Investigation Report

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

NIPSO Reference: 201915844

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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 Neurology care and treatment the complainant received from the Belfast Heath and Social Care Trust at the Royal Victoria Hospital. The complainant said that the Trust failed to identify and treat a physical cause for her distressing symptoms.

I obtained the complainant's medical records and sought advice from independent professional advisors.

I accepted two issues of complaint for investigation. The first concerned the care and treatment afforded to the complainant, while an inpatient in the RVH during the period 17 May 2017 to 8 June 2017.

My investigation found that the clinicians carried out extensive investigations before diagnosing a Functional Neurological Disorder. The consultant neurologist explained the diagnosis to the complainant and discharged her, with a recommendation for further assessments to be completed by her GP and by her consultant neurologist at Craigavon Area Hospital as an outpatient. I was satisfied that these investigations and assessments were thorough and comprehensive. I did not find any failings.

The second issue of complaint related to the complainant's attendance at the Emergency Department of the RVH on 19 March 2019 seeking an investigation of her spine. The clinicians were able to access her medical records and establish that her symptoms had already been extensively investigated. She was not admitted. I found that that was the correct decision based on the history and clinical findings at the time. I did not uphold this element of the complaint.

However, I concluded that there was a delay in examination and administration of pain relief and I upheld this element of the complaint. I recommended an apology from the Chief Executive of the Trust for the injustice of unnecessary pain and discomfort.

The Trust accepted my findings and recommendations.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) about the complainant's care and treatment on two occasions when she attended the Royal Victoria Hospital (RVH) in Belfast.

Background

2. The complainant developed symptoms following ENT surgery in 2014. She had surgery to remove her thyroid on 16 June 2016. Her symptoms worsened and continue to trouble her. The symptoms are diverse and include a weight sensation, loss of swallow reflex, metallic taste in mouth and a crawling sensation round her body.

3. She had been under the care of a consultant neurologist as an outpatient at Craigavon Area Hospital (CAH) since August 2016. He made a referral to the RVH neurology department on 4 April 2017. The complainant attended the ED of the RVH on 17 May 2017. She stated that she did this because *'the registrar to the neurologist had still not referred me'*. She was admitted and was an inpatient until 8 June 2017. She did not believe her symptoms were thoroughly investigated. She did not agree with the diagnosis of functional neurological illness and believed that the consultant neurologist discharged her prematurely.

4. The consultant Neurologist at CAH referred her to the University College London Hospitals (UCLH) National Hospital for Neurology and Neurosurgery in London for an independent assessment. She was admitted on 22 October 2018 and discharged on 9 November 2018. The discharge summary states '*complex pain and neuropsychiatry reviews suggested that her multiple symptoms were consistent with central sensitisation – a higher level sensory interpretation disorder at the level of the thalamus or above.'*

5. Another Consultant Neurologist at the RVH reviewed her on 22 January 2019 and explained to her that he could not find '*any organic pathology to count for her symptoms'* and that she might benefit from neuropsychology and neuropsychiatry.

6. The complainant went by ambulance to the RVH ED on 19 March 2019 seeking admission for further review. The ED Dr sought an opinion from a Neurology consultant. The ED doctor consulted with a more senior doctor and she was discharged. She stated that this ED doctor was rude and abrupt and would not listen to her explanation of her symptoms. She complained he did not perform a clinical examination, or offer any care and treatment.

7. Between 2014 and 2020, a number of clinicians had reviewed the complainant with a view to identifying the cause of her symptoms. Investigations were carried out across two Trust areas, and the centre of excellence at the UCLH and included the following disciplines (in alphabetical order):

- Cardiology
- Dermatology
- Dentistry
- Endocrinology
- ENT
- Gastroenterology
- General medicine
- GP
- Gynaecology
- Maxillofacial
- Neurology
- Neurophysiology
- Neuropsychiatry
- neuropsychology
- Opthamology
- Oral surgery
- Orthodontics
- Orthopaedic ICATS
- Pain management
- Palliative medicine
- Physiotherapy
- Psychiatry
- Psychology
- Respiratory
- Restorative dentistry
- Spinal surgery
- Urology

8. The complainant was dissatisfied that the Trust did not diagnose a physical cause for her debilitating symptoms. She was placed on a waiting list on 27 October 2020 to see a spinal surgeon following referrals from her GP to Musgrave Park Hospital Belfast. She was given an appointment to see the surgeon in September 2021.

