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

Report Reference: 202002477

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

The Role of the Ombudsman

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

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

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

TABLE OF CONTENTS

Page

Case Reference: 202002477
Listed Authority: Northern Health and Social Care Trust

SUMMARY

This complaint was about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's mother (the patient) between 28 October and 1 November 2020. The complainant questioned whether the Trust's decision to put in place a Do Not Attempt Cardiopulmonary Resuscitation[1] (DNACPR) order on 28 October 2020 was appropriate for the patient. She also questioned whether the Trust appropriately involved the family in that decision-making process. The complainant raised further concerns with the complaints process, which she said was lengthy and failed to address all concerns in full.

The investigation found the Trust's decision to put in place the DNACPR, and the process it followed, appropriate and in line with guidance. I appreciate this was an incredibly difficult time for the complainant and her family. I hope this report provides some reassurance that the clinicians followed the appropriate process.

The investigation identified maladministration in the Trust's handling of the complaint. This was due to the Trust's considerable delay in completing the complaints process and its failure to update the complainant during this time. The complainant was also concerned the Trust did not tell her if the patient was alone when she died. The investigation found the Trust did not provide a full and clear response to her concern. I recognised the importance for the complainant to have an answer to her question. I asked the Trust to respond to the complainant's concern.

I also recommended the Trust apologise to the complainant for the injustice she sustained, and actions for it to take to prevent these failures recurring.

[1] DNACPR - If a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or shouldn't be taken by a healthcare professional, including not performing CPR on the person.

THE COMPLAINT

1. I received a complaint about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's late mother (the patient) from 28 October 2020 to 1 November 2020. The complainant said the Trust put in place a Do Not Attempt Cardiopulmonary Resuscitation[2] (DNACPR) without consulting the patient's family. The complainant disagreed with the Trust that the patient had capacity to make this decision herself.

2. The complainant also raised concerns about the Trust's handling of her complaint.

Background

3. On 28 October 2020, the patient was admitted to Antrim Area Hospital via ambulance at approximately 20.45 after testing positive for Covid-19. On 29 October 2020 at 05.20, a doctor explained the DNACPR process to the patient.

4. The Trust sought a respiratory specialist's opinion on CPAP[3] (continuous positive airway pressure) options to consider if this was a viable option for the patient. It informed the family on 1 November 2020 that the patient would not be able to tolerate higher oxygen delivery systems (including CPAP).

5. At approximately 12.30 on 1 November 2020, the family were informed the patient's health had deteriorated and she was not tolerating food or liquids. The patient sadly died that evening at 21.05. The family were not present with the patient due to Covid-19 restrictions.

6. A full chronology is enclosed at Appendix four to this report.

Issue of complaint

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

---

[3] CPAP (continuous positive airway pressure) is a machine that uses mild air pressure to keep breathing airways open while you sleep.

Issue one:

- **Whether the Trust's actions surrounding a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order for the patient on 28 October 2020 was appropriate and in accordance with relevant standards and guidance.**
  This will include examination of the Trust's decision to seek consent from the patient for DNACPR and the family's input into the DNACPR decision.

Issue two:

- **Whether the Trust handled the complaint appropriately and in accordance with relevant guidance.**

INVESTIGATION METHODOLOGY

8. 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 included information relating to the Trust's complaints process.

Independent Professional Advice Sought

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

    - A consultant Physician in Acute Internal Medicine (MBiochem(Oxon), BMBCh(Oxon), FRCP(Edin), MMedSci(ClinEd), CMgr FCMI) (C IPA) . Divisional Director for Medicine and Director of unplanned care at a large NHS Trust, responsible for the delivery of the medical services across two large and three smaller hospitals.

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

Relevant Standards and Guidance

11. 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[4]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

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

13. The specific standards and guidance relevant to this complaint are:

    - The General Medical Council's Good Medical Practice, as updated April 2019 (GMC Guidance);
    - The General Medical Council's Guidance on professional standards and ethics for doctors: Decision Making and Consent, September 2020 (GMC Guidance on Consent);
    - British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing - Decisions relating to cardiopulmonary resuscitation, 2016 (Resuscitation Guidelines);
    - The General Medical Council's Cardiopulmonary Resuscitation (CPR) Ethical Guidance, Treatment and care towards the end of life: good practice in decision making, July 2010 (GMC Ethical Guidance);
    - The Mental Health (Northern Ireland) Order 1986 (MH Order); and
    - National Institute for Health and Care Excellence (NICE) Guideline – Decision-making and mental capacity [NG108], 3 October 2018

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

(NICE NG108).

