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

Report reference: 202400132

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk

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

I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's son (the patient) in October 2022. The patient attended the Royal Victoria Hospital on 24 October 2022 to undergo a Paracentesis procedure, to remove excess fluid from his abdomen. The Trust was unable to complete the procedure due to the patient's condition and it admitted the patient to a ward for further investigations prior to attempting it again. The patient sadly died on 28 October 2022.

The complainant raised concerns about the Trust's management of a cyst on the patient's chest, which she felt may have led the patient to develop sepsis. She also raised concerns about the Trust putting a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Notice in place for the patient, and that it failed to inform her of the severity of the patient's condition so that she could have attended the hospital to be with him.

The investigation found that nursing staff failed to notify medical staff of a cyst on the patient's chest. While this amounted to a failing in care and treatment, I found it did not have any negative impact overall on the care and treatment provided to the patient for the cyst, which was reasonable, appropriate and in line with relevant standards. It found the DNACPR process was handled in line with relevant standards, including communication with the patient's family. The investigation also found that the assessment of the patient's condition on the morning of his death, and subsequent treatment plan, was reasonable and appropriate, and there was no indication for the Trust that the patient's condition would deteriorate so acutely leading to his sudden death.

I therefore partially upheld the complaint, to reflect that whilst the care and treatment the Trust provided to the patient was, for the most part, reasonable, appropriate and in line with relevant standards, nursing staff failed to appropriately escalate the patient's cyst to doctors.

The investigation notes the terrible shock that the patient's death was for the complainant and her family, and I offer my condolences to them for their loss.

THE COMPLAINT

1. This complaint is about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's son (the patient) in October 2022.

Background

2. The patient attended hospital for a paracentesis[1] procedure, to remove fluid from the patient's abdomen. Due to abnormal blood results the Trust staff were unable to complete the procedure, and the Trust admitted the patient to Ward 6D of the Royal Victoria Hospital (the Royal) on 24 October 2022 for further investigations prior to re-attempting the paracentesis procedure.

3. During his admission to Ward 6D the Trust investigated the patient's condition and provided treatment. This included the administration of antibiotics for potential sepsis, although staff did not identify the underlying cause of the sepsis.

4. On 28 October 2022 at 10.15 the Trust informed the patient of a plan to remove five litres of fluid from his abdomen. It also informed him that due to severity of his condition he would not be a candidate for a liver transplant or intensive care support, and it was unlikely CPR[2] would be performed if his condition continued to deteriorate. Medical staff completed a DNACPR[3] form for the patient at 10.30 that day.

5. The patient's condition deteriorated on the morning of 28 October 2022 and staff updated the patient's family on his condition and severity at 11.55 but informed them that he appeared to be responding to the treatment. At 12.15 on 28 October 2022 the complainant spoke to the patient. At 12.30 on 28 October 2022 a Trust nurse noticed that the patient's appearance was grey and alerted medical staff. The patient sadly passed away at 12.39 on 28 October 2022.

6. The complainant is not satisfied with the care and treatment the Trust provided to the patient when he was in hospital.

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[1] Paracentesis is a procedure that drains excess fluid called ascites from the abdomen.
[2] CPR stands for cardiopulmonary resuscitation. It's when someone gives chest compressions to a person in cardiac arrest to keep them alive.

[3] DNACPR stands for ‘Do not attempt cardiopulmonary resuscitation (CPR)’. It means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or shouldn’t be taken by a healthcare professional, including not performing CPR on the person.

Issue of complaint

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

Issue: Whether the care and treatment the Trust provided to the patient was reasonable, appropriate and in line with relevant standards and guidance. This will consider:

- Management of a cyst on the patient's chest;
- Handling of the Do Not Attempt Cardiopulmonary resuscitation (DNACPR) Notice;
- Assessment of patient's condition and subsequent communication to the complainant.

INVESTIGATION METHODOLOGY

8. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

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

- A Clinical Hepatologist with over 25 years of experience, (MBBS MD FRCP PGCE) (H IPA); and
- A Senior Nurse with over 20 years of experience across primary and secondary care, (MSc Advanced Clinical Practice, BSc (Hons) Nurse Practitioner, MA Health Service Management, Registered General Nurse (RGN), Diploma in Adult Nursing, Diploma in Asthma, Diploma in Chronic Obstructive Pulmonary Disease (COPD), V300 Non-medical prescriber); (N IPA).

