# Investigation of a complaint against the Western Health & Social Care Trust

**Report Reference: 202003373**

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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


This complaint is about care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant's husband (the patient) from 18 October to 18 November 2021 when the patient sadly passed away.

The complainant said that despite undergoing cardiac tests since 2019, the patient died of a heart attack. She raised questions about the Trust's investigations for the patient.

The investigation found the patient did not experience a heart attack but had a thickened heart muscle and died of 'sudden cardiac death'[1]. It established failings in the patient's care and treatment. These included:

- There was no evidence to suggest the Trust considered Hypertrophic Cardiomyopathy[2] as a possible diagnosis; and
- The Trust's failure to conduct appropriate inpatient imaging to establish a definitive diagnosis before it discharged the patient from hospital.

In addition, the Trust said it agreed the patient could return to work following his discharge if he felt '*well enough'*. I was concerned the Trust did so given it had not yet reached a diagnosis for the patient and therefore it had underestimated the risk of sudden cardiac death.

Although I cannot say it would definitively have changed the ultimate sad outcome for the patient, the failure to perform inpatient imaging to establish a definitive diagnosis meant that appropriate treatment for the patient was not started at the earliest opportunity.  Understandably, the complainant will always question whether there may have been a different outcome for her husband if the Trust had conducted appropriate investigations prior to his discharge from hospital.


[1] The sudden loss of all heart activity due to an irregular heart rhythm.

[2] A condition affecting the left ventricle, the main pumping chamber of the heart. The walls of the left ventricle become thick and stiff. Over time the heart can't take in or pump out enough blood during each heartbeat to supply the body's needs.

It saddened me that the patient died and these questions remain unanswered. I wish to convey my heartfelt condolences to the complainant and her son.

I recommended the Trust apologise to the complainant and put in place learning to prevent this situation from recurring.

## THE COMPLAINT

1. This complaint was about care and treatment the Western Health and Social Care Trust (the Trust) provided to the patient from his admission to hospital on 18 October to 18 November 2021. The complainant was the patient's wife.

### Background

2. The patient, a 56 year old man, had a complicated medical history. He took medication for adrenal insufficiency[3], obstructive sleep apnoea[4], hypertension[5], and chronic kidney disease[6].

3. The patient presented for exercise stress testing at Omagh Hospital (OH) in April 2019. He did not experience chest pain during the stress test and his result was normal. The Trust did not refer the patient to cardiology at that time.

4. On 8 October 2021 the patient fell unconscious at home. Paramedics attended his home and conducted an echocardiogram[7] (ECG). They notified the patient that he had an irregular heartbeat. The paramedics advised him to attend his GP, which he did four days later.

5. On 18 October 2021 the patient again fell unconscious at home, and experienced chest pain. The complainant took him to OH, where staff carried out tests on his heart. The patient was transferred and admitted to Altnagelvin Area Hospital (AAH) Coronary Care Unit (CCU) for further investigations following the outcome of these tests. He was discharged as an inpatient from AAH on 20 October 2021, two days following his admission.

6. On 4 November 2021, the patient attended AAH for a percutaneous renal biopsy[8]. On 11 November 2021, he attended for a DPD scan[9] to determine the

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[3] Adrenal insufficiency occurs when the adrenal glands don't make enough of the hormone cortisol.
[4] Obstructive sleep apnoea (OSA) is where the walls of the throat relax and narrow during sleep, interrupting normal breathing.
[5] High blood pressure.
[6] A type of kidney disease in which a gradual loss of kidney function occurs over a period of months to years.
[7] A scan used to look at the heart and nearby blood vessels.
[8] A needle is placed through the skin that lies over the kidney and guided to the right place in the kidney, usually with the help of ultrasound.
[9] A Cardiac DPD Scan is a diagnostic procedure, which looks at the function of the heart. It is different to an x-ray and other types of scans. It involves an injection of a small amount of radioactive liquid and imaging with a special camera.

likelihood of cardiac amyloidosis[10]. The scan produced a negative result, and the Trust referred the patient to haematology to investigate a potential bone marrow problem.

7. The patient passed away suddenly on 18 November 2021. The patient's death certificate recorded the cause of death as *'Cardiac enlargement. Possible Hypertrophic Cardiomyopathy[11]'* (HCM).

