Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the South Eastern Health and Social Care Trust

NIPSO Reference: 18760

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The Role of the Ombudsman

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

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

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, 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.

TABLE OF CONTENTS

Page

EXECUTIVE SUMMARY

I received a complaint in relation to the actions of the South Eastern Health & Social Care Trust ('the Trust'). The complainant contacted this office on 18 April 2018. Her complaint concerned the antenatal care and treatment she received while a maternity patient at Ulster Hospital between August and October 2016.

The investigation of the complaint identified failures in care and treatment in respect of the following matters:

(i) Failure to ensure an appropriate consultation with advice and discussion on issues associated with cleft lip including possible amniocentesis testing and associated risks

(ii) Failures to record appropriate advice, decision making, and communication on issues associated with cleft lip including possible amniocentesis testing and associated risks with the complainant.

I am satisfied that the failures in care and treatment by the Trust I have identified caused the complainant to experience the injustice of uncertainty, upset, frustration and distress.

I recommended:

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

In order to improve the service delivery of the Trust:

- I recommended that:

(i) The Trust conduct a review of the information, advice, literature and procedures relating to discussion of amniocentesis where initiated by a

patient or when an appropriate clinical consideration.

(ii) The Trust should provide me with a report of the outcome of the review within six months from the date of the final report The report should include an action plan indicating responsibility for implementing any recommendations from the review and appropriate timescales.

(iii) The Trust should advise me within three months of progress with accessibility of the Viewpoint ultrasound archive and report system within the fetal medicine clinic at UH.

THE COMPLAINT

1. The complaint centred around the actions of the Trust in relation to the complainant's antenatal care and treatment during her pregnancy in 2016. She was booked for her maternity care on 14 June 2016 at the Ulster Hospital Maternity Unit as 'shared care' between a community midwife and the hospital. On 29 July 2016 the complainant had a private ultrasound scan which noted the baby with a 'possible cleft lip'[1]. The complainant contacted the hospital and arranged a fetal assessment clinic appointment for 16 August 2016.

2. The complainant attended for a non-routine appointment on 16 August 2016 and was initially seen by a junior doctor who had difficulty obtaining views by ultrasound scan and sought assistance from a consultant, Dr A. Dr A is an experienced Consultant Obstetrician with a specialism in fetal medicine. Dr A then performed an ultrasound scan. A further appointment for the fetal medicine clinic was arranged. These fetal medicine appointments ran in tandem with routine antenatal hospital appointments and scans. The complainant had further fetal medicine appointments on 22 September 2016 and 18 October 2016. At the same time she continued with other midwife appointments and other antenatal appointment including a routine fetal anomaly '20 week scan', on 23 August 2016. She questioned the 'reading' of the ultrasound scans that failed to detect any significant abnormality beyond the cleft lip.

Issue of Complaint

3. The issue of the complaint which was accepted for investigation in respect of the Trust was:

   Issue: Was the Trust's care and treatment of the complainant appropriate, reasonable and in line with relevant standards, specifically with regard to potential fetal diagnosis by amniocentesis and ultrasound?

[1] Cleft Lip: A cleft is a hole or gap affecting the tissues in the lip. Most cases of cleft lip occur sporadically although it can also develop as part of a syndrome – a collection of symptoms often seen together. There are over 150 syndromes that feature cleft lip – NHS Great Ormond Street Foundation Trust.

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments and that of relevant staff on the issues raised. This documentation included: the complainant's maternity medical notes and records from the Trust and information relating to the Trust's investigation of her complaint. A series of clarifications and comments were sought from the Trust during the investigation. The Director of Investigations and Investigating Officer met with senior Trust officers and clinical staff, including Dr A, who were involved in the Fetal Medicine Service. The Investigating Officer interviewed the Sister/Outpatient Manager identified by the Trust as present at one of the complainant's attendances.

5. A copy of this draft investigation report was provided to the complainant, the Trust and the relevant Trust staff for comment on factual accuracy and the reasonableness of the findings and recommendations.

