Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 202000793

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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 concerning the care and treatment received by a patient who was admitted to Antrim Area Hospital in December 2020. The patient was 91 years old and was suffering from shortness of breath. She was diagnosed with an infective exacerbation of Chronic Obstructive Pulmonary Disease and was noted to have excess fluid in her lungs. In addition, the patient had an acute kidney injury, delirium, low oxygen levels and a recent broken hip. She was initially tested for Coronavirus disease (Covid-19) on admission and the result was negative. On 24 December 2020 the patient was again tested for Covid-19 having been a close contact of another patient on the ward and was found to be Covid-19 positive. She was transferred to a designated Covid-19 ward where her condition initially improved but unfortunately then deteriorated, and she passed away on 31 December 2020.

The complaint relates to the patient's death in hospital on 31 December 2020. The complainant did not consider his mother passed away from Covid-19 as she displayed no symptoms. He believed that his mother died from heart disease as he believed this was the emphasis placed on her condition during her stay in hospital.

My investigation, which included the receipt of independent professional advice, concluded that while the patient suffered from many life-threatening comorbidities, which included heart disease, she died from Covid-19 which developed into Covid-19 pneumonia and that this was properly stated on the Medical Certificate of Cause of Death (MCCD).

THE COMPLAINT

1. This complaint concerned the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's late mother (the patient) in December 2020 prior to her death on 31 December 2020.

Background

2. The complainant brought a complaint on behalf of the patient who was 91 years old when she was admitted to Antrim Area Hospital on 4 December 2020. The patient was suffering from shortness of breath and was diagnosed with an infective exacerbation of COPD (Chronic Obstructive Pulmonary Disease)[1] and was noted to have bilateral pleural effusions (excess fluid). In addition to this the patient had an acute kidney injury, delirium and a recent broken hip. She was initially tested for Covid-19 on admission and the result was negative.

3. On 24 December 2020 the patient was again tested for Covid-19[2] having been a close contact of another patient on the ward and was found to be Covid-19 positive. She was transferred to a designated Covid-19 ward where her condition initially improved but then unfortunately deteriorated, and she passed away on 31 December 2020.

Issue(s) of complaint

4. I accepted the following issue of complaint for investigation:

Issue 1: Whether the patient's diagnosis and care and treatment prior to her death was appropriate given her co-morbidities and presenting symptoms.

[1] A combination of chronic bronchitis and emphysema in which there is persistent disruption of airflow into and out of the lungs.

[2] On 11 March 2020 the World Health Organisation (WHO) declared the novel coronavirus3 (Covid- 19), respiratory infection, outbreak as a global pandemic. The risk of severe disease and death increased amongst the elderly and those with underlying health conditions.

INVESTIGATION METHODOLOGY

5. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation consisted of all the relevant clinical records relating to the patients stay in hospital between 4 December 2020 and 31 December 2020.

6. After further consideration of the issues, I obtained independent professional advice (IPA) from a consultant physician of over forty years and an accredited geriatrician since 2001.

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

Relevant Standards and Guidance

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

   The general standards are the Ombudsman's Principles[3]:

   - The Principles of Good Administration

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

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

The specific standards and guidance relevant to this complaint are:

- Chronic obstructive pulmonary disease in over 16's: diagnosis management, NICE Guideline (NG115) updated 26 July 2019
- Braer CA: incidence and mortality of hip fractures;
- Lee A : predicting life expectancy after geriatric hip fracture, a systematic review; and
- Bernstein J : Estimating Median Survival Following Hip Fracture among Geriatric Females

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

11. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. In response to sight of this report in draft form the complainant maintained his belief that his mother did not die from Covid -19, rather she had died from heart failure and that this should have been reflected on the MCCD. The Trust accepted the findings made. As a result of the comments made, I have not altered my findings and conclusions but have made certain amendments to the original draft to provide further clarity.