**Issue of complaint**

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

**Whether the care and treatment provided to the patient by the Western Health and Social Care Trust between 18 October 2021 and 18 November 2021 was appropriate and in accordance with relevant standards.**

## INVESTIGATION METHODOLOGY

9. To investigate this complaint, I obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised.

**Independent Professional Advice Sought**

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

- A Cardiology Consultant with over 30 years' experience (C IPA).

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 IPA provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

[10] Cardiac amyloidosis is the term used when amyloid protein deposits are found in the heart.
[11] A condition affecting the left ventricle, the main pumping chamber of the heart. The walls of the left ventricle become thick and stiff. Over time the heart can't take in or pump out enough blood during each heartbeat to supply the body's needs.

## Relevant Standards and Guidance

12. 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[12]:

- The Principles of Good Administration

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

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Good Medical Practice, updated April 2014 (the GMC Guidance);
- National Institute for Health and Care Excellence Guideline: Acute coronary syndromes, NICE Guideline 185, 18 November 2020 (NICE NG 185);
- National Institute for Health and Care Excellence Guideline: Transient loss of consciousness ('blackouts') in over 16s, NICE Guideline 109, updated 1 September 2014 (NICE CG 109); and
- WHSCT's Cardiology Admissions Pathway and Acute Coronary Syndrome Management presentation, undated (the Trust's MI Protocol).

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

## THE INVESTIGATION

**Whether the care and treatment provided to the patient by the Western Health and Social Care Trust between 18 October 2021 and 18 November 2021 was appropriate and in accordance with relevant standards.**

### Detail of Complaint

14. The complainant said that despite undergoing cardiac tests since 2019, the patient died following a heart attack. She questioned if '*all the necessary investigations and protocols were followed*.'

15. The complainant also said the Trust did not make her or her husband aware of the possibility that his symptoms could lead to sudden cardiac death.

16. The complainant said her major concern is that '*his death was avoidable due to the symptoms of his heart condition being ignored or not being detected when first raised'*. She felt '*let down'* because they '*could have had a defibrillator at the house and a plan of action to save his life'*.

17. The complainant said the circumstances of her husband's death caused her '*a lot of trauma, stress and anxiety*.'

### Evidence Considered

### Legislation/Policies/Guidance

18. I considered the following policies and guidance:

- GMC Guidance;
- NICE NG 185;
- NICE NG 109; and
- The Trust's MI Protocol.

**The Trust's response to investigation enquiries**

19. The Trust said the patient attended OH on 18 October 2021 where he described months of chest pain and shortness of breath, which worsened recently. While at OH, staff performed an ECG on the patient which showed changes from a previous test. Due to concerns, it transferred the patient to AAH CCU.

20. On arrival at AAH, staff took the patient's bloods, which indicated a raised Troponin T level. There were also changes on the ECG. However, these were not specific for a heart attack. It initially treated the patient as per its heart attack / Non ST Elevation Myocardial Infarction[13] (MI) protocol.

21. The Trust said that on the morning following his admission to the AAH, the patient had further tests which ruled out heart attack. The patient also had an angiogram[14] which showed there was only '*mild diffuse narrowing*' of the heart arteries. A Transthoracic Echocardiogram[15] (TTE) showed there was no damage to the heart muscle, which would have suggested a recent heart attack.

22. The Trust stated that at the time, investigations including heart monitoring had not shown any significant problem with the patient's heart electrical system, which is known to be a potential cause of blackout associated with thickening of the heart muscle.

23. The Trust explained it performed a DPD scan on the patient on 11 November 2021 (as an outpatient) to establish cardiac amyloidosis. The scan did not report any adverse reaction, nor did it indicate any significant update of DPD, which would have indicated inherited amyloidosis (hypertrophic amyloidosis) as a likely diagnosis. It did not however, rule out any amyloidosis from the patient's bone marrow. As such, it referred the patient to a Consultant Haematologist to undertake investigations which may indicate the patient had a potential concern with his bone marrow.

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[13] More commonly known as a heart attack.
[14] An angiogram is a type of X-ray used to examine blood vessels. Blood vessels don't show up clearly on ordinary X-rays, so a special dye is injected into the area being examined. The dye highlights the blood vessels as it moves through them.
[15] An ultrasound scan of the heart.

24. The Trust said it planned to undertake further investigations for the patient, which included an MRI scan of the patient's heart, as well as a heart monitor. However, the patient passed away on 18 November 2021 from Sudden Cardiac Death. This was not the same as a heart attack.

