line with professional guidance in 2011 because (i) there was no attempt to make an advanced decision regarding CPR following admission in a patient who had a 1:10 change at presentation of death and one month and (ii) the decision of DNACPR was not specifically discussed with the family…although I suspect this practice was not uncommon at this point in time and ultimately resulted in…changes to professional and legal standards.'

75. The Trust was given an opportunity to comment on the HIPA advice. The Trust stated *'[The Consultant] would acknowledge that the note keeping for the lengthy discussion with [the patient's] daughters did not record a discussion about resuscitation and for this, he would sincerely apologise. Whilst this was clearly an oversight on his part, [he] has advised that there was a lengthy discussion about deterioration and prognosis. While he may not have recorded in the medical notes that resuscitation was discussed, he was of the understanding that [the patient's daughter] understood the implication of the conversation… [The Consultant] does not now recall if he specifically discussed resuscitation or not.'*

76. The Trust also stated *'[The Consultant] can confirm "do not resuscitate" forms are now used as a standard of care in the liver unit and resuscitation is actively discussed early with all patients and/or their families when capacity to consent is impaired.'*

77. The Investigating Officer enquired of the Department of Health (DoH) about the applicability of the guidance contained within the joint statement, to Northern Ireland. The DoH clarified that the joint statement does extend to Northern Ireland.

78. The DoH also clarified that the joint statement is *'clearly guidance and as such, there is no compulsion for it to be implemented. That said the Department is aware that it (and subsequent revised editions) has informed local policies on resuscitation decisions.'*

Analysis and Findings

79. I note the complainant's concerns that a DNACPR order was put on her late father 'without consultation' with her or her family.

80. As part of the investigation I received independent professional advice regarding the timing of the DNACPR Order being made. I therefore considered this issue as part of the investigation. There is no evidence that a DNACPR order was considered when the patient was first admitted to the RVH. There is no record that it was considered prior to 13 December 2011. I note the guidance contained within the joint statement and the advice of the HIPA that he considers the decision was not in line with guidance. That is because there was no advance consideration. I also note the clarification provided by the DoH that the joint statement provides guidance and it has informed subsequent policies relating to resuscitation decisions. I consider that the failure to consider a DNACPR order prior to 13 December 2011 constitutes a failure in care and treatment. I am also satisfied that as a result of this failing, the complainant sustained the injustice of uncertainty, distress and upset at an already distressing time. I consider had the DNACPR decision been made earlier in the hospital admission, the complainant ought to have been informed of this, and she would have received this information at an appropriate time, giving her and the family time to consider their father's serious condition.

81. I accept that a DNACPR order was placed on 13 December 2011, two weeks after the patient's admission, during a joint ward round by the Consultant and a colleague Consultant Hepatologist. I note the reasons for the DNACPR order at that time. I accept the advice of the HIPA the decision to place a DNACPR order was appropriate and reasonable in the circumstances. I have also considered the content of the joint statement and accept the HIPA's advice that the Consultant was an appropriate clinician to have made this decision.

82. I note the decision to place a DNACPR order was recorded within the medical notes. No separate form was completed as this was the practice at that time. I accept the advice of the HIPA that this was standard practice and there was no requirement to complete a form. However, I note also that since 2014, there is a requirement to complete a form in these circumstances.

83. I have considered the patient's notes and records and the HIPA advice carefully. I accept the advice of the HIPA that the patient did not have capacity to make any

decisions at the time that the DNACPR order was made on 13 December 2011. I also accept the advice of the HIPA that his consent was not required for the DNACPR order to be made.

84. Following an examination of the clinical records, I note that the Consultant Hepatologist recorded two conversations with the complainant about her father's poor prognosis. The first of these conversations took place on 8 December 2011 at 11:45.

85. The second conversation took place on 14 December 2011, during a period of time which the HIPA describes as the *'terminal phase'* of the patient's life. The HIPA advised that the record of this conversation does not include a reference to DNACPR and that he considered it would have been *'appropriate and reasonable'* to have discussed the decision with the patient's daughter. However, the HIPA stated there was no requirement to have done so in 2011. I also note the GMC good practice in relation to a discussion with the patient's family informing them that the DNACPR decision had been made. In light of this guidance and the relevant case law, I find that the complainant and her family ought to have been specifically informed of the decision that a DNACPR order was placed on their late father.