THE INVESTIGATION

Issue 1: Whether the patient's diagnosis and care and treatment prior to her death was appropriate given her co-morbidities and presenting symptoms

Detail of Complaint

12. The complainant is concerned as to the classification of his mother's death. He said that the emphasis during the patient's admission to hospital was heart disease/failure and yet this was not mentioned specifically on the MCCD. He said that the reason for his complaint is the desire to know the truth around his mother's death based on '*the actual facts'*.

Evidence Considered

The Trust's response to investigation enquiries

13. In responding to enquiries regarding this complaint the Trust stated that multiple conversations are documented in the patient's medical notes in relation to updates provided to the family concerning the patient's condition and prognosis by both medical and nursing staff. In a letter to the complainant, dated 4 June 2021, the Trust apologised if staff provided conflicting information and if they were unable to provide the complainant with accurate predictions regarding [his mother's] end of life.

14. In explaining why heart failure was mentioned by clinical staff but not included on the MCCD, the Trust stated that the patient was 91 years old, Covid-19 positive, had a background history of COPD and hence likely to have cor- pulmonale[4]. The Trust also stated that patient had Type II diabetes, left neck of femur fracture, peripheral vascular disease[5], and pulmonary hypertension[6]. She had an acute deterioration with increased oxygen requirement which unfortunately led to her death. Given the patient's recent fractured neck of

[4] Enlargement and strain of the right side of the heart caused by one of a number of chronic lung diseases

[5] Narrowing of blood vessels in the legs (sometimes arms) restricting blood flow and causing pain. The greatest risk factor is smoking

[6] A disorder in which the blood pressure in the arteries supplying the lungs is abnormally high.

femur she was referred to the Coroner. Pulmonary Hypertension is a terminology that explains heart failure due to COPD. In medical terms that is cor-pulmonale or heart failure due to COPD. The Coroner included this medical terminology as it was present in an echocardiogram (heart scan) in August 2020.

15. The Trust explained that a member of clinical staff wrote to the complainant on 6 March 2021 regarding issues relating to his mother's MCCD. It was explained that the MCCD and its contents had been discussed with the Coroner.

16. Regarding Covid-19 pneumonia being attributed as the main cause of death, the Trust stated that the patient was found to be Covid-19 negative on 4 December 2020 on admission. However she was tested and found to be Covid- 19 positive on 24 December (after being exposed to another patient in the bay who tested positive). Hence the patient was required to be transferred to a designated Covid-19 ward, namely A1, this transfer occurred on 25 December 2020. A repeat Covid-19 swab was facilitated at the complainant's request due to his concerns of a false positive having been obtained in the first test. The patient had been treated for pneumonia with antibiotics during her admission and several attempts to optimise her heart failure treatment were undertaken. In previous discussions with family these treatments have been referred to as blood pressure medication.

17. The Trust stated that the patient had multiple co-morbidities. She was admitted with exacerbation of COPD and cor-pulmonale as evidenced by pleural effusions on CTPA (a CT scan), an ECG (electrocardiogram) showing changes of right bundle branch block (irregular heartbeat) and clinical picture. Whilst she had been improving on treatment, the Trust explained there were several challenges as she kept needing oxygen, complications with acute kidney injury needing optimisation of fluid balance for her heart condition. All these are markers of frailty as well as an inability to correct pathophysiology (abnormal changes in bodily functions). The clinical picture of a sudden deterioration pointed towards a cardiac cause; this was explained to the complainant on 31 December 2020. Covid-19 infection can cause systemic imbalance and has been linked to exacerbation of cardiac dysfunction.

18. The Trust stated that the patient received antibiotics and steroids along with

supportive therapy with oxygen in the treatment of Covid-19. Following her death, an autopsy was not carried out. The decision for autopsy lies with the Coroner and the Coroner's office was happy with the facts and progress of treatment in the hospital. The Trust also noted that an autopsy is required when there is no clear cause of death which was not the case here.

