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

Report Reference: 202002531

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's father (the Patient). The Patient attended the Trust's ED having experienced 'fluttering' 'chest tightness' and a collapse. The Trust assessed the Patient and admitted him to a ward for further coronary related investigations. After those investigations the Trust discharged the Patient. The Trust arranged for outpatient follow up care. Sadly, the Patient died nine days after discharge.

The complainant said the Trust did not carry out adequate investigations of her father's symptoms. She believes if the Trust had done so the Patient may not have died that day.

The Investigation found the Trust's investigations into the Patient's symptoms were appropriate and in accordance with the guidelines. It also found that the Trust's post discharge monitoring and investigations were appropriate.

I appreciate the complainant's concern about the treatment the Patient received, particularly given his sad death shortly after discharge from hospital. However, I concluded that there were no failures in the care and treatment the Trust provided to the Patient. I therefore did not uphold the complaint.

THE COMPLAINT

1. I received a complainant about the care and treatment the Trust provided to the Patient following a syncope[1] episode accompanied by palpitations[2] and chest tightness.

Background

2. The Patient attended the Trust's ED because of the syncope episode. The Trust admitted the Patient to hospital for investigations. While he was in ED the Trust carried out a series of tests including a D Dimer[3] test and blood tests. He was admitted to a ward for further tests. Whilst in ED a doctor told the complainant the patient would be in hospital for between three and seven days.

3. When a cardiologist (Dr A) carried out her ward round on the morning of 30 December 2021 the Patient was sleeping in his wheelchair. The Patient's sleep pattern had been poor since the passing of his wife on 29 November 2020. Being a bariatric patient and having some pressure damage the Patient had an appropriate bed and air mattress at home. The ED sister had ordered an appropriate air mattress for the Patient, but it had not arrived. As a result, the Patient had '*a very poor night's rest*.'

4. Dr A asked the Patient did he nap a lot and he said that on occasion yes. Dr A told the Patient she suspected sleep apnoea[4] may have caused the syncope episode; however, she was ordering a CT scan of his chest and a chest echocardiogram. She told him that these would likely be done that day, and he could go home later that day.

5. On 30 December 2021 the Trust carried out a CT scan. On 31 December 2021 the Trust carried out an Echocardiogram[5] and diagnosed moderate aortic stenosis[6]. The Trust ruled this out as the cause of the Patient's collapse. The

[1] Syncope – sudden loss of consciousness
[2] Palpitations- a noticeably rapid, strong, or irregular heartbeat due to agitation, exertion, or illness
[3] D Dimer Test- Upon blood clotting, the levels of D-dimer increase in the blood, which makes it an indicator of specific disorders such as Stroke, pulmonary embolism.
[4] Sleep Apnoea - A sleep disorder where breathing is interrupted repeatedly during sleep. Sleep apnoea needs to be treated because it can lead to more serious problems.
[5] Echocardiogram - An imaging test that uses ultrasound to monitor the heart function.
[6] Aortic stenosis - refers to a tightening of the aortic valve at the origin of the aorta (artery) .

Trust concluded that sleep apnoea may have been the cause of the Patient's collapse.

6. The complainant was concerned that the Patient's sleep apnoea had not previously manifested itself in syncope. On 30 December she said this to the ward nurse. She also asked the Patient to call her by telephone when Dr A was on her ward rounds as she wished to speak to Dr A. Dr A did not see the Patient again after the morning ward round on 30 December 2021.

7. A doctor in Dr A's clinical team spoke to the complainant on speaker phone and told the complainant the CT scan '*was clear'* but that the echocardiogram had identified moderate stenosis. However, although intervention was not required at that point, the condition would be monitored with 6 monthly echocardiograms. The doctor also advised the Trust would refer the Patient for sleep apnoea investigations and would have an event monitor investigation both on an outpatient basis. The complainant said the syncope episode she witnessed on the 29 December 2021 was not reflective of how the Patient's sleep apnoea normally presented.

8. The Patient was discharged from hospital on 31 December 2021 and sadly died suddenly at home on 9 January 2022

9. The post mortem revealed that the Patient had; acute left ventricular failure[7]; coronary heart disease[8]; stenosis; and cardiomegaly[9]. The complainant was concerned that the Trust did not discuss these during the Patient's stay in hospital.

