Investigation Report

Investigation of a complaint against the Northern Health & Social Care Trust & the Belfast Health & Social Care Trust

NIPSO Reference: 17667 & 18096

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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.

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SUMMARY

I received a complaint about the care and treatment provided to a patient in Antrim Area Hospital from December 2014 to January 2015. The complainant, the patient's daughter, stated that the deterioration in her father's vision while he was in the hospital was not acted upon quickly enough, leading to the total loss of his sight.

All relevant documentation in relation to the patient's treatment was obtained. Independent professional advice was sought from a number of advisors to help in my assessment of the clinical judgment of the health professionals involved in the patient's care and treatment.

My investigation found that when they were alerted to the patient's 'red-eye' symptoms, medical staff failed to properly assess his vision and to seek immediate specialist advice. I also found that ophthalmology staff did not conduct a next day review to assess his condition. Instead he was given a routine appointment for nine days later.

I concluded that the ongoing significance of the patient's developing condition should have been investigated and escalated earlier. Earlier diagnosis would have ensured that antibiotics were given at the appropriate time and this would have much improved the chances of the patient retaining his vision.

I also found maladministration in respect of the Trust's handling of the complaint.

I did not find failures in relation to the overall medical and nursing care provided by the Northern Health and Social Care Trust.

In view of my findings I recommended that the complainant should receive a written apology for the failures identified in the report, and a total solatium of £1000. I also made a number of recommendations to the two Health and Social Care Trusts involved in the case, in particular that they jointly conduct a review of the Ophthalmology service provided to patients in the Northern Health and Social Care Trust, focusing on eye casualty and inpatient referral.

THE COMPLAINT

1. The patient's daughter complained about the actions of the Northern Health and Social Care Trust regarding the care and treatment of her father following his admission to Antrim Area Hospital on 21 December 2014, and her distress at subsequent events. She also complained about the Trust's complaint handling.

2. Her father was admitted to the hospital with a diagnosis of sepsis, most likely from his chest or urinary tract. He had a previous history of prostate cancer, aortic valve replacement, Diabetes (type 2), hypertension and increased cholesterol. He was admitted to Ward C3 on 22 December 2014 and treated there until transfer to Belfast on 8 January 2015. When problems with his eyes were raised, he was seen by a visiting Ophthalmology Specialty Registrar from the BHSCT on 29 December 2014 while still an inpatient in the hospital. He was then seen again by BHSCT staff as an outreach patient at an ophthalmology clinic in the hospital on 7 January 2015. The complainant raised a number of issues in relation to the medical and nursing care provided to her father. Her primary complaint centred on her father's deterioration in eyesight, leading to total loss of vision. She complained that this deterioration was not acted on quickly enough which could have allowed some of his eyesight to be saved. He lived with the loss of sight for over a year, and sadly passed away on 16 January 2016.

3. After assessment, the complaint was accepted by this Office for investigation on 8 August 2017. During the investigation of the complaint about NHSCT it was decided that the scope of the investigation should be extended to include the actions of BHSCT (by virtue of the discretion afforded by section 24 (2) of the 2016 Act). The BHSCT provided specialist ophthalmology care to the patient while he was in Antrim Area Hospital and the actions complained of in relation to the BHSCT are linked to the actions of the NHSCT. It was also determined to issue this single composite report of the investigation to both Trusts in order to provide a clear and full explanation to the family and the Trusts (including relevant health professionals) as to how I reached my

conclusions. A composite report will also help to ensure the best possible opportunity for learning from the investigation of this complaint. The NHSCT and BHSCT were informed of this decision on 16 May 2018.

Issues of Complaint

4. The issues of complaint which were accepted for investigation in respect of NHSCT are:

   Issue One: **Whether the care and treatment provided to the patient at Antrim Area Hospital from 21 December 2014 – 8 January 2015 was appropriate and reasonable?**

   Issue Two: **Whether the NHSCT's investigation of the complaint on behalf of the patient, dated 10 January 2015, was reasonable?**

   I accepted the following head of complaint for investigation in respect of the BHSCT:

   Issue Three: **Whether the ophthalmological service provided to the patient between 29 December 2014 and 7 January 2015 was appropriate?**

INVESTIGATION METHODOLOGY

5. In order to investigate the complaint, the Investigating Officer obtained from the both Trusts all relevant documentation together with their comments and that of relevant staff on the issues raised by the complainant. This documentation included: the patient's medical notes and records from both Trusts and information relating to the NHSCT's investigation of the complaint. A series of clarifications and comments were sought from the Trusts during the investigation.

6. A copy of this draft investigation report has been provided to the complainant, the Trust and the relevant Trust staff for comment.

Independent Professional Advice

7. In order to assist in my assessment of the clinical judgement of the health professionals involved in the patient's care and treatment, I obtained professional advice from the following independent professional advisors (IPA):

   A Consultant Physician and Gastroenterologist - (Consultant Lead IPA)

   A Consultant Ophthalmic Surgeon – (Ophthalmologist IPA)

   A Consultant Cardiologist – (Cardiology IPA)

   A Consultant Physician specializing in Infectious Diseases – (Microbiology IPA)

   A Consultant Neurologist – (Neurology IPA)

   A Consultant Nurse – (Nursing IPA)

   I have shared a copy of the clinical advice with the Trusts and relevant staff and I have considered comments on that advice.

