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

Report Reference: 202002511

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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 actions of the Belfast Health & Social Care Trust (the Trust). The complaint was about the care and treatment the Trust provided to the complainant's father (the patient) between 6 December 2016 and 9 October 2017. The patient sadly passed away several days after his discharge from the ICU.

The investigation established the Trust failed to provide the patient with prehabilitation before surgery, to correctly stage his cancer and to adequately assess his fitness prior to deciding to operate. In addition, I concluded it was likely that a surgical error led to a leak from the patient's surgical join. I concluded that these failings led to a loss of opportunity for the patient. I am satisfied that the failures and losses of opportunity identified ultimately led to the patient's premature death. As a result of this I am satisfied that the complainant experienced the injustice of frustration, anxiety, distress, and uncertainty about the appropriateness of the care and treatment provided to his father in hospital.

The investigation also established failings in the Trust's handling of the complaint. I am satisfied that the maladministration I identified caused the complainant and the patient to experience frustration and uncertainty and the time and trouble of bringing a complaint to this office.

The Trust carried out a number of reviews and audits following the patient's death. I commend the Trust for this. In addition to the actions the Trust carried out, I recommended that it provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also made recommendations for service improvements in relation to staff training.

I extend my sincere condolences to the complainant and his family for the loss of his father.

THE COMPLAINT

1. The complainant raised a complaint about the actions of the Belfast Health and Social Care Trust (the Belfast Trust) in relation to the care it provided to his father (the patient) between 6 December 2016 and 9 October 2017.

Background

2. The Northern Health and Social Care Trust (the Northern Trust) diagnosed the patient with a neuroendocrine tumour[1] of the stomach in 2014. The patient underwent an endoscopy[2] in November 2016 and the subsequent biopsy indicated the presence of adenocarcinoma[3]. The Northern Trust referred the patient to the Belfast Trust for specialist treatment following the discovery of the adenocarcinoma.

3. The Belfast Trust carried out a series of tests on the patient between December 2016 and June 2017, but did not find any indication of cancer. However, on 6 July 2017 the patient underwent a scan which showed an ulcerated area in the stomach; the subsequent biopsy indicated adenocarcinoma. In view of the diagnosis, the Trust arranged for the patient to undergo a gastrectomy[4].

4. The patient's consultant recommended that he undergo a period of pulmonary[5] prehabiltation[6] before surgery due to his low fitness levels. The patient's consultant planned to refer him to Antrim Area Hospital for prehabilitation. However, this did not happen and the operation went ahead without further assessment.

5. The Belfast Trust carried out a total gastrectomy on the patient on 6 September 2017. On 9 September the patient developed abdominal pains and a CT scan showed '*free*' fluid in his abdomen. Exploratory surgery on 9 September confirmed the patient's intestine was leaking but the surgeon could not locate

[1] A rare tumour that can develop in many different organs of the body. It affects the cells that release hormones into the bloodstream
[2] A procedure that uses a flexible tube with a camera to examine the upper digestive tract.
[3] A type of cancer that starts in the glands that line the inside of organs
[4] the surgical removal of part or all of the stomach
[5] Conditions of the lungs
[6] A form of healthcare intervention that takes place before a medical or surgical intervention with the aim to reduce side effects and complications, and enhance recovery.

the source of the leak. The Trust placed drains around the area of the suspected leak and transferred the patient to the ICU on 9 September.

6. The Trust transferred the patient out of the ICU on 4 October 2017 as he no longer required organ support. The patient's clinical condition deteriorated on 8 October and continued to worsen throughout the day. The Trust decided not to readmit the patient to the ICU as clinicians felt this would not save his life. The patient passed away on 9 October 2017.

7. The Trust met with the complainant on 30 October 2018 and 10 December 2018 to discuss his concerns about the patient's treatment and death. Following the meetings, the Trust commissioned an independent review into the patient's care and treatment. The Trust provided the complainant with a copy of the review on 27 June 2019.

Issue of complaint

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

1. **Whether the care and treatment provided to the patient by the Trust between 6 December 2016 and 9 October 2017 was reasonable and in accordance with relevant standards?**
   In particular, this will examine:
   - Diagnosis of adenocarcinoma;
   - Prehabilitation before cancer treatment;
   - Indication for surgery and first operation;
   - Second operation;
   - Discharge from ICU; and
   - Decision not to readmit to ICU.

2. **Whether the complaints handling by the Trust was appropriate?**

INVESTIGATION METHODOLOGY

9. In order 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

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

    - Consultant Upper GI and General Surgeon. MA, MD, FRCS (Gen) up to date with recent research and guidelines relevant to this case (G IPA);
    - Consultant in emergency and critical care with over ten years' experience including responsibility for emergency and acute services within hospitals. (I IPA); and

    I enclose the clinical advice received at Appendix two to this report.

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

12. The G IPA raised several issues in relation to the patient's care and treatment that the complainant had not raised in his original complaint. I therefore shared the G IPA's advice with the Trust prior to writing this report to give the Trust the opportunity to respond to the issues the G IPA raised.

Relevant Standards and Guidance

13. 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[7]:

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

14. 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 standards and guidance relevant to this complaint are:

    - Belfast Health and Social Care Trust (BHSCT) Policy and Procedures for Management of Complaints and Compliments March 2017 (Trust Complaints Policy)
    - British Medical Journal (BMJ) Guidelines for the management of oesophageal and gastric cancer, April 2011 (Oesophageal and gastric cancer guidelines)
    - The Department of Health's (DoH) Guidance in relation to the Health and Social Care Complaints Procedure, April 2009 (the DoH's Complaints Procedure);
    - The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
    - The General Medical Council's (GMC)Treatment and care towards the end of life: good practice in decision making, May 2010 (GMC End of Life decision making)
    - National Institute for Health and Care Excellence (NICE) Guidelines: CG83 Rehabilitation after critical illness in adults March 2009 (NICE CG83);
    - National Institute for Health and Care Excellence (NICE) Guidelines: IPG269 Laparoscopic gastrectomy for cancer July 2008 (NICE IPG269); and
    - Royal College of Surgeons (RCS): Good Surgical Practice, August

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

2014 (the RCS Guidance).

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

15. 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.

16. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant accepted the report's findings. The Trust raised a number of issues in relation to the draft report's findings and I obtained additional independent professional advice to address these issues. I have addressed the Trust's issues in the body of the report where appropriate. The Trust also asked for reconsideration of the report's recommendations on the basis of practical achievability. It made a number of suggestions for actions it could take to improve services in areas where the report found a failing. I considered the Trust's suggestions and amended the recommendations where appropriate.

THE INVESTIGATION

1. **Whether the care and treatment provided to the patient by the Trust between 6 December 2016 and 9 October 2017 was reasonable and in accordance with relevant standards?**

Diagnosis of adenocarcinoma

Detail of Complaint

17. The complainant believed the Belfast Trust did not '*adequately and clearly*' explain the patient's diagnosis to the family. Following the Northern Trust's original cancer diagnosis in December 2016, the Belfast Trust's explanation in June 2017 that the patient did not have cancer was a '*major boost*' for the family. The complainant said the subsequent diagnosis of cancer the following month left the family unable to '*fathom the inaccuracies*' of what the Trust had

previously told them. The complainant believed that because of the Trust's conflicting diagnoses, the family were 'at risk of making '*ill informed decisions*' about *'future treatment, potential risks or events*'.

Evidence Considered

Legislation/Policies/Guidance

18. I considered the following guidance:
    - GMC Guidance.

The Trust's response to investigation enquiries

19. The Belfast Trust stated the following; the patient communicated with his consultant (Consultant A) in 2016 and agreed to undergo further diagnostic procedures on the basis of his cancer diagnosis. A regional network of upper gastrointestinal clinical nurse specialists is currently in place to provide support and information to people with oesophago-gastric cancer. The Trust was '*sorry*' this '*superior support*' was not available to the patient at the time of his diagnosis and surgery.

Clinical records

20. I carefully considered the patient's clinical records. A chronology containing extracts from the relevant clinical records is enclosed at Appendix four to this report.

Relevant Independent Professional Advice

21. The G IPA advised the following: the Northern Trust found adenocarcinoma in the patient's stomach in 2016. The Belfast's Trust's subsequent investigations between January and July 2017 found no signs of cancer. The Trust carried out all '*relevant*' investigations to diagnose and stage the cancer. It was '*not clear why*' the Trust '*doubted*' the histopathology diagnosis. The Belfast Trust '*should*' have made a decision on treatment in 2016, but the cancer was still in its early stages when the biopsy confirmed the diagnosis in July 2017.

Further response from the Trust

22. The Trust agreed the timeframe from the original cancer diagnosis to its

decision to operate was '*extremely long*'. Consultant A kept the patient's tumour under review '*endoscopically'* and reviewed him in clinic while he was waiting for the patient's fitness levels and nutrition to improve.

Analysis and Findings

23. The G IPA advised the Trust's investigations to confirm and stage the cancer diagnosis were relevant. However, he questioned why the Trust considered it necessary to carry out further investigations to confirm the presence of the cancer given the original diagnosis in 2016.

24. I note that both the G IPA and the Independent Review advised that the Trust's investigations between January and July 2017 found no evidence of a cancerous lesion. I examined the patient's clinical records which document the Trust performed two endoscopies, a CT[8] scan and a staging laparoscopy[9] between December 2016 and July 2017. None of these tests showed the presence of adenocarcinoma. The complainant said that Consultant A informed the family that the patient did not have cancer '*5-6 weeks*' before the Trust confirmed the presence of a cancerous tumour in July 2017. I examined the patient's medical records and could find no evidence of any notes of contemporaneous conversations between Consultant A and the patient's family. However, an outpatient's letter from Consultant A to the patient's GP on 17 May 2017 documents that the patient's previous endoscopy did not identify '*anything to suggest…a lesion*' in his stomach. Consultant A suggested continued surveillance of the patient's stomach.

25. The GMC Guidance requires doctors to '*give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs*.' The guidance also requires doctors to *'work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:*

[8] Computed tomography scan: a medical imaging technique used to obtain detailed internal images of the body.
[9] An examination of the abdominal organs using surgical methods to determine the reason of pain or other complications of the pelvic region or abdomen.

a their condition, its likely progression and the options for treatment, including associated risks and uncertainties

b the progress of their care, and your role and responsibilities.'

26. I acknowledge the complainant's concern that the patient and the family were misled by conflicting and '*inaccurate*' diagnoses. It is also evident the Trust was unable to confirm the cancer diagnosis between January and July 2017. However, I cannot conclude from the evidence available that Consultant A informed the patient and his family that he was '*free of cancer*', and I am therefore unable to reach a decision on this element of the complaint. I consider that irrespective of this, the family evidently believed the patient was clear of cancer in June 2017. There is no doubt the subsequent diagnosis in July 2017 caused the patient and his family considerable shock and distress, and I offer my sympathy to the family.

Prehabilitation before surgery

Detail of Complaint

27. The complainant said the Trust told the family the patient could attend Antrim Area Hospital for a six-week fitness building programme prior to undergoing surgery. He asked why this did not happen when the service was available. The complainant explained that the patient took it upon himself to exercise and eat in order to improve his fitness levels. However, he believed the lack of prehabilitation would '*most certainly*' have affected the patient's treatment and his ability to cope with any complications arising from surgery. The complainant said he contacted the Trust on several occasions to find out when the prehabilitation would take place, but the Trust did not provide him with a date.

Evidence Considered

Legislation/Policies/Guidance

28. I considered the following guidance:
    - GMC Guidance;

The Trust's response to investigation enquiries

29. The Trust stated the following: the patient had '*undertaken a period of*

nutritional optimization' before undergoing surgery. There was '*evidence that this had worked*' and although the Trust considered him '*high risk*' he was fit for surgery. There was no evidence base to demonstrate prehabilitation programmes reduce '*post-operative mortality*' after major oesophagogastric surgery. The consultant surgeon counselled the patient '*extensively*' on the '*risks of surgery*'. It was the patient's '*clear wish*' to proceed with surgery. The Trust did not explain why it did not organise the prehabilitation.

Relevant Independent Professional Advice

30. The G IPA advised the following: he considered '*on the balance of probabilities*' the patient was unfit for surgery. There were no definitive tests to assess a patient's fitness for surgery and opinions between specialists differed. Prehabilitation can improve patient fitness before surgery, which means an increased chance of surviving complications. It is '*not clear*' if prehabilitation would have changed the patient's outcome in this specific case.

