



Northern Ireland

Public Services

Ombudsman

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

Report Reference: 202002565

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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: 202002565

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the Belfast Health and Social Care Trust's (the Trust) care and treatment of the complainant's late mother (the patient) both as an out-patient and in-patient in the Royal Victoria Hospital during the period of 5 August to 14 September 2019.

The patient fell on 1 August 2019. She presented to the Causeway Hospital in the Northern Health and Social Care Trust on 1 August 2019 and, after an X-ray, she was sent home. On 4 August 2019, she re-presented, in pain, to the Causeway Hospital and, following a computed tomography¹ scan (CT) which indicated a spinal fracture, she transferred to the Royal Victoria Hospital. In the Royal Victoria Hospital, the patient was given an Aspen collar² and discharged on 7 August 2019. The patient continued to become increasingly unwell and was readmitted to the Causeway Hospital on 13 August 2019. On 16 August 2019, the patient attended a scheduled review appointment with Consultant Spinal Orthopaedic Surgeon A at which she was told she did not require the Aspen collar at home. The patient continued as an in-patient in the Causeway Hospital until 10 September 2019 when she transferred to the Royal Victoria Hospital following identification of spinal cord compression. It was decided surgery was not an option, and the plan of care was to manage the patient's pain with the intention to then discharge her. Sadly, the patient died on 14 September 2019.

The complainant said the Trust did not listen to her concerns about the patient's presenting pain at the review clinic on 16 August 2019 and the Trust should have carried out further investigations for this at that time. The complainant said, over the period when the patient was in the Causeway Hospital, the complainant tried unsuccessfully to access spinal specialists' advice. The complainant also said the

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 commonly 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.

Trust did not record its consultations with the Northern Health and Social Care Trust about the patient, including review of the patient's CT scan images and did not record the concerns she raised on 16 August 2019. The complainant said the Trust failed to manage the patient's pain from 10 to 14 September 2019. She also said the Trust failed to both manage her complaint in line with its policy and to carry out a Serious Adverse Incident review.

The investigation established there were significant failings in the patient's care and treatment. The Trust did not offer the patient a different orthosis when she had difficulties with the Aspen collar and did not consistently assess, monitor and manage the patient's pain in accordance with national guidance. The Trust also did not manage the Northern Health and Social care Trust's referral for spinal advice, related to the patient, in accordance with both its standard procedure and reasonable care and failed to maintain appropriate records in line with national guidance. Further, the Trust did not escalate the complainant's concerns about the patient's deterioration to appropriate medical staff.

The investigation also found the Trust failed both to fully manage the complaint and consider a Serious Adverse Incident review in accordance with relevant procedures 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 preventing a re-occurrence of the failings.

The impact of the failings I identified 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 Belfast Health and Social Care Trust (the Trust) provided to the patient during the period of 5 August to 14 September 2019. This period included time when the patient attended a review clinic at the Royal Victoria Hospital (RVH), was an in-patient in the Northern Health and Social Care Trust hospital (NHSCT) and when she was treated as an in-patient in the RVH. The complaint also concerns the Trust's management of the complaint. 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 this report distressing.
2. I also investigated a complaint about the patient's care and treatment in the NHSCT for a similar period; specifically, from 2 to 10 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 NHSCT, x-rayed then discharged. The patient re-presented to the NHSCT on 4 August 2019, at which point a fracture was identified. The patient was then transferred to the RVH. She had further investigations in the RVH and discharged on 7 August 2019 with an Aspen collar. On 16 August 2019, the patient attended a review appointment at the RVH with Consultant Orthopaedic Surgeon A, 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 was treated in the NHSCT, arriving by ambulance. A CT scan was undertaken, along with other investigations. The radiology report from the CT scan indicated the fracture was '*sub-totally healed with no new acute bony lesion or any canal stenosis*³'. During the NHSCT's subsequent complaint investigation, after the patient sadly had passed away, it was identified

³ 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 which go from your spinal cord to your muscles.

the CT scan radiology report was incorrect and instead the scan showed significant canal stenosis because of the fracture which had led to Spondylolisthesis⁴. On 3 September 2019, the NHSCT consulted the Trust about the patient. The records indicate a member of Trust staff reviewed the scan images. The Trust reported to the NHSCT the images were reviewed and it was content with the healing of the fracture. On 10 September 2019, a Magnetic Resonance Imaging⁵ scan (MRI) was undertaken which identified there was a severe central canal stenosis, *'loss of Cerebrospinal fluid surrounding the cord⁶ and increased signal within the cord in keeping with cord oedema⁷*. At this point, the patient was transferred to the RVH. On 11 September 2019, the Trust discussed treatment options with the patient and her family, including the possibilities for spinal surgery. A decision was taken to not perform surgery, with a plan to manage the condition by stabilising the patient's neck with a collar, managing her pain, and prepare for her return home. Sadly, the patient died on 14 September 2019 in the Trust hospital from *'Bronchopneumonia due to immobility due to C7 fracture'*.

Issue(s) of complaint

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

Issue1: Whether the care and treatment which was provided to the patient by the Trust between 5 August and 14 September 2019 was appropriate and reasonable in accordance with relevant standards and guidance.

Issue 2: Whether the Trust managed the complaint in accordance with relevant standards and guidance.

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

⁴ 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.

⁵ Magnetic resonance imaging (MRI) is a type of scan which uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

⁶ 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.

⁷ Spinal cord compression

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 Orthopaedic Surgeon with 17 years' experience of trauma and orthopaedic surgery, specialising in spinal surgery MS, FRCS, FRCS(Orth) (CO 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); and
- A Consultant Anaesthetist with 20 years' experience; MBBS, MD, FRCA, LLM (Medical Law and Ethics) (CA IPA).

I enclose the clinical advice received from the CO IPA at Appendix four, the CR IPA at Appendix five, the Nurse IPA at Appendix six and the CA IPA at Appendix nine 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 Principles⁸:

- The Principles of Good Administration; and

⁸ These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- 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 Royal College of Physicians' National Early Warning Score (NEWS) 2 Standardising the assessment of acute-illness severity in the NHS, December 2017 (NEWS Guidance);
- The Nursing and Midwifery Council's Code, 2018 (NMC Code);
- The Health and Social Care Board's Procedure for the Reporting and Follow up of Serious Adverse Incidents, 2016 (HSCB SAI Guidance);
- The Belfast Health and Social Care Trust's Policy and Procedure for the Management of Comments, Concerns, Complaints & Compliments, March 2017 (Trust Complaints Policy); and
- The Department of Health's Guidance in Relation to the Health and Social Care Complaints Procedure, 2019 (DoH Complaints 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 which was provided to the patient by the Trust between 5 August and 14 September 2019 was appropriate and reasonable in accordance with relevant standards and guidance.

In particular, this considered:

- i. The advice and investigations provided to the patient;*
- ii. The Trust's actions in relation to the Northern Health and Social Care Trust's consultation about the patient between 2 and 5 September 2019, including recording of same;*
- iii. The management of the patient's pain; and*
- iv. The appropriate involvement of, and access to, relevant specialist advice, including information provided about this to the patient and her family.*

13. There were four main elements included within Issue one of the complaint, as noted above. Each of these four elements are addressed separately in the report.

i. The advice and investigations provided to the patient

14. The complainant said an opportunity to recognise deterioration of the fracture was missed during the patient's review appointment at the Trust on 16 August 2019. The complainant said she raised her concerns on 16 August 2019 with Consultant Orthopaedic Surgeon A.

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 both Issues, including all the elements of Issue one 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 5 to 7 and 16 August 2019.

Relevant Independent Professional Advice

18. The CO IPA provided advice on the patient's care whilst she was an in-patient between 5 and 7 August 2019 and when she attended the review clinic appointment on 16 August 2019. This included the patient's use of the collar and investigations commissioned. The CR IPA provided advice about the detail of the radiological investigations carried out with the patient from 5 to 7 and 16 August 2019. The CA IPA provided advice about the information provided to the patient and her family related to the decision about whether to proceed with surgery on 10 and 11 September 2019.