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

Relevant Standards

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

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

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

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

12. The specific standards relevant to this complaint are:

- General Medical Council (GMC), Good Medical Practice (2013)[2].
- NICE Clinical Guidance: Unstable angina and NSTEMI: early management (2013)[3]
- NICE Clinical Knowledge Summaries: Red Eye Scenario Management (2016) – current version but in place from 2008[4]
- NHSCT Complaints and User Feedback Policy and Procedure (2013)
- Health and Social Care Board (HSCB) - SAI Procedure (2013)[5]

13. 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.

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[2] General Medical Council (2013). *Good Medical Practice. A*ccessed: www.gmc.uk.org/guidance/good_medical_practice.asp
[3] https://www.nice.org.uk/guidance/CG94 (2013)
[4] https://cks.nice.org.uk/red-eye#!scenario
[5] HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents – October 2013

INVESTIGATION

Issue One: Whether the care and treatment provided to the patient at Antrim Area Hospital from 21 December 2014 – 8 January 2015 was appropriate and reasonable?

Detail of Complaint

14. The patient's daughter complained to NHSCT by email on 10 January 2015 shortly after he had been transferred from Antrim Area Hospital to the Royal Victoria Hospital in Belfast on 8 January 2015. She stated in her email to NHSCT she was lodging the complaint 'as instructed' by her father. The primary focus of the complaint was 'his lack of treatment …culminated in the severe and debilitating infection …which has left him completely blind'. Subsequently she wrote to the NHSCT and provided a detailed day-by-day breakdown of issues with her father's care. In summary the main issues she raised with the NHSCT, in relation to her father's care and treatment, were as follows:

    (i) 23 December 2014: failure to communicate 'heart attack' to family; and fall at bedside;

    (ii) 24 December: lack of infection control practices/nursing;

    (iii) 25 December: onset of red, swollen, painful, watery eye;

    (iv) 26 December: treatment of eye;

    (v) 27 December: issue with trainee nurse;

    (vi) 28 December: Communication with family; heart monitoring; onset of blindness;

    (vii) 29 December: issue with trainee nurse; delayed treatment for blindness;

    (viii) 30 December: delayed treatment for blindness; communication with patient/family;

    (ix) 31 December: follow up to initial eye examination; and

(x) 1 January 2015 – 8 January: resiting cannula delay; follow up regarding eyes; and transfer to Belfast

15. The NHSCT's response to the complaint was provided in two parts, the timing and reason for this are explained below. The initial response by letter dated 26 June 2015 from the NHSCT Director of Acute Hospital Services related to general nursing and ward based issues. The response stated that there was no record or recollection of staff of a fall on 23 December 2014.The reply also confirmed no isolation infection controls were warranted beyond normal nursing practice. The letter further responded on the issues of the supervision of the trainee nurse involved in the patient's care, transfer away from a Staff Nurse to Bay 4, and the delay in resiting a cannula. The NHSCT letter offered an apology for the experience with the trainee nurse and the delay in resiting the cannula.

16. The NHSCT responded further by letter dated 11 May 2016 to the medical aspects of the complaint. In a detailed letter from the NHSCT Director of Acute Hospital Services, a commentary from the medical notes is provided with some limited further elaboration. The letter summarised the NHSCT's position as:

'Your father's condition was greatly improved on his discharge from Antrim Hospital and his infection and heart failure were much better but his eyesight was very poor.

Dr […} has advised that he feels confident that your father received clinically appropriate care to a high standard. He confirms that all those involved with your father's care worked closely with each other to prioritise and treat his condition. He is however very sorry that your father lost his sight.'

17. This letter was sent 16 months after the patient's admission to the hospital and five months after his death on 16 January 2016. The letter offered his daughter an opportunity to meet if any aspect of her father's care was not understood or if she wished to discuss matters further.

18. In considering this complaint I have focused on the primary complaint regarding NHSCT's care and treatment of the patient's eyesight when problems arose. I have considered the response by NHSCT to the number of issues raised by the complainant and her documented dissatisfaction with the responses received. I provided full details of her complaint to NHSCT when I sought independent professional advice. These issues are considered below.

Evidence Considered

19. The Investigation Officer obtained the patient's NHSCT notes and records from the hospital and the complaint file held by NHSCT administration. The NHSCT was provided with an opportunity to address the complainant's outstanding concerns. In particular, an opportunity was provided to the lead Consultant and the Medical Registrar to comment on their interaction with the patient and his family. Both Doctors provided written comments by way of response to the complaint. As part of the investigation, the patient's BHSCT medical notes and records were obtained and examined for the period 8 January 2015 until his discharge.

20. In response to investigation enquiries about the complaint the NHSCT stated by letter of 17 July 2017:

'[The patient's] eyes were noted as being mildly swollen with a clear discharge and then red when the doctors was assessing and treating him for pneumonia. He started to complain of vision loss on 29 December 2014. {He] was commented[sic] on eye drops on 26 December.