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

10. 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

11. 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

12. 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 - Good Medical Practice, updated April 2019 (the GMC good practice guidance);
    - The Belfast Heath and Social Care Trust DNACPR Policy: Decision relating to cardiopulmonary resuscitation in adults, July 2014 (Trust DNACPR Policy);
    - The General Medical Council - Professional Standard, Treatment and care towards the end of life: good practice in decision making, July 2010 (GMC end of life guidance);
    - The National Institute of Clinical Excellence Guideline, Suspected sepsis: recognition, diagnosis and early management, July 2016, (NICE Guideline);
    - The British Medical Association Guidance, Decisions relating to cardiopulmonary resuscitation, 3rd Edition, 2016 (BMA guidance);
    - The Royal College of Physicians, National Early Warning Score (NEWS) 2, Standardising the assessment of acute-illness severity in the NHS, December 2017 (NEWS2 Guidance);
    - The Nursing and Midwifery Council Code: Professional standards of practice and behaviour for nurses, midwifes and nursing associates, 10 October 2018 (NMC guidance);
    - National Health Service, Skin cyst, website extract, Skin cyst - NHS (NHS Guidance).

[4] 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 considered at Appendix three to this report.

13. 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.

14. 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 and have included these comments, where relevant in this report.

THE INVESTIGATION

Issue: Whether the care and treatment the Trust provided to the patient was reasonable, appropriate and in line with relevant standards and guidance? This will consider:

- Management of a cyst on the patient's chest;
- Handling of the Do Not Attempt Cardiopulmonary resuscitation (DNACPR) Notice;
- Assessment of patient's condition and subsequent communication to the complainant.

Detail of Complaint

Management of Cyst

15. The complainant said that the patient had a cyst on his chest that he reported to the nursing team. However, they did not raise this with the medical team.

16. The complainant said that because the nurses did not pass this information onto medical staff it could have resulted in the patient getting sepsis[5].

Evidence Considered

Legislation/Policies/Guidance

17. I considered the following:

[5] Sepsis is a serious condition in which the body responds improperly to an infection.

- NMC Guidance; and
- NHS Guidance.

Relevant Trust Records

18. I carefully considered the patient's medical records.

Trust response to investigation enquiries

19. The Trust stated the patient alerted nursing staff about the cyst. However, it acknowledged they did not report it to the medical staff. It stated however, that '*the cyst did not have any impact on [the patient's] sudden deterioration'* on the morning of 28 October 2022.

Relevant Independent Professional Advice

20. The N IPA advised *'skin cysts are round lumps, often filled with fluid or pus' and* advised that they are *'usually harmless and often do not need treatment'* but if there are signs of an infection '*antibiotics can be prescribed'*. The N IPA advised the patient's records note he reported a cyst on his skin to staff and advised nursing staff did not report this to medical staff. She advised, however, that while the nursing staff failed to report the cyst to the medical team, *'there was no impact on the patient'.* This is because the Trust administered *'broad spectrum antibiotics'* to the patient during this period, which can also *'be used for skin infections'*.

21. The H IPA advised that he could not comment on the likely impact of the cyst on the patient, as nursing staff had not reported it to medical staff, and there was therefore no treatment indicated. However, he advised that *'a simple cyst of the skin, unless obviously inflamed would be an unlikely source of infection'.* The H IPA advised that *'most skin infections as a cause of sepsis relate to cellulitis*[6]*'* and advised that the more likely cause of the patient's sepsis was *'spontaneous bacterial peritonitis (SBP)'*[7]*.* He advised that while SBP was the most likely cause of the suspected sepsis, the patient's *'ascitic WCC count*[8] *was not elevated above the threshold for a definitive diagnosis of SBP'*.

[6] Cellulitis is an infection of the deeper layers of skin and underlying tissue.
[7] Spontaneous bacterial peritonitis (SBP) is one of the most frequently encountered bacterial infections in patients with cirrhosis, and

most commonly seen in patients with end-stage liver disease.
[8] Ascitic white cell count - White blood cells within ascitic fluid suggest infection or malignancy.

22. The H IPA also advised that '*there were no failings in care and treatment'* provided to the patient. He advised that *'overall, the care for this patient was very good'*.

Analysis and Findings

23. I note that the NMC guidance states that nurses should *'work cooperatively'* with colleagues. It states that to achieve this a nurse should *'respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate'.* I note from the patient's medical records that nursing staff noted *'doctor to review cyst on chest'* at 19.30 on 26 October 2022 and note the N IPA's advice that the nursing staff did not then report the cyst to medical staff for this review to take place.