Issues of complaint

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

[7] Left ventricular failure - left-sided heart failure
[8] Coronary heart disease - a build-up of fatty substances in the coronary arteries.
[9] Cardiomegaly - A condition with bigger (enlarged) heart than the normal

Whether the care and treatment provided by the Trust to the Patient between 29 December – 31 December 2021 was adequate, appropriate and in accordance with guidance and relevant standards. In particular:

- **The diagnosis and treatment of the Patient by Emergency Department on 29 December 2021;**
- **The diagnosis and treatment of aortic stenosis on 30 December 2021**
- **The treatment of sleep apnoea on 30 December 2021**
- **The discharge of the Patient on 31 December 2021.**

INVESTIGATION METHODOLOGY

11. 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

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

    A consultant cardiologist of 19 years standing. MBBS,MD,FRCP(Lon). Experience in all aspects of cardiology and specialising in the management of coronary artery heart disease. Considerable experience in the management of cardiac related syncope and valvular heart disease.

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

13. 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

14. In order 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[10]:

- The Principles of Good Administration

15. 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:

- Transient loss of consciousness ('blackouts') in over 16s (NICE guideline QS71 (NICE Guidelines) Published October 2014
- Heart valve disease presenting in adults: investigation and management NICE guideline [NG208] Published: 17 November 2021 (HVD guidance)
- Medical Notes

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

16. 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.

17. 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. I have carefully considered all of the comments received.

THE INVESTIGATION

Detail of the complaint

18. The complainant is concerned that other than the stenosis none of the coroner's preliminary findings were referenced during her exchange with Dr A's team. The complainant is concerned that despite providing information to the medical team how the Patient's sleep apnoea condition had presented previously, assumptions '*with little medical foundation'* appear to have been made about the Patient and the cause of the syncope.

19. The complainant is concerned that despite being told on the 29/30 December 2021 a number of investigations would be conducted, and the Patient would likely be in hospital for 3-7 days, after just two days and two investigations he was sent home.

20. The complainant is concerned the Patient, '*a vulnerable adult'* was discharged while the medical team were still unsure of what had caused the episode and that it would not reoccur. She notes the Trust's value statement is : *"We deliver safe, high quality, compassionate care and support to everyone including you. We are open and honest with each other and act with integrity and sincerity. We are sensitive, caring, respectful and understanding towards people we care for."* She is of the view that those values were '*abjectly'* not demonstrated during the Patient's admission.

21. The complainant understands the system is under enormous pressure but '*when patients become statistics on flow management plans something has gone terribly wrong.'* She was told by Dr A's team member that it was deemed safe for the Patient to leave hospital on 31 December. On the 09 January the family's only remaining parent passed away suddenly at home.

Evidence Considered

22. I considered the following Guidelines and clinical practice :
    - NICE Guidelines
    - HVD guidance
    - Medical Notes

The Trust's response to investigation enquiries

23. The Trust stated that the autopsy report lists the causes of death as Coronary Heart Disease, Ischaemic Heart Disease and Aortic Stenosis.

24. The Trust stated that it admitted the Patient to hospital on 29 December 2021 for tests, namely a D-dimer, CT scan and echocardiogram. The Trust stated that when Dr A saw the Patient, she suspected the cause of the syncope was sleep apnoea possibly due to it causing significant pulmonary hypertension[11]. However, she followed the guidelines for investigation of syncope despite her suspicion.

25. The Trust stated that due to the Patient's build the echocardiogram findings from 31 December 2021 were the usual standard. Dr A and another doctor (Dr B) reviewed them and '*concluded that the echocardiogram findings showed mild to moderate reduction of left ventricular (heart) function, mild thickening of the heart walls and moderate aortic stenosis.* The Trust further stated, '*the echocardiogram findings could not obtain an exact measurement of the valve however, the valve was opening well, therefore excluding severe narrowing of the valve as a cause of his blackout.'* In addition,' *they look for certain things in an echo and although it was a technically difficult study, it was good enough to provide the required information'.* The Trust stated the echocardiogram showed a high likelihood of pulmonary hypertension. The Trust considered this most likely to be due to sleep apnoea and that sleep apnoea can cause syncope.

