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

Report Reference: 202005907

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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.

TABLE OF CONTENTS

Page

Case Reference: 202005907

Listed Authority: Northern Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant in the Emergency Department of Antrim Area Hospital on 22 October 2023. It was also about how the Trust handled the subsequent complaint.

The investigation found the Trust's decision to act to prevent the complainant leaving the hospital grounds for her own safety was reasonable and appropriate. It acknowledged this was a very challenging situation for all involved. However, the investigation found the actions the Nurse In Charge (NIC) took to restrain the patient and prevent her leaving were disproportionate and contrary to relevant standards. It also found the NIC's actions in attempting to return the complainant to the ED, and how she handled the complainant's refusal to receive further treatment, were inappropriate and contrary to relevant standards. This included the NIC's attitude towards the complainant, and her action to remove the complainant's crutch as the incident unfolded. I found this behaviour concerning and not in keeping with the NMC Code. I found these actions to be failures in the care and treatment the Trust provided to the complainant.

The investigation also identified maladministration in the Trust's handling of the complaint. In particular, the Trust failed to conduct a sufficiently robust and comprehensive investigation into the complaint in a fair impartial manner. It placed too much emphasis on the NIC's statement about the incident, without taking steps to gather other potentially relevant evidence to corroborate or refute her statement. As a result, the Trust failed to give sufficient consideration to the complainant's account of events, and failed to provide an appropriate response. The Trust failed to appropriately communicate with the complainant. The investigation found its action contrary to relevant standards in complaints handling.

I therefore upheld elements of the complaint.

I recommended the Trust apologise to the complainant for the failures identified. I made recommendations for the Trust to bring about service improvement and prevent future recurrence.

THE COMPLAINT

1. This complaint concerned the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant in the Emergency Department (ED) of Antrim Area Hospital (AAH) on 22 October 2023. It was also about how the Trust handled the subsequent complaint.

Background

2. The complainant was a patient receiving treatment in Tobernaveen Upper at Holywell Hospital (Holywell). The complainant is insulin dependent and on 22 October 2023 was assessed by a doctor as being at serious risk of Diabetic Ketoacidosis[1] (DKA) due to elevated Ketones[2]. The complainant was deemed to have capacity to refuse treatment and medical staff encouraged the complainant to attend AAH for treatment.

3. The complainant agreed to attend AAH and arrived by ambulance at 23:30. A Senior Mental Health Nursing Assistant (the HNA) accompanied her to the ED.

4. The complainant registered at ED at 23.55. Blood sugar and Ketone levels were checked which indicated the complainant was not in DKA. The complainant was awaiting a doctor to review her results. The complainant decided to leave ED at 02.30 on 23 October 2023 of her own accord. The complainant was accompanied by the HNA who rang Holywell as there was no transport. The Nurse in Charge (NIC) from ED accompanied by a Patient Flow Co-ordinator (the PFC) came out to speak with the complainant and get her to return to ED. The complainant refused. A Hospital Security Guard attended (the SG), but had no active involvement in the matter.

5. The NIC was unable to encourage the complainant to return to ED and contacted the Police Service for Northern Ireland (the PSNI). Two police vehicles attended. The officers from one vehicle spoke with the NIC and declined involvement, having assessed it was not a police matter. The NIC spoke with a doctor who reviewed the complainant's medical notes. The doctor confirmed the complainant was not in DKA, and as such discharged the complainant.

[1] Diabetic ketoacidosis (DKA) is a potentially life-threatening condition that affects people with diabetes. It occurs due to a lack of insulin in the body, leading to the breakdown of fat and the production of toxic acids called ketones. Symptoms include vomiting, high blood glucose levels, and increased urine production.

[2] Ketones are a type of chemical that your liver produces when it breaks down fats. High levels of ketones in your blood is a sign that something isn't quite right.

6. A second HNA arrived from Holywell. Both HNAs and the complainant returned to Holywell in a taxi.

7. The complainant lodged a complaint with the Trust on 23 October 2023. The Trust made a stage one response to the complaint on 17 November 2023. The complainant was dissatisfied with the outcome of the stage one response. The Trust issued its final response on 13 December 2023.

8. The complainant made a complaint to this Office on 15 February 2024.

Issues of complaint

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

Issue 1: Whether the Trust, in its decision to prevent the complainant leaving Antrim Area Hospital grounds, acted in accordance with policy and guidelines.

Issue 2: Whether the Trust, in the action taken to prevent the complainant leaving the Hospital grounds, acted in accordance with policy and guidelines.

