Investigation Report

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

NIPSO Reference: 17742

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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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Appendix 1 – The Principles of Good Administration

SUMMARY

I received a complaint about Belfast Health and Social Care Trust in relation to the care and treatment given to the complainant's late mother.

Issues of Complaint

I accepted the following issues of complaint for investigation:

- Whether the Trust took sufficient action to minimise the risk of the patient's mother sustaining a fall whilst in hospital?
- Whether the Trust's Significant Event Audit (SEA) investigation was conducted in accordance with relevant policy and standards?

Findings and Conclusion

I have investigated the complaint and have found a failure in care and treatment in relation to a nurse's failure to ensure the patient had the correct footwear and to seek assistance from nursing staff before bringing her to the toilet.

I have also found maladministration in relation to the following matters:

- The SEA investigation did not have an independent chair as required under Trust policy;
- The SEA panel unfairly raised the family's expectations in a meeting by indicating that the nurse had made the wrong decision, when the SEA subsequently concluded she had not;
- The SEA investigation exceeded its published time limits by a considerable margin and failed to avoid undue delay;
- The SEA investigation failed to identify the suitability of the patient's footwear as an issue and failed to make appropriate recommendations to ensure learning;
- The SEA investigation wrongly concluded that ward staff did not escalate the incident and that senior management were not aware of the incident.

I am satisfied that the failure in care and treatment I identified caused the patient the injustice of being placed at a greater risk of falling due to the lack of appropriate footwear. I am satisfied that the maladministration I identified caused her daugher to experience the injustice of upset, uncertainty, frustration, outrage and a prolonged delay in ultimately receiving the investigation report.

Recommendations

I recommended that the Trust:

- Provide a sincere and meaningful written apology to the complainant for the injustice identified in this report. I consider this apology should provide details on the lessons learned from this investigation and a commitment that the Trust has taken action to implement my recommendations. The Trust should provide the apology within one month of the date of my final report;
- Provide the complainant with a payment of £750 by way of a solatium for the injustice identified by me which should be paid within one month of the date of my final report.

In addition to the learning identified by the Trust as a result of this complaint, I also recommended that the Trust:

- Take the necessary action to ensure that all relevant ward staff (including student nurses) have been involved in falls prevention training or instruction; in particular the importance of patients wearing appropriate footwear
- Take the necessary action to ensure that all patient safety incidents are reported according to guidance using Datixweb and actioned by relevant senior management;
- Provide an update on the progress of implementing the recommendations highlighted in the SEA report; and
- Review the practice and timeliness of sharing draft SEA reports with patient's families in order to ensure adherence to HSCB guidelines.

I recommend that the Trust develop an action plan to incorporate these recommendations and should provide me with an update within six months of the date of my final report on the progress in implementation. The update 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).

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust in relation to the care and treatment of a patient in the Mater Hospital. The patient had been admitted to the hospital overnight following a stroke and had a fall in a bathroom on the ward on the morning of 30 November 2015. She had been taken to the bathroom by a student nurse. The nurse said that the patient did not want her to be there and in order to respect her privacy she instructed her to pull the cord and waited outside. The alarm sounded and she was found lying on her left side on the floor. There was no evidence that she had sustained a head injury. However, she was found to have sustained a fracture to her left femur. The patient was transferred to the Royal Victoria Hospital (RVH) for hip surgery but died the following day after surgery on 5 December 2015. Her daughter complained that she should not have been left unattended in the bathroom and about the Trust's Significant Event Audit (SEA) investigation.

Issues of complaint

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

   Issue 1: Whether the Trust took sufficient action to minimise the risk of the patient sustaining a fall whilst in hospital?

Issue 2: Whether the Trust's Significant Event Audit (SEA) investigation was conducted in accordance with relevant policy and standards?

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 complained of. This documentation included information relating to the Trust's SEA investigation and the patient's medical records. The Trust also provided a photograph of the bathroom where the patient fell. The Investigating Officer also conducted interviews with Trust staff and the student nurse. As part of my process I shared a draft report with the complainant and the Trust. I have carefully considered those responses before arriving at my findings and conclusions.

4. After further consideration of the issues, independent professional advice (IPA) from a Nursing Advisor was obtained. The IPA is a practising nurse with seventeen years of experience working within both primary and secondary care at senior levels. The IPA has been head of clinical governance within primary care and has a sound working knowledge of clinical incident reporting.

5. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPA has 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

6. 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.

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

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

7. The specific standards are those which applied at the time the events occurred and which governed the exercise of the professional judgements of Trust staff whose actions are the subject of this complaint. The standards which applied to the exercise of the Trust's administrative functions were also considered,

The standards relevant to this complaint are set out below:

- The Trust's Falls Reduction and Prevention Policy
- HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents 2013
- National Patient Safety Agency 2007: Slips, Trips and falls in hospital
- NMC 2015: The Code. Professional standards of practice and behavior for nurses and midwifes
- National Patient Safety Agency 2009: Patient Safety Alert, Being Open, Supporting information

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: Whether the Trust took sufficient action to minimise the risk of the patient sustaining a fall whilst in hospital?

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

9. The complainant stated it was unacceptable for her mother to be left unattended in the bathroom, and that the fall could have been avoided. She also disputed that her mother would have been unable to pull the emergency cord due to the position in which she was found.

10. I refer to the Trust's Falls Reduction & Prevention Policy. I consider the following extracts of this policy to be of particular relevance to the case:

'…Policy statements:
7.1 The Registered Nurse is responsible for completing a Falls Risk Assessment as part of the admission process to identify patients at risk of falls.
7.2 Where risks are identified all preventative measures must be in place and a plan of care for patients at risk of falls must be completed
7.3 Relatives and carers must be made aware of risks and involved in preventative actions
7.4 Patients admitted to a hospital ward must be made familiar with the ward layout e.g. call bell system, whereabouts of toilets etc
7.5 Bed height should be kept at the lowest position except during direct patient care
7.6 Environment around the patient must be kept safe at all times taking into consideration patients requirements for lighting, mobility aids, items of personal care and safe access to bed, chair and locker. Staff should be vigilant at all times to any potential spills, slips or trip hazards.
7.7 Toileting needs must be assessed and a method of ensuring patients have a means of communication, which is accessible and useable, when assistance is required.
7.8 Patients identified of being at risk of falls should be included in ward safety brief…'

I have carefully considered the requirements of this policy in my assessment of the facts relating to the patient's fall.

11. I note the following entry in the nursing notes at 9.40am:*'Patient assisted x1 to the bathroom with rollator. Patient refused assistance whilst in the bathroom. Patient advised to buzz when finished. Patient buzzed and found patient lying on her left side on the floor.'*

12. I note that the patient was assessed as having a history of falls within the three months before her attendance at the hospital and was considered to be at risk of a fall. In the Plan of Care for Patients at Risk of Falls (the care plan) it is clear that she was not considered to be at risk of falls associated with her needs to visit the bathroom and did not require frequent toileting. However it is clear that she did require supervision to and from the bathroom. There were no hazards noted in the care plan in relation to footwear.

13. The Trust conducted a 'Significant Event Audit (SEA) on the fall. The report noted that the patient was moving independently for all moving and handling activities. The care plan recorded that there were no risks of falling associated with her need to visit the bathroom. However it was noted that she required supervision to and from the bathroom. The SEA report stated that the patient indicated that she needed to go to the toilet and it had been reported on handover that she had been to the toilet the previous night with her walking aid and one nurse. The student nurse looked for her slippers but could not find any at her bedside and so got her rollator and assisted her from bed to the bathroom.

14. The SEA report recorded that the student nurse proceeded into the bathroom and the patient 'shook her head at her'. The report records that the student nurse explained that she was going to assist her, but that she again shook her head forcefully, and that the nurse showed the patient the pull cord, which was situated at the left hand side of the toilet seat. It is also recorded that the patient was asked to pull the cord when she was finished and that the student nurse would come and help her. From the report, it appears that approximately two minutes later, the pull cord went off and the student nurse entered the bathroom finding the patient lying on her left side on the floor. It would appear that the patient's head was at the shower door.