Issues of complaint

9. The issues of complaint accepted for investigation were:

Issue one

Whether the care and treatment afforded to the complainant, while an inpatient in the RVH during the period 17 May 2017 to 8 June 2017, and the follow up actions were appropriate and reasonable?

Issue two

Whether the Care and treatment provided in the Emergency Department (ED) at RVH when the complainant attended by ambulance on 19 March 2019 was appropriate and reasonable?

INVESTIGATION METHODOLOGY

10. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

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

- MD , FRCP (Glas) FRCP (London) a consultant endocrinologist with over 30 years specialist experience in the management of thyroid disease
- FRCEM FRCSEd(A&E) MBBS LLM (Medical Law) RCPathME a consultant in Emergency medicine since 2007 with experience in assessment and

management of major and minor conditions as well as providing supervision for junior medical staff who attend this type of emergency presentation.

- MA DPhil FRCP, a Consultant Neurologist since 1995 with extensive experience of patients with physically and emotionally-generated symptoms.

The clinical advice received is enclosed at appendix three to this report.

12. I included the information and advice that informed my findings and conclusions within the body of this report. The IPAs provided 'advice'; however, how I weigh this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

13. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are 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[1]:

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

14. The specific standards and guidance I refer 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:

- The General Medical Council's (GMC) Good Medical Practice 2013, as updated April 2014 (the GMC Guidance);
- Functional Neurological Symptoms A guide to understanding, managing & seeking help for Functional Neurological Symptom Clinical Neuropsychology Regional Neurosciences Royal Hospitals, Belfast August 2018 (The FNS Guide).

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

Relevant sections of the guidance considered are enclosed at appendices five and seven.

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

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 INVESTIGATION

Issue one

Whether the care and treatment afforded to the complainant, while an inpatient in the RVH during the period 17 May 2017 to 8 June 2017, and the follow up actions were appropriate and reasonable?

Detail of Complaint

17. The complainant presented to the ED of the RVH on 17 May 2017 and was admitted by a registrar under the care of a consultant neurologist. The complainant stated that the staff seemed to be disinterested in her symptoms and discharged her on 8 June 2017 before completing all investigations. She said the consultant neurologist referred to her as delusional; she objected to that term. The complainant believed that she had a problem with malabsorption of medication which was not investigated.

18. The complainant subsequently attended the ED of RVH 23 July 2017 and was admitted and discharged the following day. She was seen by the neurology registrar and complained that the consultant neurologist discharged her without further treatment back to the care of the consultant neurologist at CAH for outpatient care.

Evidence Considered

19. I considered the following guidance:

- The GMC Guidance (extracts at appendix five)

The Trust's response to investigation enquiries

20. The Trust provided written responses to the complaint on 9 October 2017 and again on 4 March 2019. I attach extracts of the letter of 9 October 2017 at appendix four.

21. The Trust wrote to my office on 22 September 2020 in response to enquiries. The Trust stated that during the complainant's admission between 17 May 2017 and 8 June 2017 *'[The consultant neurologist] could find no physical basis for the symptoms despite extensive investigations complementing the thorough work-up already performed by the Consultant Neurologist at Craigavon Area Hospital. The diagnosis reached was that of a functional neurological illness'.* The consultant neurologist strongly denied calling the patient 'delusional' and states that *'he challenged [the patient] and corrected her each time she said this to him while she was an inpatient'.*

22. The Trust stated '*that the clinical records indicated her symptoms were thoroughly investigated with blood tests, nerve conduction studies and an MRI scan. Further input was also received from [another consultant neurologist] as a second opinionand assessments by a Consultant Neuropsychiatrist and a Consultant Neuropsychologist were carried out. The Endocrine team also reviewed [the patient].'*

23. The Trust also said that the consultant neurologist '*did not wish to discharge her from the ward until he was content that a thorough assessment of her symptoms had been undertaken and he was happy that she was medically fit for discharge'.*

24. The Trust explained in its letter of 9 October 2017 to the complainant (appendix four) that further tests were to be completed as an outpatient at

CAH and that there was no need for the complainant to be admitted when she presented to the ED of the RVH on 23 July 2017.

