Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Western Health & Social Care Trust

NIPSO Reference: 202000381

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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.

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SUMMARY

I received a complaint about the care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) at Altnagelvin Area Hospital (the Hospital) on 25 and 26 May 2019. The Trust acknowledged during the internal complaints process that it had initially misdiagnosed the patient following his admission to the Hospital on 25 May 2019. A correct diagnosis was made the following day. The complainant said that the Trust ought to have correctly diagnosed the patient's condition at an earlier stage, given the patient's medical history, test results, and observations. Furthermore, the complainant questioned whether appropriate and necessary tests were carried out at appropriate stages in the patient's care to have allowed a correct diagnosis to have been made at an earlier stage.

The investigation examined the details of the complaint, the Trust's response, and relevant local and national guidance. I obtained independent professional advice from a Consultant in Emergency Medicine.

The investigation found that it was not a failure in care and treatment for the Trust to have adopted an "*obstructing right side kidney stone with added infection*" as its working diagnosis in the prevailing circumstances. The investigation further found that once the working diagnosis was set, the subsequent investigations carried out in line with that working diagnosis were in line with relevant standards.

However, the investigation found that it was a failure in care and treatment for the Trust not to have taken steps to specifically exclude the potential of "*blood leaking from a previous Endovascular Aneurysm Repair (EVAR)*" in tandem with the steps it took to confirm or exclude its working diagnosis, given the nature of the patient's medical history. The investigation found that this failure established that insufficient consideration had been given to the patient's medical history when seeking to confirm or exclude potential diagnoses.

I consider this failure resulted in the injustice of loss of opportunity for the patient to have received the correct diagnosis, treatment, and potentially life-saving surgery at an earlier stage. In addition, I consider this failure resulted in the injustice of uncertainty and upset for the complainant regarding the patient's condition, treatment and clinical outlook, and for causing the complainant to question whether the patient's outcome could have been different if the failing had not taken place. It also caused the complainant the trouble of bringing a complaint to this Office.

I therefore upheld the complaint.

I recommended that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failure identified within **one month** of the date of my final report. I further recommended that that the Trust brings the contents of this report to the attention of the ED staff so they can reflect on the learnings identified in it. In addition, I recommended that the Trust brings the contents of this report to the attention of the ED doctor who assessed the patient on arrival to the ED so that the learings can be discussed in their next performance appraisal. I further recommended that the Trust provides me with evidence of having taken this steps within **three months** of the date of my final report.

The Trust accepted my recommendations.

I wish to pass on my condolences to the complainant, and her family, on the death of her father.

THE COMPLAINT

1. This complaint is about the care and treatment the Western Health and Social Care Trust (the Trust) provided to the patient at Altnagelvin Area Hospital (the Hospital) on 25 and 26 May 2019. The complaint relates to the Trust's initial misdiagnosis of the patient's condition, which has been acknowledged by the Trust and was confirmed by the Trust as part of the internal complaints process. The patient was misdiagnosed following his admission to the Hospital on 25 May 2019, before the correct diagnosis was made on 26 May 2019. The complainant considered that the Trust ought to have made the correct diagnosis initially, or at an earlier stage, on the basis of the patient's medical history, test results, and observations. In addition, the complainant queried whether the correct tests were carried out at the correct stages, which the complainant considers could have allowed the correct diagnosis to have been made initially or at an earlier stage in the patient's care.

Background

2. The patient was a 69 year old gentleman. In 2016 the patient underwent an Endovascular Aneurysm Repair[1] (EVAR) procedure in respect of an Abdominal Aortic Aneurysm[2]. Prior to this surgery, the Aortic Aneurysm had been monitored since 2014. In 2017 the patient underwent an APER[3] procedure to resolve an adenocarcinoma of the rectum[4]. At the time of his admission to Hospital, the patient was being monitored for a renal aneurysm[5], measuring 6.3cm, and was being treated for chronic kidney disease at stage 3[6].