24. Guidance on the NHS website states that *'Skin cysts do not need to be treated if they're not causing any problems'* but that if they become infected may be treated with antibiotics. I note that the N IPA advised that the cyst was unlikely to have had any impact on the patient due to the administration of *'broad spectrum antibiotics'* within 48 hours of the patient reporting the cyst to nursing staff. She advised that the prescribed antibiotics, Vancomycin[9], Metronidazole[10] and Ciprofloxacin[11] can also treat skin infections. I note from the patient's medical records that staff commenced the patient on IV Vancomycin at 10.15, Metronidazole at 10.20 and Ciprofloxacin at 10.00 on 28 October 2022.

25. Having reviewed all relevant evidence, including the N IPA and H IPA's advice, I am satisfied it is unlikely, on the balance of probabilities, that the cyst was the source of the patient's sepsis. I accept the H IPA's advice that, given the patient's overall condition and symptoms, it is more likely than not that the cause of the patient's sepsis was *'spontaneous bacterial peritonitis (SBP)'*. However, nursing staff recorded they would escalate management of the cyst to medical staff, and I am satisfied they failed to do so. I accept the N IPA's advice that this was a failure in the nursing care and treatment the Trust provided to the patient, which was contrary to the NMC Code outlined above. I therefore partially uphold this element of the complaint to reflect that failure. I consider this failure caused the patient to sustain the loss of opportunity for appropriate management of his cyst. In addition, it caused the complainant to sustain the injustice of uncertainty regarding how the Trust managed the cyst.

[9] Vancomycin is used to treat infections caused by bacteria.

[10] Metronidazole is used to treat bacterial infections in different areas of the body,
[11] Ciprofloxacin is used to treat bacterial infections in many different parts of the body.

Detail of Complaint

Handling of the DNACPR

26. The complainant states that the patient did always want to be resuscitated. She said he did not sign a DNACPR, and the medical team may have been able to resuscitate him.

Evidence Considered

Legislation/Policies/Guidance

27. I considered the following policy and guidance:

- Trust DNACPR Policy;
- GMC end of life guidance; and
- BMA guidance.

Relevant Trust records

28. I carefully considered the patient's medical records.

Trust response to investigation enquiries

29. The Trust stated that *'decisions regarding resuscitation are taken by the medical team involving patients in the decision-making process where possible'*. It also stated that *'there were lengthy discussions regarding [the patient's] suitability for resuscitation and escalating care to the intensive care'* and that staff informed the patient that if his condition continued to deteriorate resuscitation would not be in his interests. It stated that staff also informed the patient that a liver transplant would not be possible due to his ongoing alcohol intake.

30. It also stated that the patient '*had previously stated to [doctor] that he did not wish to be resuscitated as his health had significantly deteriorated'.*

Relevant Independent Professional Advice

31. The H IPA advised that the DNACPR process the Trust completed was *'in line with Trust policies, GMC & BMA guidelines'* and advised that this was documented adequately in the notes and relevant form.

32. The H IPA also advised that the *'patient had capacity and had discussed treatment options including a DNACPR decision as recorded in the DNACPR form'* and while

discussion with a patient's family or friends is *'not mandatory'* the '*decision was discussed with the patient's mother'*.

33. The H IPA advised that while *'there is no standard practice on the timing of anticipatory care plans[12]'* if the Trust had completed the anticipatory care plan when the patient was admitted to hospital it *'may have stimulated the patient to discuss matters with his family and the medical team before he was very unwell on October 28th, 2022'*.

34. The H IPA advised that given the patient's condition, the DNACPR was appropriate due to:

- *'Advanced stage of liver disease with a poor prognosis*
- *A sudden event that had led a deterioration in his clinical condition resulting in worsening prognosis*
- *Patient's previous wish for DNACPR expressed in clinic*
- *Discussion with the patient on the ward with consent for a DNACPR decision'*

Analysis and Findings

35. I note the Trust DNACPR Policy states that decisions around CPR are *'an important part of good clinical care for those at risk of cardiorespiratory arrest'* and *'consideration about the likely benefits, burdens and risks of CPR should be made as early as possible and clearly recorded for CPR or DNACPR'*.

