Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Belfast Health and Social Care Trust

NIPSO Reference: 201917314

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

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

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

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Case Reference: 201917314

Listed Authority: Belfast Health & Social Care Trust

SUMMARY

This complaint was about care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's late mother (the patient) in January and February 2020. It related to her diagnosis and treatment of mesenteric bowel ischaemia[1]. It also related to the medical team's communication with the complainant.

The investigation considered evidence obtained from the complainant and the Trust. It also considered independent medical advice from a Consultant of emergency medicine and a Consultant of gastroenterology. The investigation found the care and treatment staff provided to the patient (as an outpatient) in January 2020 appropriate.

The investigation also considered care and treatment provided to the patient following her admission to hospital in February 2020. It found the decision to postpone two investigative procedures appropriate. It also found staff's decision to feed the patient via nasogastric tube[2] appropriate. The complainant questioned why staff delayed the patient's surgical procedure she said was planned for 14 February 2020. However, the investigation could not conclude that the Trust arranged to perform surgery that day (records instead evidence staff arranged the surgery to occur on 17 February 2020). Therefore, it could not consider if a decision to postpone the procedure was appropriate.

The complainant raised concerns about management of the patient's pain. The investigation found staff could have increased the maximum prescribed dose of pain relief for the patient on 11 and 12 February 2020. However, they did not do so. I considered this caused the patient suffering and denied her the opportunity to receive appropriate pain relief during that time.

[1] When a blockage in an artery cuts off blood flow to a portion of the intestine.

[2] A special tube that carries food and medicine to the stomach through the nose.

In relation to communication, the investigation found the Consultant did not speak to the complainant for two further days following her request for an update on 8 February 2020. I considered this caused the complainant frustration and uncertainty. It also found that Gastroenterologist (B) should have taken a note of his meeting with the complainant on 10 February 2020. However, he did not do so. This meant I could not consider if Gastroenterologist (B) appropriately responded to the complainant's questions about the patient's diagnosis and treatment plan. I appreciated the absence of a finding caused the complainant disappointment, frustration, and further uncertainty.

I recommended the Trust apologise to the complainant for the failures identified and made recommendations to prevent the failures recurring. I recognised the pain and trauma the complainant said she and her family experienced during this time. I would like to offer my sincere condolences to the complainant and her family for the sad and sudden loss of their mother.

THE COMPLAINT

1. This complaint is about the actions of the Belfast Heath and Social Care Trust. The complainant raised concerns regarding care and treatment staff provided to her mother (the patient) in January and February 2020. She was also concerned with staff's communication with her as the patient's next of kin.

Background

2. The patient had a history of heart disease and chronic obstructive pulmonary disease[3] (COPD). She attended the Royal Victoria Hospital's (RVH) emergency department (ED) in 2017 reporting abdominal pain. Staff provided her with gastro-resistant[4] medication and referred her to her general practitioner (GP). She next reported abdominal pain and abnormal weight loss to her GP in August 2019. In December 2019, the GP referred her to a gastroenterologist[5] within the Trust for further investigation.

3. The patient attended the RVH's ED on 9 January 2020 reporting abdominal pain after eating. ED staff performed tests but did not admit the patient to hospital. She attended for a CT scan[6] on 13 January 2020, and for consultation with Gastroenterologist (A) on 29 January 2020.

4. On 4 February 2020, the complainant reported to the GP that the patient experienced rectal bleeding along with abdominal pain. The GP referred the patient to the RVH where staff admitted her. On 14 February 2020, the patient experienced acute mesenteric bowel ischaemia[7]. Staff performed emergency surgery in the early hours of 15 February 2020. Sadly, the patient passed away a few hours later in the intensive care unit. The complainant said Trust staff made '*poor decisions'*, resulting in the patient and her family experiencing '*distress*' and '*trauma*'.

[3] The name for a group of lung conditions that cause breathing difficulties.
[4] Medication designed to temporarily withstand attack by stomach acid.
[5] Doctors who investigate, diagnose, treat and prevent all gastrointestinal (stomach and intestines) and hepatological (liver, gallbladder, biliary tree and pancreas) diseases.
[6] A computed tomography scan is a medical imaging technique used to get detailed images of the body for diagnostic purposes.
[7] When a blockage in an artery cuts off blood flow to a portion of the intestine.

Issues of complaint

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

Issue 1: Whether the Trust provided appropriate care and treatment to the patient between 9 January and 15 February 2020.

