Investigation of a complaint against a GP practice

Report Reference: 202001760

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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 a General Practitioners' (GP) Practice provided to the patient during the period 15 April 2021 to 1 June 2021. The patient sadly took his own life on 1 June 2021. The complainant was concerned about care and treatment the Practice provided to the patient for his mental health in the period leading up to his death. The complainant was also concerned about how the Practice handled the patient's wife's complaint.

I upheld elements of the complaint. The investigation established the decisions the Practice made regarding medication, the handling of the joint assessment on 27 April 2021, and the decision not to undertake a second joint assessment on 1 June 2021 were reasonable, appropriate and in line with relevant standards.

However, it identified failures in care and treatment regarding the Practice's handling of alternative treatment options for the patient. In addition, it identified failures regarding the Practice's communication with the patient's wife and record-keeping.

The investigation also established significant failures in complaint handling. In particular I found that GP B was the subject of the complaint and as such he was not an '*appropriate person*' to conduct the investigation into himself. I was further surprised the Practice viewed him as such. I considered this a departure from the Complaints Protocol and that it caused the complainant un-necessary frustration and uncertainty in an already very difficult set of circumstances.

I recommended that the Practice provides the patient's wife with a written apology within one month of the date of the final report. I made four further recommendations for the Practice to address to instigate service improvement and to prevent future reoccurrence of the failings identified. I asked the Practice to provide my Office with an action plan regarding steps taken within six months of the date of the final report.

THE COMPLAINT

1. This complaint is about care and treatment the Practice provided to the patient, now deceased, during the period 15 April 2021 to 1 June 2021. The complainant is a family friend who raised concerns on behalf of the patient's wife. The complaint is also about the Practice's subsequent handling of the patient's wife's complaint which was investigated via the Practice's complaints procedure.

Background

2. On 15 April 2021, GP A conducted a telephone consultation with the patient, who described symptoms including low mood[1], anxiety[2], paranoia[3], and thoughts of suicide[4]. GP A prescribed the patient Mirtazapine[5].

3. On 16 April 2021, the patient's wife contacted the Practice, having found a rope hung in the couple's garage. GP A subsequently conducted a further telephone consultation with the patient.

4. On 27 April 2021, the patient's wife informed the Practice she recently removed three ropes from their home and found a concealed fourth rope. GP B conducted a face-to-face consultation with the patient. This was a joint assessment[6] involving the patient, GP B and an external approved social worker[7] (ASW). It was to determine if the patient fulfilled the criteria required for an application for admission to hospital for assessment and detention under *Article 4* of the Mental Health (Northern Ireland) Order 1986 (the 1986 Order). Prior to the assessment, the Practice notified the Police Service for Northern Ireland (PSNI) and arranged for an ambulance to be on standby. GP B (in agreement with the ASW) decided the patient did not meet the threshold for

[1] Feelings of tiredness, lacking confidence, frustration, anger and worry that will often pass after a short period of time.
[2] A feeling of stress, panic or fear that can affect your everyday life physically and psychologically.
[3] **T**hinking and feeling threatened in some way, even if there is no evidence, or very little evidence, that a person is being threatened.
[4] Having abstract thoughts about ending one's life or feeling that people would be better off without them, or thinking about methods of suicide or making clear plans to take one's own life.
[5] An atypical tetracyclic antidepressant used primarily to treat depression. Side effects can include sleepiness, dizziness, increased appetite, and may include mania, low white blood cell count, and increased suicide among children.
[6] An assessment carried out by two or more professionals assessing an individual's abilities and needs. This may be professionals from the same discipline, or may involve other professionals.
[7] An officer of a local social services authority having appropriate competence in dealing with persons who are suffering from mental disorder, acting in accordance with the Mental Health (NI) Order 1986.

admission to hospital under the 1986 Order. He instead made an urgent psychiatric referral for the patient to the local hospital.

5. On 28 April 2021, GP B arranged a further face-to-face consultation with the patient, which took place on 6 May 2021.

6. On 1 June 2021, the patient's wife informed the Practice that the patient exhibited paranoia. GP B initially conducted a telephone consultation with the patient. He followed this with a face-to-face consultation that afternoon. This consultation was not a joint assessment. GP B made a second urgent psychiatric referral for the patient. Sadly, the patient took his own life that evening.

7. The patient's wife raised a complaint to the Practice on 22 September 2021 regarding the care and treatment it provided to the patient. The Practice responded to the complaint on 3 December 2021. The patient's wife was dissatisfied with its response, and so the complainant raised her concerns with my Office, acting on her behalf.

Issues of complaint

8. The issues of complaint accepted for investigation were:

1. **Whether the Practice provided appropriate care and treatment to the patient during the period 15 April 2021 to 1 June 2021?**

   In particular, this will consider:

   - **The care and treatment the Practice provided to the patient on 27 April 2021;**
   - **The care and treatment the Practice provided to the patient on 1 June 2021;**
   - **The Practice's decision to prescribe the drug Mirtazapine to the patient; and**
   - **The Practice's decision to contact the PSNI on 27 April 2021.**

2. **Whether the Practice appropriately handled the complainant's original complaint dated 22 September 2021?**

In particular, this will consider:

- **Whether the investigation into the complaint was conducted in an impartial, objective and fair manner by a suitable person;**
- **Whether the investigation into the complaint was conducted in line with the Practice's investigation methodology;**
- **Whether the Practice kept the complainant appropriately informed of the timescales associated with the investigation; and**
- **Whether the Practice sought the complainant's agreement to a copy of her complaint being forwarded to the HSC Board.**

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

- **General Practitioner (GP)**, MBBS BSc FRCGP ILM5 MSc (med ed) – a senior GP with a special interest in regulatory medicine and complaints.

11. 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

12. 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[8]:

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

13. 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.

The specific legislation, standards and guidance relevant to this complaint are:

- The Mental Health (Northern Ireland) Order 1986 (1986 Order);
- Department of Health and Social Services (DHSS): Mental Health (Northern Ireland) Order 1986, a Guide, 1986 (DHSS Guide);
- Department of Health and Social Services (DHSS) Code of Practice on the Mental Health (Northern Ireland) Order 1986, 1992 (DHSS Code);
- Guidelines and Audit Implementation Network (GAIN) Guidelines on the Use of the Mental Health (Northern Ireland) Order 1986, October 2011 (Gain Guidelines);
- National Institute for Health and Care Excellence (NICE) Clinical Guideline 16: Self-Harm in Over 8's – Short Term Management and Prevention of Recurrence, July 2004 (NICE CG16);

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

- National Institute for Health and Care Excellence (NICE) Clinical Guideline 133: Self-Harm in Over 8's – Long-Term Management, November 2011 (NICE CG133)
- National Institute for Health and Care Excellence (NICE) Quality Standard 34: Self-Harm, June 2013 (NICE QS34);
- National Institute for Health and Care Excellence (NICE) British National Formulary[9] Extract on Mirtazapine – (BNF Extract);
- Department of Health: Guidance in relation to the Health and Social Care Complaints Procedure (April 2019) (DOH Guidance);
- Practice's Protocol – In House Complaints System, May 2020 (Complaints Protocol);
- Practice's Complaints Leaflet, 2020 (Complaints Leaflet);
- Health and Social Care Board (HSCB) Circular regarding Complaints Handling, 26 March 2020, (HSCB Circular); and
- The General Medical Council's (GMC) Good Medical Practice, updated April 2019 (the GMC Guidance).