36. I note that GMC end of life guidance states that *'CPR has a very low success rate'* and decisions around DNACPR *'are best made in the wider context of advanced care planning'*. The guidance also states that a recorded decision around DNACPR *'should be regarded as a clinical assessment and decision, made and recorded in advance by the person with lead responsibility for the patient's treatment and care'.* The guidance also states that when the person with lead responsibility for the patient's care deems that CPR will not be successful in *'restarting the patient's heart and breathing and restoring circulation*' this should be discussed *'sensitively'* with the patient with the purpose of the dialogue being to *'reach a shared understanding with the patient about their situation, the judgement and the reasons for reaching it'*.

[12] Advance Care Planning is an on-going process of conversations between a person, those important to them and those providing care, support or treatment.

37. Both the Trust DNACPR Policy and the GMC end of life care guidance state that any discussions and decisions around DNACPR should be *'recorded'.* The Trust policy states that this '*should be recorded in the patient's clinical notes'* and *'the DNACPR form'* and the GMC end of life guidance says that this should be documented in the *'patient's record and any advance care plan'.*

38. Neither the Trust DNACPR Policy nor the GMC end of life guidance make explicit reference to the need for a patient to personally sign a DNACPR form. I note the H IPA advised that *'no verbal or written consent for a DNACPR is required'* and I note that the DNACPR form to accompany the Trust DNACPR policy does not have a section for the patient's signature. The BMA guidance states (on the matter of patient's signature on DNACPR forms) that *'this is not a legal requirement'*.

39. I note from the patient's medical records that during a review of the patient by the Consultant Hepatologist on 28 October 2022 at 10.15 the consultant discussed DNACPR with the patient. The medical records state that the Consultant Hepatologist informed the patient that if his condition continued to deteriorate CPR would not be an option for him. The consultant stated that this was due to his end stage liver disease and a liver transplant would not be option for him because of his ongoing alcohol consumption. A doctor completed the DNACPR form at 10.30 on 28 October 2022. I note the records do not contain any concerns raised by the patient regarding the DNACPR decision. During a clinic appointment at the Royal Hospital on 3 August 2022 the doctor discussed DNACPR with the patient who had stated that *'he would not want to be resuscitated should his health deteriorate'.* The Trust DNACPR policy states that clinical decisions regarding CPR which are made in advance include where the *'patient has capacity and choses in advance note to have CPR attempted'.* I am satisfied there is no evidence to suggest or infer that the patient lacked capacity to discuss DNACPR with medical staff on either occasion. In response to the draft investigation report, the complainant said that she held *'power of attorney'* for the patient, and he did not have capacity due to mental instability to make any decisions regard DNACPR. The complainant said she did not have any legal documentation to confirm this. The investigating officer sought further advice from the H IPA who advised there was nothing within the patient's medical records to suggest there was an active power of attorney for medical matters. He also advised the patient signed all his consent forms which would not be consistent with an active power of attorney.

40. I note the doctor informed the complainant about the DNACPR decision during a telephone call on 28 October 2022 at 11.55. The Trust DNACPR Policy states that where a patient has capacity, their family or carers *'should not be involved in resuscitation discussions without that patient's consent'*. I note that the patient's medical records document an attempted contact with the complainant on 28 October 2022 at 11.45 *'with the patient's consent'* and am satisfied that the patient had given consent for the DNACPR decision to be discussed with his family. I am further satisfied the Trust's discussion that then took place with the family was in line with relevant standards.

41. I note the H IPA's advice that the DNACPR process was *'completed in line with trust policies, GMC & BMA guidelines'.* He also advised that the record and *'Documentation in the notes and on the DNACPR form were adequate'.* I note that relevant guidance does not require that the DNACPR form be signed by the complainant.

42. I considered the relevant standards, including the Trust's DNACPR Policy. I accept the H IPA's advice that the Trust completed the DNACPR process in line with the Trust policy and relevant standards. I am satisfied that the Trust managed the DNACPR process, including communication with the patient's family, in line with relevant standards and policy guidance. I acknowledge the complainant's concerns regarding this matter but do not uphold this element of the complaint.

Observation

43. I note the H IPA's advice that while there are no definitive timescales for completion of anticipatory care plans it may have '*stimulated the patient to discuss matters with his family and the medical team before he was very unwell on October 28th, 2022'*. I would encourage the Trust to consider this observation and apply it in practice going forward.

