Investigation Report

Investigation of a complaint against

3fivetwo Healthcare Group

NIPSO Reference: 18148

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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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EXECUTIVE SUMMARY

I received a complaint about the actions of 3fivetwo Healthcare Group (the Group) at Kingsbridge private hospital for the treatment of a patient's suspected ovarian cyst. The complainant was a patient of the Group as a result of a waiting list initiative by the South Eastern Health and Social Care Trust (the Trust).

Issues of Complaint

I accepted the following issue of complaint for investigation:

- Whether the care and treatment provided to the complainant by the Group between 29 February and 30 April 2016 was appropriate and reasonable

Findings and Conclusion

I have carefully investigated the complaint.

I have identified a failure in care and treatment in respect of the failure of a doctor within the Group (Doctor A) to have recorded the presence of severe endometriosis in the clinical records. I am satisfied that the maladministration I identified caused the patient the injustice of uncertainty and confusion regarding the extent of her endometriosis and the reasoning behind the clinical judgement made. I have also identified a failure in care and treatment in respect of Doctor A's failure to record an adequate history during her consultation on 29 February 2016. However I did not identify any injustice arising from this failure.

Recommendations

I recommended that the Group:

i. Provides a written apology in keeping with NIPSO 'Guidance on issuing an apology' dated June 2016 to the complainant for the injustice identified in this report. I consider this apology should provide details on the lessons learned from this investigation and a commitment that the Group has taken action to

implement my recommendations. The Group should provide the apology to the complainant within **one month** of the date of my final report;

ii. Provides confirmation to my office that Dr A has reflected upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report. These include the importance of accurate record keeping and providing clear and accurate information in responding to a complaint. An anonymised copy of the complaint, together with this report and her reflection on them, should be retained on her appraisal file, which will then be further discussed with her Appraiser and will be retained within the permanent appraisal database. This action should be provided to me within **three months** of the date of my final report.

iii. Provides the complainant's GP with a full and comprehensive report detailing the exact nature of her endometriosis. This report should be provided within **three months** of the date of my final report.

THE COMPLAINT

1. The complaint relates to the care and treatment provided by the Group at Kingsbridge private hospital for treatment of the complainant's suspected ovarian cyst. She had been referred to the Group by the Trust as part of a waiting list initiative. Following laparoscopic surgery on 30 April 2016, Dr A informed the complainant that she had been unable to get suitable access to perform the removal of the cyst and that she would refer her to another surgeon, Dr B who specialised in treating patients who had advanced endometriosis. The complainant said that the referral to Dr B was misleading as it suggested that she had been referred to him for endometriosis, rather than for treatment for a cyst. Dr B later successfully removed the cyst.

2. The complainant believed that Dr A ought to have removed the cyst on 30 April 2016 as she had consented to this. She believes if Dr A did not feel capable of conducting her surgery because of endometriosis then she ought to have referred her to another surgeon at an earlier stage rather than attempting the surgery. She believes she was unnecessarily put through two operations and the recovery associated with these, when it appears one would have been sufficient.

Issues of complaint

3. The issue of complaint which I accepted for investigation was:

Issue 1: Whether the care and treatment provided to the complainant by the Group between 29 February and 30 April 2016 was appropriate and reasonable.

INVESTIGATION METHODOLOGY

2. In order to investigate the complaint, the Investigating Officer obtained from the Group all relevant documentation, together with the Group's comments on the issues raised by the complainant. This documentation included information relating to the Group's response to the complaint and relevant medical records.

~~3.~~ After further consideration of the issues, I obtained independent professional advice from an Independent Professional Advisor (IPA). The IPA is a Consultant Obstetrician and Gynaecologist with considerable experience in managing benign gynaecological conditions.

4. The IPA provided an initial report dated 19 October 2018 which was shared with the Group. Due to the response provided by the Group, the IPA provided a second report dated 11 November 2018. As Dr A had not previously had the opportunity to comment on these reports, both reports were shared with her. She provided a response dated 26 November 2018 and the Senior Investigating Officer and Investigating Officer subsequently interviewed her on 6 December 2018. Following the interview, Dr A provided a further response dated 11 February 2019.

5. Due to new information and the reports supplied by Dr A, the Investigating Officer sought finalised advice from the IPA which was provided on 25 February 2019. This IPA report provided a consolidated and finalised opinion regarding the surgery performed by Dr A on 30 April 2016.