Issue 3: Whether the manner in which the Trust communicated with the complainant, was in accordance with policy and guidelines.

Issue 4: Whether the Trust handled the complaint in accordance with relevant policy and guidelines.

INVESTIGATION METHODOLOGY

10. 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, and the complainant's clinical records from Holywell.

11. My Office conducted interviews with the PFC, the SG and the HNA. In addition one of the PSNI officers in attendance was interviewed. Witness statements are at Appendix 5 of this report,

Independent Professional Advice Sought

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

    - A Mental Health nurse with over 40 years' experience of working in the National Health service, including being a senior nurse in a variety of adult acute services across the in-patient and community sectors.

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

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

Relevant Standards and Guidance

14. 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[3]:

    - The Principles of Good Administration; and
    - The Principles of Good Complaints Handling.

15. 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 of those individuals whose actions are the subject of this complaint. The specific standards and guidance relevant to this complaint are:

    - Nursing and Midwifery Council (NMC) - Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates, October 2018 (the NMC Code);
    - NICE Guidelines - Violence and aggression: short-term management in mental health, health and community settings (NG10);
    - The Northern Health and Social Care Trust - Managing Aggression and Potential Aggression, March 2019 (the MAPA Policy);
    - Department of Health: Guidance in relation to the Health and Social Care Complaints Procedure (April 2023) (DOH Guidance); and
    - The Northern Health and Social Care Trust - Complaints and Service User

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

Feedback Policy and Procedure, June 2020 (The Trust's complaint policy).

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

16. 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.

17. 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. Both the complainant and the Trust accepted my findings.

THE INVESTIGATION

Issue 1: Whether the Trust, in its decision to prevent the complainant leaving Antrim Area Hospital grounds, acted in accordance with policy and guidelines.

Issue 2: Whether the Trust, in the action taken to prevent the complainant leaving the Hospital grounds, acted in accordance with policy and guidelines.

Detail of Complaint

The decision / action taken to prevent the complainant from leaving the grounds of AAH - The decision / action taken to return the complainant to the ED department.

18. The complainant said she left AAH ED of her "*own accord*". She said she had "*capacity to make decisions regarding her treatment*" and was "*not under a Deprivation of Liberty Safeguards*"[4] **(**DOLS). She said the NIC was "*completely unprofessional, rude and laid hands on her for no reason*". The NIC "*grabbed her under the arm and attempted to drag her back into the ED*". She was using "*crutches*" at the time due to a "*physical health condition causing very unstable joints*". She resisted being dragged back but the NIC continued to try for at least 10 minutes.

19. The complaint said during the time of the event she was receiving "*inpatient help for my mental health difficulties*". She was already in a "*vulnerable state*" and the "*event still plays on her mind*".

[4] DOLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the European Convention on the Human Rights (ECHR) in a hospital or care home. The safeguards exist to provide a legal framework and protection in circumstances where deprivation of liberty appears to be unavoidable in a person's best interests.

The removal of a crutch from the complainant

The complainant said when the NIC realised she was unable to return her to ED, she "*left her taking one of her crutches*". This left her as a "*fall risk*" and having to be "*partially held up*" by the HNA. The complainant explained she could have easily been "*physically injured*" at the time of the event, however thankfully she wasn't.

The NIC was unprofessional and made inappropriate comments to the complainant

20. The complainant said the NIC proceeded to phone the police and hospital security. When police arrived the NIC was was "*talking over him and giving contradicting and untrue stories"* to them. The complainant explained the NIC stated she had "*no capacity and was under a DOLS",* which was untrue. She said the NIC was "*rude and unprofessional"* to her.

Evidence Considered

The Trust's response to investigation enquiries

The decision / action taken to prevent the complainant from leaving the grounds of AAH - The decision / action taken to return the complainant to the ED department.

21. The Trust stated the complainant was "*agitated and verbally aggressive*". The complainant was "*walking to Holywell Hospital in the middle of the night*", which was "*unsafe*". In a statement, the NIC said she held the complainant's arm using *"minimum intervention necessary*". The Trust stated the NIC's actions were as "*per the NMC Code"*, to prevent the complainant from "*putting herself in danger".* It stated the steps the NIC took were in the "*best interests to safeguard"* the complainant. It further stated the NIC did her best to "*manage a difficult situation".* The complainant was "*not being enforced to have treatment*" but rather it made efforts to "*keep the patient safe*".

