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

Report Reference: 202002627

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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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Case Reference: 202002627

Listed Authority: Northern Health and Social Care Trust

SUMMARY

I received a complaint about the Northern Health and Social Care Trust's care and treatment of the complainant's late mother (the patient) whilst an in-patient in Causeway Hospital (CH) from 2 to 10 September 2019.

The patient fell on 1 August 2019, and, over the following six-week period, she presented to hospital with significant pain on four separate occasions, three of which resulted in a hospital admission. On the final occasion, she was an in-patient from 2 September 2019 until, sadly her death on 14 September 2019.

She first presented to CH on 1 August 2019, the day of her fall and, following an X-ray, the Trust sent her home. Three days later, on 4 August 2019, the patient re-presented in significant pain and, after a computed tomography[1] scan (CT) indicated a spinal fracture, she was transferred to the Royal Victoria Hospital (RVH) in the Belfast Health and Social Care Trust (BHSCT). At the RVH she was given an Aspen collar[2] and discharged on 7 August 2019. The patient continued to become increasingly unwell and, six days later on 13 August 2019, was readmitted to CH. The Trust discharged the patient on 18 August 2019; however, two weeks later, on 2 September 2019, she presented again to CH Emergency Department (ED) by ambulance.

On 2 September 2019, the Trust carried out several investigations. These included a CT scan and an electrocardiogram[3] (ECG). The CT scan reported outcome indicated *'a sub-totally healed'* fracture '*with no … canal stenosis[4]'.* The ECG indicated potential cardiac issues. The Trust also consulted the BHSCT Orthopaedic department about the patient at this time. The patient was admitted to a cardiology ward where she remained until 10 September 2019 when, following the family's continued concerns regarding the accuracy

[1] A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body.
[2] An Aspen collar is a two-piece semi-rigid neck brace, held together by Velcro straps. The brace support is provided by plastic on the outside and soft pads to the inside. It is used most for fracture management in the neck (broken bone). The cervical collar will encourage correct spinal alignment and aim to prevent the development of potential further problems.
[3] An electrocardiogram (ECG) is a simple test that can be used to check your heart's rhythm and electrical activity.
[4] Canal stenosis is narrowing of the spinal canal in the lower part of your back. This can cause pressure on your spinal cord or the nerves that go from your spinal cord to your muscles.

of the diagnosis and treatment, the Trust carried out a full spinal Magnetic Resonance Imaging[5] (MRI). The MRI identified spinal cord compression; consequently, the patient transferred to the RVH spinal ward. Sadly, the patient died on 14 September 2019. Following the submission of the complaint, the Trust reviewed the CT scan of 2 September 2019. The review identified the CT scan had been mis-read and, rather than the fracture having been '*sub-totally healed … with no … canal stenosis*', there was spondylothisthesis[6] and which had led to canal stenosis; therefore, the CT scan report was erroneous.

The complainant said the Trust did not appropriately respond to the patient's clearly presenting symptoms of spinal cord compression and the family's continued concerns about her condition. This included failing to undertake further investigations and seek spinal specialist input. The complainant said the Trust also failed to both manage the patient's pain and appropriately manage its consultation with Orthopaedic specialists in the BHSCT. The complainant also said the Trust did not manage its Serious Adverse Incident (SAI) review process in line with policy and guidance, both in relation to timescales and scope. Further, the complainant said the Trust did not manage her complaint in accordance with the Trust's Complaints Policy.

The investigation established there were significant failings in the patient's care and treatment which ultimately contributed to her death and shortened her life.
These significant failings were:

- not carrying out appropriate neurological examinations;
- not performing an MRI in a timely manner;
- not appropriately assessing and investigating the patient's presenting symptoms throughout the period from 2 to 10 September;
- not undertaking even an initial physiotherapy assessment on three separate occasions or providing appropriate physiotherapy care; and
- failing to listen to and respond to the patient's family's concerns.

The Trust further failed to:

[5] Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
[6] Spondylolisthesis is a condition is when a vertebra slips out of place, resting on the bone below it. Spondylolysis may cause spondylolisthesis when a stress fracture causes the slipping.

- ensure effective communications across health professionals;
- facilitate appropriate senior review and input into the patient's care;
- appropriately manage consultation with, and review by, relevant specialists; and
- appropriately manage the patient's pain.

I consider the cumulative impact of the failings identified, contributed to the patient's death and shortened her life.

The investigation also found the Trust failed to manage both the SAI and the complaints process in line with relevant policies and guidance.

I recommended the Trust provides the complainant with a written apology for the injustice caused by the failures in care and treatment. I made further recommendations for the Trust to address under an evidence-supported action plan to focus on service improvement and prevent a re-occurrence of the failings.

The failings identified in this report are of significant concern to me. The impact of the failings on the quality of the family's remaining time with the patient deeply saddens me and I wish to convey my sincere condolences to the complainant and her family on the sad loss of their loved one.

THE COMPLAINT

1. This complaint was about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the patient while she was in hospital from 2 to 10 September 2019. The complainant was the late patient's daughter. From the complainant's correspondence and the Investigating Officer's conversations with her, it is clear how deeply these events have affected the patient's family. I also recognise the complainant and her family will find much of the detail in this report distressing.

2. I also investigated a complaint about the patient's care and treatment in the BHSCT for a similar period; specifically, for periods of care from 5 August to 14 September 2019. This investigation is the subject of a separate report.

Background

3. The patient had rheumatoid arthritis, joint fusions, joint replacements and osteoporosis. On 1 August 2019, the patient fell. She was treated in the Trust's Causeway Hospital's Emergency department (ED), having an x-ray, after which she was discharged. The patient re-presented to ED on 4 August 2019 with increased pain, at which point a fracture was identified. The patient was then transferred to the Belfast Health and Social Care Trust (BHSCT). She had further investigations in the BHSCT and was then discharged on 7 August 2019 with an aspen collar[7]. On 16 August 2019 the patient attended a Consultant Orthopaedic review appointment at the BHSCT where, because the patient had issues with the collar, she was told it was not necessary for her to wear this at home.

4. On 2 September 2019, the patient attended the Trust's ED via ambulance. The patient was assessed in ED where a CT scan was undertaken, along with other investigations, including an ECG. The radiology report from the CT scan indicated the fracture was '*sub-totally healed* w*ith no new acute bony lesion or any canal stenosis'.* During the Trust's subsequent complaint investigation, after the patient sadly had passed away, it was identified that the CT scan radiology report was incorrect and instead the scan showed significant spondylolisthesis which had led to

[7] An aspen collar is a two-piece semi-rigid neck brace, held together by Velcro straps. The brace support is provided by plastic on the outside and soft pads to the inside. It is used most for fracture management in the neck (broken bone). The cervical collar will encourage correct spinal alignment and aim to prevent the development of potential further problems.

canal stenosis. The patient was admitted to a cardiology ward for further investigations following ECG results of deep T wave inversion. From the patient's admission on 2/3 September 2019 until 10 September 2019, the focus of the patient's care and treatment continued to be cardiac related. On 10 September 2019, an MRI was undertaken which identified there was a severe central canal stenosis, *'loss of Cerebrospinal fluid surrounding the cord*[8] *and increased signal within the cord in keeping with cord oedema'*[9]. At this point, the patient was transferred to the BHSCT. Sadly, the patient died on 14 September 2019 from *'Bronchopneumonia due to immobility due to C7*[10] *fracture'.*

Issue(s) of complaint

5. I accepted the following issues of complaint for investigation:

Issue 1: Whether the care and treatment provided to the patient by the Trust between 2 and 10 September 2019 was appropriate and reasonable in accordance with relevant standards and guidance.

In particular, this considered:

i. The initial assessment and diagnosis of the patient from 2 to 3 September 2019;
ii. The ongoing assessment and diagnosis of the patient from 3 to 10 September 2019. This includes the appropriate involvement of, and referral to, relevant specialist advice;
iii. The process of consultation with the Belfast Health and Social Care Trust about the patient, including recording of same; and
iv. The management of the patient's pain.

Issue 2: Whether the Trust managed the incident related to the CT scan of 2 September 2019 in accordance with relevant standards and policies, including those associated with Serious Adverse Incidents (SAIs).

Issue 3: Whether the Trust managed the complaint in accordance with relevant standards and guidance.

[8] Cerebrospinal fluid (CSF) surrounds the brain and spinal cord and provides a cushion to protect them from injury. The spinal cord and CSF are surrounded by three layers of membranes. A CSF leak occurs when there is a hole or tear in the outermost layer of these membranes (dura mater), which allows some of the fluid to escape.
[9] Spinal cord compression
[10] C7 is located on the spine. The C7 vertebra is part of the lower levels of the cervical spine, near the base of the neck.

INVESTIGATION METHODOLOGY

6. 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

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

- A Consultant in Emergency Medicine for 18 years; MBChB, MD, MPH, FRCEM (CED IPA);
- A Consultant Cardiologist for over 30 years; MD FRCP (CC IPA) ;
- A Consultant Radiologist for 15 years; Bsc (Hons), MbChB, FRCR (CR IPA);
- A Nurse with 21 years' experience across primary and secondary care; RGN, MSc Advanced Clinical Practice, BSc (Hons) Nurse Practitioner, MA Health Service Management, Diploma in Adult Nursing (Nurse IPA);
- A Physiotherapist for 20 years; DProf MSc BSc (Hons) MCSP MMACP IP (Physio IPA);
- A Consultant Orthopaedic Surgeon for 18 years, specialising in spinal surgery; MS, FRCS, FRCS(Orth);
- A Consultant Anaesthetist for 21 years; MBBS, MD, FRCA, LLM (Medical Law and Ethics); and
- A Consultant Respiratory Physician for 15 years; MBBS; CCT (Respiratory and General Medicine), FRCP, European Diploma in Adult Respiratory Medicine.

I enclose the clinical advice received from the CED IPA at Appendix four, the CC IPA at Appendix five, the CR IPA at Appendix six, the Nurse IPA at Appendix seven and the Physio IPA at Appendix eight to this report.

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

Relevant Standards and Guidance

9. 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[11]:

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

10. 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, April 2019 (GMC Guidance);
    - National Institute for Health and Care Excellence British National Formulary, September 2019 (NICE BNF);
    - The Royal Pharmaceutical Society's Pharmacy Professional Guidance on the Administration of Medicines in Healthcare Settings, January 2019 (RPS Guide);
    - The Nursing and Midwifery Council's Standards for Nurses, 2018 (NMC Standards);
    - The Nursing and Midwifery Council's Code, 2018 (NMC Code);
    - The Health and Care Professions Council's Standards of Conduct, Performance and Ethics, January 2016 (HCPC Conduct and Ethics Standards);
    - The Health and Care Professions Council's Standards of Proficiency for Physiotherapists, May 2013 (HCPC Physio Standards);
    - The Health and Social Care Board[12]'s Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016 (HSCB SAI Procedure);

[11] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[12] The Health and Social Care Board (HSCB), which was in place at the time of the events associated with the complaint, has since been replaced by the Department of Health's Strategic Planning and Performance Group (SPPG).

- The Northern Health and Social Care Trust's Incident Management Policy (including Serious Adverse Incidents), June 2017 (Trust SAI Policy);
- The Department of Health's Guidance in Relation to the Health and Social Care Complaints Procedure, 2019 (DoH Complaints Guidance);
- The Northern Health and Social Care Trust's Complaints and Service User Feedback Policy and Procedure, 2016 (Trust Complaints Procedure);
- The Academy of Medical Royal Colleges Seven Day Consultant Present Care, 2012 (AMRC Consultant Care Guidance); and
- The Royal College of Physicians and the Royal College of Nursing's Modern ward rounds Executive summary and recommendations, 2021 (RCP and RCN Ward Round Guidance);
- The British Thoracic Society's Guidelines for Bronchiectasis in Adults, 2018 (Thoracic Society Guidance); and
- The British Thoracic Society's Concise BTS/ACPRC Guidelines, Physiotherapy management of the adult, medical, spontaneously breathing patient, 2009 (Thoracic Society Physio Guidance).