…[The doctors']' team took steps to have the situation reviewed by the specialist service. [The patient] received treatment for a swollen, red eye in Antrim Hospital. However this deteriorated on 29 December 2014 when [he] complained of vision loss. This was assessed thoroughly at the time by Dr […] who contacted the ophthalmology registrar for further advice regarding treatment.

…There was no delay in seeking expert medical advice from the ophthalmology department…

…From a clinical perspective no learning was identified that could have changed the course of [the patient's] treatment and care in Antrim.'

21. As part of the investigation, the patient's records were obtained from both NHSCT and BHSCT and examined. In order to obtain their advice, copies of the records and relevant correspondence was provided to the IPA's. I have noted the following entries in the clinical records to be significant. On 23 December 2014 the patient's blood tests were confirmed positive for pseudomonas aeruginosa[6]. The nursing notes record that at 11.30am on the morning of 26 December 2014 he had 'sticky eyes/lids' and a doctor had seen him. An entry in the notes at 10.30am on 26 December 2014 by an F1[7] Doctor noted 'left eye very red and swollen with clear discharge'. The record indicates that Antibiotic eye drops were prescribed and administered, and also suggests monitoring for improvement.

22. As he was seen by a number of specialist doctors who contributed to his overall care and management, advice from a number of independent professionals was sought. This was to ensure for the purposes of the investigation that each discipline which contributed to his care was assessed.

23. In relation to the patient's cardiology symptoms, and the cardiology care provided to him, the Cardiology IPA examined the relevant records and advised:

'His management was in accordance with established good practice and in line with NICE guidance...

Overall the cardiac care [he] received was timely and appropriate. I have not found any failings in his clinical care.'

I also note the explanation provided by the Cardiology IPA regarding raised

[6] Pseudomonas aeruginosa is a Gram-negative bacterium often found in soil and ground water. P. aeruginosa is an opportunistic pathogen and it rarely affects healthy individuals. It can cause a wide range of infections, particularly in those with a weakened immune system.
[7] A Foundation doctor (F1 or F2 also known as a house officer) is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical **training** programme which forms the bridge between **medical school** and specialist/general practice **training**.

levels of troponin T[8] after admission and for several days; and the likelihood of a type 2 myocardial infarct[9] as a result of his severe systemic infection causing heart strain, rather than a sudden blockage of a coronary artery. The Cardiology IPA also provided a thorough explanation of the possibility of infective endocarditis[10] on his artificial aortic valve, the potential to confirm by TOE[11] and the risks with his poor condition.

24. In relation to a possible neurological cause of the patient's symptoms and the neurology care provided to him, the Neurology IPA advised:

'The Neurology care…was generally appropriate and reasonable…involvement was correct in identifying the cause of [his] visual loss as being non-neurological.'

25. The medical team treating him were advised by the NHSCT microbiology team who identified the particular strain of infection and recommended treatment. In relation to his care in this regard, the Microbiology IPA advised

'In summary I believe that the Microbiological management of [the patient] was of a high standard and appropriate antibiotics and tests were advised in his inpatient care.'

26. As part of the investigation, I considered the role of general nursing care in escalating the patient's onset of eye symptoms was an issue, and independent nursing professional advice was obtained for these purposes. The Nursing IPA advised:

'*Nursing care was generally appropriate, reasonable and in accordance with*

[8] Troponin T is specific cardiac structural protein. A diagnosis of a Myocardial Infarction (MI) requires careful clinical evaluation, particularly of chest pain characteristics and risk assessment together with accurate ECG interpretation. It is important not to interpret an elevated Troponin T in isolation. It only indicates an MI if the clinical presentation also supports this diagnosis.
[9] Heart muscle damage often related to low blood pressure, low oxygen content or build up of acid in blood in other serious medical conditions including systemic infection – see Cardiology IPA
[10] Endocarditis is a rare and potentially fatal infection of the inner lining of the heart (the endocardium). It's most commonly caused by bacteria entering the blood and travelling to the heart. It may be more prevalent in patients with a prosthetic (artificial) heart valve. Source NHS.UK
[11] Transoesophageal Echocardiogtrraphy which involves passing a probe with an echo transducer attached down the gullet under sedation.

expected standards of nursing practice.

Nursing care and treatment was properly documented and in accordance with relevant guidance and practice.'

However, the Nursing IPA observed as potential learning that outcomes for NHSCT as follows:

(i) communication with the family regarding infection control practices could have been better

(ii) improved [increased] supervision of trainee nurses was needed; and

(iii) a debriefing for staff once a complaint had been made would have been beneficial.

27. I note that the patient's care was provided on a general medical ward under the supervision of a Consultant Gastroenterologist, who in this case accepted overall responsibility for coordinating care from multiple medical disciplines. I obtained independent professional advice from a Consultant Gastroenterologist with experience managing patients with general medical conditions on an acute ward and coordinating care from multiple medical disciplines. The Consultant Lead IPA advised as follows:

'It appears that [the patient's] treatment was reasonable, appropriate and followed standard guidelines that would be expected in any NHS hospital in the UK. However, discussion around the rise of troponin in severe sepsis - what is described as Type ii MI (heart attack) should have been succinct and clear between the clinical team and family members – that given the current state of severe sepsis, no invasive cardiac investigations are suitable and may not change the current clinical management.