22. The Trust stated the PFC phoned the doctor. Investigations confirmed the complainant was "*not in DKA therefore treatment was not required*", and she could "*return to Holywell Hospital*" to be observed at ward level.

The removal of a crutch from the complainant

23. The Trust stated the NIC disputes making the complainant "*unsteady on her crutches and leaving the patient at risk of falls*". It stated the fact the complainant required

crutches further highlighted the "*concern in regard to the patient walking to Holywell Hospital late at night*".

24. The Trust stated when "*trying to reason with the patient*" the NIC did "*try to make her understand*" they were "*simply trying to ensure that she was safe*" and not at harm from the cold or getting knocked down by a car, in her quest to get her back to Holywell. The nurse took the "*correct action, in very difficult circumstances*".

The NIC was unprofessional and made inappropriate comments to the complainant

25. The Trust stated when "*trying to reason*" with the complainant, the NIC did "*try to make her understand*" she was simply trying to ensure that she was safe and not at harm.

Witness Interviews

26. I attached summaries of the witness accounts at Appendix five of this report. I will refer to relevant extracts of the witness accounts in the analysis and findings section of this report.

Relevant Trust records

27. I completed a review of the documentation the Trust provided in response to my investigation enquiries, and the documentation I received from Holywell. I refer to the relevant records in the analysis and findings section of this report.

Relevant Independent Professional Advice

28. I enclose the clinical advice received at Appendix three to this report. I outline my consideration of the advice in my analysis and findings below.

Analysis and Findings

The decision / action taken to prevent the complainant from leaving the grounds of AAH.

29. I note paragraph 13.4 of the NMC Code, which requires nursing staff to "*take account of your own personal safety as well as the safety of people in your care*".

30. The IPA advised the complainant was detained under the Mental Health (Northern Ireland) Order 1986. She advised the complainant's decision to leave the emergency department would prompt "*any reasonable nurse to be concerned about why the patient left"* and consider the complainant *"may be intending to put herself at risk*"

31. I considered the PFC's account that both she and the NIC "*spoke with the patient and tried to encourage her to return to ED"* for a couple of minutes. I considered the

HNA account that both the PFC and NIC "*spoke with the patient, asking her to return to ED*" to speak with the doctor.

32. I note the MAPA Policy states, "*physical interventions should only be used when all other non-physical interventions have failed to manage the prevailing risk*". The preferred option in managing an aggressive situation is always to "*focus upon the use of preventative strategies*". Physical interventions should be "*used only for the minimum amount of time, using the minimum amount of restriction*" on the basis of "*prevailing risk staff are attempting to manage*".

33. I also note the NICE Guideline NG10, which states clinicians must "*ensure that the level of force applied during manual restraint is justifiable, appropriate, reasonable, proportionate to the situation"* and applied for the *"shortest time possible*".

34. I considered the NIC's account she "*responded immediately to this call and went to ensure the safeguarding of the patient, as well as the Healthcare Professional that accompanied her*". She managed to stop the complainant from leaving the hospital grounds by "*gently stopping her from moving any further towards the road*". I note the lack of clarity in this statement, I will refer to this further under the complaint handling section of my report.

35. The IPA advised the NIC's decision to prevent the complainant from leaving the hospital grounds was "*well intentioned*" and "*reasonable and justifiable in the circumstances*". I accept the IPA's advice that the NIC's decision to prevent the complainant leaving the hospital grounds was well intentioned and was out of concern for her safety and that of the accompanying HCA. I therefore find the NIC's decision was reasonable, appropriate and in line with the NMC Code. As a result I do not uphold this element of the complaint.

36. However, I have concerns about the methods the NIC employed to prevent the complainant's departure. I note the NIC's position she "*gently*" stopped the complainant from leaving. However, I also note the HNA's contemporaneous account that the NIC took hold of the complainant and put her in what would be "*termed a High-Level restraint*". The HNA stated in this account they were trained in restraint techniques, and when it is permissible to use them to varying degrees. The HNA explained in this account that a High-Level restraint is only used when a "*patient is hitting out*". They explained in this instance the complainant was "*not hitting out and it*

was therefore not a suitable level of restraint". I note the HNA's position they refused to participate in restraining the patient because they did not consider the complainant was "*behaving in a manner which would warrant any level of restraint*".