19. The CO, CR and CA IPAs' advice are enclosed at Appendices four, five and nine to this report, respectively. Those aspects of the CA IPA's advice which relate to care and treatment the NHSCT provided to the patient have been redacted from the CA IPA's advice at Appendix nine. A parallel redaction has been made for the Trust's care in the copy of this advice enclosed with the NHSCT report.

Further enquiries with the complainant related to the decision about surgery

20. Following the CA IPA's advice about the information provided to the patient and her family about the risks and benefits of proceeding and not going ahead with surgery on 10 and 11 September 2019, I sought further information from the complainant about this discussion with the Trust.

Responses to the Draft Investigation Report

21. The complainant, the Trust and individuals within the Trust, who were cited within the complaint, 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 22 and 23; 47 to 51; 69 and 70; and 98 to 101.

The complainant's response

22. The complainant provided further detail about the patient's scheduled review appointment with Consultant Orthopaedic Surgeon A on 16 August 2019. The complainant reiterated Consultant Orthopaedic Surgeon A had *'spinal expertise ... knew [the patient] previously from treating her lumbar stenosis, and also had seen her for her neck fracture'*. The complainant said, when attending this appointment, she was able to bring the patient's medical notes which were maintained as an in-patient within the NHSCT. The complainant referred to the notes of the review which state, *'today [the patient] is doing very well'* but which the complainant said, *'makes no sense at all – she was an inpatient in Causeway so therefore not doing at all well'*. The complainant reiterated that she raised concerns about the patient's *'severe pain sensations in classic C8 dermatome pattern'* but there is no record of this. The complainant said, although the presenting pain was *'classic C8 dermatome pain'*, Consultant Orthopaedic Surgeon A stated the issue was likely to be the patient's shoulder. The complainant said she believed Consultant Orthopaedic Surgeon A *'did not recognise a deterioration [he] should have recognised'*. The complainant said she was *'saddened'* the concerns she raised at this appointment were not recorded.
23. The complainant explained, although the NHSCT medical records at this time indicated the patient *'had grade 5 power in her lower limbs with only mild weakness in upper limbs, this is totally inaccurate ... [the patient] would never have had grade 5 (movement against maximum resistance) strength in her upper or lower limbs. She did not have full range in any joint, and certainly did not have grade 5. The inaccuracy of every assessment is frightening'*. The complainant said, she *'was concerned about the information being given to BHSCT by NHSCT'* and which led to her submitting a detailed letter of her concerns to NHSCT on 7 September 2019.

Analysis and Findings

24. I note the GMC Guidance states, *'you must ... promptly provide or arrange suitable advice, investigations or treatment where necessary ... provide effective treatments based on the best available evidence'*.

25. I examined the medical records for the review appointment on 16 August 2019. The record states, ' *Seen for her undisplaced C7 fracture, doing well. Does not tolerate the collar so not to bother with the collar at home. Her main concern is the right shoulder pain, x-ray shows no shoulder joint and it looks out of the cavity, refer to a shoulder specialist*'. I note there is no record of neurological concerns being raised by either the patient or her family at that time.
26. The CR IPA referenced the range of radiological investigations the Trust conducted between 5 and 16 August 2019. I note he advised these were all correctly reported. The CR IPA also advised there was no evidence of the deterioration of the fracture in any scans the Trust viewed prior to, or on, 16 August 2019. He advised the deterioration appeared to occur between the MRI on 6 August 2019 performed in the Trust and the CT scan of 2 September 2019 carried out in the NHSCT.
27. The CO IPA outlined the patient's care and treatment from 5 to 7 August 2019 in the Trust. I note he advised the care provided was appropriate, including the use of the Aspen collar at this stage.
28. The CO IPA provided detail of the patient's appointment at the review clinic on 16 August 2019. He advised the records indicate the patient was told "*not to bother with the collar at home*" because she was finding it difficult to tolerate. I note the CO IPA advised, because of the specific injury, '*it would have been reasonable to have tried another orthosis⁹ like a cervico-thoracic orthosis or a custom made Aspen type collar*'. Further, however, there was '*no certainty that a new orthosis would have prevented the fracture position from deteriorating in the future*'.
29. The CO IPA referenced the records of 16 August 2019 review clinic. He advised, given the patient's history, it would have been reasonable to consider further radiological investigations at the review clinic appointment if the patient's family raised concerns; however, he also advised these concerns were not documented and there was no record of the patient herself '*complaining of any upper limb pain, other than shoulder pain*'. The CO IPA advised, in these circumstances, '*it would have been reasonable not to have ordered any new radiological investigations*'.

⁹ Orthosis is an external device or apparatus, such as a brace or splint, used in orthopaedics to support or immobilize the spine or limbs.

30. I note the CO IPA concluded it could not be determined whether further radiological investigations would have shown changes to the fracture at that time; although, a different orthosis should have been offered but which may or may not have prevented future deterioration.
31. I accept the CR IPA's advice and am satisfied the radiological investigations undertaken from 5 to 16 August 2019 in the Trust were correctly reported and there was no indication of the deterioration of the fracture in any of the scans in this period. I accept the CO IPA's advice and am satisfied the care and treatment the Trust provided between 5 and 7 August 2019 was appropriate, including the use of the Aspen collar.
32. I refer to the complainant's comments on the Draft Investigation Report. The issues related to the NHSCT's care and treatment including the patient's assessment and records held are addressed in a separate report. Based on the available evidence, however, I note there are no records the patient or her family raised neurological concerns on 16 August 2019. Whilst I recognise the integrity of the complainant's experience in relation to this matter, I concur with the CO IPA's advice and in the absence of records of these concerns, I am unable to determine there was a basis for further radiological investigations to be commissioned. I also accept the CO IPA's advice and am satisfied, if the patient did not raise this, it was reasonable additional radiological investigations were not carried out.
33. The CO IPA advised, on 16 August 2019, the patient said she found the Aspen collar uncomfortable and Consultant Orthopaedic Surgeon A consequently told her she did not need to wear the collar at home. The CO IPA also advised that Consultant Orthopaedic Surgeon A should have offered a different orthosis at that time. I accept the CO IPA's advice. I also refer to the GMC Guidance cited at paragraph 24 above. I consider this is a failure in care and treatment and partially uphold this element of the complaint.

Injustice

34. I considered carefully whether the failing caused injustice to the patient and her family. I consider the patient lost the opportunity for a better chance of preventing the deterioration of her fracture; however, I refer to the CO IPA's advice and therefore am unable to definitively determine deterioration would not have occurred.

The decision about surgery

35. I refer to the AN IPA's advice *'there needed to be a full disclosure of risks and benefits of the operation versus not having the operation'* to the patient and her family which would *'have enabled shared decision making'* in line with GMC Guidance. I note her advice, *'this does not appear to have happened'*.
36. The complainant provided further information about the discussions the Trust had with the patient and her family on 10 and 11 September 2019 related to the patient's treatment options. The complainant said the information provided to the patient and her family was comprehensive and clear, with the Trust providing details of the benefits and risks of both carrying out the surgery and not proceeding with this. The complainant said, on 10 September 2019, the family had understood originally that the surgery was to go ahead, but also had a clear understanding at that point that the patient's condition had progressed so far that there would be no assurances of a return to previous mobility. She explained it was hoped surgery would alleviate the patient's pain and might have brought some other improvement in terms of movement.
37. The complainant said, on 11 September 2019, three consultants met with the patient and her family. These consultants were the Consultant Anaesthetist, the Consultant Orthopaedic Surgeon and an Intensive Care Unit Consultant. The complainant said the Consultant Anaesthetist explained that, following review of the patient's blood gases, he had concerns about the surgery *"as her body was not coping"*. The complainant said, the consultants also explained the patient was a *"CO² retainer."* The complainant said the three consultants explained the risks and benefits of both options and the information they provided *'was excellent and was handled with sensitivity'*. The complainant said, she believed that *'these consultants took this situation seriously'*. The complainant said the consultants explained if they did not proceed, the patient would be made comfortable and managed conservatively and sent home. The complainant understood, in this case, the paralysis would continue.
38. The complainant said the family all agreed surgery would not proceed. The complainant also specified that the patient and her husband had the opportunity to

discuss in private away from the rest of the family. She also said, as the patient had received so much surgery throughout her life, the patient did not want to have any more surgery. The complainant said the patient and her family were fully informed in making the decision and she believed this decision was the correct one.

