Investigation Report

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

NIPSO Reference: 17493

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. 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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EXECUTIVE SUMMARY

I received a complaint about the care and treatment provided to the complainant's late father whilst he was a patient in the Royal Victoria Hospital Emergency Department.

Issues of Complaint

I accepted the following issues of complaint for investigation:

- Whether the care and treatment provided was appropriate and in accordance with good practice?

- Whether the Trust's Serious Adverse Incident (SAI) investigation was completed in accordance with policy and procedure?

Findings and Conclusion

I have carefully investigated the complaint. I have identified failures in care and treatment in relation to:

(i) the delays in the patient's triage and review by a clinician;

(ii) the failure to allocate the appropriate triage category to the patient.

I am satisfied that the failures in care and treatment I have identified have caused the patient the injustice of upset, distress and inconvenience. The patient also suffered the loss of opportunity to have treatment in the Emergency Department. I also find the complainant experienced the injustice of distress and upset at observing the delays in timely care and treatment for his late father.

I have also identified maladministration in respect of the Trust's SAI investigation in relation to the following:

(iii) the delay in informing the patient's family that the SAI had begun;

(iv) the Trust's failure to meet the published timescales for completion of the SAI;

(v) the Trust's failure to maintain appropriate records of its contact with the Coroner;

(vi) the failure to appoint an independent chair to lead the Root Cause Analysis (RCA) investigation which is outwith the requirements of the Trust's SAI policy;

(vii) the failure to retain records of the RCA investigation;

(viii) the RCA investigation's failure to consider whether the patient ought to have been allocated a Category 2 (with consequential implications for his care and treatment)

I am satisfied that the maladministration I identified caused the complainant the injustice of delay, uncertainty and frustration over the SAI investigation into his father's sad death.

Recommendations

I recommend that the Trust:

i. Provides a written apology in keeping with NIPSO 'Guidance on issuing an apology' dated June 2016 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;

ii. Provides the complainant with a payment of £750 by way of a solatium for the injustice identified. This payment should be made 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 recommend that the Trust:

iii. Conducts a review of its operation of the SAI process taking into account the failings and learning arising from this investigation. It should report the outcome to me and implement an action plan to incorporate any recommendations of that review;

iv. Provides an update on the progress of implementing the recommendations highlighted in the Trust's RCA report; and

v. In addition to the recommendations identified in the RCA report, the Trust considers the observations by way of service improvements highlighted by the IPAs as a result of this investigation;

I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

THE COMPLAINT

1. The complaint concerns the care and treatment of a 75 year old patient following his admission with breathing difficulties to the Royal Victoria Hospital on 7 January 2016. His condition deteriorated and despite intervention he passed away on 23 January 2016 from heart failure. An SAI investigation and subsequent report were completed which identified failures in the patient's care, and delay during his attendance in the Emergency Department. The SAI report concluded that it was difficult to state definitely whether earlier treatment would have prevented his death and that the cardiac event most likely occurred preceding his attendance. The complainant however disputed the report's conclusion and believes the Trust has not taken responsibility for the death of his father.

Issues of complaint

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

Issue 1: Whether the care and treatment provided in the Emergency Department was appropriate and in accordance with good practice?

Issue 2: Whether the SAI investigation was completed in accordance with policy and procedure?

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised. This documentation included information relating to the Trust's SAI investigation and the patient's medical records. The Trust provided a table of Emergency Department attendances on the 6-7 January 2016.

4. The Senior Investigating Officer and the Investigating Officer in this case visited the Emergency Department to better inform the investigation as to the Trust's triage process.

5. A copy of the draft report was shared with both the Trust and the complainant. He indicated that he was content with the draft report. The Trust provided additional information in its response. I therefore sought additional Independent Professional Advice (IPA) based on the Trust's response. I have carefully considered the Trust's response in light of the additional information obtained.

Independent Professional Advice

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

   i. ED Consultant (ED Consultant IPA)
   ii. ED Nurse (ED Nurse IPA)
   iii. Cardiologist (Cardiology IPA)

7. The ED Consultant IPA is a Fellow of the Royal College of Physicians and a Fellow of the College of Emergency Medicine. The ED Nurse IPA worked as a Staff Nurse within an Emergency Department for two years and subsequently became a Junior

Sister. From January 2018, she commenced a Trainee Advanced Clinical Practitioner role within ED. The Cardiology IPA has been a Consultant Interventional Cardiologist since 2006.

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

Relevant Standards

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

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

i. The Principles of Good Administration
ii. The Principles of Good Complaints Handling
iii. The Principles for Remedy

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

The specific standards relevant to this complaint are:

i. Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (2013)
ii. The Royal College of Emergency Medicine Initial Assessment of Emergency Department Patients (2017)

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

iii. Emergency Triage: Manchester Triage Group, Third Edition (2013)

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

THE INVESTIGATION

Issue 1: Whether the care and treatment provided in the Emergency Department was appropriate and in accordance with good practice?