37. I note the IPA's advice that the NIC's use of a high-level physical hold was "*not ideal*". I note her further advice she did not consider the NIC's actions were unreasonable, however, because the NIC acted alone to manage a challenging situation, and to prevent harm coming to the complainant if she left AAH. However, the IPA also stressed the "*speculative*" nature of her advice on this point, given the divergence of witness opinions, and she did not directly witness the events herself.

38. I appreciate this was a very challenging situation for the complainant, the NIC, and the other individuals involved. Having carefully considered and weighed all available evidence, I consider it was necessary for the NIC to apply some level of restraint to prevent the complainant leaving AAH, for the complainant's own safety. I acknowledge the NIC had to act spontaneously, without any physical assistance. However, I find the NIC's actions to physically restrain the complainant at the level she did, constitute a disproportionate response to the complainant's actions, rather than the minimum amount of restriction. I note the complainant did not report any injuries as a result of the restraint used. However, she clearly articulated her belief that the NIC laid hands on her for no reason. This belief is supported by the HNA's account of the incident. I also note there is no evidence available to suggest or infer the complainant was physically violent towards the NIC, or any other party present.

39. I therefore find the NIC's actions were contrary to the MAPA Policy and NICE Guideline outlined above. I also find her actions contrary to the NMC Code, which requires nurses to respect and uphold people's human rights, and to act in their best interests at all times. I consider this a failure in the care and treatment the Trust provided to the complainant, and I therefore upheld this element of the complaint.

The decision / action taken to return the complainant to the ED department.

40. I note the following sections of the NMC Code, which require nurses to:
    - 1.5 - respect and uphold people's human rights;
    - 2.4 - respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care;
    - 2.5 - respect, support and document a person's right to accept or refuse care and treatment;

- 4.1 - balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment; and
- 4.3 - keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process.

41. I reviewed Holywell records which confirm the assessment of the complainant on 22 October 2023 documented she had "*capacity*". Its assessment was to continue to monitor the complainant, and should her "*condition deteriorate capacity would have to be reviewed*". Records also demonstrate it encouraged the complainant to "*attend AAH to receive treatment*". I considered records show the complainant later "*agreed for transfer*" and an "*urgent ambulance contacted*".

42. I note the complainant said she was "*deemed to have capacity that day by a consultant in holywell, she was detained but had capacity*". I note the IPA's advice that "*a person being subject to the Order does not mean that he or she lacks capacity; i.e. the ability to understand and use information to make a decision*".

43. I considered the Trust's response, it must be clear that the intervention that took place was "*not to enforce treatment*" but rather to keep the complainant "*safe from harm*". I considered the NIC's account that it was decided the PSNI would need to attend "*in order to safely get the patient back to Antrim Area Hospital*".

44. I also considered the PFC's account the NIC was encouraging the complainant to return to ED, advising the complainant she was "*DKA and detained*". The complainant replied she was "*fine*", she was "*not detained*" and just wanted to "*go back*" to Holywell. On arrival of PSNI officers the complainant continued to state she "*was not detained*" and the PSNI officers agreed with her. The PFC explained the NIC was "*concerned for the patient's safety*". The PFC stated the complainant was "*clearly annoyed and frustrated*" and was speaking in a "*raised voice*".

45. I considered the HNA's account that the NIC and PFC asked the complainant to "*return to ED and speak with the doctor*". They also asked if the doctor could "*come out and speak to her now*". The complainant advised "*she did not want to go back into ED or speak with the doctor*". The HNA stated the complainant never "*raised her voice during this incident*", she was never "*irate or showed aggression"* to anyone. The complainant just "*wanted to leave AAH and go home*".

46. I note the Holywell records confirm a phone call from the NIC at approximately 02:00. The record notes the NIC advised the complainant "*does not appear to be in DKA at present therefore that she should return to the ward*".

47. I note the PSNI officer stated from police arrival the NIC was not cooperative and "*provided police with two different accounts*" regarding what was happening with the complainant. The NIC initially confirmed the complainant had the "*right to refuse treatment*" and would be "*discharged accordingly*". The NIC then stated the complainant had "*no capacity*" to refuse treatment and was a "*detained patient*".

48. I further note the PSNI officer stated the NIC said the complainant "*needed to return to A&E"* and would be *"immediately discharged by the Doctor then returned back to Holywell*". The officer questioned why the complainant needed to be brought into ED, and the NIC stated police needed to "*physically bring the patient back into A&E in order to be assessed by a doctor".*

49. The PSNI officer stated they spoke with Holywell staff and confirmed the complainant had "*capacity to make decisions regarding medical treatment*". Given a capacity assessment had occurred within 12 hours and in the absence of a more recent assessment police were "*satisfied the patient had capacity to refuse medical treatment*". The PSNI officer stated police did not have the powers to "*physically bring*" the complainant back into the ED.