39. Although the records of the Trust's discussions with the patient and her family about the treatment options do not contain the full details of these discussions, in consideration of the additional information the complainant provided about these discussions, I am satisfied the Trust provided appropriate information to enable the patient to make an informed decision about the surgery.

Detail of Complaint

- ii. *The Trust's actions in relation to the Northern Health and Social Care Trust's consultation about the patient between 2 and 5 September 2019, including recording of same*
40. The complainant said the Trust missed the opportunity to note there was an error in the reading of the CT scan of 2 September 2019 as the scan was shared with the Trust at that time. She said during the complaint process, the Trust stated it has '*no record at all*' of the NHSCT sharing the CT scan with the Trust. The complainant raised concern about the lack of records in instances when other trusts consult the Trust for advice about patients. She said there should be at least '*a simple record of the ... concerns*' raised by another trust and the advice given by the Trust, as well as a record of scans being shared. The complainant said the Trust agreed there were opportunities to recognise the patient's deterioration earlier. She also said the NHSCT's records indicate the NHSCT raised the concerns and shared the scan with the Trust on 2/3 September 2019; however, the Trust informed the NHSCT that the Trust did not need to review the patient until her next scheduled review on 18 September 2019.
41. The complainant also said the Trust was unable to confirm if the NHSCT shared the CT scan of 2 September 2019 and if the Trust reviewed it because '*the system [was] purged*'. The complainant said there appeared to be an issue with sharing of information between the Trust and the NHSCT.

Evidence Considered

Legislation/Policies/Guidance

42. I considered the GMC Guidance.

Relevant Records

43. I considered the only Trust record available for the period 2 to 5 September 2019. This record was an 'audit log' of staff who accessed and/or viewed the patient's CT scan of 2 September 2019 during the period 2 to 5 September 2019. The Trust's imaging service provided the audit log. The Trust also liaised with the Business Services Organisation¹⁰ (BSO) to obtain further detail about the computer account holders who accessed and/or viewed the CT scan during this period, which additional information the Trust submitted to the investigation.

Third Party Records

44. In consideration of the consultation between the NHSCT and the Trust about the patient during this period, I requested relevant medical records held by the NHSCT for the period 2 to 10 September 2019.

Relevant Independent Professional Advice

45. The CR and CO IPAs provided advice on different aspects of the Trust's engagement with the NHSCT about the patient from 2 to 5 September 2019. The CR IPA provided advice about the Trust Radiology Department's review of the CT scan of 2 September 2019. The CO IPA provided advice on the Trust Orthopaedic Department's involvement in the consultation with the NHSCT, including the appropriateness of those involved in this.

46. The CO and CR IPAs' advice are enclosed at Appendices four and five to this report, respectively.

Responses to the Draft Investigation Report

The complainant's response

47. The complainant said she was '*distressed*' *'the normal procedure for a referral was not followed and discussions about [the patient's] care were not recorded'*. The

¹⁰ The Business Services Organisation provides a broad range of regional businesses support functions and specialist professional services to the health and social care sector in Northern Ireland.

complainant said, during this time, she also *'phoned [Consultant Orthopaedic Surgeon A's] secretary and left messages ... but there is no record of these either'*. The complainant said, *'it pains me that the Trust denied that [it] saw the scan – but when the Ombudsman became involved [the Trust] was able to show the scan was shared'*. The complainant reiterated her concerns about the inaccuracy of information the NHSCT shared with the Trust.

The Trust's response

48. The Associate Specialist (AS), who was identified in the Trust audit log as having accessed and viewed the NHSCT's CT scan images, referred to the patient's relevant record, specifically, *"[AS] has reviewed images - happy with # healing no specific recommendations until # clinic RV ... If ongoing concern email spinal referral for spinal MDM discussion"*. The AS stated this record could not refer to him as he *'was not the spinal [AS] at the time'* and further, has *'never been a [spinal AS]'*. The AS stated, whilst the CT scan images were accessed while he was logged onto the regional imaging service, *'given the date, location and time when this happened, I would have been working in the fracture clinic at this time. As this area precludes exclusive individual access to a computer, the scan could have been viewed by any doctor working in this clinic or in the department at this time'*. The AS stated it was *'inaccurate'* to assume it was he who accessed the scan. The AS stated, *'there is no mention of my name in any of the patient's records throughout her treatment journey. Furthermore, it would not be the normal practice for [a Core Trainee (CTr)] taking a spinal referral from another hospital to seek my advice. As per the established pathway, [the CTr] would contact the on call spinal registrar instead'*. The AS reiterated he *'definitely would not have offered treatment advice in a complex spinal case such as this as it is not within my area of expertise'*.
49. The Trust described the normal process for receipt and management of spinal referrals from other hospitals at that time. The Trust stated, these referrals *'would first have been taken by the CTr on-call ... depending on the information given and the complexity of the patient, [the CTr] may have asked a Registrar for advice as to the next course of action. This was not necessarily the Spinal Registrar but may have required the [CTr] or Registrar to view the available radiological images to advise on next appropriate actions'*. The Trust stated it has *'unfortunately'* no

records of what happened on receipt of the referral, including who viewed the patient's scan images. The Trust apologised for this. The Trust stated it has since implemented a revised process for these referrals which requires completion of a proforma, with a letter dictated when advice is given. The Trust stated this provides a contemporaneous record of those involved in clinical decisions about those patients referred to the service.

50. Following receipt of the Trust and AS' responses to the Draft Investigation Report, further investigation of the circumstances surrounding access to the patient's scan was undertaken. This included enquiries about Trust policies and procedures about access to computers and patient records. The Trust stated the AS was indeed *'working within the Fracture Clinic in Royal Victoria Hospital at the time the images were viewed'*. The Trust explained the clinic area has a *'central outpatient's room with clinical examination rooms either side of this'* and, in this central area, any clinical staff can review patient notes and images prior to consultations in the individual examination rooms. The Trust stated clinical staff also dictate consultation outcome letters in the central area. The Trust stated it has assumed, while the AS was with a patient in an examination room, he had *'not signed off from the computer [into which] he was logged... in the central room, and before [his] sign-in timed out, another individual, who we cannot identify, must have viewed [the patient's] images while [the AS] was still logged in'*. The Trust stated there are *'also general computers in the main fracture clinic area, which can be accessed by the multi-disciplinary teams. These are often in use [by] clinicians ... across ... multiple clinics, as well as new referrals, which have been received'*.
51. The Trust stated there *'is no specific reference within the Trust's ICT Security Policy [about] requiring staff to log out of a computer station when not in use'*; however, the policy states, *"authorised access to BHSCT networks will be granted in the first instance by means of a unique identifier.....additional security may be used to prevent unauthorised access to specific ICT systems....Users must not share passwords. The User will be held responsible for any activity on their account."* Further, the Trust stated, within *'the mandatory training programme for staff in relation to general Data Protection, it is advised as best practice to use the 'Ctrl, Alt, Delete' function to lock a computer when left unattended'*. The Trust also stated, however, *'there needs to be some recognition of the reality of running these large*

clinics with the very significant time constraints whilst having to log into and out of multiple clinical systems. Having to do so before and after every patient would significantly impact the number of patients that are able to be seen in a timely manner within the clinical session and this is therefore inappropriate. The Trust stated it has since installed a second computer in each central area within the Fracture Clinic *'to allow each clinician ... to log in under their own login'*. The Trust further explained, however, as Trust staff are always present in central areas, it had *'no concern of anyone unauthorised gaining access to a room where a computer may not have been locked'*. The Trust stated, *'in the near future'*, it will implement 'Encompass' which will provide a more streamlined solution, allowing staff to use individual portable technology to access one system.