Detail of Complaint

12. The complainant alleged that it took three hours for his father to be triaged in the Emergency Department. He also complained that his father's NEWS score was not fully calculated and this score went from a five to a four, meaning his observations changed from 1 hourly to 2 hourly. He also complained that at approximately 06.30 the doctor who was attending to his father was called away to an emergency. The complainant believes this resulted in a lack of continuity of care, and because there was no supervision his father's health deteriorated. He stated that his father was moved to the Intensive Care Unit (ICU) but after two weeks he never recovered and passed away on 23 January 2016.

13. I note that the patient attended the Emergency Department at 01.43 and at 02.24 and was triaged by a Nurse as Category 3. His observations were taken, but no NEWS score was recorded. The Triage Plan was for an ECG and bloods to be taken. At 05.25 clinical observations were checked and the NEWS score was recorded as four. It is stated that he was comfortable and was not in any pain. At 05.49 he was examined by a Speciality Registrar and it is recorded that he was awaiting a chest x-ray. It is recorded that the Registrar was called to attend another patient in resuscitation. The Nurse asked another doctor to review the complainant's father in the Registrar's absence. At 06.30 this doctor reviewed the patient and noted the NEWS score had elevated to eight. It was noted that observations were to be

closely monitored in the meantime. The patient was then moved to the resuscitation area in the Emergency Department and cardiology were contacted.

14. The Root Cause Analysis (RCA[2]) report on the management of 'patient A' whilst a patient in the Royal Victoria Hospital Emergency Department (the RCA report) identified a number of failures in his care and treatment. The report found that an ECG should have been recorded at triage and the total NEWS score was not calculated, therefore there was no clinical response to the trigger. In relation to the triage waiting times, the report found that the Manchester Triage standard is that all patients should be triaged within 15 minutes of arrival to an Emergency Department. However it was 31 minutes from arrival before the patient was triaged. The report also found that he was designated as a Category 3 'urgent patient' using the Manchester Triage Scale (MTS). According to this standard such patients should be assessed by a doctor within 60 minutes of their arrival time in the Emergency Department. However the patient waited 3 hours 36 minutes before being assessed by medical staff. The investigation panel noted between the hours of 20.00-06.30 there were 76 attendances to the Emergency Department which impacted on timeframes. However there were no deficits in the nursing or medical staff compliment on the night of 7 January 2016. The patient passed away on 23 January 2016. The cause of death was noted as left ventricular failure and ischaemic heart disease.

15. The report concluded that there were a number of delays that occurred during his attendance in terms of time to triage, undertaking of clinical observations, waiting time to be assessed by medical staff and in the undertaking of an ECG and obtaining a troponin level. The report also concluded *'It is difficult to state definitely whether more expeditious treatment would have prevented the acute pulmonary oedema that led to Patient A's sudden deterioration.'* The panel noted the significant troponin rise was likely caused by a cardiac event having occurred in the preceeding 24-48 hours prior to attendance at the Emergency Department on 7 January 2013.

16. In response to investigation enquiries, the Trust clarified that the patient was triaged

[2] An RCA is conducted as a Level 2 SAI investigation (see paragraph 30)

within 31 minutes of arrival to the Emergency Department. The Trust stated that there are five possible triage categories that can be selected: immediate (0 minutes), very urgent (10 minutes), urgent (60 minutes), standard (120 minutes) and non-urgent (240 minutes). These identify the target time in which a medical assessment should commence. The Trust stated that it was unsure why the Nurse did not calculate the NEWS score. However, it stated that a supervision session was carried out and her training in Manchester Triage was revisited. The Trust stated that the patient's history should have resulted in an ECG being recorded at triage, however this was not done. The Trust added that this was also discussed with the Nurse. The Trust confirmed that the patient did have an extended wait to be assessed by a doctor as referred to in the RCA report. It also confirmed that the Registrar who was attending the patient was called away as referred to in the RCA report. The Trust added that the report also indicated that the patient's deterioration was sudden and was responded to by medical staff immediately. It stated it apologised unreservedly for the care given to the patient, which was not of an acceptable standard.

17. The Trust was asked to explain what is considered a normal staffing compliment for such a night in the Emergency Department. It stated that the medical staffing was filled as per normal that evening, consisting of one middle grade and two junior doctors. There was funding available for an additional middle grade locum but this was unfilled. The Trust explained that the rota has now been changed so that there are usually two middle grade doctors on as well as two junior doctors. In relation to staffing levels for nursing, there were 13 Registered Nurses plus a Twilight shift and three healthcare support workers. There was also an additional staff nurse working on 6 January 2016. In relation to the Registrar being called away at 06.30, the Trust stated that she was the most senior doctor on duty. She was called to assess a patient who had been pre-alerted to the Emergency Department by the Northern Ireland Ambulance Service (NIAS). The Trust therefore considered it was clinically appropriate that this patient was assessed by the doctor on arrival. The Registrar had completed her examination of the patient's father and was awaiting test results. The Trust added that *'in an ideal world, no doctor would be interrupted during a patient interaction but the demands of the ED are fluid and reactive.'*