Independent Professional Advice

6. In order to assist in the assessment of the clinical judgement of the Trust staff involved in the complainant's care and treatment, I obtained professional advice from an independent professional advisor (IPA) with subspecialist accreditation in Fetal and Maternal Medicine – ('Consultant Obstetrician IPA')
I received clinical advice to assist my investigation of this Report. I have shared a copy of the clinical advice with the Trust and relevant staff and I have considered any comments made on that advice.

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

Relevant Standards

8. 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.

9. The general standards are the Ombudsman's Principles[2]:

    (i) The Principles of Good Administration

    (ii) The Principles of Good Complaints Handling; and

    (iii) The Public Services Ombudsmen Principles for Remedy

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

11. The specific standards relevant to this complaint are:

    (i) Fetal Anomaly Screening Programme (FASP) 2010 – collaboration of Royal College of Obstetricians and Gynaecologists (RCOG), the British Maternal & Fetal Medicine Society (BMFMS) and Society and College of Radiographers (SCoR)[3]

    (ii) General Medical Council – GMC Code (2013)[4]

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

[2] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[3] https://www.sor.org/system/files/news_story/201203/nhs_fasp_fa_standards_and_gudance_2010.pdf
[4] https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-1215_pdf-51527435.pdf

INVESTIGATION

Issue: Was the Trust's care and treatment of the complainant appropriate, reasonable and in line with relevant standards, specifically with regard to potential fetal diagnosis by amniocentesis and ultrasound?

Detail of Complaint

13. The complainant contacted NIPSO having exhausted the Trust complaints process and being in receipt of a final response to the issues she had raised with the Trust. Her complaint focused on the availability of amniocentesis[5] testing during pregnancy and the subsequent diagnosis of her baby with Trisomy 13[6] after birth. In particular she stated she made two requests to the Consultant to have an amniocentesis test. She felt her views were not acted upon and amniocentesis not ordered. She also stated that the risks around amniocentesis, chromosomal conditions and otherwise isolated cleft issues were not fully discussed. She complained that despite clear abnormalities being visible after birth that these issues had not been identified on ultrasound scanning.

Evidence Considered

14. The complainant provided the Trust with a detailed written account of her concerns and issues of complaint by letter dated 6 June 2017. She stated:

'[16 August 2016] Dr A advised that he felt that there was something on the left side, a probable cleft lip. I asked Dr A about genetic testing at that time. I asked for testing by way of amniocentesis. When I asked for the testing he told me the test brought with it a high risk of miscarriage and that there was no need to take such a risk. He did not quantify the risk to me. He advised it was too early to see abnormalities at this stage of my pregnancy…
[22 September 2016] Dr A didn't really say anything. I would ask him questions to which he would respond. He told me that everything looked normal. He told me that he was struggling to get a look at the cleft lip. At that point I asked him about the amniocentesis again. I was discouraged in relation to it. I was told that I was having a perfectly healthy baby, so there was no need to have an amniocentesis which gave rise to a risk of miscarriage. No advice was given to me by Dr A in relation to the types of

[5] Amniocentesis: a diagnostic test carried out during pregnancy to assess whether the unborn baby could develop a genetic or chromosomal condition.
[6] Trisomy 13 is a genetic disorder in which a baby has 3 copies of genetic material from Chromosome 13, instead of the usual 2 copies. It is a life-limiting condition where 90% of children suffering from the condition die in their first year.

conditions associated with cleft lip/palate. He had said previously, when I first requested the amniocentesis, that a cleft lip is associated with a small number of conditions. On this occasion, however, he did not do so. He did not enquire as to why I wished to have an amniocentesis carried out. He did not discuss the various conditions which could have given rise to the cleft lip. In short, he did not provide any information to me other than to say that I was having a perfectly healthy baby so there was no need to consider the testing.'

15. The Trust response to the complainant dated 7 August 2017, confirmed that following internal investigation:

'amniocentesis would normally only be offered if major structural abnormalities are detected on ultrasound or if there is poor fetal growth…the only issue seen on scan was the cleft lip and in Dr A's opinion, this was not sufficient to indicate a possible chromosomal abnormality and justify amniocentesis.'