15. I have read the statement of the student nurse dated 27 January 2016 which was produced during the Trust's SEA investigation. The student nurse explained that she was a nursing student from the September 2015 intake. She stated that she was on her first placement in the Ward in the medical admissions unit of the Mater Hospital from 9 November 2015 until 20 December 2015. Her statement is largely identical to the description of the incident outlined at paragraph 14 above. However it states *"...I went into the bathroom and found [the patient] lying on the floor on her* ***right*** *side (****my emphasis****)…"*

16. In response to investigation enquiries, the Trust stated that it had apologised to the family for the serious fall that occurred whilst the patient was under its care. The Trust referred to the investigation findings and the student nurse's statement as part of the SEA process. The Trust stated that the student nurse respected the patient's personal wishes as she was waiting outside for her to finish using the toilet. The Trust confirmed that it was normal procedure to instruct an elderly patient with mobility issues to use the emergency cord in a bathroom. The Trust also confirmed that student nurses regularly undertake these type of duties. The Trust added there were no handling constraints noted and that the patient would have been capable of pulling the cord. In relation to the patient's capacity to make this decision, the Trust stated that she lived at home with the support of carers and there had never been any issues raised in relation to her capacity. The Trust also stated that on admission she was oriented to time and place and the falls risk assessment undertaken by its staff had confirmed she was neither confused nor agitated.

17. In relation to her risk of falling and whether this would outweigh her wish for privacy, the Trust reiterated that there was no risk of falls associated with her need to visit the bathroom. However it was noted that she required supervision to and from the bathroom. The care plan was compiled with information supplied from the patient's daughter. The Trust stated that *'Nursing staff are required to make risk based decisions on a daily basis and despite their best efforts sometimes incidents still occur. No risk assessment can be guaranteed as 100% effective but it can*

help staff to arrive at the best decision regarding each patients' particular needs. Maintaining patient privacy and dignity is a basic premise of nursing care and staff have indicated that if they had any concerns that [she] would have fallen off the toilet, they would not have left her.'

18. As part of investigation enquiries, the Trust was asked for clarification on why the student nurse's statement records that the patient was found on her right side when the SEA report states she was found on her left side. The Trust stated that she sustained a fracture to the left neck of her femur and that the nursing notes evidence that she was found on her left hand side. The Trust added it was a very stressful event for the student nurse and that this was the first statement she had made in respect of an incident. The Trust stated it had not spoken to the student nurse in this respect but must assume she recorded right instead of left on the statement. The Trust were unable to provide a copy of the ward handover document provided to night staff as it would not have been usual practice to retain these records as they were shredded after each handover. However the Trust stated it was reported that the patient was 'up to toilet using rollator' overnight and this fact was confirmed by the student nurse's statement.

19. As part of the investigation, interviews were undertaken by my staff. In relation to the interview with the student nurse, this was undertaken on the 24 April 2018. The nurse recalled that she saw the patient trying to get out of bed and told her to wait there. She then looked for her slippers but couldn't find any and noted that the patient was wearing woolly, fluffy socks. When asked why she took the patient to the toilet without slippers she replied that she couldn't see any and the patient needed to go to the toilet. The nurse stated that she went to go into the toilet but the patient waved her hands and shook her head and said no. In her witness interview, she recalled that the patient had had a stroke and her speech was impaired and that the patient made it clear she did not want her in attendance with her. She felt she needed the patient's consent to stay in the toilet and couldn't force the issue and that she explained twice that she wanted to help her but the patient refused and she had to respect her right to say no. She explained to the patient to pull the cord when she was finished and she went outside to wait at the nurse's station which is outside the toilet at the top of the bay. She heard the

bell/buzzer go off in the toilet and entered the bathroom to find the patient lying on her right side with her head facing her.

20. At interview, the student nurse recalled that two other staff arrived at the toilet and they got the patient onto a chair. Together the student nurse and the Ward Sister got the patient into bed and undertook observations. The student nurse noted that one leg was shorter than another and she recalled that she knew the patient had sustained a hip fracture. She confirmed she helped care for the patient for the remainder of the day until she was transferred to the Royal Victoria Hospital. The patient was not angry about what had happened and wanted the student nurse to go to the hospital with her. The investigating officer asked about the comment in her statement that the patient was found on her right side. The student nurse responded that perhaps her memory was incorrect and she was now unsure which side the patient fell on. Further, she stated that the incident had taught her to take more care when a patient seeks privacy in such situations.

21. As part of the investigation enquiries, the Ward Sister was interviewed on 11 April 2018. She explained that she was the nurse in charge on the day of the fall. She recalled that when she saw the patient her head was pointing towards the door and her feet were pointing towards the toilet.

22. She stated she did not know whether the cord in the toilet was pulled accidentally or not. She said that there was no way the patient could have pulled it from where she was on the ground, her best guess is that it was pulled as she went down to the ground. She said that part of the student nurses training is to take patients to the toilet. The Investigating Officer referred to the nursing notes of the incident. The Ward Sister said the first entry was not hers, and that she did not know whose it was.

23. The Investigating Officer asked her about the need to respect a patient's dignity. She agreed that nurses should do this. She said that patients sometimes don't want nurses with them in the toilet. She also said this must be balanced with patient safety, for example if a patient is unsteady on their feet. However, regardless of privacy issues, patients should be accompanied to the toilet. In

relation to the issue of handover records, she confirmed that handover documents following shifts go into the confidential waste. In relation to the initial falls risk assessment of the patient, she assumed that information in the initial assessment could have come from the family due to the time of night the patient came into the ward. The Investigating Officer asked whether the risk assessment would usually include an Occupational Therapy (OT) assessment. The Ward Sister said that there may have been OT input if she had remained on the ward. The patient had a rollator which she would have used to get to the patient bathroom.

24. The IPA advised that the Trust's nursing admission and falls risk assessment and consequent care plan was completed in accordance with national guidance. The IPA advised that as a moving and handling assessment had been completed, it was acceptable for the student nurse to accompany her in these circumstances. In relation to the student nurse's actions in leaving her in the bathroom unattended, the IPA advised that *'[The patient] had the capacity to decide that she wanted to be left unattended in the bathroom and the student nurse had to honour this decision. To act otherwise would be to reduce [her] independence and restrict her free will.'* The IPA stated that she was oriented to time and place and was not confused. The IPA advised that *'In these circumstances it was appropriate for the student nurse to leave a patient with a known history of falls in the bathroom unattended.'* The IPA confirmed that it is considered good practice to respect a patient's wishes in this respect, which is in accordance with NMC guidance.

25. In relation to the patient's footwear, the IPA advised that *'Thick socks are not suitable for mobilising on a hospital floor as they increase the risk of falling from slipping. Falls prevention policies focus on 'modifiable risk factors' which are the things you can change as opposed to those you cannot change like a person's age. Ensuring that a person is wearing suitable footwear before they mobilise reduces their risk of falling and is a good example of a modifiable risk factor. A student nurse is supernumerary when she is on placement and is supervised by a qualified nurse…it is expected that the student nurse will seek support or advice from a qualified nurse before taking [the patient] to the bathroom.'*

26. The IPA concluded that it was acceptable for the student nurse to take the patient to the bathroom in the circumstances. However the IPA advised that *'the plan also refers to 'any hazards in relation to clothing/footwear'. The thick socks were a hazard and in such a circumstance, the student nurse did not act in line with the falls care plan by taking [the patient] to the toilet in hazardous footwear.'* The IPA agreed that the records support that the patient had the capacity to make her own decisions regarding her toileting needs. The IPA advised that *'Aside from the issue of [the patient's] footwear, the student nurse did not need to do anything differently on the morning of 30.11.2015.'* In relation to the question as to whether the fall could have been prevented, the IPA referred to the fact that the fall was not witnessed. Further, it is not clear as to the cause of the fall and whether it was caused or otherwise by slipping in unsuitable footwear. The IPA advised that *'In summary, it cannot be concluded that the fall was preventable.'* In relation to the overall care provided to the patient from 29-30 November 2015, the IPA further advised that *'In summary, the nursing care provided […] on 29th and 30th November 2015 was in line with national guidance.'*

Analysis and Findings

27. The patient's daughter complained that her mother ought not to have been left unattended in the patient bathroom when she fell, and was of the view that her mother's fall could have been avoided. I have carefully considered the facts and the available evidence in this case. The precise cause of the patient's fall has not been established. There were no witnesses to the fall and sadly the patient is deceased. As part of the investigation, statements have been obtained from both the student nurse who accompanied the patient to the bathroom and from some of the Trust staff who attended the scene after the fall had occurred. I note that the patient was assessed as being able to mobilise to the bathroom with the assistance of an individual and her rollator. Although it is accepted she was at risk of a fall, there were no known risks associated with the toileting process and she had done so previously overnight without incident. I therefore accept the advice of the IPA that the nursing assessment and falls risk assessment was completed by Trust staff in compliance with relevant standards.