18. The Trust was asked to provide details such as key timings of the 76 patients who attended the Emergency Department overnight between 20.00-06.30. The Trust provided a table which showed that the patient waited 41 minutes to be triaged in the Emergency Department and had a 3 hour 25 minute wait to be assessed by a doctor. I noted that two patients who arrived in the Emergency Department shortly after the patient had a much shorter wait, despite being assigned the same triage category of three. The first of these patients waited three minutes to be triaged and was seen by a doctor within two hours 59 minutes. The second patient waited seven minutes to be triaged and waited three hours nine minutes to be seen by a doctor. Therefore both patients were attended by a doctor before the patient, despite arriving later.

19. The Trust was asked to explain these various discrepancies. The Trust explained that there are two separate geographical areas for triage within the unit, one for walk-ins beside the main reception and one for ambulances. The Trust stated if a patient arrives by ambulance and is not deemed suitable to wait in the waiting area, the patient will be processed through the ambulance offload area. These areas independently manage their patient queues and are staffed by nurses 24/7. In relation to the patient's wait to be triaged, the Trust stated it was a particularly busy night and it sincerely regrets that he was not triaged within the current 15 minute standard. The Trust stated that while he was waiting to be triaged, a registered paramedic crew remained with him and would have immediately alerted staff if they had any concerns. The Trust added that the patient who arrived by ambulance prior to the patient was triaged at 01.17 as a Category two and required significant nursing and medical input due to the serious injuries sustained.

20. In relation to the other patients who were seen earlier despite arriving later, the Trust explained that these patients did not arrive by ambulance and were walk-ins. After registering at reception, they were called to the front of house triage which is a different location in the Emergency Department. The Trust stated this triage queue was moving faster than the ambulance queue on this particular night. The Trust also stated it is not possible due to safety reasons to move a doctor from the triage area to the ambulance area.

21. The ED Nursing IPA noted that the patient had a 27 minute wait for ambulance handover from his time of arrival and had a 41 minute wait from arrival to triage. The IPA advised the agreed standard for triage on arrival should always be within 15 minutes. The IPA advised that although staffing levels would have been appropriate in keeping with NICE provisional guidance on Emergency Department staffing, *'…in my experience, the delay for triage for this specific patient is not acceptable.'* The IPA considered 76 attendances to be a manageable amount and noted the Trust's clarification on the different triage streams. However the IPA advised *'I would have suggested however that as the ambulance stream had higher acuity patients and a delay, that a nurse could have been moved to assist in this area.'*

22. In relation to the complainant's triage Category of three (urgent patient), the IPA advised *'…I feel that a Category 2 allocation was more appropriate at the time dependent on the results of further investigations.'* The IPA acknowledged that *'although it may not have meant he was seen within 20 minutes as recommended, it is likely that this patient would have been seen quicker by a clinician. This would have likely led to quicker treatment and recognition of illness as investigations would have been requested and undertaken, e.g. ECG and arterial blood gas.'*

23. The IPA agreed with the findings of the RCA report that an ECG should have been recorded at triage and that the total NEWS score was not calculated. The IPA concluded that the time taken to triage was not in keeping with relevant standards. The IPA also concluded that *'A category 2 score would have been more appropriate based on the clinical observations and a review sooner by the medical team should have been prioritised by the nurse at triage.'* The IPA highlighted a number of service improvements and learning arising from this case.

24. In relation to the delay in the patient being assessed by a doctor, the ED Consultant IPA considered this delay was inappropriate and unreasonable. The IPA advised that *'I do believe the wait was excessive on the night in question which principally stems from the fact that it is my opinion that [the patient] should have been placed in triage category two given the fact he had chest pain and acute shortness of breath and an early warning score of 5.'* The IPA believed this would have led him to be seen and

assessed within an hour of that triage assessment, taking into account the pressures on the department. The IPA advised *'If this had taken place, I do believe that following the appropriate assessment that took place and the subsequent treatment he would have been referred to the cardiology team no later than 0430 hours on the morning of 7 January 2016.'* In relation to the doctor being called away to another patient at 06.30, the IPA advised *'although regrettable this is a fact of standard working practice in any emergency department.'* The IPA considered that as a result of the doctor being called away the patient would have suffered a further delay in his assessment and treatment.