86. I note the Trust has stated that it accepts that the record of the discussion did not include reference to resuscitation and it has offered an apology for this. I also note the Trust states that the Consultant Hepatologist considered that the complainant understood the implication of the conversation. The complainant does not agree that she understood the implication of this as the DNACPR was not mentioned specifically. I have considered the record of the discussion together with the guidance provided in the joint statement. **I conclude that the record does not show that an appropriate discussion took place with the family in relation to the DNACPR decision**. The joint statement outlines that the importance of discussion of such decisions with family members in order to assist in ascertaining the wishes of the patient.

87. I note the joint statement makes specific reference to the human rights of family members of incapacitated patients. Having considered the HIPA's advice, I am

satisfied that the patient did not have capacity at the time the DNACPR order was made. Therefore in line with a human rights based approach to investigations, I have considered the question of the family's participation in the decision to make a DNACPR order. The 'participation' principle[23], reflected in the joint statement, is a key aspect of a human rights based approach. This ensures that those individuals (in this case the patient and his family) who will be impacted by the DNACPR decision should be involved in the decision making process and that, in this case, the Trust should actively seek their views. In this case the Trust did not actively seek the views of the family. The first Principle of Good Administration is 'getting it right' which requires public bodies to act in accordance with the law and with regard to the rights of those concerned. With this in mind, the investigation of the complaint has caused me to consider how the Trust had regard to the patient's and the complainant's human rights. I consider that by failing ensure proper participation with the complainant about the DNACPR order, the Trust failed to give due consideration to her human rights under Article 8 of the European Convention on Human Rights (ECHR). This is compounded by the Trust's omission to follow the published guidance relevant at the time. In light of these I consider the Trust's omissions amount to maladministration. I am satisfied that as a result of the maladministration, the complainant sustained the injustice of distress and uncertainty regarding her late father's treatment plan.

Transfer to HDU or ICU

88. The complainant stated that her late father ought to have been transferred to 'a more suitable environment' (HDU/ICU) and this may have led to a different outcome. I have considered 'Good Medical Practice', a guidance document for doctors, issued by the GMC on 13 November 2006. I note paragraph 29 states *'you must be considerate to relatives, carers, partners and others close to the patient, and be sensitive and responsive in providing information and support…'*

89. In response to investigation enquiries, the Trust stated *'early in [the patient's] care, [the Consultant] had noted that [he] would be for escalation to higher level care if deteriorated. However, as time passed, his liver failure was worsening…and*

[23] I refer to page 5 of the Northern Ireland Public Services Ombudsman Human Rights Manual

progressive renal failure. In this context there was little HDU/ICU could have done to save [his] life as the liver failure was irreversible and this would not have been the appropriate place for [him].'

90. I have examined [the patient's] clinical records in relation to this issue of the complaint. I note he was admitted from the Emergency Department to Ward 6B (liver unit) on 29 November 2011. I note he remained on Ward 6B until his death on 15 December 2012. I also note the following extracts from his records which are relevant to this issue:

'29/11/11 D/W (discussion with) [Consultant]
Should there be a deterioration in [his] condition he would be a candidate for discussion with HDU/ICU'

'30/11/11
As per note from 29/11/11 if this man deteriorates he is to be considered for HDU/ICU with sepsis as potentially reversible
SpR[24]…d/w daughter ... Informed of condition, all questions answered'

'13/12/11WR [Consultant Hepatologist]
…not suitable for ICU…'

91. The HIPA advised that it was recorded on 13 December 2011 at 9:55 that the patient was not suitable for HDU or ICU. The HIPA also advised that the decision was made by the Consultant, with his colleague Consultant Hepatologist. The HIPA advised *'they were appropriate clinicians to make the decision not to escalate care from ward based care to critical care.'*

92. The HIPA advised that it would have been appropriate and reasonable to have transferred the patient to a HDU/ICU *'at an earlier date to optimise his fluid balance. Simply attempting fluid balance optimisation on the ward on December 7th or at the very latest December 10th…would have been appropriate and reasonable,*

[24] Specialist Registrar – a doctor undergoing advanced training in a specialist field of medicine

irrespective of location. However by December 13th when the decision not to transfer to a HDUY/ITU was correct in that escalation of care or support with dialysis would not have altered the patient's outcome.'