28. It is important in this context to ensure a patient has appropriate footwear in order to minimise the risk of falling. I understand that the student nurse felt the need to respond to the patient's request to bring her to the toilet and that she was unable to find her slippers. I acknowledge an inexperienced student nurse may not have been aware of the risk caused by inappropriate footwear. I accept the advice of the IPA that *'it is expected that the student nurse will seek support or advice from a qualified nurse before taking [the patient] to the bathroom.'* The lack of appropriate footwear was a risk factor in relation to potential falls but also in relation to injury to the patient's foot. I therefore consider the student nurse's failure to ensure the patient had the correct footwear and to seek assistance from nursing staff was a failure in care and treatment. As a consequence of this failure, the patient experienced the injustice of being placed at risk of a fall due to the lack of appropriate footwear. I cannot conclude however that this was the cause of her subsequent fall. I recognise the student nurse was mindful of her wish for privacy and in the circumstances I consider that in this instance the Trust staff had proper and adequate regard to the patient's human rights.

29. In relation to the student nurse's decision to leave the patient unattended, I accept the advice of the IPA that it was appropriate in the circumstances for the student nurse to do so. Her decision in this case was motivated by respect for the patient's desire for privacy. I am satisfied on the basis of the available evidence that this was a decision which the patient had the capacity to make. The Patient and Client Experience Standards reflect human rights principles of Fairness, Respect, Equality, Dignity and Autonomy (FREDA) and are relevant in this case. I consider that in this instance, the actions of the student nurse demonstrated regard for the patient's human rights and the FREDA values. I consider any risk to her safety in those circumstances was mitigated by the protections put in place by the Trust in the patient's bathroom. Namely the presence of support hand rails and the emergency cord for seeking help.

30. In the complainant's view her mother ought not to have been left unattended. Further, that the fall could and should have been avoided. The failing I have identified is that the student nurse did not ensure that the patient had adequate

footwear. I cannot conclude however that, but for this failing, the fall would not have occurred.

Issue 2: Whether the Trust's Significant Event Audit (SEA) investigation was conducted in accordance with relevant policy and standards?

Detail of Complaint

31. The complainant alleged that the SEA investigation was inadequate. In particular, that:
    (i) The SEA report contains a verbal statement of fact taken from the Ward which later in the report is described as untrue. Staff therefore did not realise the importance of an SEA and felt they could lie.
    (ii) The SEA investigation was not objective as it was managed and administrated by the same Trust staff.
    (iii) Relevant Trust staff who were present at the incident were not interviewed as part of the investigation.
    (iv) Despite recording on the report that *'staff have no doubt that the fall was a significant contributory factor in Patient A's subsequent death';* no further action was taken for such a serious statement.
    (v) The SEA report was in part contradictory in order to avoid blame. It said the fall from the toilet could not be avoided when the family feels it could.
    (vi) There are no recommendations in the SEA report regarding management and learning in relation to vulnerable patients who fall.
    (vii) The Trust have not properly investigated the fall. It remains unclear to the complainant why her mother was left alone; who agreed this; why she was told to pull an emergency cord and how she could have pulled a cord that was out of her reach.

32. As part of the investigation, I have considered the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents October 2013 (the 2013 procedure). This procedure provides guidance to HSC bodies on reporting and follow up to Serious Adverse Incidents (SAI's). The following criteria, referred to at

paragraph 4.2.1 of the 2013 procedure, is used to determine whether or not an adverse incident constitutes an SAI:

‘4.2.1 serious injury to, or the unexpected/unexplained death of:

- *a service user (including those events which should be reviewed through a significant event audit)*
- *a staff member in the course of their work*
- *a member of the public whilst visiting a HSC facility;’*

33. I note that SAI investigations are designated under three levels:
Level 1 Investigation – Significant Event Audit (SEA);
Level 2- Root Cause Analysis (RCA); and
Level 3 – Independent Investigation.
In this instance, a Level 1 SEA was conducted into the patient’s fall. I have included below the standards required for Level 1 SEA’s, which is relevant to this case:

…’The possible outcomes from the investigation may include:

- *closed – no new learning*
- *closed – with learning*
- *requires Level 2 or 3 investigation…*

…If it is determined this level of investigation is sufficient, an SEA report will be completed and sent to the HSCB within 4 weeks (6 weeks by exception) of the SAI being reported…

34. I note the 2013 procedure contains a template report for Level 1 SEA’s and guidance on completing this report. I note that the template report contains the following five headings to be completed with a description of each heading: What happened? Why did it happen? What has been learned? What has been changed? Recommendations following the Level One SEA.

35. The guidance on membership of the investigation for level 1 SEA investigations states *'The level of investigation of an incident should be proportionate to its significance; this is a judgement to be made by the Investigation Team. Membership of the Team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a level one investigation, it is for each team to decide who is invited, there has to be balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited. The investigation team should appoint an experienced facilitator or lead investigator officer from within the team to coordinate the review…'*

36. The Trust has established a separate procedure for Serious Adverse Incidents (SAI Procedure). The following sections of the Trust's SAI Procedure is relevant to this case:

'3.5 Informing the service user/family/carer
The principles of the Being Open Policy must be adhered to when communicating to service users, their families or carers regarding the reporting of a Serious Adverse Incident…The Co-Director responsible for the SAI is also responsible for ensuring the service user/family/carer is communicated with appropriately regarding the SAI and subsequent investigation. They will nominate the appropriate person to speak with the service user/family/carer initially and also to ensure the service user/family/carer has a link person to contact throughout the SAI process as required'…

4.1.1 Level 1 Investigation – Significant Event Audit (SEA)
'…In most circumstances, completed SEA investigations at this level will be adequate for incidents where the circumstances are of a less complex nature. In these instances it is more proportionate to use a concise SEA to ensure there are no unique factors and then focus resources on implementing improvement rather than conducting a comprehensive investigation that will not produce new learning. N.B. Family Involvement, see section 4.4…

4.4 Service User/Family/Carer Involvement

…The Co-Director responsible for the SAI should ensure the appropriate level of involvement of service user/family/carer throughout the investigation including discussion/sharing of the final report with the service user/family/carer and this should be agreed with the investigation team from the outset….Approved SAI final reports should be shared our talked through with the service user/relatives/Carer as appropriate and where this is not done, an explanation must be submitted within the SAI checklist and if pending, this should be included as an action in the subsequent Action Plan for the SAI….

Involvement specific to level 1 (SEA) report

Under the HSCB timeframe for completing level 1 investigations it may not be possible to involve the service user/family/carer in the investigation process before the final report is submitted to the HSCB. In such cases, where family involvement is deemed appropriate, the approved report should be discussed/shared with the family at a date as soon as possible after submission of the report and any issues addressed and those requiring material changes to the level 1 report should be added as an addendum and forwarded to corporate governance for sending to HSCB in a revised report…'

37. The Trust's SAI procedure contains a table outlining a summary of the SAI investigation process. The investigation team must comprise local multi-disciplinary. However the procedure requires the Chair to be independent of the service area.