16. The complainant was dissatisfied at this response, as she considered that it did not address her central concern that she had twice asked Dr A for amniocentesis testing and he had not carried out her requests. She put these matters in a further letter of 17 August 2017 to the Trust. The letter outlined that:

'At no appointment did Dr A advise that he could see the cleft clearly, in fact he continually said the opposite…I think you have missed the point of my complaint: I am not asking whether or not an amnio should have been recommended to me or not. As a mother my request was ignored and my wishes weren't listened too. I clearly and concisely asked for such testing on 2 occasions which were refused…'

17. In a subsequent response from the Trust to the complainant dated 20 October 2017, the Director of Hospital Services stated:

'…given that the scan suggested the cleft lip was an isolated finding not connected with a chromosomal problem, Dr A would have counselled you accordingly…Dr A cannot recall his consultations with you and therefore cannot comment on your claim that he refused a specific request from you on two occasions for an amniocentesis. In fact many patients are referred to Dr A requesting an amniocentesis in a routine pregnancy simply because of patient choice.'

18. The Investigating Officer obtained the complainant's maternity notes and records from the hospital for the period August 2017 to December 2017 and the

complaint file held by the Trust's administration. The Trust and Dr A were provided with an opportunity to address the complainant's outstanding concerns.

19. The complainant drew attention to and provided details of messages exchanged with family and friends about her request for amniocentesis as corroborative of her thinking of requesting amniocentesis testing prior to birth.

20. I considered the GMC Code (2013) standards 15 and 21 to be relevant:

'15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:
a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient
b. promptly provide or arrange suitable advice, investigations or treatment where necessary…
Record your work clearly, accurately and legibly
…
21. Clinical records should include:
a. relevant clinical findings
b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c. the information given to patients
d. any drugs prescribed or other investigation or treatment
e. who is making the record and when.'

Trust's Response to investigation enquiries

21. In response to investigation enquiries about the complaint the Trust stated by letter of 11 May 2018:

Amniocentesis
'The Trust would like to apologise to the complainant that she felt her wishes were dismissed or ignored. <u>There are no records to confirm that the complainant requested an amniocentesis</u>…On review of this case <u>Dr A advises he has no recollection an amniocentesis being requested</u>, however he acknowledges it has been two years since he saw the complainant. He would like to reassure the complainant that it would not be his usual practice to refuse an amniocentesis and advises he performs amniocentesis on patients who request the procedure even with completely normal pregnancies and no abnormalities on scan. The risk of miscarriage would be 1 % for any amniocentesis and again that would be the quoted risk in any discussion…
… <u>There is no record of the complainant requesting an amniocentesis in the notes</u>. Dr A has no memory of the complainant requesting an amniocentesis. As stated above, it would not be in keeping with Dr

A's practice to refuse an amniocentesis requested by any mother, but in these circumstances it would not have been something he would have directed. <u>There were other staff members present who also have no recollection of the patient requesting an amniocentesis</u>.
Unfortunately it is not possible to accurately scribe the full extent of discussions that can take place in an FMC verbatim. Many patients have an appointment that can last for 30 minutes to 1 hour and deals with very complex discussions about significant fetal abnormality and implications for that pregnancy and beyond.
There were no policies in place in relation to Fetal Medicine at the time the complainant attended the FMC. There was no national or regional guidance available apart from an Amniocentesis information leaflet'

[Emphasis added]

Ultrasound

'The visible abnormalities that the complainant refers to are not major structural abnormalities…but not measurable or visible on USS (Ultrasound Scan) by either doctor.'

22. In response to further investigation enquiries about the complaint the Trust stated by letter of 13 August 2018:

'At the booking appointment, every woman is provided with their own copy of the Northern Ireland Regional Hand held Maternity Record. This record contains a consent form for the Anomaly scan as well as information about the scan and its limitations…'