25. The Trust said that it did not have enough information prior to the patient's death to confirm an HCM diagnosis. Therefore, it did not judge the patient's risk of sudden cardiac death as high.

26. The Trust acknowledged it was extremely unfortunate that the clinicians involved in the patient's care were unable to complete their investigations prior to his sudden death.

27. In relation to informing the patient and complainant about risks, the Trust stated the Consultant Cardiologist explained to him that the raised Troponin level in his blood test was due to the thickened muscle of the heart, as opposed to a heart attack. The Consultant advised the patient it needed to perform further tests to establish the reason for the thickened heart muscle.

28. The Trust said the Consultant Cardiologist spoke with the patient and explained the TTE test showed the patient's heart muscle was '*very thick*'. The patient had no previous TTE scans showing the thickness of his heart to compare it to. It shared this information with the complainant when she joined her husband.

29. The Trust explained that the Consultant Cardiologist told the patient she wished to investigate further if cardiac amyloidosis caused the thickened heart muscle. As amyloidosis is treatable, the Consultant was keen to carry out the diagnostic tests as soon as possible. It discussed this possibility with the complainant and her husband, but stressed this was only one possible diagnosis.

30. The Trust said it discussed with the complainant and patient the possibility of another genetic cause, hypertrophic cardiomyopathy (HCM). However, the TTE of the patient's heart did not specifically indicate HCM in this case.

31. The Trust said it advised the patient of a further possible cause for his blackout in patients who have a cardiac amyloidosis diagnosis. This was bradycardia,

where the heart electrics slow down too much. It informed the patient that if investigations indicated this as a concern, it would treat him with a pacemaker device.

32. The Trust said the patient was keen to return to work. The Consultant Cardiologist advised him that if he felt well enough, which he said he did, he could do so.

**Relevant Records**

33. I enclose a chronology of events at appendix four to this report.

**Relevant Independent Professional Advice**

34. The C IPA advised that when the patient presented at OH on 18 October 2021, the Trust conducted an ECG and blood tests. The tests showed a raised troponin level, and the ECG was abnormal. The Trust transferred the patient to AAH with an initial working diagnosis of acute coronary syndrome and query arrhythmia[16].

35. The C IPA advised the Trust conducted further routine blood tests when the patient arrived at AAH. The blood tests the Trust took in OH and AAH were in accordance with NICE NG 185. The C IPA advised the Trust treated the patient in accordance with its heart attack/non ST elevation Myocardial Infarction Protocol. This was the appropriate pathway for treatment at that time.

36. The C IPA advised that the Trust performed '*12 lead ECGs'*, which were '*not normal'*. All of these showed the same changes, with '*normal sinus rhythm*[17]*, some ventricular premature beats*[18]*, and rare atrial premature beats*[19]*.*' The Trust also performed a coronary angiogram, which *'showed diffuse non obstructive coronary artery diseases*[20]*.'*

[16] An arrhythmia, or irregular heartbeat, is a problem with the rate or rhythm of your heartbeat.
[17] Normal sinus rhythm (NSR) is the rhythm that originates from the sinus node and describes the characteristic rhythm of the healthy human heart.
[18] A premature ventricular contraction (PVC) occurs before a regular heartbeat, there is a pause before the next regular heartbeat. PVCs can occur in isolation or in repeated patterns.
[19] Premature atrial contractions (PACs) are extra heartbeats that start in the upper chambers of your heart. A pause and a strong beat may follow the extra heartbeat, making it feel like a skipped beat.
[20] This less common form of CAD occurs when your heart's arteries inappropriately constrict, malfunction after branching into

37. The C IPA advised the patient did not have a heart attack[21]. *'The coronary angiogram showed that there were no blockages or clots in the coronary arteries.'*

38. The C IPA advised that there are a variety of reasons for a raised troponin level. This includes conditions that cause a thickening in the heart (cardiac hypertrophy). The transthoracic echocardiogram (TTE) performed on the patient showed marked thickness of the patient's heart.

39. The C IPA advised the Trust performed a DPD scan (which is specific for investigating cardiac amyloid) on 11 November 2021 with a negative result. The Trust referred the patient to haematology following the DPD scan. The C IPA advised '*I am not sure that it was appropriate to continue trying to make a diagnosis of cardiac amyloidosis, particularly with the negative DPD scan, and the lack of consideration of other causes of heart muscle thickening on echocardiography.*'

40. The C IPA advised the Trust could have conducted further investigations to establish reasons for the patient's thickening heart muscle. This included *'cardiac magnetic resonance imaging [MRI scanning] and/or CT scanning.'* Continued telemetry for ECG monitoring *'would also have been appropriate, to try to establish an arrhythmic cause of syncope[22].'*

41. The C IPA further advised that a multidisciplinary team discussion involving a cardiologist with an interest in cardiomyopathies[23], and a cardiac electrophysiologist[24] with an interest in arrhythmias and syncope, would have been appropriate.