Analysis and Findings

52. I refer to the GMC Guidance. I note it states, *'promptly provide or arrange suitable advice, investigations or treatment where necessary'*, *'you should make records at the same time as the events you are recording or as soon as possible afterwards'* and *'clinical records should include: relevant clinical findings, the decisions made and actions agreed, and who is making the decisions and agreeing the actions, who is making the record and when'*.
53. I refer to the Trust's response to investigation enquiries at Appendix three. The Trust confirmed a named CTr received the NHSCT referral about the patient on 3 September 2019 and, on 4 September 2019, the CTr relayed advice to the NHSCT which he stated had been provided by an AS. I note the Trust stated the normal process would be, on receipt of a referral, a proforma hard copy would be completed and this would then be discussed with the appropriate consultant with review of any scans at the Trauma meeting the following day. The Trust stated this did not happen on this occasion. The Trust confirmed there were no records of any discussions about the patient during this period of 2 to 5 September 2019 related to either the Trust's interaction with the NHSCT or internal discussions. The Trust stated Trauma meetings are not recorded and, therefore, there are no records of whether the patient was discussed, or the scan reviewed at the Trauma meeting on 4 September 2019. The CTr stated he was *"unable to recall from memory if this was discussed given the considerable time lapse"* and although the standard referral

proforma was not in the patient's notes, the CTr *"states he is meticulous with this record keeping and would have documented a referral proforma, however he cannot account for the missing document"*.

54. I note the Trust confirmed, however, on 3 September 2019 at 16:28, a member of Trust staff reviewed the CT scan of 2 September 2019. The Trust explained this information was not previously identified because the Imaging Service was not generally familiar with the application of the specific audit required to elicit this information. The Trust apologised this information was not previously available and for *'the undue upset the lack of clarity caused'*. The AS also provided comment. He stated, because there was no reference in the notes to his involvement, this *'reiterates the fact that I was in not in any way involved in providing treatment advice to the referring hospital'*. The AS also stated, *'generally I do not have involvement in the referrals or management of patients with spinal conditions'*.
55. The 'audit log' and detailed information from BSO indicate, on 3 September 2019 at 16:28, a member of Trust staff reviewed the CT scan images of 2 September 2019. I note in the NHSCT's records, on 3 September 2019, it is documented *'D/W (discuss with) Ortho [CTr] [name of CTr] -history relayed will look at [the] CT scan and D/W senior'*. The NHSCT's records document, on 4 September 2019, *'called back by ortho [CTr] [name of CTr] [AS] has reviewed images - happy with # healing no specific recommendations until # clinic RV ... If ongoing concern email spinal referral for spinal MDM discussion'*.
56. The CR IPA advised there was no evidence the Trust's Radiology Department reviewed the CT scan of 2 September 2019; rather the only records related to review by Orthopaedics. I note the CR IPA opined, there was no *'clear documented record of the orthopaedic team's interpretation of the imaging on 3/9/19'* and there should be *'more accurate recording of the review of imaging'*.
57. The CO IPA referenced the Trust records and advised there was no record of whether the member of Trust staff who viewed the scans discussed these with a consultant. I note he also advised, however, there was no detail of *'what clinical information'* the NHSCT gave to the Trust CTr or what information the CTr

conveyed to the member of Trust staff with whom he discussed the NHSCT referral. The CO IPA advised the NHSCT records *'indicated that there was no significant neurological deterioration in the pt's condition'*, although this contradicted the complainant's comments the patient was *'deteriorating neurologically'*. The CO IPA specified, the NHSCT's records of 5 September 2019 *'mentions that the patient had Gr 5 power (normal) in her lower limbs with only mild weakness in her upper limbs'*; however, on 8 September 2019, the weakness in the patient's upper and lower limbs was documented. The CO IPA opined, *'it is my assumption that what actually may have happened is that the [Trust] may not have been told that the [patient] was showing neurological deterioration and the CT was reported as showing the fracture was healing and so the [Trust] might have felt everything was progressing satisfactorily and not taken any further advice'*.

58. The CO IPA advised, the normal practice for on-call arrangements should be the on-call CTr would consult the on-call AS and then, if required, the AS would contact the consultant. The CO IPA referenced his previous advice about the lack of documentation of what clinical details the NHSCT gave to the CTr and what the CTr then conveyed to the member of Trust staff from whom he sought advice, particularly in the context the NHSCT did not document significant neurological deterioration until much later. The CO IPA referenced the Trust's normal spinal referrals process. He advised the reassurance from the erroneous CT scan report and the possible lack of *'clinical information about any significant neurological deterioration of the patient'* may have resulted in a decision to not discuss the case with the spinal consultant. I note the CO IPA further advised, however, the Trust did not apply its normal process for spinal referrals and, *'because of the patient's history, complexity and the patient being known to spinal consultants in the Belfast trust, onward referral to a spinal consultant should have been considered.'*
59. I note the CO IPA concluded, the Trust should have recorded the discussion and interaction with the NHSCT, and the case should have been discussed with a spinal consultant.
60. I refer to the AS' comments that he believes he had no involvement with the patient. I also refer to the Trust's suggestions about the circumstances of the viewing of the patient's scan. I refer to and accept the CO IPA's advice and am satisfied, because

the patient's case was complex, given her recent history and because she was a known patient, *'onward referral to a spinal consultant should have been considered'*. I am unable to conclude whether the CTr, or any other member of Trust staff involved at that time, sought advice from an appropriate spinal specialist, in line with both the Trust's normal process and the CO IPA's advice. I consider, however, there is clear evidence on 3 September 2019, a member of Trust staff reviewed the patient's CT scan of 2 September 2019. Further, there is clear evidence, on 4 September 2019, the CTr provided advice to the NHSCT which the CTr stated an AS provided. Further, I accept the CO IPA's advice and am satisfied it is unclear what clinical information about the patient's neurological condition either the NHSCT gave to the Trust or the CTr gave to the member of Trust clinical staff from whom he sought advice. This is of particular note in the context the NHSCT did not record neurological deterioration in the patient until 8 September 2019. I also consider there is no evidence the patient was referred to a spinal consultant.

61. I refer to the GMC Guidance cited at paragraph 52 above. I consider the failure both to record any of the interaction with the NHSCT, which the evidence confirms occurred on 3 and 4 September 2019; and document any internal discussions or decisions about the patient during this period constitute failures in care and treatment. Based on the information the Trust provided about its spinal and trauma referrals process, although this process is not documented, I also consider the Trust failed to apply the normal procedure on 3 and 4 September 2019 in relation to the patient. I also accept the CO IPA's advice and am satisfied the Trust's interactions with the NHSCT should have been recorded. Further, I accept the CR IPA's advice and am satisfied there should have been more accurate records of the review of the scans. I consider these constitute failures in care and treatment.
62. I consider appropriate clinical records allow clinicians to explain and justify their actions post-event; however, most importantly, they inform care. Such failings seriously undermine the confidence of patients and their families in the quality of their care and treatment. Based on the available evidence, I consider it would have been reasonable to refer the case to a spinal consultant. This is because of the patient's specific circumstances and, as noted in paragraph 53 above, the normal Trust process for spinal referrals would have been discussion and review by the Trauma meeting and/or a consultant but this was not followed. In the absence of

appropriate clinical records, I am unable to determine with whom the responsibility for failing to ensure review of the patient's case by a spinal consultant lies. I do, however, find the Trust's failure to do so constitutes a failure in care and treatment.

63. I refer to my findings at paragraphs 61 and 62 above and, therefore, uphold this element of the complaint.

Injustice

64. I considered carefully whether the failings caused injustice to the patient and her family. I consider, because of the failings, the patient and her family lost the opportunity for a more accurate and timely diagnosis and for the patient to receive optimum treatment, with an ultimately sad outcome for the patient.

Detail of Complaint

iii. The management of the patient's pain

65. The complainant said the Trust did not manage the patient's neuropathic pain¹¹, even though she was on a spinal ward. The complainant also said, '*the pain team were only called when we begged for more pain relief*'. She also said, eventually, she requested the involvement of the palliative care team because she believed this team would know the most effective solution for the patient's levels of pain. She said there should be a '*clear pathway*' to access appropriate pain management for those patients with '*intolerable pain*'.