50. I considered the witness accounts provided and note that none of the witnesses describe the complainant as attempting to leave hospital grounds following the arrival of PSNI officers. On foot of the IPA's advice on mental capacity and detention under the Order, I am satisfied the complainant was assessed to have capacity and had a right to refuse treatment. The clinical records demonstrate the complainant was not in DKA and as such was not at immediate medical risk. I also note the IPA's advice to this effect. As such, I am satisfied it was safe for the complainant to be permitted to return to Holywell. I consider it was then a matter for Holywell staff to continue to monitor the patient and if necessary review the patient's capacity.

51. I acknowledge the NIC was acting under pressure to ensure the safety of the complainant. However, having carefully considered and weighed all available evidence, including the IPA's advice, I find the NIC's decision to request PSNI officers to escort the complainant back into ED to permit the doctor to assess and

discharge the complainant was incorrect in the circumstances. I find the complainant had capacity and had the right to refuse further medical treatment. I find given the complainant was in the care of PSNI officers within the grounds of the hospital, the NIC had an opportunity, on the arrival of police, to speak to the doctor, confirm the complainant did not require treatment and arrange for the patient to return to Holywell. She did not do so. The NIC's actions were therefore contrary to the sections of the NMC Code, outlined above. I consider this to be a failure in the care and treatment the Trust provided to the complainant. I therefore uphold this element of the complaint.

The removal of a crutch from the complainant

52. The NMC Code requires nursing staff to "*treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*".

53. In addition, the MAPA Policy states the preferred option in managing an aggressive situation is always to "*focus upon the use of preventative strategies*". Physical interventions should be "*used only for the minimum amount of time, using the minimum amount of restriction*" on the basis of "*prevailing risk staff are attempting to manage*".

54. I note the complainant said that following the NIC restraining her, she "*left me, taking one of my crutches*". The complainant said this left her at "*risk of falling*" and she was "*having to be partially held up by the health care assistant".* The complainant said the NIC *"proceeded to phone police and security".*

55. I considered the HNA's account the complainant had two crutches. The NIC "*removed the left crutch*" from the complainant. This, and the use of restraint, caused the complainant to "*be off balance*". The HNA stated she had her arm out and the "*patient had hold of my arm*" was using it to "*help steady herself*". She asked the complainant to sit down as she was "*concerned for her safety*". The complainant did not sit down at any stage. The NIC then let go of the complainant and "*walked into ED*" taking the crutch with her.

56. The IPA advised the NIC's removal of one of the complainant's crutches was "*likely to have been inappropriate*" unless, for example, there was an immediate threat of the complainant "*possibly using it as a weapon, which is not suggested in the statements*".

57. I considered the Trust had an opportunity to check CCTV footage to ascertain if there was any evidence which may refute or support this issue of complaint. I note the Trust's statement there are "*no CCTV cameras outside the ED*". CCTV footage is only "*kept for a limited time, unless specifically requested*". I considered whilst there are no cameras outside the ED, there are cameras located within the ED department. I consider the Trust failed to consider this evidential opportunity and as such there was potential evidence I could have considered that was lost. I will cover this in more detail in the complaint handling section of my report.

58. I therefore had to make my determination on this issue of complaint based on the witness evidence that is available to me. I note the PFC was not present throughout the entire incident. I also note the complainant and the HNA both said the NIC removed the crutch before the arrival of PSNI and the SG. I considered the HNA's account that this was "*the first occasion I had met*" the complainant in a "*professional capacity*". I did not know the complainant "*outside of work*". On this basis I therefore consider the HNA to be an "*independent witness*".

59. I considered the NIC's account makes no reference to the crutch "*being used as a weapon".* I therefore consider there was no justification for the NIC to have removed the complainant's crutch in attempting to legitimately prevent her leaving the hospital premises. Based on the evidence available I find the NIC did remove the complainant's crutch, and in doing so acted inappropriately, which put the complainant at risk of a fall. I am further concerned about the lack of regard the NIC gave to the complainant's dignity in taking such an action. I consider the NIC's actions to be contrary to the section of the NMC Code outlined above, and therefore a failure in the care and treatment the Trust provided to the complainant. I therefore uphold this element of the complaint.