3. The patient was admitted to the Hospital on 25 May 2019 due to back and abdominal pain, pain when passing urine, and feeling generally unwell. Whilst in the emergency department (ED) at the Hospital, the patient underwent a venous blood test[7], a urine dip test[8], a chest x-ray, an abdominal x-ray, an

[1] A type of minimally-invasive endovascular surgery used to treat pathology of the aorta mostly commonly an abdominal aortic aneurysm.
[2] A bulge in the main blood vessel running from the heart to the stomach.
[3] Abdomino Perineal Excision of the Rectum – the surgical removal of part of the large intestine.
[4] Rectal Cancer.
[5] A bulging weakened area in the wall of an artery to the kidney.
[6] Kidney disease is a severe condition in which the kidneys slowly start to fail, leading to a build-up of harmful elements in the blood that would otherwise be filtered out through the kidneys. Stage 3 kidney disease means that the kidney's function has been cut by half.
[7] A needle is inserted into a vein to collect a sample of blood for testing.
[8] Diagnostic test to determine pathological changes in a patient's urine in standard urinalysis.

Electrocardiogram[9], blood tests and a blood sugar test. A CT-KUB scan[10] was requested by the attending junior doctor at this time, but it was declined by the radiology department on the basis that the patient should be assessed by the specialist team before such a scan was done. The tests yielded the following results and observations:

- Haemoglobin tests[11] showed a decrease from 126g/l at 19.40 to 100g/l some 3 hours later;
- Creatinine level tests[12] showed an increase from 175 to 359;
- CRP tests[13] showed an increase from 84.3 to 138.2; and
- The patient's feet were observed to be oedematous[14] and discoloured.

4. The patient was diagnosed to be suffering from an "*obstructing right side kidney stone with added infection*". Following this diagnosis, the patient was transferred to a ward. The patient was seen by the senior surgical team the following morning, Sunday 26 May 2019.

5. That day a CT scan took place. The scan determined that the patient had been misdiagnosed – and that he was instead suffering from "*blood leaking from a previous Endovascular Aneurysm Repair (EVAR)*". The Hospital arranged for the patient to be transferred to the Royal Victoria Hospital in Belfast by ambulance for urgent medical intervention. Unfortunately, the patient passed away after leaving the Hospital by ambulance, but before that medical intervention could take place in Belfast.

6. The complainant raised a complaint to the Trust on 11 July 2019 about the care and treatment provided to the patient at the Hospital. The Trust provided its response to the complainant on 5 October 2020.

[9] A test to produce a graph of voltage versus time of the electrical activity of the heart using electrodes placed on the skin.
[10] Computed tomography: kidneys, ureters and bladder – used to obtain images from different angles of the urinary system and surrounding structures.
[11] Test to determine the level of hemoglobin (a protein) in red blood cells – to give an indication of the blood's ability to carry oxygen throughout the body.
[12] A test to measure how well the kidneys are performing their job of filtering waste from the blood.
[13] C-Reactive protein test – measures the amount of CRP in the blood to detect inflammation due to acute conditions, or to monitor the severity of disease in chronic conditions.
[14] Swollen as a result of the build-up of fluid.

Issue of complaint

7. The issue of complaint accepted for investigation was:

Was the care and treatment provided to the patient by the Trust at Altnagelvin Area Hospital on 25 and 25 May 2019 reasonable, appropriate and in line with relevant standards?

INVESTIGATION METHODOLOGY

8. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. Documentation gathered included information relating to the Trust's handling the complaint.

Independent Professional Advice Sought

9. Independent professional advice was obtained from the following independent professional advisor (IPA):

- **Consultant in Emergency Medicine (IPA)**, FRCEM, FRCEd(A&E), MBBS, LLM (Medical Law), RCPathME, with over 14 years' experience in the role.

The clinical advice received is enclosed at Appendix two to this report.

10. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'; however how this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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

The general standards are the Ombudsman's Principles[15]:

- The Principles of Good Administration

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

13. The specific standards and guidance relevant to this complaint are:
    - National Institute for Health and Care Excellence (NICE) Guideline 118 - Renal and Ureteric Stones – Assessment and Management, January 2019 (NICE NG118);
    - National Institute for Health and Care Excellence (NICE) Guideline 156 – Abdominal Aortic Aneurysm – Diagnosis and Management, updated March 2020 (NICE NG156);
    - Department of Health, Social Services and Public Safety (DHSSPS) - The Quality Standards for Health and Social Care, March 2006 (Quality Standards); and
    - The General Medical Council's (GMC) Good Medical Practice, April 2013 (GMC Guidance).

14. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that I took into account everything I consider to be relevant and important in reaching my findings.

15. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings. Both the complainant and the Trust responded to my Office to confirm that they had no further comments to make. The Trust said the report was "*balanced*", and that it accepted the recommendations. These positions were taken into consideration when I finalised this report.

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

THE INVESTIGATION

Was the care and treatment provided to the patient by the Trust at Altnagelvin Area Hospital on 25 and 25 May 2019 reasonable, appropriate and in line with relevant standards?

Detail of Complaint

16. The complaint relates to the Trust's initial misdiagnosis of the patient's condition. The complaint raised the following connected concerns regarding the care and treatment the Trust provided to the patient on 25 and 26 May 2019:

    - Whether the Trust took the patient's medical history into consideration when making its initial diagnosis. The complainant said that she felt if the patient's medical history had been given sufficient consideration, that the correct diagnosis may have been made in the first instance – or that the incorrect diagnosis may have been corrected more quickly;
    - Whether the Trust carried out the appropriate tests, scans and observations at appropriate times when making the initial diagnosis - and whether the Trust correctly assessed the results of these within the context of the patient's medical history. The complainant considered that if the Trust had ordered the correct tests and scans at the correct time - and correctly assessed the results of the tests, scans and observations - that the correct diagnosis may have been made in the first instance, or that the incorrect diagnosis may have been corrected more quickly.

Evidence Considered

Legislation/Policies/Guidance

17. I refer to the following policies and guidance which were considered as part of investigation enquiries:
    - NICE NG118
    - NICE NG156
    - Quality Standards
    - GMC Guidance

Relevant extracts from the above are enclosed at Appendix three of this Report.

The Trust's response to investigation enquiries

18. The Trust accepted in its responses to both the original complaint and this Office's enquiries that it had initially misdiagnosed the patient following his admission to the Hospital.

19. The Trust stated in its response to the original complaint that a "*full history and examination was conducted*" by the attending doctor, and that the patient's "*past medical history*" of an EVAR "*was taken into account*". The Trust said the patient was attended to by a "*speciality level doctor*" on admission, who consulted with an "*Emergency Medicine level Registrar*", and then by a "*Surgical Dr in ED*".

20. The Trust stated that the rupture of an EVAR is a "*rare 'phenomenon'*", but that "*a history of a previous EVAR repair and the possibility of a leaking aneurysm should have been, and was, considered*". The Trust went on to say that despite this consideration, "*your father's clinical presentation and initial investigations appeared to our staff to indicate renal stone with infection and this was our doctors' working diagnosis*". The Trust stated in its response to this Office's enquiries that "*the clinical picture appeared more consistent with an infective process, hence the misdiagnosis*".

21. The Trust stated that a potential EVAR leak was not taken into consideration in the management of the patient's care, as that was not the working diagnosis at the time. The Trust stated that "*appropriate treatment*" was "*instigated*" for the working diagnosis.

22. In terms of tests, scans and observations, the Trust stated that "*a CT scan to examine your father's abdominal aorta was not requested as the ED medical team considered his diagnosis to be an infected kidney stone*". The Trust said that, given the working diagnosis, "*the decision was made that the CT could wait until the next day*". The Trust went on to say that "*appropriate bloods*" were obtained, and that the patient received "*regular nursing observations*" in the ED. The Trust explained that a "*bilateral BP check*" did not take place, as this would not be a "*baseline observation*" given the working diagnosis. Regarding the haemoglobin, creatinine, and CRP test results, and the observation of the

patient's feet as "*oedematous and discoloured*", the Trust stated that these were "*interpreted as part of a septic (infection) picture*"

23. The Trust explained that when the patient was transferred to a ward, "*he was not seen by the medical staff again overnight*". The Trust identified and acknowledged during the internal complaints process that the pain relief administered to the patient did not relieve his pain. This was despite advice being sought from the "*on-duty registrar, which is considered a senior level DR*" regarding the patient's ongoing pain. The Trust provided an apology for this to the complainant as part of the internal complaints process.

24. The Trust acknowledged during the internal complaints process that "*the diagnosis of your father's problem was delayed due to staff not being sufficiently aware of the possibility of the failure of an EVAR graft*". The Trust stated that whilst it "*is not possible to say with certainty*" that the delay in a correct diagnosis being made "*led directly to his death*", it can be said that it led to "*discomfort and distress*" for the patient. The Trust provided an apology to the complainant in this respect, and stated that it has taken learnings from this situation. The learning is to ensure staff are aware of the potential leaking of an EVAR when diagnosing patients with this medical history.