Relevant Independent Professional Advice

19. Overall, the IPA advice which I received was that the treatment and care the patient received between 4 December 2010 and 31 December 2020 was correct and in keeping with the NICE guidelines prevailing at the time.

20. The IPA advised that the patient had background COPD consequent on long term smoking resulting in chronic cor pulmonale (*"pulmonary heart" which is heart failure secondary to lung disease).* Cor pulmonale resulted in pulmonary hypertension (a disorder in which the blood pressure in the arteries supplying the lungs is abnormally high and which can damage the heart) and this was identified on the echocardiogram in 2020. Towards the end of August 2020, she had had a fall, fracturing her left neck of femur for which she underwent surgery *(hemiarthroplasty).*

21. The patient was admitted to hospital on 4 December 2020, presenting with shortness of breath and delirium. The IPA advised she was treated with appropriate antibiotics which were correctly escalated when she became poorly. The patient was delirious throughout her hospital stay and the records show that despite daily ministrations of the physiotherapy and occupational teams, they were unable to help her due to her ongoing delirium (causing confusion and agitation).

22. The IPA advised that records show that on admission on 4 December 2020 she was Covid-19 negative. A CXR (chest x-ray) on 5 December 2020 showed up a patch of lung collapse *(atelectasis)* in the left midzone with fluid in both lungs *(pleural effusions).*

23. The IPA advised the patient was treated as having '*infective exacerbation of*

COPD, with appropriate antibiotics, oxygen and inhalers. She was reviewed by the respiratory specialist nurses on different occasions. While on the ward, the COPD with cor pulmonale caused her to need additional nasal oxygen prescription to safely maintain her blood oxygen levels. A repeat CXR (chest x-ray) on 15 December 2020 showed that the patient had by then developed a new pneumonia in the lower zone of her right lung.

24. The IPA advised that while she was in hospital, another patient on her ward contracted Covid-19 and the patient thus became a Covid-19 contact. The patient then herself tested positive on Christmas Eve 2020. A chest x-ray on 30 December 2020 showed progression of her pneumonia with a new shadow in the upper zone of the left lung in addition to the lower zone of her right lung. By then her oxygen requirement had increased. The IPA noted this probably represented the onset of Covid-19 pneumonia, to which she succumbed on 31 December 2020.

25. The patient was 91 years of age and suffered from type 2 diabetes, previous delirium, COPD, chronic cor pulmonale, peripheral vascular disease, hypercholesterolaemia (excess cholesterol in the bloodstream) and macular degeneration (a problem with the retina affecting peripheral vision). Regarding her recent fall and hip fracture surgery, the IPA advised that hip fracture in elderly patients is independently associated with a high mortality rate. The median survival is highly correlated with age, such that an estimation equation, (100 - Patient Age) ÷ 4, offers a reliable shorthand for approximating it. By that reckoning, not taking into the equation her various co-morbidities, the patient's estimated survival after the hip fracture surgery would have been approximately 2.25 years. When one considers the COPD and chronic cor pulmonale, in a frail lady, that time frame of 2.25 years would have been adversely altered.

26. The IPA advised that the patient had COPD with heart failure secondary to lung disease (chronic cor pulmonale / pulmonary hypertension). That she had developed Covid-19 pneumonia was suggested by new shadows in the CXR plus the sudden increased oxygen requirement. The IPA also advised it was, therefore, most likely that the Covid-19 pneumonia was the direct and immediate

cause of her death. In other words, if she had not contracted Covid-19 on Christmas Eve 2020, death may have supervened later due to the co-morbidities, in the main being cor pulmonale. In other words, she may not have died on 31 December 2020 if she had not developed Covid-19 pneumonia. Although she suffered from heart disease, this was not the immediate cause of her death on 31 December 2020. The IPA stated therefore the cause of death stated in the Medical Certificate of the Cause of Death (MCCD) is accurate.