Analysis and Findings

31. I acknowledge the complainant's conviction that a course of prehabilitation prior to surgery would have improved the patient's ability to cope with the post-operative complications. The G IPA advised he believed the patient was unfit for surgery. I examined the medical records which document that this was also the opinion of a consultant anaesthetist who carried out a pre-operative assessment and recommended the patient undergo a period of pulmonary prehabilitation. This did not happen, and the medical records do not explain why. I note that in a meeting with the complainant on 30 October 2018, the Trust stated it was an '*unforeseen oversight*' that it did not organise the prehabilitation. It is evident from the Trust's responses to the complainant and this office that it is unable to confirm why it did not refer the patient for prehabilitation. It is also unclear why the Trust subsequently decided the patient was fit for surgery in September as I can find no evidence that it assessed the patient's fitness between recommending him for prehabilitation and electing to proceed with surgery.

32. In its response to the draft report, the Trust stated a '*senior consultant anaesthetist*' undertook an assessment of the patient's fitness and '*felt*' him to be '*a candidate for resection*'. I examined the patient's records. A consultant anaesthetist assessed him on 18 July 2017. The assessment form documented the patient's comorbidities and concluded he was '*quite frail'*. It went on to record the patient should undergo a '*period of pulmonary rehabilitation*' at which point '*he may be a candidate*' for total gastrectomy.

33. There is no indication that the Trust reviewed the patient's fitness again despite its awareness that he did not undergo prehabilitation. It is therefore clear the Trust recommended the patient for a total gastrectomy without reassessing his fitness. It stated that it did this because '*it was clear*' the patient's cancer had '*progressed*' during a '*short period*'. However, the patient's cancer had not progressed to the extent the Trust believed, due to an incorrect interpretation of an endoscopy the Trust carried out on 6 July 2017, which I have addressed below. I am therefore satisfied my original findings were correct.

34. While I acknowledge the G IPA's advice that there are no definitive tests to assess a patient's fitness for surgery, the patient's records reflect the concerns treating clinicians had about his fitness levels in July 2017. The Trust felt it necessary to refer him for prehabilitation. It then operated on him without any prehabilitation and without further assessing his fitness levels. On this basis I accept the G IPA's advice that the patient was unfit for surgery in September 2017. I find this extremely concerning.

35. The GMC Guidance requires doctors to '*promptly provide or arrange suitable advice, investigations or treatment where necessary*.' It also requires doctors to '*refer a patient to another practitioner when this serves the patient's needs'*. I consider that having determined the patient required a period of pulmonary prehabilitation before surgery, the Trust should have provided this service to him. I consider that its failure to do so is a failure in care and treatment and I uphold this element of the complaint.

36. In considering the impact the Trust's failure to arrange prehabilitation had on the patient, I examined the G IPA's advice and the findings of the Independent

Review. The Independent Review concluded that prehabilitation '*probably wouldn't*' have helped the patient to recover from his post-surgery complications. In addition, while the G IPA noted the potential benefits of prehabilitation, he advised that it was '*not clear*' if it would have changed the patient's outcome. Although it may not be possible to determine whether a period of prehabilitation would have helped the patient to recover from the complications following surgery, I consider the patient sustained the injustice of the loss of opportunity to undergo prehabilitation to improve his fitness before surgery. In addition, I am satisfied the complainant sustained the injustice of frustration, uncertainty and anxiety at the Trust's lack of progress in arranging the prehabilitation, particularly as he was aware that this intervention had been recommended. I acknowledge the complainant will always question if prehabilitation would have made a difference to the patient's outcome.

Indication for surgery and first operation

Detail of Complaint

37. In his complaint to the Trust and this Office, the complainant raised concerns that Consultant B, the surgeon who performed the operation on 6 September missed the hole that caused the leak into the patient's abdomen. He said Consultant B told him he could not understand how he missed the hole. The complainant also questioned the adequacy of Consultant B's record of the procedure.

38. Although the complainant did not question the Trust's advice to the patient that its suggested course of action to treat the cancer was a total gastrectomy, the G IPA did question the appropriateness of this proposed surgery. In his advice the G IPA questioned the Trust's decision to proceed with the total gastrectomy given the Trust found the patient's cancer was at an early stage and could have been treated with a less invasive procedure. In addition, he raised the possibility that the leak from the surgery site was due to a surgical error.

39. As the complainant was unaware of these issues and therefore could not have raised them with the Trust, I shared the G IPA's advice with the Trust to give it the opportunity to comment on it. Although the indication for surgery is not a

matter the complainant raised in bringing his complaint to me, in my view it is important that I address it in this report. This is because it is relevant to the complainant's general concern that the care and treatment the Trust provided was not appropriate and led ultimately to the patient's '*premature*' death.

Evidence Considered

Legislation/Policies/Guidance

40. I considered the following guidance:
    - GMC Guidance;
    - Oesophageal and gastric cancer guidelines; and
    - RCS Guidance

Relevant Independent Professional Advice

41. The G IPA advised the following: the endoscopy the Trust carried out on 6 July 2017 '*suggested*' the presence of an ulcer and linitis plastica[10]. The Trust's decision to proceed with a total gastrectomy under these circumstances was '*reasonable*'. However, following the operation, tests showed the patient's cancer was still at an early stage. Therefore, the findings of the endoscopy were '*inaccurate*'. This '*begs questions*' of the endoscopist's interpretation of the scan. An Endoscopic Ultrasound[11] (EUS) of the stomach '*may have helped*' gauge the depth of the ulcer. Given the concerns over the patient's fitness and the fact his cancer was in the '*very early*' stages, endoscopic mucosal resection[12] (EMR) may have been a '*viable and safe*' alternative.