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

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

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

THE INVESTIGATION

Detail of Complaint

Issue 1: Whether the care and treatment provided to the patient by the Trust between 2 and 10 September 2019 was appropriate and reasonable in accordance with relevant standards and guidance.

In particular, this considered:

i. *The initial assessment and diagnosis of the patient from 2 to 3 September 2019;*
ii. *The ongoing assessment and diagnosis of the patient from 3 to 10 September 2019. This includes the appropriate involvement of, and referral to, relevant specialist advice;*
iii. *The process of consultation with the Belfast Health and Social Care Trust about the patient, including recording of same; and*
iv. *The management of the patient's pain.*

13. There were four main elements included within Issue one of the complaint. Each of these elements are addressed separately below.

i. The initial assessment and diagnosis of the patient from 2 to 3 September 2019

14. The complainant believed the error in the CT scan report of 2 September 2019 should have been identified during the period of assessment on 2 to 3 September 2019 because the patient '*had clear symptoms of spinal cord compression'*. The complainant said she, as a physiotherapist herself and her husband as a paramedic, challenged the CT scan result at the time with both the ED and Cardiology doctors.

Evidence Considered

Trust's response to investigation enquiries

15. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to the enquiries related to all the elements of the complaint is at Appendix three to this report.

Legislation/Policies/Guidance

16. I considered the GMC Guidance.

Relevant records

17. I considered the patient's medical records for the period 2 to 3 September 2019.

Relevant Independent Professional Advice

18. The CR, CED and CC IPAs provided advice on different aspects of the patient's initial assessment and diagnosis from 2 to 3 September 2019. The CR IPA provided advice on the appropriate parameters of the CT scan. The CED IPA provided advice about neurological examinations and investigations undertaken whilst the patient was in ED. The CC IPA provided advice on the complexities of the patient's clinical symptoms; initial investigations and potential diagnoses; and the consultation with BHSCT.

19. Key extracts from the CED, CC and CR IPAs' advice are detailed at paragraphs 20 to 32 below. The CED, CC and CR IPAs' complete advice are enclosed at Appendices four, five and six to this report, respectively.

CR IPA's Advice

20. The CR IPA advised the CT scan requested on 2 September 2019 was adequate to identify deterioration and spondylolisthesis.

CED IPA's Advice

21. The CED IPA advised, on 2 September 2019, the patient was assessed in ED at 10:46, where two main differential diagnoses were considered. These were cardiac ischaemia[13] and nerve pain secondary to neck injury. The CED IPA referenced the nursing notes which documented the patient had "*altered sensation in the ring and little fingers of the right hand"* and which the CED IPA explained '*is compatible with nerve irritation/damage affecting the C8 dermatome'.* The CED IPA advised the medical staff's initial neurological examination was indicated as "*normal for patient"* but which the CED IPA advised *'contradicts the details'* recorded by the nursing staff and the nursing notes referenced handover notes from ambulance staff with *"paraesthesia (numbness) in 4th and 5th fingers of the right hand".*

22. The CED IPA advised two sets of investigations were undertaken, in accordance with the two main differential diagnoses. These were a CT scan for the neck/nerve injury and an ECG and cardiac blood test for the cardiac ischaemia. The CED IPA advised the CT was reported as normal; however, both cardiac tests were abnormal and therefore further investigation into this diagnosis was required. The patient was therefore referred to cardiology. The CED IPA advised the medical staff's actions in

[13] Cardiac ischemia is decreased blood flow and oxygen to the heart muscle.

seeking input from cardiology at this time were *'reasonable*' as the two potential diagnoses were investigated, with the results indicating the cardiac ischaemia was '*more likely'* and the nerve/neck injury *'less likely'*.

23. The CED IPA advised the patient was examined by another doctor at 18:20 on 2 September 2019, and at this point, the same two differential diagnoses were considered. The CED IPA advised the detail of this examination referenced the patient was "*moving all 4 limbs"* but contains no further detail of a neurological examination. The CED IPA explained the patient was reviewed again on 3 September 2019, with a plan to either confirm or exclude cardiac ischaemia and to discuss the arm pain with orthopaedics.

24. The CED IPA advised there was '*no evidence of disregard and inappropriate response to the patients' family's concerns during this period'.* The CED IPA referenced the nursing notes and ambulance staff handover and advised, '*overall … consideration'* was given to these notes. The CED IPA opined the referral and focus on cardiology in ED was *'appropriate'* as it was supported by initial investigations and potentially presented a more immediate *'life-threatening'* condition.

25. The CED IPA referred to the neurological examinations and investigations undertaken whilst the patient was in ED. He advised, during the initial examination, *'the specific neurological complaint of paraesthesia in the right hand'* was noted but this was not found in the subsequent neurological examination. The CED IPA advised, *'it is debatable whether there is enough detail noted in the examination note at this time to firmly refute that the patient had numbness of part of the right hand – the neurological findings noted are quite generic and non specific'.* The CED IPA concluded this neurological examination was '*partially adequate*'. The CED IPA referred to the second neurological examination which was undertaken at 18:20 on 2 September 2019. The CED IPA explained, although the doctor might have considered the potential cardiac issue as being the primary focus, the doctor noted the secondary potential diagnosis of nerve injury and which the CED IPA advised, '*should prompt a thorough neurological examination'.* The only neurological examination documented at this time is "*moving all 4 limbs"*, which the CED IPA advised was *'inadequate'*. The CED IPA advised, whilst *'it is impossible to be certain, more complete neurological examination at this stage may have raised the*

level of suspicion of nerve injury higher. This in turn may have reduced the threshold for requesting an MRI of the neck, which in turn may have led to an earlier diagnosis of the spinal cord compression'.

26. The CED IPA advised it was '*appropriate'* to accept a CT scan report from a consultant radiologist as *'definitive'.* The CED IPA outlined the parameters of CT scanning and advised CT scans are *'adequate'* for identifying the issue which, in the patient's case was later confirmed as present. He further explained, whilst in cases where the concern may be neuropathic, MRI would be the optimal imaging approach, '*many centres will perform a CT first to delineate bony pathology before proceeding to MRI'.* In this case, therefore, a CT scan reported as normal would be '*reassuring'*. The CED IPA further advised, however, as there was clinical concern about nerve injury*, a 'MRI should have been performed within a reasonable timeline'.* The CED IPA explained the parameters of this would be *'open to debate'* but if there were *'ongoing concerns about nerve injury it would seem reasonable to perform MRI within the first 24-48 hours of admission'.*

27. The CED IPA also advised, however, emergency MRIs are normally arranged where there is clear concern about spinal cord compression but whilst the patient was in ED*, 'the available information suggests that damage/irritation to the spinal nerve (i.e. where it exits the spinal cord) is more the concern rather than damage to the actual central spinal cord'* and therefore, it was *'reasonable'* an emergency MRI was not requested whilst the patient was in ED but '*as there were ongoing concerns'* a MRI should have been considered '*shortly thereafter*'.

28. The CED IPA concluded, as a neurological cause of the patient's symptoms was considered as a possible diagnosis, a full neurological examination should have been documented and '*the clinical examination undertaken does not appear to have focussed appropriate, detailed examination on relevant areas given the clinical history'.*

CC IPA's Advice

29. The CC IPA provided context for the patient's condition in relation to her medical history. She advised, the patient's case was complex as she had '*severe longstanding rheumatoid arthritis'* and associated treatments which made '*clinical (and radiological) assessment very difficult'.* The CC IPA explained, in particular,

the patient's joint fusions would have made '*clinical examination of her ability to move difficult'* and therefore neurological assessment would have presented difficulties.

30. The CC IPA referenced the actions and investigations undertaken whilst the patient was in ED. She confirmed the ECG results of '*deep T wave inversion*[14]'. The CC IPA advised, on 3 September 2019, a discussion took place with a named orthopaedic Senior House Officer (SHO) from the BHSCT. The BHSCT SHO contacted the Trust on 4 September 2019 and informed the Trust that an Associate Specialist Orthopaedic Surgeon[15] (SpR) had reviewed the images and was happy with the fracture healing. The CC IPA advised, the BHSCT indicated, if there was further concern, the Trust should email a spinal referral for discussion at the Multidisciplinary Team (MDT) meeting. It was noted the patient was already scheduled to attend a review at the fracture clinic.

31. The CC IPA advised, in the context of the ECG and blood results, a potential diagnosis of myocardial infarction[16] *'was reasonable'*. The CC IPA also referenced ED's consideration of a diagnosis related to the neck fracture and orthopaedic review. She advised both possibilities were appropriately investigated during this period. The CC IPA referenced the erroneous CT scan report, which she advised would have provided false reassurance. The CC IPA advised cardiology staff *'could not be expected to interpret scans such as this in such a complex patient'* and would therefore rely on the radiologist's report, '*at least initially'.* She further advised, the consultation with BHSCT orthopaedics would also have been reassuring.

32. The CC IPA advised, because of the patient's complexity, it would have been appropriate to refer the patient's case to a consultant orthopaedic surgeon or to a spinal multi-disciplinary team rather than rely on input from junior staff; however, the CC IPA opined, at this stage this would have been an action to be taken by the

[14] Inverted T waves in an electrocardiogram (ECG) are associated with coronary heart disease.
[15] Associate specialists have at least four years postgraduate experience, two of which are in their chosen specialty. Many of these doctors have chosen to step into this position rather than pursue a traditional consultant training pathway. This is usually for reasons such as geographical stability and the chance to work regular hours in a chosen specialty which in turn often provides a better work-life balance. There are routes for these doctors to become consultants if they later want to, although many prefer to continue in the chosen career.
[16] Heart attack.

BHSCT orthopaedic staff rather than the Trust. I refer to paragraph two above. The actions of the BHSCT are considered in a separate investigation report.

Responses to the Draft Investigation Report

33. The complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. Where considered appropriate, comments are either reflected in changes to the report or are outlined in paragraphs 34 to 36; 68 to 79; and 125.

The complainant's response

34. The complainant referred to the CED IPA's advice and queried what cognisance ED gave to the information detailed on the ambulance handover sheet. The complainant also queried whether the ED IPA considered the lower limb symptoms indicated a neurological issue. The complainant believed the patient's '*presenting symptoms of abnormal rippling sensations in both legs, loss of power and inability to walk, having been previously independent were over looked*'. The complainant said she *'felt strongly that the neurological assessment undertaken was also inaccurate. 'Power tone and sensation all normal for patient' is inaccurate as the history tells of abnormal rippling sensations in both legs as well as the loss of power and [the patient] no longer being able to walk. C8 is numb. [The patient] is unable to sit, stand or walk. This was not normal for the patient'.* The complainant said, because of this, there should have been further investigation into the patient's legs.

35. The complainant also said, because of the presenting symptoms, the ambulance team '*spinal boarded'* the patient. She reiterated that *'loss of sensation and power and abnormal sensations all point to an issue with the spinal cord. The arm pain was related to nerve irritation at the fracture site and the fact that the C8 dermatome was numb also indicates an issue at the fracture site. These symptoms should have prompted concern about cord compression and made the scan result questionable'.* The complainant referred to the ambulance handover record, *'pain right arm, numbness in legs, abnormal sensation. 73 yo felt change in condition of both legs. Pain 10/10. Tried to walk – numbness/weak. Felt her legs going beneath her. Impression – cord impingement'.* The complainant said the '*abnormal*

sensations and loss of power of legs were missed in the investigations … this is due to the neurological assessment being inadequate'. The complainant said the assessment only mentioned the referred arm pain but did not refer to the loss of power and sensation in the legs which *'contradicts the ambulance handover sheet'.* The complainant said she believed this meant the pursuit of the *'cardiology route was not so reasonable'.*

36. The complainant referred to the ED IPA's advice about ED's consideration of the family's concerns at the time. She said, although she has no '*written evidence*' of her version of events, she reiterated that, when the ED Consultant told her the CT scan was normal, she said this was impossible, given the patient's symptoms. Further, she repeated this in her discussion with the Cardiac Registrar in ED, prior to the patient's transfer to the ward. She said she repeated this every time she was able to speak with a nurse or doctor. She also raised this in emails to the consultant; however, the Trust staff did not listen to her.