Relevant excerpts from medical records

25. Relevant excerpts from the patient's medical records are enclosed at Appendix four to this Report.

Relevant Independent Professional Advice

26. The IPA advised that the patient was admitted to Hospital suffering from severe lower back pain for over two days, as well as pain passing urine, abdominal pain, and feeling unwell. The IPA further advised that when the patient was admitted to hospital, his pain was categorised as "*6/10*", and he was assigned to triage category two – prompting further assessment within 10 minutes of arrival. The IPA went on to advise that the patient was not seen within that timeframe, but that the delay did not cause the patient any "*unnecessary pain*".

27. In terms of "*an obstructing right side kidney stone with added infection*", the IPA advised that typical symptoms include a "*generally constant and dull*" pain, with "*severe exacerbations of colicky pain spreading from the loin to the groin*". The IPA advised that patients can be "*sweaty, pale and vomit*", and often have a history of "*kidney stone disease*". In terms of sepsis infection, the IPA advised that "*fever and shakes (rigors)*" may be indicators.

28. In terms of "*blood leaking from a previous EVAR*", the IPA advised that this is "*relatively uncommon*" and that it "*most commonly occurs within a few weeks of the procedure*". The IPA further advised that symptoms include "*sudden onset severe pain +/- collapse*" – and that the patient is often "*distressed, pale, sweaty, with a high heart rate and low blood pressure*". The IPA went on to advise that the patient's skin may be "*discoloured*", and they may experience a "*tender pulsatile and expansile mass in the abdomen*". The IPA advised that "*new onset flank/back pain in the elderly may represent a leaking aortic aneurysm, even if there is blood in the urine*".

29. In terms of whether the symptoms the patient presented with were more reasonably consistent with a diagnosis of an infected kidney stone, or a leaking EVAR, the IPA advised that "*it is very difficult to make an absolute recommendation*" on that point as "*both conditions can present in very similar ways, and it is well documented that the two conditions can be difficult to distinguish on clinical assessment alone*". The IPA further advised that the symptoms the patient presented with, together with the CRP test results, the white blood cell count, and the fact that the patient did not present as "*hypotensive or tachycardic*" at the time of presentation could "*reasonably point towards*" kidney disease with "*an infective process*". The IPA subsequently advised that the Trust's initial "*clinical findings*" were *"consistent with renal calculi*".

30. The IPA also advised that the patient was 69 years old with no history of kidney stone disease. The IPA advised that "*general teaching recommends*" that aortic aneurysm be considered "*in any older patient who presents with symptoms that could be renal colic*". The IPA further advised that the patient's medical notes show that his pain was severe and not "*adequately relieved*" by intravenous

pain relief, and that he was recorded as having a renal aneurysm measuring 6.3cm. The IPA advised that given these factors, the possibility of an aneurysm that was expanding or leaking "*should be high on the list of possible conditions that required exclusion during the assessment*".

31. The IPA advised that whilst the clinical symptoms could "*easily have been attributable to*" an infected kidney stone, the patient's medical history, and present monitoring of a renal aneurysm meant "*that it should have been a priority to 'prove' that his symptoms were not a result of a leaking aneurysm or previous EVAR*". The IPA explained that "*whilst this condition may not have been the number one differential diagnosis, the consequences of not identifying it as early as possible are clear and the onus is on the clinical teams to prove it is not the case rather than assume the symptoms are due to another cause*".

32. The IPA revisited this matter in his further advice, following additional radiography reports the Trust provided. The IPA ultimately advised that "*I consider that it would be unfair and inappropriate to criticise the doctor who, following an initial clinical assessment made a provisional diagnosis in good faith that turned out to be incorrect once all the investigations were completed*". The IPA further advised that "*one of the most useful tools in medicine is time*" and that "*investigations do not always take place instantaneously*". The IPA also advised, however, that "*one of the key challenges for an ED doctor is to exclude life threatening conditions first whilst determining what is causing the patient's symptoms*".

33. In terms of the tests, scans and observations, the IPA advised that "*the tests alone are not diagnostic of a single condition*", and that they are required to be considered "*in conjunction with*" clinical evaluation and investigations. The IPA advised that "*the results in the patient could easily be those of a patient with an obstructing right sided kidney stone with infection*". The IPA also advised that given the patient's medical history and present monitoring of a renal aneurysm, "*the diagnosis of a leak or complications of an EVAR should have been excluded as a priority before settling on the alternative diagnosis*".