14. 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.

15. A draft copy of this report was shared with the complainant, the Practice, and GPs A and B for comment on factual accuracy and the reasonableness of the findings and recommendations. I gave careful consideration to the comments I received before I finalised this report.

THE INVESTIGATION

Issue 1 - Whether the Practice provided appropriate care and treatment to the patient during the period 15 April 2021 to 1 June 2021?

In particular, this will consider:

[9] UK pharmaceutical reference book containing a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medicines available on the UK National Health Service (NHS).

- **The care and treatment the Practice provided to the patient on 27 April 2021;**
- **The care and treatment the Practice provided to the patient on 1 June 2021;**
- **The Practice's decision to prescribe the drug Mirtazapine to the patient; and**
- **The Practice's decision to contact the PSNI on 27 April 2021.**

Detail of Complaint

Care and treatment the Practice provided to the patient on 27 April 2021

16. The complainant raised the following concerns regarding care and treatment the Practice provided on 27 April 2021:

    - GP B did not '*fully appreciate*' the patient's condition. Also that he did not take '*timely and appropriate*' action to ensure the patient was not at risk of harming himself when applying the criteria in *Article 4* of the 1986 Order (Article 4 criteria);
    - GP B was '*dismissive*' of the patient's wife's input, instead accepting the patient's '*superficial presentation*' and words at '*face value*';
    - GP B did not '*challenge*' or '*probe*' the patient about giving away his work uniform or on the number of ropes hung in the home; and
    - GP B did not notify the patient's wife he intended to conduct a joint assessment. Also, that he did not explain what it was or the '*importance*' and '*implications*' of it. This meant the patient's wife could not contribute to it.

Care and treatment the Practice provided to the patient on 1 June 2021

17. The complainant raised the following concerns regarding care and treatment the Practice provided on 1 June 2021:

- GP B did not '*fully appreciate*' the patient's condition. Also that he did not take sufficiently proactive '*timely and appropriate*' action to ensure the patient was not at risk of harming himself;

- GP B was '*dismissive*' of the patient's wife's input, in favour of accepting the patient's '*superficial presentation*' and taking the patient's words at '*face value*';

- GP B focused on the patient's paranoia rather than potential self-harm or suicidal intentions, and gave '*no consideration*' to the potential link between them; and

- GP B incorrectly determined the patient could '*keep himself safe*', because the patient sadly took his own life later that day.

The Practice's decision to prescribe the drug Mirtazapine to the patient

18. The complainant said on 15 April 2021, GP A prescribed medication to the patient that '*may have exacerbated his paranoia and suicidal intentions*'. He was concerned about the safety of Mirtazapine for the patient, given his medical history and the '*noted serious side effect of increasing the risk of a patient thinking about harming themselves or ending their life*'.

The Practice's decision to contact the PSNI on 27 April 2021

19. The complainant said the Practice did not inform the patient and his wife it intended to contact the PSNI in preparation for GP B's joint assessment.

Evidence Considered

Legislation/Policies/Guidance

20. I refer to the following policies and guidance which I considered as part of investigation enquiries:
    - The 1986 Order;
    - DHSS Guide;
    - DHSS Code;
    - Gain Guidelines;
    - NICE CG16;

- NICE CG133;
- NICE QS34;
- BNF Extract; and
- GMC Guidance.

The Practice's response to investigation enquiries

21. The Practice denied the GPs failed to '*appreciate*' the patient's '*condition*'. It said the GPs '*endeavoured to provide a treatment plan, best suited to his condition*'. This included '*the prescribing of medication, appropriate referrals to mental health services and regular reviews and support from the GP Practice*'.

22. The Practice also denied it was dismissive of the patient's wife's '*concerns*' and failed to give appropriate '*weight*' to her input. It explained the GPs gave the patient's wife '*time to express*' her '*concerns*'. The Practice said the GPs recorded these concerns in the patient's clinical records and gave them '*consideration*' when '*formulating a management plan*'.

Care and treatment the Practice provided to the patient on 27 April 2021

23. The Practice explained GP B listened to the patient's wife and was '*sufficiently concerned*' about the information she provided. It said it took '*prompt action*' to consult with the patient, arranging an appointment for that afternoon.

24. The Practice said, '*given the history and recent behaviour*', GP B undertook a joint assessment of the patient, alongside an external ASW. The Practice explained the joint assessment was to determine if the patient '*fulfilled the criteria required for an application for admission to hospital for assessment and detention*' under the 1986 Order.

25. The Practice explained GP B (in agreement with the ASW) decided the patient did not meet the criteria for admission to hospital. The Practice said GP B '*acknowledged*' the patient was '*suffering from mental ill-health*'. However, he did not consider there was '*a substantial likelihood of serious physical harm*' to

the patient or others. The Practice explained GP B considered the following in reaching this conclusion:

- the patient's appointment with a psychologist earlier that day, which GP B considered showed '*insight and a desire to engage in treatment to get better*';
- the patient '*denied wanting to self-harm*' and expressed that *'he saw a future*'; and
- the patient described '*his family being a protective factor against self-harm*'.

26. The Practice explained GP B considered the patient would benefit from '*ongoing specialist support*'. He therefore made '*an urgent referral*' to the local hospital for the patient the same day.

Care and treatment the Practice provided to the patient on 1 June 2021

27. The Practice explained the patient's '*presenting complaint was one of paranoid ideation*'. It said the patient's wife '*did not raise any concerns about suicidal ideation*' in her initial phone call with GP B. It said GP B listened to the patient's wife and arranged to speak with the patient. The Practice explained when GP B subsequently spoke with the patient on the phone, the patient '*said he did not have any thoughts of self-harm*'.

28. The Practice said GP B asked the patient if he had any thoughts of self-harm during the subsequent face-to-face consultation, and the patient '*denied*' having any.

29. The Practice explained GP B therefore '*explicitly considered*' the '*risk of self-harm*', and '*did not feel the threshold was met*' for another joint assessment on this occasion. The Practice explained the '*main purpose*' of the face-to-face consultation was to '*manage*' the patient's '*paranoid feelings*'.

The Practice's decision to prescribe the drug Mirtazapine to the patient

30. The Practice explained GP A prescribed Mirtazapine following the telephone consultation with the patient on 15 April 2021. It said the patient described his '*mood was low*' with an '*element of anxiety*'. The Practice explained the patient also described he had been '*feeling quite paranoid*' and had '*thoughts of suicide over the previous few days, specifically thoughts of hanging himself*'.

31. The Practice said GP A discussed Mirtazapine with the patient and '*side effects including the possibility of drowsiness and increased anxiety*'. The Practice explained the patient '*agreed to commence this medication*'. It said GP A referred the patient to the '*home treatment team*'[10] (HTT), and the Practice kept the patient's medical options under '*careful review*'.

The Practice's decision to contact the PSNI on 27 April 2021

32. The Practice explained it was '*[GP B]'s customary practice*' to notify the PSNI when he planned to conduct a joint assessment. The Practice said this is a precautionary measure in case a patient becomes aggressive or refuses to travel to hospital and it requires '*police intervention*'. The Practice explained GP B put the PSNI on notice, but did not ask them to attend the assessment.

