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

Report reference: 202006521

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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

I received a complaint about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant when he attended the Emergency Department (ED) at Antrim Area Hospital overnight on 12-13 July 2022. The complainant called an ambulance to take him to hospital when he believed he had experienced a stroke.

The complainant raised concerns the Trust failed to fully investigate his symptoms, and had left him for too long in a corridor following his triage in the ED.

The investigation found the Trust provided appropriate care and treatment to the complainant following his attendance at the ED. I identified there were some delays in the complainant's treatment experience. However, these did not impact on his overall care and treatment.

I therefore did not uphold this complaint.

THE COMPLAINT

1. This complaint was about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant overnight on 12-13 July 2022 following his attendance at the Emergency Department (ED) of Antrim Area Hospital (AAH).

Background

2. The complainant attended the ED at AAH late on the night of 12 into 13 July 2022 as he believed he was experiencing a stroke. The Trust initially reviewed the complainant in triage at 01:19. The complainant waited from the completion of his triage until 08:49 when a Consultant examined him.

3. The complainant said he had a previous stroke in April 2022.

Issue of complaint

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

   Whether the assessments, care and treatment the Trust provided to the complainant at Antrim Area Hospital Emergency Department on the night of 12-13 July 2022 were reasonable, appropriate, timely, and in accordance with relevant policies and standards.

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 advisors (IPAs):

   - A Consultant in Emergency Medicine and Major Trauma, MBBS, FRCEM, MBA, PGDMedEd, FFMLM, with 16 years' experience (ED IPA); and
   - A certified and GMC accredited Stroke Consultant, MBBS MRCP LLM MSc, with 10 years' experience (S IPA).

I enclose the clinical advice received at 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 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

8. 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[1]:

   - The Principles of Good Administration.

9. 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:

   - General Medical Council - Good Medical Practice, updated April 2019 (the GMC Guidance);
   - National Institute for Healthcare Excellence, Stroke and ischaemic attack in over 16s: diagnosis and initial management, 13 April 2022, (NICE Guidance NG128);
   - Northern Health and Social Care Trust, Stroke-Management Policy, 17 February 2021 (The Trust's Stroke Management Policy); and
   - University of Birmingham and Walsgrave Hospitals NHS Trust, Does the Manchester triage system detect the critically ill?, December 1999, (Manchester Triage System).

[1] 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.

10. 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

Whether the assessments, care and treatment the Trust provided to the complainant at Antrim Area Hospital Emergency Department on the night of 12-13 July 2022 were reasonable, appropriate, timely, and in accordance with relevant policies and standards.

Detail of Complaint

11. The complainant raised concern with the Trust's care and treatment when he attended the ED. The complainant said he experienced a stroke approximately three months prior to this incident. He said the Trust didn't carry out the correct tests or procedures to diagnose a stroke, and after it completed his triage, it left him for approximately eight hours before a Doctor examined him. He said his experience has had a long-lasting detrimental impact on his health.

The Trust's response to investigation enquiries

12. The Trust stated the complainant presented and registered at the ED on 13 July 2022 at 00:50. The Trust stated it triaged him at 01:19, and noted he had noticed reduced mobility the previous evening (12 July 2022) from 21:00, but had full power to all limbs, and had a normal level of consciousness. The Trust categorised the complainant with a Manchester Triage Score[2] (MTS) of four, meaning a Doctor would examine him within two hours. A Doctor examined the complainant in the ED at 08:49 on 13 July 2022, and he had a CT brain scan at 11:00, with the report available at 11:36. The Trust acknowledged the complainant experienced a '*lengthy delay*' for him to see a Doctor, explaining this was due to *'sustained crowding in the Emergency Department'.*

[2] The Manchester Triage System (MTS) is a standardized method used in emergency departments to assess the urgency of patient needs and prioritize treatment.

13. The Trust stated when a Doctor in the ED assessed the complainant, he was not displaying any symptoms of a stroke, but explained he experienced '*weakness and unsteadiness'* to his legs. He advised the Doctor of a previous CVA[3]. Examination of the complainant's chest and cardiovascular system was '*unremarkable'.* The FAST[4] examination was negative, and the Doctor referred him for a CT brain scan.