34. Regarding the CT scan, the IPA advised that "*current standards would recommend*" that a CT-KUB scan take place within 24 hours of admission for "*an obstructing right side kidney stone with added infection*". The IPA went on to advise that the Trust had the option to arrange for a CT-KUB scan to take place on the patient's admission at 19.45 on 25 May 2019, but opted to wait until 11:22 on 26 May 2019. The IPA advised that given the working diagnosis settled on by the Trust at the time, the 24-hour requirement was met. The IPA subsequently clarified that the "*investigations*" ordered by the junior doctor at the time were "*appropriate*" to confirm or exclude the working diagnosis.

35. In terms of whether the scan ought to have taken place earlier given the patient's medical history and symptoms, the IPA advised that the Trust ought to have taken specific steps to exclude a leaking EVAR as a priority before settling on a working diagnosis of an infected kidney stone. The IPA advised that the exclusion of a leaking EVAR could have been done "*with an urgent CT scan at the time of admission*", and further advised that the scan "*should have been carried out whilst the patient was in the emergency department*". The IPA advised that if the scan had taken place sooner, the correct diagnosis would have been made sooner, and "*this would have prompted the team to arrange transfer to the tertiary centre sooner*". The IPA acknowledged the 24 hour standard, but advised that while "*some investigations can wait (as per NICE guidance) there are other time critical investigations that need to be completed during the out of hours period to prevent adverse outcome*".

36. The IPA advised that a CT-KUB scan had been requested for the patient on the night of his admission by the junior doctor attending to the patient, but was turned down by the radiography department on the basis that a "*specialist team*" should examine the patient before such a scan was ordered. The IPA advised that it was "*not clear*" what the radiography department's rationale was in making this decision - but given the working diagnosis of an infected kidney stone, the decision was in line with relevant standards. The IPA also advised that the exclusion of a leaking EVAR as the diagnosis "*would have been reasonable justification for an immediate CT scan*", despite those standards.

37. The IPA advised that the radiography department's decision regarding the timing of the scans was based on the information the ED supplied – but that the Trust had not provided this information. The Trust subsequently provided radiology reports setting out details of the imaging the ED requested. Upon review of these documents, the IPA advised the imaging requests were for an abdominal x-ray, a chest X-ray, and a "*CT Renal Both*". The IPA further advised that the stated purpose for the x-rays was to look for signs and infection, and the purpose of the CT scan was rule out an "*obstructive stone*". The IPA went on to advise that, based on the working diagnosis presented to the radiography department, "*the scan was completed in line with relevant standards*".

38. The IPA advised that at the point at which the radiography department turned the scan down, the patient's case "*could have been escalated to the senior ED doctor on duty as a further review and re-discussion with radiology may have prompted the scan sooner*". The IPA further advised, however, that even with the working diagnosis of an infected stone being adopted "*urgent imaging*" ought to be have been sought in order to determine whether or not immediate intervention was required – given the patient's known poor kidney function at the time of admission. The IPA nonetheless advised that imaging did take place within the required 24 hour timeframe.

39. The IPA advised that discussion and review of the patient's case with a senior doctor on duty at that time "*would be appropriate to decide if further investigation or intervention was needed overnight*". The IPA clarified that if a more senior staff member been part of the initial assessment, the patient's "*significant background medical history*" may have been considered "*more relevant*" when imaging was being ordered.

40. The IPA further advised that "*the patient was known to have chronic kidney disease so the risk of further deterioration if there was an obstruction was high. As a result, if a CT scan had been done this would have identified if any obstruction was present. The nature of the scan would also have identified the leaking EVAR*". The IPA advised that the patient was reviewed by a senior doctor the following day, 26 May 2019. The IPA further advised that "*it is*

important for the Trust to consider what senior staffing is available overnight and at weekends to ensure experienced clinical assessment is undertaken early and junior doctors always have the support of senior colleagues to assess unwell and complex patients".