25. In relation to the two separate triage systems for walk in patients and ambulance arrivals, the IPA advised that; *'…the fact that patients self-presenting were triaged earlier than those patients arriving by ambulance which at first sight appears counter-intuitive. However it is not uncommon to have two systems of triage, one serving ambulance arrivals and the other serving patients who walk in.'* The IPA however recommended that the Trust should *'consider whether the service cannot be reconfigured to ensure there is not a differential wait for triage between the ambulance stream of patients compared with the walk-in patients.'* The IPA concluded that *'Overall, I believe the standard of care was appropriate, but the timeliness of the care was unreasonable due to the fact that the severity of [the patient's] condition was not appropriately assessed at triage.'* The IPA further concluded that *'Whether an earlier assessment and treatment would have altered his outcome is a question that needs to be asked of a cardiologist.'*

26. The Cardiology IPA agreed with the conclusion of the RCA report that it is likely the complainant had experienced a cardiac event prior to attendance but *'…given the fact that he presented with breathlessness, a cough and desaturation it seems likely that he was in pulmonary oedema on admission and was allowed to remain in this untreated in the emergency department.'* In relation to whether the patient's death on 23 January 2016 could have been avoided by more expeditious treatment, the IPA advised *'This is impossible to know with any accuracy.'* The IPA further advised *'Whereas it is not clear whether or not earlier detection and treatment of his condition would have made a difference to the ultimate outcome, it is certain that opportunities*

were missed to deliver prompt and effective early care. Undoubtedly [the patient] was not given the best chance of surviving.' The IPA concluded that due to the failures identified by the RCA, *'It is frankly impossible to say whether remedying any of the above would have allowed [him] to survive as this is a perilous medical presentation, but what is certain is that what slender chances he had were further very significantly reduced by the delays and failures in care.'*

27. The Trust stated it *'would acknowledge and agree with both the Nursing and ED Consultant IPAs recommendation that [the patient] should have been allocated a Category 2 triage priority.'* The Trust stated that the Emergency Department nurse documented that the patient was short of breath with a saturation of 80% on room air when assessed at home by the NIAS personnel. The Trust stated that this history and observations would meet a Category 2 triage allocation and the Trust fully understands why both the ED Nurse and Consultants IPAs have highlighted this in their reports. The Trust added that as per the MTS definition, 80% saturations on room air are very low saturations which meet a Category 2 discriminator.

28. However the Trust stated that the nurse *'then assessed [the patient] within the triage where she recorded his saturations as improved to 95% on 3L of O2 (OXYGEN) coupled with shortness of breath. She therefore allocated a Category 3 on the basis of those observations. As per the MTS definition, low saturations are defined as less than 95%; therefore the panel considered this decision to be reasonable and in line with MTS scoring. At the time of triage, [the patient's] clinical signs and symptoms gave him a triage Category 3. The panel however accept that using clinical judgment should probably have resulted in his care being escalated*.' The Trust highlighted that the NIAS handover sheet stated that he did not have any chest pain and was not in respiratory distress. The Trust stated that *'The ED Consultant has stated in his report that [the patient] had chest pain; however on presentation and at triage this was not the case.'*

29. The Investigating Officer sought clarification from the ED Nurse IPA on the triage category. The IPA advised; *'I will clarify that the patient should have been allocated a category 2 triage score due to the fact that the patient had O2 levels of 80% on room*

air therefore meeting one of the discriminators rather than categorising it based on O2 levels of 95% on supplemental oxygen. It is acknowledged that this score would have had to be allocated before the results of further investigations were available. Although the patients NEWS score would have been a 5, this is not a discriminator in the Manchester Triage System.'

30. The Investigating Officer also sought clarification from the ED Consultant IPA on the Trust's assertion that the patient did not report chest pain at triage. The IPA advised *'I accept that no chest pain was documented at triage and therefore would not have been factored into the triage assessment and therefore the triage category. However, even in the absence of such a complaint of chest pain, he would still be placed in category 2 rather than 3. With regard to the chest pain as the ED clinician documented intermittent chest pain for several days along with shortness of breath then in my view, chest pain should have been noted at triage.'*

The Trust's response to my draft report

31. Initially the Trust accepted the IPA's advice. However, it then stated that it disagreed with the ED Nurse IPA regarding the Manchester Triage Score (MTS), saying that the MTS is not designed to be a detailed clinical assessment as this would not be possible at the point of triage. It stated the initial observations carried out by the triage nurse indicated a NEWS score of 6 with Sp02 95% on 3litres oxygen and respiratory rate 20 and that the patient's heart rate was within normal limits. The SP02 was not 80% as reported by the Nurse IPA. The Trust stated that the triage nurse must triage and assess the patient as they present at the point of triage, and the nurse documents these particular findings. It commented that the triage nurse does not simply record the patient's Sp02 reading when the NIAS first found the patient at home, and which was recorded prior to the patient's hospital presentation.

32. The Trust stated it did not agree with IPA that the patient ought to have been categorised at Category 2 at the time of initial triage presentation. The patient had been triaged using shortness of breath (SOB) presentation with a discriminator of low Sp02: this meant he was rightfully and correctly triaged as Category 3. This patient had Sp02 95% on 3 litres of oxygen which is fully supported by MTS as

Category 3- a patient with <95% Sp02 on oxygen should be category 2.