Detail of Complaint

Assessment of patient's condition and subsequent communication to complainant

44. The complainant said that staff should have informed her earlier of the patient's deteriorating condition, so that she could have attended the hospital sooner and the patient would not have had to die alone.

Evidence Considered

Legislation/Policies/Guidance

45. I considered the following guidance:

- NICE Guideline
- NEWS2 Guidance

Relevant Trust records

46. I carefully considered the patient's medical records.

Trust response to investigation enquiries

47. The Trust stated that at the time the doctor spoke to the complainant (28 October 2022, 11.55) the patient *'appeared to be responding to the intravenous antibiotics and intravenous fluids given'* and '*there was no warning that he would deteriorate acutely'* and there was therefore *'no indication to ask the family to come to the ward immediately, rather than later on that day'*.

Relevant Independent Professional Advice

48. The H IPA advised that on the morning of 28 October 2022 *'an acute clinical deterioration'* occurred. However, *'the patient remained clinically stable'* and '*had responded to the initial treatment'*. The H IPA advised this is evidenced by *'improvement in blood pressure, fall in NEWS2 score of 6 at 07.25hr to 4 at 10.30hr on October 28th'*.

49. The H IPA advised the patient had *'presumed sepsis'*, and the Trust's management of this *'was reasonable, appropriate and timely'*. He advised the Trust followed *'NICE and BSG[13] guidance with prompt intravenous antibiotic therapy and fluids, analgesia'* as well as investigating the source of sepsis through *'blood and cultures, ascitic fluid examination and chest x ray'*.

50. The H IPA advised that *'there was no indication that the patient's condition would further deteriorate so acutely'.* The H IPA advised that while the cause of death was unclear it was likely to be as a result of sepsis of that *'led to deterioration of his advanced chronic liver disease complicated by portal hypertension and liver failure'*.

[13] British Society of Gastroenterology.

51. The H IPA also advised that he could not identify any failings in the communications between the medical team and the patient's family, advising the patient *'was updated on his clinical problems and management daily plan with no request to inform his family'.*

Analysis and Findings

Assessment of patient's condition

52. In review of the patient's medical records, I note that the patient had an uncomfortable night between 27 and 28 October 2022. At 01.20 on 28 October 2022 nursing records document the patient complained of breathing problems and abdominal pain. At 07.00 the patient reported feeling nauseous. The patient's NEWS2[14] score at 02.00 on 28 October 2022 was at 1. NEWS2 guidance recommends that a patient with a score of 1-2 should be monitored on a minimum six hourly basis. The patient's NEWS2 chart was completed again at 07.10 on 28 October 2022 and the patient's score had increased to 5, indicating a deterioration in his condition. The chart notes a decrease in the patient's blood pressure, an increase in his heart rate and temperature. NEWS2 guidance recommends that for a patient with a NEWS2 score of 4, clinical staff should consider sepsis. Nursing records document that staff notified the *'hospital co-ordinator'* about the patient's condition, following monitoring at 07.10.

53. Medical staff reviewed the patient at 07.50 and in response to his symptoms the treatment plan included a fluid bolus[15], IV paracetamol, ECG[16] and a chest x-ray. Staff reviewed the patient again at 10.00; noted observations and prescribed antibiotics. A further review by medical staff at 10.15 took place and the clinical notes include reference to *'sepsis mx [management] and investigation'*.

54. The patient's NEWS2 scores indicate that from 07.10 on 28 October 2022 the patient's condition deteriorated. I note that the NICE Guideline states that a NEWS2 score of *'5 or 6 suggests a moderate risk of severe illness of death from sepsis'*. The NICE Guideline also states that a NEWS2 score of '*7 or above'* or *'a single parameter contributes 3 points to their NEWS2 score'* could mean that '*A person is also at high risk of severe illness or death from sepsis".* I note from the patient's NEWS2 chart that the patient's reduced blood pressure parameter scored at 3

[14] The National Early Warning Score (NEWS) 2 determines the degree of illness of a patient and prompts critical care intervention.

[15] Fluid bolus therapy (FBT) is a standard of care in the management of the septic, hypotensive, tachycardic and/or oliguric patient.
[16] An ECG (electrocardiogram) is a test that records the electrical activity of the heart, including the rate and rhythm.

meaning that he was potentially at high risk of severe illness or death from sepsis. I note the H IPA's advice that the patient had presumed sepsis, and the Trust treated him for this.