14. The Trust stated the complainant, when seen by a Doctor, did not have an '*acute right sided weakness'.* It explained it performed a CT brain scan with results indicating no new acute infarct[5]. A Cerebral Infarction is a stroke, which is a blockage in an artery in the brain, resulting in tissue death in the brain, therefore the scan did not indicate the complainant had experienced a stroke. The working diagnosis for the complainant at this time was '*worsening mobility',* and it referred the complainant to a multi-disciplinary team (Occupational Therapy and Physiotherapy) for review.

15. The Trust stated a physiotherapist, while assessing the complainant on 14 July 2022, noted new sudden onset of right sided symptoms, and immediately referred him to the Stroke Team for further management.

16. The Trust stated two of its other Consultants conducted separate independent reviews of the complainant's medical notes, and both were satisfied the Trust provided the appropriate care and treatment to the complainant.

Relevant Independent Professional Advice

17. I include the IPA advice at Appendix two of this report. I outlined my consideration of that advice in the analysis and findings below.

Analysis and Findings

18. In terms of the complainant's wait time in the ED, NICE NG128, section 1.1 outlines and emphasises the importance of rapid recognition of symptoms and diagnosis of stroke. The Guidance recommends that a validated tool such as FAST (Face Arm Speech Test) '*to screen people with sudden onset of neurological symptoms for a diagnosis of stroke or transient ischaemic attack.*'

[3] In medicine, CVA stands for Cerebrovascular Accident, which is another term for a stroke.
[4] FAST stands for Face, Arms, Speech, and Time, and it's an acronym used to help recognize the most common signs of a stroke.
[5] Infarcts are commonly caused by blockages in arteries, but can also result from other issues like rupture of a blood vessel, mechanical compression, or vasoconstriction.

19. The ED IPA advised the Trust triaged the complainant approximately an hour after his arrival at the hospital, and assessed him as a category four patient on the MTS. Category four indicates a condition which does not necessarily require immediate care, and is considered less urgent than, for example, a heart attack. I noted the complainant's ED record shows Triage recorded ''*reduced mobility tonight from 9pm, 5/5 power now to all limbs, GCS 15* .' Notwithstanding this, the ED IPA advised the complainant should have been more appropriately categorised as a category three patient, which indicates '*Urgent - conditions needing attention within 60 minutes, like serious eye injuries or abdominal pain*.' However, he also advised the wait the complainant experienced in the ED did not have a detrimental effect on the patient's outcome.

20. The records document an ED Doctor assessed the complainant at 08:59 on the morning of 13 July 2022. In its response to investigation enquiries, the Trust explained the ED was extremely busy, and it acknowledged this was not the waiting time it would want a patient to experience. I noted the ED IPA's advice that a wait of eight hours is considerably longer than the recommended time, but that '*this is common in many ED across the UK*'. I noted the complainant, whilst having to wait for this lengthy period of time in the ED, did not specifically refer to any further deterioration in his condition or symptoms during that period.

21. I consider triage prioritisation is such that if a patient with a more serious condition presents to the ED, the Trust will need to prioritise that patient over those already waiting, inevitably resulting in patients already triaged, dropping on the priority list. I am satisfied that this, combined with general over-crowding within EDs nationwide, is why the complainant had to wait so long.

22. Having considered all available evidence, including the ED IPA's advice, I find the complainant's wait in the ED was longer than the Trust's published target. However, I am satisfied the duration of the complainant's wait was outside the Trust's control, given how busy the ED was that night, and the wider context of ED resourcing in Northern Ireland. Having considered the ED IPA's advice, I find the Trust did not assign the complainant the appropriate triage category to reflect his symptoms. Had the Trust assigned the complainant the correct category, his target wait time would have reduced. However, I am satisfied that this miscategorisation did not have any impact on the timeframe within which a doctor was able to assess the complainant on that particular night, given the overall wait he experienced. I am therefore satisfied it

did not impact the overall care and treatment the complainant received, or his eventual outcome. On this basis, I do not uphold this element of the complaint as a failure in care and treatment the Trust provided in these circumstances. However, I strongly encourage the Trust to reflect on the ED IPA's advice in terms of correctly categorising patients for triage in its practice going forward.