33. The Trust stated if he had an Sp02 of 80%, it would be highly unlikely it could have been maintained at an Sp02 of 95% on 3 litres of oxygen. The Trust explained a patient at home could be obtund[3] initially which may explain the initial low reading, or they may have been cold, hence the initial reading may have been inaccurate. The Trust's view is that the patient's respiratory rate of 20 and pulse of 89 suggests a more accurate Sp02 of the one recorded by the triage nurse in the Emergency Department. The fact that the patient had a NEWS score 4 at 05.25 hrs would suggest to the Trust that he was relatively still stable.

34. The Trust also provided further information on recent work undertaken within the Trust regarding SAI's, which I welcome. I have included this additional information below.

''A review of SAI processes has been completed and resulted in recommendations. Fourteen in total were identified and shared widely within the Trust. There is an action plan for the ongoing monitoring of these recommendations which include an improved support structure for SAI Chairs and bespoke RCA training, peer review of reports, mentoring/ buddy system and an SAI Chair Forum.

Following the publication of the "Inquiry into Hyponatraemia-related deaths" (January 2018) a number of recommendations were outlined as part of the process around SAIs. These included:

- *Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs')*
- *Trusts should seek to maximise the involvement of families in SAI investigations*
- *Training in SAI investigation methods and procedures should be provided to those employed to investigate.*

[3] To dull or blunt, especially to blunt sensation or deaden pain

Under the direction of the Department of Health, a number of work streams to assist in the review and progression of these recommendations have been set up during 2018. This includes focus on the engagement with the service user/ family / carers linked to the SAI process. The Trust is fully engaged in this regional piece of work…

….The Trust identified and trained 20 senior staff in May 2018 in the RCA methodology. The allocation of independent chairs for SAIs requiring RCA methodology commenced in October 2018 within the Trust…

…The Trust would advise the Ombudsman that the corresponding SAI linked to this review has not yet been closed by the Trust. The Trust is now introducing an additional audit step that will require independent validation of the implementation of actions as described within the action plan….

…The recommendations associated with this SAI review will be collated into an overall action plan particular to the Ombudsman's report…

35. As part of this investigation, the Investigating Officer shared the Trust's view with the ED Nurse IPA and sought clarification on this issue. The ED Nurse IPA noted the Trust's response outlined above and advised that *"I acknowledge that the saturations of 80% were with the ambulance and not in A&E. Despite the patient having O2 saturations of 95%, it is acknowledged in the trust's response that this reading was on 3L of O2 therapy. Based on the Emergency Triage Book (2013), it is highlighted that 'Low SPO2' as a discriminator is saturations of <95% on air and not on oxygen, therefore this discriminator doesn't really apply when the patient was on oxygen therapy. I have noted one documented reading of the patient's oxygen saturations on room air but do note this was when the clinician reviewed (documented as 88% on RA). I don't feel based on this response I would alter my initial advice. The triage process should be accompanied by a degree of clinical judgement and in comparison, of a triage category 2 vs 3, I feel that the O2 only been 95% on supplemental oxygen (not air), would warrant a category 2 triage rather than a 3….*The IPA further advised *"It would have been possible physically to check his reading on air but in my view would have been inappropriate and detrimental to do so."*

Analysis and Findings

36. I acknowledge that the Trust's RCA investigation concluded that the following failures occurred in the care and treatment provided to the patient on 7 January 2016:
    i. delays in terms of time to triage
    ii. undertaking of clinical observations (NEWS)
    iii. delays in waiting time to be assessed by medical staff
    iv. undertaking/recording of an ECG
    v. obtaining a troponin level

37. The Fifth Principle of Good Administration requires public bodies to 'Put things right' by acknowledging when mistakes have happened, apologise and explain what went wrong. I welcome that these failings have been documented in the RCA investigation report and communicated to the patient's family in accordance with this principle. However due to information I have uncovered during my investigation, I will further consider the delays in triage and medical assessment.

38. In relation to the delay in triage, I acknowledge that the RCA report found that the patient waited 31 minutes to be triaged and that this exceeded the 15 minute standard. However I have established that he waited a total of 41 minutes to be triaged upon arrival by ambulance. In relation to the delay in being seen by a doctor, according to the RCA report he subsequently waited 3 hours 36 minutes to be seen by a clinician. This therefore exceeded the 60 minute standard. However as highlighted by the ED Nurse IPA, he waited 3 hours 25 minutes to be seen by a clinician. Although there are discrepancies in the respective waiting times, what is clear is that both triage and medical assessments were beyond targets. I therefore conclude the delays in the patient's triage and clinical examination to be a failure in care and treatment. As a consequence, I am satisfied that he experienced the injustice of upset, distress and inconvenience in the lack of timely care he received in the Emergency Department. I also consider that the patient's son (the complainant) who attended with him in the Emergency Department experienced the injustice of

distress, upset and uncertainty at witnessing the delays in care and treatment for his father.