42. The C IPA advised the Trust also considered the patient's longstanding diagnosis of high blood pressure (hypertension) as a possible cause of cardiac hypertrophy (thickening of the heart muscle). The echocardiography showed

tiny vessels, or are squeezed by the overlying heart muscle.

[21] The NHS defines a heart attack as '*a serious medical emergency in which the supply of blood to the heart is suddenly blocked, usually by a blood clot*'. (https://www.nhs.uk/conditions/heart-attack/).

[22] A loss of consciousness for a short period of time.

[23] Cardiomyopathy is a general term for diseases of the heart muscle, where the walls of the heart chambers have become stretched, thickened or stiff. This affects the heart's ability to pump blood around the body.

[24] An electrophysiologist, also known as a cardiac electrophysiologist or cardiac EP, is a cardiologist who focuses on testing for and treating problems involving irregular heart rhythms, also known as arrhythmias.

left ventricular hypertrophy[25]. Although thickening is typically asymmetric in HCM, the Trust should have considered it as a cause of the thickening of the patient's heart in this case. However, the C IPA could not confirm the Trust considered HCM from the records.

43. The C IPA agreed with the Trust's assertion that it could not make a definitive diagnosis of HCM prior to the patient's death. However, it should have considered all causes of hypertrophy in parallel, rather than concentrating on amyloidosis as a possible cause, which the patient's medical notes suggested. Despite the Trust explaining to the complainant that it did not have sufficient information to make a diagnosis of HCM, it did not record its consideration of HCM in the patient's medical notes.

44. The C IPA advised that the patient having fainted, along with structural heart disease, may have been due to malignant ventricular arrhythmia and this may be a precursor of sudden cardiac death, as happened in this case. As the patient fainted while sitting, and did not have any other early indications of a specific heart issue, the Trust should have made more effort to reach a diagnosis while the patient was an inpatient at AAH. This would have allowed the Trust to arrange appropriate treatment.

45. The C IPA advised that without a definitive diagnosis it is difficult to estimate the risk of sudden cardiac death in any patient. However, the Trust should have considered the patient as high-risk. This was based on his presentation, his abnormal ECG, non-sustained ventricular tachycardia, and structural heart disease.

46. The C IPA advised '*it would have been wise to make a definitive diagnosis (ideally as an inpatient) before the patient was advised to return to work.*' The C IPA also advised '*unexplained syncope has implications for driving, which do not seem to have been taken into consideration.*'

47. The C IPA did not consider the Trust provided appropriate management, care and treatment to the patient while he was an inpatient in the AAH. The Trust

[25] (LVH) is a condition in which there is an increase in left ventricular mass, either due to an increase in wall thickness or due to left ventricular cavity enlargement, or both.

should have performed further inpatient imaging to establish a diagnosis. The C IPA advised 't*he risk of sudden cardiac death was underestimated.'*

48. The C IPA advised that the medical records evidence several conversations between Trust staff, the patient, and complainant during his time at the AAH, about both his condition and its investigations.

49. The C IPA advised that as there was no definitive diagnosis, it would have been difficult to discuss risks and prognosis; '*if a definitive diagnosis had been made, (probably by MR scanning), a better risk assessment could have been carried out.'*

**Complainant's Response to Draft Report**

50. The complainant said she was aware that her husband had died of heart related issues, and not specifically what she termed a '*heart attack'*. She said had her husband known there was a serious issue with his heart, he would not have gone back to work. He did not return to work '*until he was advised that it was ok to do so.'* She said '*at no time did we think that this could lead to a sudden cardiac death.'*

51. The complainant reiterated her devastation at the sudden loss of her husband.

**Trust's Response to Draft Report**

52. The Trust clarified that the patient did not experience a heart attack.

53. The Trust stated the patient wanted to go home from his first day of admission and it struggled to keep him in hospital '*for the length of time'* it did. It also outlined risks of '*detaining patients in the hospital environment'*. It said it needs to balance keeping a patient in hospital '*when follow-up investigations can be conducted by way of out-patient clinics'*. It also stated it '*told the patient he could not drive'.*

54. During his admission, there was no documented broad complex tachycardias[26]. The patient had an episode of syncope prior to admission, '*but in the setting of labile BP[27]'*.