38. The Trust has also established a Procedure for Reporting and Managing Adverse Incidents (the Adverse Incident Procedure) which provides guidance on reporting and managing all adverse incidents, which must be reported. An adverse incident is defined as ***'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation.'*** A list of possible adverse incidents is included in this document and 'falls' are included on the list. The procedure states that *'all adverse incidents must be recorded on*

an electronic Trust incident form (Datixweb).' This procedures outlines the following responsibilities of the reporter:

'…Complete a Trust Incident Report Form, documenting fact only, not opinion…Send the incident form for approval, by either clicking 'Submit' on the electronic form or passing the white and green copy of the paper form, along with any attachments, to the approving/line manager for your area…Report the incident to your line manager as soon as possible after it has occurred. The line manager may well have already received notification via Datixweb however it is important that staff do not rely solely on this for communication…'

39. The Adverse Incident Procedure outlines the following responsibilities of the approving manager:

'…Review the incident form to ensure that all relevant sections are complete and accurate and make amendments if required. It is good practice to discuss any amendments with the incident reporter. Complete the investigation and approval sections. Note: the mandatory fields should be completed as soon as possible and no later than 7 days after the reported date…Click 'Save' on the electronic form, or forward the white copy of the form to Corporate Governance…Inform any other relevant bodies/persons as appropriate. Ensure that appropriate feedback is given to the reporter of the incident.'

40. In response to investigation enquiries, the Trust provided a copy of 'Datixweb for Incidents Approving Managers Guidance' (the Datixweb guidance). This guidance highlights that the approving manager must complete section 10 of the Datixweb form and approve section 11 of the form. Section 2.3 of the Datixweb guidance outlines the manner in which the approving manager must complete the 'Investigator/Manager Access Field'. It states *'It is possible to give other Datixweb users access to incidents reported to you, This can be useful for incidents where review/investigation responsibilities are shared, for joint review/investigation or for when you want to bring someone up to date on particular incident…An email with*

a link to the incident will automatically be sent to the names selected, informing them that they have been added as an investigator…'.
The above extracts from these guidance documents are relevant to my consideration of the issues in this case.

41. A meeting was held on 7 April 2016 between the patient's family and the SEA investigation team. The minutes record as follows:

'…The family queried [the Ward Sister's] account of what happened in the shower/shower room. [The Ward Sister] stated that [the patient] had fallen from the toilet and pulled the emergency cord after this fall. [The complainant] said she could not understand or agree with [this] explanation of what had happened. They felt it was a physical impossibility that their mother could have pulled the cord…

…[The complainant] queried what the standard practice was with regards to such frail patients and would it not be more appropriate to override a request for privacy and instead remain with them for their own safety? [It was] stated that although nursing staff strive to achieve a balance between caring for the patients and respecting their privacy, she accepted that the right decision was not taken on this occasion and has resulted in a loss of trust on the part of the family. [She was] advised that nursing staff are required to make risk-based decisions on a daily basis and, despite their best efforts, there are occasions when staff get it wrong…

…The team agreed that it was unacceptable that [the patient] had fallen whilst in the Trust's care and agreed that [she] and her family had suffered as a result…'

42. I refer to an email dated 11 December 2015 from the Trust's Risk and Governance team which states as follows:
'A Major/Catastrophic Severity or Extreme Risk Incident has been entered on Datix. Please find attached a summary of the incident. Please review the severity, consequence and likelihood for accuracy and arrange for the record to be updated on Datixweb. Alternatively note any amendments on the summary sheet and

return by email to myself as soon as possible. We will then update Datix as required.'

43. In response to investigation enquiries, the Trust stated that it cannot find a record in the final report that the Ward Sister's statement was untrue. The Trust stated all staff involved were aware that this was a formal investigation and lack of candour is unacceptable and could result in disciplinary action. The Trust stated that at the meeting with the family on 7 April 2016 the Assistant Service Manager (ASM) advised that it was her belief the Ward Sister had given the student nurse permission to take the patient to the bathroom. However the ASM stated that she would confirm this and get back to the family. She contacted the family on 22 April 2016 to confirm that this was incorrect as the student nurse had not sought permission to take the patient to the toilet. The student nurse had been advised at the handover that the patient was able to mobilise with supervision and therefore permission was unnecessary. The Assistant Service Manager apologised to the family for providing them with incorrect information at the meeting on 7 April 2016.

44. In response to concerns about the independence of the SEA investigation, the Trust stated the process is intended to be non-threatening and impartial. The Trust explained it would be usual practice for managers with responsibility for the affected service area to facilitate a complaint/SEA investigation. The Trust also stated the key staff responsible were involved in the investigation into the patient's fall. Further, the Trust confirmed it would not be usual practice to involve every staff member in that investigation. The Trust stated that at the meeting on 7 April 2016 the family had asked for staff to be disciplined, but that it had not identified any matters that were felt to require follow up under its own disciplinary process. The Trust added the family were advised at the meeting that it was unacceptable that the patient had fallen whilst in its care and agreed that both she and her family had suffered as a result.

45. The Trust disputed having admitted that the fall could not have been avoided. It stated that although the patient was known to be at risk of falls whilst mobilising, staff did not believe that she was at risk during the toileting process. In relation to

the SEA report and its recommendations, the Trust stated it was the investigating team's belief that staff had acted in the best interests of the patient. Further, the investigating team did not consider that any recommendations were required in this respect. The Trust confirmed in meetings with the patient's family that it takes falls management extremely seriously and this formed part of the Trust's Quality Improvement Plan. The Trust's analysis of data on falls and the roll out of Falls Care Bundles was also discussed with the family.

46. In relation to the thoroughness of the SEA investigation, the Trust stated the investigation was conducted by a Consultant Physician, a Consultant Orthogeriatrician, two senior managers with nursing background and a Governance and Quality Manager. The Trust stated it believed that the investigation was robust. The Trust disputed the complainant's view that the investigation was inconclusive. The patient had been taken to the toilet by the student nurse as it had been indicated that she was capable of using the toilet with the aid of a staff member and had successfully done so the previous night. The Trust stated the student nurse was respecting the patient's privacy and dignity by waiting outside the bathroom in close proximity.

47. In relation to why four versions of the SEA report were produced, the Trust stated SEA reports often have several draft versions but it is unusual for these to be shared with the families. In this instance the family were keen to meet with the Trust prior to completion of the final report and after each draft was shared, a number of minor amendments were made at the family's request. The Trust confirmed that no consideration was given to escalating the incident to a Level 2 Root Cause Analysis investigation as the SEA panel believed the report to be thorough.

48. The Trust was asked to clarify the statement made in the incident report that *'Student had left at patient's request, in hindsight she should have stayed but she was trying to respect the patient's privacy.'* The Trust stated that this comment was made at the time of reporting the incident and prior to any investigation of events. The Trust added however after weighing up the facts of the case, that senior staff believe that the student nurse took this decision whilst acting in the best interests

of the patient. The Trust stated the student nurse was respecting the patient's privacy and dignity and advised the patient what to do when she finished in the bathroom.

49. As part of the investigation the Governance Manager was interviewed in relation to the meeting with the patient's family on 7 April 2016. A decision was made to proceed in the absence of the Ward Sister. The student nurse was also not present at that meeting. The Assistant Service Manager (ASM) had previously discussed the incident at length with the Ward Sister and therefore would be in a position to answer questions on her behalf. The Governance Manager said she would have preferred the Ward Sister being there however those present made a collective decision to proceed as the family wanted answers as to what had happened to their mother. The Governance Manager said that in this case the incident reporting policy was not followed and they identified a failure as a result of this. The IR1 form did not contain sufficient information and ought to have been kept as up to date as possible. For example the form had not been updated to record that the patient had died. The Governance Manager stated she needed to be informed when a serious incident occurs. In this case, however, she was not told when the incident happened.

50. By way of explanation as to why boxes were missing from the SEA report template, the Governance Manager stated this information would be recorded elsewhere in the report. She indicated there were various iterations in the report due to going back and forwards with the family regarding its content. She noted that this was a guidance document and although the format is usually followed by staff there is some room for flexibility. She confirmed that the person who completes the IR1 form should ensure its content is accurate, and that she would expect a Sister to update the form as and when required. She noted that the form was not updated when the patient's fracture was confirmed and when she died, although it ought to have been. She confirmed they generally do not record a rationale as to why a Level 1 investigation is not escalated to a Level 2 investigation.