Further Independent Professional Advice following Draft Investigation Report Responses

37. Following receipt of the complainant's comments on the Draft Investigation report, the CED IPA provided further advice about the Trust's assessment of the patient whilst she was in ED on 2 September 2019. Key extracts from this further advice are detailed in paragraphs 38 and 39. The CED IPA's full advice is enclosed at Appendix 11 to this report.

CED IPA's Advice

38. In his further advice, the CED IPA referred to specific records in the patient's medical notes and reiterated his original opinion that the Trust gave appropriate consideration to both the ED nursing notes and ambulance handover information in assessing the patient. The CED IPA also referred to his original advice about the Trust's neurological examinations whilst the patient was in ED but also further advised the neurological examination was '*limited by the extent of the patient's rheumatoid arthritis'.* Further, although the *'lower limb symptoms described … could indicate a neurological issue … weakness of legs and/or falls are a very common presenting complaint in this age group, and very few are ultimately due to an acute neurological issue'.*

39. Overall, the doctors took *'account of the presenting complaint and formulated two main differential diagnoses'* related to cardiac issues or a further neck injury. The outcome of the ECG investigations indicated possible acute coronary syndrome whilst the CT scan was reported to ED staff as normal. Therefore, ED has *'evidence supporting one diagnosis (acute coronary syndrome) and refuting the other diagnosis (neck injury)'.* ED's role *'is primarily acute assessment and treatment of emergency health conditions'* and often a patient will not receive a *'definitive diagnosis' whilst in ED.* Decisions about treatment are based on the most likely diagnosis, in consideration of *'conditions [which] are likely to cause immediate harm or complications'.* A patient's *'diagnostic journey does not stop'* in ED and *'ongoing or evolving symptoms [should] prompt re-assessment of the patient [with a possible] change in diagnosis or treatment priorities'.* The CED IPA's conclusions and recommendations for learning and improvement remained unchanged from his original report.

Analysis and Findings

40. I note the CR IPA's advice the CT scan was adequate to identify both deterioration and spondylolisthesis. I accept this advice.

41. I refer to the complainant's response to the Draft Investigation Report at paragraphs 34 to 36. I note, however, both the CED and CC IPAs advised the investigations into two potential diagnoses during the period of 2 to 3 September 2019 were reasonable and appropriate. Further the CED IPA advised the ambulance and nursing information was considered in the patient's assessment. The CED and CC IPAs also advised the initial focus on the potential cardiac diagnosis was appropriate in the context of the ECG and blood results, the false reassurance of the erroneous CT scan report and the consultation with BHSCT. I accept the CED and CC IPAs' advice.

42. Whilst the CED IPA advised the CT scan was an appropriate initial investigation, I note he also advised, given the concern about a possible nerve injury and ongoing concerns, an MRI should have been performed within 48 hours. The CED IPA also advised the neurological examinations at this time were not adequate. I accept the CED IPA's advice.

43. I refer to paragraphs 40 and 41 above and am satisfied the initial assessment and diagnosis of the patient from 2 to 3 September 2019 was appropriate with the exceptions of the failures to conduct appropriately detailed neurological examinations and an MRI within the initial 48-hour period. I consider these exceptions constitute failures in care and treatment. Therefore, I partially uphold this element of the complaint.

Injustice

44. I considered carefully whether the failings caused injustice to the patient and her family. I refer to the CT scan of 2 September 2019, which although mis-read at the time, indicated spondylolisthesis which had led to canal stenosis. Therefore, I consider because of these failings, the patient lost the opportunity of a more accurate and timely diagnosis and to receive optimum treatment options. I also consider, because of this lost opportunity, the patient experienced distress from unnecessary pain because her condition deteriorated without appropriate, timely intervention. I also consider the patient's family experienced upset about the patient's distress, and worry about the uncertainty of the patient's diagnosis.

45. I refer to the CC IPA's advice it would have been appropriate to refer the patient to an orthopaedic consultant because of the complexity of the case. The process of consultation with the BHSCT about the patient is considered under Issue one (iii) below.

Detail of Complaint

ii. The ongoing assessment and diagnosis of the patient during the period 3 to 10 September 2019. This includes the appropriate involvement of, and referral to, relevant specialist advice

46. The complainant said, throughout the further period of 3 to 10 September 2019, there was inadequate assessment, including *'poor neurological assessment'* and inadequate investigation and escalation of neurological symptoms. The complainant said the patient's family '*had to watch [the patient] lie suffering excruciating pain and deteriorating symptoms'.*

47. The complainant said, every day during this period, she raised concerns about the patient's deteriorating neurological symptoms with doctors. She said, finally on 7 September 2019, she submitted a five-page letter to the Trust medical staff in which she outlined her concerns in detail, the patient's history since her fall and requested further investigations. The complainant said, '*by the time they listened it was too late – [the patient] was not fit for surgery and ended up paralysed, and died on 14.09.2019'.* The complainant said the patient's family *'feel very let down and so hurt by not being listened to, and [their] concerns not being taken seriously or escalated … [she] believe[s] [the patient's] journey could have been a lot less painful for all concerned had concerns been listened to and escalated when they should have been … [she] daily recalls all the missed opportunities and the discussions and concerns raised, and [her] desperation for someone to listen*'. The complainant said, because of the experience, she has been prescribed anxiety medication and her father '*had a breakdown. He found the meetings too much to cope with as he was so upset at recalling the pain [the patient] went through'.*

Evidence Considered

Legislation/Policies/Guidance

48. I considered the GMC Guidance, the HCPC Conduct and Ethics Standards and the HCPC Physio Standards.

Relevant Records

49. I considered the patient's medical records from 3 to 10 September 2019. I also considered additional information provided by the complainant, including a letter, dated 7 September 2019, given to the medical staff in the Trust.

Relevant Independent Professional Advice

50. The CC and Physio IPAs provided advice on different aspects of the patient's ongoing assessment and diagnosis from 3 to 10 September 2019. The CC IPA provided advice on the level of consultant input to the patient's care, as well as the Trust's actions in relation to further investigations for the patient's symptoms whilst she was in the cardiology ward. The Physio IPA provided advice on the physiotherapists' actions, particularly in relation to assessment of the patient.

51. Key extracts from the CC and Physio IPAs' advice are detailed in paragraphs 52 to 67 below. The CC and Physio IPAs complete advice are enclosed at Appendices five and eight to this report, respectively.

CC IPA's Advice

52. The CC IPA outlined the pathway of the patient's care and treatment from 3 to 10 September 2019.

53. The CC IPA referenced a neurological examination on 5 September 2019 and another on 8 September 2019. She advised neurological observations were also recorded on 3, 5 and 8 September 2019. The CC IPA advised, on 5 September 2019, a SHO reviewed the patient on the cardiology ward and subsequently '*questioned spinal referral for MDT discussion*' in relation to the patient's pain. The CC IPA advised, on 8 September 2019, a SHO on the cardiology ward suggested a discussion about a possible neurological condition. On 9 September 2019, it was suggested the patient's orthopaedic consultant, in BHSCT, be informed of her admission and there were discussions with radiology about further investigations and a whole spine MRI was then performed.

54. The CC IPA referenced the initial cardiac investigation results of 2/3 September 2019 and reiterated the focus on cardiac was reasonable until the angiogram on 6 September 2019. She advised, after the angiogram, '*continuing cardiac concern was inappropriate'*. The CC IPA advised, hypertrophic cardiomyopathy '*had already essentially been excluded'* on 3 September 2019 and, because of the patient's '*continuing severe pain, with neurological signs and symptoms',* the cause of the pain should have been reassessed. Further, although pain in the arm is associated with cardiac issues, arm weakness is not; however, '*this symptom was not further investigated or queried'.* The CC IPA further explained, hypertrophic cardiomyopathy is a chronic condition, not usually associated with chronic continuous pain, and therefore, *'diagnosis at that particular time was not critical'.*

55. The CC IPA advised, the Trust should have reviewed the clinical picture, '*which was out of context with the CT scan report and the orthopaedic opinion*'. The CC IPA explained the patient exhibited '*new symptoms and signs since her previous*

admission' and, whilst the patient was in ED, nerve injury was suggested as a potential diagnosis. The CC IPA advised, despite these signs and the family's concerns, the ward medical staff did not take any steps to seek further advice. The CC IPA outlined several possible paths of further investigation as she advised, it *'would have been appropriate'* to take further actions. These included a consultant personally: - examining the patient, including seeing if she could stand; asking radiology to review the scan report, in consideration of the continuing pain and increasing weakness; seeking an orthopaedic consultant's opinion; or asking the patient's consultant rheumatologist to review the patient, as this consultant would be familiar with the patient and worked within the Trust.

56. The CC IPA detailed consultant input into the patient's care. She advised a consultant reviewed the patient whilst she was in ED; there was consultant review on a ward round on 5 September 2019; and, on 8 September 2019, a consultant cardiologist was involved in a discussion with the patient's husband about concerns. She advised it was not clear if it was a consultant who reviewed the patient on 3 September 2019. The CC IPA advised, other than on these occasions, there were no other records of consultant input into the patient's care.

57. The CC IPA advised, after 3 September 2019, *'assessment and management on the ward was unsatisfactory'.* The nursing staff and the junior medical staff were aware of ongoing pain and new leg weakness; however, after the patient's return to the ward on the same day, following the completion of the tests at another Health and Social Care Trust hospital (AH); *'no neurologic assessment was undertaken'*. The CC IPA advised the patient was not reviewed for more than 36 hours after her return from AH. The CC IPA advised, on 8 September 2019, two junior medical staff, who recognised the patient's deterioration, separately suggested spinal /neurological and senior review but this was not forthcoming. The CC IPA referenced the record the "*cardiologist was not in hospital today"* and advised, '*senior review should always be available'.* The CC IPA advised *'senior review was requested at least twice'* but was not available. She opined the cardiology junior medical staff were *'unsupported'.*

58. The CC IPA also referred to the absence of physiotherapy assessment, despite referral to the Physiotherapy department. She advised this was '*a missed opportunity',* which if it had taken place may have identified the issue earlier.

59. The CC IPA provided advice on the Trust's actions in response to the patient's family's concerns. She advised, in the context of the family's appropriate knowledge, and in the context of the patient's symptoms, recent history and the elimination of the immediate concern about cardiac issues, further actions should have been taken to investigate the family's concerns. The CC IPA also referenced the complainant's letter of 7 September 2019, in which the patient's history and the family's concerns were detailed. She advised the letter *'should have prompted clinical reassessment*'. Further, the CC IPA advised, when there was reassessment, it was conducted by junior staff as senior review was not available.

60. The CC IPA concluded, whilst on the ward, consultant input *'was not adequate'.* She advised*,* junior medical staff twice requested senior review, but this was not available and *'this was not appropriate'.* Further*,* once the cardiac issues were no longer of primary concern, *'good practice'* would have involved the consultant personally exploring several possible options *'at a consultant to consultant level'.* She also advised, there was no physiotherapy assessment, which, *'if it had taken place … may have identified the issue earlier';* and the *'delay in diagnosis of spinal cord compression led to delay in offering appropriate treatment.'*

Physio IPA's Advice

61. The Physio IPA referenced the physiotherapy records and advised there were records for 4, 7 and 9 September 2019; however, *'physiotherapists' involvement with the patient was very limited'*. She advised *'there are no documented physiotherapy assessments … No assessment (subjective and objective examination of the patient) was carried out'.* Further, on 4 September 2019, *'the physiotherapists could (and really should) have carried out a baseline assessment*' while waiting for X-ray results.