The inpatient medical care was relatively well documented that would generally be seen in any busy acute hospital trust in the UK.

On 26th December when it was noted that [the patient's] left eye is red, painful and with clear discharge, at that stage he was very unwell with sepsis and was on IV antibiotic, and topical therapy with chloramphenicaol was

prescribed and advised to be monitored. The case should have been discussed with eye casualty as painful red eye is a medical emergency.'

28. The complaint focuses on the circumstances which led up to the complainant's father losing his sight, The Ophthalmology IPA advised [author emphasis]:

*'**From an ophthalmic perspective it is regrettable that no attempt was made to formally assess his vision in each eye when he first complained of red eyes on 26 December 2014.** By formal assessment I mean that his visual acuity should have been tested with each eye separately with his reading glasses to see if he could read newsprint of varying sizes. As the eyes remained red this should really have been done on 26th. 27th. and 28th. December 2014. It is impossible to say with hindsight but it is likely that the visual acuity in the red, left eye with swollen lids, was much worse than in the right eye. This would have alerted the team to the fact there was a serious problem with the left eye earlier. This would have emphasised the need for a specialist ophthalmic examination, much earlier.*

Earlier diagnosis would have ensured that the intra-vitreal antibiotics were given earlier particularly to the right eye which would have much improved the chances of DM retaining vision. The earlier this condition is recognised and treated with intra-vitreal and intravenous antibiotics the better the prognosis.'

29. By letter dated 10 May 2018, the NHSCT Director of Surgical & Clinical Services responded to the IPA reports, accepting the contents of the Neurology, Cardiology and Microbiology IPA reports without comment related to the issues of complaint. The NHSCT accepted in the main the advice provided by the Nursing IPA with some caveats regarding the evidence/analysis and attribution of Pseudomonas infection. In relation to the Gastroenterology Consultant Lead IPA advice, the NHSCT responded by providing comments from the lead Consultant which stated:

'The family were advised on a number of occasions that [the patient's] main clinical problem was his infection and it was this that had caused his heart attack, rather than just a pure heart problem. The Cardiologist agreed and it

was explained to the team that the best option for his heart was to cure his infection.

There is no eye casualty in Antrim Hospital and it was discussed instead with an ophthalmologist.'

The NHSCT responded to the Ophthalmology IPA advice and stated:

'The Trust accepts that on reflection there is work to be done with the Belfast Trust to strengthen the cross Trust referral / consult process for ophthalmology inpatients who require immediate assessment.'

Analysis and Findings

30. The complainant provided the NHSCT with a detailed account of her family's recollections, concerns and issues of complaint shortly after her father was discharged from NHSCT. She accepted that some of the observations were more minor, for instance her concerns about the reference to patient stimulation. However, she clearly articulated the significant issues of concern regarding her father's loss of eyesight, infection and cardiac treatment.

31. I have taken account of the NHSCT response to the complainant of 26 June 2015 which dealt with some of her complaints. I note the NHSCT finding no records or evidence of a fall, explanation of food hygiene practice and isolation nursing as well as infection control practices. The NHSCT response also dealt with the supervision of trainee nurses, her complaint about individual nurse attitude and delay in resiting cannula of some 6-11 hours. Following the Investigation Officer discussing these areas with the complainant it was accepted they did not warrant investigation in the context of the seriousness of the 'red eye' aspects of the complaint.

32. I note that the letters from the NHSCT on 26 June 2015 and 11 May 2016 to the complainant failed to identify the bacterium in the positive blood cultures taken from the patient as pseudomonas aeruginosa. I can find no explanation for the omission of that information and it is surprising given that the

microbiology records clarify the presence of the organism in the initial sample. The complainant provided information on the prevalence of pseudomonas in Antrim Area Hospital. Given that the initial blood cultures taken from the patient shortly after admission were subsequently tested positive for pseudomonas (23 December 2014) I am satisfied there is no hospital acquired infection aspect in this case.

33. I have considered the detailed comments of all IPA's relating to the complainant's care. His clinical presentation was complex and challenging. This is confirmed by all the IPAs. All IPA's were of the opinion that the attempts by NHSCT clinicians to diagnose and treat his underlying infection and sepsis were reasonable and appropriate. I accept this advice and find that the general medical care and treatment provided to him in respect of neurology, cardiology, microbiology and overall clinical management met accepted clinical practice standards and guidelines.

34. The Cardiology IPA generally found the cardiology treatment as reasonable and appropriate and found no detriment or deterioration arising from any particular aspect. However, I note that the records of clinical decisions on treatment and examinations were not adequately recorded in line with GMC guidance, with respect to considering the TOE procedure. I consider that the cardiology staff should be reminded of the GMC guidance.