6. I have shared this draft report with the complainant and the Group for comment or factual accuracy and the reasonableness of my conclusions. The complainant provided a response to the draft. The Group and the doctor also provided a response to the draft report. I have considered and reflected the comments of both parties in

the final report. Following receipt of comments on the draft report, the Investigating Officer sought further advice from the IPA which was provided on 7 June 2019.

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

Relevant Standards

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

   The general standards are the Ombudsman's Principles[1]:

   i. The Principles of Good Administration
   ii. The Principles of Good Complaints Handling
   iii. The Principles for Remedy

9. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the Trust staff and individuals whose actions are the subject of this complaint.

   The specific standards relevant to this complaint are:

   i. General Medical Council (GMC) 'Good Medical Practice' 2013

10. I have not included all of the information obtained in the course of the investigation in this report, but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

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

INVESTIGATION

Issue 1: Whether the care and treatment provided to the complainant by the Group between 29 February and 30 April 2016 was appropriate and reasonable.

Detail of Complaint

11. The complainant stated that following a consultation with Dr A on 29 February 2016, she was advised that she had a 5cm ovarian cyst. She consented to having this ovarian cyst removed via laparascopy[2] (or by laparotomy[3] if necessary). She also consented that, if necessary, her ovary could be removed and that this would be done along with the removal of any endometriosis. The complainant stated she attended Kingsbridge on 30 April 2016 and Dr A assured her that she would remove the cyst and deal with any endometriosis[4] she encountered during this procedure. However instead Dr A came to see her in recovery and advised that "she couldn't get access" to remove the cyst. She also informed her that she had made a referral to a different surgeon.

12. The complainant stated she was referred to Dr B. At her appointment on 14 June 2016, he told her that she had been referred to him for her endometriosis, not a cyst. The complainant stated that she never attended at any stage to have her endometriosis treated and Dr B did not seek to remove it. The complainant believed that Dr B conducted the cystectomy with less bruising or invasion than Dr A managed. Dr B also advised her in recovery that it was straightforward and that he had removed a paratubal[5], not an ovarian[6] cyst.

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[2] *Laparoscopy* is a type of surgical procedure that allows a surgeon to access the inside of the abdomen (tummy) and pelvis without having to make large incisions in the skin. This procedure is also known as keyhole surgery or minimally invasive surgery.
[3] A laparotomy is a surgical incision (cut) into the abdominal cavity. This operation is performed to examine the abdominal organs and aid diagnosis of any problems, including abdominal pain.
[4] *Endometriosis* is a condition where tissue similar to the lining of the womb starts to grow in other places, such as the ovaries and fallopian tubes. *Endometriosis* can affect women of any age, but it's most common in women in their 30s and 40s.
[5] A paratubal cyst is a closed, fluid-filled sac that grows beside or near the ovary and Fallopian tube, but is never attached to them. It is located at the ligament between the uterus and the ovary, and usually it is unilateral and benign
[6] An *ovarian cyst* is a fluid-filled sac that develops on a woman's *ovary*. They're very common and don't usually cause any symptoms. Most *ovarian cysts* occur naturally and disappear in a few months without needing any treatment.

13. The complainant said that she did not accept Dr A's explanation that the procedure was abandoned for her own safety. She believes Dr A could have referred her to Dr B at any stage. She also complained that she was shocked to discover that Dr A admitted she only dealt with stage one-two endometriosis and she had stage four endometriosis. The complainant stated that Dr A was therefore not qualified to operate on her. She also stated that having to undergo two procedures under anesthetic put her at increased risk and her health has suffered as a result. She stated she had to endure pain from 30 April 2016 until 7 September 2016 when Dr B removed the cyst and alleviated her symptoms.