62. The Physio IPA advised, on 7 September 2019, the physiotherapy entry in the notes indicates a clinical question about the weight-bearing status of the right arm to be documented or clarified before physiotherapy assessment. The Physio IPA

advised, *'it appears the physiotherapist assumed that someone would read this entry in the notes and get back to the physiotherapist with the required information.'* The Physio IPA advised, on 7 September 2019, the physiotherapists '*should have made the effort to find out this information (weight-bearing status of the right arm) for themselves on the day … It was not appropriate or helpful to write a question in the notes, expect someone to read this and respond to it, and to refuse to see the patient until this had been actioned'.* The Physio IPA opined, on 9 September 2019, the records indicate the physiotherapists *'refused a third time to assess the patient'.* The Physio IPA advised, *'at the very least, the physiotherapists should have followed up on their own clinical queries (entered in the notes two days earlier)'.*

63. The Physio IPA advised, whilst there may have been concerns about mobilising the patient because of uncertainty about her neurological condition, the physiotherapists were still required to assess the patient and '*communicate effectively with other members of the multidisciplinary team*' and '*not leave clinical questions 'hanging' in the records'.* Further, physiotherapy is equally important for the patient who is immobilised in bed with consideration of '*breathing exercises, circulation, skin integrity, muscle and joint care'*. She advised, the physiotherapists' failure to attempt any physiotherapy assessment or treatment also had the potential to cause the patient increased risk of developing a chest infection or painful joints. The Physio IPA advised, physiotherapists '*are trained to recognise signs and symptoms of cord compression, and had they assessed the patient then their findings might have assisted the medical team with their management of the patient'.* Further, the physiotherapists could have provided support in relation to the patient's rheumatoid arthritis and assisted nursing staff with transfer issues or concerns.

64. The Physio IPA referenced that the patient was known to a rheumatologist in the Trust, and it would be good practice to contact this consultant. The Physio IPA explained it would be important for the rheumatology team to know the patient was an in-patient and, also, the consultant could have *'provided key advice and help in relation to the patient's care'.* The Physio IPA advised anyone involved in the patient's care could have contacted the consultant rheumatologist, including the physiotherapists. She further advised, whilst this would not be a physiotherapist's

specific responsibility, she would have expected the physiotherapists to have enquired about this if it was not clear in the patient's notes that this had been actioned.

65. The Physio IPA referenced the Trust's actions in the circumstances of the erroneous CT scan report, set against the context of the patient's presentation, and advised what the approach should be when the results of tests do not '*fit with the clinical picture'.* She further referenced the '*protocol for post-trauma review of spinal imaging*' when the BHSCT did not question the CT report, given the patient's symptoms, overall clinical history, and recent trauma. The Physio IPA advised the patient was at a *'high risk of # after trauma'.* She further advised, *'we do not treat a scan report – we treat the patient in front of us and if the features do not fit then we need to question the scan and/or the working diagnosis'.* The Physio IPA advised the Trust's actions *'meant that the patient was cared for and treated WITHOUT SPINAL PRECAUTIONS for over a week (between 02/09/19 and the MR report on 10/09/19). This could have led to an avoidable worsening of the patient's neurological status'*. The Physio IPA referenced the family's concerns which were raised during the period of care and advised, *'it is of note that during this time the concerns of the patient's daughter (a physiotherapist) and son-in-law (a paramedic) were largely ignored'.*
66. The Physio IPA concluded, *'it was not appropriate for the physiotherapists to have refused any form of assessment of the patient (on three separate occasions between 02/09/19 and 10/09/19) because they were waiting for further information'.* Further, the Physio IPA referenced the HCPC Conduct and Ethics Standards and the HCPC Physio Standards. She advised, the physiotherapists did not discuss any concerns about the patient, including reasons for not assessing the patient, with other staff involved in the patient's care. Specifically, in accordance with these standards, *'it was not good practice for the physiotherapists to have written a clinical question in the notes then expect another healthcare professional to read and respond'.* She also referenced the physiotherapists' failure to follow up on their own clinical question, which she advised was *'unreliable and unsafe*' practice. The Physio IPA further concluded, '*patient care was directly affected because of this poor communication style and method of information gathering'.*

67. The Physio IPA also provided advice on the Trust's records which she opined '*was poor in places'* including physiotherapy notes.

Responses to the Draft Investigation Report

The complainant's response

68. The complainant said, every time she was able to speak with a nurse or doctor, she reiterated her concerns about the patient's presenting symptoms. Further, she said she also raised this in emails to the consultant; however, the Trust staff did not listen to her.

69. The complainant acknowledged the erroneous scan result '*was misleading'*. She said she '*did not expect the [Cardiology] staff to be able to read the scan'* but she *'would have expected them to question the result with [the patient's] presentation and also because [she] questioned it every day and requested neurological examinations'.* The complainant said she recognised that the junior medical staff indicated the patient required senior review but senior review '*was not forthcoming'*. Further, she sent several emails to the consultant's secretary about her concerns. The complainant said, following the patient's return from AH on 6 September 2019, the complainant asked to speak to the consultant but was told the consultant was off and would not be back until Tuesday 10 September 2019.

70. The complainant referred to the patient's medical records of 4 to 8 September 2019, which she said indicated that she raised her concerns about the patient's neurological symptoms with staff throughout the patient's admission, including the need for a spinal referral and further radiological investigations. The complainant said she '*felt so unbelievably frustrated. To remember the agony [the patient] was in is unbearable – can you imagine being moved while your fractured neck is impinging on your spinal cord'.* The complainant said, despite continually highlighting these issues, the Trust did not carry out any formal neurological assessment until 8 September 2019, after she submitted a detailed letter to the consultant. The complainant also said the only reason the Trust carried out an MRI was because, on Sunday 8 September 2019, she explained in detail that this was necessary because of the existing *'C7 fracture, previous pathological fractures of T spine and known lumbar stenosis [and] the positive babinski reflex, the abnormal*

movement of the right leg and the loss of motor control also of the right leg'. The complainant said that a patient's family should neither need to highlight to staff symptoms which warrant investigation nor explain what examinations are required. The complainant said, at that time, the doctor told her '*it would be unlikely to get a full spine MRI'* and when this was agreed, he said *"you have got your full spine MRI".* The complainant said she considered this implied she '*was getting something I did not deserve'.*

The Trust's response

71. The Trust stated it considered it was '*acceptable'* that physiotherapists in an acute hospital setting defer patient assessment until intervention has been confirmed as safe. The Trust stated the primary reason for the referral of the patient to physiotherapy on 4 September 2019 was to mobilise. The Trust stated the physiotherapists were '*reasonably cautious'* in deferring the assessment and intervention until they had clarification about the scapular fracture, given the patient's pain and neurological symptoms. The Trust further stated, by 5 September 2019, it was identified the patient required an angiogram which in turn became the main priority of care. The Trust stated the patient was therefore not available for physiotherapy review on 6 September 2019 as she was in AH undergoing an angiogram.

72. The Trust stated a physiotherapist reviewed the patient on 7 September 2019; however, as this was a Saturday, any physiotherapists working on that day *'would be expected to see patients with acute respiratory needs and those who needed physiotherapy input to plan for discharge'.* The Trust stated physiotherapy *'would not be able to provide baseline assessments on every complex patient within the hospital due to the conflicting time constraints and pressures across the whole site'.* The Trust stated the physiotherapist would also have been conscious of the recorded concerns about pain and muscle weakness. The Trust stated physiotherapy reviewed the patient on Monday 9 September 2019, at which point concerns about spinal fractures and motor weakness in her upper and lower limbs had been identified, with the patient awaiting an MRI. The Trust stated because of this, physiotherapy again deferred the assessment. The Trust stated that the deferral of the patient's assessment related to *'unknown orthopaedic management*

plans'. The Trust stated '*physiotherapy would use clinical reasoning to avoid any further injury to be caused to any fracture site as the full management plan had not been clearly identified. This was correct and would be standard practice'.*

73. The Trust also stated, however, it acknowledged the documentation does not reflect the full clinical reasoning behind the decision to defer assessment and does not state how physiotherapy communicated this to the MDT. The Trust stated physiotherapists would normally record any queries about orthopaedic management plans in the patient's notes and then follow-up directly with medical staff. The Trust stated it accepted '*there is no record of any conversation having taken place'* with physiotherapy and medical staff and acknowledged this '*should have been documented more clearly'*.

74. The Trust also stated the pathway of communication between the Trust and the BHSCT spinal or orthopaedic team would be carried out by medical staff to medical staff and would not involve physiotherapy directly. Medical staff would then share any information with the MDT. The Trust stated this pathway would also apply in relation to consultation with the Trust Rheumatology department; therefore, physiotherapy would not be in direct contact.

75. The Trust stated a consultant cardiologist carried out the post take ward round on 3 September 2019, but a registrar documented the ward round. The Trust stated the patient's named consultant cardiologist was on leave during some of the patient's period as an in-patient; however, '*there are arrangements in place at all times for cover by consultant colleagues*' and junior doctors are informed about these arrangements during induction. The Trust described the induction process and the specific arrangements for contacting consultants. The Trust stated, during normal hours of Monday to Friday 9:00 to 17:00, issues should be escalated to '*the staff grade doctor or consultant directly looking after the patient'*. The Trust stated, outside these hours, issues should normally be escalated initially to the most senior doctor working with the junior doctor at that time and which can then be escalated to the consultant-on-call if necessary. The Trust stated junior doctors can also contact the consultant-on-call directly if this is more appropriate. The Trust stated

there is a consultant-on-call rota on the intranet, but usually the junior doctor will call the switchboard to speak with whoever is on-call.

76. The Trust challenged the CC IPA's advice that the junior doctors *"were unsupported"*. The Trust stated *'it is not clear from the medical notes'* that junior doctors attempted to contact a consultant when there were concerns after the patient returned from AH. The Trust stated, in keeping with the practice at other hospitals, junior doctors should add newly admitted and repatriated patients to the take sheet. The Trust stated this is to ensure consultants can note any significant findings or recommendations because all patients listed on the take sheet are reviewed by a consultant on the morning ward round. The Trust stated a consultant cardiologist carried out a ward round on both Saturday 7 and Sunday 8 September 2019. The Trust stated a consultant does not read every patient's notes during weekend rounds. The Trust stated it is not aware of this occurring in any hospital. The Trust stated at that time the patients highlighted for review over the weekend are identified '*on a Friday'* but the patient 'was not on this list as she was not in the hospital at the time of the weekend handover meeting on Friday 6 September 2019 as she was in AH and returned at 19:00. The Trust stated it introduced a 'Patients of Concern' section on the take sheets to address this gap which requires junior doctors to record patients of concern for discussion with the consultant in the morning.

77. The Trust further stated, since that time, it introduced a board round to ensure there is an update on each patient for the weekend team. The Trust stated this occurs before the post take ward round starts in the morning and involves a brief update from nursing staff about all the ward patients. The Trust confirmed the consultant cardiologist on-call on the morning of Sunday 8 September 2019. The Trust also confirmed the consultant on-call for the remainder of that weekend was a medical consultant.