14. I enclose relevant sections of the guidance considered at Appendix four to this report.

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

16. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue one:

- **Whether the Trust's actions surrounding a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order for the patient on 28 October 2020 was appropriate and in accordance with relevant standards and guidance.**
  This will include examination of the Trust's decision to seek consent from the patient for DNACPR and the family's input into the DNACPR decision.

Detail of Complaint

17. The complainant raised concern with the Trust's decision to seek the patient's consent for DNACPR following her admission to hospital on 28 October 2020. The complainant did not believe the patient had sufficient capacity to make a decision on DNACPR. She said that during her Facetime call with the patient, before the ambulance took her to hospital, she *'had no capacity to understand which daughter I was let alone understand a doctor explaining a DNACPR process to her at 05.20'.* The complainant believes the patient did not sign any DNACPR forms and the family should have been involved in this decision making.
18. The complainant said the Trust was still considering treatment options for the patient (including CPAP) however these did not take place. The complainant

believed the doctor made a *'terminal decision'* in placing a DNACPR on her mother, which she said was based on her age and clinicians' prioritisation of other Covid-19 patients in the hospital.

Evidence Considered

Legislation/Policies/Guidance

19. I considered the following policies and guidance:
    - GMC Guidance;
    - GMC Guidance on Consent;
    - Covid Guidelines;
    - Resuscitation Guidelines;
    - MH Order; and
    - NICE NG108.

The Trust's response

Trust's decision to place DNACPR on the patient.

20. The Trust stated it admitted the patient with bilateral pneumonia[5] on 28 October 2020. The patient was '*COVID positive'* on admission.

21. The Trust stated it discussed and agreed care needs with the patient on admission. The Consultant Physician for the Trust confirmed that a DNACPR order was in place for the patient. Whilst the DNACPR order was in place, the Consultant Physician stated it considered all treatment options. *'This did not mean the patient was not actively treated but should the patient's heart stop then the medical team would not attempt to restart the heart…medical staff feel it is important to discuss this with patients at an early stage and have an agreed plan in place should there be further deterioration'*

22. The Trust stated where a patient is deemed to have capacity, medical staff discuss resuscitation with the patient to obtain their views. The issue of

[5] Bilateral pneumonia is a serious infection that can inflame and scar your lungs. It affects the tissue around the tiny air sacs in your lungs. You can get this type of pneumonia as a result of COVID-19. Bilateral types of pneumonia affect both lungs.

capacity *'is a complex issue and is specific to the issue that is being discussed and specific to that period of time'*. In relation to agreeing to the DNACPR, a Consultant Physician reviewed the patient after admission and considered *'[the patient] had the capacity to make that decision'*. It would not have been appropriate to have repeated discussions regarding DNACPR.

23. The Trust stated there are several factors that *'contribute to the decision making regarding DNACPR and the decision for DNACPR was done on the basis that [the patient] was not a suitable candidate for ICU/HDU[6]'*. This was based on her comorbidities[7], exercise tolerance and her physical state. The chances of a successful resuscitation and outcome after admission to ICU would be very low based on her underlying health condition. Without ICU, most resuscitation attempts are '*futile*' as per evidence-based medicine. DNACPR was a multidisciplinary team decision, taken by a senior trainee doctor and agreed the following day by the Consultant Physician in charge.

24. The Trust stated whilst there was a DNACPR order in place, *'all possible options were considered along with a respiratory specialist opinion who did agree that she would not be able to tolerate higher oxygen delivery systems like CPAP'*.

25. The Trust stated the medical death certificate recorded the cause of death as Type 1 Respiratory Failure,[8] Bilateral Community Acquired Pneumonia and Covid-19 infection.

[6] Intensive Care Unit/High Dependency Unit
[7] Comorbidity occurs when a person has more than one disease or condition at the same time. Conditions described as comorbidities are often chronic or long-term conditions.
[8] Type 1 respiratory failure occurs when the respiratory system cannot adequately provide oxygen to the body.

Family input into DNACPR decision.