33. The Practice said GP B also arranged for an ambulance to be on stand-by in case the joint assessment showed the patient required hospitalisation, and required transport to the hospital. The Practice explained in GP B's experience, the ambulance service will '*routinely ask*' if the GP has informed the PSNI when making that arrangement.

Relevant Independent Professional Advice

Care and treatment the Practice provided to the patient on 27 April 2021

[10] Provides a range of intensive mental health treatments and therapeutic services to patients aged 18-65 who are experiencing an acute disruption to their ability to function adequately in the community as a result of severe mental illness

34. The IPA said GP B and the ASW spoke with the patient without his wife present. She advised this was in line with the GAIN Guidelines, particularly as GP B previously spoke to the patient's wife separately.

35. The IPA advised that GP B's record of the joint assessment indicated he considered the information the patient's wife provided as part of his assessment under the 1986 Order. The IPA said the medical notes document GP B discussed the ropes the patient's wife found, as well as the patient's decision to give his uniform to his son.

36. I asked the IPA if GP B had specifically '*challenged*' the patient on these points, as the complainant had expressed concerns about this. The IPA advised it was '*unclear*' from the medical records whether GP B specifically '*challenged*' the patient on these issues or whether he only discussed them. However, the IPA also advised it would '*not necessarily have been appropriate*' for GP B to have specifically challenged the patient on these points at this time The IPA said GP B's record of the type of discussion he had with the patient in respect of these issues '*should*' have been '*more clear and detailed*'. The IPA also said GP B could have been more proactive in arranging to explore these issues again during a subsequent consultation or ensuring the referred organisations (see below for more detail) did so.

37. The IPA referred to the patient's medical records and advised GP B '*did share*' his '*concerns*' with the patient as part of the assessment. However, she further advised that GP B's record for this discussion ought to have been more detailed.

38. The IPA said GP B decided the patient did not meet the criteria for admission to hospital. She referred to GP B's record of the joint assessment and advised his decision was reasonable, appropriate and in line with relevant standards. The IPA also advised it would have been '*reasonable and appropriate*' for GP B to have explored voluntary admission to hospital with the patient. However, the medical records do not evidence that GP B did so.

39. The IPA advised GP B spoke with the HTT and referred the patient to it. She said GP B also '*made an urgent psychiatric referral for the patient at a local*

hospital' and referred him to the Self-Harm Intervention Programme[11] (SHIP). The IPA advised GP B's actions were in line with GAIN Guidelines. These state that when a GP decides a patient does not meet the criteria for admission to hospital, they should explore '*alternative support*' for the patient.

40. However, the IPA also advised the GAIN Guidelines state '*any alternative plan should identify a named professional who will have responsibility for ensuring its implementation. It should be recorded in writing and copies made available to all those who need them, subject to the needs of confidentiality*'. The IPA said it is '*unclear*' from the patient's medical records who this named professional was, if the Practice documented an alternative plan; and if it was, whether it shared copies of it with the patient and his wife.

41. Regarding the immediate aftermath of the joint assessment, the IPA advised it was '*unclear from the medical records*' what communication, if any, GP B had with the patient's wife about what transpired during the assessment. The IPA said it would have been '*reasonable and appropriate*' for GP B have '*included further details of his communication with the patient's wife in the medical notes*'. She also advised the '*detail provided is insufficient to meet GMC Standards*'.

Care and treatment the Practice provided to the patient on 1 June 2021

42. The IPA referred to GP B's record of the consultation with the patient. The IPA advised the records document GP B discussed the patient's paranoia with him, as well as thoughts of self-harm. She said the patient confirmed he had not had any more of these thoughts since the previous consultation. However, the IPA advised GP B's record was '*unclear*' as to the specific weight he gave to these factors during the consultation.

43. The IPA advised GP B decided it was not necessary to conduct a further joint assessment because the patient had not expressed new thoughts of self-harm or suicide. The IPA said this decision was '*reasonable and appropriate*' based on the information GP B had to hand at the time of the consultation, despite the lack of detail in the medical records.

[11] A service offered by qualified counsellors that helps people who self-harm to deal with the issues that are causing distress.

44. The IPA advised, however, it was '*not clear*' from the medical records whether GP B discussed the option of voluntary or non-voluntary admission to hospital with the patient on this occasion. The IPA said it was '*reasonable*' to expect GP B to have discussed the option with the patient, given his previous presentation on 27 April 2021.

45. The IPA advised the medical notes document GP B took the patient's wife's concerns into consideration during this consultation, and that it was '*reasonable and appropriate*' for him to have done so. However, the IPA also said it was '*unclear*' from the patient's medical notes how much consideration GP B gave to the patient's wife's input. Therefore, GP B's records '*contain insufficient detail*' about this.

46. The IPA advised GP B prescribed the patient medication to address his paranoia. The IPA said following the consultation, GP B wrote to the Mental Health Unit at the local hospital to update the unit about developments in the patient's condition. The IPA advised GP B also '*made a second urgent psychiatric referral*' for the patient. She said GP B's actions were '*reasonable and appropriate*'. However, the IPA advised the patient's medical records did not document the named professional for this plan, whether the plan was written down, and if it was, whether copies were made available to the patient and his wife.

The Practice's decision to prescribe the drug Mirtazapine to the patient

47. The IPA referred to the BNF Extract and advised Mirtazapine is '*used to treat mental health conditions such as major depression*'. The IPA said the BNF extract states suicidal behaviours as a side-effect of the medication, but the '*frequency*' of this is '*unknown*'.

48. The IPA advised the patient's medical notes show GP A '*discussed*' Mirtazapine and its side-effects with the patient prior to prescribing it on 15 April 2021, and the patient was '*happy to proceed*'.

49. The IPA said, however, Mirtazapine is '*not recommended as a first-line treatment for depression*' in NICE CG133. The IPA advised NICE CG133 states

doctors '*should*' prescribe a selective serotonin reuptake inhibitor[12] (SSRI) '*in the first instance*', unless the patient is '*contraindicated*[13]'. The IPA said patients are more likely to switch onto Mirtazapine if they have '*not adequately responded*' to other anti-depressant medications.

50. The IPA advised there was '*no evidence*' in the patient's medical notes to '*suggest*' the patient '*was, or may have been, contraindicated*' in respect of SSRIs. The IPA said NICE CG133 does not specifically state it is inappropriate for a GP to prescribe this drug as a first-line treatment, but that it was '*unusual*' for GP A to have done so, in the absence of contraindication. The IPA also advised it was '*unclear*' from the medical records why GP A prescribed Mirtazapine and whether she discussed any alternative medications with the patient before prescribing it. The IPA said she would '*expect*' GP A to have recorded her rationale for prescribing Mirtazapine in the patient's medical notes.

51. I asked the IPA if GP A's decision to prescribe Mirtazapine to the patient was reasonable, appropriate and in line with relevant standards, given his medical history and presenting symptoms. The IPA advised GP A's decision was not specifically inappropriate, unreasonable or contrary to relevant standards. However, she advised that nonetheless, it *'may have been more appropriate*' for GP A to have prescribed a SSRI in the first instance, given the guidance in NICE CG133.