35. The complainant's primary concern related to the onset of 'red eye' with swelling and clear discharge from her father's left eye. She complained that her father's underlying pseudomonas aergionosa infection was not assessed and treated as early as possible, causing him to lose his sight. She records that the family noted her father's eye red on the visit on 25 December 2014 and raised the matter with nursing staff. There is no record of this in the nursing records at that time. The first record of a concern appears in the nursing notes as occurring on 26 December 2014 at 11.30. The time recorded is after the time recorded in the medical notes for the attendance by the Doctor who stated he had been 'ATSP' (Asked To See Patient). I find on balance it is likely that

the request for a doctor to see the patient was made after the previous doctor attendance at 14.30 on 25 December 2014 and before 10.30 on 26 December 2014. I accept the complainant's concerns in this regard were raised on the ward on 25 December 2016.

36. The Ophthalmology IPA advice has been accepted by the BHSCT Consultant Ophthalmologist as an 'excellent' piece of work. I accept the Ophthalmology IPA advice regarding the following:

    (i) appropriate visual acuity assessment and potential referral to eye casualty as early as 26 December 2014 was warranted and did not occur. The Consultant Lead IPA also advises on the urgent need to assess and treat 'Red Eye' symptoms. This is a failure in the NHSCT care and treatment of the patient; and

    (ii) the Ophthalmology IPA advised, after the initial assessment on 29 December 2014 by BHSCT, that the circumstances and decisions on commencing the appropriate treatment ought to have been reviewed the next day. The purpose of that review ought to have been to decide if intra-vitreal antibiotics could be administered at that time. It was not appropriate that the review was left for a routine appointment some nine days away. I have given further consideration to this issue later in this report.

37. I uphold the complaint in part in that I find a failure by NHSCT to appropriately assess and make timely decisions to seek expert advice regarding the patient's eye condition. This failure continued after the initial inadequate assessment as several other doctors and consultants examined or reviewed him. The ongoing significance of his developing "red eye" condition should have been further and sooner investigated and escalated. In consequence of these failings I consider the patient suffered the injustice of a loss of opportunity for earlier treatment which may have ensured a different outcome for him. I consider that the complainant sustained the injustice of distress, frustration and anxiety at the NHSCT delay in appropriately assessing and caring for her father's eye condition. Given the impact that loss of vision had on the patient's quality of life

in his last 12 months, it is of concern to me that the NHSCT staff did not act more swiftly. The loss of vision would have caused distress, frustration and anxiety to the patient's relatives in witnessing his loss of independence and his requirements for attention and care. I accept that there is no degree of certainty about any potential retention of his sight. I deal with the appropriate remedy in the Conclusion section of this report.

Issue Two: Whether the NHSCT's handling of the complaint on behalf of the patient, dated 10 January 2015, was reasonable?

38. The patient's daughter complained about her father's care and treatment by email to NHSCT on 10 January 2015. After receiving the appropriate consent the NHSCT logged the complaint on 28 January 2015. The complainant stated that the NHSCT response to her complaint was substantially delayed, and did not adequately address the main issue of concern, namely the loss of her father's eyesight.

39. In response to the initial complaint the NHSCT responded by letters of 26 June 2015 and 15 May 2016. I have previously set out details of the Trust's response to the complaint.

40. The NHSCT Complaints and Service User Feedback Policy and Procedure applicable at the time was the February 2013 version. It is clear that an October 2014 version also existed which was not provided to the Investigating Officer in this case. The Trust also provided an August 2016 version of the policy. All Trusts were required to adopt a complaint policy and procedure in line with regional HSC Complaints Procedure (2009) under the Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009[12].

41. All versions of the NHSCT complaints policy state in the Executive Summary:

'Effective service user and public involvement is an important part of our

[12] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20Complaints%20Procedure%20Directions%202009.pdf

governance arrangements…helps to improve the quality of services we offer…

We are strongly committed to listening to our service users, investigating their concerns, issues and complaints and making improvements where necessary.'

The NHSCT Complaints Policy also outlines in detail the respective roles of staff, managers, complaints staff, Directorate investigating Officers, Assistant Directors, Directors, the Engagement, Experience and Equality (Triple E) Group and Chief Executive.

Analysis and Findings

42. I have carefully examined the complaint material provided by the NHSCT. I have found the following:

i) The complaint was graded as either medium (NHSCT letter of 4 December 2017) or high level (chronology provided by NHSCT attached to letter of 4 December 2017). In either case NHSCT did not provide evidence of a contemporaneous record of the grading or appropriate identification on the risk matrix.

ii) The complaint was forwarded directly to relevant staff on 30 January 2015. There is no record or contemporaneous evidence of any discussion of the complaint between the Governance Manager, relevant Assistant Director, Director or Chief Executive (Policy 26.6.1)

iii) There is no evidence or record of a contemporaneous discussion of the appropriate level of investigation to be carried out eg Root Cause Anlysis (RCA) for complaints graded medium or above. (Policy 26.6.1)

iv) There is no evidence of consideration of the potential for the complaint to be escalated to a Serious Adverse Incident[13] and dealt with accordingly (Policy 26.6.2 and 26.6.3). The NHSCT response by letter of 4 December 2017 on this point states:

[13] See definition and reference to risk grading in Appendix Four

'[The patient] was admitted with severe sepsis secondary to pseudomonas aeruginosa. Unfortunately the organism developed resistance to initial therapy leading to a further episode of sepsis which resulted in endophalmitis[14]. This was considered as a secondary diagnosis/complication in [his] medical condition. It was not treated as a clinical incident.'