41. The Trust subsequently provided details of its senior staffing in the ED on those days. Having reviewed this information, the IPA advised that the senior staffing levels were "*in line with standard staffing in emergency departments*". The IPA revisited the matter of senior review he had initially identified, and advised that "*additional input and advice were sought from the surgical team who admitted the patient which was appropriate*". The IPA went on to advise that "*the patient was assessed by the duty surgical SHO who agreed with the initial ED diagnosis and felt further investigations could wait until the morning*". The IPA also advised that "*senior surgical review*" was completed "*within 12 hours of admission*", which was which is in line with relevant standards. The IPA ultimately advised that "*it is impossible to determine whether an earlier senior review prior to whilst would have prompted different or earlier investigations. I would speculate that the decision would have been to wait for the investigations as ordered and review with the results. Which is a decision that I do not consider to be unreasonable*".

42. The IPA ultimately advised that medicine in an "*imprecise science*" in which "*many presentations may have symptoms which overlap*". This means that diagnoses require "*confirmation or exclusions before definitive treatment can take place*", which is not instantaneous. The IPA advised that "*it is a significant challenge to get a final diagnosis immediately every time*", and that "*it is often a work in progress*".

43. The IPA ultimately advised that "*it is fair to conclude that the Trust followed appropriate standards of care during the assessment and investigation of the patient based on the condition that was being investigated during the first few hours of the patient's admission*". The IPA advised that once the correct diagnosis was made "*staff acted promptly to access the definitive care for the patient*".

Analysis and Findings

44. The complainant was concerned that the Trust had not given sufficient consideration to the patient's medical history when making its initial diagnosis. The complainant was also concerned that the Trust had not correctly interpreted the results of the tests, scans and observations made – and had not ordered the correct scans at the correct time. The complainant considered that the correct diagnosis may have been made initially, or the incorrect diagnosis corrected more quickly, if the patient's medical history had sufficiently considered - and if the results obtained had been assessed in the context of that medical history.

45. The Trust acknowledged that it had initially misdiagnosed the patient's condition. The Trust's position was that the misdiagnosis took place because the symptoms the patient presented with were consistent with a diagnosis of "*an obstructing right side kidney stone with added infection*" – which the Trust said was more common than the rare condition of "*blood leaking from a previous EVAR*". The Trust said that the patient's medical history was taken into consideration, but as the kidney stone was considerably more likely to be the case, it was adopted as the working diagnosis. The Trust's position was that the test and scan results, together with the clinical observations made, were consistent with a diagnosis of "*an obstructing right side kidney stone with added infection*". The Trust said that the correct tests took place, and took place in a reasonable timeframe – and eventually led to the correct diagnosis being made

46. The patient's ED notes for 25 May 2019 state "*Aortic Aneurysm with previous EVAR*" in respect of the patient's medical history. These notes also state the working diagnosis as being "*IMP – infected kidney stone*". In terms of further investigations, the notes state "*surgical referred. CT-KUB OOH if requested by surgeons*", and "*CT-KUB – infected? Obstructed kidney? Radiologist advises specialist opinion. Will scan OOH if they want it*".

47. Having reviewed all relevant evidence, I am satisfied that the patient's history of an EVAR was recorded by the ED doctor. I am also satisfied that, as a result,

that the Trust gave consideration to that medical history when assessing the patient on his initial presentation to the ED. In addition, I am satisfied that the initial diagnosis made was "*an obstructing right side kidney stone with added infection*", and that this was an incorrect diagnosis, made on 25 May 2019. The correct diagnosis was "*blood leaking from a previous EVAR*", made on 26 May 2019.

48. In terms of whether the consideration given to the patient's medical history of an EVAR was appropriate and sufficient when reaching the initial diagnosis, I note the IPA's advice. In particular, I note the IPA's advice that the symptoms for the two conditions are "*similar*" and that it has been "*documented*" that "*the two conditions can be difficult to distinguish on clinical assessment alone*".

49. I also note the IPA's advice that "*an obstructing right side kidney stone with added infection*" is a considerably more common condition than "*blood leaking from a previous EVAR*" – and that the latter tends to occur within a short period of the EVAR surgery taking place. The patient's surgery took place three years prior to his admission to Hospital on 25 May 2019.

50. I accept the advice of the IPA that the symptoms the patient presented with were consistent with both the incorrect working diagnosis, and the subsequent correct diagnosis. I also accept the IPA's advice that the correct condition was "*uncommon*", especially given the passage of time between the patient's EVAR surgery and his presentation to the ED.