The Practice's decision to contact the PSNI on 27 April 2021

52. The IPA said GP B notified the PSNI on 27 April 2021 of his intention to conduct a joint assessment with the patient involving an ASW. The IPA advised this was reasonable, appropriate and in line with relevant standards. The IPA

[12] a class of drugs that are typically used as antidepressants in the treatment of major depressive disorder, anxiety disorders, and other psychological conditions.
[13] something (such as a symptom or condition) that is a medical reason for not doing or using something, such as a treatment, procedure, or activity.

advised '*it would be nice for the family to be aware of this*', but notifying the family is not required under the GAIN Guidance.

Analysis and Findings

Care and treatment the Practice provided to the patient on 27 April 2021

53. The Practice's records document that following a phone call from the patient's wife, the patient attended an in-person consultation with GP B and an ASW on 27 April 2021. This was to jointly assess if the patient met the *Article 4* criteria (Appendix five refers). The records document that following their assessment, GP B and the ASW did not consider the patient posed significant harm to himself or others. Therefore, he did not meet the criteria for admission to hospital.

54. The complainant raised concern with this decision. He said the Practice was '*dismissive*' of information the patient's wife provided. The complainant also said the Practice did not tell the patient's widow about the joint assessment, explain the purpose of it, or involve her in it. He raised further concern the Practice did not '*challenge*' the patient about ropes found in his house or his action of giving away his work uniform.

55. I firstly refer to the complainant's concern that GP B did not sufficiently consider the patient's wife's input. I note GP B made a record of his telephone call with the patient's wife. GP B then arranged a joint assessment to consider the *Article 4* criteria. The medical records evidence GP B discussed the information the patient's wife provided with the patient during the joint assessment. That being, the ropes the patient's wife found, the patient's decision to give his uniform away, and her concerns about suicidal ideation. I accept the IPA's advice it was reasonable and appropriate for GP B to have done so. Therefore, based on the records and the IPA's advice, I am satisfied that during the joint assessment, GP B appropriately considered information the patient's wife provided.

56. I refer to the complainant's concern the Practice did not involve the patient's wife in the process. I appreciate the patient's wife would have preferred for the

Practice to have explained what the assessment entailed and to have been present for it. I do not doubt she would have been able to contribute meaningfully to it. However, the IPA advised the decision to conduct the assessment without the patient's wife present was appropriate and in accordance with the GAIN Guidelines. I note that both this guidance and NICE CG86 state patients should attend the initial assessment alone. Therefore, I accept the IPA's advice. The GAIN Guidelines state the patient can specifically request that someone accompanies them during the assessment. However, there is no evidence the patient made such a request on this occasion. I am also satisfied the guidance did not require the Practice to explain the assessment to the patient's wife in advance.

57. I note the IPA advised GP B's record was '*unclear*' what communication, if any, he had with the patient's wife regarding the outcome of the joint assessment. GP B stated he did not speak with the patient's wife about this, which is why there is no record of such a conversation taking place. He explained *paragraph 18* of the GAIN Guidance sets out it is for the ASW, and not the GP, to communicate with a patient's family about the outcome of the joint assessment. I note this paragraph states '*the ASW is required under Article 40 (4) to provide the nearest relative with a written statement of the reasons for not applying for the patient's admission if the ASW has been acting on the request of the nearest relative*'. I am satisfied, therefore, it was not GP B's responsibility to communicate with the patient's wife on this occasion. GP B acknowledged it would have been best for him to have recorded in the patient's medical notes that the ASW communicated with the patient's wife. I agree with this and would encourage GP B to reflect on this going forward. However, I do not consider this amounts to failure in record-keeping.

58. I refer to the complainant's concern that GP B did not '*challenge*' the patient about his actions. The patient's medical records document GP B discussed issues relating to the ropes, his uniform and suicidal ideation with the patient during the joint assessment. I accept the IPA's advice it may not have been appropriate for GP B to have specifically '*challenged*' the patient on these issues, given his presenting symptoms. I note the IPA's advice GP B could

have discussed these issues with the patient at a later date although I note there was no requirement under the guidance to do so.

59. However, the IPA advised that GP B's record ought to have been clearer and more detailed. I note GP B's position that GPs are under considerable time constraints that limits, and that as a result it is not possible for GPs to keep '*verbatim*' records of consultations in medical notes. I acknowledge and understand the pressure GPs are under in this respect, and I have no expectation for GPs to keep '*verbatim*' records of their assessments. However, I also note *Standard 19* of the GMC Guidance, which requires doctors to record their work '*clearly, accurately and legibly*' and keep clinical records detailing decisions made. I consider that maintaining accurate and appropriate records affords protection to staff involved in a patient's care by providing a clear record of their actions and the treatment provided. The absence of a complete record prevents me from establishing the extent of GP B's discussion with the patient and his consideration of the issues discussed. I therefore accept the IPA's advice recording GP B's records. I am satisfied the absence of this detailed record did not impact care and treatment provided to the patient. However, I consider it a service failure.

60. The medical records document GP B made onward referrals for the patient with both the local hospital and the HTT. I accept the IPA's advice that GP B's actions in doing so were reasonable and appropriate.

61. I refer to the complainant's concern that the Practice did not correctly apply the *Article 4* criteria to the patient. I reviewed *Article 4* of the 1986 Order, which sets out two criteria a GP must apply when assessing a patient for admission to hospital. The first is whether the patient '*is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment*'. The second is whether '*failure to so detain him would create a substantial likelihood of serious physical harm to himself or to other persons*'. The DHSS Guide and the DHSS Code each state a GP must satisfy themselves a patient meets both criteria before recommending admission to hospital.

62. In terms of the first criterion, having reviewed the patient's medical notes, I am satisfied GP B discussed the patient's recent and past suicidal ideations with him, as well as his feelings of anxiety and paranoia. GP B also discussed the patient hanging ropes in his home, giving his uniform to his son, and seeing a psychologist. Having reviewed this record, and considered the IPA's advice, I am satisfied GP B considered the first criterion.

63. In terms of the second criterion, the patient's medical notes document GP B identified and discussed with the patient the key issues of concern he had regarding risk of self-harm. This was following his prior conversation with the patient's wife. The notes document GP B also asked the patient to explain his feelings and his understanding of his own risks. NICE CG16 requires GPs to explore these matters with a patient as part of applying the *Article 4* criteria. The notes also document GP B discussed the patient's current and past suicidal ideation, his current symptoms and the personal and social circumstances he was in at the time. Furthermore, GP B discussed the protective factors of the patient's significant relationship with family, particularly his grandchildren. NICE NG133 requires GPs to explore these factors when applying the *Article 4* criteria.

64. Having reviewed these records, and the IPA's advice, I am satisfied GP B met the requirements of NICE CG16 and NICE NG133 when he assessed the patient under the *Article 4* criteria.

65. Based on the IPA's advice, I am satisfied GP B's consideration of both criteria during the joint assessment was reasonable and appropriate. On this basis, I consider GP B also adhered to the relevant standards set out in the DHSS Guide and the DHSS Code.

66. Regarding the outcome of the joint assessment, the IPA advised that the decision the patient did not require admission to hospital for further assessment was reasonable, appropriate and in line with relevant standards. I accept her advice. Therefore, based on the evidence available, I have not identified a failure in the care and treatment provided to the patient regarding this decision.