Evidence considered

The complainant's medical records

14. Dr A's notes of her initial consultation with the complainant on 29 February 2016 record that the patient had a history of pain on her right side. Following an ultrasound scan, she recorded *'Rt ovarian cyst – simple 5cm'.* Her notes also record the plan was for *'laparascopy – ovarian cystectomy'.* In a follow up letter to her GP, Dr A stated *'Transvaginal ultrasound reveals a normal sized uterus and a 5cm simple ovarian cyst on the right side. This is almost certainly the cause of her pain, the uterus was normal and there was no free fluid present. The left ovary was normal…"*

15. Dr A's notes of the laparoscopy on 30 April 2016 record that *'instrumentation to uterus- very difficult'* and *'access to deep pelvis – difficult'.* In relation to the findings of the ovaries, the doctor recorded:
'Right ovary-normal, mobile, 2-3 spots of endometriosis
Left ovary, multiloculated, adherent to sidewall.'
The notes also record *'Due to access difficulty, diagnostic only, refer to Dr B for further mm[7]'.*

16. In a follow up letter to her GP, Dr A stated she found a very deep pelvis and access to uterus and pelvis was very difficult due to the high Body Mass Index (BMI) and deep pelvis. Dr A stated *'I was able to identify some very small spots of*

[7] management

endometriosis in the right ovarian fossa[8], while on the left side the ovary was multiloculated[9] and with adhesions around it binding it to the left pelvic sidewall. Due to difficulty in access and complexity of the surgery I simply carried out a diagnostic laparoscopy and I have referred this lady to my colleague Dr [B] who is a specialist in minimal access surgery to assess his input in her management…'

17. I note Dr A sent a referral letter to Dr B dated 30 April 2016. This letter notes a BMI of 31 and that on instrumentation access to uterus was very difficult. Dr A also noted access to the abdomen was fairly simple and she visualised a very deep pelvis. Dr A stated *'There was a small amount of endometriosis in the right ovarian fossa and the left ovary appeared somewhat loculated and adhesed to the left pelvic sidewall.* ***I could not see any clear evidence of any ovarian cysts despite having observed one on ultrasound scan*** *(**my emphasis**). This lady complains of right sided pelvic pain and I wonder if it is related to the endometriosis done on the right hand side. Due to the combination in difficulty in access and a very deep pelvis I did not feel that it will be safe in my hands to access and treat this endometriosis, so with this in mind I would ask for your expertise with regards to this lady's management and whether or not you feel she needs a repeat procedure…'*

18. I note that the complainant was referred to Dr B and attended a consultation on 14 June 2016. Dr B's notes record that a *'7cm simple right sided ovarian cyst*' was identified via ultrasound. In a follow up letter to her GP, Dr B stated *'Scanning confirms a 7-cm simple cyst. Her left ovary appeared polycystic…'* I note from Dr B's notes of the surgery on 7 September 2016 that a 6cm right paratubal cyst was identified and removed.

19. I have included the following chronology of events detailing the complainant's treatment for ease of reference:

[8] A shallow depression on the lateral wall of the pelvis, where in the ovary lies
[9] Having many small cavities or cells

Date	Event	Outcome
15 January 2016	Patient transferred to 3fivetwo by SEHSCT as part of waiting list initiative	
29 February 2016	Initial consultation with Dr A and ultrasound scan	Dr A identified a simple 5cm **right-sided** ovarian cyst
30 April 2016	Dr A performs laparascopy on the complainant	Dr A records **right** ovary as *'normal'* with '*2-3 spots of endometriosis'* and **left** ovary as *'multiloculated'* and *'adherent to side wall'*. Abandons surgery and refers patient to Dr B.
30 April 2016	Dr A sends letter to GP	Confirms surgical findings as above
30 April 2016	Dr A sends referral letter to Dr B	Confirms surgical findings as above and states she could find no evidence of any ovarian cysts
14 June 2016	Initial consultation with Dr B and ultrasound scan	*'7cm simple **right sided** ovarian cyst*' was identified via ultrasound
7 September 2016	Dr B performs second laparoscopy on the complainant	A 6cm **right** paratubal cyst was identified and successfully removed.

Response from Dr A to complaint

20. Dr A provided a report dated 25 May 2017 to the Group in response to this complaint. Dr A stated she *"**boarded** [the patient] for a laparoscopy to treat the endometriosis and remove the ovarian cyst which was present."* Dr A stated *…"At the time of laparoscopy I identified that the pelvis was deep and the **right sided ovarian cyst** (**my emphasis**) was adherent to the pelvic side wall and the tube on*

that side. In the interest of the best outcome for the patient, I felt that it was more appropriate that [the patient] have her surgery carried out by a sub-specialist who would deal with endometriosis that is present to this extent. I am a general gynaecologist and I deal with stage 1-2 and have done for many years, however in my experience if a patient has endometriosis present at laparaoscopy extending beyond these stages the outcome ultimately is better for that patient if it is operated on by a sub-specialist in minimal access surgery and that was my assessment at the time of the surgery. I must emphasise I was acting in the absolute best interest of the patient. The appearance and difficulty of the surgery was unanticipated but again, I must emphasise that correlation with no invasive testing was poor…"