Evidence Considered

Legislation/Policies/Guidance

66. I considered the NICE BNF Guidance, the RPS Guide, the GMC Guidance, the NEWS Guidance, the NMC Standards and the NMC Code.

Relevant records

¹¹ Neuropathic pain can happen when the nervous system is damaged or not working correctly. Pain can come from any of the various levels of the nervous system, including the spinal cord. Neuropathic pain can be caused by ... spinal nerve compression or inflammation. Medicines commonly prescribed for neuropathic pain include ... Pregabalin.

67. I considered the patient's medical records from 10 to 14 September 2019; in particular, the patient's medication records (Kardex).

Relevant Independent Professional Advice

68. The Nurse IPA provided advice on different aspects of the management of the patient's pain. The Nurse IPA's advice is enclosed at Appendix six to this report.

Responses to the Draft Investigation Report

The complainant's response

69. The complainant referred to the patient's medical records and said, on 12 September 2019, the records indicate the doctor discussed the patient's increased pain, *"very severe, consistent. Visibly uncomfortable in bed. Neuropathic pain in both arms"* with a plan to refer *"to pain team first thing tomorrow morning"* and then on the following day, 13 September 2019, it is recorded, *"pain team review priority this morning"*. The complainant said, however, the family *'waited all morning for the pain team to come but they did not appear. This was a very distressing morning – we kept asking when the pain team would come ... We were so desperate for someone to help with the pain that my sister-in-law went into the corridor and found a member of staff ... and asked him to do something as we felt we were getting nowhere'*. The complainant said the pain team did not arrive until 13:00 and was only going to prescribe 50mg of pregabalin and which level of dose, the complainant said, the patient was already in receipt prior to her fall. The complainant said 50mg of pregabalin *'is not the prescribed dose recommended for neuropathic pain in NICE guidelines.'*

70. The complainant reiterated it was she who requested input from the palliative care team and not the Trust pain team. Further, the complainant said, in the early hours of 14 September 2019, she also had to request ward staff contact the palliative care consultant, to enable use of a syringe driver when the patient remained in pain. The complainant said, following the patient's transfer from NHSCT to the Trust, when the Trust and the patient decided surgery was not an option, the Trust was aware the patient was experiencing neuropathic pain. She said at this point, the Trust's plan was to keep the patient comfortable with a view to discharge; however, the pathway for the management of the patient's pain, including referral to the pain

and palliative care teams was '*not at all effective*'. The complainant said it is '*traumatising*' the '*horrific*' pain the patient suffered '*could have been avoided*'.

Analysis and Findings

71. I refer to the NICE BNF Guidance. I note the patient's medical records indicate, from 10 to 12 September 2019, the dosage of Pregabalin prescribed for the patient, 25mg, was approximately one sixth of the recommended dose for neuropathic pain in the NICE BNF Guidance. On 12 September 2019, the dosage was tripled to 75mg but was still approximately half the dose recommended for neuropathic pain in the NICE BNF Guidance. On 13 September 2019, the dosage was in line with the NICE BNF Guidance. The patient's medical records also indicate the patient had a prescription of 50mg of Pregabalin prior to this period of care. Throughout the period, the dose of Diazepam prescribed was the minimum recommended dose for muscle spasms in the NICE BNF Guidance. On 13 September 2019, Morphine was commenced but the dose prescribed was half the minimum dose detailed in the NICE BNF Guidance.
72. I refer to the Trust's response to investigation enquiries at Appendix three. I note the Trust apologised for the patient's suffering and it had previously acknowledged the issue related to the dosage of Pregabalin which could have been identified earlier. The Trust also detailed several learning and improvement actions being implemented around pain medication and management, including highlighting the necessity to check recent pain medication prescriptions in foundation doctors' induction and developing more effective pathways to both the Acute Pain team and Palliative Care teams' services.
73. The Nurse IPA detailed the pain medication administered to the patient from 10 to 14 September 2019. She referenced the RPS Guide and advised, with one exception, the medication was administered in line with this. Specifically, where medication is either withheld or declined, this should be clearly recorded at the time, together with the reason if known, and the prescriber notified with "*appropriate action ... taken as necessary*". I note she advised, on 13 September 2019, Longtec was not administered in line with the prescription but the rationale for this was not recorded. The Nurse IPA further advised, however, other records indicate,

on 13 September 2019, the pain management team agreed Pregabalin should be increased as Longtec was not controlling the neuropathic pain and, therefore, there was no impact from the failure to document the reason.

74. The Nurse IPA referenced the NMC Standards, the NMC Code and the NEWS Guidance. I note she advised, from 11:00 to 18:00 on 11 September 2019, the patient's pain was not scored. The Nurse IPA also advised, however, the nursing evaluations document the patient *"slept for long periods"* which *'would indicate that the medications prescribed were effective at this time. Despite pain not being scored on the 11th, there does not appear to have been an impact on the patient, NEWS was stable, with no rise in physiological parameters such as pulse and respirations which can indicate pain'*.
75. The Nurse IPA advised, however, on 12 September 2019, the records indicate the patient *'was in pain this day'*; specifically, neuropathic pain, *'with severe, constant pain, shooting down both arms'*. The Nurse IPA further advised, whilst the *'Longtec, Shortec and Paracetamol were effectively controlling her generalised pain, her neuropathic pain was not controlled on 25mg BD Pregabalin from the morning of 12th'*. The Nurse IPA also advised, on 12 September 2019, *'there was a long period of time from 09:39 to 23:00 when nurses did not monitor or assess the patient's pain'*. I note she explained, although NEWS was documented at 13:20 and 16:00 on 12 September 2019, the nurses did not ask the patient about pain and, therefore, failed to identify the patient *'was in severe pain at these times, and therefore failed to escalate this to the doctor'*. The Nurse IPA opined, the increase in the Pregabalin prescription and referral to the pain team could have happened earlier, *'certainly at 13:20'* which would have eased the patient's pain earlier.
76. The Nurse IPA advised, on 13 September 2019, although the Pregabalin was to have increased to 50mg, the change to the prescription was not added to the prescription chart. Consequently, the patient was only given 25mg of Pregabalin as *'nurses can only administer what is prescribed and would have been unable to administer the increased dose'*. I note the Nurse IPA further advised, however, the nurses should have highlighted this to medical staff at 10:00 on 13 September 2019 but did not. The Nurse IPA advised the pain team reviewed the patient at 13:00 and 50mg of Pregabalin administered at 14:50 but this could have been carried out

sooner if it had been escalated at 10:00. She advised the patient was, therefore, *“left in severe, constant’ neuropathic pain down both arms all day and this pain was difficult to control up until she was actively dying during the evening of 13th’.*

77. The Nurse IPA advised, the records indicate the Pain team initially proposed palliative care at 13:00 on 13 September 2019, after which, the patient’s family wanted to explore this further. I note the Nurse IPA opined this was *‘reasonable’.*
78. The Nurse IPA advised the records indicate the nurses liaised with the palliative care team and followed this team’s instructions on 13 September 2019 at 22:00. Further, the nurses escalated the patient to medical staff. I note the Nurse IPA opined, these actions were reasonable.
79. The Nurse IPA provided advice about the nurses’ actions on 14 September 2019. She advised, at 00:10 on 14 September 2019, the records indicate the family raised concerns about the patient still being in pain on the prescribed medication. I note the Nurse IPA referenced the NMC Standards and Code and advised, *‘it is reasonable that the family, who are with the patient at all times, would notice this before nursing or medical staff. It is in line with nursing standards to respond to their concerns which they did’.*
80. I accept the Nurse IPA’s advice and am satisfied the pain medication administered to the patient during the period of care was in line with that prescribed and with the RPS Guide except for Longtec on 13 September 2019 but which absence had a documented rationale elsewhere and which did not impact on the patient.
81. I refer to the complainant’s comments on the Draft Investigation Report the patient’s family sought the involvement of, and engaged with, the palliative care team rather than Trust staff. Whilst I recognise the integrity of the complainant’s experience in relation to this matter, based on the available evidence of the patient’s records, I accept the Nurse IPA’s advice and am satisfied the nursing staff’s engagement with the palliative care team and response to the family’s concerns about the patient’s pain on 14 September 2019 were reasonable.