Relevant Trust records

25. The independent professional advisors reviewed the relevant clinical notes and records and referred to them in their advice where appropriate.

26. I attach a copy of the discharge note dated 8 June 2017 as appendix six.

27. I note that the patient attended another consultant neurologist in the RVH on 22 January 2019. He concluded that there *'was no organic pathology to count for her symptoms'* and suggested Neuropsychology and Neuropsychiatry review.

Relevant Independent Professional Advice

Neurology consultant IPA (N IPA)

28. Regarding the admission on 17 May 2017, the N IPA advised:
'*The plan appears to have been to undertake neurophysiological studies to find any evidence of neuropathy, review [the patient's] medication and obtain a neuropsychiatry opinion. Whilst these could have been undertaken as an outpatient, there is no reason to think that admission was not appropriate to facilitate prompt management of [the patient's] condition.'*

29. The Investigating Officer asked the N IPA's opinion about the consultant neurologist's communication with the patient. He advised:
'The patient was told on 18 May [2017] that it was unlikely that the clinical team would find a physical basis for her symptoms, and that although she might have a mild neuropathy this would not explain her symptoms. This appears to have met GMC standards of good communication.'
He also advised that discussions with the patient on 23 May and 31 May 2017 meet the GMC standards of good communication.

30. The investigating Officer asked the N IPA whether the clinical investigations carried out over the 3-week period the patient was in the RVH were appropriate. He advised that:

- The patient had a number of blood tests which were appropriate;
- The referral to a neurophysiologist for nerve conduction study on 23 May 2017 was appropriate; ***'****No significant abnormalities were found (absent left peroneal sensory response is likely attributable to a mild pressure neuropathy) and no action was required';*
- The consultant referred the patient to another consultant on 7 June 2017 for a second opinion, which was appropriate. '*There was little evidence to support a diagnosis of small fibre neuropathy, either clinically or neurophysiologically…It might, however, have been reasonable to consider a definitive test for the presence of small fibre neuropathy by punch biopsy of the skin';*
- The patient's symptoms including a weight sensation, loss of swallow reflex, metallic taste in mouth, a crawling sensation round her body were *'clearly documented'* and **'***As they are not symptoms of organic neurological disease, the conclusion that they were emotionally-generated symptoms was reasonable' and*
- Referral to a neuropsychiatrist on 26 June 2017 was appropriate.

31. The N IPA also advised:
'[The complainant''s] time in hospital was an opportunity to have her assessed by various clinical teams. The clinical opinion of functional neurological disorder was reinforced to her, and she underwent neurophysiological investigation. This was an opportunity to ensure that no stone had been left unturned to ensure a physical cause for her symptoms was not missed.
On two occasions (20/5 and 23/5) low blood pressure readings were obtained from a cuff on [the complainant's] left arm, though repeat measurements on the right arm were normal. Otherwise her blood pressure was within the healthy range. I consider this not to be clinically significant, and no treatment was required.'

32. The Investigating Officer asked the N IP if the endocrine advice sought by the consultant was followed. He advised:
'[The patient] was completely reliant on thyroid hormone supplements following her total thyroidectomy in June 2016.
The endocrinological opinion was that C's abnormal thyroid function tests were indicative either of malabsorption or C failing to take her thyroid supplements.

The half life of thyroxine is 9-10 days, to achieve very low thyroxine levels with a thyroid stimulating hormone level of >50 would mean not taking the drug for several multiples of the half life of thyroxine. She must therefore not have been taking any thyroid supplement for several weeks.
I note that the thyroid function tests were repeated and were again very abnormal, ruling out laboratory error. I also note that when the patient was provided with supervised medication in hospital, her serum thyroxine level rapidly returned to normal so that on 30 May her free thyroxine level was near normal. This rules out malabsorption as a cause.'

33. The N IPA advised that the patient was medically fit for discharge on 8 June 2017. In relation to the referrals recommended on the RVH discharge letter, he advised:
'Gastroenterological opinion may have been considered because of the possibility that C was not absorbing her medication normally, short synacthen test to investigate whether abnormal cortisol production by the adrenal glands could be contributing to C's symptoms of fatigue and weakness and neuropsychiatry because of the presence of emotionally-generated symptoms. Whilst these referrals appear reasonable, the chance of detecting any physical abnormality which could be related to her clinical presentation was clearly remote as none of her symptoms could plausibly be attributed to an endocrine or gastroenterological disorder (sensation of something in her mouth, pain all over her body, strange sensations when she moves, feeling of heaviness in the legs, etc.). No clear justification for the referrals is documented but the neuropsychiatry referral was clearly appropriate'.