78. The Trust addressed the circumstances in which the patient was not reviewed by a consultant on Monday 9 September 2019. The Trust stated, on Monday 9 September 2019, two of the cardiology consultants were offsite at a management meeting. The remaining consultant attended his usual Monday morning outpatient

clinic; however, if ward staff had called him, he would have been available. The Trust stated a senior SHO reviewed the patient and discussed her care with '*senior/ specialist staff',* including a radiologist and the BHSCT spinal team. The Trust stated the cardiology consultant who attended the outpatient clinic that morning '*will have [caried out] a ward round in the afternoon'* but '*it is not possible at this stage to comment on how many patients or referrals he had to see that afternoon'.*

79. The Trust stated it was '*not possible to provide any evidence*' of actions taken by senior doctors or the Trust, under GMC guidance, in response to the junior doctors failing to follow the Trust's process for escalating concerns for senior review. The Trust stated, *'it is likely there was informal discussion with them but due to the time that has passed since this case occurred, [it] cannot be more definitive'.*

Further Independent Professional Advice following Draft Investigation Report Responses

80. Following receipt of the Trust's comments on the Draft Investigation report, the CC and Physio IPAs provided further advice about the role of senior medical staff in the patient's case and physiotherapists care of the patient respectively. Key extracts from the CC and Physio IPAs' further advice are detailed in paragraphs 81 to 84 and 85 to 86 respectively. The CC IPA's full advice is enclosed at Appendix 12 and the Physio IPA's complete advice is enclosed at Appendix 13 to this report.

CC IPA's Further Advice

81. The CC IPA referred to her original advice and highlighted that the patient's complex health issues would have made '*assessment and management difficult'.* While an inpatient in CH during the period 2 to 10 September 2019, the patient's symptoms increased and '*new signs*' developed. However, the patient's care was *'made even more difficult'* because the patient's spinal CT scan of 2 September 2019 was incorrectly reported. The CC IPA cited '*three main issues … the medical staff did not recognise the severity of the neck problem until Sunday 8th September 2019. Even then, they did not recognise the urgency with which it should have been treated; the medical notes record that the patient was seen only once by a consultant during her hospital stay; and the junior staff recognised that consultant review was required, but despite hospital policies, this did not happen'.* The CC IPA referred to the patient's records and advised, apart from when the patient attended

AH which focused on cardiac issues and which care was provided by another health trust, there is no evidence the patient was seen by a consultant other than on 5 September 2019. Further, there is no evidence the patient was seen on a routine daytime ward round on 7 September 2019, despite a record on 6 September 2019 that the morning team would consider the concerns about neurology and the patient's spine. On 8 September 2019, on two occasions, two different junior doctors recorded the patient required senior review, but this did not happen. There is also no evidence in the records that a consultant saw the patient on the post take ward rounds.

82. When a consultant saw the patient on 5 September 2109, three days after admission, the consultant *'did not recognise the seriousness of the neurological signs'.* This consultant also recorded on the same day that the patient's husband had concerns about the failure to investigate "*the orthopaedic side of things"* and were not "*managing [the patient's] pain properly"* '*but did not follow-up on this'.* Although the consultant *'may have initially been reasonably reassured by the [erroneous] CT scan report … the team should have had another discussion with the ortho/spinal team at this point, as the ongoing pain and increasing weakness were not explained by the CT scan report. If things are not going as expected, it would be reasonable to review the case to date and reassess'.* There is no evidence of any further consultant input; therefore '*the patient appears to have only been seen once by a consultant during her first four full weekdays in hospital, and not at all during two weekend days'.* The CC IPA referred to the AMRC Consultant Care guidance which details three standards of care. Standard one states, '*hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway'.* The CC IPA advised that although this has not been '*universally implemented because of a lack of resources, this is considered good practice'.*

83. The CC IPA also referred to recommendations made in the RCP and RCN Ward Round Guidance. Although the frequency of ward rounds is not specified in this guidance, it clearly states how ward rounds should be structured and carried out. Specifically, *'before the ward round, "structured information from shift handovers*

should be available; patient questions and concerns [should be] gathered; [have a] board round or huddle to prioritise patients and highlight issues from the whole team; undertake individual professional reviews to inform multidisciplinary bedside review'. The CC IPA advised that if the Trust ensured '*senior ward rounds met these criteria, it is likely that senior input would be improved. The board round or huddle prior to the formal ward round should include discussion of EVERY PATIENT, ensuring that those with complex needs and/or ongoing problems be identified, so that they can be included in the formal ward round'.* In consideration of these standards and guidance, the Trust should have had these arrangements in place at the time of the patient's care.

84. The junior doctors '*recognised neurological deterioration, but did not appreciate that certain features, including increasing weakness and loss of bladder control, suggested that the deterioration should be treated as an emergency'.* Although the junior doctors recognised and recorded that senior review was required, *'there is no evidence that they did anything to arrange it'* which is contrary to the Trust's stated process. Further, it appeared to be '*accepted that if the consultant of record was not available, they could wait until that consultant was available. While the Trust response indicates this responsibility lies solely with the junior doctors for not following the escalation process covered in induction, it is significant two different junior doctors did not follow the suggested known escalation process. This poses the question of whether this is a culture in the hospital/Trust, a failure in the induction process or did these junior doctors just not bother. If the first of these, the Trust needs to consider how it addresses such a culture, if the second it needs to review the effectiveness of its induction process and if the last, how did it deal with the junior doctors' inappropriate actions. Ultimately, under GMC guidelines the senior doctors have responsibility for both the care of their patients when transferring care to others and the supervision of junior staff'.* The CC IPA advised that senior medical staff did not discharge their responsibilities in relation to either the supervision of junior medical staff or in ensuring appropriate delegation and transfer of care in accordance with the GMC Guidance prior to, during and after the events. '*A sick patient with complex evolving problems, culminating in a neurological emergency, was seen only once by a consultant during a 6 or 7 day hospital stay'.*

Physio IPA's Further Advice

85. The physiotherapists were *'right to be cautious'* about "*mobilising"* the patient until further information was available; however, on receipt of the referral, a *"reasonably cautious' approach to treatment … did not obviate the need to carry out an initial assessment of the patient, which might have included other aspects of inpatient physiotherapy care'*, including breathing and circulation exercises, and which exercises '*might also impact on the ability of the patient to mobilise'*. In accepting a referral related to mobilisation of the patient, the physiotherapists discharged their '*duty of care to check if it was 'safe' to mobilise the patient*' but did not fulfil their '*duty of care … to follow up … on such check/s in a timely fashion [and] … ensure effective communication with the wider team, and to fully document all this in the patient records'.* The Physio IPA continued to be *'concerned about how the physiotherapists communicated and subsequently followed up on their request for further information*'.

86. The Physio IPA referred to the Trust's comments on the Draft Investigation Report about the failure to record both the clinical decision making and the communication of this to the MDT. She advised *'if the clinical reasoning and communication did indeed take place as the Trust says it would have done … not documenting this (i.e., not keeping full and contemporaneous clinical records) is itself an example of poor practice and represents a failure to adhere to the HCPC standards'.* Further, in the absence of 'documented evidence of either the clinical reasoning or communication with the wider team, there is no evidence any of these actions did occur'. The Physio IPA referred to her original advice, which she confirmed as unchanged.

Additional Independent Professional Advice

87. In considering the impact of the patient's immobility on her prognosis and associated treatment options, I sought additional advice from several other independent advisors. Specifically, a Consultant Orthopaedic Surgeon IPA (CO IPA), a Consultant Anaesthetist IPA (CA IPA) and a Consultant Respiratory Physician IPA (CR IPA). I also obtained further additional advice from the Physio IPA. Key extracts from each of the IPA's advice are reflected in paragraphs 88 to

91 below. The full advice each IPA provided is enclosed at Appendices 14, 15, 16 and 17 respectively. Those aspects of the CA IPA's advice which relate to care and treatment the BHSCT provided to the patient have been redacted from the CA IPA's advice at Appendix 15. A parallel redaction has been made for the Trust's care in the copy of this advice enclosed with the BHSCT report.

88. The CO IPA advised the optimum treatment for the patient '*would have been surgical intervention to restore the anatomy, stabilization of the spine and decompression'.* The CO IPA advised it was '*very likely'* that the delay in accurately diagnosing the patient led to her becoming increasing immobile. The CO IPA advised, if the patient had received an accurate diagnosis earlier, during the period of 2 to 9 September, surgery would have been an option at that stage. I note the CO IPA concluded, although *'it would be difficult to predict'* whether the patient would have developed bronchopneumonia if she had surgery, *'it would be reasonable to suggest her immobility … probably increased the risk of developing bronchopneumonia'* and '*the patient's chances of survival would have been better and her risk of developing bronchopneumonia reduced with timely surgical intervention'.*

89. I note the AN IPA advised, from an anaesthesia perspective, if the Trust had correctly diagnosed the patient in the period between 3 and 9 September 2019, she would have been fit for surgery. The AN IPA also advised, '*leaving [the patient] bedridden meant that she had a high chance of developing a chest infection and dying because of that'.*

90. The Resp IPA referenced the patient's records and advised that the first indications of bronchopneumonia in the patient, specifically, *'breathlessness/ increased work of breathing and chest signs on examination',* presented on the afternoon of 12 September 2019. The Resp IPA advised, the '*pneumonia … could have started to develop subclinically in the hours, or a few days, before it became manifest'.* I note the Resp IPA's advice, *'immobility does increase the risk of developing bronchopneumonia. Reduced mobility and being horizontal in bed for prolonged periods predisposes to stasis of secretions in the lung, areas of atelectasis/ collapse developing in the lungs, and increased chance of infection'.* The Resp IPA concluded, although *'it is difficult to quantify the exact effect immobility has had in*

this patient developing bronchopneumonia, it is likely to have had a significant impact'.

91. In her additional advice, the Physio IPA referenced the patient's records and advised, there were '*no documented physiotherapy assessments, or evidence that the [physiotherapy note] entries related to face-to-face consultations'.* The Physio IPA also referenced her original advice and reiterated '*the importance of physiotherapy in the patient who is immobilised in bed'*, including breathing and circulation exercises, and that a '*possible consequence of not having physiotherapy'* whilst immobilised was '*an increased risk of developing a chest infection*'. The Physio IPA referenced the patient's clinical history of bronchiectasis '*which can make them more vulnerable to infection'.* The Physio IPA also referenced the Thoracic Society Guidance and the Thoracic Society Physio Guidance. She advised these documents *'include physiotherapy management'* for the condition, and that the latter guidance '*systematically reviewed the evidence surrounding physiotherapy management of the spontaneously breathing medical respiratory adult patient and provided graded recommendations for practice'.* The Physio IPA concluded there was no evidence that 'p*hysiotherapy was carried out'* between 2 and 10 September 2019, during which period, *'the patient was immobilised in bed … [the patient] had a pre-existing respiratory disease (bronchiectasis), which put her at an increased risk of developing a chest infection'*. I note the Physio IPA further advised, although '*it is not possible to say if the absence of physiotherapy care was responsible for the onset of bronchopneumonia … it does represent a missed opportunity to give a treatment intervention aimed at mitigating the risk of the patient developing bronchopneumonia.'*

Analysis and Findings

92. In relation to inadequate consultant input into the patient's care, the Trust stated, *'there is always consultant cover in the hospital'*. The Trust further stated, there are a team of three cardiology consultants and during the week, there will always be one of these present. The Trust stated, *'junior doctors can direct any queries to the consultant who is in the hospital'.* I note the Trust stated it was unsure why no consultant was asked to see the patient during the period of 7 to 9 September 2019. The Trust stated the patient's *'name is not on the take sheet for that date. It is likely that the consultant on duty that weekend would not have been unaware of her*

unless told by some other source'. The Trust stated nursing staff and junior doctors are aware there is always someone on call and if a need for senior review is identified, '*these reviews are initiated by informing more senior staff of the situation and asking for input'.* I refer to the Trust's response to the Draft Investigation Report in which it challenged the CC IPA's advice that the junior doctors *"were unsupported"* and stated it did not appear the junior doctors attempted to contact a consultant when there were concerns after the patient. The Trust stated it has made amendments to this process since 2019 to try to avoid similar situations happening.