[11] Pulmonary hypertension - high blood pressure within the lungs

26. The Trust stated there was some calcium noted in the coronary arteries on the CT scan, however, *'this was common finding in people of the Patient's age. In the absence of angina[12] or significantly raised troponin[13] the Trust would not perform further assessment of the coronary arteries.'*

27. The Trust stated that although the Patient's heart function was not normal his CT scan didn't show pulmonary oedema[14]. The investigations conducted did not look at the coronary arteries, but clinicians noted some calcification[15] on his CT scan which would indicate a degree of coronary disease. Dr A stated that *'her investigations of the Patient did not show any indicators of a heart attack'.*

28. The Trust stated that the doctor who assessed the Patient after referral from ED to the cardiology service for review was a junior doctor and not a specialist cardiology doctor. The Trust stated that the average stay in hospital for syncope is 24-72 hours and some guidelines (unspecified) recommend the Trust will investigate this on an outpatient basis. The Patient stayed in hospital for two days.

29. At the meeting with the Trust the complainant queried whether additional tests/observations would have helped her father. The Trust stated that the only test not performed was an implantable loop recorder under the skin, but stated this would not have changed the outcome. The Trust stated that Dr A said she must weigh up the risk of tests.

30. The Trust stated that bed pressures did not influence Dr A's decision to discharge the patient. Dr A assessed the risks of discharge against staying in hospital. The Patient was at high risk of covid complications and there was an outbreak on another part of the ward therefore, she was concerned that he didn't remain in hospital too long.

31. The Trust stated that it *'quite frequently discharges patients without a firm diagnosis of their syncope and often outpatient assessment or an implanted*

[12] Angina - Angina is chest pain caused by reduced blood flow to the heart muscles. It's not usually life threatening, but it's a warning sign that you could be at risk of a heart attack or stroke.
[13] Troponin - a protein that's released into the bloodstream during a heart attack.
[14] Pulmonary oedema - a condition caused by too much fluid in the lungs. This fluid collects in the many air sacs in the lungs, making it difficult to breathe. In most cases, heart problems cause pulmonary oedema
[15] Calcification - Coronary artery calcification is a collection of calcium in your heart's two main arteries.

monitor is required to make the diagnosis.' The Trust stated that it had carried out all appropriate investigations prior to discharge. The Trust referred the Patient to the sleep service as an outpatient. No other investigations were indicated. The Patient would not have been able to do a treadmill and a tilt test would not have been helpful. These tests are very difficult for bariatric patients.

32. The doctor who assessed the Patient when he was referred to the cardiology service for review was a junior doctor and not a specialist cardiology doctor. Dr A stated the average stay in hospital for syncope is 24-72 hours and that some guidelines recommend it is investigated as an outpatient. The patient stayed in hospital for two days.

33. The Trust stated the junior doctor took a good history of the Patient with the complainant present. The Patient had a murmur[16] and chronically swollen legs. He did not report breathlessness. Dr A reported that blood tests and ECG showed no heart attack or heart rhythm disturbances on monitoring.

Relevant Independent Professional Advice

34. The IPA provided advice about the care and treatment the Trust provided to the Patient. The IPA's full advice report is enclosed at Appendix two of this report.

Analysis and Findings

The diagnosis and treatment of the Patient by Emergency Department on 29 December 2021

35. The IPA advised that it is reasonable to give the Next of Kin some indication of the likely duration of an admission. For patients who present with 'common problems such as collapse' there is an approximate length of stay that would be expected in patients where no sinister cause is found. The Trust stated that the doctor who assessed the Patient in ED was a junior doctor and not a cardiologist. Dr A stated that the average stay in hospital for syncope is 24 – 72 hours.

[16] Murmur - an extra unusual sound in a heartbeat. Echocardiogram is the main test to determine the cause.

36. The ED doctor who advised the complainant of the length of stay in hospital the Patient could anticipate was not a cardiologist. During the Patient's admission to hospital the Trust carried out investigations to establish the cause of the syncope.

37. Paragraph 1.1.4 of the NICE HVD says on referral and assessment for adults with murmur and non-exertional syncope, follow the recommendations in the NICE guideline on transient loss of consciousness ('blackouts') in over 16s. Paragraph 1.1.2.2 of the NICE Guidelines states ' record a 12 lead electrogram (ECG) using automated interpretation. This was carried out in ED.