34. The patient attended another consultant neurologist in the RVH on 22 January 2019. He concluded that there *'was no organic pathology to count for her symptoms'* and suggested Neuropsychology and Neuropsychiatry review. The N IPA agreed that this was appropriate.

35. The N IPA concluded:
'The patients' C's case is complex, but on review there are two striking findings that provide clues to the diagnosis. The first is the persistently low serum folate

level when she first presented despite apparently being prescribed folic acid by her GP, and the second is very low thyroid hormone level whilst in hospital, again whilst prescribed essential thyroxine supplements, both in the context of a patient who did not suffer from malabsorption. The only explanation for such findings is that the patient is deceiving her doctors by not taking medication she was prescribed, and this makes the diagnosis of factitious[2] disorder highly likely.'

Endocrine IPA

36. The Investigating Officer asked the Endocrine IPA to summarise the endocrine investigations and treatment during the complainant's three-week admission to the RVH commencing 17 May 2017. He advised:
'The thyroid function test that was carried out conclusively showed marked under replacement of thyroid hormone. This would be only the consequence of not adhering to the replacement therapy or the much less likely possibility of a recent change in absorption. There was no evidence of Coeliac disease which was excluded as a cause of issues with thyroxine absorption.
Given that thyroid balance in 2016 was much less abnormal and the dosage of thyroxine at 150 ug was at a level where the vast majority would have normal thyroid function it is difficult to explain on the basis of anything other than non-regular intake. Indeed within a very short period of time in hospital the thyroid function test on the 30th May had already begun to improve with hospital administered thyroxine in a higher dose. I cannot see any later thyroid tests. The endocrine review at the time in May 2017 was in my opinion appropriate but should have led to ongoing endocrine review after discharge.

Analysis and Findings

37. The consultant neurologist at CAH made a referral to the RVH neurology department on 4 April 2017 for a second opinion. The complainant was so distressed by her ongoing symptoms that she did not wish to wait for the appointment at the RVH to be scheduled. The complainant presented at the ED of the RVH on 17 May 2017. She was admitted under the care of a consultant neurologist.

[2] a false belief or opinion.

38. The consultant performed a number of blood and nerve conduction tests and a MRI of the brain was performed on 4 June 2017. This meets standard 15 in the GMC Guidance as follows:
'You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must… promptly provide or arrange suitable advice, investigations or treatment where necessary.'

39. Standard 15 of the GMC Guidance also states *'refer a patient to another practitioner when this serves the patient's needs'.* During the complainant's three-week admission, the consultant neurologist referred the patient to another consultant neurologist on 7 June 2017 for a further opinion and to a neuropsychiatrist and neuropsychologist. A number of other assessments were recommended, to be carried out as an outpatient at CAH. I consider this also met the GMC standard and evidences that her symptoms were thoroughly investigated.

40. I accept the opinion of the N IPA that the patient's symptoms '*are not symptoms of organic neurological disease'* and *'The clinical opinion of functional neurological disorder* [FND] *was reinforced to her.'* He advised *'there was little evidence to support a diagnosis of small fibre neuropathy, either clinically or neurophysiologically'.*

41. The complainant did not agree with the diagnosis of a functional neurological illness. Paragraph 31 of the GMC Guidance states '*You must listen to patients, take account of their views, and respond honestly to their questions'.* The consultant neurologist at the RVH advised that he explored the issue of functional neurological symptoms with the complainant '*at great length'* and spent several hours discussing her symptoms and offering explanations. This is clearly evidenced in the clinical records. The fact that the complainant did not agree with the consultant neurologist is not in itself evidence of a failure in communication. I accept the advice of the N IPA that communication during consultations on 18, 23 and 31 May met the GMC standards of good communication.