93. I refer to the GMC Guidance. I note it states,

'16. In providing clinical care you must:

b) provide effective treatments based on the best available evidence

d) consult colleagues where appropriate

33. You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

34. When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.

40. You must make sure that all staff you manage have appropriate supervision'.

94. I note the CC IPA's advice the *'assessment and management on the ward was unsatisfactory'.* In particular, the CC IPA's advice that, once the potential cardiac issues were cleared, further assessment and investigation of the symptoms which were not associated with cardiac issues should have taken place. Specifically, the patient's arm weakness and the chronic continuous pain; however, these symptoms were '*not further investigated or queried'.* Further, I note the CC IPA's advice the patient's history and the family's ongoing concerns, including those raised by *'appropriately knowledgeable people'* should have prompted clinical reassessment. The Physio IPA concurred with this advice. I accept this advice. I am very concerned staff did not listen, and appropriately respond, to the patient's family continued concerns. I also refer to the GMC Guidance points 16 (b) and 33, cited at paragraph 93 above. I consider these constitute failures in care and treatment.

95. I refer to the HCPC Conduct and Ethics Standards. I note this states:

'2.6 You must share relevant information, where appropriate, with colleagues involved in the care, treatment or other services provided to a service user.
10.1 You must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to.'

96. I note the HCPC Physio Standards state:
'4.2 be able to make reasoned decisions to initiate, continue, modify or cease techniques or procedures, and record the decisions and reasoning appropriately.
4.3 be able to initiate resolution of problems and be able to exercise personal initiative.
8.1 be able to demonstrate effective and appropriate verbal and non-verbal skills in communicating information, advice, instruction and professional opinion to service users, colleagues and others.
9.1 be able to work, where appropriate, in partnership with service users, other professionals, support staff and others
9.2 understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team.
9.4 be able to contribute effectively to work undertaken as part of a multi-disciplinary team.
14.3 be able to gather appropriate information.
14.4 be able to select and use appropriate assessment techniques.
14.5 be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment.
14.6 be able to undertake or arrange investigations as appropriate'.

97. I note the Physio IPA's advice the physiotherapists' failure to undertake any form of even *'initial'* assessment on three occasions '*was not appropriate.* Further, the physiotherapists' failures to communicate effectively with other health professionals, which *'was not good practice';* to follow up on their own clinical question, which was *'unreliable and unsafe*' practice and fully document all this in the patient's records indicated a failure to fulfil aspects of their '*duty of care'.* The Physio IPA also advised the failure to record the clinical decision making and communication of this to the MDT did not accord with '*HCPC standards'* and which is *'poor practice*'. She concluded, without records of the clinical decision making and communication with

the MDT, *'there is no evidence any of these actions did occur'.* I accept her advice. I also refer to the HCPC Conduct and Ethics Standards and the HCPC Physio Standards cited at paragraphs 95 and 96 above. I consider these constitute failures in care and treatment.

98. I also considered the evidence related to cardiology consultants' input to the patient's care and treatment, along with the referral to and involvement of other specialists in her care.

99. I note the CC IPA's advice that junior medical staff in Cardiology documented the need for senior review by a consultant from Cardiology on at least two occasions, but the senior review did not take place and this '*was not appropriate'*. Further, I refer to the CC IPA's advice consultant input to the patient's care during the overall period of admission on the ward *'was not adequate'* and was not in line with '*good practice',* including the structure and conduct of ward round arrangements at that time. I also refer to the CC IPA's advice, in line with the GMC Guidance, consultants have responsibility both to ensure appropriate care of their patients when transferring care to others and for the supervision of junior staff. Further, the consultant should have personally taken further actions to investigate the patient's ongoing neurological symptoms. These possible actions included consulting with other specialists; for example, a consultant radiologist, consultant orthopaedic surgeon and/or the patient's consultant rheumatologist. I accept the CC IPA's advice. I note the Physio IPA also advised the patient's consultant rheumatologist should have been consulted. I also accept this advice.

100. I refer to the Trust's statement there is always someone on call and nursing and junior medical staff are aware of this. Further, the Trust amended its process '*to try to avoid similar situations happening'.* I consider, whilst the Trust indicated a consultant would have been available for review, the evidence clearly indicates this did not happen. Further, as the CC IPA further advised, I consider the Trust is responsible for the failure to secure senior review whether this arose because of '*a culture in the hospital/Trust, a failure in the induction process or [because the] junior doctors just [did not] bother'.* I also consider, the Trust's statement the process has since changed to mitigate a repetition of this, indicates an appropriate process was not applied at that time. I am very concerned staff did not ensure appropriately

senior review of the patient during the period of 3 to 10 September 2019. I also refer to the GMC Guidance, points 16 (d), 34 and 40, cited at paragraph 93 above. I consider the failures of appropriate senior review and input to the patient's care, supervision of junior staff and appropriate consultation with other specialists constitute failures in care and treatment.

101. I refer to my findings at paragraphs 94, 97 and 100. Therefore, I uphold this element of the complaint.

Injustice

102. I considered carefully whether the failings caused injustice to the patient and her family. I refer to paragraph 44 above, in which the injustice for Issue one (i) is addressed; specifically, the mis-read CT scan of 2 September 2019 indicated spondylolisthesis which had led to canal stenosis. I consider, therefore, the further failings, cited in paragraphs 94, 97 and 100 also caused the patient to lose the opportunity of a more accurate and timely diagnosis and to receive optimum treatment options. I consider, because of this lost opportunity, the patient also experienced distress from unnecessary pain because her condition deteriorated without appropriate, timely intervention. I also consider the patient's family experienced: - upset about the patient's distress; worry about the uncertainty of the patient's diagnosis; and frustration as their concerns were not addressed.

Detail of Complaint

iii. The process of consultation with the Belfast Health and Social Care Trust about the patient, including recording of same

103. The complainant raised concerns about the process of the Trust's consultation with and sharing of information with the BHSCT about the patient. In particular, she was concerned the advice was neither sought nor given by the most appropriate professionals and appropriate detail of what information was shared and who was involved in any decision-making was not recorded.

Evidence Considered

Legislation/Policies/Guidance

104. I considered the GMC Guidance.

Relevant records

105. I considered the patient's medical records from 2 to 10 September 2019.

Third Party Records

106. In consideration of the consultation between the Trust and BHSCT about the patient during the period of care, I requested relevant medical records held by the BHSCT for the period 3 to 10 September 2019.

Relevant Independent Professional Advice

107. The CC IPA provided advice on the Trust's consultation with the BHSCT. A key extract from this advice is detailed at paragraph 108 below. The complete CC IPA's advice is enclosed at Appendix five.

108. The CC IPA advised there were several discussions with BHSCT, but these were carried out by junior medical staff and, given the complexity of the case, *'it is unfortunate that the discussion'* was not at consultant level. Further, the CC IPA referenced the record of 4 September 2019 in which it was documented the BHSCT suggested referral for spinal MDT if there were ongoing concerns. She advised, '*despite the patient's clinical presentation, this did not happen'.* The CC IPA further advised, *'the mechanism/process used for seeking/receiving the orthopaedic advice was not appropriate. This should have been discussed consultant to consultant … at least the Trust should have ensured the patient's case was reviewed by an orthopaedic consultant.*

Analysis and Findings

109. In the patient's Trust records, on 3 September 2019, it is documented, '*D/W (discuss with) Ortho SHO [name of SHO] -history relayed will look at CT scan and D/W senior'.* I note, on 4 September 2019, it is recorded, *'called back by ortho SHO [name of SHO] SpR has reviewed images - happy with # healing no specific recommendations until # clinic RV … If ongoing concern email spinal referral for spinal MDM discussion'.*

110. I refer to paragraph 106 above. The BHSCT stated there are no records of the consultation between the Trust and BHSCT during the period of care, prior to 10

September 2019 and the SHO with whom the Trust communicated could not recall the discussion. Further, however, the BHSCT provided records obtained from the BHSCT's imaging service. I note these 'audit logs' indicated, on 3 September 2019 at 16:28, a named SpR reviewed the CT scan images of 2 September 2019. The BHSCT also confirmed this in the response to investigation enquiries.

111. I consider the records indicate the Trust consulted the BHSCT on 3 and 4 September 2019 and a SpR in BHSCT reviewed the images. I also consider the evidence indicates the BHSCT's advice to the Trust was, it was content with the healing of the patient's fracture and there were no specific recommendations; however, if there were continued concerns, the Trust should email a referral for discussion at a spinal MDT. I also consider however, other than the provision of the CT scan, there is no detailed record of what information the Trust gave to the BHSCT about the patient's clinical presentation. I refer to the GMC Guidance which states, '*clinical records should include relevant clinical findings.'*

112. Further, I note the CC IPA's advice, *'the mechanism/process used for seeking/receiving the orthopaedic advice was not appropriate. This should have been discussed consultant to consultant … at least the Trust should have ensured the patient's case was reviewed by an orthopaedic consultant'.* I accept this advice.

113. I also note the CC IPA's advice, although the BHSCT suggested referral for spinal MDT if there were ongoing concerns, '*despite the patient's clinical presentation, this did not happen'.* I refer to the Physio IPA's advice, she had concerns about the '*local protocol for post-trauma review of spinal imaging and consultation when, in referring to the orthopaedic specialists, given how the patient was presenting neurologically, the CT report was not at least questioned'.* I accept both the CC and Physio IPAs' advice. Whilst the BHSCT's actions in relation to this are addressed in a separate report, I am satisfied the Trust's failures to: - record the detail of the clinical information about the patient's presentation, which it provided to the BHSCT; refer the patient for spinal MDT discussion when concerns persisted; and ensure an Orthopaedic consultant reviewed the patient's case constitute failures in care and treatment. Therefore, I uphold this element of the complaint.

Injustice

114. I considered carefully whether the failings caused injustice to the patient and her family. I refer to the CC IPA's advice, *'delay in diagnosis of spinal cord compression led to delay in offering appropriate treatment'* and consider, the patient lost the opportunity of a more accurate and timely diagnosis and to receive optimum treatment options; and the patient's family's experienced worry about the uncertainty of the patient's diagnosis.

115. I refer to the findings at paragraphs 43, 101 and 113 above. I also refer to the CO, AN, Resp and Physio IPAs' advice at paragraphs 88 to 91. I accept the CO and AN IPAs' advice that, if the patient had received an accurate diagnosis earlier, in the period of 2 to 9 September 2019, she would have been fit for surgery. Further, I accept the CO IPA's advice surgery was the appropriate treatment for the patient's condition. I also accept the Resp and Physio IPAs' advice that the patient's immobility '*is likely to have had a significant impact'* on her development of bronchopneumonia and the *'absence of physiotherapy care … does represent a missed opportunity to give a treatment intervention aimed at mitigating the risk of the patient developing bronchopneumonia.'* Therefore, I consider the failings identified shortened the patient's life.

Detail of Complaint

iv. The management of the patient's pain

116. The complainant said the patient suffered unnecessary pain which was not appropriately relieved. She said there should be an appropriate pathway in place to escalate concerns about inadequate control of a patient's pain to obtain appropriate and specialist advice and intervention. The complainant said both the type of medication administered was not appropriate for neuropathic pain throughout the period of care and the patient was in significant pain on one occasion for two hours without relief during a period of nurses' handover.

Evidence Considered

Legislation/Policies/Guidance

117. I considered the NICE BNF Guidance, the RPS Guide, the GMC Guidance and both the NMC Standards and NMC Code.

Relevant records

118. I considered the patient's medical records from 2 to 10 September 2019; in particular, the patient's medication records (Kardex).

Relevant Independent Professional Advice

119. The CC and Nurse IPAs provided advice on different aspects of the management of the patient's pain. The CC IPA advised on the pain medication prescribed and the Nurse IPA about medication administered. Key extracts from the CC and Nurse IPAs' advice are detailed in paragraphs 120 to 124 below. The CC and Nurse IPAs' complete advice are enclosed at Appendices five and seven to this report, respectively.

CC IPA's Advice

120. The CC IPA detailed the pain medication prescribed to the patient during the period of 2 to 10 September 2019. The CC IPA advised the medication prescribed was appropriate; however, was also '*inadequate in that it failed to control the patient's pain'.* The CC IPA advised the failure to control the patient's pain *'should have stimulated a search for the cause of the pain'* and '*advice should have been sought from a pain management team'.* The CC IPA opined, access to a pain management specialist '*should be available'.* The CC IPA also advised, however, there was no evidence of respiratory depression.