Issue 2: Whether the Trust appropriately communicated with the patient's family during her admission.

INVESTIGATION METHODOLOGY

6. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

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

- A Consultant of emergency medicine for over 14 years (E IPA); and
- A Consultant Gastroenterologist for over 13 years (G IPA).

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

Relevant Standards and Guidance

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[8]:

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

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

10. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - The General Medical Council's (GMC) Good Medical Practice, updated April 2019 (the GMC Guidance);
    - The World Health Organisation's (WHO) Guidelines for the Pharmacological and Radio-therapeutic Management of Cancer Pain in Adults and Adolescents, 2018 (WHO Pain Management Guidelines); and
    - The National Institute for Health and Care Excellence's (NICE) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, Clinical Guideline 32, updated 4 August 2017 (NICE CG32).

11. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

12. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the Trust provided appropriate care and treatment to the patient between 9 January and 15 February 2020.

Detail of Complaint

13. The complainant was concerned that staff missed opportunities to diagnose and treat the patient's condition prior to her admission to hospital in February 2020. This included treatment provided to the patient during her ED attendance on 9 January 2020 and following her outpatient appointment on 29 January 2020.

14. The complainant also raised the following concerns about the patient's admission to the RVH from 4 February 2020:
    - Staff postponed investigative procedures that may have led to earlier diagnosis and treatment;
    - Staff did not prescribe adequate pain relief for the patient;
    - Staff used a nasogastric (NG) tube[9] to feed the patient; and
    - Staff postponed surgery she said they planned for 14 February 2020.

Evidence Considered

Legislation/Policies/Guidance

15. I considered the following guidance:
    - GMC Guidance;
    - WHO Pain Management Guidelines; and
    - NICE CG32.

The Trust's response to investigation enquiries

Treatment as an outpatient

16. The Trust said the patient's previous clinical investigations did not document any symptoms in keeping with chronic[10] mesenteric ischaemia[11] (CMI). It explained that CMI was '*one of several diagnoses'* Gastroenterologist (A) considered following his consultation with the patient on 29 January 2020. It said that on the same day, he booked the patient to attend for a CT angiogram[12]. The Trust scheduled the procedure to occur on 6 February 2020 in Belfast City Hospital (BCH).

[9] A special tube that carries food and medicine to the stomach through the nose.
[10] A condition or disease that is persistent or long-lasting in its effects, or a disease that comes with time.
[11] A condition in which plaque builds up in the major arteries that supply blood to the small intestine or small bowel.
[12] A test used to look at the blood vessels that supply the small and large intestines.

Postponement of investigative procedures as an inpatient

17. The Trust said staff cancelled the patient's CT angiogram scheduled for 6 February 2020 (in the BCH), as by then she was an inpatient in the RVH. It said staff rescheduled the procedure to occur on 7 February 2020 in the RVH. The Trust explained that while the CT angiogram showed narrowing of the arteries, blood continued to flow to the bowel.

18. The Trust said staff also arranged a flexible sigmoidoscopy[13] for the patient to occur on 7 February 2020. It explained the procedure was to exclude other causes for the patient's symptoms (although clinicians considered other causes unlikely). However, staff had to rearrange the procedure '*to facilitate a CT scan that was deemed more urgent'*. The Trust explained the sigmoidoscopy procedure ran separate to tests to confirm CMI. Therefore, the delay did not affect the diagnosis or the patient's treatment plan.

19. The Trust said the patient experienced acute[14] mesenteric ischaemia on 14 February 2020. It explained that any postponement of investigations did not result in a missed opportunity to diagnose the acute event.

Pain relief

20. The Trust explained that from admission, staff controlled the patient's pain with paracetamol, dihydrocodeine[15], short-tec[16], and long-tec[17]. It said both nursing and medical teams observed the patient's pain levels to ensure it responded to the prescribed analgesia. The Trust explained the patient's pain *'increased in severity'* when her '*bowel infarcted*[18]' on 14 February 2020.