26. The Trust recognised it was *'good practice for medical staff to discuss the DNACPR decision with family but unfortunately this is not always possible, and the decision is ultimately a medical decision and neither the patient nor family are required to sign the DNACPR form'.* As per medical notes, the doctor recorded a conversation on 1 November 2020 with the patient's daughter. The notes document, '*Family update, discussed with daughter, informed that the Patient is critically unwell, not doing well on maximum double flow oxygen, blood showing critical lack of oxygen in the blood, informed daughter that she is on the ceiling of care and not able for CPAP or ICU for mechanical ventilation, informed that we will continue with maximum double flow oxygen and giving medication, if the patient deteriorates further it will be comfort care'.* The notes record the daughter understands and agrees with the plan.

27. The Trust stated the patient was in hospital at the height of the COVID-19 pandemic. This presented challenges and difficulties, particularly with communication with hospital staff due to the imposed visiting restrictions. The restriction on families being allowed to visit patients added *'anxiety for everyone'*.

28. The Trust stated it developed the use of the *'Family Liaison Service to assist ward staff in providing ongoing updates in relation to patients' condition and also assisting in promoting the use of virtual visiting'*. It developed the Family Liaison Service and purchased electronic tablets towards the end of 2020 to enable staff to update families, this promoted virtual visiting. This service was not always available as it was mainly facilitated by staff working additional hours. The Trust apologises that this was not offered.

29. The nurse in charge on the patient's ward agreed to permit visiting for family members. However, the patient's condition deteriorated. The Trust stated it was *'sorry the efforts we had taken to communicate seem to have failed at times for you and your family and apologise for the anxiety this caused'*.

Relevant Independent Professional Advice

30. The C IPA advised: *'a patient is deemed to have capacity by default unless a specific test called the 'two stage test' is performed which proves that they do not'.* The Trust did not need to undertake an Abbreviated Mental Test Score[9] (AMTS) for the patient as it would have no bearing on whether resuscitation would have worked or not.

31. The C IPA advised: appropriate information was gathered and the issue of DNACPR discussed with the patient. '*The key information needed was an understanding of how fit the patient was and whether this equated to any possibility of them surviving resuscitation successfully'*. The patient provided staff with this information when asked.

32. The C IPA advised: due to the patient's comorbidities and level of physiological reserve, she would have '*no chance'* of undergoing successful resuscitation. He referred to the Resuscitation Guidelines and advised *'[the patient] would fall under the guidance relating to those who had no prospect of successfully undergoing resuscitation'*. The decision for DNACPR is fully documented.

33. The C IPA advised: while the DNACPR was in place, staff considered other treatments and medications. On 30 October 2020, the patient was given dexamethasone[10]. This was standard treatment for those with Covid-19 who required oxygen at the time. Other treatments were considered and ruled out, the first being the drug remdesivir[11]. The second was CPAP. However, it was felt this was not in the patient's best interests. The reason for this was that CPAP is often used as a holding measure before more definitive treatments are used (such as being put on a breathing machine).

34. The C IPA advised: CPAP was one *'not likely to benefit the patient. It would also have been distressing and likely to prolong death (rather than give any*

[9] The Abbreviated Mental Test Score is a 10-point test for rapidly assessing elderly patients for the possibility of dementia. It is also used to assess for mental confusion (including delirium) and other cognitive impairments.
[10] Dexamethasone is similar to a natural hormone produced by your adrenal glands. It is often when your body does not make enough of it. It relieves inflammation (swelling, heat, redness, and pain) and is used to treat certain forms of arthritis; skin, blood, kidney, eye, thyroid, severe allergies; and asthma.
[11] Remdesivir is a drug used to treat COVID 19.

meaningful chance of life)'. Due to the patient's phsyiological state prior to admission, *'a breathing machine was not an option for them because they would not have survived'*. Regrettably, the patient catching Covid-19, and experiencing the severity of the infection they did, *'there were no treatments available that would have changed this'*.

35. The C IPA advised: based on the information provided, the Trust's actions in terms of the patient's care plan were reasonable and appropriate. *'A sensible ceiling of care was decided upon (Ward based care with supplementary oxygen and steroid treatment)'*.

36. The C IPA advised: *'there was no specific guidance in place regarding treatment at the time, however the decisions taken are in line with an acceptable standard of practice and similar decisions were made for many patients in similar circumstances'*.