*55.* The Trust said it explained and documented that there were several possibilities for left ventricular hypertrophy on the patient's transthoracic echocardiogram. However, '*cardiac amyloidosis was the most likely on TTE images and would have fitted with the patient's other comorbidities.'*

56. The Trust stated it documented HCM alongside hypertensive heart disease[28], and sarcoidosis[29].

*57.* The Trust stated it was not correct for the IPA to advise that it should not have pursued a haematological referral, or accepted that it was not Cardiac Amyloidosis, because the DPD was negative. The negative result only made one form of Cardiac Amyloidosis (TTR[30]) '*less likely'*. However, it did not rule out AL Amyloidosis[31], which is treatable.

58. The Trust accepted it should have asked for an inpatient cardiac magnetic resonance (CMR) scan, which may have ruled out Amyloidosis. However, by having this performed while the patient was still in hospital, '*it is not at all clear that this would have altered management or prevented an SCD[32].'* Given the patient's post-mortem could not definitively differentiate between HCM and hypertensive heart disease, '*it is unclear that a CMR would have been able to differentiate this either.'*

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[26] Broad complex tachycardias is a cardiac rhythm with a rate >100 beats per minute and a QRS width >120 milliseconds (ms). The QRS complex represents the depolarization of ventricles. It shows the beginning of systole and ventricular contraction.
[27] Labile blood pressure is described as when a person's blood pressure frequently fluctuates between normal and high.
[28] Changes in the left ventricle, left atrium, and coronary arteries as a result of chronic blood pressure elevation, which increases the workload on the heart inducing structural and functional changes.
[29] A condition that causes your immune system to overreact and make lumps or nodules called granulomas.
[30] ATTR amyloidosis is caused by a protein called transthyretin, or TTR, that changes its shape and forms into fibrous clumps. These clumps of misshapen protein are deposited into various organs and peripheral nerves, which can cause them to function abnormally.
[31] AL amyloidosis (amyloid light chain or primary amyloidosis) is a rare disease that happens when abnormal light chain proteins in your body gather on your organs and tissues. It's a serious illness that may become chronic or may cause life-threatening medical conditions.
[32] Sudden cardiac death

59. The Trust explained that since this case, the Consultant has altered their practice and will now always perform an inpatient cardiac magnetic resonance scan.

60. The Trust stated that many patients with both HCM and Cardiac Amyloidosis continue to work. The patient in this case said he felt well and was keen to return to work - there was no reason at the time to prevent this.

61. The Trust added that there are inherent risks of detaining patients in the hospital environment, and that to do so brings with it risks of its own, such as hospital acquired infections and errors in medication. It said although not specific about this case, there is a balance to be struck and a judgement to be made when considering keeping a patient in hospital, when follow-up investigations can be conducted by way of out-patient clinics.

**Analysis and Findings**

62. The complainant was very concerned that despite undergoing investigations, the patient died due to a '*heart attack*'. She questioned if the Trust followed '*all the necessary investigations and protocols*.'

63. I note the Trust outlined the investigative tests it carried out for the patient upon his arrival to both OH and AAH. In relation to the blood tests and ECGs conducted, I note the C IPA's advice that these were in accordance with NICE NG 185 and NICE CG 109. I accept this advice and consider these tests appropriate.

64. I note the Trust's disagreement regarding the use of the term 'heart attack'. The Trust stated that this term '*characterises the phrase, and that of 'myocardial infarction', as absolute terms which they are not.'* The Trust explained there are '*vernacular and scientific understandings of the term 'heart attack' that sit awkwardly together*.' The Trust continued '*To some extent the same applied to the more medical term 'myocardial infarction', translated as established death of myocardial muscle, but often that term is used when heart muscle has not been permanently injured.'* The Trust was advised that the term was initially used by the complainant.