42. The G IPA advised Consultant B performed the operation using '*standard techniques.'* He had '*no concerns*' about Consultant B's findings following the operation. The operation notes were '*comprehensive*', '*clear and legible*' and included a descriptive diagram. He had '*no concerns*' about the documentation. However, an early leak on day three following the operation '*usually*' suggested

[10] A variant of diffuse stomach cancer in which the stomach wall becomes thick and rigid.
[11] A medical procedure in which endoscopy is combined with ultrasound to obtain images of the internal organs in the chest, abdomen and colon. It can be used to visualize the walls of these organs.
[12] A minimally invasive procedure to remove irregular tissue from the digestive tract. Compared to open surgery, it allows a patient to recover more quickly with less pain

a '*technical error*' such as incomplete anastomosis[13]. It would be '*impossible*' to determine at this stage if Consultant B made an error during the operation.

The Trust's response to Investigation enquiries and IPA

43. In relation to the diagnosis of linitis plastica, Consultant B stated the following: while the diagnosis at the time was '*plausible*', he agreed '*in retrospect*' his conclusion was '*incorrect*'. When he performed the endoscopy, he was concerned by the presence of an ulcer and the fact that the patient's stomach was '*poorly distensible upon insufflation*'[14]. The '*abnormality*' in the patient's stomach '*may have been*' due to other findings on the pathology report. He agreed '*in retrospect*' an EUS '*may have altered*' the staging[15] of the patient's cancer and he would feed this back to the multidisciplinary team (MDT).

44. The Trust stated the following: '*unfortunately*' the patient experienced an early anastomotic leak[16]. This was a '*rare event'*. Consultant B stated that he '*completely agreed*' with the G IPA and the leak could be '*evidence of poor technique*'. He never had such a leak occur after surgery '*before*' or '*since*' the patient's operation. He has since attended theatre sessions with colleagues to ensure his technique was '*consistent with theirs*'. He stated that had the patient not experienced an anastomotic leak he would '*have likely*' made a good recovery and benefited from his surgery.

45. In relation to Consultant B's documentation of the operation, the Trust stated he wrote the operation notes in a '*legible fashion*' and all elements were included in line with the guidance. The unit policy is now to type all notes following the Independent Reviews findings. Operation notes '*are now added*' to the Northern Ireland Electronic Care Record (NIECR) to enable other clinicians to '*locate and access*' them.

Analysis and Findings

[13] A connection made surgically between adjacent blood vessels, parts of the intestine, or other channels of the body
[14] Did not expand well when air was blown into the cavity.
[15] The determination of the extent of a cancer.
[16] A leak of luminal contents from a surgical join. They are an important complication to recognise following gastrointestinal surgery when an anastomosis has been formed.

Operation notes

46. I acknowledge the complainant's concerns about the quality of Consultant B's record of the operation. I examined the complaint file and I note the independent reviewer commented he was '*surprised that operation notes within the …Trust are brief, handwritten entries in the medical records'.* I note however, the independent reviewer did not criticise the quality or content of the operation notes. I examined the patient's medical records which document that Consultant B completed a form called a BCH Operation Record. The document records in handwritten form the indication for surgery, the surgeon's findings, and an extensive description of the procedure. These are accompanied by a diagrammatic representation of the procedure and post-operative instructions to ward staff.

47. Good Surgical Practice requires surgeons to '*record clinical information in a way that can be shared with colleagues and patients and reused safely in an electronic environment*'. It also states surgeons should '*ensure that there are clear (preferably typed) operative notes for every procedure. The notes should accompany the patient into recovery and to the ward and should give sufficient detail to enable continuity of care by another doctor'*. It provides a list of details the notes should contain.

48. The surgical team made handwritten notes of the patient's operation and filed them in the patient's medical records. The current guidance recommends surgeons make typed notes which should be stored electronically. However, I note the Trust has taken steps to rectify this following criticism from the independent reviewer. In relation to the quality of the notes, the G IPA advised he had '*no concerns*' about the notes, which were '*comprehensive, clear and legible*'. I accept this advice. In summary having considered the medical records, the guidance and the G IPA's advice, I am satisfied the surgeon's record of the operation was of a reasonable standard.

Decision for total gastrectomy

49. In relation to the issue of the indication for surgery, I acknowledge the Trust's response that given its interpretation of the patient's endoscopy which

suggested linitis plastica, the MDT considered a total gastrectomy to be the most appropriate course of treatment. I considered Oesophageal and gastric cancer guidelines which states treatment recommendations '*should be undertaken in the context of a UGI MDT taking into account patient co-morbidities, nutritional status, patient preferences and staging information'.* I note the G IPA's advice that the Trust's decision to offer the patient a total gastrectomy following a potential diagnosis of linitis plastica was '*reasonable*'. I could not find recommendations for treatment of linitis plastica under any of the current guidance. However after referring to numerous papers on the subject, for example this[17] referenced by the G IPA from the Royal College of Surgeons, I accept the G IPA's advice.

50. However, I examined the patient's medical records. The notes document that tests on samples of the patient's tissue removed during the operation showed the presence of '*early gastric cancer*' (T1bN0M0[18]). The Oesophageal and gastric cancer guidelines state '*Endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD) can eradicate early gastro-oesophageal mucosal cancer. EMR should be considered in patients with oesophageal mucosal cancer and both EMR and ESD should be considered for gastric mucosal cancer'.* The G IPA advised that '*on the balance of probabilities*' the patient should not have been offered surgery due to his '*poor fitness and high risk*'. He further advised that given the '*very early*' stage of the cancer, EMR may have been a '*viable and safe*' alternative to surgery. Having considered the medical records and the relevant guidance, I accept the G IPA's advice.

51. In its response to the draft report the Trust stated that the endoscopic staging of the cancer '*correctly identified*' the patient's tumour was '*not endoscopically resectable*'. This is because it was an '*ulcerating signet cell adenocarcinoma*'. I examined the patient's endoscopy report from 6 July.2017. The report documented the presence of a gastric ulcer which a biopsy subsequently confirmed was an adenocarcinoma. The Trust did not identify presence of an

[17] Survival following operative management of gastric linitis plastica compared with non-operative management | The Annals of The Royal College of Surgeons of England (rcseng.ac.uk)
[18] Early stage cancer

ulcerated signet cell adenocarcinoma until it had removed the patient's stomach. I note in his additional advice the G IPA advised that contrary to the Trust's initial findings the pathologist's report did not find a clearly defined ulcer in the patient's stomach. However, this would still have '*very likely, precluded*' EMR.

