Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Lisnaskea Health Centre

NIPSO Reference: 202000826

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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Listed Authority: Health Service Providers - GP

SUMMARY

I received a complaint about the written response the Maple Healthcare Lisnaskea Health Centre (the Practice) issued to the patient on 29 September 2020.

The patient received a Pandermix[1] Swine Flu[2] vaccination on 26 October 2009, and since the vaccination, the patient has suffered from severe shoulder pain. The patient attended the Practice on 14 August 2020 and asked her GP if the Practice had considered whether there was a direct link between her shoulder pain and the vaccination she received in 2009. The Practice provided the patient with a 34 page letter of response to her enquiry. Within its response the Practice provided the patient with a summary of the treatment she received and referrals the Practice made on her behalf. The Practice advised the patient that the GP wrote to the Trust's Orthopaedic Consultant on 7 July 2020 asking for an opinion on the possible relationship of the patient's shoulder problems and the Swine Flu injection. The Practice provided a response to the patient on 29 September 2020.

The investigation established the Practice's written response to the patient on 29 September 2020 was appropriate, and the complaint was not upheld.

[1] Pandemrix is an influenza vaccine for influenza pandemics, such as the 2009 flu pandemic.
[2] Swine influenza is a severe respiratory infection caused by the virus H1N1.

THE COMPLAINT

1. I received a complaint about the actions of Maple Healthcare Lisnaskea Health Centre (the Practice).

Background

2. The patient received a Pandermix[3] Swine Flu[4] vaccination (the vaccination) on 26 October 2009, and said she suffered an immediate adverse reaction. The patient said she suffered from extreme shoulder and arm pain, head pain, muscle spasms, freezing of the shoulder, dizziness and felt nauseated following the receipt of the vaccine.

3. The patient attended the Practice on 1 July 2020 and requested the GP write to the Trust's Orthopaedic Consultant to seek an opinion on any potential relationship between her shoulder problem and her vaccination. The GP wrote to the Trust's Orthopaedic Consultant on 7 July 2020 requesting this information. The Practice informed this Office it did not receive a response to this letter.

4. The patient visited the Practice on 14 August 2020 and verbally asked the Practice if it considered there was a link between her shoulder pain and the Pandermix vaccination she received in 2009. The Practice considered the patient requested clinical information as opposed to making a complaint. The Practice responded by letter to the patient on 29 September 2020 and stated, *'as I am a GP, I am unable to comment on whether the injection you had in 2009 is directly related to your shoulder symptoms. The specialist tests you have undergone are best interpreted by a specialist, in this case an orthopaedic surgeon […], I recommend seeking a definitive answer from him if he is able to do this'*. The Practice advised this Office it holds no information which verifies whether the patient contacted the Orthopaedic surgeon following the Practice's letter on 29 September 2020.

[3] Pandemrix is an influenza vaccine for influenza pandemics, such as the 2009 flu pandemic.
[4] Swine influenza is a severe respiratory infection caused by the virus H1N1.

Issue of complaint

5. The issue of complaint accepted for investigation was:

Whether the Practice's written response to the patient on 29 September 2020 was appropriate and followed relevant guidance.

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

- MB ChB GPSI (Diab), qualified and registered General Practitioner for 46 years.

I enclose the clinical advice received at Appendix three to this report.

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'. However how I weighed this advice 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 which are 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[5]:

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

- The Principles of Good Administration; and
- The Principles of Good Complaints Handling.

10. I did not include all of the 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.

11. A draft copy of this report was shared with the patient and the Practice for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the Practice's written response to the patient on 29 September 2020 was appropriate and followed relevant guidance.

Detail of Complaint

12. The issue of complaint is about the Practice's written response to the patient on 29 September 2020 following the patient's verbal complaint to the Practice on 14 August 2020. The patient said her GP failed to take appropriate action and refer her to the appropriate specialist to investigate the possibility the vaccination had caused the patient's shoulder problems. As a result, she believes this led to debilitating physical health and deterioration in her mental wellbeing.