The Group's response to investigation enquiries

21. The Group stated the complainant was provided with a response as to why the cyst could not be removed. This was due to problems Dr A encountered accessing her pelvis during surgery. In relation to the complainant's concerns regarding Dr A's competency to operate, the Group stated pre-operatively she noted a 5cm ovarian cyst on the right side which she thought was the cause of the complainant's pain and planned a laparoscopy and ovarian cystectomy[10]. This was the indication for surgery, not endometriosis. However during surgery Dr A identified a very deep pelvis and could not see any evidence of ovarian cysts and therefore referred her to Dr B, a specialist in minimal invasive surgery. The Group stated there was a small amount of endometriosis in the right ovarian fossa that was seen intraoperatively. As this had not been identified before surgery, it therefore had no bearing on the decision to operate. The Group added that Dr A's competency in managing stage three and four endometriosis therefore had no relevance in the decision making process regarding surgery.

Independent professional advice dated 19 October 2018

22. The IPA was satisfied with Dr A's consultation on 29 February 2016 and advised *"History, examination, and proposed treatment plan was appropriate."* The IPA did not consider further diagnostic tests such as MRI were necessary before undertaking surgery. The IPA considered Dr A's decision to perform a laparoscopy was in accordance with clinical standards. The IPA also considered that Dr A was

[10] An ovarian cystectomy is surgery to remove a cyst from your ovary.

appropriately qualified to undertake the surgery on 30 April 2016 *"as her presumptive diagnosis for her pain symptoms was a large right ovarian cyst."* The IPA did not consider there was any evidence that Dr A should have referred the patient to Dr B before attempting the surgery. However the IPA did not consider the surgery conducted by Dr A on 30 April 2016 was according to clinical standards. The IPA advised that *…"I am of the opinion that the paratubal cyst was also present at the time of the laparoscopy in April and a thorough examination of the pelvis, adnexa and lower abdomen would have revealed its presence. The pictures from the operation are inconclusive in that the views do not allow me to confidently say that a thorough examination was carried out…"*

23. The IPA acknowledged the surgical complexity encountered by Dr A and suggested a *"surgical assistant could have been used to assist using alternative forms of uterine manipulation such as swab in the vagina."* The IPA advised *"Given all this, it leads me to conclude that the paratubal cyst was missed due to its location within bowel loops/fat…unlike difficulty in instrumenting uterus which is unexpected, Dr [A] already knew beforehand of [the patient's] raised BMI and should be aware of the associated technical challenges and the mitigating steps necessary to achieve full diagnosis and treatment."* In relation to Dr A's decision to abandon the surgery and refer the patient to Dr B, the IPA advised she acted within her limitations and in the patient's best interest. The IPA also noted the lack of surgical assistants at the two operations in April and September and advised *"…the absence of a qualified surgical assistant for therapeutic laparoscopy operations is below the standard of care expected…"*

24. The IPA concluded that *"In my opinion, on first laparoscopy, diagnosis of paratubal cyst was missed. Notwithstanding the surgical difficulties Dr [A] encountered, the missing diagnosis is unfortunate and below standard of care expected. A thorough examination of all the pelvic organs was feasible and some of the surgical challenges encountered could have been foreseen and mitigated accordingly, or if not due to lack of relevant surgical experience, an onward referral to the appropriate surgeon arranged at the outset."* In relation to the consequences of this failure, the IPA advised *"Fortunately, the delay in diagnosis and treatment has extended the patient's pain and suffering, have been first referred in Feb 2015 and finally treated*

in September 2016, but not resulted in any serious adverse outcome due to the benign nature of the paratubal cyst. The overall delay from referral to treatment is in breach of NHS commitments to safe and effective patient care, and is in need of urgent review should [the patient's] case not be an isolated event."