52. I note the G IPA also advised that the Trust first diagnosed the patient as having an adenocarcinoma in November 2016 with '*no mention*' of an ulcer. The Trust did not describe an ulcer until July 2017, eight months after the initial diagnosis. The G IPA advised there was '*little doubt*' the patient's cancer progressed in the intervening months. Therefore, the Trust '*should*' have made its treatment decision in 2016 and discussed it with the patient when EMR '*may have been possible*'.

Surgical procedure

53. I examined the patient's medical records which document that on 9 September, three days after his operation the patient developed '*abdominal pain*' and a fluid leak from his surgical wound. Doctors requested an '*urgent*' scan which showed '*free abdominal fluid*'. Consultant C performed emergency surgery on the patient. The G IPA advised that a leak three days after the original surgery '*usually*' suggested a '*technical error*' such as incomplete anastomosis. While the G IPA advised it would now be '*impossible*' to tell if Consultant B made an error during the operation, I note Consultant B stated he '*completely agreed*' with the G IPA and the leak could be '*evidence of poor technique*'. I welcome Consultant B's candour in relation to this issue.

54. RCS Guidance states that surgeons should '*carry out surgical procedures in a timely, safe and competent manner, and ensure that you follow current clinical guidelines in your field'*. I note and accept the G IPA's advice that Consultant B performed the operation using '*standard techniques'* and that he had '*no concerns*' about Consultant B's findings following the operation.

Overall

55. In summary, the Trust made an inaccurate diagnosis of the patient's condition following the endoscopy on 6 July 2017. The Trust diagnosed the patient with

linitis plastica, an advanced stage of stomach cancer that required treatment in the form of a total gastrectomy. It also identified the presence of an ulcer which was not apparent during the initial diagnosis in 2016. The G IPA considered on the '*balance of probabilities*' that the patient was not fit to undergo surgery at that time. The Trust carried out a total gastrectomy on the patient on 6 September. Three days later the patient developed an anastomotic leak. The G IPA advised that a leak occurring so soon after surgery was '*usually*' the result of a '*technical error*' by a surgeon. While he clarified it was '*impossible*' to be certain if this was the case, I note Consultant B agreed the leak could be '*evidence of poor technique*'. Therefore, on balance I consider it was likely to be a technical error during surgery that caused the anastomotic leak. The G IPA advised that had the Trust correctly diagnosed the patient it could have treated his cancer by way of EMR, a potentially '*viable and safe*' alternative.

56. I am therefore satisfied on the balance of probabilities it was the Trust's failure to consider treatment by way of EMR in 2016, its failure to ensure that the patient was fit for surgery and the likelihood of a technical error by the surgeon during the operation which ultimately led to his untimely death.

57. In its response to the draft report the Trust stated an anastomotic leak was a '*recognized* (sic) *complication*' after a total gastrectomy and that '*internationally rates approach 10%*'. It further stated the leak did not represent '*error or negligence*'. The report did not conclude that surgeon who performed the operation was negligent. The report based its finding on the G IPA's advice that a leak three days after the operation was '*usually*' due to a technical error. It also considered Consultant B's agreement with this view and his admission that the leak may have been '*evidence of poor technique*'. Therefore, while I acknowledge the Trust's response and also acknowledge the finding is not definitive, I am satisfied on the balance of probabilities that my original conclusion was correct.

58. The GMC Guidance requires doctors to prescribe *'treatment…only when you have adequate knowledge of the patient's health and are satisfied that the… treatment serve(s) the patient's needs*'. It also states doctors should '*provide effective treatments based on the best available evidence*.' In addition RCS

Guidance that surgeons when '*providing elective care for patients with non-urgent conditions,*(should) *carry out procedures that lie within the limits of your competence and the range of your routine practice'*

59. I consider these actions represent a failure in the patient's care and treatment. As a result of the failures identified, I am satisfied the patient experienced the injustice of the loss of opportunity to have his cancer correctly staged and his fitness for surgery adequately assessed. These failures led to the Trust's decision to operate on the patient. This resulted in an anastomotic leak; '*likely*' the result of an error during surgery which further contributed to the patient's deterioration and eventual death. I therefore uphold this element of the complaint. In addition, I am satisfied that the complainant experienced the injustice of distress and uncertainty about the appropriateness of the care and treatment provided to his father following the diagnosis of linitis plastica.

Post-operative care

Detail of Complaint

60. The complainant said he was dissatisfied with the Trust's '*lack of urgency*' around the increase in the patient's C-Reactive Protein[19] (CRP) in the period following the gastrectomy. He was also dissatisfied that the Trust did not undertake additional investigations in response to the increase in the patient's CRP. He believed this contributed to the patient becoming unwell.

Evidence Considered

Legislation/Policies/Guidance

61. I considered the following guidance:
    - GMC Guidance;
    - RCS Guidance

The Trust's response

62. The Trust stated the following: on the ward, the patient initially recovered well from surgery and there were no '*intra operative events'.* The patient

[19] A substance the liver produces in response to inflammation. A high level of CRP in the blood can be a marker of inflammation, or infection.

experienced '*a recognised post-operative complication, which was managed appropriately*'.

Relevant Independent Professional Advice

63. The G IPA advised the following: '*multiple*' post-operative ward care notes documented an early expected recovery. The patient's lactate[20] levels were high on 6 September but improved with antibiotics. On 7 September the patient's CRP and white cell count (WCC) were elevated and he was experiencing abdominal pain. These were '*expected*' symptoms in the period following the operation. On 9 September clinicians became concerned that the patient's surgical join was leaking following an increase in CRP and WCC levels in addition to increasing abdominal pain. The Trust performed a CT scan which confirmed the diagnosis. The Trust's actions were '*timely*' and followed a *'logical progression*' in care management. Post operative care was '*reasonable and appropriate*'.

Analysis and Findings

64. I examined the patient's medical records which document that on 7 September at 20.30 his CRP was 296 and his WCC was 20. A doctor examined the patient who reported abdominal pain that he (the patient) thought was linked to constipation. On 8 September the patient reported some abdominal discomfort. His CRP had risen to 394. His CRP rose again on 9 September. A doctor examined him and found him to be '*clinically stable*'. The patient reported he was '*feeling well*'. On the evening of 9 September, the patient reported abdominal pain and his wound was leaking serous fluid[21]. A senior doctor requested an urgent CT scan, and the Trust sent the patient to theatre later that evening.