The surgical procedure

21. The Trust said the vascular surgery team did not consider it possible to treat the patient's diseased blood vessels with surgery. While it considered vascular stenting[19] an option, the patient required specialist imaging to check for an

[13] A test to look inside the lower part of the large bowel.
[14] Acute conditions are severe and sudden in onset.
[15] A semi-synthetic opioid analgesic prescribed for pain.
[16] An opioid pain-reducing drug.
[17] Used for the relief of moderate to severe pain over a period of 12 hours.
[18] Tissue death (necrosis) due to inadequate blood supply to the affected area.
[19] Stenting supports the walls of the blood vessel and prevents it from closing up again.

access point. It said the patient underwent a second CT angiogram on 11 February 2020 to '*plan access for a potential stent'*. The Trust explained the procedure again showed that blood continued to flow to the patient's bowel.

22. The Trust said that on 12 February 2020, the vascular multidisciplinary meeting (MDM) agreed to attempt stenting for the patient. The team planned to perform the surgery on 17 February 2020. The Trust explained the patient experienced a complete loss of blood flow to the bowel on 14 February 2020. It said staff performed emergency stent placement and surgery to remove the diseased gut. Sadly, the patient passed away a number of hours following surgery.

Relevant Independent Professional Advice

23. A Consultant of emergency medicine (E IPA) provided advice on the care and treatment ED staff provided to the patient on 9 January 2020.

24. A Consultant Gastroenterologist (G IPA) also provided advice on the care and treatment gastroenterology staff provided to the patient in January and February 2020.

The complainant's response to the draft report

25. The complainant explained there is no diagnostic test for acute mesenteric bowel ischaemia. Therefore, doctors base their diagnosis on clinical symptoms. She explained that given the patient had vascular calcification in the CT scans, she believed doctors could have diagnosed the illness sooner and with a relative present.

Pain relief

26. The complainant provided an email exchange she had with Gastroenterologist (A) on 14 February 2020. The email informs Gastroenterologist (A) that doctors were '*reluctant*' to prescribe longtec for the patient on 13 February 2020.

The surgical procedure

27. The complainant said she found it '*hard to believe'* the records did not evidence that the Trust scheduled the procedure to occur on 14 February 2020. In her email exchange she had with Gastroenterologist (A) on 14 February 2020, the complainant referred to the decision to cancel the surgery planned for that

morning. She explained that although Gastroenterologist (A) '*did not state in his response the procedure was cancelled, he acknowledged what I wrote, and therefore I presumed a decision was made to reschedule the surgery to Monday'*. The complainant said this raised questions regarding the appropriateness of the documentation and decision making. She also said she felt the Trust was '*stringing us along and being dishonest and giving us false hope'*.

Analysis and Findings

Treatment as an outpatient - ED

28. I firstly refer to the patient's attendance at the RVH ED on 9 January 2020. The complainant asked what conclusion ED staff reached during the patient's attendance. The E IPA advised that staff did not confirm a specific diagnosis. However, the test results *'ruled out bowel obstruction, perforation, or severe infection*'. He further advised that findings from tests undertaken did not indicate the need for an urgent CT scan or other emergency investigation.

29. I appreciate the complainant said both she and the patient were concerned with the apparent lack of action taken. However, the E IPA noted the patient was due to attend for further investigations as an outpatient in the days following her ED attendance. He also advised that in the absence of any clinical features requiring emergency admission, he considered staff's actions '*reasonable*'. I accept his advice. I am satisfied ED staff provided appropriate care and treatment to the patient on 9 January 2020. I hope this reassures the complainant that actions ED staff took were appropriate.

Treatment as an outpatient - gastroenterology

30. I note the patient attended for a CT scan on 13 January 2020 and for an outpatient appointment with Gastroenterologist (A) on 29 January 2020. The complainant questioned why Gastroenterologist (A) did not act more quickly to treat the patient's condition.

31. I firstly refer to the patient's CT scan. The G IPA advised the scan showed '*furred up vessels*[20]*'*, which supplied blood to the patient's gastrointestinal tract and other vital organs. However, it '*did not show direct signs of gut ischaemia'*.

32. I note in his letter to the patient's GP, Gastroenterologist (A) explained he wished to rule out gut ischaemia as '*a priority'*. On the same day as the consultation, he arranged for the patient to have a CT angiogram to check the blood flow to her bowel. Trust staff booked the procedure to occur on 6 February 2020, eight days after the consultation.

33. GMC Guidance states that doctors must '*promptly provide or arrange suitable advice, investigations or treatment where necessary'*. I appreciate the complainant's concern, especially given the patient's weight loss and more persistent abdominal pain at that time. However, Gastroenterologist (A) arranged the CT angiogram within red flag[21] timescales. The G IPA advised that given the patient's presentation at that time, he considered this timescale '*reasonable*'. I accept his advice and am satisfied Gastroenterologist (A) arranged investigations with sufficient urgency. I hope this reassures the complainant that Gastroenterologist (A) acted quickly and within red flag timescales.