The NIC was unprofessional and made inappropriate comments to the complainant

60. Paragraph 1.1 of the NMC Code requires nursing staff to "*treat people with kindness, respect and compassion".* Paragraph 2.6 requires nurses to "*recognise when people are anxious or in distress and respond compassionately and politely*".

61. I considered the accounts the PFC and the SG provided who both confirmed they did not witness the NIC make any inappropriate comments. I note the SG stated he was standing "*approximately 6-8 feet away from the patient*" at the time.

62. I considered the HNA's account the NIC was "*condescending and degrading*" in the manner in which she spoke with the complainant. The HNA stated the NIC was "*very rude and showing no empathy or compassion*". I considered whilst she did not witness two of the comments the complainant said the NIC made, the HNA stated she did witness the NIC refer to the complainant as "*childish*".

63. I considered the PSNI officer's account the NIC "*became very hostile and aggressive*" and "*consistently spoke over Police and would not allow police to speak*". The NIC "*did not agree with anything Police said and demanded we do what she instructed*". She also called "*police unprofessional and stated that we had failed to do our job".* The complainant was "*calm and compliant at all stages*".

64. I note the PSNI officer stated the complainant disclosed the duty nurse had "*been rude to her*". I also reviewed Holywell records, which note the HNA reported the nurse in ED was "*acting inappropriately*", and asked the staff member to "*restrain*" the complainant. The nurse made "*unhelpful comments*" towards the complainant calling her "*childish*", to which the complainant became "*tearful to staff*". I consider the notes made soon after the incident corroborate both the complainant, and the HNA accounts to my office.

65. I note the HNA stated the NIC left, telling the complainant she "*would not be arranging for an ambulance*" to take us back to Holywell as the complainant "*did not receive any treatment*". The NIC stated we should "*figure out how to get back to HH by ourselves*". The HNA stated they were left "*standing outside the hospital in the cold and rain*" for about 45 – 60 minutes. I note the IPA's advice that it was inappropriate for the NIC to have allowed the complainant and the HNA to stand outside the ED in those conditions. I note the records from Holywell document that the ED "*declined to return*" the complainant in an ambulance and contacted a taxi.

66. I find the NIC spoke to the complainant in an inappropriate manner, and failed to take into account the complainant's mental health. I note the IPA's advice that if my investigation concluded the NIC acted in this way, then her "*professional attitude and behaviour was not in accordance with the NMC Code*". Overall, I find the manner in which the NIC treated the complainant to be highly concerning. I find the NIC failed to comply with the NMC Code, given she failed to communicate with the complainant with "*kindness, respect and compassion"* and deal with the complainant "*compassionately and politely"* as required by the NMC Code. I consider this to be a

failure in the care and treatment the Trust provided to the complainant. I therefore uphold this element of the complaint.

Summary

65. In respect of this issue of complaint, my investigation found no failings in the NIC's decision to prevent the complainant from the leaving the grounds of AAH, to prioritise her safety. I therefore did not uphold this element of issue one of the complaint. However, my investigation found failures in the manner in which the NIC sought to prevent the complainant from leaving AAH. It also found failures in the NIC's decision / action taken to return the complainant to the ED department, the removal of a crutch from the complainant and the NIC being unprofessional and making inappropriate comments to the complainant. I therefore upheld elements of issue one and, in full, issue two of the complaint. I will address injustice to the complainant in my conclusion to this report.

Issue 3: Whether the manner in which the Trust communicated with the complainant, was in accordance with policy and guidelines.

Issue 4: Whether the Trust handled the complaint in accordance with relevant policy and guidelines.

Detail of Complaint

66. The complainant said she was "*highly disappointed*" in the way the Trust handled her complaint and in its communication with her in the responses it provided. She said the Trust did not take any of her "*views of events into account*" and provided "*incorrect findings*" on such events.

Evidence Considered

The Trust's response to investigation enquiries

67. The Trust stated it issued formal responses to the complainant on 17 November 2023 and 13 December 2023, communicating the outcome of its investigation appropriately. Upon its review of this complaint it felt the "*steps taken by the member of staff were in the best interests to safeguard the patient*". On reflection, the Trust acknowledged that statements from other witnesses would have been "*beneficial and allowed a more complete investigation"* into the complainant's concerns.