65. The medical records document the rise in the patient's CRP and continued abdominal discomfort and pain in the three days after his operation. However, I note that staff did not document any acute events prior to the patient's clinical

[20] An essential test in the assessment of sepsis in acutely unwell patients
[21] A clear fluid that fills the inside of body cavities.

condition deteriorating on the evening of 9 September. The G IPA advised the patient's elevated CRP levels and abdominal pain would be '*expected*' following the operation. He advised the Trust's post operative care was '*appropriate*'. I accept the G IPA's advice.

66. RCS Guidance requires surgeons to '*ensure that patients receive satisfactory postoperative care and that relevant information is promptly recorded and shared with the relevant teams*'. In addition, the GMC guidance requires doctors to '*a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
b promptly provide or arrange suitable advice, investigations or treatment where necessary
c refer a patient to another practitioner when this serves the patient's needs'.

67. Having considered the medical records, the relevant guidance and the G IPA's advice I consider clinicians provided appropriate post operative care to the patient between 6 and 9 September. Therefore, I do not uphold this element of the complaint.

Second Operation

Detail of Complaint

68. The complainant noted that the surgeon (Consultant C) who operated on the patient on 9 September could not find the source of the leak. As a result, Consultant C rinsed the infected area out and closed the wound. He asked how the surgeon could '*just leave it and hope it heals itself*?'

Evidence Considered

69. I considered the following guidance:
    - RCS Guidance

The Trust's response

70. The Trust stated Consultant C '*couldn't definitively*' find the source of the leak either from '*the outside*', or by performing an endoscopy. He cleaned out the

contaminated area and '*left some drains*' at the anastomosis. Clinicians then transferred the patient to the ICU.

Relevant Independent Professional Advice

71. The G IPA advised the following: Consultant C was able to assess the full length of the small intestine and the surgical joins during the second operation. He '*found air*' coming from one of the joins but could not identify a '*visible defect*'. He was '*correct*' to inspect the surgical site, but not to disturb it '*too aggressively*' as the join was '*fragile*' in the early stages. He '*appropriately*' washed out the area, placed intra-abdominal drains around the area of the suspected leak and arranged for the placement of a nasogastric tube[22]. It would not be appropriate to '*fix*' a small leak if the source was not visible.

Analysis and Findings

72. I examined the patient's medical records which document that Consultant C performed a laparotomy[23] on the patient on 9 September. Consultant C noted '*endoscopic inspection of anastomosis grossly intact but undoubtedly origin of leak'*. The consultant placed drains near the site of the leak and referred the patient to the ICU.

73. RCS Guidance requires surgeons to '*carry out surgical procedures in a timely, safe and competent manner, and ensure that you follow current clinical guidelines in your field*'. I was unable to identify any specific guidance relating to the procedure carried out by Consultant C, however the G IPA referenced a study cited in the Journal of Thoracic Disease[24] which states '*Multiple studies comparing non-operative management of anastomotic leaks and surgical intervention (irrigation and debridement of leak site or endoluminal stent) have demonstrated "no statistical difference" in time to closure of leak'.* I note the G IPA's advice that the surgeon was '*correct*' to inspect the site, but not to disturb it as the join was fragile after surgery. Consultant C acted '*appropriately*' by

[22] a thin, soft tube that is passed through the nose, down through the throat, and into the stomach. It is used to deliver food or medicine to the stomach for people who have difficulty eating or swallowing.
[23] a type of open surgery of the abdomen to examine the abdominal organs
[24] Management of anastomotic leaks after esophagectomy and gastric pull-up - Famiglietti - Journal of Thoracic Disease (amegroups.org)

washing out the site and placing drains by it. In the absence of specific guidance, I accept the G IPA's advice. Therefore, having considered the advice and the patient's records, I am satisfied Consultant C's actions during the second operation were reasonable and I do not uphold this element of the complaint.

Discharge from ICU

Detail of Complaint

74. The complainant believed that the Trust transferred the patient out of the ICU prematurely. It did not carry out appropriate '*safety checks and assessments*' before it discharged him. It did not provide him with the '*one to one*' nursing he required. The Trust's decision led to the patient's '*premature passing*'.

Evidence Considered

Legislation/Policies/Guidance

75. I considered the following guidance:
    - NICE CG83.

The Trust's response to investigation enquiries

76. The Trust stated the following: the patient spent 24 days in the ICU. He had sepsis and required organ support. By the time of his discharge, he did not need organ support and treatment had '*controlled*' his sepsis.

Relevant Independent Professional Advice

77. The I IPA advised the following: in the 72 hours prior to his transfer back to the ward ICU staff did not undertake any interventions or physiology that could not have been carried out or managed on '*a surgical ward*'. Nurses on the ICU did not raise '*an incident*' about the appropriateness of transferring the patient to another ward. He would '*expect*' the nursing notes to reflect concerns about the safety of such a transfer. The complications that arose after surgery '*eroded*' the '*physical reserves*' of a patient who was already '*high risk*' before the procedure. The Trust's decision to discharge him from the ICU '*would not'* have caused him detriment. Any interventions needed to reduce his '*clinical risk*' could be carried out by staff on a surgical ward. The medical notes do not

record the ratio of nurse-to-patient care on the ward, or in the ICU. Overall, it was '*appropriate*' to transfer the patient back to the ward on 4 October.

Analysis and Findings

78. I examined the patient's medical records which document that on 27 September the Trust weaned the patient off the ventilator in the ICU, though he remained extremely ill and required continuing oxygen therapy. NICE CG83 requires critical care teams to perform a '*comprehensive clinical reassessment to identify* [a patient's] *current rehabilitation needs* before their discharge from critical care. This should include: '• *physical, sensory and communication problems* • *underlying factors, such as pre-existing psychological or psychiatric distress* • *symptoms that have developed during the critical care stay*'. The ICU records contain a critical care handover to the ward staff in addition to medical and nursing reviews and a discharge summary. I note the I IPA's advice that staff on the surgical ward could have carried out any interventions ICU staff performed in the 72 hours before the patient's discharge. In addition, the I IPA advised there was no record of staff raising concerns about the safety of the discharge. As staff on the surgical ward could have carried out any interventions to manage clinical risk, the Trust's decision to discharge him from the ICU would not have caused him detriment and as such was '*appropriate*'.