51. In terms of tests, scans and observations, I note and accept the IPA's advice that the results of the patient's haemoglobin, creatinine and CPR tests were equality indicative of both the incorrect and correct diagnoses. I further note and accept that the observation of the patient's feet as being oedematous and discoloured was equality indicative of the two conditions.

52. In addition I note and accept the IPA's advice that once the working diagnosis had been made, the clinical investigations the Trust ordered to confirm or exclude it were correct, and in line with relevant standards.

53. In this respect, I note that the Trust ordered two x-rays and a CT-KUB scan to take place whilst the patient was in the ED, before he was admitted to a ward. I further note that the x-Rays took place before the patient was admitted to a ward, whereas the CT-KUB scan took place at 11:30 the following day. I accept the IPA's advice that it is unusual for CT scans to take place "*out of hours*".

54. I note the IPA's advice that relevant standards dictate a CT scan for a suspected kidney stone ought to take place within 24 hours of presentation to the ED. I note and accept the IPA's advice that the patient's scan took place within this timeframe – and therefore was carried out in line with relevant standards.

55. I also note the IPA's advice that whilst it is unusual for CT scans to take place "*out of hours*", they can in an emergency situation. I note the IPA's advice that if the ED had specifically requested that an CT-KUB scan take place to confirm or exclude an EVAR leak, then it would not have been unreasonable for this to have taken place "*out of hours*". However, I note and accept the IPA's advice that the imaging requests were specific that it was kidney stone that was to be confirmed or excluded. As a result, I am satisfied that the actions of the radiography department were in line with relevant standards.

56. I note the IPA's initial advice that the intervention of a more senior staff member in the ED may have resulted in the CT-KUB scan request being reconsidered and carried out more quickly. However, I note and accept the IPA's ultimate advice that the patient's case was reviewed by senior staff in the ED at the time, and that a full senior review took place within 24 hours – which was in line with relevant standards. I further note and accept the IPA's advice that the senior staff member reviewing the patient's case in the ED endorsed the working diagnosis which had been made. I am satisfied, therefore, that the patient's review by senior staff took place, and took place in line with relevant standards.

57. I note and accept the IPA's advice that if the CT-KUB scan had taken place whilst the patient was in the ED, then the correct diagnosis could have been made at an earlier stage. On foot of the IPA's advice, I consider that if the

imaging request had specified that the CT-KUB scan was also to exclude a potential EVAR leak, then the scan would have taken place more quickly.

58. Having reviewed all relevant evidence, I am satisfied that the symptoms the patient presented with, and the results of tests and observations made, were consistent with both the incorrect and correct diagnoses. I consider that when presented with these factors, the Trust adopted the more common condition as its working diagnosis, and proceeded to conduct further investigations to confirm or exclude that working diagnosis specifically. I accept the IPA's advice that the working diagnosis was made "*in good faith*".

59. I further find that the Trust ordered the correct tests and scans - and recorded the correct observations. I find that the Trust's assessment that the test results and observations were indicative of an infected kidney stone was reasonable, and that the CT-KUB scan that was ordered to specifically confirm or exclude the working diagnosis took place in line with relevant standards.

60. However, I also accept the IPA's advice that, given the patient's age and medical history, the Trust ought to have taken steps to specifically exclude the more serious possibility of an EVAR leak as part of the assessment process. This did not take place, and instead the Trust focused wholly on the more likely diagnosis. It was only when scans were carried out to further investigate the working diagnosis specifically that the correct condition was identified.

61. If the patient's age and medical history had been given sufficient consideration at the time, and if the possibility of an EVAR leak been included as part of the information on the request for a CT scan, I find that, on the balance of probabilities, this would have impacted on the timing of the CT-KUB scan ordered. I consider the inclusion of this information would have had an impact on the decision making of the radiologist and it would have been reasonable and appropriate for the scan to have taken place as an emergency - given the nature of the patient's condition and the need to exclude an EVAR leak, which is a serious condition.

62. I consider it was not inappropriate for the ED doctor to have identified the incorrect diagnosis as the most probable cause of the patient's symptoms - given the patient's symptoms, test results and observations. Nonetheless I consider it was not in accordance with good medical practice that steps were not taken to exclude the more serious potential diagnosis in tandem with the more likely diagnosis – rather than focusing solely on the more likely of the two.