51. In response to the question as to why other staff members who were present after the fall were not interviewed, the Governance Manager stated that a nurse took the relevant statements and she cannot recall a discussion about interviews with staff apart from the student nurse and the Ward Sister. The Ward Sister was the line manager and also witnessed what occurred after the fall. Therefore it was her view that potentially nothing would be gained from interviewing the other staff. The Governance Manager said that at this level an investigative plan or strategy would not have been developed. She added that since the patient was alone in the toilet when she fell, the views of others on when or how the emergency cord was pulled are all hypothetical. In relation to the independence of the panel, she stated the SEA team generally ought not to be independent as SEA methodology would dictate that those involved in the incident/patient's care are best placed to participate in the review. However with the benefit of hindsight she has realised that this case may also have benefited from an Independent Review of the Nursing Care. This in her view may have provided the patient's family with additional assurance that staff involved could not provide. She indicated that she recognised concerns about this. Therefore, in future, the Trust will be taking on those seen as independent to sit on other SAI panels.

52. In relation to the timescales of the SEA, the Governance Manager acknowledged that it took much longer than 4 weeks. However, she also confirmed that those working on an SEA have to do so alongside their normal jobs and were not given time off to work on this. This issue has been considered by the Trust and those working on SAI's are now going to be given time to complete the investigation. The Governance Manager commented that the delay was also partly caused by the family coming back with issues, leave and sickness absence and that the 4-6 week timeframe is very challenging and is rarely met.

53. At interview, the Investigating Officer referred to the Ward Sister's comment in the minutes of the 7 April 2016 meeting that she stated that the patient had fallen from the toilet and pulled the cord after her fall. The Governance Manager stated that this may have been communicated to the family, possibly in error. She suggested it could have been misunderstood by the family as the Ward Sister did not attend the meeting. The Investigating Officer referred to comments in the minutes of that

meeting in which the Trust informed the family it was unacceptable that their mother fell in its care. The Governance Manager stated that it was unacceptable for any patient to fall when in care but that all falls are not necessarily avoidable and that this comment was said with the benefit of hindsight. The Investigating Officer suggested that the wording in the minutes that the student nurse made the wrong decision is more definitive and that the family are likely to have been confused as to why the SEA report did not reach that conclusion. The Governance Manager stated these comments were made in the context of the family pressing the Trust to admit that it had 'murdered their mother'. She confirmed that there is a balance between respecting a patient's dignity and privacy and ensuring the patient's safety. She added that the student nurse, in her view, made a risk-based decision. She had protected the patient's privacy and dignity, and considers that at the time, without the benefit of hindsight, that this was a reasonable decision.

54. The Investigating Officer asked whether the Trust's SEA investigation was robust and if there was anything they would do differently. The Governance Manager indicated that with the benefit of hindsight it would have been better if the Ward Sister had attended the meeting with the family. Further, she considered that when the family returned with further queries an Independent Nurse should have been engaged. She confirmed there is no record of consideration given to proceed to a Level 2.

55. As part of the investigation the Trust's Service Manager was interviewed. She confirmed that she was the Chair of the SEA investigation panel. She became aware of the incident only after a complaint was received and the patient had passed away. She was not made aware when the patient had died as the patient had been moved to another hospital. She accepted there were 'headings' missing from the SEA report, however issues of concern were to be covered within the report and the template produced by the Trust was only a guide. In relation to

timescales, her explanation for the delay was the frequent need to revert to the family to accommodate additional changes they suggested.

56. The Service Manager believed that the IR1 was updated following the death of the patient. She indicated at interview that as the patient was transferred to the Royal Victoria Hospital following her fall the Ward Manager may have forgotten to check on the patient's progress following her move. She said that changes have now been made to ensure that a patient is tracked following such an incident if they are transferred to another hospital. This is now highlighted by Trust staff on a board in the sister's office. She did not believe there was a need to speak with staff other than those involved as part of the investigation. In relation to the student nurse's statement, she said that she was certain that the patient fell on her left side. Therefore the error was a mistake in the student nurse's statement.

57. The Investigating Officer asked about her understanding of the Trust's procedure once an IR1 is submitted. She stated that when the Ward Sister submitted the IR1 to the Ward Manager it was a matter for the Ward Manager to decide what, if any, action is necessary. The Trust Manager accepted that when the patient's fracture was identified later that day the incident could have been treated as an SAI. However, the Ward Manager did not escalate the matter. At interview she also accepted that if the matter had been referred further, a further investigation could have occurred before the family made a complaint. In hindsight she believed that everyone was at the meetings who should have been, with the exception of the Wad Sister. Although she was not present at this meeting and was unsure of the context of the meeting, she pointed out that her previous contact with the family had been difficult.

58. As part of the investigation the Assistant Service Manager explained that she had chaired the April 2016 meeting. She explained that in relation to the patient's fall, she had not been informed until later in the day and that she became aware of the incident only because there was a delay in transferring the patient to the Royal Victoria Hospital. She found out much later on when the Ward Sister phoned saying a patient had fallen. She confirmed she was working late that evening and was asked about the incident as she advised to phone a blue light ambulance

because of a delay in transferring the patient to the hospital. She outlined it was a few days later before she had an opportunity to speak to the Ward Sister to find out what happened.

59. The Investigating Officer referred to an extract from the April 2016 meeting which recorded that the Ward Sister had made a comment about the patient pulling the emergency cord in the toilet and the timing of same. The Investigating Officer explained that it would be of concern to the family as to how the Ward Sister was aware of this fact given she didn't witness the fall and she has since confirmed that she didn't say this. The Assistant Services Manager confirmed the word 'stated' adds further confusion to the issue. She was of the view that there was an initial conversation about the fact that the patient must have pulled the emergency cord after she fell. At the meeting she had told the family that they couldn't be clear about what happened. She was of the view this must have been misunderstood as it is clear that only the patient was in the bathroom at the time and there were no eye witnesses to the event.

60. The Investigating Officer also referred to the April 2016 minutes which record the views of attendees at the meeting to the effect that the wrong decision had been made in not going into the bathroom with the patient. The Assistant Services Manager outlined if the patient is judged competent (and there was nothing to suggest that the patient failed to understand instructions) then, from a clinical point of view, the Trust staff must respect her wish. She stated that this also has been lost in the context of the meeting and in the series of events. She stated at the meeting there were new queries emerging and in particular new queries had been raised on that day, and explained that the recorded paragraph in the minutes would have reflected a discussion of approximately one hour. She was trying to get across to the family that some falls cannot be prevented and are outside of the Trust's control, and that sometimes falls do happen. The family had difficulty accepting this. She stated it was explained at the meeting that it was unfortunate that the fall occurred in the Trust's care. However at that time they had difficulty locating the student nurse and they didn't have a complete picture of what had happened.

61. At interview, the Investigating Officer referred to the IR1 form. The Investigating Officer outlined that he had asked her in advance of the interview whether there was evidence of an investigation being carried out to support what was stated on this form. She confirmed she was unable to find any evidence. She also confirmed that an online system is used for recording incidents and it doesn't automatically go to the next tier of management. She stated there were difficulties in staff becoming aware that the patient had died and that she was not aware of this fact until the complaint had been received by the Trust.

62. The Ward Manager at the time of the incident was interviewed. She was not on duty when the patient fell. She stated she was not aware that the patient had died until her family had complained to the Trust. She cannot recall if she took notes of the discussions. At interview she confirmed that she believes she may have spoken to other staff who were on duty at the time but she can't recall who they were. She did recall however when considering the severity of the incident she had to consider a matrix. She then graded the incident amber (major). She stated that she was certain she had discussed the fall with the Assistant Service Manager but can't recall whether grading of the incident was discussed at this time.

63. She stated that at no time during her time as a Ward Manager had she designated an incident to be an SAI, as this was not a matter for her to decide. At interview she confirmed her understanding was that when she completes the IR1 form and hits the 'Submit' button the form would automatically be electronically sent to Clinical Governance and Health and Safety. It would then be a matter for that team to decide whether it is an SAI. She had no recollection of stating on the form *'In hindsight she should have stayed.'* From a nursing perspective she had no issues with the actions of the student nurse as it was her view that she was respecting the patient's privacy in the circumstances.

64. As part of investigation enquiries, the Trust was asked to comment on whether the Assistant Services Manager was aware of the incident. Also, the Trust was asked to confirm whether this was contrary to the SEA report's findings. The Trust stated that it was a failure of ward processes as it would be its expectation that the Ward Manager at the time of the incident would follow up patients who have fallen and

have been transferred elsewhere for further treatment. The Trust confirmed that the Assistant Services Manager had overall responsibility for the ward. She believed the submitted IR1 form automatically goes to management, the Trust accepted that it is not the role of the nursing staff to decide whether an SAI is required. However, the Trust confirmed it is the Ward Manager's responsibility to follow up on incidents on the ward and to escalate these where appropriate as potential SAIs.

