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

Report Reference: 202005167

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

This complaint was about the care and treatment the Southern Health and Social Care Trust (the Trust) provided to the complainant's late father (the patient). The patient attended the Trust's Emergency Department after falling at his home. While in hospital he displayed symptoms of delirium. The Trust discharged him on 10 December 2020. However, he deteriorated and returned to hospital several days later. Sadly, the patient died while in hospital, on 27 January 2021. The complainant raised concerns the Trust should not have initially discharged the patient. He also said the Trust caused the patient to become Covid-19 positive by moving him between wards without obtaining up-to-date test results. The complainant stated had the Trust kept the patient in hospital and provided appropriate care and treatment he would still be alive today.

The investigation established failures in the patient's care and treatment. In particular, the investigation found the Trust should have kept the patient in hospital for further observation and that he was discharged prematurely. The investigation also found the Trust did not adhere to Covid-19 guidance by moving the patient between wards without up-to-date test results. These failures caused the complainant and his family to sustain the injustice of uncertainty and distress. The available evidence does not establish the failings contributed to the patient's death.

I recommended the Trust apologise to the complainant for the injustices he sustained. I also recommended the Trust share this report, and its findings, with the staff who provided the care and treatment to the patient to encourage nonrecurrence.

I extend my sincere condolences to the complainant and his family for the loss of his father.

THE COMPLAINT

1. This complaint was about the actions of the Southern Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to his late father (the patient) on 10 December 2020, and from 14 December 2020 to 31 December 2020.

Background

2. On 29 November 2020, the patient presented to Craigavon Area Hospital after a fall at home, and the Trust admitted him with suspected rib fractures. While in hospital he displayed confusion and agitation. On 8 December 2020, the Psychiatric Assessment Team assessed the patient, concluding he had Delirium[1]. The Trust discharged the patient on 10 December 2020.

3. The patient deteriorated and an ambulance brought him back to hospital on 14 December 2020. The Trust admitted him to the Intensive Care Unit. He began to recover and Trust staff moved him to Ward Two South on 21 December 2020. On 30 December 2020, staff moved him to Ward Three South. On 1 January 2020, the patient began to deteriorate. On 2 January 2021, the Trust transferred him back to Ward Two North. The patient's condition fluctuated over the following weeks. He sadly passed away on 27 January 2021.

Issue of complaint

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

Issue 1: Whether the care and treatment the Trust provided to the Patient on 10 December 2020 and from 14 December 2020 to 31 December 2020 was appropriate, reasonable, and in accordance with relevant standards.

In particular this will include:

- The decision to discharge the Patient on 10 December 2020; and
- Whether it was appropriate for the patient to be moved from Ward 2 North Respiratory to Ward 3 South on 31 December 2020 whilst a Covid result was outstanding

[1] Delirium is a temporary mental state that results in confusion, anxiety, incoherent speech, and hallucinations. It can develop suddenly due to fever, intoxication, and certain medications.

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

6. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):
    - A qualified General Surgeon with over 20 years of experience.

    I enclose this clinical advice as Appendix two to this report.

7. 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 complaint was a matter for my discretion.

Relevant Standards and Guidance

8. To investigate complaints, I must establish a clear understanding of the standards. I also refer to relevant regulatory, professional, and statutory guidance.

    The general standards are the Ombudsman's Principles[2]:
    - The Principles of Good Administration

    I enclose this guidance as Appendix one to this report.

9. The specific standards and guidance are those which applied at the time the events occurred. These governed 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 Covid-19 infection prevention and control guidance 2020 (Covid-19 guidance).
    - Department of Health (DOH), 'Discharge Planning, Ready to go?', March 2010 (discharge guideline).

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

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

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

11. 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. I gave careful consideration to the comments I received in preparing this final report.

THE INVESTIGATION

Issue 1: Whether the care and treatment the Trust provided to the Patient on 10 December 2020 and from 14 December 2020 to 31 December 2020 was appropriate, reasonable, and in accordance with relevant standards.