Unfortunately that explanation does not reflect the Ophthalmology IPA's advice which is referred to previously in this report. Further, NHSCT did not provide documentation to indicate or record any discussion about the necessity to seek comment from BHSCT about the ophthalmology aspects of the complaint and no such contact took place. As a consequence there was no liaison with the BHSCT regarding ophthalmology care (HSC Policy 3.22). The absence of these records calls into question how the issues of the complaint were adequately identified and by whom (Policy 26.6.5). This fundamental step in the decision making process regarding the patient's case is not recorded.

v) There is no evidence or contemporaneous record of the appointment of a Directorate Investigating Officer to undertake and complete the investigation (Policy 26.6.3 and 26.6.4) The NHSCT letter of response to the Investigating Officer dated 4 December 2017 did not identify the Directorate Investigating Officer. This was despite a direct question to 'confirm the identity'. However, the letter indicated that the Consultant Microbiologist involved in the care provided to the patient completed the Investigation Checklist and Learning Alert.

vi) The Investigation Checklist as completed by the Microbiologist records verbal and written reports only from Microbiology staff as follows: (i) 'No' against 'information sought from complainant'; (ii) 'No' against 'other evidence source eg expert/independent advice sought'; (iii) 'No' against need for meeting considered with the complainant and (iv) 'None' against 'Details of other actions taken during the investigation?'

[14] Endophthalmitis is an inflammatory condition of the eye usually caused by infection

The checklist is dated 9 February 2015, one week after receipt. I find it difficult in the circumstances to describe this as an 'investigation'. It appears that the Consultant Microbiologist completed the form when he had been asked to provide his comments on the complaint in early February 2015. There is no evidence of an NHSCT investigation adopting a 'Root Cause Analysis' approach as was required by NHSCT Complaint policy (Policy 26.6.1).

vii) I find there is no evidence or contemporaneous record that the NHSCT complied with the NHSCT Complaints Policy under the following sections:

26.6.4 – lack of coordination of investigation

26.6.5 – consideration of appropriate investigation techniques

26.6.6 – no identifiable Investigating Officer to discuss with Assistant Director or Director.

26.6.7 – records or evidence relating to investigation not generated or maintained.

26.6.8 - No record of consideration of meeting the complainant or record of reasoning of deciding not to meet her

26.6.9 - No evidence of draft response prepared by investigating officer: it appears the initial response was prepared between 15 and 25 June 2015 but no records or contemporaneous evidence of the nature of the investigation undertaken has been provided by NHSCT beyond the contents of the letter. Similarly with the NHSCT response of 11 May 2016 no records or contemporaneous evidence of the nature of the investigation undertaken has been provided by NHSCT beyond the contents of the letter.

viii) There is no record or contemporaneous evidence to explain why the complaint was not responded to by 25 February 2015. I refer to Paragraphs 26.6.13 and 26.6.16 of the complaints policy. The various disciplines of cardiology, microbiology and neurology had provided their comments by 13 February 2015. The explanation offered to the complainant and my Office was that the unplanned absence of the lead

Consultant and the complexity of the case delayed the complaint response. However, the Consultant's period of absence did not commence until 11 May 2015 by which time the complaint response was already 74 days overdue. From the available NHSCT records there is no obvious explanation for this period of delay. I have no doubt that the unplanned absence of the lead Consultant was a significant factor in the NHSCT delay in responding to the complaint. However, I have identified that the complaint response was significantly overdue before he went on leave. Further, he returned even on a phased basis there was additional delay. I note that the NHSCT attempted to source another consultant to investigate the complaint. However, I find that the NHSCT failed to take action as required by the NHSCT complaints policy.

ix) The initial NHSCT response to the complainant of 26 June 2015 was 120 days overdue beyond the NHSCT complaint policy timescale. The further full response on clinical aspects of the patient's care of 11 May 2016 was 441 days overdue. I acknowledge that the NHSCT apologised for the delay. However, in the context of the clinical failings I have identified in this report I conclude that investigation undertaken by the NHSCT was inadequate.

x) There are no records or contemporaneous evidence of an investigation which meets NHSCT policy, regional procedures and HSC Practice Directions. This is of concern given my findings relating to the patient's ophthalmology care.

xi) There is no adequate evidence of escalation or appropriate consideration by the Chief Executive's office or the Triple E Group of the continuing delay in responding to the complaint or the detail of the nature of the investigation ongoing. The NHSCT provided a copy of an Executive Team briefing paper which recorded the complaint as '40+ days'. In fact it was 90 days overdue at that stage. The paper describes the complaint as

'A daughter was unhappy with the substandard care and complete disregard for her father's condition whilst in Antrim Area Hospital.

Complaint is still ongoing as there are a number of professions involved. The complaint has been escalated to the Assistant Director.'