39. Furthermore, my investigation has revealed that the patient waited longer to be triaged and reviewed by a clinician than other patients who arrived after him. These patients were allocated the same triage category. One patient waited three minutes to be triaged and was seen by a doctor within 2 hours 59 minutes. Another patient waited 7 minutes to be triaged and was seen by a doctor within three hours 9 minutes. I have established that that this is due to the fact that he arrived by ambulance whereas the other patients were 'walk ins' to the Emergency Department. The Trust has clarified that the separate ambulance triage queue was moving slower on this particular evening.

40. I am concerned that this situation could lead to some patients who arrive by ambulance having a longer wait than patients who are described as 'walk-ins'. However I accept the advice of the ED Nurse IPA that *'It is acknowledged that the process of different streams, ambulatory and ambulance, is a widespread accepted method of triage used in numerous A&E departments.'* Although the wider issue is outside the remit of this investigation, it would be prudent for the Trust to consider the IPA's recommendation relating to reconfiguring this service.

41. The patient was assessed as a Category 3 patient. I have established that he was assessed in triage as having a saturation of 95% on O2 therapy and was noted to have been 80% on room air with the NIAS personnel. According to the MTS, very low SaO2 is a discriminator for a Category 2 score. Very low SAO2 is defined as *'a saturation <95% on O2 therapy or <90% on air.'* As the patient was noted to have been 80% on room air with the NIAS personnel, I accept the advice of the ED Nurse IPA that a Category two score would have been more appropriate. I have carefully considered the Trust's view in response to my draft report of 14 November 2018. I do not agree that the patient was rightly and correctly triaged as Category 3, as the discriminator for this category (low SpO2: a saturation of <95% on air) is not applicable in this instance as this reading could not be taken in Emergency Department. The IPA has highlighted that the triage process should be accompanied by a degree of clinical judgement. I accept this advice and conclude

that the failure to allocate the patient the appropriate triage category was a failure in care and treatment.

42. I note the target waiting time to be seen by a doctor for Category 2 patients is in fact 10 minutes, not 20 minutes as stated by the IPAs. However the standard is 60 minutes for Category 3 patients. Ultimately the patient waited a total of 3 hours 25 minutes to be seen by a doctor. As a consequence of this failure in care and treatment, he experienced the injustice of a loss of opportunity to have more expeditious treatment. However based on the advice of the Cardiology IPA, I am unable to conclude that earlier treatment would have improved his outcome and prevented his death from the pulmonary oedema.

43. In relation to the Emergency Department clinician being called away, I note that according to the RCA report she had completed her examination at 06.08 and was awaiting test results. She was called to the resuscitation area at 06.27. At 06.30 unfortunately the patient's condition began to deteriorate and he was subsequently moved to the resuscitation area. I accept the advice of the ED Consultant IPA that *'…although regrettable this is a fact of standard working practice in any emergency department.'* **I therefore do not uphold this aspect of the complaint.**

44. In concluding this issue, I have found that the patient was not allocated the appropriate triage category. This failure was significant as it undoubtedly added to the delay in receiving the necessary care and treatment on what was a busy night in the Emergency Department. However I am unable to conclude if such earlier treatment would have prevented his deterioration and eventual death. Overall, I conclude that the care and treatment provided to the patient in the Emergency Department was inappropriate and not in accordance with good practice. **I therefore uphold this issue of complaint.**

Issue 2: Whether the SAI investigation was completed in accordance with policy and procedure?

Detail of complaint

45. The complainant stated that at the second meeting with the Trust to discuss the SAI report (29 November 2016) he was not happy with the answers to his questions. He wanted to know whether if things had been done properly, would his father still be alive today. However he stated that they replied '*We don't know. But we are going to implement changes.*' He complained that the Trust were not accepting responsibility for his father's death.

46. 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 (SAIs). 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;'*

47. I note that SAI investigations are designated under three levels:
Level 1 Investigation – Significant Event Audit (SEA);
Level 2 Investigation - Root Cause Analysis (RCA); and
Level 3 Investigation – Independent Investigation.

In this instance, a Level 2 RCA was conducted into the patient's death. I have included below the standards required for Level 2 RCAs, which is relevant to this case:

'The investigation must be conducted to a high level of detail. The investigation should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation…On completion of Level 2 investigations, the final report must be submitted to the HSCB: within 12 weeks from the date the incident was discovered, or within 12 weeks from the date of the SEA.'

48. The guidance also contains a template RCA report with further guidance on completing each section of the report. In relation to team membership, it states *'…best practice would indicate that investigation/review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.'*

49. I note that Councillor Tim Attwood complained about the RCA Report to the Trust on behalf of the complainant on 26 February 2016. The SAI notification form dated 8 June 2016 records that the Coroner was informed on 23 January 2016. On 27 June 2016 Councillor Attwood was advised that the issues of complaint were to be investigated under SAI process and that the complaint triggered this process. Councillor Attwood was also advised of the 12 week target for completion of the SAI. I note that the RCA panel was chaired by a Consultant in Emergency Medicine and Governance Lead. The panel also consisted of a Clinical Coordinator for ED and a Consultant Cardiologist. The methodology of the investigation was based on a review of patient records, interviews with the Emergency Department nurse and the doctor who treated the patient.