65. The Trust referred to the 'Investigator, Managers access' section of the IR1 form and explained it would be usual practice for the approving manager to select any other relevant staff for further consideration/investigation. The Trust stated it would have expected the Health and Safety Unit, the Assistant Service Manager or the Trust's Service Manger to have been selected. This would have sent an alert email into the system to note the IR1 content and to make a decision regarding a way forward. The Trust added that on 13 January 2016 the report was forwarded to the Governance Manager who in turn sent it to the Assistant Service Manager and the Service Manager. However by this stage the patient's family had already submitted the complaint and the decision had been taken to escalate to SAI.

66. The Trust was asked to clarify why the email forwarded by Risk and Governance on 11 December 2015 to the Governance Manager appears to show that ward staff correctly escalated the incident by submitting the IR1 form. Therefore the Assistant Service Manager or the Trust's Service Manager were aware of the incident. The Trust confirmed that the Assistant Service Manager was advised of the incident on the evening of the fall. The Trust also confirmed given the length of time that has elapsed, there is no further evidence available that this matter was escalated to any other manager. The Trust accept that it ought to have considered the initiation of SAI processes at this point. In relation to the email on 11 December 2015, this occured when the Governance Manager received a query email asking them to consider if the incident meets SAI criteria. In this instance, a query email was forwarded on 12 January 2016. However, at this point the complaint had already been received by the Trust and the SAI process had begun.

67. The Trust stated the summary of the incident referred to in this email was not attached to the email to the Governance Manager. It is also not attached to the Datix record. However I note that the incident number is recorded on the email which would have facilitated the incident being accessed on the system. In relation to action taken by the Governance Manager in response to this email; the Trust confirmed that she had received the email and that it would be her usual practice to forward the email to the relevant manager for grading confirmation or to telephone that manager about the incident in order to initiate the appropriate checks. The Trust stated that due to the length of time that has elapsed, the Governance Manager cannot identify definitively the staff she would have referred the matter to. However the Trust clarified that she believes it would have been escalated to the Assistant Services Manager as this would be usual practice.

68. In relation to the staff's reporting of the patient's fall, the IPA advised that *'ward staff reported the incident in line with local and national guidance by completing an incident form (IR1) and submitting it via Datix. The evidence of this is noted within an email from … (Risk and Governance) to [the Governance Manager] dated 11.12.2015.'* The IPA also advised that the fall was an 'adverse incident' and ought to have been reported in line with the Trust's Adverse Incident reporting and management policy. This in turn would have prompted a Level 1 SEA. The IPA further advised that although the IR1 form was completed in a matter that met national and local standards, the updated IR1 form did not identify issues relating to student nurse support and inappropriate footwear provided to the patient.

69. In relation to the independence of the SEA panel, the IPA advised *'The Trust's SAI procedure states that for a Level 1 SEA the Chair must be from outside the service area. However, the Chair was from within the same service area, Acute and Unscheduled Care. The staff managing the SEA were therefore not sufficiently independent.'* In relation to the SEA report's recommendations, the IPA also advised on the failing to recommend a service change in relation to footwear and the supporting of student nurse as staff need to ensure that patients are wearing suitable footwear before mobilising. The IPA did not agree with the conclusion of the SEA report as *'there should have been consideration of the type of footwear worn by [the patient] and the fact that a student nurse decided to mobilise her in*

socks without seeking support from a qualified nurse.' In conclusion, the IPA advised that the SEA investigation *'lacked a 'duty of candour' as it was not conducted in a timely manner, which would be following on from the initial IR1 form.'* The IPA advised *'this was a lost opportunity to learn and improve from this incident and also to give the family the answers they deserved. There were also learning points from this incident that the Trust have not included within the SEA.'* The IPA concluded that the SEA investigation did not meet relevant regulatory standards.

70. As part of the investigation, the IPA advice was shared with the Trust and the Service Manager and Governance Manager who also provided a response to the IPA on behalf of the Trust. The Trust stated that the approving manager did not forward the IR1 on to any other manager or staff member. The Trust also stated that the Ward Sister verbally advised the Assistant Services Manager of the need to expedite an ambulance for the patient's transfer to RVH. The Trust reiterated that although this incident was appropriately reported, senior staff believe it was not sufficiently escalated. The Trust stated that although the Chair was a senior manager with Acute/Unscheduled Care, several of the staff participating in the SEA were from other Trust services. The Trust acknowledged that although its policy is to have an Independent Chair of an investigation, this has often proven practically difficult to implement across the Trust. However, the Trust explained it has recognised these difficulties for some time. In light of these difficulties, five new SAI chairs have been appointed and trained to ensure increased impartiality in the SAI process. I welcome this initiative by the Trust, which in my view is necessary to ensure the public's trust and confidence in the process.

The complainant's response to my draft report

71. In response to my draft report and initial findings, the complainant clarified that she had not received a draft of the SEA report until 8 September 2016, a time lapse of over 9 months from her mother's fall. She also stated she had not received drafts of the report prior to 8 September 2016, by which time the report had already been signed and forwarded to HSCB. She stated she therefore considered it incorrect to state that she had received any drafts of the SEA report. She received a letter

from a senior manager within the Risk and Governance Department dated 20 February 2017 stating the investigation had to be reopened in May 2016 as *"it is felt that this hadn't been thorough enough".* She therefore disputes the Trust's assertion that the investigation was robust. Further, she stated that she was not informed about the decision to reopen the investigation in May 2016.

72. The complainant also disputed that the Assistant Service Manager clarified in a telephone call on 22 April 2016 that the student nurse had made the decision based on the discussion at the handover on the ward. She stated the Assistant Service Manager had informed her that the Ward Sister had not given permission as it was the senior nurse who had given permission in this instance. She disputed this at the time as the senior nurse advised her that she had been on a break when the incident occurred. She also confirmed that there was no further clarification from the Assistant Service Manager. She had only become aware that the incident occurred because of the handover from the SEA report. The complainant also disputed the assertion that the family had pressed the Trust to admit it had *"murdered their mother"*. She stated the issue of liability for the accident was only raised as a direct result of the Trust's statements about the staff decision-making.[2]

The Trust's response to my draft report

73. In response to my draft report, the Trust stated the Assistant Services Manager was initially made aware of the fall when she was asked to expedite the transfer to the RVH on the day of the fall. The incident was later escalated on 11 December 2015 in order to ensure confirmation of the grading of the incident. The Trust stated that senior managers were adamant that they were not aware the patient had died after this incident. They were concerned that the death had clearly escalated the incident to catastrophic level and that there had been no follow up of the incident at ward level, as would be expected by senior management. However the Trust also confirmed that, since this incident occurred, its practices have

[2] An Addendum was issued after the publication of the final report (Appendix 1), stating that the complainant had also raised concerns in relation to the accuracy of information supplied by the student nurse. In particular she refuted the suggestion that her mother wanted the nurse to go to the RVH with her. However, I did not make a finding on this issue as this was not a matter for this investigation.

changed. The Ward Sister now contacts the ward where the patient has been transferred to ascertain the patient's condition. This contact continues on a daily basis until the patient returns or is discharged.

Analysis and Findings

74. The complainant raised a number of concerns about the SEA investigation. In addition, my investigation has raised a number of other concerns. I have therefore outlined my findings on this issue in the following paragraphs.

75. The complainant complained about the independence of the SEA investigation, as it was managed by Trust staff who were subject of the investigation. I have found that the SEA panel was chaired by a Service Manager within Acute/Unscheduled Care. The Chair was therefore not independent as Ward E falls under her remit. I note that Trust policy clearly requires that Level 1 SEA's must be conducted by an independent chair. I note this requirement has been acknowledged by the Trust who stated this has often been very difficult to implement across the Trust. However the Trust has confirmed that it has recently appointed five new SAI chairs to ensure increased impartiality in the SAI process.