37. There is no authority in law to discuss this decision with the family. It is those who have the expertise and experience who can judge *'whether a medical treatment would or would not be appropriate'*.

38. The C IPA advised: the care of the patient and the decision making throughout was appropriate and *'there are no deficiencies in judgement or treatment'*.

Complainant's response to the draft report

39. The complainant said her main concern was the '*respect and treatment'* of her mother.

40. The complainant referred to the Trust's position that the patient had capacity to make the DNACPR decision. She said the patient could not walk unaided, and the fact the patient told staff she could demonstrated she did not have '*full capacity*'.

41. The complainant said the Trust had no record of the DNACPR discussion. She understood the Trust's reasons for the DNACPR. However, she believed the manner in which the Trust dealt with the matter fell '*below any good practice'.*

42. The complainant believed the hospital made a '*terminal decision'* and that families in similar situations '*will be proved correct'* in the future. She said the Trust's decisions caused her, her family, and the patient '*trauma*'. The complainant believed that while the Trust may have made similar decision for others, it '*does not mean they were the correct decisions and do not equate to Acceptable standards of Practice, more like regrettable practices'.*

The Trust's response to the draft report

43. The Trust acknowledged this office's investigation was a *'comprehensive and transparent process'* and accepted its findings.

Analysis and Findings

44. I considered this issue in terms of the IPA's advice and guidance as well as the Trust's response to the complaint. In addition to this, I examined the relevant clinical records from the Trust and looked at the relevant policies and guidelines.

Trust's decision to place DNACPR on the patient.

45. The Trust stated that where a patient is deemed to have capacity, medical staff discuss resuscitation with them to obtain their views. The complainant was concerned that her mother did not have capacity to make a decision on DNACPR. In her response to the draft report, the complainant explained that as the patient told staff she could walk five metres unaided (which she could not), this evidenced she did not have capacity to make such a decision.

46. I considered the Trust's records relating to the patient's capacity to make the DNACPR decision. They document the Trust discussed individual care needs with the patient. The records also evidence the medical team and physiotherapist documented the patient was '*bright and alert'* and able to converse with the doctor. The Trust stated that a Consultant Physician

reviewed the patient after admission and based on the patient's responses, he considered *'[the patient] had the capacity'* to make the decision regarding DNACPR.

47. I refer to the GMC Guidance on Consent. Standard 81 states that doctors must start from the position that '*every adult patient has capacity to make decisions about their treatment and care'*. In relation to assessing capacity, Standard 82 states that doctors should '*draw reasonable conclusions about your patient's capacity during your dialogue with them'*. This includes asking the patient questions and considering their response. I appreciate the complainant's concern; especially given she believed the patient's responses evidenced she did not have capacity. However, the C IPA advised the records evidenced that staff based their decision on a number of questions rather than just the statement the complainant identified. The C IPA advised the patient's responses demonstrated her capacity. I accept his advice. Based on the evidence available, I consider staff acted in accordance with the GMC Guidance on Consent when establishing if the patient had capacity.

48. The complainant was also concerned with the Trust's decision to place a DNACPR on the patient. She explained that at the time doctors made the decision, they were still considering alternative treatment options for the patient.

49. I note that up until 1 November 2020, doctors were considering CPAP for the patient. However, they informed the family that they did not consider it suitable. The C IPA agreed with this decision. He advised the use of CPAP was one *'not likely to benefit the patient. It would also have been distressing and likely to prolong death (rather than give any meaningful chance of life)'*. I accept his advice. I also refer to the Resuscitation Guidelines which state that a DNACPR decision does not mean that clinicians will stop treatment of a patient; it only relates to the decision not to attempt CPR. Therefore, I do not consider that the decision to continue treatment during that time would have prevented clinicians from making the DNACPR decision.

50. I considered the Trust's decision making process for the DNACPR. I again refer to the Resuscitation Guidelines. They state:

'8.4 - The overall responsibility for making an advanced decision about CPR rests with the senior clinician (Doctor or Nurse) … He or she should always be prepared to discuss a DNACPR decision with other healthcare professionals involved in the patient's care. Foundation medical staff may complete the form but must consult with senior medical staff and document this'.*

51. The Trust records document the DNACPR was a multidisciplinary team decision, taken by a senior trainee doctor and agreed the following day by the Consultant Physician in charge. I note the C IPA's advice that the process was undertaken and recorded appropriately. I accept his advice and consider the action taken was in accordance with the Resuscitation Guidelines.