50. In response to investigation enquiries, the Trust stated that staff met with the complainant and his representative, Councillor Attwood. At these meetings an apology was given and condolences expressed to the complainant on the death of his father. The Trust explained that following receipt of the complaint, the initial investigation recognised the possibility of a SAI having occurred. This required further investigation by way of RCA methodology. The Trust stated the RCA

investigation identified a number of failings in the Trust's systems and processes which led to delays in the complainant's father's care. The Trust stated it takes responsibility for these failings and has undertaken to address these and improve the service for patients. The Trust added the RCA investigation team were unable to definitively say whether more expeditious treatment would have prevented the acute pulmonary oedema that led to the patient's sudden deterioration.

51. The Trust was asked to provide records of the two meetings held with the complainant. The Trust confirmed that meetings were held on 5 August 2016 and 29 November 2016, however no formal record of these meetings was kept. The Trust stated the meeting on 29 November 2016 was to explain the RCA report face to face and sincere apologies were given for the failings outlined in the report. The Trust also confirmed that RCA investigation staff did not keep any formally written notes of interviews with staff or team meetings. The Trust stated that the Chair of the RCA panel used handwritten notes as an 'aide memoire' during meetings and used these to draft the report. However these were disposed of once he had a working electronic draft to circulate amongst the team. The Trust added however it would acknowledge that relevant records should have been kept where appropriate.

52. The Trust confirmed that although the panel Chair is not independent of the service area, he had not been involved in the care of this patient in the Emergency Department. The Trust stated it recognises it is best practice for the Chair of the panel to be independent of the service area; however this has not always been feasible. The Trust added that since this report was finalised, it has reviewed its SAI processes and has appointed six new SAI Chairs who will undertake all future Trust RCA investigations. The Trust stated it will therefore ensure that future RCAs will be chaired by someone independent of the service area.

53. In relation to the notification of the death to the Coroner on 23 January 2016, the Investigating Officer contacted the Coroner's Office to verify that the death was reported to it. The Coroner's Office advised that they had no record of the death being notified by the Trust. Enquiries were made of the Trust to ascertain why it is recorded on the SAI notification form that the Coroner was informed when this did not appear to be the case. The Trust stated that the doctor who certified the death

did not think the case was discussed with the Coroner as it would be his normal practice to document this in the notes. The Trust further stated that the Governance and Quality Manager would not have recorded this on the SAI form unless advised by the service that there had been a discussion with the Coroner or that this was recorded in the notes. The Trust was however unclear where this information originated. The Trust has explained that a project commencing rollout of the provision of a reference number for discussions with the Coroner was not fully implemented until April 2017. However the complaint pre-dates this revised process. The Trust has confirmed that the learning from this case will be for the submitting team to record on the SAI notification form the unique reference number provided by the Coroner when contacted by Trust staff.

54. The ED Consultant IPA advised that having reviewed the correspondence *'that highlights the root cause analysis investigation has deviated from best practice which has been accepted by the Trust.'* The IPA acknowledged that these limitations and deviations are well recognised and widespread, and further advised; *'I therefore believe pragmatically speaking the investigation report was completed to an appropriate standard.'*

Analysis and Findings

55. The complainant submitted his initial complaint via Councillor Attwood to the Trust on 26 February 2016. I note that the Trust initially treated it as a complaint and had prepared a draft response in May 2016. However this was not issued as the Trust decided the complaint would be investigated as an SAI. I note from the 'Serious Adverse Incident Notification Form' that the section relating to whether the service user's family has been informed states that this was to occur in the week commencing 6 June 2016. This form was then sent to the HSCB on 8 June 2016, instigating the commencement of the SAI. However I note an internal email dated 21 June 2016 states that the family had not yet been advised of the SAI and *'we would not have treated this as an SAI without having received the complaint.'* From Trust records I note that Councillor Attwood was informed on 27 June 2016 that the issues of complaint are now to be investigated under SAI processes which would take 12 weeks. I note the final report was sent to the HSCB on 1 November 2016, which is

20 weeks after commencement of the SAI investigation.

56. I am critical of the delay in informing the patient's family that the SAI had begun. The SAI notification form indicates that this was to occur on 6 June 2016, but did not until 27 June 2016 and only at the continued persistence of Councillor Attwood. I am also critical that the Trust failed to meet the published timescales for completion of the SAI. The Trust is required to send the report to the HSCB within 12 weeks, however it did not do so until 20 weeks later on 1 November 2016.

57. I have established that the Trust recorded on the SAI notification form that the death was reported to the Coroner on 23 January 2016. I am critical that there is no supporting evidence that this referral to the Coroner was ever made. The Trust has accepted that it is unclear where this information originated and stated since April 2017 all discussions with the Coroner regarding a death are now provided with a reference number that will be recorded on the SAI form. I consider the Trust failed to maintain appropriate records of its contact with the Coroner in this instance. However I note and welcome that the Trust has since taken remedial action to prevent future recurrence by including a reference number from the Coroner on the SAI form.