93. The HIPA also advised *'it is possible that earlier intervention with appropriate fluids either on base ward or HDU could have altered his outcome.'*

94. The HIPA further advised there was no other ward onto which he could or should have been transferred to optimise his treatment.

95. The Trust was given an opportunity to comment on this independent professional advice. In response, the Trust stated *'[The Consultant] felt escalation to HDU/ICU was appropriate when [the patient] first presented to hospital due to the nature of his presentation with sepsis. However, after several days and in the context of progressive liver failure in a 67 year old patient who was not eligible for liver transplantation he felt escalation was futile. It was clear [he] was going to die of his liver disease, which was deteriorating daily, even before he began to develop co-existing renal failure. [The Consultant] ensured he sought the opinion of his colleague [Consultant Hepatologist] on a joint ward round to ensure the decision he was making was appropriate. It would have been extremely uncommon for such a patient to have been referred or accepted to the RVH HDU or ICU in 2011.'*

96. The HIPA was provided with the Trust's comments and asked to advise further on the issues raised. The HIPA clarified *'it would have been futile to escalate this gentleman's care late in his clinical presentation to a critical care environment. I therefore agree with the response from the Belfast Trust. However, as I stated in my report earlier and better fluid balance may have been better facilitated in a high dependency area.'*

Analysis and Findings

97. I note the complainant's allegations that her father ought to have been transferred to a HDU or ICU and that this may have led to an improved prognosis for him.

98. I also note following examination of the clinical records in this case that consideration was given to transferring the patient to one of these wards, earlier in his hospital admission. It is recorded on both 29 and 30 November 2011 that the Consultant Hepatologist noted that should his condition worsen, he would be a candidate for transfer to HDU or ICU. I note on 30 November 2011, the record reflects that the patient could be considered for transfer with sepsis, as it was *'potentially reversible*'.

99. I also note that there is no record that transfer to HDU or ICU was considered by clinicians until it was ruled out during a ward round on 13 December 2011. I note the Trust stated that as the patient's condition deteriorated, the condition became irreversible. I accept the advice of the HIPA that this was an appropriate decision to have made in the circumstances. However I also note the advice of the IPA that it would have been appropriate and reasonable to have transferred him to HDU/ICU earlier in his hospital admission. I note the HIPA's reason for this is that it was considered that fluid balance could have been optimised in this setting.

100. I note the Trust stated that it would have been '*extremely uncommon'* for a patient to have been referred or accepted to the RVH HDU/ICU in 2011.

101. I have considered all of the information available to me on this issue of complaint. I accept the advice of the HIPA that better fluid balance may have been better facilitated in HDU. However, I also note the advice that improving fluid balance could also have been carried out on the ward. I therefore cannot conclude on balance, that transfer to a HDU or ICU would have led to improved fluid management, and thus improved prognosis in relation to the patient's condition. **I therefore do not uphold this element of the complaint.**

102. The HIPA advised that the decision in relation to transfer of the patient ought to have been considered at an earlier time. There is no evidence that this decision was kept under review by the clinicians treating him. I accept the advice of the IPA and consider that in line with Standard 1(b) of 'Good Medical Practice' this ought to have been kept under review. I consider the failure to do so amounts to a failure in care and treatment.

103. However, it is evident that the possibility of transfer to HDU/ICU was communicated to the complainant at the time when it was considered on 30 November 2011. I consider it reasonable therefore that there was a raised expectation on the complainant's part that transfer would continue to be considered by the medical team treating her father. As noted above, the investigation has not disclosed evidence that the issue was considered again until 13 December 2011. I have considered the Trust's response to this issue and note that the deterioration which it states ruled out the patient's admission to HDU/ICU, occurred after 30 November 2011 and before 13 December 2011. I consider that at that point, the complainant ought to have been informed that her father was no longer a candidate for HDU/ICU. I consider the failure to do so was a failure to provide information to patients' relatives as stated in the GMC 'Good Medical Practice' and this failure constitutes maladministration. I am satisfied that as a result of the maladministration I have identified, the complainant sustained the injustice of uncertainty and upset regarding her late father's treatment plan.