42. I note that the complainant presented with very low thyroid hormone level whilst in hospital, despite being prescribed thyroxine supplements by her GP. I accept the advice of the N IPA advised that '*when the patient was provided with supervised medication in hospital, her serum thyroxine level rapidly returned to normal so that on 30 May her free thyroxine level was near normal. This rules out malabsorption as a cause.'* The discharge note (appendix six) states *'we feel with treatment of her thyroid function her symptoms may resolve'* and listed a number of other investigations to be carried out *'If there are no improvements*.'

43. The complainant believed she was discharged prematurely. I note the discharge letter from RVH on 8 June 2017 recommended *'referral to GI and endocrine team could be made*, *vitamin A,E,D,K, HIV[3], VDRL[4] serology, short synacthen test could be checked.'* I understand that the complainant would have preferred that these further investigations were carried out in the RVH. However, I accept the advice of the N IPA that she was medically fit for discharge on 8 June 2017 and it was, therefore, reasonable to arrange these through the consultant neurologist at CAH as an outpatient. I consider that it was reasonable that the consultant neurologist at the RVH did not readmit the complainant on 23 July 2017 to complete these tests.

44. The Endocrine IPA also advised re thyroid function tests (TFTs) that '*it is difficult to explain on the basis of anything other than non-regular intake. Indeed within a very short period of time in hospital the thyroid function test on the 30th May had already begun to improve with hospital administered thyroxine in a higher dose.'* I note that the discharge letter of 8 June 2017 requested that the GP monitors her Thyroid function, however the Endocrine IPA advised that there should have been ongoing endocrine review after discharge. I note that the discharge note recommended the consultant neurologist at CAH follow this up and that the GP also monitors TFTs.

[3] human immunodeficiency virus
[4] The Venereal Disease Research Laboratory test

45. The complainant also presented with low serum folate level despite her GP's prescribing supplements. Both IPAs view this is as another indication that the complainant was not always compliant with her medication with consequential detriment to her general health.

46. The complainant was concerned that low blood pressure recorded during this admission was not treated. I note that the discharge note requests that the GP monitor this in the community before adjusting her medication. This is reasonable.

47. The complainant's GP made several referrals to Musgrave Park for examination by a spinal surgery and the Trust recently gave her an appointment for September 2021. I agree with the advice of the N IPA that the Trust ensured that '*no stone had been left unturned'* in diagnosing the complainant. I therefore conclude that the care and treatment afforded to the complainant, while an inpatient in the RVH during the period 17 May 2017 to 8 June 2017, and the follow up actions were appropriate and reasonable. I do not uphold this issue of complaint.

Issue two

Whether the Care and treatment provided in the ED of the RVH when the complainant attended by ambulance on 19 March 2019 was appropriate and reasonable?

Detail of Complaint

48. The complainant had been under the care the care of the consultant neurologist at CAH as an outpatient until discharge at review on 7 February 2019. He referred her to a consultant in anaesthesia and pain management at that time. The complainant said she went by ambulance to the ED of the RVH at around noon on 19 March 2019 with symptoms of severe neck pain, photophobia and headache in addition to her regular symptoms. She brought literature with her regarding spinal damage. She believed she should have been seen by a spinal consultant urgently. She considered the doctor who saw her was rude and abrupt.

49. She complains a junior doctor gave her only a cursory examination and she was not seen again until after 19:00, by a registrar from the neurology department. She states she explained to him her symptoms and the length of time she had been experiencing them and that she was feeling suicidal. She complains that he did not carry out a clinical examination and discharged her without any further intervention.

Evidence Considered

Legislation/Policies/Guidance

50. I considered the following guidance:

- The FN Guide (appendix seven)

The Trust's response to investigation enquiries

51. The Trust stated '*no issues of complaint concerning the RVH Emergency Department regarding the ED Dr were raised by the complainant to allow the Trust to respond*'. I confirm that my office accepted this issue for investigation to save the complainant and the Trust the inconvenience of taking the issue through local resolution.

Relevant Trust's records

52. The independent professional advisor reviewed the relevant clinical notes and records and referred to them in their advice where appropriate

Relevant Independent Professional Advice

Consultant in emergency medicine (ED IPA)

53. The Investigating Officer asked the ED IPA if the junior doctor's assessment on 19 March 2019 was satisfactory in terms of examination, observations and tests. He advised:

'Clinical observations were recorded and fall within normal acceptable limits. Blood investigations and urinalysis were requested. [The complainant] was assigned triage category 3 which would suggest she should have been assessed by a doctor within 1 hour of arrival.