79. The complainant was concerned that when the Trust transferred the patient back to the ward, he no longer received the one-to-one nursing care he would have received in the ICU. The I IPA advised the patient's records do not document the ratio of nursing care the Trust provided, either on the ward, or in the ICU. I examined the medical notes which do not record nursing ratios in the care plan. I am unable to determine if this had a detrimental effect on the patient. However, I refer again to the I IPA's advice that the discharge was '*appropriate*' and nursing staff in the ICU raised no concerns about it.

80. Having considered the medical records and the relevant guidance, I accept the I IPA's advice. I am therefore satisfied that it was appropriate for the Trust to discharge the patient from the ICU on 4 October. Consequently, I do not uphold this element of the complaint.

Decision not to re-admit to ICU.

Detail of Complaint

81. The complainant asked why, given the patient's deterioration on 6 October the Trust did not readmit him to the ICU despite the family's request. He said '*surely it was worth a try*' to save the patient's life.

Evidence Considered

Legislation/Policies/Guidance

82. I considered the following guidance:
    - GMC End of Life decision making

The Trust's response to investigation enquiries

83. The Trust stated it '*felt*' the patient's outcome would not '*have been altered*' had it readmitted him to the ICU. The complications he developed on the ward prevented '*any chance of recovery*'. He would not have '*withstood*' further organ support and ventilation. The decisions the clinical team made about the patient's care were '*correct*' and in his best interests.

Relevant Independent Professional Advice

84. The G IPA advised the following: he agreed with the principle that any decision to return the patient to the ICU should consider whether it would help his '*chances of survival*', quality of life and if it would ultimately '*benefit*' him. Given the patient's condition and chances of recovery the Trust's decision not to return him to the ICU was '*reasonable*'.

85. The I IPA advised the following: the patient '*although stable*' was '*very debilitated*' upon discharge from the ICU. The I IPA advised the patient had a '*mountain to climb*' to recover sufficiently to go home. He referred to the ICU consultant's note which stated that returning the patient to the ICU would not save his life; it would only '*prolong his death*'. The I IPA advised that he agreed with that assessment and that the Trust's decision not to readmit the patient to the ICU was '*reasonable and appropriate'*.

Analysis and Findings

86. I acknowledge the complainant's concern over the Trust's decision not to readmit the patient to the ICU when his condition began to deteriorate. It is understandable that having stabilised the patient's condition previously, the complainant felt a further admission to the ICU was '*worth a try*' in order to save his life. I considered the conclusions of the Independent Review which found the Trust's decision not to readmit was '*appropriate*' as the patient's likelihood of recovery following his deterioration was '*negligible*'. I note further both IPAs' advice that the Trust's decision was '*reasonable*'. The I IPA agreed with the conclusion of the ICU doctor that readmitting the patient would not save his life.

87. I examined the patient's medical records which document the ICU consultant's consideration of the decision whether to readmit the patient to the ICU. The consultant noted the patient's pre-existing lung disease was '*much worse than originally thought*'. He noted the patient had '*great difficulty*' weaning from a ventilator in the ICU and his reserves were '*extremely low*'. The consultant felt that further critical care support would not save the patient's life as his lung function '*would not support*' another episode of intubation and ventilation.

88. GMC End of Life Decision Making requires doctors to '*use specialist knowledge, experience and clinical judgement, together with any evidence about the patient's views (including any advance statement and/ or advance care plan), to identify which investigations, treatments or options for managing the patient's condition (including the option to take no action) are in the patient's clinical interests and to decide which of those options is likely to result in their overall benefit'.*

89. I note that the independent reviewer and both IPAs agreed with the ICU consultant's clinical judgement. Therefore, having considered the guidance, both IPAs' advice and the medical records I am satisfied the Trust's decision not to readmit the patient to the ICU on 8 October was reasonable and appropriate. Therefore, I do not uphold this element of the complaint.

2. **Whether the complaints handling by the Trust was appropriate.**

Detail of Complaint

90. The complainant believed the Independent Review the Trust commissioned into the patient's death was not '*comprehensive*'. The complainant said he was '*extremely disappointed*' the Trust did not give him the opportunity to speak to the consultant who conducted the review. He believed that because of this the Review did not consider all '*relevant information and evidence*.' He also questioned the Review's '*impartiality*'.

91. The complainant also said that he was '*astonished*' none of the surgeons involved in the patient's care attended the meetings he had with the Trust to discuss his complaint. He asked how the Trust could provide an adequate response to his complaint when none of the '*main players*' were involved in the process.

Evidence Considered

Legislation/Policies/Guidance

92. I considered the following guidance:
    - Trust Complaints Procedure.

The Trust's response to investigation enquiries

93. The Trust stated the following: it '*adhered*' to the complaints process. It met the complainant on 30 October and 10 December 2018 to discuss his concerns about the patient's treatment. The Clinical Director of General Surgery, *'who is also a senior upper gastrointestinal surgeon*' attended a meeting. It commissioned an Independent Review and shared the complainant's comments and concerns with the reviewer. The surgeon who operated on the patient on 6 September offered a '*further informal meeting*' with the complainant in order to explain '*the events*' which led to the patient's passing.

Analysis and Findings

94. The complainant was concerned he did not have an opportunity to speak to the

consultant who conducted the Independent Review. He believed this meant the investigation of the patient's death was not '*comprehensive*'. I reviewed the Trust's complaints procedure. There is no specified requirement for the Investigating Officer, whether internal or external, to seek input from the complainant when conducting an investigation. The policy specifies that all complaints '*will be thoroughly investigated in a manner appropriate to resolving the issues in an efficient and effective manner* '. I acknowledge it is the complainant's view the Trust's investigation did not achieve this.

95. I examined the minutes of the meeting between the complainant and the Trust held on 10 December 2018. Both parties identified the need for an independent review and agreed on ten draft terms of reference. I note that nine of the ten terms of reference related directly to medical issues. The non-medical issue related to communication with the family which the reviewer described as '*poor*' and falling '*below an acceptable standard*'.