Ultrasound

'In 2008, Viewpoint was first installed on one PC in the Ulster Hospital Maternity Unit. In March 2017, a business case was completed and approved for installation of Viewpoint on an Ultrasound Scanner in the Ulster Hospital, and one in both Lagan Valley Hospital and Downe Hospital. In September 2017, a project mandate was approved to enable the installation to be progressed.
A request was then made to extend the scope of the installation. A series of meetings were arranged with the supplier and Trust Teams. A second business case was requested. In April 2018, a request was made to progress the original business case, i.e. installation of Viewpoint on an Ultrasound Scanner in the Ulster Hospital, and one in both Lagan Valley Hospital and Downe Hospital. In May 2018, this request was approved.
In June 2018, a business case for the extended scope was drafted. This includes installation on an additional 14 PCs across the Trust. This business case will be submitted for consideration in September 2018.
During August 2018, roll out of the original business case will be completed, i.e. installation of Viewpoint on an Ultrasound Scanner in the Ulster Hospital, and one in both Lagan Valley Hospital and Downe Hospital.'

In response to an enquiry, the Trust, in an email of 17 September 2019, stated:
'With regards to Viewpoint project, the Trust is currently reviewing the Viewpoint workflow processes which are specific to Women and Child

Health. Once these workflow processes are agreed and costed, the Trust will complete a business case, and when approved will implement the system within the areas specific to Women and Child Health.'

Clinical Records

23. As part of the investigation, the complainant's 'hand held' records were obtained from the Trust and examined. In order to obtain advice, copies of the records and relevant documentation were provided to the IPA. I have noted the following summary from entries in the complainant's records to be significant in considering this complaint:

16 August 2016	The complainant attended non routine arranged first fetal medicine appointment. Dr A notes USS 'Difficult Views Possible Cleft' Review in 6 weeks
23 August 2016	Fetal Anomaly USS Cleft lip noted but heart and major organs normal
22 September 2016	Second fetal medicine appointment Dr A notes USS 'Probable bilateral cleft' 'L sided cleft lip seen. Probable R side also' 'Cannot visualise palate' 'No other Structural Anomaly seen' Review in 4 weeks
18 October 2016	Third fetal medicine appointment Dr A notes USS 'Poor views today R side cleft'
29 December 2016	The complainant began induced labour

31 December 2016	The complainant gave birth to baby girl
3 January 2017	Diagnosis of Trisomy 13

24. The medical notes for the baby were also obtained and examined.

25. In order to follow up the Trust's suggestion that there were 'other staff present who had no recollection of the patient requesting an amniocentesis' further details were sought. The Trust identified the Outpatient Manager, a senior and experienced midwife, as being present for the 22 September consultation. The investigating officer interviewed the Outpatient manager who confirmed she had no independent recollection of the consultation in question, had been on sick leave for a large part of 2017 and had not been approached by the Trust as part of its investigation of the complaint.

Relevant Independent Professional Advice (IPA) (including the Trust's response to IPA)

26. The Consultant Obstetrician IPA advised

> *'There is clearly a discrepancy between the patient's recollection of the consultation, and the documentation.*
>
> *It would be established good practice to discuss and provide written information regarding the cause of the cleft lip, possible treatment options, the small risk of associated structural or chromosomal problems, and refer to a specialist team. From the record, only the latter occurred. It would be my practice to explain that the risk of associated chromosome problems is small in the case of apparently isolated cleft lip. I would explain that amniocentesis would be the only way of diagnosing/excluding a chromosome problem, and that amniocentesis carries a risk of miscarriage of 0.5-1%. In the case of an apparently isolated cleft lip, it would be my practice to explain that the risk of miscarriage may be greater than the risk of finding a chromosome problem, but amniocentesis would be an option open to the patient.'*

27. I note that the Consultant Obstetrician IPA also advised on the clinical records:

> *'Therefore, I would not (based on the documentation) consider the discussion to be appropriate, reasonable, or in line with relevant guidance. I believe the majority of fetal medicine practitioners would have discussed the option of amniocentesis in the case of an apparently isolated cleft lip. However I believe*

there may be a range of opinion regarding this and that some practitioners, especially if confident in their ultrasound findings of an apparently isolated unilateral cleft lip, may not have offered amniocentesis.
…The documentation on 22/9/16 briefly documents the relevant clinical findings, but does not include the information given to the patient. It would also be established good practice to document negative (ie normal) ultrasound findings in more detail.
The documentation on 18/10/16 is similarly lacking'.