Nurse IPA's Advice

121. The Nurse IPA outlined the pain medication which was administered to the patient from 2 to 10 September 2019. She advised the pain medication levels administered were in accordance with the prescription, other than ibuprofen and methotrexate. The Nurse IPA advised there was no reason recorded for not administering Methotrexate, and failure to administer this would have affected the patient's rheumatoid arthritis. The Nurse IPA referenced the RPS Guide and explained both a code and a rationale for the omission of the medication should be recorded.

122. The Nurse IPA advised the maximum dosage and frequency of pain medication was not exceeded and therefore concerns about the patient's pain did not need to be escalated. She further advised, however, the patient's refusal of ibuprofen on 4 September 2019 at 22:00 and the reason for this should have been escalated and

documented at the time. The Nurse IPA advised this was escalated on 5 September 2019 and remedial action taken.

123. The Nurse IPA referenced the variation between the nursing records and the clinical records. She advised the former indicates the patient was not in uncontrolled pain on 4 September 2019, whilst the clinical records note the patient's family informed the medical staff the patient had been "*in agony"* on 4 September 2019. The Nurse IPA outlined the medical staff's further enquiries into this which resulted in it being documented the patient said she had asked for pain medication '*three to four times but that "everyone was busy".* The Nurse IPA concluded, therefore, the patient asked for additional pain medication on 4 September 2019; however, this was not administered until her family complained in the evening. The Nurse IPA suggested, as the patient could not take the ibuprofen in the form offered at that time and vomited after Oramorph, it was *'most likely*' she would have refused these; however, additional paracetamol could have been given to her; and further, Shortec had been prescribed at 15:45 and, therefore, could have been given prior to its administration at 21:00. The Nurse IPA referenced the NMC Standards and NMC Code and advised, the nursing staff did not act in accordance with these. The Nurse IPA concluded the nurses did not identify the patient's pain on 4 September 2019 and therefore the patient was in pain until 21:00. She advised patients should be actively asked about pain, in line with nursing standards.

124. The Nurse IPA outlined the management of the patient's pain on 7 September 2019. She advised pain relief was not requested that morning and that there were *"no complaints"* of pain through the day. The Nurse IPA advised the records indicate pain management during the day was appropriate because nurses administered regular pain relief and administered additional pain medication when requested. The Nurse IPA, however, also referenced the delay in administering Longtec and paracetamol from 18:00 to 22:00 on 7 September 2019. She referenced the NMC Code and advised, as there was no documented rationale for this delay, it was not appropriate. She further advised, this delay meant, given the patient's chronic pain it *'is suspected'* she was in uncontrolled pain for four hours from 18:00 until 22:00. The Nurse IPA further referenced the NMC Code and advised the administration of analgesia should be prioritised over administrative duties and nursing handovers.

Responses to the Draft Investigation Report

The complainant's response

125. The complainant referred to the management of the patient's pain on 4 September 2019. She said she was '*so upset at the pain [the patient] had been in … on the ward that I had to be comforted by another nurse on duty who agreed that I should not have found my mum in that condition. I also had to look for a nurse to get the medication given. It is upsetting that this incident is not recorded in the [patient's] notes'.* The complainant also referred to the management of the patient's pain on 7 September 2019. She said, because of the patient's agony, she approached the nursing station *'at least six times but was waved away as they were in hand over'.* The complainant also said, when the handover was complete, *'the nurse went straight over to another patient on the ward who was independently mobile … they did not come to [the patient]. [The patient's husband] was so upset he actually had to leave [while the complainant] stayed with [the patient] until the pain relief was administered and she settled to sleep. [The complainant] stayed until after 11 pm as [she] was afraid of her having to suffer further … Again this incident is not recorded in the notes'.* The complainant said the patient's husband said *'seeing [the patient] … was like watching an animal in a cage being tortured'.*

Analysis and Findings

126. I refer to the NICE BNF. I note the dosages of all the pain medications prescribed were within the parameters outlined in this guidance, including that of Oramorph for the elderly.

127. I note the GMC Guidance states, '*in providing clinical care you must take all possible steps to alleviate pain and distress whether or not a cure may be possible'.*

128. I note the CC IPA's advice, whilst the pain medication prescribed was appropriate, it was *'inadequate*' to control the patient's pain and medical staff should have sought advice from a pain management specialist. I accept the CC IPA's advice. I refer to the GMC Guidance cited at paragraph 127 above and consider this to be a failure in care and treatment.

129. Further, in relation to the administration of pain medication, I note the Nurse IPA's advice, the omission of Methotrexate, with no documented rationale for doing so, was inappropriate and would have impacted on the patient's rheumatoid arthritis. I refer to the Nurse IPA's advice, the reason for the patient's refusal of ibuprofen should have been documented and the refusal should have been escalated contemporaneously. The Nurse IPA also advised the nursing staff did not appropriately identify the patient's pain on 4 September 2019, in accordance with the NMC Standards and Code and delayed the administration of pain medication on 7 September 2019. I am critical nursing staff did not follow national guidance and standards. I accept the Nurse IPA's advice. I consider these to be failures in care and treatment.

130. I refer to my findings in paragraphs 128 and 129 above and therefore uphold this element of the complaint.

Injustice

131. I considered carefully whether the failings caused injustice to the patient and her family. I consider because of the failings, the patient experienced distress because of the avoidable and unnecessary pain she suffered; and the patient's family experienced upset as they watched the patient in pain.

Issue 2: Whether the Trust managed the incident related to the CT scan of 2 September 2019 in accordance with relevant standards and policies, including those associated with Serious Adverse Incidents (SAIs).

Detail of Complaint

132. The complainant said the scope of the SAI[17] the Trust conducted was '*inadequate*'. She said the SAI only focused on the error in the CT scan report, but she believed this should be extended to consider the entire time of the patient's care from 2 to 10 September 2019. The complainant said the patient '*had clearly deteriorating Neurological signs, and never sat up or walked again, but rather became*

[17] A Serious Adverse Incident (SAI) is defined as any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage.

progressively more paralysed'. She said she reported the deterioration to the Trust medical staff each day, finally submitting a detailed letter of her concerns and the need for further investigations, after which it was a further three days before the MRI highlighted the spinal cord compression.

Evidence Considered

Legislation/Policies/Guidance

133. I considered the HSCB SAI Procedure and the Trust SAI Policy.

Relevant records

134. I considered the records of correspondence between the complainant and the Trust related to both the complaint and the SAI, including the minutes of meetings on 17 and 22 October 2019 and 21 January 2020.

Relevant Independent Professional Advice

135. The CED, CC and Physio IPAs all provided advice about whether there was a clinical basis for the Trust to have extended the scope of the SAI process to include relevant aspects of the patient's care; specifically, care in ED, on the cardiology ward and that provided by physiotherapy.

136. The CR IPA provided advice about the Trust's application of the SAI process in relation to the clinical aspects of the radiology error.

137. The CED, CC and Physio IPAs' advice are at Appendices four, five and eight to this report, respectively. The CR IPA's advice is at Appendix six to this report.

Analysis and Findings

Radiology SAI process and timelines

138. I refer to the CR IPA's advice at Appendix six. I note the CR IPA advised the actions taken as part of the SAI audit itself were reasonable. I accept the CR IPA's advice.

139. I refer to the HSCB SAI Procedure. I note it states, following a SAI notification, a significant event audit '*will immediately be undertaken'* and a learning report should be '*submitted to the HSCB within 8 weeks of the SAI being notified'.* Further, '*any adverse incident that meets the criteria … should be reported within 72 hours of the incident being discovered using the SAI Notification Form'.*

140. I also refer to the Trust SAI Policy and note it states,
'*In the event of the occurrence of an incident which has resulted in harm to a service user, the earliest appropriate contact [to the service user or family as appropriate] should be made to advise that the incident is being investigated including, where required, its reporting and investigation as a Serious Adverse Incident.*

Communication should also be timely: service users and/or their carers should be provided with information about what happened as soon as practicable. It is also essential that any information given is based solely on the facts known at the time. Trust staff should explain that new information may emerge as an incident investigation is undertaken, and service users and/or their carers should be kept up-to-date with the progress of an investigation'.

141. The records referenced in paragraph 134 above indicate, because of the complaint, the patient's CT scan was reviewed on 8 November 2019, at which point the error was identified. After the error was identified, there was further correspondence between the Trust and the complainant and one meeting. The minutes of the meeting on 21 January 2020 indicate the error was discussed at this meeting but the three letters from the Trust do not. The first indication a SAI was to be conducted was in a letter from the Trust, dated 10 May 2021, issued in response to the complainant's query about referral of the error to the GMC. This was approximately 18 months after the error was identified. I note the SAI meeting was held on 28 September 2021, approximately four and a half months after the SAI was to be initiated and finalised on 16 December 2021, more than two years after the error was identified. The patient's family were then informed of the SAI outcomes two months later.

142. I consider the Trust did not act in accordance with the HSCB SAI Procedure as the CT scan report error, which led to '*harm'* as defined within the SAI procedure, was identified on 8 November 2019 but a SAI was not instigated for approximately 18 months rather than 72 hours as stipulated in the HSCB SAI Procedure. Further, the SAI learning outcomes report was not completed until seven months after the SAI was instigated. I also consider the Trust did not act in accordance with the Trust SAI Policy because it failed to inform the patient's family of the SAI investigation until 18 months after the harm was identified and then only after the complainant queried whether the error should be referred to the GMC. Further, the Trust failed to keep the patient's family *'up-to-date with the progress*' of the SAI investigation with no updates from 13 May 2021 until 15 February 2022 and did not inform the family of the SAI outcomes until two months after the process completed.

143. I consider therefore the Trust failed to act in accordance with the first, second and sixth Principles of Good Administration. Specifically, '*Getting it right*' which requires public bodies to act in accordance with its own policies and relevant guidance; *'Being customer focused'* which requires public bodies to keep to its service standards; and '*Seeking continuous improvement'* which stipulates public bodies should ensure it learns lessons from complaints and uses these to improve services and performance. I consider the failures identified constitute maladministration.

Scope of the SAI

144. I refer to the Trust SAI Policy and note it states,
'*Principle of multidisciplinary responsibility*
This policy applies to all staff that has key roles in the service user's care. Most Trust health and social care provision involves multidisciplinary teams and communication with service users and/or their carers following an incident that led to harm, should reflect this. This will ensure that the Being Open process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual'.

145. The CED IPA referenced the scope of the SAI. He advised a SAI '*should have reviewed the whole patient journey to identify learning points, rather than being solely focussed on the CT scan'*. Further, '*it is almost universal and good practice in an SAI review to identify multiple areas for learning and improvement, when a*

whole patient journey is reviewed … This seems particularly relevant in this case, as the outcome of the case has been severe (death) and concerns about multiple stages of the patient journey have been raised in detail by the family of the patient'. The CED IPA explained, when a SAI is appropriately performed, it creates an opportunity for future care of patients and '*equally importantly*', sharing the outcomes can *'assist [the deceased patient's family] with the grieving process'.* I note the CED IPA advised, the Trust should conduct a further SAI for this case, considering the full patient journey.

146. The CC IPA also advised the scope of the Trust should have extended the scope of the SAI to include *'other clinical issues which should be addressed'*. I note the CC IPA made specific reference to the supervision of junior medical staff and the Trust's '*failure to further investigate the clinical symptoms and picture which were not in keeping with the CT report'.*

147. I note the Physio IPA advised there was no physiotherapy assessment undertaken which was detrimental to the patient's care and, therefore, the Trust *'should have included the care provided by Physiotherapy in its SAI review*' of the patient's care.