65. I also note the Trust's reference to US National Heart, Lung and Blood Institute which suggests '*a heart attack, also known as myocardial infarction, happens when the flow of blood that brings oxygen to a part of your heart muscle suddenly becomes blocked.'* The Trust explained that it is this failure of oxygen supply to meet metabolic demand that can result in fatal dysrhythmia, heart failure, ischaemic pain, infarction of myocardium, etc. The Trust states '*In classical teaching this could involve a ruptured plaque in an artery, or even a clot blocking an artery. But the classical picture is by no means ubiquitous.'*

66. The Trust said the tests indicated there was no damage to the patient's heart muscle, which indicated he did not have a 'heart attack'. The C IPA agreed with the Trust's finding, which she based on the coronary angiogram, as it did not show any *'blockages or clots in the coronary arteries'*. I am satisfied, based on the evidence available, that the patient did not suffer a myocardial infarction due to a blood clot.

67. The Trust referred to the C IPA advice received and said that during the patient's admission, there was no documented broad complex tachycardias[33]. It agreed the patient had an episode of syncope prior to admission, '*but in the setting of labile BP'.*

68. I put this to the C IPA. She advised that a telemetry strip, dated 19 October 2021 at 18:20, '*clearly shows 8 consecutive ventricular premature beats'*, which met the standard criteria for the diagnosis of non-sustained tachycardia. The C IPA advised the strip was annotated by hand '*?BCT x 8',* meaning '*query broad complex tachycardia x 8 beats*.' This was another way to describe non-sustained ventricular tachycardia. Therefore, there was documentary evidence of a broad complex tachycardia. The C IPA further advised that '*although someone noted this (in handwritten annotation), and there is reference to it in a nursing note made on 20/10/21 at 00:55, it does not appear to be mentioned in the medical notes'.* The C IPA clarified her advice by quoting the following from

[33] Broad complex tachycardias is a cardiac rhythm with a rate >100 beats per minute and a QRS width >120 milliseconds (ms). The QRS complex represents the depolarization of ventricles. It shows the beginning of systole and ventricular contraction.

the medical notes: '*telemetry didn't reveal and bradyarrhythmias [abnormally slow heart rhythms]'* and '*nil overnight on telemetry'.*

69. The C IPA advised that *'Medical staff have apparently overlooked the non-sustained ventricular tachycardia, which is clearly documented.'* I reviewed the patient's medical notes and confirmed they contained a handwritten annotation as referred to by the C IPA. On this basis, I accept the C IPA's advice.

70. The Trust stated the patient's heart muscle was '*thickened*' and that he required further tests to determine the reason for this. To test for amyloidosis, the Trust performed a DPD scan. The C IPA advised this action was appropriate. However, as the test produced a negative result, the C IPA advised the Trust should have ruled out this diagnosis. However, instead it referred the patient to haematology. The C IPA advised '*I am not sure that it was appropriate to continue trying to make a diagnosis of cardiac amyloidosis, particularly with the negative DPD scan, and the lack of consideration of other causes of heart muscle thickening on echocardiography*.' I accept this advice.

71. The C IPA advised although the patient's thickened heart muscle was not asymmetric, the Trust should have considered HCM as a possible diagnosis. The Trust said it spoke to the patient about HCM. However, the patient's medical records did not reference this conversation. In response to the draft report, the Trust stated its consideration of HCM is evidenced in its investigations and correspondence. However, the C IPA did not find such evidence within the medical records. In the absence of this documented consideration, I cannot be satisfied the Trust did consider HCM as a possible diagnosis. I consider this a failure in the care and treatment of the patient.

72. The Trust said it planned to conduct further investigations for the patient to establish a reason for the thickened heart muscle. However, the patient passed away before this could be arranged. I do not accept this position as I note with concern the C IPA's advice that the Trust should have conducted these investigations while the patient remained an inpatient in AAH. This should have included MRI or CT scanning, continued telemetry for ECG monitoring, and a multi-disciplinary discussion. I note the Trust's comment that due to the Covid-

19 pandemic, a '*decision to keep the patient in hospital at that time was not necessarily safe at that time.'* However, I accept the C IPA's advice that the Trust should have made '*more effort'* to reach a diagnosis before it discharged the patient two days following his admission.

73. I note that in response to the draft report, the Trust disagreed with the C IPA's advice that it should not have pursued a haematological referral, or accepted that the patient's condition was not Cardiac Amyloidosis, because the DPD was negative.