96. I examined the Trust's complaint file which documents that it provided the independent reviewer with the patient's medical records. In addition, it provided him with the minutes of the meetings of 30 October and 10 December as amended by the complainant. In relation to the medical issues, I consider it reasonable and appropriate that the consultant made his findings based on the information contained in the medical records. While I acknowledge the complainant's concerns that he did not have the opportunity to speak to the consultant, I am satisfied his report considered all '*relevant information and evidence*' in relation to the patient's medical care and treatment.

97. In relation to the issue of communication with the family, the complainant met with the Trust on two occasions. On both occasions the complainant expressed his concerns about the patient's care and treatment. This also included the complainant's dissatisfaction about the '*quality of information*' the Trust provided to the family about the patient's diagnosis and course of treatment. The Trust provided the independent reviewer with copies of the minutes of these meetings as amended by the complainant. I note the independent reviewer found that the Trust's communication with the family was '*poor*'. On this basis I am satisfied the independent reviewer had sufficient information,

including the complainant's views and concerns, to make a finding on the standard of the Trust's communication with the family.

98. The complainant was concerned that the '*main players*' were not involved in the complaints process. The Upper Gastrointestinal Consultants involved in the patient's care did not attend either of the meetings between the Trust and the complainant. The Trust stated that the Clinical Director of General Surgery, *'who is also a senior upper gastrointestinal surgeon*' attended a meeting. The records document the Clinical Director attended the meeting on 30 October when the complainant and the Trust discussed three of the issues raised by the complainant. The Clinical Director did not attend the meeting which took place on 10 December to address the issues not covered in the initial meeting.

99. I examined the minutes of the meetings, and it is apparent the Trust's representatives were unable to address a number of the complainant's concerns or questions. I note the independent review also highlighted this issue concluding that the answers the Trust gave during the meetings '*added to the family's concerns*.' I note the Trust's complaint policy states that if the Trust arranges a meeting with a complainant it should ensure '*the relevant Trust staff are present at the meeting*'. Given the inability of the Trust's representatives to answer the complainant's concerns, I consider the relevant staff were not present at the meetings.

100. 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'* and to ensure that '*staff are equipped and empowered to act decisively to resolve complaints*.' In its response to the complainant during the meetings of 30 October and 10 December 2018, I do not consider that the Trust meets these standards for the reasons outlined above. I consider that the failure to act in accordance with the relevant guidance and to equip staff with the relevant information to resolve the complaint constitutes maladministration.

101. Consequently, I am satisfied that the maladministration identified caused the complainant to experience the injustice of frustration, uncertainty and the time

and trouble of bringing a complaint to this office. Therefore, I partially uphold this issue of complaint.

CONCLUSION

102. The complainant raised a complaint about the care and treatment the Trust provided to the patient between 6 December 2016 and 9 October 2017. The complainant was also concerned about the way in which the Trust handled his complaint.

First issue

103. The investigation established failures in the care and treatment in relation to the following matters:

- The failure to provide the patient with prehabilitation; and
- The failure to correctly stage the patient's cancer.
- The decision to proceed with a total gastrectomy

104. I am satisfied the failures in care and treatment caused the patient to sustain the injustice of the loss of opportunity to be provided with prehabilitation prior to surgery, to have the progress of his stomach cancer correctly staged and to have his fitness levels adequately assessed before surgery. In addition, I am satisfied the complainant sustained the injustice of frustration, uncertainty, anxiety, and distress. In my view the failures referred to above precipitated a chain of events that led to the patient's deterioration and untimely death.

105. I recognise that this report may be distressing for the complainant to read. It must have been very difficult for him to witness his father's deterioration in hospital, following the first operation and again after his discharge from the ICU. I consider there was uncertainty and distress for the complainant at a stressful time. I acknowledge that this uncertainty will unfortunately continue as he will always question whether things could have been different if the Trust had correctly staged his father's cancer, correctly assessed his fitness and provided him with the opportunity to have his cancer treated in a less invasive manner.

Second Issue

106. The investigation established maladministration in relation to the following matters:
    - Failure to answer the complainant's concerns in accordance with the guidance.
107. I am satisfied the maladministration identified caused the complainant and his family the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office.

Recommendations

108. I note that following the patient's death the Trust undertook the following actions:
    - A review of the events leading up to the patient's anastomotic leak '*to learn what its cause was and reduce the risk of such a leak happening again*.'
    - Discussion of the patient's case over the course of three weekly Mortality and Morbidity meetings. This led to the '*inception of an audit to include all patients who had a gastrectomy since the unit formed*' with the aim of '*of identifying what the leak rate following gastrectomy was, whether it was in keeping with national standards and help to identify patients at higher risk for the future*'.
    - Gastrectomy Anastomotic leak audit:
    - Upper GI Specialty Mortality Review and Patient Safety meeting to discuss the patient's '*experience in depth*';
    - Introduction of '*physio led*' prehabilitation;
    - Macmillan support for patients with gastric cancer;
    - Six monthly audit of anastomotic leak rates;
    - Six monthly audit of peri-operative mortality rates;
    - Consultant B attended theatre with other surgeons to ensure consistency of technique;

- Adoption of the NELA (National Emergency Laparotomy Audit) pathway for patients undergoing re-operation as an emergency following surgery;
- Six monthly audit of indication and outcomes of all OG (Oesophago-Gastric) surgery; and
- Introduction of policy where patients have an extended stay or suffer serious complications, to arrange regular formal documented family meetings.

I welcome the Trust's actions and the acknowledgement that there was significant learning to be taken from the events surrounding the patient's care and treatment.

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

110. I further recommend for service improvement and to prevent future recurrence:

- The Trust provide evidence of the actions it has taken following its review of the patient's care and treatment;
- The Trust review guidelines and consider the use of staging EUS for select cases of malignant ulcers; (in accordance with national guidelines)
- Given the complexities of managing early gastric cancers, the OG Team should seek available options for developing and maintaining their skills in endoscopic lesion recognition and endoscopic management of early gastric cancers; and
- The Trust remind staff to ensure that all relevant staff attend meetings with complainants in accordance with relevant guidance.

111. I recommend that the Trust implement an action plan to incorporate these recommendations and should provide me with an update **within three months** of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate,

records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

MARGARET KELLY

Ombudsman **July 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 relevant guidance, 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, 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.