104. As part of the investigation of the complaint, I received independent professional advice regarding the nutrition administered to the patient during his admission at the hospital. I therefore considered this issue as part of the investigation.

105. I considered ESPEN Guidelines and note at Section 2.3 the following relevant extract:

> *'An energy intake of 35–40 kcal/kg BW/d*[25] *(147–168 kJ/kgBW/d) and a protein intake of 1.2–1.5 g/kgBW/d are recommended (C)'*

106. The HIPA advised in relation to the period between 7 and 9 December 2011 *'[The patient] still had no substantial nutrition as noted by the dietician on December 9th.'* The HIPA was asked if nutrition (or lack of) was an issue in relation to the overall prognosis. The HIPA advised *'protein-energy malnutrition is common in patients with cirrhosis and associated with poor survival… [the patient] did not receive*

[25] Per kg body weight per day

substantial nutrition according to accepted guidelines and as recorded in his notes. It is possible that his lack of nutrition adversely affected his outcome.'

107. The Trust was given an opportunity to comment on the IPA's advice I received. The Trust stated *'[The Consultant] agrees that nutritional support in decompensated cirrhotic patients is important, however providing nutritional support to drowsy, confused and often agitated patients is challenging. [The patient] repeatedly pulled out his Nasogastric tube[26] when it remained in place…'*

108. The HIPA was asked to comment on this response and advised further *'I agree with both statements [of the Trust]…by the time an ileus[27] developed [the patient] was entering the terminal phase of his admission. The only option at this time would have been parenteral nutrition[28], which would have only been instigated if judged clinical [sic.] appropriate. No parenteral nutrition in view of [the patient's] deterioration was understandable.'* The HIPA later clarified that he considered the decision not to move to parenteral nutrition, to be appropriate and reasonable.

Analysis and findings

109. I note the advice and opinion of the HIPA that the patient did not receive appropriate nutrition in line with published guidance during his hospital admission. However, I also note the issues and difficulties raised by the Trust in relation to nasogastric feeding and the HIPA accepts these comments as understandable. The HIPA later clarified that the action taken was appropriate and reasonable. I conclude that the patient did not receive adequate nutrition within the period highlighted by the HIPA and this is a failing in care. However, there were no alternatives available to the medical staff treating him at that time, in order to minimise the risk of the nasogastric tube being displaced. I note the further comments of the HIPA in relation to the patient's deteriorating condition and I am unable to conclude that the provision of adequate nutrition would have improved his overall prognosis. **I therefore do not make any finding in relation to this issue.**

[26] A tube that is passed through the nose to the stomach to provide nutrition to patients who are unable to eat
[27] A failure of the muscles in the intestine to contract, as they would normally do
[28] the provision of nutrients by the intravenous route

110. The complainant stated in the complaints meeting on 13 May 2016 that she feels 'her father would still be alive had different decisions been made.' I note the advice of the HIPA regarding the patient's prognosis upon admission. In response to the sharing of the IPA advice, the Trust stated it did not agree with the prognosis of the HIPA in terms of the predicted mortality rate of a patient in this condition. While I note the complainant's belief, I accept the advice of the HIPA on the issue of mortality. However, I cannot conclude on this issue.

Issue 2: The Trust's investigation of the complaint about the patient's care and treatment

111. The patient's family commenced legal proceedings against the Trust in June 2013. Following a decision to discontinue these proceedings, the complainant wrote to the Trust's Complaint Department on 25 January 2016. She complained that this correspondence was not treated as a complaint by the Trust, rather, it was treated as an enquiry. She also complained that the Trust informed her that an independent investigation would be carried out and this did not subsequently take place. She further complained that the Complaints Department did not adequately communicate with her during this process, specifically that telephone calls were unanswered and that there was unreasonable delay in her receiving the responses from the Trust. I will address each element of this issue of complaint in turn.