Postponement of investigative procedures as an inpatient

34. The complainant was concerned that staff delayed investigative procedures following the patient's admission to hospital on 4 February 2020. Records evidence that staff cancelled the CT angiogram scheduled to occur on 6 February 2020 in the BCH. The Trust explained it did so as at the time it was due to occur, the patient was an inpatient at the RVH. Staff then rearranged the procedure to occur on 7 February 2020 in the RVH, which showed that blood continued to flow to the patient's bowel.

[20] The walls of the arteries can become furred up with fatty deposits.

[21] Red flag appointments are the highest priority and usually occur within two weeks from the initial consultation.

35. I appreciate the concern the complainant said she and the patient experienced following cancellation of the procedure. However, by that time, the patient was an inpatient at the RVH and the procedure was to occur in a different hospital. I note staff rescheduled the CT angiogram to occur in the RVH on 7 February 2020, the day after the initial date, which was still within red flag timescales. The G IPA considered this decision appropriate and I accept his advice. I consider it was reasonable for staff to postpone the procedure for the reasons outlined. I am also satisfied that staff performed the CT angiogram within a reasonable time.

36. The complainant also raised concerns that staff postponed the patient's colonoscopy originally scheduled for 7 February 2020. The records evidence the patient was due to have a flexible sigmoidoscopy that day rather than a colonoscopy[22]. Therefore, I considered the postponement of this procedure.

37. I note from the records that staff postponed the sigmoidoscopy on 7 February 2020 and rescheduled it to occur on 10 February 2020. However, staff again postponed the procedure and it occurred on 12 February 2020. In response to my enquiries, the Trust explained staff rescheduled the procedure due to another patient's more urgent CT scan. However, I note staff did not document this (or any other) reason in the records. I would ask the Trust to remind staff of the importance of documenting reasons for their decisions in the medical records.

38. I considered if the postponements of the procedure were appropriate. The Trust explained it did not perform the sigmoidoscopy procedure to confirm mesenteric ischaemia. Therefore, it did not consider the postponements caused any delay to the diagnosis or subsequent treatment plan. It also said the procedure would not have identified the acute ischaemia that occurred two days later. The G IPA considered information gained from the sigmoidoscopy '*minimal*' and the time taken to perform the procedure reasonable. I accept his advice.

[22] A colonoscopy examines the entire colon, while a sigmoidoscopy covers only the lower part of the colon.

39. I appreciate both the patient and complainant were keen to understand the cause of the patient's symptoms. However, the records provide evidence that staff undertook the procedure to rule out a diagnosis of chronic mesenteric ischaemia rather than confirm it. Therefore, while it is clear the postponements occurred, I do not consider they delayed confirmation of the diagnosis or any related treatment.

40. The complainant also referred to the patient's CT scan performed on 14 February 2020. She enquired how long the patient had to wait to have the scan. The CT request form does not require staff to document the time of their request. However, the clinical records indicate that medical staff first contacted radiology at approximately 16:30. The records later document the patient was in CT at the time nursing staff wrote the note (19:15). The G IPA considered this timing reasonable and advised staff required time to stabilise the patient before transferring her to CT. I accept his advice. Therefore, I do not uphold this element of the complaint.

Pain relief

41. The complainant was concerned about pain relief prescribed for the patient during her admission. It is clear from the records the patient experienced considerable pain. I appreciate how distressing this must have been for the complainant and her family.

42. When considering this element of the complaint, I referred to the WHO Pain Management Guidelines. The Trust explained that while typically used for cancer patients, its staff follow the same principles for patients who have difficulty managing pain.

43. The complainant asked why staff only initially prescribed the patient paracetamol. I note ED staff on 4 February 2020 recorded the patient's pain score as 4/10. The records document the patient administered her own paracetamol while in the ED. They further document that while still in the ED in

the early hours of 5 February 2020, staff prescribed the patient an opiate (codeine[23]).

44. Following admission to the ward, the records document staff prescribed the patient paracetamol and dihydrocodeine. I note the G IPA considered this appropriate. I accept his advice. The WHO Pain Management guidelines state clinicians can prescribe patients who experience moderate pain a mild analgesic (such as paracetamol) combined with an opioid. Therefore, I am satisfied that at that time, clinicians prescribed the patient pain relief in accordance with relevant guidance.