25. In response to the IPA, the Group stated that Dr A did not request a surgical assistant for this procedure as *'…presumably she felt it was a simple cyst and aspiration or removal would have been relatively straightforward and well within the confines of her ability and that of the nursing team supporting her that day*…' The Group stated that it is the clinical responsibility of the surgeon to bring a surgical assistant. The Group explained a first assistant can be provided by Kingsbridge Private Hospital provided sufficient notice is given to the Theatre Manager, which is custom and practice in private hospitals in NI and across the UK.

26. In relation to the laparoscopy, the Group stated Dr A had *'noted that the case was far more complex than initially anticipated. There was evidence of advanced endometriosis and adhesions consistent with advanced endometriosis (not known prior to the laparascopy) and wisely Dr [A] chose to limit the surgery to a diagnostic procedure only and to refer the patient to a more appropriate surgeon who was experienced in dealing with advanced endometriosis. The independent expert supported this*...' The Group also stated it would have been clinically reckless to insert a second port as Dr A had no intention of proceeding to extensive surgery on this patient. The Group believed the act of inserting a second port in a pelvis that was already affected by severe endometriosis would have exposed the patient to unnecessary harm.

27. The Group referred to the IPA's confirmation that the proximity of the fallopian tube and the ovary can often give a confusing picture by ultrasound or even at laparoscopy and an ovarian cyst can quite easily be confused with a paratubal cyst. The Group added that both can often get merged together and be adherent to one another especially in endometriosis. The Group disputed the patient's view that she was unnecessarily subjected to two procedures because the first surgeon was inappropriately qualified to address her problem. The Group explained that the reason for her referral was assessment of an ovarian cyst which was entirely within Dr A's competencies. The Group added it is unfortunate that the complainant

endured two procedures which ultimately was due to clinical necessity rather than a maladministrative process.

Independent professional advice dated 11 November 2018

28. The Investigating Officer sought further clarification from the IPA in light of the Group's comments. The IPA referred to the letters dated 30 April 2016 following the first laparoscopy which report findings of *'small spots/amounts of endometriosis'.* The IPA advised *'the original description therefore does not support diagnosis of advanced endometriosis and/or bowel adhesions which the recent response letter refer to.'* The IPA referred to Good Medical Practice guidance and standards on record keeping. In relation to the surgical assistants, the IPA advised *'I am happy that the organisation has the capacity for surgical assistants as necessary, and any criticism in relation to this can be deleted from my report.'*

29. The Investigating Officer sought further clarification on whether Dr A ought to have identified the paratubal cyst on 30 April 2016, given the contributing factors identified. The IPA advised *'There is no denying that the patient needed two procedures for treatment of her cyst and that on balance of probabilities, the diagnosis of paratubal cyst was missed at her first operation. The question whether this is a failing of care is complex – there were contributory factors, some expected such as raised BMI and others unexpected such as a deep pelvis and difficulties in instrumenting the uterus.'* The IPA reiterated that the presence of severe endometriosis as suggested by the Group *'is not supported by findings as documented at either of the two surgical operations'*. The IPA concluded *'Overall, given all of the above, failure to diagnose the paratubal cyst, is not a definitive failure of care, but an opportunity for the surgeon and organisation to reflect on their practice which should not be missed by either.'*

Response from Dr A to IPA dated 26 November 2018

30. Dr A explained that she detected what appeared on an ultrasound scan as a simple **left sided** (**my emphasis**) ovarian cyst. Dr A added that during laparoscopy, *'I could clearly identify a* ***cystic swelling on the left side*** (**my emphasis**) *of the pelvis which appeared multi-loculated and haemorrhagic in nature. These on the surface are the appearances of an ovarian cyst. There were multiple bowel adhesions and the cyst mass appeared densely adherent to the pelvic side wall. The appearances of*

multiple adhesions within the pelvis in my experience are present either due to endometriosis or a history of severe pelvic inflammatory disease…' Dr A stated she had to make an intra-operative decision and was concerned that she would have to divide significant adhesions to gain full mobility of the cystic structure in order to remove it which would have made the second surgery more difficult. With this in mind, on the day she felt it was in the best interest of the patient to refer her to a specialist surgeon. Dr A added *'For clarity, I referred the complainant onto Dr B for both the removal of the cystic structure as well as the treatment of any residual endometriosis that may be uncovered during that removal as he saw fit during the surgical process.'* She stated she is absolutely delighted that she ultimately did not require removal of her ovary on that side and is very sorry that the complainant did not feel her post-operative explanation of events was clear to her.