68. It stated its Clinical Services Manager undertook a "*review of the patient's follow on*

concern", and "*acknowledged the distress the patient experienced".* However he felt "*reassured the main concern of the NIC was de-escalation of the difficult situation"* and the *"immediate safety and welfare of the patient and members of the public*". The Trust acknowledged, due to the investigation undertaken by my office, the HNA had information that would have been potentially relevant to its investigation. It acknowledged the HNA reported the NIC asked her to "*restrain the patient*" and documented the NIC made "*unhelpful comments towards the patient who became tearful*". The Trust stated it accepts that "*statements should have been sought to ensure a thorough complaints investigation had taken place*".

69. The Trust stated that, nonetheless, it gave "*full consideration*" to the complaint. It stated it examined ED documentation and sought a statement from the NIC. The Trust stated it considered its investigation at the time was "*proportionate, appropriate and fair*". It felt the NIC did her best to "*manage a difficult situation*" whilst responsible for the care and oversight of a busy ED.

Relevant Trust records

70. I completed a review of the documentation the Trust provided in response to my investigation enquiries, and the documentation I received from the complainant. I refer to the relevant records in the Findings and Analysis section of this report.

Analysis and Findings

71. The Trust's Complaints Policy, paragraph 26.6.5 states, "*All issues identified in the complaint must be identified and reviewed fully".* It outlines a range of different techniques, which may involve a "*review of manual and / or electronic patient / client records, obtaining verbal or written reports from the relevant health or social care staff*". I consider this section of the procedure refers to the Trust's investigation process.

72. The first Principle of Good Complaints Handling requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. The third Principle requires public bodies to "*provide honest, evidence-based explanations and give reasons for decisions*". The fourth principle requires public bodies to "*ensure that complaints are investigated thoroughly and fairly to establish the facts of the case*" and *"ensure that decisions and actions are proportionate, appropriate and fair*".

73. I reviewed the Trust's first stage response to the complaint and compared it to the account the NIC provided. I found the Trust used the wording from the NIC's

response to the complaint, and added little to this account in its own response.

74. I also reviewed the NIC's account, which referred to the "*violent nature*" of the complainant. I considered the Trust's response there is "*no documented evidence*" the complainant had been "*violent towards staff*". It is of concern, therefore, that the Trust took no steps to check the validity of the NIC's statement.

75. I note the NIC stated the PFC on that night *"accompanied myself the whole time I was in communication with this patient*". I find it surprising the Trust did not record an account from the PFC to verify this statement. I consider the Trust should have done so, to ensure it gathered all evidence potentially relevant to its investigation. My investigation found the PFC left the area on three occasions, which calls into question the inference the PFC could "*fully verify the account*" the NIC provided.

76. I note the NIC's account included the statement that she managed to stop the complainant from leaving the hospital grounds by "*gently stopping her from moving any further towards the road*". I note the lack of clarity in this statement. I also note that whilst the NIC's account makes reference to the complainant "*refusing to come back*". it does not outline the extent of the "*non-physical interventions*" she undertook with the complainant to encourage her to remain at the Hospital before resorting to the use of a "*physical intervention*".

77. To make a determination on a complaint as to whether the non-physical / physical interventions were in compliance with the MAPA Policy, the Trust investigation should have established the facts. Therefore, the Trust should have interviewed the NIC, and sought the clarity that was necessary for it to make a determination on this issue of complaint.

78. I considered Holywell's records, which note the accounts the HNA provided on return to the hospital. The records corroborate the accounts provided to my office. I note the Trust did not review this evidence during its investigation.

79. I considered the Trust's response to my office which confirms it gave "*no consideration to reviewing CCTV footage"* within the ED department. The review of this footage may have provided evidence to refute or support the complaint made.

80. I note the Trust failed to request records from Holywell, conduct CCTV enquiries and interview all relevant parties in investigating the complaint. I also consider the Trust should have formally interviewed the NIC, challenged the inaccuracies in her

account, and put to her the evidence additional witnesses provided. This would have resulted in a more thorough investigation of the complaint. It also would have demonstrated the Trust gave full consideration to the complainant's view about the events, free from any potential bias.

81. Under its Complaints Policy, the Trust should conduct any investigation in an "*impartial manner*". An impartial investigation is one that is "*conducted in a fair and unbiased manner*". The purpose of such an investigation is to provide a "*fair and impartial process for the complainant and respondent*" and to reach "*reasoned findings*" based on the "*information gathered*".

82. I find the Trust's response lacked impartiality and the Trust did not conduct its investigation in an impartial manner, given it failed to conduct reasonable enquiries before responding to the complaint. The Trust's investigation demonstrates it accepted the word of the NIC over the complainant in making its determination. I do not agree with the Trust's statement its investigation was 'proportionate, appropriate and fair'. I consider the Trust's actions demonstrate it did not give sufficient consideration to the complainant's view of events.