67. I refer to GP B's actions following the assessment. *Part 2* of the GAIN Guidelines states that where the patient does not meet the *Article 4* criteria, GPs are required to explore alternative treatment options. I accept the IPA's advice that GP B put in place reasonable and appropriate referrals for the patient's ongoing care and support. However, the IPA also advised that in addition to these referrals, GP B should have explored voluntary admission for assessment as one of these alternative options. I note GP B's position that he could '*recall*' discussing this with the patient, and his reference to the ASW's report in support of this. GP B did not refer to any part of his notes in support of his position. I reviewed the ASW's report. It states '*Agreed with GP that the criteria for admission to Compulsory admission to hospital have not been met. Hospital not appropriate at present*'. Upon reviewing this in context, I do not consider that can reasonably be interpreted as representing a record of a discussion of voluntary admission. I therefore accept the IPA's advice in this respect. On foot of this advice, I consider GP B failed to comply fully with *Part 2* of the GAIN Guidelines regarding discussing the potential for voluntary admission as part of exploring alternative treatment options. Whilst I find the referrals GP B made to be reasonable and appropriate, I consider his failure to discuss the potential for voluntary admission to be a failure in the care and treatment provided to the patient.

68. In addition, I accept the IPA's advice that GP B should have produced a written plan setting out alternative treatments put in place for the patient and shared that plan with the patient and his wife. I also accept the IPA's advice that GP B should have identified and recorded a named person to have overall responsibility for that treatment plan. Both *part 2* of the GAIN Guidelines and *code 2.28* of the DHSS Code require GPs to put these provisions in place. I consider GP B failed to adhere to this guidance. Whilst I am satisfied GP B discussed the alternative treatment plan with the patient, he failed to provide the require details in writing. I note GP B's position that because the information was recorded on PARIS[14], it was no longer necessary to provide a written alternative treatment plan. I asked the IPA about this. She advised that whilst PARIS captures the type of information contained in such a plan, it is still '*good*

[14] Electronic care record system used by the health service in Northern Ireland.

practice' to provide a written plan in line with the Gain Guidance. As a result, I consider this a failure in the patient's care and treatment.

69. I consider these failures caused the patient the loss of opportunity to have full autonomy over his care and treatment. In addition, I consider it caused the patient a further loss of opportunity to have the reassurance of a written plan outlining his future treatment. Furthermore, I consider these failures caused both the patient and his wife to experience uncertainty and anxiety regarding his ongoing treatment.

70. I partially uphold this element of the complaint.

Care and treatment the Practice provided to the patient on 1 June 2021

71. The complainant raised concerns with the Practice's decision not to conduct a further joint assessment. He said the Practice did not consider the link between paranoia and suicidal ideations when making that decision. He said the Practice did not give sufficient consideration to the patient's wife's input, and took the patient's words at '*face value*'.

72. I refer to GP B's record of this consultation. I note the record documents GP B discussed both paranoia and self-harm with the patient. The IPA advised it was reasonable and appropriate for GP B to have done so. Therefore I am satisfied GP B considered both paranoia and self-harm during this consultation.

73. Regarding the patient's wife's input, the medical records document she raised concerns about the patient feeling paranoid. They document the patient's wife said the patient felt he was being '*followed*', '*watched*' and '*photographed*', but '*HAs [sic] not expressed any more thoughts of self harm*'. They document GP B then spoke with the patient by phone. GP B subsequently conducted a face-to-face consultation with the patient later that day, where he expressed feelings of '*paranoia*' and being '*watched*'. They document the patient's wife was present for this consultation. The IPA identified this also, and advised as a result, GP B considered the patient's wife's input as part of the consultation. She also advised it was reasonable and appropriate for GP B to have done so. I accept

her advice. I am satisfied, therefore, that GP B considered the patient's wife's input when treating the patient that day.

74. However, I note the IPA's advice that GP B's record of the consultation was '*unclear*' in terms of the extent of the discussion he had with the patient about his paranoia and risk of self-harm. She also advised that GP B's record contained '*insufficient detail*' of the extent of the consideration he gave to the patient's wife's input. Having reviewed the records for this consultation, I accept her advice.

75. I again refer to *standards 19-21* of the GMC Guidance, which require doctors to record their work '*clearly, accurately and legibly*' and keep clinical records detailing decisions made. Whilst I acknowledge the time constraints and pressures GPs work under, I nonetheless consider GP B failed to adhere to this standard in these respects. I do not consider it a failure in the care and treatment provided to the patient. I consider it a failure in record-keeping constituting a service failure. However, I consider neither the patient, nor his wife, sustained injustice as a result of it.

76. I refer to GP B's decision not to conduct a further joint assessment. I accept the IPA's advice that, despite the record keeping failure, GP B's decision was nonetheless reasonable and appropriate, given the patient's presenting symptoms that day. I appreciate the patient sadly took his own life a few hours after this consultation took place. However, I also appreciate GP could only base his decisions on the information presented to him during his interactions with the patient and his wife that day. That being, the patient experienced paranoia but had not expressed any new thoughts of self-harm or suicidal ideation. GP B then prescribed the patient medication to address his paranoia. Taking the IPA's advice into consideration, I am satisfied GP B would have been unable to predict what would transpire from the information he had to hand at the time. Therefore, on foot of the IPA's advice, I am satisfied GP B's decision was reasonable and appropriate.

77. I note the IPA's advice that GP B ought to have discussed voluntary or non-voluntary admission to hospital with the patient as an option, given the patient's

previous presentation on 27 April 2021. I also note GP B's comments that if non-voluntary admission were to be discussed, this would have bene part of a further joint assessment. Having considered the IPA's advice, I am satisfied GP B's decision not to hold a second joint assessment was reasonable, appropriate and in line with relevant standards. I am therefore also satisfied that, in this context, it would not have reasonably been necessary for GP B to have discussed non-voluntary admission on that day. Consequently, I am satisfied it would not have been reasonably necessary for GP B to have discussed voluntary admission with the patient on that day. I am satisfied this finding is consistent with the IPA's advice that a second joint assessment on this day was not necessary.

78. I refer to the alternative treatment plan GP B put in place. I accept the IPA's advice that GP B's prescription and referral for the patient were reasonable and appropriate. The then IPA referred to *Part 2* of the GAIN Guidelines and advised that GP B failed to document a written alternative treatment plan on this occasion also. She advised GP B failed to identify and document the name of a nominated individual responsible for the plan and provide copies of that plan to the patient and his wife. However, I note GP B's comments that because this consultation was not a joint consultation under the GAIN Guidance, the requirement to put a written plan in place, and provide it to the complainant did not apply. I obtained further advice from the IPA in this respect. The IPA ultimately advised that GP B would only have been required to take these steps if he can conducted a joint consultation on that date.

79. Nonetheless, I am mindful of Standard 32 of the GMC Guidance that requires doctors to give patients the information they want or need to know, in a way they understand. Standard 49 requires doctors to share information with patients that they need to make decisions about their care, which includes information about who is responsible for each aspect of their care. The GMC Standards do not state this information must be written down. I consider it would have been beneficial for the patient if GP B had provided a written alternative treatment plan on this occasion. However, having considered all

relevant documentation, including GP B's comments and the IPA's further advice, I am satisfied GP B was not required to do so.

80. I therefore partially uphold this element of the complaint, to reflect that whilst there was no failure in care and treatment, there was failure in record-keeping that constitutes a service failure. However, I encourage GP B to reflect on my observation that it would have been beneficial for the patient to provide a written alternative treatment plan on this occasion.