23. In terms of observations during the complainant's wait in the ED, the ED IPA advised that it is important that staff conduct regular observations of a patient, and if any decline noted, staff should escalate the patient. The ED IPA advised the Trust appropriately monitored the complainant and recorded his observations in his medical records. Having considered the complainant's ED medical notes I accept the ED IPA's advice. I am satisfied the Trust monitored the complainant and recorded its observations appropriately during his time in the ED.

19. In terms of tests and procedures to diagnose the complainant's condition, I considered the NICE Guideline NG128 which states at paragraph 1.3.3 '*perform scanning as soon as possible and within 24 hours of symptom onset in everyone with suspected acute stroke without indications for immediate brain imaging*.' A review of the patient's medical records established the Trust acted in accordance with this guideline by requesting the patient undergo a CT scan on the morning of 13 July 2022.

20. The complainant said he had no recollection of having a CT scan performed. The ED IPA advised the Consultant referred the complainant for a CT brain scan at 9:22am on the morning of 13 July 2022. The ED IPA advised the result of the CT scan, reported at 11:07am, showed '*there were no symptoms or signs of an acute stroke',* but did show evidence of an old infarct. The result reported '*No evidence of acute intracranial haemorrhage or extra-axial collection*[6].' On reviewing the patient's medical notes I am satisfied the Trust documented a CT scan of the patient's brain, with the results appropriately recorded. I also noted that the patient's medical records show the patient underwent an MRI brain scan the following day, 14 July 2022. I find, therefore, the Trust conducted a CT scan for the complainant, and did so in line with relevant standards.

24. The ED IPA advised that because the Trust conducted the CT scan, '*there was an appropriate assessment, and investigations ordered.'* The Trust reviewed these

[6] The phrase "no evidence of acute intracranial haemorrhage or extra-axial collection" in a radiology report means that a CT scan or MRI did not reveal any fresh bleeding within the brain or any fluid collections outside the brain tissue, but within the skull.

results appropriately, and '*appropriate follow-up and assessment arranged'.* I note clinicians in the ED referred the complainant to a Multi-Disciplinary Team to receive treatment to increase his leg strength and mobility. The ED IPA advised this referral was '*sensible'.* I therefore find that whilst the complainant had to wait in the ED longer than published targets to undergo investigations and procedures, once he did the Trust conducted them reasonably, appropriately and in line with relevant standards.

25. Subsequent to his attendance at the ED, the Trust admitted the complainant and during a review by a member of the multi-disciplinary team, the complainant demonstrated a '*weakness of the right side, dysmmetria (difficulty controlling range of movements) on the right side, normal speech, and normal vision. The suspected diagnosis was one of new stroke, possible in the posterior circulation territory*.'

26. It was following these new symptoms of a suspected stroke later the same day, that the Consultant admitted the complainant to the Stroke Ward. The Stroke Team initially assessed the complainant the following day, at 08:50 on 14 July 2022. The S IPA advised that at that time '*a diagnosis of lacunar stroke*[7] *was suspected.'* I noted the S IPA advised in terms of acute treatment for the complainant, it was *'unclear at what point the patient may have had the stroke.'* He continued it '*may have occurred at some point between 07:49 on 13/07/2022 and 14:30 on 13/07/2022.'*

27. I considered the NICE Guidelines NG128 which states at paragraph 1.3.1 '*Admit everyone with suspected stroke directly to a specialist acute stroke unit after initial assessment, from either the community, the emergency department, or outpatient clinics. (An acute stroke unit is a discrete area in the hospital that is staffed by a specialist stroke multidisciplinary team. It has access to equipment for monitoring and rehabilitating patients. Regular multidisciplinary team meetings occur for goal setting.)*' I am satisfied the Trust appropriately transferred the patient to the Stroke Unit within the hospital following his confirmed diagnosis of stroke. I therefore find the Trust acted in accordance with the NICE Guidelines NG128.