63. I find, therefore that the Trust ought to have included an EVAR leak or expanding annuerysm as a differential diagnosis when assessing the patient.

64. I find this to be a failure in the care and treatment the Trust provided to the patient. This failing resulted in the injustice of the loss of opportunity for the patient to have undergone an earlier CT-KUB scan, and to have received the correct diagnosis, treatment, and potentially life-saving surgery at an earlier stage.

65. This failing also resulted in the injustice to the complainant of uncertainty regarding the patient's true condition, treatment and clinical outlook. Furthermore it resulted in the injustice to the complainant of upset – in that the complainant has continued to question whether the patient's outcome could have been different if the failing had not taken place.

66. Nonetheless, I note and accept the IPA's advice that even had the correct diagnosis been made at that time, it cannot be concluded that the patient would have survived the operation to correct the EVAR leak, given the nature of the condition.

67. I also note, however, the IPA's advice that the possibility of an EVAR leak ought to have been "*high on the list of possible conditions*" given the patient's medical history – and that as a result, the potential of an EVAR leak ought to have been specifically excluded as a "*priority*".

CONCLUSION

68. I received a complaint about the care and treatment provided to the patient on 25 and 26 May 2019.

69. The investigation established that the consideration given to the patient's medical history was insufficient - and therefore unreasonable and inappropriate. As a result, the investigation established that there was a failure in the care and treatment the Trust provided to the patient in this respect which lead to a delay in diagnosis, onward referral to the tertiay centre, and potentially life-saving surgery.

70. It was not unreasonable for the Trust to have adopted an infected kidney stone as its working diagnosis, given the symptoms displayed, the results of tests and observations, and the rarity of an EVAR leak. However, the investigation nonetheless established that the Trust ought to have taken steps to specifically exclude the potential of an EVAR leak in tandem with the steps it took to confirm or exclude an infected kidney stone – on the basis the patient's medical history.

71. The investigation also established that once the working diagnosis had been adopted, the subsequent steps the Trust took to confirm or exclude that specific diagnosis were in line with relevant standards.

72. I am satisfied that the failure identified caused the injustice of loss of opportunity for the patient – as well as the injustice of uncertainty and upset for the complainant. It also caused the complainant the trouble of bringing a complaint to this Office.

73. The complaint is therefore upheld. Whilst relevant standards were met regarding the timing of the scans and medical assessments for the renal blockage and infection, the Trust ought to have given greater consideration to the patient's medical history, and acted accordingly to exclude an EVAR leak given the seriousness of this condtion. Had the Trust done so, it is more likely than not that the correct diagnosis would have been made at an earlier stage. It cannot be concluded, however, that if the correct diagnosis had been made initially or earlier, that the outcome for the patient would have been different, given the nature of the patient's condition.

Recommendations

74. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failure identified within **one month** of the date of this report.

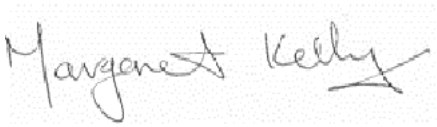
75. I note the Trust has indicated that it has taken learnings from the internal complaints process. Specifically, that it has highlighted the 'Think Aorta' campaign in the Hospital, and provided training to ED staff to assist in the identification of EVAR-related complications. I commend the Trust for the steps it has taken in this respect.

76. Nonetheless, I further recommend, for service improvement and to prevent future reoccurrence, that the Trust:

    I. brings the contents of this report to the attention of the ED staff so they can reflect on the learnings identified in the Report regarding the importance of giving sufficient consideration to a patient's medical history in adopting possible differential diagnoses - particularly where this involves a possible serious alternative diagnosis for the symptoms;
    II. brings the contents of this report, and the learnings identified in it, to the attention of the ED doctor who assessed the patient on his arrival at the ED, so that these can be discussed with the ED doctor as part of their next performance appraisal; and
    III. provides me with evidence of having done so within **three months** of the date of my final report.

77. The Trust accepted my recommendations.

78. Finally, I wish to pass on my condolences to the complainant, and her family, on the death of her father. Throughout my examination of this complaint I fully recognise the evident care and devotion shown by the complainant to ensure that her father received appropriate care and attention. I hope that my report has gone some way to address the complainant's concerns and provide some reassurance for her and her family.



MARGARET KELLY
Ombudsman
20 July 2022

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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