82. I consider the records indicate the levels of some of the patient's pain medication were not reflective of the recommended dosage levels in the NICE BNF, particularly Pregabalin which was specifically for neuropathic pain and, until 13 September 2019, were half the level prescribed to the patient prior to her fall. I refer to the complainant's comments on the Draft Investigation Report about the Trust's plan to make the patient comfortable prior to an intended discharge and therefore, the Trust was aware of the patient's neuropathic pain. I consider this accords with the clinical plan detailed in the patient's records. Therefore, I consider during the period of 11 to 14 September 2019, the patient was given a clear diagnosis of spinal cord compression, which is a cause of neuropathic pain, and was treated on a spinal ward. I consider, therefore, the Trust should have reasonably been expected to recognise the need to appropriately manage the patient's neuropathic pain from the onset of this period and in accordance with both the clinical plan and the NICE BNF Guidance but did not. I also consider the Trust acknowledged the prescription of Pregabalin for most the patient's care was not appropriate and the pathway of access to the Acute Pain and Palliative Care teams' services was not as effective as it should have been. I accept the Nurse IPA's advice and am satisfied, from 11:00 to 18:00 on 11 September 2019 and on 12 September 2019, the patient's pain was not assessed or monitored in line with the NMC Standards and NEWS Guidance. Further, I accept the Nurse IPA's advice and am satisfied the nurses failed to highlight to medical staff the increased dose of Pregabalin had not been recorded on the prescription chart, in line with the NMC Code. I consider these to be failures in care and treatment and, therefore, uphold this element of the complaint.

Injustice

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

Detail of Complaint

iv. *The appropriate involvement of, and access to, relevant specialist advice, including information provided about this to the patient and her family*

84. The complainant said, when she had concerns about the patient's deterioration, she was unable to contact anyone in the spinal team. She said she contacted the spinal ward, the fracture clinic and the patient's spinal consultant's secretary (Consultant Orthopaedic Surgeon A) but to no avail. The complainant said another secretary in the department told her she would email the complainant's concerns to Consultant Orthopaedic Surgeon A; however, there is no record this happened. The complainant said there should be clear guidelines and a pathway to contact an appropriate professional in such circumstances.

Evidence Considered

Legislation/Policies/Guidance

85. I considered the GMC Guidance.

Relevant records

86. I considered email correspondence the complainant provided, relating to the period of 2 to 10 September 2019.

Relevant Independent Professional Advice

87. The CO IPA provided advice about the Trust's actions in relation to the complainant's attempts to seek advice from the spinal team during the period 2 to 10 September 2019.

Analysis and Findings

88. I note the GMC Guidance states, *'you must be considerate to those close to the patient and be sensitive and responsive in giving them information and support'* and *'when you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support'*.

89. I note the Trust referenced the meeting with the complainant on 6 November 2019 and stated, at this meeting it was agreed, *'the communication pathways 'had broken down''* and an apology was offered. The Trust explained, at that time, Consultant

Orthopaedic Surgeon A's secretary worked part-time; however, it has introduced a new system of cover when staff are unavailable.

90. The CO IPA explained consultants in the National Health Service would not be in-situ daily; therefore, responses to emails or messages may not be immediate. He advised, however, if messages had been passed to Consultant Orthopaedic Surgeon A, he should have responded or followed up as soon as possible but there was no evidence he was informed of these concerns. I note the CO IPA further opined, the Orthopaedic administrative team should have taken further steps to access specialist orthopaedic advice; for example, telephoned the specialist directly or contacted the on-call orthopaedic registrar or consultant. The CO IPA advised, *'this did not appear to happen'*.
91. I refer to the GMC Guidance cited at paragraph 88. I consider there is no evidence the Orthopaedic secretaries communicated the complainant's concerns to Consultant Orthopaedic Surgeon A and, therefore, there is no evidence Consultant Orthopaedic Surgeon A failed to act in accordance with the GMC Guidance.
92. Further, however, I accept the CO IPA's advice and am satisfied the Trust should have taken additional actions to ensure a response to the complainant's concerns. I refer to the Trust's previous acknowledgement and apology for the break-down in communications, and the improvement introduced to provide cover for administrative staff when they are not available. I consider, however, these only addressed the apparent gap created by the secretary's part-time hours. I consider, in the context the complainant made several attempts to contact Consultant Orthopaedic Surgeon A through several secretaries and there is no evidence these concerns were communicated to any appropriate medical staff, this constitutes a failure to act in accordance with the first and second Principles of Good administration, *'Getting it right'* and *'Being customer focused'*. Specifically, *'providing effective services; ensuring people can access services easily; dealing with people helpfully and promptly ... bearing in mind their individual circumstances'*; and *'responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers'*. I consider these

failings constitute maladministration. I therefore uphold this element of the complaint.

Injustice

93. I considered carefully whether the failing caused injustice to the patient and her family. I consider the patient and her family lost the opportunity for a more accurate and timely diagnosis and receiving optimum treatment. This is because, if they had been able to access a spinal consultant to explain their concerns, further investigations may have been carried out earlier. I also consider the patient's family experienced frustration because they could not speak with anyone about their concerns.

Issue 2: Whether the Trust managed the complaint in accordance with relevant standards and guidance

Detail of Complaint

94. The complainant said there were delays in the Trust's responses to the complaint, including prior to the onset of Covid-19. The complainant said she made the complaint on 25 September 2019 and a meeting was then held on 6 November 2019; however, the Trust did not issue a substantive response or the minutes of this meeting until 28 February 2020 which was '*over three months later*'.
95. The complainant said she believed the process was then placed on hold because of Covid-19 and therefore believed she could not respond to the Trust's response of 28 February 2020 for some time. She said she did not receive a response to her follow-up enquiries of 24 September 2020 until 24 June 2021. The complainant also queried whether the Trust should have raised a Serious Adverse Incident (SAI) review following the complaint.

Evidence Considered

Legislation/Policies/Guidance

96. I considered the GMC Guidance, Trust Complaints Policy, the DoH Complaints Guidance and the HSCB SAI Guidance.

Relevant records

97. I considered the complaints correspondence between the complainant and the Trust and the Trust's internal correspondence and records related to the complaint.

Responses to the Draft Investigation Report

The Trust's response

98. The Trust apologised for both the delay in providing the complainant with a written response to her complaint and for the *'undue upset and frustration this caused at what was already a difficult time'*. The Trust acknowledged the response issued to the complainant *'later than would have been required by'* its complaints procedure. The Trust also referred to the minutes of the meeting of 6 November 2019, however, and stated, at this meeting, the process of approval of the meeting minutes was explained the complainant, including it might take between eight and twelve weeks to complete the approval process. The Trust stated this *'anticipated delay was due to ongoing pressures'* within the service. The Trust also stated, at this meeting, Consultant Orthopaedic Surgeon A provided the complainant with his email address and invited her to contact him if she had any further questions. The Trust referred to records of email communications with the complainant which it provided and stated, *'there was active communication with the complainant throughout the process of investigation and she was kept informed of the progress of her complaint'*. The Trust further stated, the process for approval of the meeting minutes included approval by the Chair of Division of Trauma and Orthopaedics; however, this individual has since retired and therefore, unfortunately, the Trust cannot provide any further explanation for the delay. The Trust acknowledged the delay was *'unacceptable'* and for which it apologised.
99. The Trust referred to the complainant's comments about the progress of the complaint process following the onset of Covid-19. The Trust referred to records of communications with the complainant, which it provided, and stated, on 6 March 2020, the complainant submitted comments on the minutes of the meeting of 6 November 2019 to the Trust. The Trust stated, in this email, the complainant also

queried if she could submit further questions to which the Trust replied on the same day indicating further queries could be submitted and which would then be passed to the service for response. The Trust stated it did not receive any further correspondence from the complainant until 31 August 2020. The Trust stated, at that time, the complainant said she *“believed complaints were on hold”*; in response, however, the Trust reiterated further questions could be forwarded. The Trust stated it received the complainant’s further questions on 24 September 2020, which correspondence it acknowledged the following day. The Trust stated, on 23 October 2020, the Trust wrote to the complainant about the delay in responding to her outstanding concerns. The Trust stated it was at this point it indicated there were delays related to Covid-19.