27. The term pulmonary hypertension in the patient's records, was taken from an echocardiogram report from 2020 which said 'pulmonary hypertension' was found. Cor pulmonale / pulmonary hypertension was not the immediate cause of death and is therefore correctly listed in the MCCD among "Other significant conditions contributing to death but not related to the cause of death". Thus, Type 2 diabetes mellitus, fracture neck of femur, chronic obstructive lung disease, peripheral vascular disease and pulmonary hypertension were all correctly included in this category in her MCCD.

28. The IPA advised that sadly, the patient succumbed to Covid-19 pneumonia. She was especially vulnerable to Covid-19 given her age and associated co-morbidities. The deterioration that occurred when she developed Covid-19 pneumonia was not unexpected and could not have been prevented.

29. I was advised that the need to discuss the death with HM Coroner arose because of the patient's recent surgery for fracture neck of femur. It is mandated in law that the Coroner must be informed (among other circumstances) if there was death following a surgical operation. Discussion with the Coroner's office takes place invariably over the telephone. In this case the medical notes show that it was a telephone discussion that took place. In the main, the Coroner's officer would have wished to know if death was caused by the operation. The IPA confirmed that is the question he would ask the doctor presenting the case to him. If the cause of death was determined to be the surgical operation, he would ask for an autopsy and order and inquest.

30. The IPA advised that, not having sight of the medical notes, as it was a telephone discussion, the Coroner's officer is guided by the facts and story related to him by the junior doctor. The recommendation made by the Coroner is thus based on the

information discussed with him. The Coroner's officer is an experienced person and the IPA gave credence to the cause of death which he has suggested. Based on reviewing the medical notes, the IPA advised that '*it is obvious that the cause of death on the MCCD, as suggested by the coroner was correct'*.

Analysis and Findings

31. I considered the information received from the IPA and fully accept his advice. I note that the patient contracted Covid-19 and tested positive for this illness on 24 December 2020. I also note, a second test which also showed positive was carried out and that Covid-19, developing into Covid-19 pneumonia, was ultimately the condition which directly led to patient's death on 31 December 2020. I set out my reasoning for this conclusion in the following paragraphs and hope that it provides the complainant with the reassurance which he seeks.

32. The complainant queried the classification on his mother's death on the Medical Certificate of Cause of Death (MCCD). On this document it states, under the heading Disease or Condition Directly Leading to Death 'Covid-19 – pneumonia'. An Asterix beneath this section explains that the disease or condition directly leading to death 'does not mean the mode of dying e.g. heart failure, asthma etc. It means the disease, injury or complication which caused death. Alongside the heading 'Other significant conditions contributing to the death but not related to the disease or condition causing it', it states 'COPD, Type 2 diabetes, Left neck of Femur, Peripheral vascular disease, pulmonary hypertension'.

33. These entries on the MCCD made no sense to the complainant given the information he states he was receiving from the hospital concerning his mother's heart problems during her admission. The complainant believed that his mother did not pass away from Covid-19 as she displayed no overt symptoms but rather that she passed away due to heart disease. As his remedy when he brought his complaint to this office, the complainant sought to know the truth around his mother's death based on 'actual facts'.

34. The independent professional advice which I received, is very clear that the direct and immediate cause of the patient's death developed from Covid-19. I further

accept the advice that the care and treatment the patient received while a patient in Antrim Area Hospital between 4 December 2020 and 31 December 2020 was appropriate for her various conditions and in keeping with the guidelines prevailing at the time. The advice is very clear on these points and provides a detailed explanation of the medical facts surrounding the patient's serious health conditions and presentation, many of which were life limiting and which had the potential to cause the death of the patient at any time.

35. It is evident that when the patient was admitted to hospital on 4 December 2020 with shortness of breath, she was already very ill. She suffered from a number of conditions, any one of which can cause serious problems, including death, in the elderly, and which had developed over the previous years. Many of the conditions were those which affect the lungs such as COPD and, at the time of admission, she had bilateral pleural effusions (excess fluid in the lungs). I note that conditions such as these, over the years put extra pressure on the efficiency of the heart and cause damage to it. The advice which I received, that cor pulmonale/pulmonary hypertension had been noted on an echocardiogram from 2020 showed that damage had already been done to this area.