Cardiovascular and respiratory examination recorded did not identify any concerns

and it is noted that there was no palpable tenderness during the examination and notes 'pain deep inside her body'. Mobility was assessed and recorded that C mobilised well with a tripod rollator support.

Blood investigations - full blood count, Urea and electrolytes were normal, urinalysis was also normal.

C was prescribed analgesia and antispasmodic medications which were administered at 16:35.'

54. The Investigating Officer asked the ED IPA if the clinicians took into account the complainant's history sufficiently. He advised:

'On review of the notes there are details recording the chronology of [the complainant's] condition and the various interventions she had undergone since 2014. This suggests that the doctor attending her took the time to ask about her condition in detail and due to the complex nature sought specialist advice... I therefore consider it entirely reasonable for the doctor to seek advice from the neurology team (and also her senior ED colleagues).'

55. An ST6 doctor took over the complainant's care from the junior doctor. The ED IPA advised:

'*The information provided by [the ST6] outlined that her case had been discussed with the neurology consultant who advised that she had an ongoing problem that did not require emergency admission. So, whilst [the complainant] disagreed with this decision, the ED team had sought specialist opinion with respect to what the most appropriate course of action would be and have followed this advice which was appropriate as from the assessment made within ED there were no clinical findings to suggest an acute emergency condition that needed admission for investigation or treatment.'*

56. The complainant asked to be referred to a neurologist and sought a lumbar puncture. This was declined. The Investigating Officer asked the ED IPA if this was appropriate. He advised:

'A lumbar puncture as requested by [the complainant] was not indicated in the opinion of the attending doctors and as a result they are quite right to decline to perform this invasive procedure which in itself carries risk of complication.

I consider that efforts were made to explain the plan to [the complainant] but it appears she disagreed with this plan… The [ST6] has recorded that [the complainant] has stated "she would kill herself if she did not get a lumbar puncture". ..This was evaluated by the senior ED doctor and determined not to be an acute threat to the patient, so he was happy to continue with the plan for discharge. The hospital staff provided transport home for the patient in the form of a taxi with her partner.'

57. The Investigating Officer asked the ED IPA if the decision not to admit was clinically correct. He advised:
'The complainant had presented to the emergency department with a 'neurological complaint'. She had an assessment by the ED team, underwent baseline investigations to rule out acute emergencies. e.g., sepsis. Her case was discussed with the neurology team on duty with advice obtained from their consultant. There were no clinical findings to suggest that emergency admission was required. Whilst her symptoms may not have been fully explained, no acute or life-threatening conditions were identified. As a result, it was appropriate not to admit C on the 19 March 2019.'

58. The ED IPA identified the following areas for improvement:
'She had an initial triage assessment [at 12.57] within 15 minutes of arrival in line with good practice, but unfortunately had a delay before being attended by an ED doctor. There was also a delay before providing C with analgesia [16.35] for the moderate pain she complained of at triage.'

59. The ED IPA concluded:
'I consider that the assessment and investigations undertaken in the ED on 19 March were of a reasonable and appropriate standard, the doctor who initially attended C sought senior and specialist advice appropriately and this advice was then acted on. C had requested a treatment that the ED team did not consider appropriate, so this was declined. C was discharged with her partner.'

Analysis and Findings

60. The complainant attended the ED of the RVH on 19 March 2019 with distressing symptoms of pain and photophobia, in addition to her longstanding symptomology. She brought with her literature relating to spinal injuries and sought a neurology assessment and a referral to a spinal consultant.

61. I note that the patient had attended a review with another consultant neurologist in the RVH on 22 January 2019. He concluded that there *'was no organic pathology to count for her symptoms'* and suggested Neuropsychology and Neuropsychiatry review.

62. I note that the consultant neurologist at CAH discharged her from his care and referred her for pain management as an outpatient about six weeks before, on 7 February 2019.

63. I note that the complainant was triaged at 12:57 on 19 March 2019. An ED Dr attended at 15:25, took a detailed history, carried out a physical examination and appropriate tests. Analgesia and antispasmodic medications were administered at 16:35. He also consulted with a consultant neurologist for advice. I accept the advice of the ED IPA that assessments and investigations were appropriate.