52. The Resuscitation Guidelines further state that a decision on whether to attempt CPR should be made '*only after careful consideration of all factors relevant to the patient's current situation'*. The C IPA advised that in making its decision, the Trust obtained key information to determine how fit the patient was and whether she would have survived resuscitation successfully. He further advised that the patient would not have survived a successful resuscitation due to her comorbidities and level of physiological reserve. Therefore, the C IPA considered the decision to put in place the DNACPR appropriate. I accept his advice.

53. Based on the evidence available to me, I have not identified a failure in the process the Trust followed when it put in place the DNACPR for the patient. I do not uphold this element of the complaint. I recognise the difficult circumstances the complainant and her family experienced. I hope that knowing staff made the DNACPR decision in accordance with guidelines and in the patient's best interests brings some reassurance for the complainant and her family.

Family input into DNACPR decision.

54. The complainant raised the concern that she nor any other member of her family were consulted with regarding the DNACPR. Therefore, they did not have any input into the decision.

55. I note the Resuscitation Guidelines state that *'making a decision not to attempt CPR that has no realistic prospect of success does not require the consent of those close to the patient'*. They further state that *'the patient and those close to the patient have no right to insist on receipt of treatment that is clinically inappropriate. Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate'*.

56. I note that in his advice, the C IPA referred to these guidelines and advised there is '*no authority in law'* to discuss the decision of DNACPR with the family.

    While there is no obligation for clinicians to seek consent from those close to the patient for such decisions, I consider it favourable to obtain their views before taking such medical decisions. I note the Trust stated it recognises it is *'good practice for medical staff to discuss the DNACPR decision with family but unfortunately this is not always possible'*.

57. I note the GMC Guidance on Consent states that clinicians should seek views of those close to the patient when making medical decisions. However, this is only in situations where they deem the patient does not have capacity. Given clinicians deemed the patient did have capacity, I do not consider the Trust had an obligation to seek input from the patient's family before putting the DNACPR in place. Although I fully appreciate why the family wished to input into this decision, I have not identified that the Trust failed in its care and treatment of the patient by not doing so. I do not uphold this element of the complaint.

Issue two:

- **Whether the Trust handled the complaint appropriately and in accordance with relevant guidance.**

Detail of the Complaint

58. The complainant said the Trust protracted the complaints process and it did not address her concerns in full. In particular, the complainant said the Trust did not respond to her question of whether the patient was alone when she died.

As a result, this prolonged the pain and angst the complainant and her family felt.

Evidence Considered

Legislation/Policies/Guidance

59. I considered the following guidance:
DOH Complaints Procedure; Point 8.7.

The Trust's response

60. The Trust received a complaint letter from the complainant on 15 September 2021, which it acknowledged on 17 September 2021.

61. The Trust provided an internal email from 28 September 2021, which stated that the complaint response was due to be shared with the Assistant Director by 12 October 2021, and the Director by 15 October 2021. The Trust was due to issue its response to the complainant by 26 October 2021.

62. The Trust stated: it responded to the complaint on 9 December 2021. The complainant sent follow up questions following receipt of its response. However, it was unable to resolve the complainant's concerns. On 31 March 2022, it offered to meet with the complainant, which she declined.

63. Regarding the issue of whether anyone was with the patient when she died, the Trust stated:
'There is a registered nurse assigned to the bay at all times. It is documented that after handover a nurse went into the bay and was with [the patient] when staff contacted the doctor to come to assess her as she appeared to be deteriorating'. The Trust stated this nurse was with the patient when she became unresponsive at 21.05.

The complainant's response to the draft report

64. The complainant welcomed the written apology for her family and the recommendation for the Trust to respond to complaints with an appropriate

timeframe. She said learning outcomes for the Trust should include *'communication with families'.*

Analysis and findings

65. I note the HSC Complaints Policy states that complaints *'will be investigated thoroughly, treated confidentially and responded to fully in writing within 20 working days'*. The complainant submitted her complaint on 15 September 2021. While the Trust made contact with the complainant on 17 September 2021, it did not provide its response until 9 December 2021; more than 60 working days following receipt of the complaint. I find this delay unacceptable.