58. In relation to the constitution of the RCA panel, I have found it was chaired by a doctor who was not independent of the service area. I note that Trust policy clearly indicates that Level 2 RCAs 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 indicated it has appointed six new chairs to ensure future RCAs are conducted by an independent chair. I note that the Trust has taken action to ensure the independence of this process in future. However, in this instance the RCA investigation did not have an independent chair. I consider the failure to appoint an independent chair to lead the RCA investigation does not meet the requirements of the Trust's SAI policy.

59. I am also critical the Trust did not retain any records of the RCA investigation. There are no records of meetings with the family and interviews with staff, which the RCA report state had occurred. There is therefore no written information retained as a

basis for the conclusions reached in the RCA report. There is also no recorded reasoning for the consideration of the appropriate level of reporting, including a consideration of the proportionality of the investigation to the complexity of the event. I note the Trust has acknowledged that relevant records should have been kept as appropriate.

60. The complainant stated that the Trust were not accepting responsibility for his father's death. The RCA panel concluded that it was unable to state whether more expeditious treatment would have prevented the acute pulmonary oedema that led to his sudden deterioration. I note the Cardiology IPA concurs with this conclusion as the IPA advised it is impossible to say whether the patient would have survived. I therefore conclude that the conclusion of the RCA panel was reasonable and appropriate. However the RCA report did not refer to the appropriateness of the triage category. I consider that a robust SAI investigation should have raised the issue of the appropriateness of the patient's triage category. I therefore conclude that the RCA investigation failed to consider whether he ought to have been allocated a Category 2, and the potential implications of this on his subsequent care and treatment.

61. Fundamentally the SAI process is a tool for ensuring patient safety by the timely learning of lessons. It depends on investigative quality and independence. I have identified a number of failings in the SAI investigation relating to the quality and independence of the investigation. I have tested these failures by the Trust against the Principles of Good Administration. The First Principle requires a public body to 'Get it Right' by acting in accordance with its own policy and guidance. The Second Principle requires a public body to be 'Customer Focused' by dealing with people helpfully, promptly and sensitivity, bearing in mind their individual circumstances. The Third Principle 'Being Open and Accountable' requires a public body to keep proper and appropriate records. I consider the Trust in carrying out the SAI failed to adhere to these principles, which amounts to maladministration. Overall, I conclude the SAI investigation was not completed according to policy and procedure. As a consequence of this maladministration, the patient experienced the injustice of delay, uncertainty and frustration in the time taken and the rigor of the SAI investigation into his father's sad death. **I therefore uphold this issue of complaint.**

CONCLUSION

62. The complainant submitted a complaint to me about the actions of the Trust in relation to his father's death.

I have carefully investigated the complaint and have identified failures in care and treatment in relation to:

(i) the delays in triage and review by a clinician;

(ii) the failure to allocate the appropriate triage category.

I am satisfied that the failures in care and treatment I have identified have caused the patient the injustice of upset, distress and inconvenience. He also suffered the loss of opportunity to have treatment in the Emergency Department. I also find that the complainant experienced the injustice of distress and upset at observing the delays in timely care and treatment to his late father.

I have also identified maladministration in respect of the Trust's SAI investigation in relation to the following:

(ix) the delay in informing the patient's family that the SAI had begun;

(x) the Trust's failure to meet the published timescales for completion of the SAI;

(xi) the Trust's failure to maintain appropriate records of its contact with the Coroner;

(xii) the failure to appoint an independent chair to lead the RCA investigation which is outwith the requirements of the Trust's SAI policy;

(xiii) the failure to retain records of the RCA investigation;

(xiv) the RCA investigation failure to consider whether the patient ought to have been allocated a Category 2 (with consequential implications for his care and treatment)

I am satisfied that the maladministration I identified caused the complainant the injustice of delay, uncertainty and frustration over the SAI investigation into his father's sad death.

Recommendations

63. I recommend that the Trust:

vi. Provides a written apology in keeping with NIPSO 'Guidance on issuing an apology' dated June 2016 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;

vii. Provides the complainant with a payment of £750 by way of a solatium for the injustice identified by me. This payment should be made 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 recommend that the Trust:

viii. Conducts a review of its operation of the SAI process taking into account the failings and learning arising from this investigation. It should report the outcome to me and implement an action plan to incorporate any recommendations of that review;

ix. Provides an update on the progress of implementing the recommendations highlighted in the Trust's RCA report; and

x. In addition to the recommendations identified in the RCA report, the Trust considers the observations by way of service improvements highlighted by the IPAs as a result of this investigation;

I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any

relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

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

MARIE ANDERSON
Ombudsman **February 2019**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.

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

5. Putting things right

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

6. Seeking continuous improvement

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