64. I note that the junior doctor consulted with a more senior F6 doctor who explained the plan for discharge to the complainant at 17:26. I accept the advice of the ED IPA that this was appropriate.

65. The investigation of issue one of this complaint concerned the complainant's previous attendances at the RVH. The complainant was well known to the neurologists at the RVH who carried out investigations during her admission on 17 May 2017 and a review as an outpatient as recently as 22 January 2019. I accept the advice of the ED IPA that the decision not to admit the complainant on 19 March 2019 was taken jointly by the consultant neurologist and senior ED clinicians. I am satisfied that the decision not to admit was based on a pool of knowledge and experience of the complainant's symptoms which had been

extensively documented in the complainant's notes and records. The neurology team had previously diagnosed FNS and repeated assessments were not going to change that.

66. I accept the advice of the ED IPA that there was no justification for performing a lumbar puncture or consulting a spinal expert. I find that the decision do discharge the complainant on this occasion was entirely reasonable.

67. However, I did find that that although triage was completed promptly, there was a delay of several hours before the complainant was seen by a doctor. This meant that pain relief was not administered promptly. This was a failing.

68. I included the full FNS guidance at appendix seven. This provides a detailed and comprehensive guide to FNS. It reinforces that these symptoms are real, multifactorial and often very distressing. Given the number of medical specialisms I listed at paragraph seven, the extract below particularly resonates with me regarding the complainant's experience to date:

'*There is a big risk people end up attending many different doctors, departments and having repeated tests and different medications. If the problem is actually related to Functional Neurological Symptoms, this will generally not help much and in fact can make things worse. For example a medication might seem to work, but then quickly stops working again and generates new symptoms through negative side- effects. This adds further to the confusion. Also people who have been seen by many doctors, hospitals and have had failed treatments,naturally end up feeling very fed up and start to lose hope, and trust. Getting to a clear diagnosis and coming to an end of needing tests and seeing different doctors is usually a vitally important factor to starting to get better.'*

69. On this occasion, the complainant wished to see a spinal consultant. I note that her GP referral to see a spinal consultant was eventually accepted after a number of refusals following ICATs triage. She was placed on a waiting list on 27 October 2020 and was given an appointment for September 2021.

70. I sincerely hope that the complainant can, with the help of her GP and other allied professionals, accept her diagnosis and find some relief from her FNS.

CONCLUSION

71. I received a complaint about the Neurology care and treatment the complainant received from the Belfast Heath and Social Care Trust. The complainant said that the Trust failed to identify and treat a physical cause for her distressing symptoms.

72. I accepted two issues of complaint for investigation. The first concerned the care and treatment afforded to the complainant, while an inpatient in the RVH during the period 17 May 2017 to 8 June 2017. The second related to the Care and treatment provided in the Emergency Department (ED) at RVH on 19 March 2019.

73. In relation to issue one, the investigation established that the clinicians carried out extensive investigations before diagnosing FNS. The consultant neurologist explained the diagnosis to the complainant and discharged her with a list of further assessments to be completed by her GP and CAH consultant neurologist as an outpatient. She did not accept the diagnosis and continued to search for a physical cause for her distressing symptoms. Assisted by the IPA advice, I was satisfied that the assessments carried out during her admission and those proposed following discharge were thorough and comprehensive. I did not uphold this issue of complaint.

74. The second issue of complaint related to the complainant's attendance at the ED on 19 March 2019. Prior to this, she had been under the care of a consultant neurologist at CAH who referred her for extensive investigations by multiple clinicians, as listed at paragraph seven. She had recently been discharged from his care and referred for pain management. She attended ED on 19 March 2019 seeking an investigation of her spine. The clinicians were able to access her medical records and establish that her symptoms had already been extensively investigated. I accept the IPA advice that there was no justification for an admission on that occasion. I found that this was the correct decision based on the history and clinical findings and I did not uphold this element of issue two of the complaint.

75. I found the delay in examination and administration of pain relief at 16:35, following triage at 12:57, to be a failing. This failing caused the complainant the injustice of unnecessary pain and discomfort. I uphold this element of issue two of this complaint.

Recommendations

76. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failure to administer pain relief to the complainant promptly within **one month** of the date of this report.

Margaret Kelly **24 January 2022**
Ombudsman

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being customer focused

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

Being open and accountable

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

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.