45. The records evidence that staff regularly reviewed the patient's level of pain throughout her admission. In response to her reports of increased pain, staff prescribed the patient shortec on 9 February 2020, reaching the maximum dose on 11 February 2020.

46. The G IPA advised that given the severity of the patient's pain, staff should have reviewed and increased the maximum dose sooner (on 11 or 12 February 2020). I acknowledge the G IPA did not consider this a failure in the patient's care, as staff controlled her pain '*most of the time'*. However, this suggests there were occasions where staff did not adequately control the patient's pain.

47. The WHO Pain Management Guidelines state that while it can be impossible to eliminate pain completely, the goal is '*to reduce pain to a level that allows for a quality of life that is acceptable to the patient'*. I consider staff should have taken every opportunity to manage the patient's pain to a level where she was comfortable. I also consider that by not increasing the maximum dose of pain relief earlier, staff missed an opportunity to adequately control the patient's pain.

48. The complainant said a doctor informed the patient on 13 February 2020 they were '*reluctant'* to move her onto longtec pain relief as she was due to have surgery the next day. She said doctors instead prescribed intravenous

[23] An opiate medication typically used to treat mild to moderate degrees of pain.

Pabrinex[24] and she asked what purpose it had. The G IPA advised that Pabrinex provides vitamins B and C to malnourished patients. He explained clinicians do not use it to relieve pain. I hope this answers the complainant's query.

49. The complainant also questioned why doctors did not move the patient onto longtec at that time. I note the records do not document any discussion regarding longtec on this date. The G IPA advised the records document the patient's pain level as satisfactory that day. Therefore, he considered the decision not to move the patient onto longtec at that time '*reasonable*'. I accept his advice. I note clinicians prescribed longtec on 14 February 2020 when the patient's pain level increased.

50. I appreciate the complainant's concern regarding staff's treatment of the patient's pain during her admission. I note staff regularly reviewed the patient's pain and largely responded with appropriate analgesia. However, as outlined in paragraph 48 of this report, I consider staff missed an opportunity to increase the maximum dose of shortec on 11 and 12 February 2020. I consider this a failure in the patient's care and treatment and uphold this particular element of the complaint. I consider this failure denied the patient the opportunity to receive appropriate pain relief on these dates and caused her to suffer unnecessarily. I recognise how distressing this must have been for the patient, and also for the complainant, to witness.

Nasogastric feeding

51. The complainant asked who made the decision to introduce NG tube feeding for the patient. I note the records for Gastroenterologist (B)'s ward round on 11 February 2020 requested a dietician's review. The dietician then recorded a note which documents, '*appropriate to commence NG feeding'* and outlines the reason for their decision. I note the G IPA's advice that based on these notes, the dietician and medical team jointly agreed to commence NG feeding, which he considered appropriate. I hope this answers the complainant's query.

[24] Provides additional vitamins B and C into the veins to correct deficiencies that may have occurred.

52. The complainant also questioned if the decision to feed the patient with an NG tube rather than using total parenteral nutrition[25] (TPN) was appropriate. The G IPA advised he did not consider TPN feeding would have benefitted the patient given her presentation at that time. He further advised that TPN is '*a high risk treatment because of the vascular risk, risk of infection and the risk of the bowel not getting nutrition'*. I accept his advice. I am satisfied staff made appropriate decisions regarding feeding for the patient.

53. I appreciate the complainant's concern regarding feeding for the patient, especially given her mother's weight loss and reduced oral intake. I hope this finding reassures the complainant that the decisions made regarding feeding were appropriate.

The surgical procedure

54. The complainant questioned why staff postponed the patient's surgical procedure she said was arranged for 14 February 2020. I note the records for the previous day document the medical team decided to perform mesenteric stenting[26] with interventional radiology[27]. However, I cannot find any indication in the records to suggest staff scheduled the procedure to occur on 14 February 2020. Instead, the records document the radiology team scheduled the surgery to occur on 17 February 2020.

55. The complainant explained a male doctor informed the patient they would perform the procedure on 14 February 2020. However, the records do not evidence this interaction. The records document Gastroenterologist (A) informed the patient of the plan for stenting during his ward round that morning. However, the note recorded at the time of the ward round documents that he awaited confirmation of the slot from radiology. It does not document a proposed date or time for the procedure.