100. The Trust acknowledged the delays in responding to the complainant’s further questions of 24 September 2020. The Trust stated the service, from which a response was required, *‘provides an unscheduled and acute fracture service’* for Belfast residents and *‘a regional service for more complex fractures’*. The Trust stated, during the period of the management of the complaint, *‘the service was under extreme pressure’*. The Trust stated, between December 2019 and January 2020, there was an impact from industrial action and then, in early 2020, further pressure arose from planning for Covid-19 and the subsequent shutdown on 16 March 2020. The Trust stated this period was a source of *‘significant pressures on all teams and their ability to manage complaints processes’*. The Trust stated, *‘clinical commitments superseded administrative work, as the clinical staff were engaged in providing frontline patient care’*. The Trust stated these *‘clinical pressures regrettably resulted in delays to the Trust’s complaint response to [the complainant’s] outstanding questions’* of 24 September 2020 and for which the Trust *‘sincerely’* apologised.

101. The Trust stated *‘there is likely to be learning for both [the NHSCT and the Trust]’* because, although the NHSCT misread the CT scan on 2 September 2019, *‘if a member of the [Trust’s] spinal team’* had reviewed the scan on 2/3 September 2019, the displacement may have been identified. The Trust also stated, in the absence of *‘documentation that outlines that the referral was escalated to a Registrar or Spinal Consultant at that time’*, the Trust *‘can only ascertain that this*

did not happen'. The Trust further stated, *'with hindsight, the service now feels that an SAI should have been raised when it was identified that there had been a delay to transfer and treatment in the context of fracture displacement. However, this was not understood at that time. It was thought that an SAI did not appear to be indicated as [the patient's] condition deteriorated due to the fracture becoming displaced'* and *'this led to a poor outcome for [the patient] which ... given her medical history and clinical presentation'* was *'not surprising'*; however, *'the SAI should have been raised when the circumstances surrounding the delayed transfer were fully understood'*. The Trust queried whether initiation of an SAI at this stage would cause *'additional hurt and upset to the family'* but also stated it would take actions based on the Ombudsman's final recommendations.

Analysis and Findings

102. I refer to the DoH Complaints Guidance. I note it states, *'a complaint should be acknowledged in writing within 2 working days of receipt ... a full response will be provided within 20 working days ... As soon as the HSC organisation becomes aware that the relevant response timescale is not achievable they must provide the complainant with an explanation. The complainant must be updated every 20 working days on the progress of their complaint by the most appropriate means'*.
103. I also refer to the Trust Complaints Policy. This 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. The Trust Complaints Procedure also states, in line with the Department of Health requirements, a written response should normally be issued within 20 working days. I note it also states, when this is not possible, the complainant should be advised of the delay and the reasons for the delay and the Trust should provide the complainant with ongoing updates about any additional delays and progress of the complaint investigation. The Trust Complaints Policy also outlines complaint responses should *'address the issues raised in a proportionate and fair manner ... provide a full explanation of all issues raised'*.
104. I also refer to the HSCB SAI Guidance which defines an adverse incident as *'any event or circumstances that could have or did lead to harm, loss or damage to people ...'*. The HSCB SAI Guidance outlines the SAI criteria, including, *'serious injury to, or the unexpected/unexplained death of: - a service user'* and *'any adverse*

incident which meets one or more of the above criteria should be reported as a SAI'. The HSCB SAI Guidance specifies if an adverse incident meets the SAI criteria, it should be reported within 72 hours of the incident being discovered. The HSCB SAI Guidance also explains its purpose, which is to *'ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; and provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations'*. I further refer to the Trust Complaints Policy which also considers SAIs.

105. I refer to the GMC Guidance which states, *'comply with systems to protect patients... To help keep patients safe you must: b. contribute to adverse event recognition'*.
106. I reviewed the records cited in paragraph 97 above. I also refer to the Chronology of the Complaint at Appendix eight to this report.
107. The Trust received the complainant's letter of 25 September 2019 the following day. The Trust held a meeting with the complainant on 6 November 2019, but the Trust did not issue either the minutes of this meeting or its substantive response to the complaint until 28 February 2020. This was 73 working days after the meeting. I refer to the Trust's comments on the Draft Investigation Report, at the meeting on 6 November 2019, the Trust explained the process of approval of the meeting minutes and the likely timeline of up to 12 weeks. This is recorded in the minutes of the meeting. I also recognise the issue of the meeting minutes and the Trust's complaint response would be interdependent. I note, however, the meeting minutes did not issue until approximately 16 weeks after the meeting, not 12. In the intervening period, the complainant had to request updates, starting approximately eight weeks after the meeting, which correlated with when the minutes might have been ready to issue in consideration of the Trust's indicative timeline. I also consider, although the Trust communicated to the complainant it anticipated a lengthy period would be required before approval and issue of the minutes, in consideration of the Trust's Complaints Policy which stipulates minutes associated with complaints meetings should issue within ten working days, the anticipated delay itself was substantial and this period of delay did not coincide with Covid-19.

In the Trust's response of 28 February 2020, the Trust apologised for the delay but did not provide an explanation for this.

108. I refer to the Trust's response to the Draft Investigation Report and the associated records about the sequence of events between the issue of both the Trust's substantive complaint response and minutes of the meeting and the complainant's second letter of 24 September 2020. The records confirm on 6 March 2020, the Trust clarified with the complainant she could submit any outstanding questions. The complainant's next submission to the Trust was on 24 September 2020. The Trust acknowledged this the following day. I note there is no evidence to indicate the Trust told the complainant the complaints process was in abeyance in the intervening period between 6 March and 24 September 2020.
109. On 23 October 2020, the Trust issued an update to the complainant about her complaint which indicated there was a delay related to Covid-19 and for which the Trust apologised. On 16 November 2020, 37 working days after her follow-up letter, the complainant requested an update; however, there is no evidence the Trust responded to this enquiry. On 12 April 2021; 1, 11 and 20 May 2021; and 3 and 7 June 2021, the complainant again enquired about progress, to each of which enquiries, the Trust responded either the same or the following day. In each of the Trust's responses to these enquiries, the Trust apologised for the delays but did not provide any explanations. I note, for a period of approximately eight months from 23 October 2020 until 17 June 2021, the Trust only provided updates at the complainant's request. Further, the Trust did not respond to the first of these requests at all and, in following responses, whilst the Trust offered apologies for the delays, it did not provide any reasons for the delays. On 17 June 2021, the Trust initiated an update to the complainant; however, in this update, the Trust neither apologised nor explained the delay. On 24 June 2021, the Trust issued a substantive response to the complainant's letter of 24 September 2020 in which it apologised for the delays and stated it was due to Covid-19.
110. I further refer to the records referenced in paragraph 97. There is an email of 2 October 2019, from the Trust Medical Director to several Trust staff in which he asked the email recipients to *'confirm that an IR1¹² has been completed, an SAI*

¹² IR1 is the form to be used to record and report adverse incidents to the Northern Ireland Adverse Incident Centre

considered ...'. The email recipients were a Consultant Orthopaedic Surgeon and the Co-Director of Trauma and Orthopaedics Service; and copied to the Deputy Medical Director, a manager in the Medical Director's office, another Consultant Spinal Surgeon and the Service Manager for Trauma and Orthopaedics. I also refer to the Trust's response to investigation enquiries at Appendix three. The Trust stated, *'there are no records of discussion around this case. Unfortunately due to staff changes since that time, there is no memory or record of what was discussed or agreed. An incident was not recorded at the time and an SAI was not reported - there is no record of the discussion or rationale at the time and in light of this they will review this case to establish if an SAI is required'*. I note, however, further investigation identified two of the recipients appear to still occupy the same roles as at that time; specifically, the Co-Director of Trauma and Orthopaedics Service and the Medical Director.