112. The complainant raised concerns about the Trust's treating her complaint as an enquiry. I have considered the 'Complaints in Health and Social Care – Standards & Guidelines for Resolution & Learning' (the HSC Complaints Procedure) published by DHSSPS on 1 April 2009. In particular I note the following extracts from that procedure which are relevant to that issue:

'***1.31*** *It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides* ***not to take legal action****. If he/she then wishes to pursue their complaint through the complaints process the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot then be investigated under the HSC complaints procedure.'*

*'**2.1** A complaint is "**an expression of dissatisfaction that requires a response**"'*

***'2.43** A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event…'*

***'2.45** There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.'*

113. There is no provision within the HSC Complaints Procedure for dealing with a concern from a member of the public or a patient/patient's family as an 'enquiry'.

114. In response to investigation enquiries, the Trust stated that: *'the issues raised by the complainant in her letter dated 18 January 2016 to the Trust's Complaints Department were managed as an Enquiry and were not managed under the HSC Complaints Procedure for the following reasons:*

> *a) A letter of complaint was received from [the complainant's sister] by the Trust's Complaints Department on 28 January 2014 concerning her father… However since there was an ongoing litigation case [reference number] in relation to the issues raised at that time, the complaints process ceased as per Trust policy and the complaint was closed on 29 January 2014.*
> *b) A letter dated 18 January 2016 was then received by the Trust Complaints Department on 25 January 2016 from [the complainant's sister]. The letter stated that the family had withdrawn from the legal process…the letter also stated that time had lapsed but requested that Trust investigate their concerns and provide a response.*
> *c) The service area agreed to consider the question raised as an Enquiry as it concerned the death of her father. Consent was sought on 17 January 2016…*

d) The service area met with the complainant on 13 May 2016 to discuss her concerns. During the meeting an independent review was considered however since the service manager subsequently was made aware by the Clinical Director that the Trust had obtained an independent review via the legal process

e) A further meeting was offered … to discuss the Trust's independent report; however, [the complainant] declined this offer and requested a closing letter which the Trust provided on 10 January 2017…'

115. The Trust referred also to the HSC Complaints Procedure and stated *'under these guidelines the Trust has discretion to look at matters that have been brought to their attention outside of the DoH complaint timescales. In these circumstances the Trust may, on a case by case basis, agreed in good faith to investigate these matters but that the issues raised are not classified as a "formal complaint" and will therefore not be managed as per the standard complaints process. In such cases these "out of time" complaints will be categorised as enquiries.'*

116. As part of investigation enquiries, the Trust was asked what the differences were, in treating an issue as an 'enquiry' as opposed to a complaint. The Trust stated *'the principles for investigation and for seeking remedy for enquiries follow those for formal complaints however one of the significant differences is that an enquiry will not be subject to the 20 working day response timescales applied to formal complaints. Due to the historical nature of the issues raised in an enquiry, additional time for investigation is often required…enquiries are not formally graded in terms of risk, however Trust staff will consider the issues raised in each enquiry…'* The Trust also clarified that it does not have a separate policy for handling enquiries.

117. As part of the investigation, the Trust's complaints files were examined and a chronology of events relating to the complaint was prepared.

118. I note an internal email within the Trust dated 26 January 2016 which states *'… As this gentleman passed away in 2011, we cannot treat this as a complaint rather an enquiry we will respond to in writing…'*

119. I note various internal emails within the complaints records which refer to the issues being addressed as 'an enquiry' due to it being *'out of time'*. I also note a reference to there having been *'failed litigation'* in an internal email dated 30 December 2016.

Analysis and Findings

120. The Trust's complaints file records on 26 January 2016 the decision not to treat the complainant's concerns as a complaint. At this time, the rationale for the decision appears to have been the passage of time since her father's death.