28. The S IPA advised that once stroke had been confirmed on an MRI scan, the complainant's treatment, management, investigations, and medications '*were appropriately provided'.* The Trust treated the complainant with dual antiplatelet

[7] A lacunar stroke (lacunar infarct) is a stroke that happens when a blood clot blocks one of the small blood vessels deep in your brain.

therapy (DAPT)[8] followed by single antiplatelet therapy[9] (an example of a single antiplatelet is aspirin), statins, and his other routine medication. The S IPA advised these are the '*appropriate investigations and treatment given to a patient with ischaemic stroke*'.

29. The S IPA also advised the complainant's presentation in the ED, such as bilateral leg weakness and unsteadiness '*may well be related to a stroke syndrome'* and '*may have started the day before on 12/07/2022.'* However, he also advised the complainant was FAST negative, and that fact '*made the diagnosis of stroke very difficult'.* The S IPA also advised the complainant had pre-existing right-sided weakness due to an earlier stroke in April 2022. The S IPA advised that this would have made *'ascertainment of new neurological symptoms even harder.'*

30. The S IPA advised that, '*the timing of the stroke is impossible to accurately verify.'* He advised that to have started thrombolysis[10] or any other acute investigation or treatment, '*may have caused harm.'* In explaining this the S IPA advised the complainant's presentation was not classical or straightforward, and said '*amidst the complexity of examination findings, lack of obvious FAST signs, pre-existing stroke in the left basal ganglia with mild residue weakness, the diagnosis of stroke was arrived at a stage later than what would normally have been the case.'*

31. I acknowledge the complainant said this incident has had a lasting detrimental impact on both his mobility and his mental acuity. However I also noted the S IPA advised that there is no evidence of long lasting severe detriment. The S IPA advised follow-up clinical records note the complainant '*was independently mobilising, with normal speech and swallow.'* The clinical notes record the complainant had '*normal mood and memory with independent ability to manage housework.'*

32. I am satisfied with the S IPA's advice who, in summary, advised '*the atypical presentation, lack of discrete examination findings initially, pre-existing stroke residual weakness'* all made the definitive diagnosis of the stroke difficult. The S IPA continued '*This is unfortunate but not an uncommon occurrence and not all stroke presentations are clear cut. The overall care and management was within keeping of available resources and expertise, taking into account the atypical presentation.'* I

[8] Dual antiplatelet therapy (DAPT) involves taking two antiplatelet medications to prevent blood clots.
[9] Single antiplatelet therapy is a common treatment for secondary prevention of cardiovascular events, like heart attacks and strokes, after an initial period of dual antiplatelet therapy.
[10] Thrombolysis is a medical treatment that involves using drugs to break down blood clots. These drugs, known as thrombolytics, are often used in emergency situations like heart attacks and strokes to restore blood flow and prevent tissue damage.

accept this advice which is corroborated by a review of the complainant's medical notes, and in particular the fact that he had experienced a previous stroke earlier in 2022.

33. The ED IPA advised that investigations conducted within the ED were appropriate and reasonable, and I am satisfied that this was the case. The S IPA advised that whilst it is possible the patient's stroke, which was subsequently diagnosed, began earlier than it was diagnosed, there is no evidence to suggest the symptoms of the patient's subsequent stroke should have been identified in the ED, given the clinical test results and observations made at that time while the patient was still in the ED.

34. I am satisfied the assessments, care and treatment the Trust's ED provided to the complainant were reasonable, and in accordance with relevant guidance. I have not identified any failing by the Trust while the complainant was in the ED. I therefore do not uphold this complaint.

CONCLUSION

35. I received a complaint about the care and treatment the Northern Trust provided to the complainant when he presented at the ED in AAH late on 12 February into 13 February 2022. I did not uphold the complaint for the reasons outlined in this report.

36. I appreciate the complainant may be disappointed with my findings. However, I can assure him that I reached them following my full consideration of the evidence and relevant guidance. I hope this helps to reassure the complainant that the Trust's actions were appropriate when he attended the Antrim Area Hospital ED on 12-13 July 2022.

MARGARET KELLY
Ombudsman **October 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.