74. The C IPA agreed that Amyloidosis is one possible cause of cardiac hypertrophy with syncope. However, she advised it is not the most common, and there was no evidence to suggest the Trust considered any other potential cause in this instance. The C IPA advised that investigation for Amyloidosis was reasonable, '*but should not have precluded consideration of any other diagnosis such as hypertrophic cardiomyopathy, which is more common.'*

75. The C IPA advised that '*Syncope in the context of hypertrophic cardiomyopathy should be managed urgently by consideration of an implantable cardioverter defibrillator (ICD)'*[34]. She further advised that the Trust missed its opportunity to implant the device because it did not consider any diagnosis other than Amyloid. The Trust should have conducted '*further inpatient imaging'* and monitored the patient (as an inpatient) with telemetry, pending a diagnosis. I accept this advice.

76. The medical records do not specifically document the Trust's rationale for discharging the patient before it reached its diagnosis, nor its consideration regarding any risk to the patient from Covid-19 at that time. Therefore, I am unclear as to why it did not conduct the tests referred to while the patient remained in hospital. I refer to Standard 15(b) of the GMC Guidance which requires clinicians to '*promptly provide or arrange suitable advice, investigations or treatment where necessary*.' I consider that by not conducting these tests to enable it to reach a diagnosis prior to discharging the patient, the

[34] An ICD is a device implantable inside the body, able to perform defibrillation.

Trust failed to act in accordance with this standard. I am satisfied this represents a failure in the patient's care and treatment.

77. In its response to investigation enquiries, the Trust stated the patient was keen to return to work. I understand the Trust told the patient he could do so if he '*felt well enough'* and I note the patient, who was unaware of the risks, did so. However, based on the C IPA's advice, I consider the Trust should not have agreed to this prior to establishing the reason for the patient's thickened heart muscle. Specifically, the C IPA advised the *'the risk of sudden death was underestimated*' by the Trust.

78. I refer to Standard 49 of the GMC Guidance which requires clinicians to share with patients information about their care, including '*associated risks and uncertainties'*. I consider that by agreeing the patient could return to work without a confirmed diagnosis, the Trust failed to act in accordance with this standard. I am satisfied this represents a failure in the patient's care and treatment. Given the failures identified, I uphold this complaint.

79. The complainant was concerned the Trust did not tell her or her late husband he was at risk of sudden cardiac death. The C IPA advised that had the Trust reached its diagnosis prior to discharge, it would have been in a better position to communicate the risks to the patient. Therefore, I consider the failure identified caused the patient and complainant to sustain the loss of opportunity for the patient and the complainant to be made aware of the risks to his health. I further consider the patient and complainant experienced the injustice of uncertainty.

## CONCLUSION

80. This complaint was about care and treatment the Trust provided to the patient. I uphold the complaint. The investigation found there was no evidence to suggest the Trust considered HCM as a possible diagnosis. It also found the Trust should have conducted its further investigations before it discharged the patient from hospital. Furthermore, I am concerned the Trust agreed for the patient to return to work despite it failing to establish reasons for his thickened heart muscle.

81. Clearly these failures had significant impact on the patient and also the complainant. I consider the failures caused both the patient and complainant the loss of opportunity for them to be made aware of the risks to the patient's health.

82. I also consider the failings caused the patient and complainant to sustain the injustice of uncertainty. While I cannot say it would definitively have changed the ultimate sad outcome for the patient, the failure to perform inpatient imaging to establish a definitive diagnosis meant that appropriate treatment for the patient was not started at the earliest opportunity. Understandably, the complainant will always question whether there may have been a different outcome for her husband if the Trust had conducted appropriate investigations prior to his discharge from hospital.

83. I recognise the loss and grief the complainant experienced since losing her husband in November 2021. I do not doubt the impact this complaints process has had on the complainant. I wish to offer through this report my condolences for the complainant and her son.

**Recommendations**

84. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019). This apology should acknowledge the injustice caused to her a result of the failures identified (within **one month** of the date of this report).

85. I also recommend the Trust conducts a Serious Adverse Incident Report (SAI) into the death of this patient to identify learning for the Trust. The Trust should forward to my office a copy of the outcome of the SAI (within **three months** of the date of this report).

86. I further recommend for service improvement and to prevent future recurrence that the Trust:
    i. Discusses the findings of this report with all clinicians involved in the patient's care, and staff members reflect on the case and discuss it as part of their next appraisal; and

ii. Provides training to relevant staff about the importance of reaching a diagnosis prior to discharging high risk patients and before agreeing they may return to work. In providing this training, the Trust should consider Standards 15(b) and 49 of the GMC Guidance.

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

**MARGARET KELLY**
**Ombudsman** **October 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.