76. I note that the Trust has taken action to ensure the independence of this process in future. However, I note that in this instance the SEA investigation did not have an independent chair. In considering this aspect of the complaint, I have had regard to the Principles of Good Administration. The First Principle requires public bodies to 'Get it Right' by following existing policy and procedural guidance. I consider the failure to appoint an independent chair to lead the SEA investigation into the patient's fall does not meet the requirements of the Trust's SAI policy. The failure to comply with the Trust's policy in this regard does not comply with the First Principle of Good Administration, and constitutes maladministration. As a consequence of this maladministration, the complainant experienced the injustice of uncertainty, frustration and upset at the lack of independence in the constitution of the SEA panel. This has undermined her faith in the impartiality and objectivity of the investigation into her mother's fall and understandably she finds it difficult to

accept the conclusions of the SEA report. **I therefore uphold this aspect of her complaint.**

77. I have carefully considered the adequacy of the Trust's SEA investigation in this case. The complainant stated that the Ward Sister's statement in the SEA report was untrue. The Trust has clarified that this report referred to a statement made at the 7 April 2016 meeting that it was her belief that the Ward Sister had given the student nurse permission to take the patient to the bathroom. The Assistant Services Manager advised the patient's family that she would confirm this and revert to them. The Trust stated that she informed the family on 22 April 2016 that the student nurse had not sought permission to take the patient to the toilet. That is because she had been advised at the handover that she could mobilise her with supervision. I note the SEA report explains that the family were contacted and advised of the factual error in the report. I note also that the Assistant Services Manager apologised for this error.

78. In response to the draft report, the complainant disputed that clarification was provided on 22 April 2016 as the Assistant Services Manager told her that the nurse in charge had given the student nurse the required permission. The complainant stated she was unaware of the handover explanation until it appeared in the SEA report. It is clear there are conflicting views on the precise nature of the information provided on 22 April 2016. There is no record of the telephone call. I am therefore unable to conclude on the information provided to the patient. However I note that the student nurse had stated in her statement dated 27 January 2016 that she was informed at handover that the patient was able to mobilise to the bathroom and had done so overnight. I acknowledge that the Assistant Services Manager's communication had initially caused confusion. However, I consider clarification on this issue was eventually provided in the SEA report.

79. The complainant stated that a number of staff present in the ward at the time were not interviewed as part of its investigation. The Trust took evidence from the student nurse and the Ward Sister as part of its investigation. The investigation has disclosed that a second student nurse and a ward liaison officer had observed

the patient in the bathroom after the fall. However, the Trust did not interview these staff. The Trust stated that the relevant staff were interviewed as part of the investigation and that it was not usual practice to involve every staff member. I have carefully considered the circumstances of the fall. It was not necessary for the Trust to interview these individuals as they did not witness it. It is not disputed that the fall occurred and their accounts would not (in my view) provide any additional information on the cause of the incident. The Trust's SAI guidance leaves the issue of interviewing staff for the discretion of the SEA panel. The Trust spoke to the student nurse and the Ward Sister and I accept the Trust's view that the relevant staff were involved in the SEA investigation.

80. The complainant alleged that despite meetings with the Trust the circumstances of the fall have not been properly investigated and those circumstances remain unclear. Her view was disputed by the Trust who stated it believed its investigation to be robust. The Trust reiterated that it was clear the patient was left alone as requested by her and that (at the time) the student nurse was respecting her privacy and dignity by waiting in close proximity. The questions arises as to how she could have pulled the emergency cord that was clearly out of her reach. In its response, the Trust stated it is adjacent to the toilet and extends to seat level.

81. In response to the draft report, the complainant challenged the Trust's view that the investigation was robust and referred to a letter she received dated 20 February 2017 from a senior manager in Corporate Governance. This letter states; *"…In relation to your mother's incident. I have been advised that this was reported as an SAI in January 2016 and a review commenced at that time. However, in May 2016 it was felt that this hadn't been thorough enough and it was agreed to revisit the review. Unfortunately at that stage the individual leading the review went on leave and as you will be aware [the] Governance Manager and Service Manager commenced leadership of the review. Multiple queries from you and your family remained outstanding and it was explained that addressing these queries would add to the investigation timeline and it would take approximately a further 12 weeks to progress to completion of the report."*

82. I am critical that the Trust did not provide a copy of this letter until a late stage in this investigation. The correspondence clearly evidences that the Trust's initial investigation was inadequate and required a further review. The Trust has not provided an explanation as to why there were deficiencies in the initial investigation. However I consider that the completed SEA report and investigation of the incident was adequate and provided an explanation of the circumstances of the patient's fall to her family. In relation to whether the patient was able to pull the cord that was out of her reach, any conclusion regarding this matter would be speculative as the fall was not witnessed.

83. At the meeting on 7 April 2016 I note the patient's family were told that *'the right decision was not taken on this occasion'* and that it was unacceptable that she fell in the Trust's care. The Governance Manager stated in interview that these comments were made with the benefit of hindsight and the family were pressuring them to admit to 'killing their mother'. She added that she now believed the student nurse made the right decision. I consider it significant that the SEA report did not conclude that the student nurse had made the wrong decision. I would question the validity of the comments made in this meeting.

84. In considering this issue, I have again had regard to the Principles of Good Administration. The Third Principle requires public bodies to 'Be open and accountable'. The Trust's comments that it felt pressured to appease the family and ultimately it did not believe the student nurse had made an error do not demonstrate openness and a willingness by the SEA panel to be accountable for errors made. The SEA panel therefore unfairly raised the family's expectations in this meeting by indicating that the student nurse had made the wrong decision when the SEA subsequently concluded that she had not. I conclude the Trust's comments to the family in this regard does not comply with the Third Principle of Good Administration, which constitutes maladministration. As a consequence of this maladministration, the complainant experienced the injustice of uncertainty and frustration at having her expectations unfairly raised that the Trust was indicating it initially believed that the student nurse had made the wrong decision. This was also unfair to the student nurse who would not have had an opportunity to respond to these accusations.

85. The Trust failed to meet the timescales for completion of the SEA. The Trust is required to send the report to the HSCB within 4 weeks of the incident being reported. The incident was reported to the HSCB on 19 January 2016. However, the report was not sent to the HSCB until 32 weeks later on 1 September 2016. The Trust has raised mitigating factors to explain this significant delay. The Trust has commented on the unrealistic timeframe and also referred to the sharing of the draft report with the family as a reason for some of the delay. I accept that the timescale of 4 weeks may be difficult to achieve in a complex case given the need to arrange meetings with the panel, relevant witnesses and members of the family. However, the SAI timeline demonstrates periods of inactivity and the first draft was not shared with the family until September 2016, eight months after the investigation began. Furthermore, the Trust has acknowledged in correspondence to the complainant that the investigation was revisited in May 2016 as it was considered it had not been sufficiently thorough. The inadequacies in the original investigation undoubtedly contributed to the delay in completion of the investigation and the distress and confusion suffered by the complainant

86. I also acknowledge that in this case the Trust were also using the SAI as a means to provide answers to the family's complaint. However this should not lead to multiple drafts and delay in issuing the final report. The Trust's SAI procedure states that it may not be possible to involve the family in advance of submission of the final report. It states that in this scenario the Trust should meet with the family as soon as possible thereafter and any changes are sent as an addendum to the report. It is not my role to comment on the Trust's SAI procedure. Rather, I can consider only the application of that procedure by the Trust. The Second Principle of Good Administration requires public bodies to act within reasonable timescales and published time limits and to avoid undue delay. I conclude the Trust did not meet the requirements of this principle by exceeding its published timescale. This excessive delay constitutes maladministration. In consequence of this maladministration, the complainant experienced the injustice of uncertainty, frustration, upset and inconvenience.

87. The complainant stated that despite the report concluding that the fall was a contributory factor in her mother's death, no further action was taken. She also complained about the conclusion that the fall could not be avoided when the family feels it could. The Trust stated the family wanted the Trust to admit liability for the patient's death and for staff to be disciplined. However the Trust advised them that a culture of blame was not desirable and that it did not identify any matters that required action under its disciplinary process. The Trust also identified that the patient had been assessed as able to mobilise to the toilet with supervision and there was no known risk of the toileting process itself. I consider that although the report concluded the fall was a contributory factor in the patient's death, it had not identified any failures in the actions of the student nurse as she was respecting the patient's dignity and privacy and had complied with the risk assessment.