Interview with Dr A dated 6 December 2018

31. The Investigating Officer sought clarification from Dr A regarding her labelling of the diagram in her surgical notes of 30 April 2016. In particular, clarification was sought regarding her finding of a normal right ovary despite a right sided cyst having been identified on ultrasound. Clarification was also sought regarding the contradictory statements she has supplied since the complaint was made in relation to her findings. She accepted that she got the operation note wrong as she has labelled the left and right ovary the wrong way round. She confirmed that the findings should therefore be reversed and the cyst was on the right ovary. She said she normally draws a picture based on what she sees on the screen but agreed that a standardised approach to these diagrams would be beneficial.

32. Dr A also accepted that her statement in her letter to Dr B that there was no evidence of an ovarian cyst is incorrect and contradictory and that she accepts Dr B would have been confused about this. She stated the presence of severe endometriosis is what she meant by the ovary being multiloculated and adherent to side wall as this can be caused by endometriosis. She suggested that she would be happy to design a new operative proforma that has the diagram already on it and labelled.

33. Dr A stated that on reflection she should have spent more time speaking to the

complainant in more detail about what had happened during the surgery and what this would mean. She stated this case has been a learning point for her. In relation to the use of a surgical assistant, she acknowledged the point made by the IPA that this could have helped and is something she will think about in future for a potentially similar complex procedure. Dr A explained she had scrub nurses on the day who were trained to be surgical assistants but she felt it was more appropriate to refer to Dr B. She added that thankfully Dr B scanned the patient and removed the cyst on right side but appreciates that she has caused confusion.

Response from Dr A dated 11 February 2019

34. Following the interview, Dr A provided a further response to investigation enquiries. She stated that she diagnosed a **right sided** (**my emphasis**) cystic structure following a scan. During the surgical procedure, Dr A stated *'My impression without division of adhesions was that this arose from the **left side*** (**my emphasis**) *of the pelvis as I could identify the right ovary separately…'* Dr A stated she decided to stop the procedure at this point and refer the patient to a specialist. She said *'I note that the operation note describes a **left sided*** (**my emphasis**) *ovarian mass. The cystic structure actually turned out to be a **right sided*** (**my emphasis**) *paratubal cyst. Because the cystic structure was adherent and midline behind the uterus without separating adhesions etc. it was difficult for me to actually identify which side of the pelvis structure originated from. As I could identify the **right*** (**my emphasis**) *ovary separately I could confirm it did not arise from the **right*** (**my emphasis**) *ovary. The cystic structure was fixed in the midline behind the uterus covering the **left*** (**my emphasis**) *ovary from vision, the paratubal cyst was buried. I note both the Independent examiner and the medical director support my decision to record as much information as possible and refer patient on for more complex surgery. Dr B at the secondary surgery was able to separate the cystic structure from the **left*** (**my emphasis**) *ovary revealing the cyst to be a **right sided*** (**my emphasis**) *paratubal cyst. This in no way contributes to any morbidity for the patient. In fact being a paratubal cyst reduced the risk of oophorectomy for the patient.*

35. Dr A stated she noted the IPA's comments in relation to the need for a surgical assistant however had one been present this would not have changed her actions or decisions. She acknowledged the IPA's suggestion of the insertion of another

laparoscopic port to aid bowel retraction. However as pointed out by her Medical Director, the insertion of each port carries a risk of morbidity and harm to the patient. Dr A also noted the IPA's view that the proximity of the fallopian tube and the ovary can give a confusing picture at ultrasound. She added that she noted both the IPA and her Medical Director agree that the ultimate nature and location of the cyst did not affect the outcome of the case. Dr A reflected that she has found this investigation very helpful and educational to her practice and reiterated her apology to the complainant.