28. In relation to the ultrasound scans issue, the Consultant Obstetrician advised:

'***Ultrasound findings**:*
The findings and description of the apparently isolated, possibly bilateral, cleft lip are appropriate, reasonable, and in line with relevant guidance. It is appropriate to say that the palate is not easily seen on ultrasound. I would agree with the Trust response letter regarding the other postnatal features (head shape, wrists, heels, ears) would not always be seen on prenatal ultrasound.
…
1. I would advise use of an electronic reporting and archiving system in fetal medicine (already noted in the Trust response letter).'

29. In conclusion the Consultant Obstetrician IPA advised:

'The question of when to discuss chromosome problems and the option of invasive testing continues to be a challenge for fetal medicine specialists.

The balance is between:
1. discussing the possibility in every case of fetal anomaly (which has not only the risk of miscarriage from the procedure, but also the psychological morbidity of worry to the parents, especially if they decide not to proceed with testing but wait until birth)
versus
2. discussing the possibility in more selected cases, which has the risk of missing some cases of chromosome problems.

In this case I understand the approach the fetal medicine specialist has taken, and their approach may have been because they wished to protect the patient from the worry and anxiety of knowing there was a small association with chromosome problems, but my views are that amniocentesis should have been offered in this case'

30. By email dated 10 December 2019, the Trust responded that it had no further comments on the Consultant Obstetrician IPA report. Dr A took the opportunity to make his own comments. He stated:

'… I would agree with a large proportion of what [the IPA] has said.
… In relation to whether an Amniocentesis was offered or not I have consistently said I cannot remember the specifics in this case and accept that the record during the visits is lacking in this detail.

… In my internal responses within the Trust I have said that it would be my practice to discuss the risk of an underlying chromosomal abnormality in the order of 1- 2% in these cases where no other structural anomaly is seen on USS. Part of that discussion would involve talking about an amniocentesis and the risk of miscarriage in the order of 1/150 cases. I cannot prove this was discussed but I would consider this more likely than not.
I also note that FASP England states in their literature re Cleft Lip

> *'The second scans will involve careful assessment of the fetus to identify any additional abnormalities. Where appropriate, the offer of karyotyping (by chorionic villus sampling (CVS) or amniocentesis) to exclude a chromosomal abnormality should be discussed'*

The emphasis is on the wording 'where appropriate'- and as the [IPA] reports that practice does differ especially where no additional underlying abnormality is detected on ultrasound. Either practice I suggest would fit with the guidance by FASP above.'

Analysis and Findings

31. This complaint related to patient requests around amniocentesis testing and the ultrasound scanning. The complainant was very clear that she requested advice and amniocentesis testing on two occasions. She has raised other conversations and communications she had with family, friends and hospital staff around the failure to have amniocentesis testing. There was no record of: any patient request for amniocentesis advice; patient request for amniocentesis testing; clinician advice around risk of underlying chromosomal abnormality; or clinician advice about amniocentesis and risks of miscarriage. Dr A has indicated that he has no specific recollection of the consultations and the other member of staff that the Trust identified also has no recollection of the consultation where she was present. The complainant also raised whether ultrasound scanning could have ascertained other fetal abnormalities.

32. During the course of the investigation the Trust provided details of steps taken to address issues with ultrasound scan records and record keeping in fetal medicine. I was given details of the proposed roll out of the Viewpoint digital ultrasound image storage system. The Trust have confirmed that some 14 viewpoint terminals will shortly be in use in the Trust. This step should enhance ultrasound image storage, review and reporting. The Trust also provided copies of three fetal medicine pathway booklets which have been introduced. These booklets aim to prompt specific areas of discussion and enhanced recording by

clinicians. I note that the booklet for fetal structure abnormality specifically asks the clinician to record that a discussion of amniocentesis testing has taken place. I welcome this service improvement. I urge the Trust to ensure that use of the booklet and record keeping is appropriately monitored to achieve the service improvement by means of suitable regular auditing.