38. Paragraph 1.1.2 of the HVD guidance says offer an echocardiogram to adults with a murmur if valve disease is suspected (based on the nature of the murmur, family history, age or medical history) and they have:
signs (such as peripheral oedema) or symptoms (such as angina or breathlessness) or an abnormal ECG. I note the Patient had evidence of a heart murmur on admission to ED. An Echocardiogram was carried out on 31 December 2021 at the request of Dr A and no sinister cause for the Patient's episode of Syncope was detected.

39. I am satisfied that the investigations the Trust carried out in relation to the Patient's syncope episode were in accordance with the relevant guidelines and it found no *'sinister'* cause. I observe the investigations were carried out within the time frame Dr A advised was normal. I do not uphold this element of the complaint.

The diagnosis and treatment of aortic stenosis on 30 December 2021

40. The Patient was admitted to the Trust's Hospital having suffered a syncope episode along with palpitations and chest tightness. The Trust carried out several investigations during his admission namely blood tests, D Dimer Test, CT scan and an echocardiogram.

41. The IPA advised that routine blood tests carried out by ED ruled out a heart attack and the D Dimmer test and CT scan showed no signs of pulmonary embolism.

42. The IPA advised *'echocardiographic images were poor'.* Both cardiologists and the echo technician determined that the aortic valve was restricted but not '*severely stenosed*.' No formal doppler flow measurement of the valve could be obtained due to the poor images. In this situation one relies on a visual assessment of the valve which the Trust described as restricted but seen to be opening. If the valve had been severely stenosed there would have been no significant movement in the valve leaflets. The IPA advised therefore*, in difficult circumstances the determination of mild aortic stenosis' was reasonable. More importantly, severe aortic stenosis , the only level of severity that could possibly have been related to a syncopal episode, was ruled out.'*

43. The IPA also advised *'given the clinical presentation and the reassuring cardiac investigations performed no further cardiac investigations were indicated during the hospital admission or in the immediate period post-discharge.'* The IPA advised the tests performed by the Trust were *'entirely appropriate and performed to appropriate standards'.*

44. Dr A stated in her report to the coroner that she was concerned the Patient may have significant sleep apnoea which can cause pulmonary hypertension which can lead to syncope. To exclude this, and especially given the Patient's raised D- Dimmer, she requested an in-patient CT pulmonary angiogram. She reported to the coroner that the CT scan showed no evidence of pulmonary embolism or right heart strain. The IPA advised that some calcium was noted on the coronary arteries on the CT scan '*but this is common in people of the Patient's age*.

45. I reviewed the NICE guidelines, medical records and Dr A's report to the coroner dated 15 March 2022 and I accept the IPA's advice. I am satisfied that when Dr A first attended to the Patient on 30 December 2021, she took account of the Patient's full medical history, the results of tests carried out by ED the previous day and made her own clinical observations including carrying out a

CT scan and an echocardiogram. I note Dr A reported the Patient had no new symptoms since admission. I also note the Patient remined on a cardiac monitor whilst those investigations were arranged. Given all of this, I am satisfied that in the *'difficult circumstances',* referred to by the IPA Dr A made a *'reasonable'* diagnosis of mild aortic stenosis.

46. The IPA advised Dr A arranged a follow up transthoracic echo in 6 months '*(sooner that the British Society of Echocardiography guidelines given the difficult study)' to monitor the aortic stenosis*. He advised she also arranged an '*urgent'* 7-day ECG monitoring to further evaluate for arrhythmia with a clinical review in three months. The IPA advised that the finding of mild aortic stenosis prompted the ordering of repeat surveillance echocardiogram which was reasonable and Prolonged Holter monitoring[17] to further evaluate for Arrythmia[18] was planned – *'again entirely reasonable and good practice.* He advised all of this was done in accordance with the NICE guidelines and NICE HVD guidelines.

47. Given all the above I am satisfied that Dr A provided reasonable care and treatment to the Patient regarding a possible cardiac cause of his syncope in accordance with the relevant guidelines. In addition, I am satisfied that further monitoring arranged by Dr A after the Patient's discharge from hospital was in accordance with relevant guidelines. Based on the IPA advice I conclude that there were no further additional tests that should have been carried out. Consequently, I do not uphold this element of the complaint.

48. I observe the IPA advised the history of chest tightness was vague so not treating it along the lines of Angina was not unreasonable and any treatment is unlikely to have impacted on the outcome.

Sleep Apnoea

[17] Holter monitoring - A Holter monitor is a small, battery-powered medical device that measures your heart's activity, such as rate and rhythm
[18] Arrhythmia - A condition characterised by abnormal heart rhythm. This may result in either too fast or slow heartbeat.