121. In response to investigation enquiries, the Trust referred to the HSC Complaints Procedure and stated that the Complaints Manager has discretion to *'extend the time limit'* for complaints to be accepted by the Complaints Department. I have considered the provision in the HSC Complaints Procedure and note that this is correct. The Trust also cited reasons why this case was handled as an 'enquiry' and not a complaint. However, the HSC Complaints Procedure does not make reference to an 'enquiry'. Neither does it refer to a discretion to treat a complaint as an enquiry, or the procedure for same. I also note the Trust referred to 'formal complaints'. The HSC Complaints Procedure does not make provision for 'formal', or indeed 'informal' complaints. The Trust has confirmed it does not have a separate policy or guidance for treating issues as 'enquiries'. The Trust also clarified that complaints accepted 'out of time' are designated as 'enquiries'.

122. I accept that the HSC Complaints Procedure provides for discretion in the acceptance of complaints after a certain time period. However, the investigation into this complaint has not disclosed a record of the decision under this provision having been made, or the reasons for it. The third Principle of Good Complaint Handling, 'Being open and accountable' requires the Trust to keep 'full and accurate records'. Also this principle states that public bodies should as a matter of good administrative practice give reasons for decisions made. I consider the failure to record reasons for its decision constitutes maladministration by the Trust.

123. The first Principle of Good Complaint Handling is 'Getting it right' which requires public bodies to have clear governance arrangements regarding the processing of complaints. The investigation has found no evidence of the designation of concerns as 'enquiries' within the HSC Complaints Procedure. I consider this action was contrary to the Trust's policy and constitutes maladministration.

124. I have found no evidence that the complainant was informed that her complaint was being treated by the Trust as an enquiry or, the estimated timescale for a response. The second Principle of Good Complaint Handling requires public bodies to 'be customer focused' by having 'clear and simple procedures'. I consider the Trust failed to meet this Principle on this occasion and this failing constitutes maladministration.

125. I am satisfied that as a result of the maladministration I have identified above, the complainant sustained the injustice of frustration and uncertainty.

126. The complainant complained about the investigation into her concerns. I have considered the HSC Complaints Procedure and note paragraph 3.28 which states *'The investigator should establish the facts relating to the complaint and assess the quality of the evidence. Depending on the subject matter and complexity of the investigation the investigator may wish to call upon the services of others…These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include the involvement of…independent experts…'*

127. In response to investigation enquiries, the Trust stated that during the meeting on 13 May 2016, *'it had been suggested that the Trust would consider obtaining an independent review, however, when [Service Improvement Manager] spoke to the Clinical Director she was advised that an independent expert report had already been completed as part of the legal process…'*

128. The Trust also communicated to the complainant by telephone that the Service Improvement Manager *'discussed the content of the Trust's independent report. [The complainant] was upset and stated that the Trust had selected someone in their own*

favour to write the report. [Service Improvement Manager] reassured [her] that since the report was completed under the legal process, the report was unbiased…'

129. The Trust further stated *'the family's solicitors had commissioned two expert reports and both had commented that the overall standard of care was good…that fluid management was appropriate.*

130. As part of investigation enquiries, the Trust was asked about the decision making process which determined that the original expert report was accepted as an independent review of the care and treatment. The Trust stated *'the enquiry investigating team, mindful of the requirements outlined in the civil procedure rules…agreed that this existing report addressed all the requisite conditions to be of sufficient independence…to make it unnecessary to seek another review at this time. The Trust's position in regard to obtaining a further expert review was made clear in correspondence with the complainant's advocate on the 19th September 2016.'*

131. I have examined the minutes of the meeting which took place between the complainant and the Trust on 13 May 2016.. Under the heading Q.2 I note the following extract *'[Service Improvement Manager] and [Complaints Manager] have suggested an Independent Review, given the Trust has not read [the complainant's] two Independent Reviews. This will be arranged to gain some closure on what the core medical treatment should have been at the time…'*

132. By internal email dated 17 June 2016, it is documented that the complainant was informed by telephone that an independent review had been carried out in the context of legal proceedings. Following this communication, her advocate asserted that she did not consider this report to be independent. I note that this advocate was informed by email on 5 July 2016 that the Trust was not going to obtain a further expert report.