83. I find the Trust failed to properly investigate the complaint at both stages of its complaints process, and as such did not comply with the Complaints Policy, nor the Principles of Good Complaints Handling. I also find the Trust's response to the complaint should have been more comprehensive and it should not have, in the most part, simply repeated the NIC's account of events. Any response to a complaint should highlight the investigation undertaken, the evidence considered and the Trust's rationale for its decision. As such, the Trust's handling of this complaint, and its communication with the complainant fell short of the required standards. I consider these failures in complaints handling constitute maladministration. I therefore uphold both elements of the complaint.

84. I welcome the Trust has acknowledged "*this complaint has highlighted the need to ensure complaints reviewers have carried out a thorough investigation and if this is felt to be lacking this should be highlighted to the appropriate complaints reviewer*".

Observation

85. The Trust's stage 1 response to the complainant included "*there were discussions in private with PSNI who attended in regards to their behaviour and management of the*

situation. PSNI made apologies and this was accepted".

86. I considered the PSNI officer stated there was a private conversation between Police and the NIC, who allegedly called Police "*unprofessional and deemed us incompetent"* in our ability to carry out our duty. Police did make apologies for the way "*Police and the NIC got into a disagreement*" in front of the complainant. Again, Police did not agree with the NIC in terms of "*physically bringing the patient into the hospital*" if she was deemed to have "*capacity*" and could "*refuse treatment*".

87. I am concerned the Trust may have taken an "*inference*" from PSNI's acknowledgement that police were in the wrong when it came to their handling of this incident. It is of concern the Trust took no steps to verify the validity of this statement and failed to consider the Trust's letter may have ended up on the public domain.

88. Prior to making any such statement which infers criticism to the professionalism of another organisation and / or their staff the Trust should have taken reasonable steps to verify the information. As such, the Trust should have permitted the officers who were in attendance an opportunity to provide witness accounts and consider their "*version of events*". I would ask the Trust to reflect on this matter and consider reminding persons charged with investigations to gather and fully evaluate all relevant evidence before issuing its response.

Summary

89. In respect of this issue of complaint, my investigation found failings in the Trust's investigation and its communication / response to the complaint. I therefore upheld issues three and four of the complaint.

CONCLUSION

90. I received a complaint about the care and treatment the Northern Health and Social Care Trust provided to the complainant in the Emergency Department of Antrim Area Hospital on 22 October 2023. It was also about how the Trust handled the subsequent complaint. My findings were as follows:

    - I did not uphold the element of the complaint regarding the decision to prevent the complainant from leaving the hospital grounds, to preserve her safety. However, I upheld the element of complaint regarding the manner in which the NIC prevented the complainant from leaving AAH. I considered this to be a failure in the care and treatment the Trust provided to the complainant.

- I upheld elements of the complaint regarding the decision / action taken to attempt to return the complainant to the ED department, the removal of a crutch from the complainant and the NIC being unprofessional and making inappropriate comments to the complainant. I consider these are failures in the care and treatment the Trust provided to the complainant.
- I also upheld the concern about the Trust's handling of the internal complaint, including those about the quality of its investigation and response to the complaint. I consider this a failure of the Trust's handling of the complaint, which constitutes maladministration.

91. As highlighted within this report, I find the manner in which the NIC treated the complainant to be of significant concern. I am satisfied the failures in care and treatment identified caused the complainant to sustain the injustice of distress and a lack of consideration of her dignity. I am also satisfied the maladministration caused the complainant to sustain the injustice of uncertainty and frustration regarding the Trust's handling of her complaint and the robustness of the investigation undertaken. The failures also caused her to take the time and trouble of bringing a complaint to this office.

Recommendations

92. 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 as a result of the failures in care and treatment and maladministration identified, within **one month** of the date of my final report.
93. I recommend that within **three months** of the date of my final report, the Trust provides staff with training on complainant handling, and reminds staff charged with the responsibility of investigating complaints of the requirement to conduct a robust investigation and provide a full and accurate response to each issue of complaint.

94. I also recommend the Trust share the contents of this report with the NIC and discuss the learning identified as part of her next performance appraisal.

95. The Trust should provide evidence to this office that it implemented these recommendations in the periods specified.

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.

Appendix 2 - PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions and actions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.