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

Report Reference: 202400130

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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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Listed Authority: Northern Health and Social Care Trust (the Trust)

SUMMARY

This complaint is about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) at Antrim Area Hospital (AAH) on 27 December 2023.

The patient presented to the emergency department (ED) at AAH on 27 December 2023, referred by his general practitioner (GP). After completing investigative tests for the patient, the Trust discharged him from the ED on the same day (27 December 2023). The complainant was concerned with the Trust's decision to discharge her father given his poor health. She believed the Trust should have admitted him for further treatment.

I upheld the complaint. The investigation found the Trust did not act in accordance with relevant guidelines. It also identified that the decision to discharge the patient from the ED back to his GP, with no further follow-up arranged, was a failure in his care and treatment.

I recommended the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failure identified within **one month** of the date of my final report. I further recommend that the Trust brings the contents of this report to the attention of the relevant staff so they can reflect on the learnings identified in it.

I was sad to learn of the patient's death the month after the events in this report. I wish to pass on my condolences to the complainant and the patient's wider family.

THE COMPLAINT

1. This complaint is about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the patient on 27 December 2023.

Background

2. The patient presented himself to the Emergency Department (ED) following a referral from his General Practitioner (GP) on 27 December 2023. He presented with a cough and shortness of breath. The patient had already completed two courses of antibiotics and a course of steroids in the community. The patient had Chronic Obstructive Pulmonary Disease[1] (COPD), Parkinson's Disease[2], and Progressive Supranuclear Palsy[3] (PSP) amongst a list of 38 conditions.

3. After conducting investigations including blood tests, an x-ray and an ECG, the Trust made the decision to discharge the patient with no further treatment.

4. On 29 December 2023, the patient reattended ED with worsening shortness of breath. The patient was admitted to hospital and commenced treatment. However, his condition sadly deteriorated, and he died in hospital on 14 January 2024.

Issues of complaint

5. I accepted the following issue of complaint for investigation:
Whether the Trust's decision to discharge the patient on 27 December 2023 was reasonable and appropriate, and in accordance with relevant policies and guidance.

INVESTIGATION METHODOLOGY

6. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the

[1] A progressive lung condition that makes it difficult to breathe due to damage to the lungs.
[2] A progressive neurological condition that affects movement and causes problems in the brain.
[3] A neurological condition that causes problems with balance, movement, vision, speech and swallowing which is caused by brain cell damage.

complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

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

    - Doctor of Emergency Medicine, MB, ChB, FRCEM, PhD, with over 10 years' experience as an Emergency Department Consultant.

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

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

Relevant Standards and Guidance

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

    The general standards are the Ombudsman's Principles[4]:

    - The Principles of Good Administration

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, updated April 2019 (the GMC Guidance).
    - National Institute for Health and Care Excellence, Chronic obstructive pulmonary disease in over 16s: diagnosis and management, July 2019 (NG115).

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

- National Institute for Health and Care Excellence, Pneumonia in adults: diagnosis and management, October 2023 (CG191).
- National Institute for Health and Care Excellence, Suspected acute respiratory infection in over 16s: assessment at first presentation and initial management, October 2023 (NG237).
- National Health Service, Chronic Obstructive Pulmonary Disease (COPD) and exacerbations or 'flare ups', April 2024 (NHS Guidance)

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

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

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

THE INVESTIGATION

Whether the Trust's decision to discharge the patient on 27 December 2023 was reasonable and appropriate, and in accordance with relevant policies and guidance.

Detail of Complaint

13. The complainant disagreed with the Trust's decision to discharge the patient from ED on 27 December 2023 following a recommendation to attend by his GP. The complainant believed given the patient's condition the Trust should have admitted him for ongoing care.

The Trust's response to investigation enquiries

14. The Trust stated its tests showed crackling sounds[5] from the patient's lungs and a respiratory rate of 20 with oxygen saturations of '*88% on 2 litres of*

[5] Abnormal sounds heard during breathing, often described as popping, rattling, or crackling sounds.

oxygen'. The Trust stated that a '*cardiovascular system examination showed a pulse of 98, blood pressure of 94/58 and a temperature of 36.6'*. The Trust stated the patient's Glasgow Coma Scale[6] was 15 and he had a '*mild peripheral oedema*[7]'.

15. The Trust stated it performed bloods and chest x-ray, with the patient's bloods showing a '*normal white cell count of 8.7, slightly low platelets of 127, slightly low haemoglobin*[8] *of 124 and a raised CRP*[9] *of 107*'. The patient's chest x-ray was interpreted as '*normal*' by the Trust.

16. The Trust stated the patient's initial NEWS2[10] score on arrival was six, '*but subsequently at 14:30 it was recorded as 3 (improved)*'. The patient also had an ECG which was interpreted as '*normal sinus rhythm*' by the Trust.

17. The Trust stated it made the decision to discharge the patient. It stated, '*although he had ongoing shortness of breath he had been treated with recent antibiotics with steroids, and had a few crackle sounds from the lungs but he had no new oxygen requirement, normal white cell amount and normal D-dimer*'.

18. The Trust stated the doctor suggested that after discharge, the patient could have a follow-up again with his GP who *'could consider outpatient referral to the respiratory team for further management if required*'.

Relevant Clinical Records

19. I completed a review of the documentation the Trust provided in response to my investigation enquiries. I also reviewed the documentation received from the complainant.