36. I accept the IPA's advice that on admission to hospital, the patient was appropriately treated for COPD and the other underlying heart conditions with the appropriate medications and oxygen therapy and inhalers. These were correctly escalated as the patient's condition deteriorated. She was seen by a specialist respiratory nurse and was visited daily by the physiotherapy and occupational teams. It appears that there may have been a temporary improvement in the patient's condition as I note an entry in the medical records, dated 11 December 2020, stating that the patient could be considered for discharge once she was off oxygen therapy for 24 hours. However, I note that a further scan on 15 December 2020, showed that the patient had developed a new pneumonia in the lower zone of her right lung. By 24 December 2020 events had progressed further and I note an entry in the medical records stating that the patient was not fit for home and that the family had been informed of this.

37. The patient had tested negative for Covid-19 on admission on 4 December 2020 but unfortunately tested positive on 24 December 2020. This test was repeated with the same outcome, due to the complainant's concerns that the first test may have been a false positive. I am advised by the IPA that this then progressed into

Covid-19 pneumonia as evidenced by a sharp need to increase her oxygen intake and the development of a new shadow on the upper zone of her left lung in addition to that on the lower zone of her right lung. The complainant was aware that his mother had been tested positive for Covid-19 on 24 December 2020 and while he remains convinced that she displayed no overt symptoms, I accept the advice I have received that this progressed to Covid -19 pneumonia, as evidenced by the increase in oxygen requirement and the development of a new shadow in her upper left lung. The complainant has also expressed his doubts that his mother was being treated for the symptoms of Covid-19. He accepts that she was receiving oxygen due to the exacerbation of COPD and fluid in her lungs but I accept the advice of the IPA that the continuing incremental increasing requirement for oxygen represented appropriate treatment for the onset of Covid-19 pneumonia. I also accept that while the patient was receiving antibiotics and steroids as treatment for a number of the co-morbidities from which she suffered, these medications were also used to treat the Covid-19 pneumonia.

38. It was this progression into Covid-19 pneumonia which was the direct and immediate cause of the patient's death on 31 December 2020. It is evident that this progression commenced upon the positive test for Covid-19 on 24 December 2020. The IPA explained that if the patient had not contracted Covid- 19 on 24 December 2020 she may not have died on 31 December and that death, while it may, and probably was, relatively imminent, would have occurred at a later date due to her other comorbidities. I accept the explanation that the patient's immediate death was not caused by heart disease[7] (though this had undoubtedly weakened her overall condition and state of health) and that the direct cause of her death was Covid-19 pneumonia.

39. Based on the IPA advice received, I understand that prior to the onset of Covid-19 pneumonia, if the patient were to die during this period of treatment, the most likely cause of death would have been the heart disease and lung problems from which she suffered, as evidenced by the pulmonary hypertension/corpulmonale. This was the case up to the positive Covid-19 test on 24 December 2020 and this is the impression received by the complainant during his telephone calls to the medical team treating his mother. At the time of this complaint there were severe restrictions on family members attending hospital due to the Covid-19 pandemic and I fully accept the difficulties experienced by medical staff in communicating

very emotive and difficult situations to relatives over the telephone. I also fully appreciate the difficulties experienced by families in such circumstances whereby the opportunities to have events and conditions explained to them face to face were severely limited.