88. However it is my view that the report did not deal with the issue regarding the suitability of the patient's footwear which was clearly referred to in the student nurse's statement as she had noted her slippers were missing. I accept the advice of the IPA that there ought to have been consideration given to the type of footwear worn by the patient. The complainant also stated that there are no recommendations in the report regarding ongoing management of falls of vulnerable patients. I also accept the advice of my IPA that the report ought to have made a recommendation about footwear to ensure patients are wearing suitable footwear before mobilising. I have established that appropriate footwear is a fundamental aspect of a falls risk assessment. However, I cannot conclude that this failing caused the patient's death. The First Principle of Good Administration requires public bodies to 'Get it Right' by acting in accordance with its policy and guidance. I consider the Trust's failure to consider the suitability of the patient's footwear during the SEA investigation and to make appropriate recommendations does not comply with this principle, and constitutes maladministration. However I am unable to conclude that the patient experienced an injustice arising from this maladministration as she was unaware of its potential significance.

89. The SAI report also concluded that there was *'a failure on the part of the ward team to identify the incident as an SAI and to subsequently escalate matters to*

Management. This failure to recognise the incident as a potential SAI resulted in a significant delay in the case being reported as an SAI and caused significant further upset to the family who were left frustrated and angry with the lack of follow up.' The Trust has maintained throughout this investigation that senior management were unaware of the incident as a manager was not selected on the incident form. Further staff were not aware the patient had died until the family submitted a complaint. The Trust also stated that ward staff did not follow up on the incident when she was transferred. However the Trust has now implemented changes so that contact is made between the respective wards to ascertain a patient's condition until they are returned to the original ward or discharged.

90. I find the Trust's stance on this issue to be both surprising and concerning due to an email sent on 11 December 2016 from Risk Governance to the Governance Manager, who confirmed that she received this email notifying her of the incident. However, the Trust could not definitely say what action she took on receipt of the email due to the passage of time. In my view this email provides sufficient justification for the ward staff to escalate the incident to senior management given the Ward Manager had approved the incident form on Datixweb. The latter was received by Risk & Governance and referred to the Governance Manager. I accept she may not have been aware of the patient's death and that it was not Trust protocol at this point to check on a patient's condition when transferred to another ward. However I welcome that the Trust has initiated changes to remedy this issue as a result of this incident.

91. I note that the Ward Manager did not select a manager to send her report to. The Trust's guidance does not make this a requirement; rather it is an option. I note however that the report was sent to a senior manager. I have also found that the Ward Sister had informed the Assistant Services Manager (a member of the SEA panel). I am concerned to note that the Governance Manager (a member of the SEA panel) did not acknowledge this fact during the SEA investigation. I am also concerned that this information was not provided to this Office until a late stage of my investigation. I am therefore critical that the SEA report concluded ward staff did not escalate the incident to senior management. This is clearly inaccurate. I am satisfied that this incident was of such a nature that it met the criteria for an

SAI. I welcome that the Trust has therefore accepted that an SAI investigation ought to have been initiated at this point.

92. The Third Principle of Good Administration requires public bodies to be 'Open and Accountable' by taking responsibility for actions of their staff. I consider the Trust's SEA investigation report was erroneous in the following respects:
(i) it wrongly concluded that ward staff did not escalate the incident; and
(ii) it wrongly concluded that senior management were not aware of the incident
I conclude this failure to be contrary to the Third Principle, which constitutes maladministration. In light of these errors, I am satisfied that the Trust failed to meet the requirements of the Third Principle. As a consequence, the patient experienced the injustice of outrage and frustration regarding the Trust's investigation, which was attended by maladministration.

93. Although I have not upheld all of the complaints regarding the Trust's SEA investigation, I have identified a number of significant failings in this respect. I accept the advice of my IPA that overall the SEA investigation and report *'lacked a duty of candour'* and was not conducted in a timely manner. In particular, the IPA has highlighted and I accept that learning points surrounding the inappropriateness of the patient's footwear were not identified. Further, in the report the Chair was not independent from the service area. I have also identified excessive delay by the Trust in completion of its investigation. The Trust unfortunately raised the family's expectations by indicating in the April 2016 meeting that it was accepting responsibility for the fall when it clearly did not. I therefore conclude that the SEA investigation was attended by maladministration.

CONCLUSION

94. I received a complaint about the actions of the Belfast Health and Social Care Trust in relation to the care and treatment of the complainant's late mother. She also complained about the Trust's investigation of her mother's fall.

I have investigated the complaint and have found a failing in care and treatment in relation to the student nurse's failure to ensure the patient was wearing the correct footwear. I have also found maladministration in relation to the following respects:

(i) The SEA investigation did not have an independent chair as required under Trust policy;

(ii) The SEA panel unfairly raised the family's expectations in a meeting by indicating that the student nurse had made the wrong decision when the SEA subsequently concluded she had not;

(iii) The SEA investigation exceeded its published time limits by a considerable margin and failed to avoid undue delay;

(iv) The SEA investigation failed to consider the suitability of the patient's footwear and failed to make appropriate recommendations to ensure learning;

(v) The SEA investigation wrongly concluded that ward staff did not escalate the incident and that senior management were not aware of the incident.

I am satisfied that the failure in care and treatment I identified caused the patient the injustice of being placed at a greater risk of falling due to the lack of appropriate footwear. I cannot however conclude that this failing led to her sad and untimely death. I am satisfied that the maladministration I identified caused the complainant to experience the injustice of outrage, uncertainty, upset and frustration.

Recommendations

95. I recommend that the Trust undertake the following actions:

(i) Provide a written apology for the injustice identified in this report. The Trust should provide the apology to the complainant within one month of the date of my final report;

(ii) Provide the complainant with a payment of £750 by way of a solatium for the injustice identified by me which should be paid within one month of the date of my final report.

I would have also recommended service improvements in relation to the Trust's approach to SAI's. However I am conscious of ongoing work in this regard following the publication of the report into 'The Inquiry into Hypnoatremia-related Deaths' in January 2018.

In addition to the learning identified by the Trust as a result of this complaint, I also recommended that the Trust:

(iii) Takes the necessary action to ensure that all relevant staff (including student nurses) have been involved in falls prevention training or instruction; in particular the importance of patients wearing appropriate footwear

(iv) Takes the necessary action to ensure that all patient safety incidents are reported according to guidance using Datixweb and actioned by relevant senior management;

(v) Provides an update on the progress of implementing the recommendations highlighted in the SEA report; and

(vi) Reviews the practice and timeliness of sharing draft SEA reports with patient's families in order to ensure adherence to HSCB guidelines.

I recommend that the Trust develop an action plan to incorporate these recommendations and should provide me with an update within six months of the date of my final report on the progress in implementation. The update 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).

I can confirm the Trust has indicated it accepts my findings and will implement all recommendations within the timeframe.

Marie Anderson

MARIE ANDERSON
Ombudsman **February 2019**

Appendix 1

The Public Services Ombudsman Act (Northern Ireland) 2016

INVESTIGATION REPORT
UNDER SECTION 43 OF THE 2016 ACT

ADDENDUM
Case Reference Number 17493

The following note provides details of points of concern raised by Mrs Glynis Dilworth in relation to my report into the care and treatment provided to her late mother, Mrs Elizabeth Taylor, by the Belfast Health and Social Care Trust.
This addendum should be kept with and read in conjunction with the report.

Mrs Dilworth's response to my draft report:

96. Page 37, paragraph 72. The following change is inserted: *Mrs Dilworth also raised concerns regarding the accuracy of information supplied by the student nurse. In particular, Mrs Dilworth refuted that the student nurse continued to care for her mother and that her mother asked the student nurse to go to the RVH with her. Mrs Dilworth stated that due to her stroke, her mother's speech was incoherent. Mrs Dilworth also stated that the student nurse did not attend to her mother during the period after the fall.*

Analysis and findings

97. Page 39, Paragraph 78. The following change is inserted: *Mrs Dilworth also raised concerns in relation to the accuracy of information supplied by the student nurse, in particular she refuted that her mother communicated to the student nurse that she wanted her to go to the RVH with her. However I have not made a finding on this issue as this was not a matter for this investigation.*

Marie Anderson

MARIE ANDERSON
Ombudsman

December 2018

APPENDIX TWO

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.