111. I refer to the Trust's comments on the Draft Investigation Report about learning from the patient's case and it *'now feels that an SAI should have been raised when it was identified that there had been a delay to transfer and treatment in the context of fracture displacement'*.
112. Whilst there is evidence the Trust told the complainant of an anticipated delay in the issue of the minutes of the meeting from the outset, I consider the Trust both failed to meet these extended timelines and the timelines were significantly different to those stipulated in the Trust Complaints Policy. I also consider the Trust's response to the complainant's first letter was not issued in timelines which accorded with either the DoH Complaints Guidance or the Trust Complaints Policy. I consider the Trust also failed to act in accordance with the DoH Complaints Guidance and the Trust Complaints Policy because it did not provide the complainant with regular updates about the investigation but rather only responded to her requests. Further, I consider there were no presenting extenuating circumstances at that time, such as Covid-19; therefore, the delays and lack of updates were not reasonable.
113. Whilst I recognise the complainant believed the onset of Covid-19 had impacted on the progression of complaints, I consider there is no evidence the Trust prevented the complainant from progressing her further concerns and complaint between March and September 2020.

114. During the period from the submission of the complainant's follow-up letter of 24 September 2020 until the Trust's substantive response in June 2021, I recognise the impact Covid-19 had on health and care services and the unremitting pressure placed on staff to respond to ever-changing situations in an adaptive and coordinated way. Therefore, I consider in these circumstances, it was reasonable for the Trust to prioritise '*clinical commitments [over] administrative work, [with] clinical staff engaged in providing frontline patient care*'. I also consider, however, the Trust failed to take steps to keep the complainant updated about the investigation progress and the reasons for delay. I consider such actions were not dependent on the clinical staff who were involved in prioritising clinical care at that time. I consider, therefore, in relation to this, the Trust did not act in accordance with either the DoH Complaints Guidance or the Trust Complaints Policy. In particular, I consider it was not appropriate the Trust did not respond to the complainant's request for an update on 16 November 2020 until she enquired again 101 working days later.
115. I consider the email of 2 October 2019 from the Trust Medical Director indicates an adverse incident arising from the complaint should have been recorded and reported and a SAI considered. I consider there is no evidence either action was taken forward. Further, I consider in its response to the Draft Investigation Report, the Trust acknowledged a SAI should have been raised. I refer to the HSCB SAI Guidance cited at paragraph 104 above. I consider the opportunity to learn lessons was disregarded and critical learning lost to medical staff. There was also a lost opportunity to give the patient's family answers they deserved. I consider this constitutes a failure to act in accordance with the HSCB SAI Guidance and the GMC Guidance cited in paragraphs 104 and 105 above.
116. I consider because of these failures, the Trust did not act in accordance with the first, fifth and sixth Principles of Good Complaints Handling. The first Principle, '*Getting it right*' requires public bodies to act in accordance relevant guidance; ensure lessons are learned from complaints; and deal with complainants promptly. The fifth Principle, '*Putting things right*' stipulates public bodies should provide prompt remedies. The sixth Principle, '*Seeking continuous improvement*' requires public bodies to:- use all feedback and the lessons learnt from complaints to

improve service design and delivery; have systems in place to record, analyse and report on learning from complaints; regularly review the lessons to be learnt from complaints; and where appropriate, tell the complainant about the lessons learnt and the changes made to services, guidance or policy. I consider this constitutes maladministration and therefore partially uphold this element of the complaint.

Injustice

117. I considered carefully whether the failings caused injustice to the patient's 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 this resulted in the patient's family being unable to obtain closure about the outstanding concerns.

CONCLUSION

118. I received a complaint about the care and treatment the Trust provided to the complainant's late mother over several periods of care from 5 August to 14 September 2019. I upheld three and partially upheld two of the five elements of the complaint for the reasons outlined in this report.

119. 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.

120. The investigation established:

- The Trust failed to offer the patient a different orthosis on 16 August 2019 when she had difficulties with the Aspen collar.
 - I recognise this failure caused the patient and her family to sustain the injustice of the loss of opportunity for a better chance of preventing deterioration of the patient's fracture.

- The Trust failed to: - appropriately manage the patient's neuropathic pain in accordance with the NICE BNF Guidance; consistently assess and monitor the patient's pain in line with the NMC Standards and NEWS Guidance; and escalate associated concerns.
 - I recognise these failings caused the patient to sustain the injustice of avoidable pain and, because of the unnecessary pain, she sustained the

injustice of distress. I also recognise the patient's family sustained the injustice of upset as they watched the patient in pain.

- The Trust failed to act in accordance with both the Trust's own normal procedure, and reasonable care, by not ensuring a spinal consultant considered the NHSCT's referral of the patient on 3/4 September 2019. Also, the Trust did not act in accordance with either '*Domain one*' of the GMC Guidance or the Trust's normal procedure because there were no records of either the Trust's engagement with the NHSCT about the NHSCT's referral of the patient, or the Trust's internal discussions about the referral on 3 and 4 September 2019.
 - I recognise these failings caused the patient and her family to sustain the injustice of the loss of opportunity for a more accurate and timely diagnosis and for receiving optimum treatment, with an ultimately sad outcome for the patient. In relation to the second of these, this is because, if appropriate records had been maintained, there would have been a better chance of follow-up by the spinal team.

- The Trust failed to act in accordance with the first and second Principles of Good Administration, '*Getting it right*' and '*Being customer focused*' because the complainant's concerns about the patient's deterioration were not communicated to appropriate medical staff.
 - I recognise these failings caused the patient and her family to sustain the injustice of the loss of opportunity for a more accurate and timely diagnosis and for receiving optimum treatment. This is because, if they had been able to access a spinal consultant to explain their concerns, further investigations may have been carried out earlier. I also recognise the patient's family sustained the injustice of frustration because they could not speak with anyone about their concerns.

- In managing the complaints process, the Trust failed to act fully in accordance with the Trust Complaints Policy and the DoH Complaints Guidance. Also, the Trust failed to act in accordance with the HSCB SAI Guidance; and medical staff did not act in accordance with the GMC Guidance, '*Domain two*'.

- 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 the outstanding concerns.

Recommendations

121. 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).
122. 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*', '*Record your work clearly, accurately and legibly*' and '*Domain two, Safety and quality, Contribute to and comply with systems to protect patient*';
 - the NMC Standards, '*Annexe B: Procedures for assessing needs for person-centred care*';
 - the NMC Code, sections 10 and 13;
 - the RPS Guide;
 - the NICE BNF;
 - NEWS Guidance;
 - the Trust's standard process for receipt and management of spinal referrals;
 - the DoH Complaints Guidance and the Trust Complaints Policy; and
 - the HSCB SAI Guidance.

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

123. I further recommend the Trust should ensure relevant staff are given the opportunity to reflect on the findings of this report and the full CO and Nurse 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.

124. I refer to the learning and improvement actions related to the management of pain which the Trust stated it has either implemented or initiated. I welcome this demonstration of the Trust's commitment to learning and improvement and recommend these improvement actions are fully implemented and the outcomes shared with this office when complete. These should be evidenced by documentation related to the induction of foundation doctors and any new or revised policies, procedures or guidance related to accessing the Acute Pain and Palliative Care teams' services.

125. Further, I refer to the Trust's response to the Draft Investigation Report the Trust now considers *'an SAI should have been raised when it was identified that there had been a delay to transfer and treatment in the context of fracture displacement'*. For the benefits of shared learning and improvement to patients' care and services, the Trust should undertake a SAI. Further, in line with the HSCB SAI Guidance, the Trust should appropriately communicate with the complainant about the SAI and any subsequent investigation.

126. The Trust should review its documentation and practice related to the receipt and management of referrals from other health trusts. This should include the maintenance of appropriate records of liaison with the referring health trust and internal discussions and decisions.

This should be evidenced through sample audits of records, which should include an audit of the Trauma and Orthopaedic Department. 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.

127. The Trust should review its documentation and practice in the Trauma and Orthopaedic Department, in relation to the communication of concerns raised about patients to appropriate medical staff.

This 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.

128. 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 staff read and understood any related policies).

MARGARET KELLY
Ombudsman

August 2024

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.

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.