49. The IPA advised whilst on Ward C the Patient displayed *'daytime sleepiness and drowsiness as well as sleeping a lot through the day at home and waking with breathlessness. These are typical symptoms of sleep apnoea.'* The IPA also advised *that no specific tests were performed.* He advised 's*leep apnoea is diagnosed on the basis of clinical history , symptoms and signs exhibited by the patient . The only formal test is sleep studies.'*

50. The IPA advised that '*it is more about what the cardiologist ruled out as a result of the investigations. The syncopal episode could have many causes, the investigations ruled out , or made much less likely, the common and sinister causes of sudden collapse.* He advised i*n the absence of revelation of a clear cause using the standard tests performed the cardiologist reasonably concluded that sleep apnoea may have been contributory'*. He also advised *'it is common to evaluate patients with sudden collapse and not determine a clear cause despite best efforts. In these cases, one has to rely on clinical judgement as to possible cause.*

51. I note the complainant stated her father's sleep apnoea had not previously presented as syncope. I reviewed the medical records and the Trust response which stated *the echocardiogram showed a high likelihood of pulmonary hypertension.* The Trust considered this *most likely to be due to sleep apnoea and that sleep apnoea can cause syncope*. I refer to my findings above as well as the IPA's advice regarding the absence of a clear cause of the syncope episode using the standard tests performed. On this basis, I am satisfied Dr A's conclusions that sleep apnoea **may** have caused or contributed to the episode of syncope the Patient experienced was reasonable and appropriate in the circumstances.

52. I note Dr A referred the Patient on for heart further monitoring and sleep apnoea tests on an outpatient basis. I accept the IPA's advice that it is common to evaluate patients with syncope and not determine a clear cause despite best efforts. Given the referral for further monitoring and investigations on an outpatient basis I consider this may be the case in this instance. I am satisfied that Dr A followed the relevant guidelines in investigating the Patient's syncope. I do not uphold this element of the complaint.

The discharge of the patient on 31 December 2021

53. The IPA advised that in considering the Patient's suitability for discharge Dr A took account of the following:
    - Clinically the Patient showed no evidence of recurrent loss of consciousness;
    - No evidence of Arrhythmia;
    - No evidence of a heart attack or stroke;
    - No evidence of any significant abnormality on multiple conventional tests;
    - The patient was reported to be well when in hospital and did not require prolonged in-patient care; and
    - Standard management and investigation of a patient with syncope had been carried out over an appropriate period of time.

54. The IPA also advised that consideration of the above factors was in accordance with clinical practice. He advised that no omissions of care are recognised and that NICE Guidelines for management of syncope describe most of the care for a syncopal patient to be out patient based. Having concluded that Dr A carried out her investigations in line with the relevant guidance and reached a reasonable conclusion that the syncope episode may have been related to the Patient's sleep apnoea, I accept the IPA advice.

55. I have found above that the Trust carried out the appropriate tests in accordance with the relevant guidelines and did not find a 'sinister ' cause for the Patient's syncope episode. Therefore, Dr A reasonably considered further in patient investigations were not necessary. I have also found that Dr A determined a likely cause of the syncope episode may have been the Patient's sleep apnoea. I have noted that Dr A referred the Patient for further heart monitoring and sleep studies. I reviewed the medical records and I accept the IPA's advice that Dr A took several factors into account when reviewing the Patient's suitability for discharge. Taking account of all of this I consider A's decision to discharge the patient on 31 December 2021 was reasonable, appropriate and in line with the relevant guidelines. I do not uphold this element of the complaint.

CONCLUSION

56. I received a complaint about care and treatment the Trust provided to the Patient during the period 29 – 31 December 2021. I did not find any failings in discussions at ED, the cardiological investigations, the consideration of sleep apnoea and the reason to discharge the Patient. I am satisfied the care and treatment to the patient was reasonable, appropriate and in accordance with guidance and relevant standards.

57. I understand that it is difficult for a family when a loved one passes away, and in the case of the complainant's father, in such a sudden manner. It is a testament to the love and commitment shown by the family, to their father, that the complainant made the decision to pursue this matter and to seek a resolution to her concerns. I wish to take this opportunity to offer my condolences to the family.

MARGARET KELLY
Ombudsman **16 August 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.