Relevant Independent Professional Advice

[6] A neurological assessment tool used to measure a persons level of consciousness after a brain injury.
[7] An accumulation of fluid causing swelling.
[8] Occurs when there isn't enough haemoglobin in the red blood cells to carry oxygen throughout the body.
[9] Raised C-reactive protein in the blood indicates the presence of inflammation or infection in the body.
[10] National Early Warning Score 2 – a scoring system used in hospitals to assess and track the condition of patients, particularly those at risk of deterioration.

20. I enclose the IPA's advice at Appendix 2 of this report. I outline my consideration of the advice in my analysis and findings below.

Analysis and Findings

21. NG115 defines an exacerbation of COPD[11] as a '*sustained worsening of the patient's symptoms from their usual stable state which is beyond normal day-to-day variations, and is acute in onset*'. The guidance also states that commonly reported symptoms are '*worsening breathlessness, cough, increased sputum production and change in sputum colour*'.

22. The GP letter states the reason for referral on 27 December 2023 was a three-week history of symptoms consistent with an exacerbation of his underlying COPD. The IPA advised the patient's presentation supported the GP's view. That being that he was suffering from an exacerbation of his COPD, in line with NG115. I accept this advice.

23. NG115 states that patients attending hospital due to an exacerbation of COPD should have '*an arterial blood gas test*[12] *performed, along with a chest x-ray and an ECG*'. NHS guidance states an arterial blood gas (ABG) is conducted '*if you have a more severe flare up of your COPD or if there is concern that you are not getting better*'. The records evidence the patient '*received an ECG and x-ray'.* The IPA advised that given the patient received '*two courses of antibiotics and a short course of steroids with no improvement*' and '*did not have a blood gas test performed*', the Trust should have conducted an ABG for the patient in line with guidance. I accept this advice. I consider the decision not to perform an ABG a failure in the patient's care and treatment.

24. Paragraph 1.3.1 of NG115 outlines a table of factors to consider when deciding where to treat a patient with exacerbations of COPD (included in Appendix 3). The patient's medical records document his 'level of activity' as poor. The

[11] A sudden worsening of a person's COPD symptoms, beyond their usual day-to-day variations, and often lasting for several days.
[12] A blood test that measures the levels of oxygen and carbon dioxide in the blood, as well as the bloods pH, which indicates its acid-base balance.

records also document the patient had worsening peripheral oedema; that he was already receiving long-term oxygen therapy; and that his oxygen saturation levels were below 90%. The patient's ECG was 'nil acute' which the IPA advised '*a raised heart rate can be associated with infection*'. His CRP was 'raised' at 107 with the IPA advising '*in the context of bacterial infection, a value of greater than 100 is likely to be significant'*. The IPA advised that given the patient had all these symptoms, the Trust should have admitted him to hospital for treatment, in line with NG115. I accept this advice.

25. The GMC guidance states that in providing clinical care you must '*adequately assess a patient's conditions, taking account of their history, including symptoms'*. It also states that '*in providing clinical care you must promptly provide (or arrange) suitable advice, investigation or treatment where necessary'*. Given the Trust did not perform an ABG or admit the patient for treatment (in accordance with NG115), I cannot be satisfied the Trust met these standards. I note the IPA advised that on 27 December 2023, '*the patient was discharged back to the care of the GP without any discharge medications*' and that '*no further follow up of the patient was arranged*'. Given the Trust also did not provide or recommend treatment for the patient in the community, I again consider it did not act in line with the GMC guidance.

26. I consider this a failure in the care and treatment the Trust provided to the patient. I therefore uphold this complaint.

27. The IPA advised that '*while it is possible that starting more intensive treatment two days earlier may have benefited the patient, it is likely the clinical course would have been similar, and the patient's outcome would have been the same*'. I accept the IPA's advice. I therefore cannot definitively state that the Trust's actions led to a further decline in the patient's health. However, I consider both the patient, and the complainant sustained injustice due to the Trust's actions. I outline this injustice in my conclusion to this report.

CONCLUSION

28. I received a complaint about the Trust's decision to discharge a patient who presented himself at ED following GP referral on 27 December 2023.

29. The investigation identified a failure in the Trust's decision not to perform an ABG on the patient. It identified a further failure in its decision not to admit the patient for further treatment of an exacerbation of his COPD. Therefore, I uphold the complaint.

30. I note the patient was admitted to hospital after reattending ED two days later, on 29 December 2023. I consider that for the intervening period, the failures identified caused the patient to sustain the injustice of uncertainty, distress, and a loss of opportunity to receive earlier treatment for his symptoms. I also consider they caused the complainant to sustain the injustice of uncertainty, upset and frustration regarding her late father's care and treatment. I acknowledge that the process would have undoubtedly been a worrying, confusing and frightening time for the patient, the complainant, and their family.

Recommendations

31. I recommend the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (July 2019), for the injustices caused as a result of the failures identified within **one month** of the date of the final report.

32. I further recommend, for service improvement and to prevent future recurrence, that the Trust:

    i. Brings the contents of this report, and the learnings identified in it, to the attention of relevant staff who provided care and treatment so they can reflect on the findings;

    ii. Provides training to relevant staff. The training should focus on the following:

        (i) The circumstances in which it is appropriate to perform an ABG on patients, in line with NG115;

(ii) The circumstances on when it is appropriate to admit a patient for further treatment, in line with NG115 and GMC Guidance.

33. Finally, I wish to offer my condolences to the patient's daughter and family members following the death of the patient. It is clear the complainant has fought to seek answers surrounding the care and treatment of her father. I hope my report goes some way to address the concerns raised, and provides some answers for the patient's family.

CORINNE NELSON
Director of Investigations **May 2025**

Appendix 1
PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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