Analysis and Findings

133. The complainant stated that at a meeting as part of the handling of her complaint, the Trust stated that it would carry out an independent review of her late father's care and treatment. I have considered the minutes of this meeting, which took place on 13

May 2016. I note the minutes state that such a review would be *'considered'* by the Trust. I also note that the instruction of an independent expert as part of an independent review, is provided for in the HSC Complaints Procedure.

134. Following this meeting, Trust staff dealing with her concerns were made aware that an independent expert's report had been obtained in the context of legal proceedings, and for this reason, a further report was deemed not necessary. I have considered all of the evidence available to me regarding this issue. I am mindful of the requirement of the Trust to protect public funds where possible. I therefore consider that it was appropriate and reasonable that the Trust did not obtain a further independent report. **I do not uphold this element of the complaint**.

135. The complainant was informed by email about the fact that there was a previous report on 17 June 2016, and was informed of Trust's decision not to seek a further report, through her advocate, on 5 July 2016[29]. I consider this was a reasonable timeframe for informing her of this decision.

136. She complained about the Trust's communications with her and delays in responding to her concerns. I note the following extracts from the HSC Complaints Procedure which are relevant to this issue:

> ***1.4****…Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint…'*
>
> *'**3.8** Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options for pursuing the complaint and the consequences of following these options. Throughout the process, the Complaints Manager should assess what further action might best resolve the complaint and at each stage keep the complainant informed.'*

[29] Issues regarding communication with during the complaints process will be addressed further in point (iii)

*'**3.25** …The complainant and those identified as the subject of a complaint should be advised of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales. All those involved should be kept informed of progress throughout…'*

137. In response to investigation enquiries, the Trust stated the Service Improvement Manager *'was following up on several queries following the Trust meeting with [the complainant]. [Service Improvement Manager] requested time to consider the further queries raised as she had not been involved in the previous meetings about [her] father.'*

138. In response to the complaint that she was required to make numerous telephone calls expressing her concerns, the Trust stated *'[The complainant] telephoned [Complaints Manager] on the 12th and 13th October 2016 advising she had receipt of the meeting notes and had multiple questions to discuss with him. [Complaints Manager] wrote to [the complainant] on 13th October 2016 requesting she put her questions in writing. On 17th October 2016 [she] subsequently emailed her questions … and contacted the complaints department on the 1st November 2016 and was contacted by [different Complaints Manager]…the complaints department advised that a final draft closing letter was with the Director, for review and signature. A letter dated 10th January 2017 was subsequently sent to [the complainant].'*

139. I have considered the Chronology of complaint handling by the Trust.

140. I note references to telephone calls within internal email correspondence. However, there is no corresponding telephone note of these calls within the Trust's complaints records.

141. By letter of 19 February 2016 the Trust informed the complainant her complaint was delayed as investigations were ongoing.

142. I also note within the complaints records an internal email dated 7 December 2016 stating *'…this lady had phoned numerous times regarding her letter from HQ…'*

Analysis and Findings

143. The complainant complained about the Trust's communication with her during the complaints process, in particular she complained that telephone calls she made to the Trust went unanswered. Following examination of the Trust's complaints records, I note there was no separate record kept of telephone conversations between Trust staff and the complainant. I am therefore unable to comment on the timing of the telephone calls, if they were returned and if they were, what was discussed. There are references to telephone calls in internal emails between Trust staff dealing with the complaint. However, there is no record of the telephone call itself. The third Principle of Good Complaint Handling requires public bodies to be 'open and accountable' by 'keeping full and accurate records'. I consider the Trust has failed to meet this standard with respect to the recording of telephone calls between the Trust and the complainant. I consider this failing constitutes maladministration. In the absence of a formal record, I am unable to make any finding in respect of this aspect of the complaint.

144. I also note she complained that there was unreasonable delay in the time taken by the Trust to respond to her complaint. I note the HSC Complaints Procedure which refers to the timescale envisaged for the resolution of complaints. However I am mindful that the Trust state her concerns were not addressed through this process.

145. I am pleased to note that the concerns were acknowledged by the Trust in a timely manner. However, its meeting with the complainant took place some three months after the initial letter of complaint was received. I note she was informed by a letter dated 19 February 2016 that there would be a delay in responding to her complaint. However, this letter did not explain that a meeting was going to be arranged, or what the process would be.