33. During the course of the investigation I was provided with the Trust complaint file. The file contained relevant letters, draft letters and emails. The file does not contain any record of the investigation actions including any comments made by staff when approached during the investigation. As the Trust investigation was the earliest attempt to establish events and the near recollection in time of participants I would expect some form of auditable trail or record of who was spoken to, when, what they said and any analysis before response letters are drafted. This approach is in keeping with the HSC Complaints Guidance and staff guidance on conducting an investigation. I consider that the Trust should reflect on its complaint investigation practice to ensure a robust investigation is carried out and recorded in an auditable format for future review.

34. I have carefully considered the detailed comments of the Consultant Obstetrician IPA at paragraph 29 relating to the complainant's care. The complainant's clinical presentation was one of a pregnancy with some degree of clarity that the fetus was exhibiting a cleft lip. The ultrasound scan views were noted as 'difficult' or 'unclear'. No other fetal structural abnormalities were recorded as visible. I note that the Trust has accepted the IPA advice. I welcome the comments of Dr A in accepting the lack of detail recorded at the consultations.

35. I consider that the use of ultrasound scanning in cases of fetal abnormality can be a beneficial diagnostic test. The limitations are known, but the Viewpoint archive system will allow recording of ultrasound images from different consultations for comparison and review. As there are no stored images for analysis I was unable to conclude that there were fetal abnormalities capable of being observed on ultrasound. I noted with some concern that the Viewpoint system is not fully accessible across the Trust. **I do not uphold this element**

of the complaint.

36. I accepted the advice of the Consultant Obstetrician IPA in relation to the actions of Dr A on the question of amniocentesis, outlined at paragraph 28. The medical notes lacked evidence of a clear record of any discussion of amniocentesis whether a request from the patient or as a clinical analysis of a possible option to test where the ultrasound views were unclear. There was no record of any discussion of any risks associated with amniocentesis or discussion of abnormalities associated with cleft lip. Dr A in his comments asked me to consider that it is more likely than not that this took place. In the same way that the available record does not bear out the account that the complainant gives of requests for amniocentesis, the record also does not bear out Dr A's comments on his routine practice. I noted Dr A's acceptance that his note is lacking. I noted the information provided by the complainant provides some corroboration as to her requests for amniocentesis. I concluded on the balance of probabilities that a request for amniocentesis was made by the complainant and appropriate advice not given and recorded during the consultation. I consider that appropriate advice in a medical consultation is a fundamental element of the empowerment of the patient to exercise their own choice in making decisions. This is a recognition of the human rights based approach to the doctor patient relationship.

37. I considered the GMC Code standards 15 and 21 relevant in relation to Dr A's actions. Insufficient contemporaneous records were made in the complainant's clinical notes. I concluded that the failure to record advice, testing options and patient decision making amounted to failures in care and treatment. **I uphold this element of the complaint.**

38. I am satisfied that the failures in care and treatment caused the injustice of uncertainty, upset, frustration and distress to the complainant. The question of remedy is dealt with in the conclusion.

CONCLUSION

A complaint was made to me about the actions of the Trust in the antenatal care and treatment the complainant received.

The investigation of the complaint identified failures in care and treatment in respect of the following matters:

(iv) Failure to ensure an appropriate consultation with advice and discussion on issues associated with cleft lip including possible amniocentesis testing and associated risks

(v) Failures to record appropriate advice, decision making, and communication on issues associated with cleft lip including possible amniocentesis testing and associated risks with the complainant.

I am satisfied that the failures in care and treatment by the Trust I have identified caused the complainant to experience the injustice of uncertainty, upset, frustration and distress.

Recommendations

I recommended:

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

In order to improve the service delivery of the Trust I recommended that:

(i) The Trust conduct a review of the information, advice, literature and procedures relating to discussion of amniocentesis where initiated by a patient or when an appropriate clinical consideration.

(ii) The Trust should provide me with a report of the outcome of the review within **six** months from the date of the final report. The report should include an action plan indicating responsibility for implementing any recommendations from the review and

appropriate timescales.

(iii) The Trust should advise me within three months of progress with accessibility of the Viewpoint ultrasound archive and report system within the fetal medicine clinic at the Ulster Hospital.

The Trust accepted the findings and recommendations in this report.

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, coordinating 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 COMPLAINTS HANDLING

Good complaint handling by public bodies means:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.