The Practice's decision to prescribe the drug Mirtazapine to the patient

81. I reviewed the patient's medical records. GP A prescribed the patient Mirtazapine on 15 April 2021. I note the records document that GP A '*discussed trial Mirtazapine and explained SE[15]s including risks of drowsiness into the following day and pt happy to proceed*'.

82. The IPA referred to the BNF Extract and identified Mirtazapine as an anti-depressant. I accept the IPA's advice it lists '*anxiety*' as a more common side-effect of the medication, and '*suicidal behaviours*' as a side-effect of '*unknown frequency*'.

83. I refer to NICE CG133, which states '*when considering antidepressants, selective serotonin reuptake inhibitors (SSRIs) may be preferred because they are less toxic than other classes of antidepressants*'. The IPA advised that as Mirtazapine is not a SSRI, it may not be the '*preferred*' anti-depressant for patients not contraindicated for SSRIs. I note the IPA's advice there is '*no evidence*' in the patient's medical records to suggest he was contraindicated for SSRIs. Therefore, she consider it '*unusual*' for GP A to have prescribed it to the patient as a '*first-line of treatment*'.

84. However, the IPA further advised that NICE CG133 does not prohibit prescribing Mirtazapine as a first line treatment. Therefore, I do not consider GP A's decision to do so contrary to relevant standards or that it amounts to a failure in care and treatment. However, by way of observation, I encourage the Practice to reflect on the IPA's advice that GP A's decision was '*unusual*'. I also

[15] Side Effects

ask it to take this into consideration when prescribing anti-depressant medications in the future.

85. In terms of record-keeping, I am satisfied GP A discussed Mirtazapine with the patient, and the side-effects associated with it. However, I note GP A did not record why she decided to prescribe Mirtazapine, and did not record whether she considered any alternatives before doing so. As a result, it is not apparent why GP A opted to prescribe Mirtazapine rather than a SSRI. I accept the IPA's advice that GP A should have recorded these considerations in the patient's medical notes – particularly where there is no evidence to suggest the patient was contraindicated in respect of SSRIs.

86. I again refer to the GMC Guidance, which requires GPs to record their work '*clearly accurately and legibly*'. This includes '*decisions made and actions agreed*', as well as '*any drugs prescribed*'. GP A may have had a valid reason for prescribing this medication. However, the absence of this records prevents me from establishing the reasons for her decision. I find GP A failed to adhere to these standards when she did not record why she prescribed Mirtazapine for the patient rather than an SSRI. I consider this a service failure.

87. The complainant explained the patient's wife was concerned if this medication was '*safe*' for the patient to take given his symptoms at that time. While I did not find a failure in the decision to prescribe the medication, I consider a record outlining the reasons for the decision would have helped alleviate some of the patient's wife's concerns. Therefore, I am satisfied this failure caused the patient's wife to experience uncertainty and anxiety regarding the decision.

88. I therefore partially uphold this element of the complaint.

The Practice's decision to contact the PSNI on 27 April 2021

89. Having reviewed all relevant evidence, including the IPA's advice, I am satisfied GP B contacted the PSNI on 27 April 2021 to notify them he was to conduct the joint assessment. I am also satisfied GP B did not ask the PSNI to attend the Practice at any point before, during or after the joint assessment.

90. *Part 2* of the GAIN Guidance (Appendix five refers) sets out that clinicians should not '*routinely*' ask the PSNI to attend joint assessments. The PSNI should only attend where there is a risk of resistance. I note the complainant's position in his comments that this means GP B should not have notified the PSNI about this joint assessment. However, the guidance does not specifically require a clinician to notify the PSNI of a joint assessment, but it does not prohibit it either.

91. On this basis, I am satisfied GP B's action of notifying the PSNI was not contrary to relevant standards. I also accept the IPA's advice that it was reasonable and appropriate in the circumstances for GP B to have notified the PSNI. I therefore do not uphold this element of the complaint.

92. The complainant was also concerned that GP B did not inform the patient or his wife that he notified the PSNI. I note the guidance does not require GPs to do so. Therefore, I accept the IPA's advice that GP B's actions were in accordance with relevant standards.

93. However, I note the IPA's advice it would have been '*nice for the family to be aware of this*'. I consider this advice to be particularly pertinent given he had paranoia and anxiety about the police watching him. I encourage GP B to reflect on this observation and take it into consideration when making such decisions in the future.

Issue One Summary

94. On foot of the above findings, I partially uphold issue one of the complaint.

Issue 2 - Whether the Practice appropriately handled the complainant's original complaint dated 22 September 2021?

In particular, this will consider:

- **Whether the investigation into the complaint was conducted in an impartial, objective and fair manner by a suitable person;**

- **Whether the investigation into the complaint was conducted in line with the Practice's investigation methodology;**
- **Whether the Practice kept the complainant appropriately informed of the timescales associated with the investigation; and**
- **Whether the Practice sought the complainant's agreement to a copy of her complaint being forwarded to the HSC Board.**

Detail of Complaint

95. The complainant said the Practice failed to handle the patient's wife's complaint (the complaint) in line with the DOH Guidance, and its own complaints protocol. In particular, the complainant raised concerns about the following aspects of the Practice's handling of the complaint:

- The Practice failed to appoint a suitable person to investigate the complaint which impacted upon the impartiality, objectivity, fairness and consistency of the process;
- The Practice did not discuss the complaint with the patient's wife initially;
- The Practice did not '*advise*' the patient's wife of timescales for addressing her complaint;
- The Practice was not sufficiently '*supportive*' of the patient's wife;
- The Practice did not follow its investigation methodology and so failed to respond to the points raised in the complaint in an accurate and consistent manner;
- The Practice did not consider seeking input from independent experts as part of its investigation; and
- The Practice did not '*seek*' the patient's wife's '*agreement*' to share her complaint with the Health and Social Care Board.

Evidence Considered

Legislation/Policies/Guidance

96. I referred to the following policies and guidance which I considered as part of investigation enquiries:
    - DoH Guidance;
    - Complaints Protocol;
    - Complaints Leaflet;
    - HSCB Circular; and
    - GMC Guidance.

I enclose extracts from the above at Appendix five to this Report.

The Practice's response to investigation enquiries

97. Regarding a suitable person, the Practice explained GP B '*conducted the investigation*' into the patient's wife's complaint, '*assisted by the Practice Manager*' in her '*role as Complaints Manager*'. The Practice explained GP B was a '*GP Partner*' in the Practice.

98. The Practice said its Complaints Protocol states if a complaint is '*clinical in nature*' it should be dealt with by a '*Practice Partner who is not subject to the complaint*'. The Practice acknowledged GP B was subject to the complaint and it therefore '*deviated*' from the Complaints Protocol. The Practice explained it considered that GP B was the '*appropriate person*' to '*take the lead*' in investigating the complaint. It said this was due to '*extenuating circumstances*' such as it being a '*small rural healthcare organisation*', '*circumstances in the partnership at the time*' and the impact of the COVID-19 pandemic. The Practice explained it felt '*this approach*' would '*allow the complaint to be investigated in a comprehensive and expedient manner*'.