Detail of Complaint

Discharge on 10 December 2020

12. The complainant said the Trust wrongly discharged the patient on 10 December 2020. He believes the Trust did not treat the patient's condition appropriately. The complainant stated if the Trust had treated the patient's infection and kept him in hospital a few more days he would still be alive.

Ward Transfer

13. When the patient began to recover the Trust moved him from Ward Two North Respiratory to Ward Three South, on 31 December 2020. The complainant stated the Trust moved the patient before receiving his Covid-19 test results, and it should not have done this as it was unsafe.

Documentation and records I examined

14. I reviewed the documentation the complainant and the Trust provided in response to my investigation enquiries. I enclose relevant extracts at Appendix three to this report.

The Trust's response to investigation enquiries

15. The Trust stated, based on the clinical assessment and clinical information available, the decision to discharge the patient was correct. On 10 December 2020, the patient's kidney function had returned to baseline levels, his inflammatory markers were normal, and his pain was under control. His last episode of delirium was on 7 December 2020.

16. In October 2023, the Trust met the complainant and his family to discuss their concerns. During this meeting, it stated had it been able to predict what happened after the discharge it could have kept the patient in hospital. However, it was not possible to predict what happened. Although the outcome was not what staff wanted, the Trust could not think of anything they could have done differently.

17. The Trust explained when the patient entered Ward Two North Respiratory, staff had separated it into sections. The back of the Ward was for Covid-19 positive patients, and the front was for Covid-19 negative patients. It said it kept infection control measures in line with Covid-19 national guidance at that time, within the limitations of its estate.

Relevant Independent Professional Advice

18. The IPA provided advice about the care and treatment the Trust provided to the patient. The IPA's full advice report is available at Appendix two to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

Discharge on 10 December 2020

19. The discharge guideline states discharge is an essential part of care management in any setting. It notes premature discharge can leave the patient with unmet needs and increase the likelihood of readmission. For this reason, the discharge guideline states it is crucially important to identify any factors that would make a patient's discharge problematic. The discharge guideline also states the responsibility for the assessment and planning of discharge rest with the ward team. It states on the day of discharge the consultant responsible for a patient's care, or a person they delegate, decides whether they are ready for discharge.

20. The IPA advised there are no set criteria for determining whether a patient is ready for discharge. Instead, hospitals discharge patients when a clinical opinion states it is safe to do so. The IPA noted a patient's observations and blood tests should be within normal or acceptable limits, and the aim of a discharge is to minimize the risk of harm.

21. I reviewed the patient's discharge letter, dated 11 December 2020. According to this record, the patient fell at home and attended hospital on 21 November 2020 with several rib fractures. It also states he had new confusion. The IPA advised several other factors compounded the patient's health problems: diabetes[3], heart disease[4], Chronic Obstructive Pulmonary Disease (COPD)[5], chronic kidney impairment (CKI)[6], excess alcohol intake, and Post Traumatic Stress Disorder (PTSD)[7]. The Trust staff treated the patient with fluids, pain relief, oxygen, and alcohol withdrawal medication.

22. The IPA advised the patient had episodes of altered mental state during his initial stay in hospital. He explained the patient's normal brain scan, medical treatment, and resolving oxygen saturation made organic issues unlikely. He advised it is possible a background of alcohol excess and PTSD exacerbated his mental state leading to aggression and conspiratorial thinking, particularly at night. The IPA noted this condition commonly resolves when patients return to their natural environment. The IPA advised given the complexity of the patient's background it was difficult to determine whether infection contributed to his mental state. He advised his altered mental state appears to have manifested as early as 4 December 2020 when infection was unlikely.