This is confusing as the various professionals had provided their comments within the original complaint timescale and the lead Consultant had just gone on leave two weeks previously. The reference to 'escalation' to Assistant Director is not reflected in the records provided as part of this investigation. In any event the NHSCT Complaint Policy requires that both the Assistant Director and Director ought to have been informed of the complaint and also the delay.

xii) In the NHSCT complaint records I have considered further evidence of communications with the patient and the NHSCT Complaints Department and Chief Executives Office on the issue of the delay. The complainant was also unhappy with the response to the complaint as she believed it did not deal with all of the issues raised by her.

43. The failures I have outlined by the NHSCT to properly apply their own policy and procedure for complaints shows the Trust failed to meet the Principles of Good Complaints Handling set out in Appendix Two. I conclude that this amounts to maladministration by the NHSCT. I find that the complaint handling was attended by significant delay, failure to follow policy and failure to conduct a thorough investigation specifically addressing the issue of ophthalmology care in conjunction with BHSCT. I therefore uphold this part of the complaint. I accept that the injustice of uncertainty, upset, and frustration would have also been caused to the patient and equally to the complainant in relation to the NHSCT complaints handling. I deal with the issue of remedy for those injustices in the conclusion of this report.

Issue Three: Whether the ophthalmological service provided to the patient between 29 December 2014 and 7 January 2015 was appropriate?

44. The complaint also related to the treatment of the patient's eye condition during the period 29 December 2014 to 8 January 2015. The complainant identified

the delay in treating her father's eye condition. The BHSCT were unaware of that complaint until contacted by my Office in September 2017. The ophthalmology service in Antim Area Hospital was provided by BHSCT staff. In this case, the BHSCT staff provided advice by telephone, travelled to the hospital for an initial assessment on 29 December 2014, and arranged a review at the hospital's eye clinic on 7 January 2015. The clinic appointment was arranged on a routine basis as this was the next available date.

45. As part of investigation enquiries, the patient's notes and records were obtained for the period 8 January 2015 until his discharge from BHSCT.

46. The Ophthalmology IPA advised [author emphasis]:

'[29.12.14] 20.30 – [Patient] was examined by a Specialist Registrar, ST 7, from the Royal Victoria Hospital, Belfast. He gave a 3-5 day history of a red left eye followed by a 1 day history of a red right eye and then approximately a 1 day history of bilateral severe visual loss. For the record, apart from reading glasses, [he] had had no previous eye problems. His visual acuity at that time was hand movements in the right eye and perception of light in the left eye. There was evidence of severe inflammation in the anterior segments of both eyes with a trace of hypopyon (white blood cells) in the right eye. Despite dilating him it was not possible to obtain any useful view of the fundus (back of the eye). This is largely because the pupils, particularly the left, would not dilate well due to inflammatory adhesions. The differential diagnosis was documented as:

1. *Bilateral endogenous endophthalmitis.*
2. *Bilateral uveitis.*
3. *Bilateral cataracts.*
4. *Bilateral ischaemic neuropathy.*

[The] case was discussed at length with […] the Consultant Ophthalmologist on call on 29 December 2014.

In view of the patient's poor current medical condition no intervention was felt to be appropriate. The patient was continued on I/V Meropenem and Gentamicin. It was felt that intra-vitreal samples for microbiology and antibiotics were not required. The Specialist Registrar discussed the most likely diagnosis with the family stressing that [he] was unlikely to retain any sight. The Registrar also discussed the case with […] the Microbiologist who was happy with systemic Ciproxin 400mgs a day to be added. This has been shown to have good vitreous penetration. In addition it was noted that intra-venous Meropenem has good central nervous system penetration (CNS). He said he would arrange for review by the ophthalmology team who visit Antrim Area Hospital twice a week …

07.01.15 – {He] was seen by […] Consultant Ophthalmologist. She recorded a visual acuity of no perception of light in the right eye and barely perception of light in the left eye. His intraocular pressures were significantly raised at 38mms/Hg in the right eye and 36mms/Hg in the left eye. There was bilateral corneal oedema and conjunctival injection. His pupils were very small. There was fibrin (inflammatory material) over both pupils with no hypopyon. Her opinion was that the only way to salvage any sight (if at all possible) was to give bilateral intra-vitreal antibiotics. She planned to discuss this with her Royal Victoria Hospital colleagues in particular the feasibility of doing this and where. She explained this to [his] son … saying that an Ophthalmology ward would not be the appropriate place to safely treat somebody with [his] serious medical problems.

…

[After 29 December 2014 Ophthalmology assessment]… ***I do feel however that he should have been reviewed the next day by an experienced Ophthalmologist to see if, with planning, it was possible to give the intra-vitreal antibiotics****'*

47. The BHSCT was provided with a copy of the Ophthalmology IPA and the Director of Surgery and Specialist Services responded by letter of 10 May 2018 and stated:

'…the report produced by the IPA is excellent…no further information to add...nor…disagree with any part of the report.

…this case did highlight a weakness of the on-call system that was in place at the time. The system has since been adjusted such that there is now a formal handing over of patient care after a night on-call.'