55. The NICE Guidelines states that treatment for suspected sepsis in an acute hospital setting includes conducting blood tests, giving '*broad-spectrum intravenous antibiotic treatment'* and *'intravenous fluid bolus*'. The IPA advised that the treatment of the patient's suspected sepsis was '*reasonable, appropriate and timely'* and included '*prompt intravenous antibiotic therapy and fluids, analgesia'* as well as investigating the source of sepsis through *'blood and cultures, ascitic fluid examination and chest x ray'.* I note from the patient's records that the patient received IV antibiotics, Vancomycin, Metronidazole and Ciprofloxacin, and a fluid bolus. I note the patient's clinical records note that the patient was *'fluid responsive'* at 10.00.

56. I note from the patient's medical records that when staff reviewed him at 10.15 on 28 October 2022 the treatment plan included proceeding with paracentesis in the afternoon once the patient's *'fluids had resuscitated'* to make him *'more comfortable and improve breathing'*.

57. I note the treatment the Trust provided to the patient for suspected sepsis was in line with NICE guidelines and I accept the IPA's advice that the patient was treated appropriately for his evolving symptoms. I note medical staff did not anticipate the further deterioration in the patient's condition, as they had set out a plan to continue with the paracentesis procedure in the afternoon of 28 October 2022. I accept that the Trust's assessment of the patient's evolving condition and the treatment it provided was reasonable and appropriate and in line with relevant standards.

Communication of patient's condition to complainant

58. I note that at 11.55 on 28 October 2022 a doctor spoke to the complainant to update her on the patient's condition. The doctor informed the complainant of the patient's deterioration that morning but note that the belief at this time (11.55) was that the patient was responding to treatment. I note also that the doctor informed the complainant that they *'have to be prepared in case he deteriorates'* and explained why CPR was not deemed appropriate for the patient.

59. I note from the patient's medical records (at the 10.15 review) that the medical team planned to carry out the paracentesis procedure to remove five litres of fluid from the

patient's abdomen in the afternoon of 28 October 2022. I accept the H IPA's advice that the patient *'responded to the initial treatment'* and *'there was no indication that the patient's condition would further deteriorate so acutely over the next two hours and suddenly die'*. Having considered all relevant evidence, including the H IPA's advice, I am satisfied the Trust accurately communicated the patient's condition to the complainant during the doctor's telephone call with her. I am further satisfied the patient's condition sharply deteriorated after this call. I acknowledge the terrible shock that the patient's death had for the complainant and her family, particularly as the patient was alert and spoke to her on his mobile phone at 12.15 on 28 October 2022. In response to the draft investigation report the complainant said the Trust never informed her that the patient had sepsis or suspected sepsis and had they done so she would have appreciated how ill the patient was. I note from the patient's medical records the Trust did not use the term sepsis or suspected sepsis during the conversation between the doctor and the complainant (28 October 2022, 11.55). The records show the doctor informed the complainant there was *'evidence of infection'*. While I am satisfied the Trust's communication with the complainant at that time was reasonable and appropriate, I would suggest that going forward the Trust consider informing a patient or their family where the patient has sepsis or suspected sepsis.

Summary - Assessment of patient's condition and subsequent communication to complainant

60. I note the findings at paragraphs 57 and 60 above and do not uphold this element of complaint.

CONCLUSION

61. I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's son (the patient) in October 2022.

62. While I found that the nursing staff did not report the patient's cyst to the medical team and this amounted to a failing in nursing care, I am satisfied that overall, it did not have a significant negative impact on the care and treatment provided to the patient. I found that the DNACPR process was managed in line with relevant standards and the Trust DNACPR policy. I also found that the medical team communicated the status of the patient's condition in line with the medical evidence

available at the time and could not have predicted that the patient's condition could have deteriorated so quickly. I partially upheld the complaint, to reflect that whilst the care and treatment the Trust provided to the patient was, for the most part, reasonable, appropriate and in line with relevant standards, nursing staff failed to appropriately escalate the patient's cyst to doctors.

63. I acknowledge the significant loss suffered by the complainant and her family and offer my condolences on the loss of her son.

Recommendation

64. I recommend that the Trust apologise to the complainant for the failure of nursing staff to bring the cyst to the attention of medical staff.

65. I further recommend that the Trust bring this report and its findings to the attention of nursing staff who provided care to the patient while he was in hospital.

66. The Trust confirmed it accepted the findings and recommendations outlined in this report.

MARGARET KELLY **September 2025**
Ombudsman

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.