56. The nursing records for 14 February 2020 document that a nurse informed the complainant the patient was '*not for stenting today'*. They further document

[25] The feeding of nutritional products to a person intravenously, bypassing the usual process of eating and digestion.
[26] Stenting is a minimally invasive procedure that widens a blocked artery and increases blood flow to the intestines.
[27] A medical subspecialty that performs various minimally-invasive procedures using medical imaging guidance.

nursing staff informed the family the patient was not on the list for that day, and it was a '*provisional list'*. I also refer to the email exchange the complainant had with Gastroenterologist (A) on 14 February 2020 in which she refers to the decision to cancel the procedure, and Gastroenterologist (A) replied, '*hoping for Monday'*.

57. I do not consider these interactions provide definitive evidence that the Trust confirmed with the patient or her family that it would perform the surgery on 14 February 2020. However, I consider it suggests the Trust may have placed the patient on a provisional list for that date.

58. It is likely this situation resulted from a miscommunication. I consider this unfortunate especially as the patient and her family expected surgery to occur earlier. While I cannot definitively conclude on this matter, I note the G IPA advised that based on the clinical situation at that time, the decision to perform the surgery on 17 February 2020 was appropriate. I hope this provides some reassurance for the complainant. I note that due to the patient experiencing acute ischaemia, staff performed surgery as an emergency late on 14 February 2020.

59. The complainant outlined the trauma she and her family experienced in the days leading to their mother's sad and sudden death. I recognise this and offer my sincere condolences to them for having to witness these traumatic events. While I have not upheld all of the complainant's issues, I hope my findings go some way to provide answers to their outstanding concerns.

Issue 2: Whether the Trust appropriately communicated with the patient's family during her admission.

Detail of Complaint

60. The complainant said Gastroenterologist (B) informed the patient of her diagnosis on 8 February 2020. She explained the patient had difficulty sharing the diagnosis with her family. The complainant questioned why, in this situation, the doctor did not share information with her (as the patient's next of kin) about the diagnosis and treatment plan at that time.

61. The complainant said she met with Gastroenterologist (B) two days later on 10 February 2020 after he obtained the patient's consent. However, he did not answer all of her questions. The complainant also said Gastroenterologist (B) did not inform her he was going on leave.

62. The complainant raised a further concern that staff did not inform her of the decision to postpone the patient's surgery on 14 February 2020.

Evidence Considered

Legislation/Policies/Guidance

63. I considered the following guidance:
    - GMC Guidance.

The Trust's response to investigation enquiries

64. The Trust explained its staff '*openly and honestly'* communicated '*all decisions, options and aspects of care'* with the patient and her family.

Relevant Independent Professional Advice

65. A Consultant Gastroenterologist (G IPA) also provided advice on staff's communication with the complainant in February 2020.

The complainant's response to the draft report

Gastroenterologist (B)'s meeting with the complainant

66. The complainant said she asked Gastroenterologist (B) how many of the vessels to the patient's gut were '*completely blocked'*. However, he did not answer. She explained this made her family anxious.

67. The complainant explained that if the Trust openly and clearly communicated with her and her family, it would have provided reassurance regarding the

patient's care. She said that in general, the Trust's communication with both patients and families was '*poor*'.

Analysis and Findings

Communication of the diagnosis and treatment plan

68. The clinical records for 8 February 2020 evidence that Gastroenterologist (B) saw the patient during his ward round at 09:20. The entry documents, '*mesenteric ischaemia; NEWS 0; ongoing pain with eating; plan: await input from surgeon/IR [interventional radiology]*'. It is not clear from this record what information Gastroenterologist (B) shared with the patient about the diagnosis, if any.

69. The nursing records at 15:00 on 8 February 2020 document the complainant's request to speak with the medical team. It also documents that nursing staff passed her request onto an F2 doctor. However, there is no record to suggest the doctor either passed on the request to a more senior doctor, or spoke with the patient's family.

70. I appreciate a junior doctor may not have been in a position to discuss the patient's diagnosis and/or treatment plan in detail. However, the G IPA advised the medical team should have shared what information they knew at that time with the patient's next of kin (the complainant). I accept his advice. GMC Guidance requires doctors to be '*considerate to those close to the patient and be sensitive and responsive in giving them information and support'*. In accordance with the guidance, I consider it was reasonable for Gastroenterologist (B), as the person in charge of the patient's care, to speak to the complainant following her request that day. If he was not able to speak with the complainant, I consider he should have informed her as such, or tasked a colleague to speak to her on his behalf. However, he did not do so. I note that following an email from the complainant, Gastroenterologist (B) met with the family on 10 February 2020. However, I consider the absence of an update for those two days caused the complainant and her family frustration and uncertainty. I uphold this element of the complaint.