23. The IPA advised by 10 December 2020 the records show the patient's observations were within normal limits. I reviewed these records and note they state there were no significant concerns regarding his mental state and the psych team did not feel their input was necessary. However, the IPA advised the patient's blood tests showed his inflammatory markers had risen. He advised these results were 'unexpected' ten

[3] Diabetes is a condition where a person's blood glucose level is too high. It can happen when a person's body does not produce enough insulin or when the insulin it does produce its not effective. Diabetes can cause thirst, weight loss, delayed healing and blurred vision. Diabetes can also cause a range of complications, including heart attack, kidney problems, and eye problems.
[4] Heart disease is a general term referring to conditions that adversely affect a person's heart.
[5] Chronic Obstructive Pulmonary Disease is a condition that prevents airflow to a person's lungs, causing breathing problems, such as a persistent cough and shortness of breath. There is no cure for COPD, and it causes permanent damage to the lung. However, treatment can slow its progression.
[6] Chronic kidney impairment, otherwise known as chronic kidney disease (CKD), is a long-term condition where the kidneys do not work as well as they should. It is a common condition often associated with getting older. Symptoms include tiredness, swollen ankles, shortness of breath and feeling sick.
[7] Post-traumatic stress disorder (PTSD) is a mental health condition caused by stressful, frightening or distressing events. Someone with PTSD often relives the traumatic event through flashbacks and nightmares. They may have problems sleeping, feelings of isolation, irritability and guilt.

days after the initial injury. Given these changes, the IPA stated the Trust should have been concerned about the patient developing pneumonia, despite the normal observations, and it was possible he was developing an infection. The IPA advised the Trust should have considered examining the patient's chest and repeating his chest X-ray. The changes in the blood tests should have led to repeat radiological investigations. The IPA advised the Trust should have considered keeping the patient for observation for at least a further 24 hours and repeated his blood tests instead of discharging him.

24. The IPA advised the Trust was mainly focused on the patient's mental state. On 9 December 2020, it appeared the patient was still experiencing delirium. I reviewed the patient's medical records and note the Psychiatry Team stated they were not happy to discharge him in this state. The following day by late morning there was no formal assessment of his mental state. However, the nursing records stated the patient seemed in good form. The medical record for 09.30 on 10 December 2020 stated, 'no further delirium'. The IPA advised this lucid period correlates with the patient having episodes and did not guarantee his delirium resolved. He advised there appeared to be no formal review of the patient's mental condition prior to discharge. The IPA advised the Trust should have reviewed the patient for a longer period before considering him mentally fit for discharge.

25. The IPA advised the Trust failed to review the patient's bloods and repeat his chest X-ray. Due to the inadequate assessment, it appears there was doubt about his mental health. The IPA advised the discharge was therefore not satisfactory. He further advised that, on balance, the Trust was "unwise" to discharge the patient without further evaluation.

26. The IPA advised, on balance, it is not possible to determine whether the inappropriate discharge caused or contributed to the patient's death. The patient returned to hospital on 14 December 2020, four days after the discharge. He received treatment and died nearly six weeks later, on 27 January 2021. The IPA advised if the patient had remained in hospital and deteriorated there, he would have received treatment sooner. However, it is reasonable to assume he would not have received treatment significantly sooner, such that it would have prevented his death. The IPA advised the rib fractures, pneumonia and Covid-19 infection were factors in his death rather than the inappropriate discharge.

27. Having reviewed all relevant evidence, I am satisfied the Trust failed to appropriately assess the patient's condition and therefore discharged him prematurely. I find the Trust did not adhere to the discharge guideline, which required it to review the patient on the day of discharge and determine whether he continued to need medical care in the hospital. I conclude the Trust's decision to discharge the patient on 10 December 2020 in these circumstances was a failure in care and treatment. I therefore uphold this aspect of the complaint.

28. I note the IPA was unable to determine with certainty whether the discharge contributed to the patient's death. I accept, on the balance of probabilities, the inappropriate discharge did not cause a significant delay in treatment such that it led to the patient's death. However, I accept a delay did occur and it caused the patient to sustain the injustice of not receiving treatment sooner.

29. Moreover, I note the complainant, and his family experienced the injustice of uncertainty and distress. They asked the Trust to reconsider the discharge due to their concerns for the patient's wellbeing. They had fears they could not provide him with the necessary care at home. The Trust acknowledged these concerns but did not act on them. The failure to accurately assess the patient meant the complainant and his family had to care for him and respond to his deteriorating condition at home. Had the Trust acted appropriately, the complainant and his family would not have had to endure this uncertainty or distress.