146. The meeting took place on 13 May 2016. Subsequently, the minutes were issued to her on 5 October 2016, some five months following the meeting. I also note that it is recorded within Trust emails that she made telephone calls in the intervening period, querying why the minutes had not been issued. Finally, I note there was no written correspondence issued during this time, informing her of a delay in the issue of the minutes of the reasons for the delay.

147. Further, I note that following receipt of the minutes of the meeting, the complainant contacted the Trust by telephone expressing concerns. A letter was sent asking her to put these concerns in writing, which she did, on 17 October 2016, by email. The investigation has not found evidence that this email was acknowledged by the Trust.

148. It is recorded within email correspondence that she contacted the Trust again on 1 November 2016 seeking a letter that the complaint was closed, in order to bring her complaint to my Office. I note the Trust issued this letter to her on 10 January 2017. During the intervening period, it is recorded that she made telephone calls to the Trust seeking an update.

149. I have considered all of the above information and conclude there was excessive delay incurred by the Trust in responding to the complainant's concerns. Although the Trust state the complaint was not handled in accordance with the HSC Complaints Procedure, this gives a comparable timeframe for my consideration. I consider an almost one year timeframe for closure of the issues is unacceptable. I also consider the failure of the Trust to update the complainant during this time aggravates the delay. The second Principle of Good Complaint handling is 'Being customer focused' which requires public bodies to deal with complainants 'promptly and sensitively, bearing in mind their individual circumstances'. I consider this standard has not been met in this case. **I consider therefore these failings constitute maladministration and I uphold this element of the complaint**.

150. I am satisfied that as result of the maladministration I have identified above, the complainant sustained the injustice of uncertainty and frustration.

CONCLUSION

151. I received a complaint about the actions of the Belfast Health and Social Care Trust.

152. I have investigated the complaint and have found a failure in the care and treatment the patient received in respect of:

- Failure to appropriately administer fluids in the period between 7 December 2011 and 13 December 2011;
- Failure to keep the decision of transfer to HDU/ICU under review; and
- Failure to consider a DNACPR order prior to 13 December 2011.

153. I have found maladministration in respect of the following:

- Failure to have an appropriate discussion with the family following a DNACPR order being made;
- Failure to communicate that the patient was no longer a candidate for HDU/ICU;
- Failure to record reasons why the time limit for accepting complaint was extended;
- The designation of the complainant's concerns as an enquiry;
- Failure to inform the complainant that her concerns were being treated as an enquiry;
- Failure to keep records of telephone calls; and
- Failure to respond to the complainant's concerns in a timely manner.

154. I am satisfied that the failures in care and treatment, and the maladministration which I identified caused the patient to experience the injustice of loss of opportunity to receive the appropriate fluids, and uncertainty. I am also satisfied that the complainant experienced the injustice of distress, upset, uncertainty, frustration, and time and trouble in bringing her complaint to my Office.

155. I have not found a failure in care and treatment or maladministration in respect of:

- The decision not to transfer the patient to HDU or ICU; and
- The decision not to carry out a further independent review of his care and treatment during the complaints process.

Recommendations

156. I recommend:

- The Chief Executive of the Trust provide the complainant with an apology for the failings identified, within one month of the date of my final report; and
- The Trust make a payment of £1500 to the complainant by way of solatium for the injustice of loss of opportunity, distress, upset, uncertainty and frustration

157. I consider there were a number of lessons to be learned which provide the Trust with an opportunity to improve its service, and to this end I recommend that the Trust:

- Provide training to complaints staff regarding the requirement for record keeping, in particular in relation to telephone calls and where the time limit for accepting complaints is extended;
- Reconsider the practice of deciding to treat certain complaints as 'enquiries', in particular how time is managed and how the decision is communicated to the complainant; and
- Provide training to relevant staff of the content of the joint statement and the human rights based approach.

158. I recommend that the Trust implement an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of the 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).

159. I am pleased to note that the Trust accept my findings a recommendations in relation to this case.

Marie Anderson

MARIE ANDERSON
Ombudsman

September 2018

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.