Gastroenterologist (B)'s meeting with the complainant

71. The complainant was concerned Gastroenterologist (B) did not answer all questions she put to him during their meeting on 10 February 2020. She explained that one of the questions put to Gastroenterologist (B) was whether all of the vessels to the patient's gut were blocked. I considered the records for this date. However, they do not contain a note of the meeting.

72. The records for 11 February 2020 contain a retrospective note that refers to the meeting the previous day. While the note documents Gastroenterologist (B) '*explained [the] plan'*, it does not outline what questions the complainant asked or what specific information Gastroenterologist (B) shared.

73. The G IPA advised Gastroenterologist (B) should have documented the discussion, '*with (at least) the most important questions / discussion points answered'*. I accept his advice. GMC Guidance requires doctors to create and retain appropriate records. It states they should document the notes at the time of the event or '*as soon as possible afterwards'*. Furthermore, taking appropriate records affords protection to staff involved in a patient's care by providing a clear record of their actions and the reasons for them. I consider Gastroenterologist (B) should have documented the questions asked and his responses, and retained the note in the patient's records, in accordance with GMC Guidance.

74. I do not consider the failure to document a note of the discussion impacted the patient's care and treatment. However, the absence of a complete record prevents me from establishing whether Gastroenterologist (B) shared relevant information with the complainant and appropriately answered her questions. I appreciate the complainant will likely find it disappointing that I am unable to make this finding. I also consider it will cause her frustration and further uncertainty.

75. The complainant also said Gastroenterologist (B) did not inform her he was taking leave from the hospital. The G IPA advised it is '*not custom nor necessary'* to inform patients or their family they are taking leave. I do not consider it was necessary for Gastroenterologist (B) to share this information

with the complainant. I note Gastroenterologist (B) handed over the patient's care to Gastroenterologist (A) who continued treatment in his absence.

Communication of the decision to postpone the stenting procedure

76. The complainant said staff did not inform her of the decision to postpone the surgery originally scheduled for 14 February 2020. Earlier in this report I established that staff may have placed the patient on a provisional list for that day. However, they later decided to perform surgery on 17 February 2020.

77. The records do not document what information staff initially provided to the family regarding placing the patient on a provisional list. However, I would have expected staff to have made clear at that time that as it was provisional, surgery may not occur on that date. Given the complainant's concerns, I cannot be satisfied that staff provided that information to the family. I would ask the Trust to remind staff of the importance of communicating full and clear information regarding treatment to those close to the patient.

CONCLUSION

78. This complaint is about care and treatment Trust staff provided to the patient in January and February 2020. It also relates to staff's communication with the complainant. I do not uphold all elements of the complaint. However, I uphold two elements for the reasons outlined in this report. I also identified that in accordance with GMC Guidance, Gastroenterologist (B) should have created and retained a note of his meeting with the complainant held on 10 February 2020. However, he did not do so. I recognise the impact the failures had on the patient, the complainant, and their family.

Recommendations

79. I recommend within **one month** of the date of this report:

    i. The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused to her as a result of the failures identified; and

ii. The Trust shares this report with staff involved in the patient's care. It should also discuss the case and my findings with relevant staff at their next appraisal, and ask them to reflect on the failures identified.

80. I further recommend the Trust provides training to relevant staff involved in the patient's care and treatment. It should provide me with an update on this training within **three months** of the date of this report. The training should incorporate the following:

i. The importance of creating and retaining contemporaneous records in accordance with Standard 21 of the GMC Guidance;

ii. The prescription of appropriate pain relief in accordance with the WHO Pain Management Guidelines; and

iii. The importance of sharing information with those close to the patient in accordance with Standard 33 of the GMC Guidance (and after they obtain relevant consent).

81. I recognise the effect the sudden and unexpected death of the patient had on the complainant and her family. Their grief and loss is very evident in their correspondence with both my office and the Trust. I hope this report goes some way to address the complainant's concerns.

MARGARET KELLY
Ombudsman **30 March 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.