Ward Transfers

30. I note the Covid-19 infection prevention and control guidance 2020, states moving patients from their single room/cohort area should occur for "essential purposes only". Staff in the initial ward must inform staff at the receiving destination whether "the patient has possible or confirmed Covid-19".

31. The IPA advised hospitals transfer patients between wards to escalate or deescalate treatment. He explained they must take steps to avoid transferring a patient with risk factors to a low-risk area. The IPA also said Covid-19 test results should be available prior to any transfer to enable staff to minimise risks. Regular swabbing for Covid-19 therefore assists staff in isolating at risk patients and preventing the spread of infection.

32. Having reviewed the records, I note the patient received treatment in the ICU from 15 December to 21 December 2020. The discharge documents for this period indicate the Trust diagnosed and were treating the patient for Hospital acquired pneumonia[8], acute on chronic kidney injury[9], metabolic derangement[10], delirium, and rib fractures.

33. The patient had several Covid-19 tests and ward transfers during this period:
    - On 20 December 2020 at 07.30, he had a Covid-19 test. The results came back on the same day at 17.45, showing he was Covid-19 negative.
    - On 21 December 2020, the Trust staff transferred the patient to the front of Ward Two North Respiratory.
    - On 27 December 2020 at 16.00, the patient had another Covid-19 test. These results came back on 28 December 2020 at 21.54, as negative.
    - On 31 December 2020, the Trust staff transferred the patient to a side-room on Ward Three South.
    - On 1 January 2021, the patient became unwell. The Trust staff moved him to a side-room and took a Covid-19 swab at 15.30. The results came back on 2 January at 00.15, and showed the patient had Covid-19. Following this positive test result the patient returned to the back of Ward Two North Respiratory.
    - On 2 January 2021, the patient had another Covid-19 test at 10:30. These results came back on 3 January 2021 at 08:30, as positive.
    - On 10 January 2021, the Trust staff moved the patient to Ward Two South but did not take a Covid-19 swab. They moved him to Ward Four south on 15 January 2021.
    - On 16 January 2021 at 15.53, the patient had a Covid-19 test, which came back negative.

34. Having reviewed the medical records, I note the cause of death was Covid pneumonitis[11], ischemic cardiomyopathy[12], CKD, type 2 diabetes, and COPD.

35. I note the Trust's explanation that when the patient entered Ward Two North Respiratory staff had separated it into sections. The back of the Ward was for Covid-

[8] Pneumonia is inflammation of the lungs, usually caused by an infection. Most people get better in 2 to 4 weeks, but babies, older people, and people with heart or lung conditions are at risk of getting seriously ill and may need treatment in hospital. Symptoms of pneumonia can start suddenly or gradually over a few days. They include a cough, shortness of breath, a high temperature, chest pain, an aching body, feeling very tired, loss of appetite, and feeling confused.
[9] Acute on chronic kidney injury is the sudden loss of kidney function.
[10] Metabolic derangement refers to conditions that affect any aspect of metabolic function. These conditions include diabetes (see above).
[11] Covid pneumonitis is a from of pneumonia. It occurs when a person's immune system attacks the covid infection in their lungs.
[12] Ischemic cardiomyopathy is a condition where the heart muscle is weakened due to a lack of blood supply to the muscle.

19 positive patients, and the front was for Covid-19 negative patients. The IPA advised it seems Ward Two North was a more acute ward, and the Trust downgraded patients when it deemed it reasonable to do so. However, there is no entry in the medical records to explain why the Trust staff transferred the patient on 31 December 2021.

36. The IPA advised the patient's NEWS chart observations were satisfactory two days prior to the transfer, on 29 December 2021. Therefore, he noted it would be reasonable to assume the patient was Covid-19 negative prior to the transfer. However, good practice mandated the patient have an up-to-date test result in case he had developed Covid-19 since the test on 27 December 2020. On 31 December 2020, the patient had a NEWS of four and a temperature of 38C. The IPA advised his symptoms and temperature on the day of the transfer indicate he may have had Covid-19 despite the earlier negative test result.