99. Regarding its investigative approach, the Practice set out the steps it took when it investigated the complaint. The Practice explained the GPs '*undertook a detailed review*' of the patient's clinical notes '*supported by the Practice Manager*'. The Practice said the GPs reviewed relevant telephone calls, as well as the GAIN Guidance and the BNF Extract relating to Mirtazapine. The

Practice explained the GPs '*individually reflected on the care they provided*' and '*discussed their respective approaches*' to treating the patient together.

100. The Practice explained this process allowed it to prepare a '*detailed response*'. It said the Practice Partners reviewed the response before it issued it on 3 December 2021. The Practice said the GPs did not keep any records of these discussions and reviews.

101. Regarding timescales, the Practice explained it was under '*significant pressure*' during this time due to the impact of the COVID-19 pandemic. The Practice provided the investigation with a copy of the HSCB Circular, and said this set out that '*certain requirements*' in the DOH Guidance could be '*relaxed*' due to the '*impact*' of COVID-19. The Practice acknowledged the HSCB Circular required the Practice to ensure complainants were '*kept as up to date as possible*' regarding the status of complaint investigation. The Practice explained it '*endeavoured to keep [the patient's wife] informed as to the status of their investigation into her complaint*'.

102. Regarding the HSC Board, the Practice said it provided an anonymised copy of the patient's wife's complaint to the HSC Board in line with the requirements in *paragraphs 4.14 – 4.16* of the DOH Guidance. The Practice explained it sets out in its Complaints Protocol it will do so, and therefore '*the view was taken that "agreement" of the complainant is not required*'.

Analysis and Findings

103. Regarding a suitable person, *paragraph 3.26* of the DOH Guidance states an investigation should be conducted by a '*suitable person*' the Practice appoints. It then states investigations '*should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner*' and '*must uphold the principles of fairness and consistency*'.

104. The Complaints Protocol states when the Practice receives a complaint, the Practice Manager will '*discuss with one of the Partners*' whether it is administrative or clinical in nature. It states the Practice Manager will

investigate administrative complaints, and a '*Partner not subject to the complaint*' will investigate clinical complaints.

105. Having reviewed all relevant evidence, I note the Practice handled the patient's wife's complaint as a clinical complaint, and appointed GP B to investigate. I am satisfied GP B was the subject of the substance of the complaint.

106. I note the '*extenuating circumstances*' the Practice referred to. However, I also note there are Partners in the Practice other than GP B and GP A. Therefore, there are other Partners who could potentially have investigated the complaint. When commenting on the draft investigation report GP B explained that whilst there were other partners available, three had only recently taken up their posts, one was preparing to retire, and one was not in a position to take on an investigation. He stated on this basis, the Practice decided these partners would not be appropriate to investigate the complaint. I note this position. However, the Practice also had the option to seek outside support from the (then) Health and Social Care Board to investigate the complaint. I also consider it could potentially have been beneficial for a new partner to the Practice to conduct the investigation, to demonstrate impartiality and objectivity. Therefore whilst I note the '*exceptional circumstances*' the Practice and GP B outlined, both in its response to my Office's initial enquiries and in comments on the draft investigation report, I do not consider they constitute reasonable justification for the Practice's departure from its Complaints Protocol.

107. I find, therefore, GP B was not a '*suitable person*' to investigate the complaint and I am surprised that the Practice viewed him as such. I consider the Practice's actions in appointing him impacted upon the impartiality and objectivity of the investigation process and failed to uphold the values of fairness and consistency, as the DOH Guidance requires.

108. Regarding initial communication with the patient's wife, the DOH Guidance requires the Practice to '*involve the complainant from the outset*' and '*seek to determine what they are hoping to achieve from the process*'. It requires the Practice treat complainants '*sympathetically*' and involve them in the decision about how their complaint is '*handled and considered*'. It requires the Practice

to involve the complainant throughout the complaints handling process, and to '*discuss*' its approach to the complaint.

109. In addition, the Practice's Complaints Protocol states it will contact the complainant '*as soon as possible*' on receipt of a complaint for an '*initial informal discussion*' before commencing a formal investigation. It states the investigator will '*engage with people involved*', which includes the complainant.

110. Having reviewed all relevant documentation, I am satisfied the Practice acknowledged the patient's wife's complaint at the outset of the process. However, the Practice failed to contact the patient's wife for an initial discussion regarding the complaint, to discuss how it was going to handle the investigation and involve her in it, and to seek more information on what she wanted from the process. I consider the Practice should have done so in line with its Complaints Protocol. I acknowledge the patient's wife set out her desired remedies in her complaint letter. However, I consider the Practice should have discussed these with the complainant at the outset. In the course of this investigation, the Practice liaised with the Coroner about the appropriateness of it responding whilst the Coroner's verdict on the patient's death was outstanding. The Practice eventually told the complainant it had done so. However, there was no discussion of this with the patient's wife in advance. I consider the Practice should have done so as it related to how the Practice intended to handle the complaint.

111. I consider, therefore, the Practice failed to comply with the DOH Guidance and its own Complaints Protocol in its initial communication with the patient's wife.

112. Regarding communication with the patient's wife about timescales, the DOH Guidance and the Complaints Protocol required the Practice to '*keep the complainant informed*' of '*progress*' and '*anticipated timescales*' at each stage of its investigation into a complaint. It states the Practice should discuss timescale at an early stage, particularly if it expects the investigation to take longer than the defined timeframe. The guidance requires the Practice to '*provide the complainant with an explanation*' for not meeting its timescales, and to update the complainant on its progress every 20 working days. The

HSCB Circular required the Practice to '*make complainants aware*' of any COVID-19 related delays, but that it must still investigate complaints in line with DOH Guidance.

113. Upon review of the relevant complaint documentation, I note as follows:

- 22 September 2021 – the patient's wife lodged her complaint;
- 27 September 2021 – the Practice acknowledged the complaint. The Practice did not indicate in this letter the investigation may take longer than the timeframe set out in the Complaints Protocol, whether due to COVID-19 or the complexity of the concerns raised;
- 13 October 2021- the Practice wrote to the complainant with a query, but provided no information regarding timeframe or delay;
- 29 October 2021 - the Practice wrote to the patient's wife to apologise for its delay in providing a response, and to explain its contact with the Coroner. However, it did not provide an estimated extended timeframe for the investigation, or when it would provide a further update on the investigation.
- 24 November 2021 - the Practice wrote to the patient's wife to explain the Coroner authorised the Practice to respond to the complaint. The Practice said it would issue a response '*shortly*'. However, it did not provide an estimated timeframe for the response, or when it would provide a further update on the investigation to the patient's wife.
- 3 December 2021 – the Practice issued its response. The patient's wife said she received it on 16 December 2021.

114. I accept it may not always be possible for a Practice to fully respond to a complaint within the stated 20 day timeframe. This is especially given the increased pressure the Practice likely experienced during the pandemic. However, I consider the Practice ought to have anticipated that an extension to the target timescale was required. Furthermore, it ought to have advised the patient's wife of the reason for the delay and a revised timescale in accordance

with the guidance. However, it failed to do so. As a consequence, I consider the Practice also failed to provide the patient's wife with sufficient support during the complaints process, as the DOH Guidance requires.

115. Regarding its investigative approach, the DOH Guidance requires the Practice to have a '*clear system to ensure an appropriate level of investigation*'. It states the Practice should use a '*range of investigating techniques*' that are '*appropriate to the nature of the complaint and to the needs of the complainant*' to make findings of fact and to identify any shortcomings. It sets out the Practice's response must '*address the concerns expressed by the complainant and show that each element has been fully and fairly investigated*'.