148. I refer to the Trust SAI Policy and note it states,
'*Principle of multidisciplinary responsibility*
This policy applies to all staff that has key roles in the service user's care. Most Trust health and social care provision involves multidisciplinary teams and communication with service users and/or their carers following an incident that led to harm, should reflect this. This will ensure that the Being Open process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual'.

149. I accept the CED IPA's advice, good practice in the SAI process would be to have considered the patient's whole journey of care. I also accept the CC IPA's advice there were other clinical issues to be addressed and the Physio IPA's advice the lack of physiotherapy assessment was detrimental to the patient. Further, I accept both the CC and Physio IPAs' advice the care cardiology and physiotherapy provided should have been included in the SAI review. I also consider the Trust SAI

Policy includes a *'Principle of multidisciplinary responsibility'* involving '*all staff that has key roles in the service user's care. Most Trust health and social care provision involves multidisciplinary teams … incidents usually result for systems failures and rarely from the actions of an individual'.* Therefore, I consider the Trust did not act in accordance with good practice or the Principle of Multidisciplinary Responsibility in the Trust SAI Policy. The opportunity to learn lessons was disregarded and critical learning lost to staff. There was also a lost opportunity to give the family answers they deserved.

150. I consider because of this, the Trust failed to act in accordance with the first and sixth Principles of Good Administration. These are '*Getting it right'* which requires public bodies to act in accordance with relevant guidance, its own policy and guidance, established good practice and taking reasonable decisions, based on all relevant considerations; and '*Seeking continuous improvement'* which stipulates public bodies should ensure it learns lessons from complaints and uses these to improve services and performance. I consider this constitutes maladministration.

151. In consideration of my findings at paragraphs 143 and 150, I uphold this element of the complaint.

Injustice

152. I considered carefully whether the failings caused injustice to the patient and her family. I consider because of the failings, the patient's family experienced frustration and uncertainty because of the delays in the SAI process and because all their concerns about the patient's care were not considered in the SAI. I also consider this resulted in the patient's family being unable to obtain closure about their outstanding concerns.

Issue 3: Whether the Trust managed the complaint in accordance with relevant standards and guidance

Detail of Complaint

153. The complainant said the Trust '*concluded*' her complaint on two occasions. She said after the second of these, she raised a further query which in turn led to a SAI being progressed. The complainant said the Trust's first formal response was not

issued until seven months after a meeting was held to discuss the complaint and when she responded to this with further outstanding queries to be investigated, the Trust did not respond for almost four months.

Evidence Considered

Legislation/Policies/Guidance

154. I considered the Trust Complaints Procedure and the DoH Complaints Guidance.

Relevant records

155. I considered complaints correspondence between the Trust and the complainant from 7 October 2019 to 6 January 2021. This included the minutes of related meetings.

Analysis and Findings

156. I refer to the DoH Complaints Guidance and the Trust Complaints Procedure. Both of these state a complaint will be acknowledged within two working days and a written response should normally be issued within 20 working days. Both also state, when this is not possible, the complainant should be advised of the delay and the reasons for this, and the body should provide the complainant with ongoing updates about any additional delays and progress of the complaint investigation. I note the Trust Complaints Procedure states delays in issuing the written response *'should not normally exceed an additional 20 working days'*; therefore, a complainant '*should not have to wait longer than 40 working days for a response from the Trust.'* Further, the Trust Complaints Procedure states*, 'when a meeting is held as part of the complaints process, the record of the meeting should be shared with the complainant within ten working days.'*

157. I reviewed the records cited in paragraph 155 above. The complainant's letter of 7 October 2019 was received and acknowledged on 14 October 2019. Two meetings, related to the complaint, were then held on 17 and 22 October 2019. The Trust issued written correspondence to the complainant on 17 December 2019, but this letter did not contain any detail in response to the issues raised in the complaint, rather it referenced the meetings held and planned as part of the complaints process. The notes of the meetings on 17 and 22 October 2019 were

enclosed with this letter; therefore, issued 43 and 40 working days after these meetings respectively. A further meeting was held on 21 January 2020.

158. I note the Trust did not, however, issue any further correspondence or updates to the complainant until 25 August 2020. This letter was a substantive response to the complaint of 7 October 2019. The minutes of the last meeting, held on 21 January 2020, were enclosed with this letter. This letter and the enclosed minutes were issued 147 working days after the last meeting associated with the complaint. In the intervening period, the Trust did not issue any updates, apologies, or explanations for delays to the complainant. In this letter of 25 August 2020, the Trust apologised for the delay, citing Covid-19 pressures as the reason. In this letter, the Trust also indicated it considered the complaint investigation to be complete.

159. On 28 September 2020, the complainant responded to the Trust's letter of 25 August 2020 detailing queries and concerns which she believed were outstanding because they had not been appropriately addressed in the complaints process. I note the Trust neither acknowledged this letter nor responded to it until 6 January 2021. This was 69 working days after the complainant's further correspondence. During the intervening period, the Trust did not provide any updates on the progress of further enquiries, nor did it either apologise or offer reasons for the delays. In the letter of 6 January 2021, the Trust apologised for the delay but did not offer any explanation for this.

160. I consider the Trust both acknowledged the complainant's first letter of complaint and took appropriate steps in resolving the complaint through meetings until 21 January 2020, in accordance with the Trust Complaints Procedure.

161. I consider the minutes of the 17 and 22 October 2019 and 21 January 2020, however, were not issued in accordance with the timelines specified in the Trust Complaints Procedure, with the delay in the issue of the last of these being significant. Further, I recognise it is reasonable there were pressures associated with Covid-19 which impacted on the management of complaints during the period between 21 January and 25 August 2020. I consider, however, the Trust's failure to provide the complainant with, at a minimum, updates, apologies and explanations

for the delays represents a failure to meet the requirements of both the DoH Complaints Guidance and the Trust Complaints Procedure.

162. I consider because of this, the Trust failed to act in accordance with the first and second Principles of Good Complaints Handling. These are '*Getting it right'* which requires public bodies to act in accordance with relevant guidance; and *'Being customer focused'* which stipulates public bodies deal with complainants promptly. I consider these failures constitute maladministration and therefore partially uphold this element of the complaint.

Injustice

163. I considered carefully whether the failings caused injustice to the patient and her family. I consider because of the failings, the patient's family experienced frustration and uncertainty because of the delays and lack of updates about progress in the complaints process. I also consider because of this, the patient's family were unable to obtain closure about their outstanding concerns and had to take additional time and trouble in bringing the complaint to this office.

CONCLUSION

164. I received a complaint about the care and treatment the Trust provided to the complainant's late mother during the period of hospitalisation from 2 to 10 September 2019. I upheld five and partially upheld two of the seven elements of the complaint for the reasons outlined in this report.

165. The failures identified in this report are of significant concern. I recognise how difficult and upsetting this may be for the patient's family to read and wish to offer my heartfelt condolences to the complainant and her family. It is clear to me that, throughout the period of care, the family were doing their utmost to ensure their much-loved mother was receiving appropriate care and treatment and their concern for her at all times is evident.

166. The investigation established the Trust failed to: -

    i. both conduct appropriately detailed neurological examinations whilst the patient was in ED and perform an MRI within the first 48-hour period of the patient's care;

ii. appropriately assess and investigate the patient's care and treatment needs whilst on the cardiology ward. This included a failure to undertake a physiotherapy assessment and take account of the patient's family's concerns;

iii. facilitate appropriate senior review and input to the patient's care; appropriately consult with other specialists; and ensure effective communications across health professionals; and

iv. record the detail of the clinical information about the patient's presentation, which it provided to the BHSCT; refer the patient for spinal MDT discussion when concerns persisted; and ensure review of the patient's case by an Orthopaedic Consultant.

- I recognise these failings caused the patient to sustain the injustice of the loss of opportunity for a more accurate and timely diagnosis and to receive optimum treatment options. I also recognise, because of this lost opportunity, the patient sustained the injustice of distress from unnecessary pain because her condition deteriorated without appropriate, timely intervention; and the patient's family sustained the injustice of upset about the patient's distress and worry about the uncertainty of the patient's diagnosis.

- In relation to the failure to take account of the patient's family's concerns specifically, I recognise this also caused the patient's family to sustain the injustice of frustration.

167. I consider the cumulative impact of these failings shortened the patient's life.

168. The Trust also failed to appropriately manage the patient's pain.
    - I recognise this caused the patient to sustain the injustice of distress because of the avoidable and unnecessary pain and the patient's family to sustain the injustice of upset as they watched the patient suffer in pain.

169. In managing the SAI process, the Trust failed to act in accordance with the HSCB SAI Procedure, the Trust SAI Policy and good practice.
    - I recognise this caused the patient's family to sustain the injustice of frustration and uncertainty because of the delays in the SAI process and

because all their concerns about the patient's care were not considered in the SAI. I also consider this caused the patient's family to sustain the injustice of being unable to obtain closure about their outstanding concerns.

170. In managing the complaints process, the Trust failed to act fully in accordance with the DoH Complaints Guidance and the Trust Complaints Procedure.
    - I recognise this caused the patient's family to sustain the injustice of frustration and uncertainty because of the delays and lack of updates about progress in the complaints process. I also consider this caused the patient's family to sustain the injustice of being unable to obtain closure about their outstanding concerns.

Recommendations

171. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustices caused because of the failures identified (within **one month** of the date of this report). Further, I recommend a senior member of Trust staff provides the complainant with this apology in a face-to-face meeting, during which the Trust should also outline the proposed improvements.

172. I recommend the Trust should ensure relevant staff are reminded of the importance of: -
    - the GMC Guidance, *'Domain one, Apply knowledge and experience to practice'*, '*Domain two, Contribute to and comply with systems to protect patients'* and '*Domain three, Communicate effectively';*
    - the HCPC Conduct and Ethics Standards, sections two and ten;
    - the HCPC Physio Standards, sections four, eight, nine and 14;
    - the NMC Standards, '*Annexe B: Procedures for assessing needs for person-centred care';*
    - the NMC Code, paragraph 1.4 and section 10;
    - the HSCB SAI Procedure and the Trust SAI Policy;
    - the DoH Complaints Guidance;
    - the Trust Complaints Procedure;
    - AMRC Consultant Care Guidance; and

- RCP and RCN Ward Round Guidance.

This should be evidenced by records of information sharing and/or training.

173. I further recommend the Trust should ensure relevant staff are given the opportunity to reflect on the findings of this report and the full CED, CC, CR, Nurse, Physio and AN IPAs' advice in consideration of their own practice and which should be noted in appraisal documentation. This should also be evidenced by records of information sharing.

174. The Trust should review documentation and practice in the cardiology unit in relation to the following: -
    a) the process of ensuring appropriate specialist pain management advice;
    b) the documented detail of clinical findings; and
    c) discussions with other professionals about patients and evidence of follow-up actions where recommendations are made.

    In relation to (b and c), please include, in particular, where senior review has been requested and consultation with professionals outside the Trust has taken place.

    The review should be evidenced through sample audits of records. The Trust should take action to address any identified trends or shortcomings and provide this Office with an update of findings and corrective actions, as appropriate.

175. For the benefits of shared learning and improvement to patients' care and services, the Trust should undertake a further SAI to incorporate those elements which were not included within the scope of the original SAI. Specifically, the SAI should consider the patient's entire care and treatment during the period of 2 to 10 September 2019. This should include the care and treatment ED, Cardiology and Physiotherapy provided to the patient. Further, in line with the HSCB SAI Guidance, the Trust should appropriately communicate with the complainant about the SAI and any subsequent investigation. The Trust should also provide the SAI outcomes to this office.

176. I refer to the Trust's statement that it made changes to the process for requesting senior review to avoid recurrence of similar situations. The Trust should also give cognisance to the documents referenced by the CC IPA, the AMRC Consultant Care Guidance and the RCP and RCN Ward Round Guidance when developing the revised process. The Trust should provide further details and evidence of these changes to this office.

177. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six** 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 **September 2024**

Appendix One

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.