66. Following the Trust's response on 9 December 2021, the complainant wrote to the Trust on 16 December 2021 and asked follow up questions. I note in this correspondence, the complainant asked if anyone was present with the patient when she died.

67. I note that following this, the Trust corresponded with the complainant to advise her of a delay in its response and to apologise for it. On 27 January 2022, the Trust offered to meet with the complainant. However, she declined, preferring a written response.

68. I note the Trust sent to the complainant a copy of the DNACPR process and its decision-making on 27 January 2022, to which the complainant asked further questions. The Trust provided a further response. However, the complainant felt the Trust's response did not answer if someone was with the patient when she died.

69. I accept it may not always be possible for the Trust to fully respond to a complaint within the stated 20 day timeframe. However, the DOH Complaints Procedure requires Trusts to notify complainants when it expects a delay, the reason for it, and when it expects to provide its response. Having considered the Trust's complaints file, I note that staff from the complaints team made significant efforts to seek updates on the process from those responsible for the investigation of the complaint. However, the team did not receive any meaningful updates that it could share with the complainant. This resulted in

the Trust not corresponding with the complainant during the 60 day period (until 9 December 2021). I am disappointed that those involved in the investigation of the complaint failed to demonstrate sufficient urgency to provide a response or meaningful updates. I consider that had the Trust updated the complainant, it may have provided her reassurance that it was considering her complaint.

70. I note the complainant's repeated requests for a response to her question as to whether someone was present with the patient when she died. I acknowledge the Trust's comments that a registered nurse was always assigned to the bay, and it is documented that after handover a nurse went into the bay and was with the patient. However, I do not consider it provided a definitive answer as to whether the patient was alone when she died. I am disappointed the Trust did not do so.

71. I understand this issue is very delicate and sensitive. The thought of anyone's loved one being alone when they die is extremely emotive. I recognise the difficult circumstances the Covid-19 pandemic caused, especially as it prevented family from being with loved ones at the end of their life. I also recognise that much of the impact of the pandemic was out of the Trust's control. However, by not addressing the complainant's concern with sufficient clarity, I consider it added to her upset and prevented her from resolving her concern.

72. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with '*complainants promptly and sensitively, bearing in mind their individual circumstances'*. I consider the Trust failed to meet these principles in its handling of the complaint. I am satisfied this constitutes maladministration. I consider this led to the complainant experiencing frustration, uncertainty and upset. I am also satisfied that it caused the complainant the time and trouble of bringing her complaint to my office.

CONCLUSION

73. I received a complaint regarding the actions of the Northern Health and Social Care Trust. The complaint concerned the care and treatment provided to the patient between 28 October 2020 and 1 November 2020. While I recognise the difficult circumstances the complainant and her family encountered during this time, I did not identify a failing in the care and treatment the Trust provided to the patient. I hope this brings an element of reassurance to the complainant and her family.

74. My investigation found maladministration in relation to the Trust's handling of the complaint. In particular, it identified that the complaints process experienced a significant delay and the Trust failed to update the complainant on its progress. It also established that the Trust failed to fully and clearly respond to the complainant's concern about whether the patient was alone when she died.

75. I am satisfied the failures identified caused the complainant to experience the injustice of frustration, uncertainty, and upset. I am also satisfied it caused the complainant the time and trouble of bringing her complaint to my office.

Recommendations

76. I recommend **within one month** of the date of this report:

    i. The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (July 2019), for the injustice experienced caused to her as a result of the maladministration identified; and

    ii. The Trust's Chief Executive reminds staff charged with the responsibility of investigating complaints of the need to provide clear, full and accurate responses to all issues of the complaint within a reasonable timeframe. This will enable the Trust to meet the target timeframe set out in relevant guidance. I further recommend that within **one month** of the date of this report, the Trust provides a full and clear response to the complainant's question as to whether anyone was with the patient when she died on 1 November 2020.

77. I recognise the effect the death of the patient had on the complainant and her family. Their grief and loss is very evident in their correspondence with both my office and the Trust. I hope this report goes some way to address the complainant's concerns. I also wish to offer my sincere condolences to the complainant and her family.

MARGARET KELLY
Ombudsman

April 2024

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 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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