116. In the Complaints Protocol, the Practice sets out its investigation methodology as to '*gather and review all relevant information*', which includes '*service user notes/case file*', as well as '*relevant policies /procedures/ standards*'. In terms of record-keeping, the Complaints Protocol states the Practice will keep '*a detailed record of the complaint, investigation and outcome*' to include all correspondence and minutes of any meetings. The Complaints Protocol and Leaflet both state the Practice will '*address the concerns expressed*' and '*provide patients with an explanation for what has happened*'.

117. In the original complaint, the patient's wife said she wanted a '*full investigation*' into the concerns she raised. Having reviewed the response, I am satisfied the Practice provided information to address the concerns the patient's wife raised, and to provide explanations for actions it took. However, I consider there are shortcomings in the robustness of the Practice's investigative approach that failed to adhere to relevant standards.

118. The Practice said the GPs undertook a detailed review of the clinical notes, reflected on the care they provided, discussed their respective approaches to treating the patient together, and reviewed the relevant standards. However, the Practice did not keep any records of the investigation process to support this position. This is not in accordance with its Complaints Protocol. The records evidence that the only document produced to demonstrate the investigation the Practice conducted is its response. Whilst this reflects the

outcome to the investigation, it is not indicative of the methodology applied, and does not set out detail of the approach the Practice took to the investigation, or the weight it applied to various factors. Due to the absence of documentation to support the investigation, I cannot reasonably conclude that the response was fully accurate, as the DOH Guidance requires.

119. In addition, due to the investigator being the subject of the complaint, I cannot reasonably conclude that the response was balanced, as the DOH Guidance requires.

120. Regarding independent experts, the DOH Guidance permits the Practice, in '*collaboration*' with the complainant, to '*call upon the services of others*' to assist in its investigation. This includes the use of '*independent experts*', who '*may be considered beneficial*' to '*give an independent perspective on clinical issues*'.

121. The guidance permits the Practice to determine how it will approach an investigation, as long as it meets relevant standards. In addition, the guidance does not require the Practice to consider independent experts. However, it requires it to ensure its investigation is objective, fair and balanced. It is of concern to me that on this occasion, the individual assigned to conduct the investigation was himself subject to the complaint. I therefore consider the Practice ought to have explored involving an independent expert in its investigation, and ought to have discussed it with the complainant at the outset, to ensure its investigation met these requirements.

122. Regarding the HSC Board, the DOH Guidance and the Complaints Protocol required the Practice to provide an anonymised copy of the complaint and response '*within 3 working days of the response being issued*'. The Practice must '*ensure that the complainant is aware and agrees to his/her complaint being forwarded to the HSC Board*'.

123. The Practice's Complaints Leaflet states '*please be aware that anonymised copies of all written complaints received and responded to directly at Practice level will be forwarded to the Health and Social Care Board for monitoring*

purposes. If you do not wish for your documentation to be provided to the HSCB you should let the Practice know'.

124. Having reviewed all relevant evidence, I note the Practice did not specifically seek the patient's wife's express agreement to provide the HSC Board with a copy of her complaint. However, I am satisfied the Practice was clear in its Complaints Leaflet that it intended to share a copy of the complaint with the HSC Board, and if the patient's wife objected to this, she could let the Practice know. I note the Practice provided a copy of the Complaints Leaflet to the patient's wife on 27 September 2021. I also note there is no record of the patient's wife making such an objection as part of the internal complaints process. Therefore, I am satisfied the Practice did notify the patient's wife of its intentions albeit as part of a general information leaflet.

125. The first Principle of Good Complaints Handling, '*getting it right*', requires a public body to adhere to relevant policies and standards, including its own, and to take account of established good practice. In addition, the fourth Principle of Good Complaints Handling '*acting fairly and proportionately*', requires a public body to ensure complaints are investigated thoroughly and fairly, handled by an individual not subject to the complaint, and that actions are proportionate, appropriate and fair. I consider the Practice failed to adhere to these Principles in the manner in which it handled the patient's wife's complaint.

126. I consider the failure to appropriately handle the complaint constitutes maladministration. I am satisfied it caused the patient's wife to experience uncertainty and frustration, as well as the loss of opportunity to have her complaint handled in line with the Practice's Complaints Protocol. Furthermore, it caused the complainant and the patient's wife the time and effort of bringing this complaint to my Office.

127. Therefore, I uphold issue two of the complaint.

CONCLUSION

128. I received a complaint about care and treatment the Practice provided to the patient during the period 15 April 2021 to 1 June 2021. It was also about how the Practice handled the complaint.

129. In respect of issue one, the investigation established as follows:

- GP B's handling of the joint assessment on 27 April 2021, including notifying the PSNI, was reasonable, appropriate and in line with relevant standards. However, there was a failure in care and treatment regarding the alternative treatment plan he put in place for the patient. There were also failures in record-keeping that constituted service failures.

- GP B's decision that a second joint assessment was not necessary on 1 June 2021 was reasonable, appropriate and in line with relevant standards. GP B therefore provided reasonable and appropriate care and treatment to the patient on this occasion. However, there was a failure in record-keeping which constituted a service failure; and

- The care and treatment GP A provided to the patient was reasonable, appropriate and in line with relevant standards. However, there was a failure in record-keeping.

130. The failures in care and treatment caused the patient and his wife to sustain the injustice of experience uncertainty and anxiety. The patient also sustained loss of opportunity. However, I am satisfied the failures in record-keeping did not cause either the patient or his wife to sustain injustice.

131. In respect of issue two, the investigation established there were failures in complaint handling. These failures constituted maladministration and caused the patient's wife to sustain the injustice of uncertainty, frustration, and loss of opportunity. They also caused the patient's wife and the complainant the time and effort of bringing this complaint to my Office.

132. Therefore, I partially uphold issue one of the complaint and I fully uphold issue two.

Recommendations

133. I recommend that the Practice provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (August 2019), for the injustices caused as a result of the failures identified within **one month** of the date of the final report.

134. I further recommend, for service improvement and to prevent future reoccurrence, that the Practice:

I. brings the contents of this report, and the learnings identified in it, to the attention of relevant staff who provided care and treatment so they can reflect on the findings;

II. brings the contents of this report, and the learnings identified in it, to the attention of all staff involved in handling complaints, including Partners, so they can reflect on the findings set out;

III. Provide training to relevant staff to include the following:

- The importance of adhering to the GAIN Guidance regarding alternative treatment plans for patients considered not to meet the *Article 4 criteria*;
- The important of adhering to *sections 19-21* of the GMC Guidance regarding record-keeping; and
- Complaints handling

IV. implements an action plan to incorporate these recommendations and provide me with an update within **six months** of the date of my final report. The Practice should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any relevant policies).

135. Finally, I wish to offer my condolences to the patient's wife, and to her family, following the death of her husband. It is clear that the patient's wife did her best to seek the best care and treatment for her husband in very worrying circumstances. I hope my report goes some way to address the concerns the

complainant identified and provide some reassurance for the patient's wife and her family.

MARGARET KELLY
Ombudsman
17 April 2024

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing 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 where appropriate 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 and actions 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 learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.