Independent professional advice dated 25 February 2019

36. Due to the recent response from Dr A and conflicting information, the Investigating Officer sought finalised advice from the IPA on a number of issues. In relation to Dr A's recording of the diagram in her surgical notes, the IPA advised *'At a laparoscopy, the gynaecological surgeon looking down at the pelvis through a camera introduced through the umbilicus, is perfected orientated with the patient i.e. surgeon and patient perspective are the same. Left is left, right is right, front is front and back is back. On reviewing the surgical diagram and accompanying notes/correspondence, I have no doubt that it was labelled correctly.'* In relation to the whether the cyst discovered by Dr A was found on the left or right side, the IPA advised *'The operation notes suggest a normal right ovary and a multiloculated left ovary which was adherent to the left side-wall. A multiloculated ovary does not necessarily equate to an ovarian cyst. The ovarian cyst which was diagnosed on pre-operative USS was a simple cyst i.e. not multi-loculated. The USS picture which is included in the notes confirms a uniloculated cyst.'*

37. In relation to the accuracy of Dr A's statement to Dr B that she found no evidence of an ovarian cyst, the IPA advised *'It supports her contemporaneous recording of the notes and accompanying letters to GP and referral to Dr B.'* The IPA advised that Dr A expected to find a unilocular cyst based on the ultrasound findings but did not find this and therefore concluded that there was no ovarian cyst despite having recorded a left multi-locular ovary. The IPA referred to Dr A's report dated 11 February 2019 and advised *'Overall, Dr A's new claim that she did indeed find an ovarian cyst at the operation in April, is a materially new fact being presented and one which is not supported by contemporaneous evidence as recorded in the notes.'* The IPA was

asked to provide an explanation as to why a right sided cyst was diagnosed following a scan however Dr A stated she discovered a left sided cyst during surgery. The IPA reiterated that Dr A recorded a multi-locular ovary on the left side which was adherent to the side wall but he cannot find any record confirming a left ovarian cyst. The IPA further advised that *'The exact nature of this ovary including size is not recorded, and therefore it is difficult to confirm/refute findings as per Dr A's new statement. However, as outlined above, the two descriptions multiloculated ovary vs unilocular ovarian cyst do not reconcile. It is however possible that there was a true cyst in the right ovary as seen on pre-operative USS and one which subsequently regressed in size by the time of the operation in April. Nevertheless, it still means that there was a large right paratubal cyst which was missed.'*

38. The IPA advised that Dr A's recent response *'does not reconcile with her own previous contemporaneous records. The statement does not also agree with Dr B's record of operative findings in September.'* In relation to whether Dr A failed to diagnose the presence of a right sided paratubal cyst on 30 April 2016, the IPA referred to Dr A's recent statement dated 11 February 2019. The IPA recalled that in his original report, he opined that there was a high possibility that Dr A failed to diagnose the right sided paratubal cyst. The IPA advised *'Overall, it is indeed feasible to miss the diagnosis of the paratubal cyst due to circumstances outlined in Dr A's statement in February 2019. But this is not supported by her own contemporaneous notes nor by Dr B's operation notes. Therefore, in the absence of additional corroboratory evidence from the second operation, I still opine that diagnosis of right para-tubal cyst was missed. However, allowance has to be made for the overall surgical difficulty on the day, including incomplete views of the pelvis due to difficulty in instrumenting uterus, raised BMI, and also the absence of a cyst which Dr A expected to be in the right ovary – if given these set of circumstances, Dr A did not proceed with a full exploration of the pelvis and expedited surgery for reasons of safety, then it was entirely appropriate to do so. In which case, there is no failing in care. However, Dr A statements since introducing new facts which are not corroborated by contemporaneous evidence are unhelpful and confusing.'*

39. The IPA did not consider the records supported Dr A's new statement. The IPA advised *'It is however, up to Dr A, how best to reflect on the circumstances around*

the care provided and to review her recent statement, which is both confusing and clearly makes a case for sub-standard care.' The IPA concluded that *'Dr A in all likelihood failed to diagnose the para-tubal cyst at first operation in April. This failing has to be interpreted in the background of the surgical difficulty encountered and need to deliver safe effective care in which case there is no failure in duty of care i.e. the failure to diagnose is not a failing in duty of care given the circumstances.'*

The complainant's response to the draft report

40. The complainant states that at her consultation with Dr A on 29 February 2016, she gave Dr A a detailed history of her endometriosis which indicated a level of endometriosis that Dr A herself admitted she was not skilled to operate on. She therefore believes that having been informed of her previous endometriosis, she should have referred her onto someone with expertise in dealing with advanced endometriosis. The complainant stated that she had a previous MRI scan with 3FiveTwo that showed endometriosis. She has also stated that as she was a South Eastern Trust patient, her full medical history should have been made available to aid decision making. The complainant disputes that it was reasonable for Dr A to have performed the laparoscopy on 30 April 2016 as she had given Dr A all the facts about her medical history and it is unfortunate that she was not in possession of all the facts with regards to her limitations. The complainant added she believed it was clinically reckless to operate on a patient that has level 4 endometriosis, who told the surgeon the severity of their condition and the surgeon operated anyway. She therefore believes that the investigation has not taken into account her past medical history.