Analysis and Findings

48. I have carefully examined the Ophthalmology IPA advice and the BHSCT response. I accept the Ophthalmology IPA advice that the BHSCT care and treatment was appropriate and timely, when contacted by NHSCT staff. The advice also confirms that the decision not to attempt to give intra-vitreal antibiotics on 29 December 2014 was appropriate given the patient's serious health condition at that time.

49. On the question of timely follow up of the patient, I also accept the Ophthalmology IPA advice that it would have been appropriate to review the situation the next day after 29 December 2014 and/or subsequently rather than await an appointment at the routine eye clinic some nine days away. I consider this to be a failure in care and treatment by BHSCT staff and to have been ongoing from 29 December 2014 until his transfer. The system for handover, referral, prioritization, and monitoring of patients did not ensure that he was reviewed as a priority. I uphold this part of the complaint

50. I consider that the injustice sustained by the patient from this failing in care and treatment was the lost opportunity for consideration of earlier treatment which may have produced a different outcome for him. I consider the complainant and her family sustained the injustice of distress, frustration and anxiety at the delay in appropriately assessing her father's eye condition. I cannot conclude on the potential outcome for the patient had an urgent review taken place by an experienced ophthalmologist. I am satisfied that he and his family were caused distress, frustration and anxiety. I accept that there is no degree of certainty about any potential retention of his sight. However, the complainant and her family have suffered the injustice of uncertainty in this regard. I deal

with the appropriate remedy for this injustice in the conclusion section of this report.

51. Following the issue of my draft report I received detailed comments from the complainant. The Investigating Officer met her to clarify the issues she raised in her comments. I noted her view that greater emphasis should be placed on: the failure of medical staff in the hospital to appreciate the significance of “red eye” management and treatment over the period 26-29 December 2014, the failure of senior medical staff at BHSCT to follow-up the initial assessment on 29 December 2014 over the succeeding days rather than await a routine review appointment, and the NHSCT handling of the complaint in terms of delay and failing to address the “red eye” issue with BHSCT. After consideration, I made amendments to the report to take account of these comments.

CONCLUSION

I have investigated the complaint and have found failures in the NHSCT care and treatment in relation to the following matters:

(i) Delay in assessing visual acuity;

(ii0 failure to seek expert ophthalmology assistance in diagnosing condition after onset of ‘red eye’ symptoms

I have also found significant failures by NHSCT amounting to maladministration in relation to the following matters:

(i) Deficiencies in the NHSCT complaints process including excessive delay;

(ii) failure to appropriately address issues involving inter-Trust services;

(iii) inadequate investigation; and

(iv) failure to consider a Serious Adverse Incident investigation.

I have found failures in BHSCT care and treatment in relation to the following matters:

(i) Failure to ensure an urgent review by an experienced ophthalmologist on the availability of treatment options for the patient.

I am satisfied that the failures I have identified caused the patient to experience the injustice of a loss of opportunity for earlier treatment which may have resulted in a different outcome for him regarding his eyesight. The delay in complaint handling caused him the upset, distress and anxiety in not obtaining redress for this injustice through the complaint process during his lifetime.

I am satisfied that the failures in care and treatment and maladministration by NHSCT and BHSCT I identified caused the complainant and her family to experience the injustice of uncertainty, upset and distress.

I have not found failures in NHSCT care and treatment:

(i) General medical and nursing care provided to the patient from 21 December 2014 to 8 January 2015.

RECOMMENDATIONS FOR REMEDY

I recommend:

- The complainant should receive a written apology from the NHSCT Chief Executive for the failures identified in this report and a payment of £750 by way of solatium for the injustices I have identified within one month from the date of this report.

- She should receive a written apology from the BHSCT Chief Executive for the failures identified in this report and a payment of £250 by way of solatium for the injustices I have identified within one month from the date of this report.

In order to improve the service delivery of the NHSCT and BHSCT, I recommend that:

(i) NHSCT and BHSCT jointly conduct a review of Ophthalmology service provided to NHSCT patients, with a particular focus on eye casualty and inpatient referral.

(ii) The Trusts should provide me with a report of the outcome of the review

within three months from the date of my final report The report should include an action plan indicating responsibility for implementing recommendations and timescales.

(iii) The Trusts should provide me with an update on implementing the action plan within six months of the date of my final report. The update should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training materials, training records and/or self-declaration forms which indicate that staff have read and understood any related policies or procedures).

In order to improve the service delivery of the NHSCT, I recommend that:

(i) NHSCT should conduct a review of the operation of their complaint process in light of the findings in my report including: delays in responding; compliance with complaints policy; adequacy of investigation; and screening for SAI issues.

(ii) NHSCT should prepare a report on the outcome of the review. The report and an action plan incorporating any recommendations should be provided to me within three months from the date of my final report.

(iii) The Trust should update me within six months, of the date of my final report, on progress on implementing recommendations from the review. The update should include evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training materials, training records and/or self-declaration forms which indicate that staff have read and understood any related policies or procedures).

I welcome the fact that both NHSCT and BHSCT have accepted my findings and recommendations in full.

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.