Practice's response to investigation enquiries

13. The Practice stated during the patient's appointment with the General Practitioner on 14 August 2020, the patient asked if the Practice considered her shoulder problems were as a result of the immunisation in 2009. The Practice stated it understood this to be a request for clinical information as opposed to a complaint. The Practice wrote a letter to the patient dated 29 September 2020, detailing a written response in relation to this request for clinical information.

Relevant Practice records

14. The Practice provided the patient's medical records as well as an explanation of the care and treatment the patient received. The Practice also provided this Office with its 29 September 2020 response to the patient.

Response to the draft Investigation Report

15. Both the patient and the Practice were given the opportunity to provide comments on the draft Investigation Report. Where appropriate, comments have been reflected in changes to the report.

Relevant Independent Professional Advice

16. The IPA advised the response from the Practice *'is very detailed and possibly in some places too much so, but the rationale of including everything cannot be criticised as the patient now has a complete history of her consultations at the practice, referrals made by the practice to specialist colleagues and the responses received thereto'*. The IPA acknowledged within his advice that the patient was left with a loss of trust in the system and with her GP as she *'has read numerous articles about what she seems to be suffering and its possible causes but cannot get anyone to confirm a diagnosis or confirm the linkage which she feels is obvious'*.

17. The IPA advised after reading the letter it seems that the patient *'has been taken seriously by the various medical professionals she has seen and never been treated dismissively in any way. She has been seen on numerous occasions and referred to appropriate specialists on numerous occasions (and re-referred as appropriate). These specialists have conducted numerous investigations and repeated them as appropriately necessary and have never been unwilling to look at every aspect of the case'*.

18. The IPA advised no further response from the Practice to the patient seemed to be appropriate.

Analysis and Findings

19. The patient said the GP failed to take appropriate action and refer her to the appropriate specialist to investigate the possibility that the vaccination had caused the patient's shoulder problems.

20. The Practice stated during the patient's appointment with the GP on 14 August 2020, the patient asked if the Practice considered her shoulder problems were a result of the vaccination in 2009. The Practice provided a detailed written response to the patient on 29 September 2020 outlining the patient's previous medical history and advising her to seek advice from a specialist regarding the cause of her shoulder problems.

21. The letter sent from the Practice to the patient dated 29 September 2020 is very comprehensive and is made up of thirty-four pages. The letter outlines the chronology of events following the patient's Swine Flu vaccination in 2009. The chronology includes referrals and re-referrals to specialists to escalate the patient's side effects and includes details of letters sent from the specialists to the GP regarding the patient's condition. At the end of the letter the GP advised the patient that they are unable to comment whether the vaccination she had received in 2009 was directly related to the patient's shoulder pain. The GP recommended the patient contact the Orthopaedic Surgeon that had previously treated the patient, to provide her with a definitive answer on her shoulder symptoms.

22. The IPA advised the letter the Practice issued to the patient on 29 September 2020 was very detailed and provided the patient with a complete history of consultations at the Practice, and Practice referrals made to specialists' colleagues. The IPA advised the Practice reviewed the patient on numerous occasions and it also appropriately referred the patient to the appropriate specialists on numerous occasions. The IPA advised *'no further response seems to be appropriate'*.

23. I considered all of the available evidence, including the advice of the IPA. I accept the advice of the IPA that the letter the GP issued to the patient on 29 September 2020 was appropriate, and no further response from the Practice

was required. I also accept the IPA's advice *'the practice has endeavoured diligently to try to help in any and every way possible with both therapeutic pharmaceutical intervention, physical therapy and giving sympathy and consideration'*. After consideration of all of the evidence available to me I do not uphold this complaint.

24. I acknowledge it has been a very distressing and frustrating time for the patient, and I can imagine that it is very difficult for the patient to continue to suffer ongoing symptoms which she believes are linked to a vaccination she received in 2009.

CONCLUSION

25. I received a complaint about whether the Practice's written response provided to the patient on 29 September 2020 was appropriate. I do not uphold this complaint for reasons outlined in this report.

26. The investigation established that the Practice's written response to the patient on 29 September 2020 was appropriate and it was appropriate for the Practice to direct the patient to seek advice from an Orthopaedic Surgeon.

Margaret Kelly
Ombudsman **2023**

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.