37. The IPA advised the transfer suggests the Trust staff were either "ignorant" of the need to have a test before the move, or routine swabbing had no bearing on this transfer. He advised from an infection control perspective, moving a patient without up-to-date testing is "unwise" unless the circumstances are extreme and mandate a transfer. The IPA explained a Covid-19 test on 31 December 2020 would have possibly been positive. If so, the transfer either would not have happened or would have required the patient to isolate.

38. I find that, in line with the Covid-19 infection prevention and control guidance 2020, the Trust should have had an up-to-date Covid-19 test before moving the patient. I consider the Trust's actions to be a failure in the care and treatment it provided to the patient.

39. I also find the Trust should have recorded its reasons for the ward transfer. Whilst I am satisfied the Trust's failure to make this record did not constitute a failure in care and treatment, I consider it constitutes a service failure in record-keeping. The Third Principle of Good Administration, 'being open and accountable', requires public bodies to keep proper and appropriate records and to record reasons for its decisions. I find the Trust failed to adhere to this Principle in this respect.

40. Regarding the impact of these failures, I note the complainant's belief the transfer between wards caused the patient to contract Covid-19 and contributed to his death.

Having reviewed the available evidence, I do not consider there is sufficient evidence to establish the patient got Covid-19 due to the ward transfers. I note the Trust has stated there is “no doubt” the patient got Covid-19 while in hospital. Aside from the Covid-19 positive tests on 1 and 2 January 2021, it is not possible to determine when, exactly, the patient contracted Covid-19.

41. The IPA advised it is difficult to surmise whether the Trust’s failure to have an up-to-date Covid-19 test result prior to the ward transfer impacted upon the patient, in part because the transfer back was so quick. He noted moving the patient without an up-to-date Covid-19 test result may have caused no harm in this case. However, he explained the situation could have been different, hence the reason the move was “unwise”. I note the failure may have had no impact on the patient but am satisfied it was nevertheless unwise. I am satisfied this failure did cause the complainant to sustain the injustice of uncertainty and distress at not knowing whether the ward transfer had impacted the patient.

42. Furthermore, I observe the Trust’s records show it also did not swab the patient for Covid-19 prior to his transfer to Ward four South on 15 January 2021. Per the IPA’s advice, I am mindful the decision to transfer patients without Covid-19 tests posed a risk to all patients within Covid-19 free wards and undermined efforts to prevent the spread of the illness.

43. I also acknowledge the difficult circumstances Trust staff faced during the period in question. The Covid-19 pandemic placed unprecedented pressure on our health service, including the Trust and its staff in this case.

CONCLUSION

44. This complainant was about the care and treatment the Trust provided to the patient on 10 December 2020, and from 14 December 2020 to 31 December 2020. The complainant said the Trust prematurely discharged the patient and failed to test him for Covid-19 before transferring him between wards. He said the Trust’s failures resulted in the patient’s death.

45. I upheld elements of the complaint. Specifically, I found the Trust failed to assess the patient’s condition on 10 December 2020 and adhere to the discharge guideline, and therefore discharged him prematurely. I also found the Trust failed to follow Covid-19 guidance by not testing the patient prior to moving him between wards.

46. I recognise the failures caused the complainant and his family to sustain the injustice of uncertainty and distress. However, based on the available evidence, I do not find these failures contributed to the patient's death.

47. I offer through this report my condolences to the complainant for the loss of his farther.

Recommendations

48. 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 injustice caused because of the failures identified within **one month** of the date of the final report.

49. Furthermore, I also recommend the Trust bring this report to the attention of staff who provided care and treatment to the patient. I recommend they review the findings, and reflect on the learnings, particularly regarding a patient's suitability for discharge, the importance of rigorous Covid testing prior to ward transfers, and the importance of keeping detailed records of decisions.

Margaret Kelly
Ombudsman

July 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.