40. It is evident from the complainant's response to receipt of the draft report that his understanding from his daily telephone calls to his mother's ward was that her condition was improving. This may well have been the case temporarily and I am satisfied that her condition would have fluctuated on a day-to-day basis. Regardless of the content and intent of the updates received, it is clear that the life-threatening seriousness of the patient's condition, even prior to contracting Covid-19, was not fully impressed upon the complainant during this unprecedented time. While the patient's condition may have improved slightly from one day to another, the underlying grave medical condition remained. However, once the patient succumbed to Covid-19 pneumonia after 24 December 2020, I accept she was especially vulnerable, given her age and comorbidities many of which had already led to a weakening of the heart and lungs and that Covid -19 is the condition which ultimately proved to be the primary cause of death.

41. In addition to the patient's age and the listed heart and lung conditions from which she suffered, she had type 2 diabetes, peripheral vascular disease and elevated cholesterol. The patient had also suffered a recent hip fracture for which she had surgery. I note the advice received which evidences that hip fracture in elderly patients is known to be associated with high mortality rate with the estimated survival time following surgery decreasing with the age of the patient. While I am not suggesting that the recent hip surgery was a direct cause of death, the statistics provided by the IPA are particularly stark and would suggest that taken together with the other conditions, they did represent other significant conditions which would have weakened the body, contributing to the death but not being related to the disease or condition causing it and thus this being noted in the second part of the MCCD was correct.

[7] Heart disease is a broad term that encompasses a wide range of heart conditions, one of which is heart failure.

42. I also consider that at this stage that I should provide an explanation of how and why a MCCD is issued and as to the situation which existed at the time of the patient's death. A MCCD is not a death certificate as such, rather it is the document which enables the deceased's family to register the death. The registration provides a permanent legal record of the fact of death and enables the family to arrange burial and to settle the deceased's estate. The Coronavirus Act 2020 which came into effect on 25 March 2020 contained clauses which slightly amended the MCCD process to take account of the situation throughout the United Kingdom and the Covid-19 outbreak. It allowed more flexibility for a medical practitioner to sign a MCCD. Basically it stated that if a Doctor had treated a deceased patient within 28 days and the death was as a result of a natural illness, then the MCCD could be completed as normal. However, it also allowed another practitioner from the same hospital or GP practice to sign the MCCD, provided the death was as a result of a natural illness, and the practitioner could state the cause of death to the best of their knowledge and belief.

43. In this case a telephone conversation was correctly undertaken with the coroner's office, as the coroner must be informed of a death if there has been a recent surgical intervention and he must be satisfied that the death did not occur as a result of that surgery. The Clinical Summary of the MCCD records this discussion and states that the coroner decided that the recent surgery for fractured neck of femur was not a direct link to the cause of death. It is for this reason that a post-mortem was not required and the coroner did not physically view the patient after death. The telephone conversation with the coroner's office was undertaken by a doctor other than the consultant, but under the consultant's guidance. The IPA has referenced this in the medical record of 1 January 2021 and has advised that following his review of all the medical notes, it was obvious to him that the cause of death on the MCCD, as suggested by the coroner was correct. I accept this advice.

CONCLUSION

44. I received a complaint concerning the death of the complainant's mother on 31 December 2020. The complainant had expressed his concerns regarding the stated cause of death. The independent professional advice which I received, and

which I accept, is that the patient's death from Covid-19 pneumonia was as a direct cause of developing Covid-19. I accept that, while the patient suffered from a number of comorbidities, many of which were life threatening and could have caused her death at any time, the immediate cause of her death was Covid-19 for which she had tested positive on 24 December 2020 and which developed into Covid-19 pneumonia. I further accept the advice that prior to her death, the care and treatment received by the patient was appropriate and clinically justified.

45. Finally, I wish to pass on my condolences to the complainant and his family on the death of a much-loved mother. Throughout my examination of this complaint, I fully recognise the distress experienced by the complainant over the issues which he has raised. I hope that my report has gone some way to address his concerns. I understand that he may continue to disagree with the conclusions I have reached but I wish to assure the complainant that I have reached this conclusion only after the fullest consideration of the medical records and the advice I have received.

MARGARET KELLY
OMBUDSMAN **July 2023**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being customer focused

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

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.

  Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.