41. The complainant stated she disagreed with Dr A's comment that thankfully there was no impact on the patient as she endured five months of pain and had to take two leave absences from work, which emotionally and financially impacted her. She also stated that two surgeries do impact a person and she found it very hard to recover after the second so reading this comment has upset her greatly. In relation to Dr A's record keeping, the complainant stated that it is unprofessional and lacks integrity that someone changes their report two years later. She agrees completely that the failure to record the presence of severe endometriosis in her clinical records was a failure in care and treatment. The notetaking was mentioned in numerous other

occasions in the report and she is appalled by this. She added that at the end of this process she wishes for her GP to receive a full and comprehensive report from the Group detailing the exact nature of her endometriosis. This will therefore be available to any doctor or surgeon within the Trust in future. The complainant stated she had primarily complained about Dr A however the IPA made reference to surgical assistants. Although Dr A encountered difficulty with her surgery there were none present for her second surgery which concerns her. To read in the report that the presence of a surgical assistant could have helped terrified her.

42. The complainant reiterated that if Dr A had taken her past history into consideration she would have known it was not just an ovarian cyst that she was dealing with but a complex gynaecological history incorporating endometriosis and PCOS. Before the surgery she told her she was going to remove the cyst and deal with any endometriosis that she saw which shows that she was aware of her endometriosis. The IPA does not take her past history into account when assessing any decision making. The complainant added she is well aware that endometriosis is not shown on an ultrasound as she was diagnosed via laparoscopy aged 17 which she informed Dr A of. When she was recently referred back to a gynaecologist, they read through her medical notes as she explained her history. They immediately picked up about her endometriosis and history in relation to ongoing problems. The fact that Dr A's notes are mentioned so frequently in the report worries her and makes her feel she didn't make comprehensive notes from when she first saw her.

43. The complainant stated she is more than just a fee collected from the Trust by a private hospital and that is how she has been made to feel. In the NHS she would have been passed to another surgeon immediately and this should have happened in her case. A surgical assistant would have been there to assist. She was transferred to the Group to expedite her treatment and was left instead trying to heal from a first surgery, waiting in pain for another for five months only to begin the healing process again. Her care was substandard in comparison to everything she has experienced within the NHS. She can honestly say she will never use the Group again after her experience.

<u>The Group's response to the draft report</u>

44. The Group stated it would like to first and foremost unreservedly apologise to the complainant for any inconvenience or harm she has experienced during her treatment episode and subsequent investigation. The Group is reassured that the Ombudsman has concurred that Dr A did work within her clinical abilities; albeit there were significant errors in clinical recording of information which she must take note of and remedy as part of a learning outcome. The Group will notify Dr A's responsible officer in her Trust of the outcome of the report so that this will be included in her ongoing appraisal.

Dr A's response to the draft report

45. Dr A stated she wanted to acknowledge the findings of the draft report and emphasise that she has reflected and learned from the investigation. She did not dispute the accuracy of the report. Dr A offered her sincere apologies to the complainant for any distress caused as a result of this complaint and reassures the complainant that she has taken this complaint very seriously. Dr A stated she returned to this case review after a prolonged sick leave and apologises for any confusion in her collection or reports. Dr A stated she had fully reflected on the report, particularly the aspects for learning including; accurate record keeping, labelling of diagrams and communication with patients following the procedure and complaint handling. It is very rare in her career for a surgery not to go as planned and in hindsight in these unusual circumstances she should have reviewed the complainant the following week to go over the findings in detail. In terms of active learning, she has completed a case reflection template which will be discussed at her next appraisal. She has also completed continuing professional development modules.

The complainant's past medical history

46. The Investigating Officer obtained the complainant's previous medical records from the Trust. These records state that the complainant was diagnosed with endometriosis at the age of 18 and received laser treatment in 2001. She had a laparoscopy in 1995 at which time she was told her bowel was stuck to her uterus. The Investigating Officer also obtained the complainant's MRI results following a scan by another Doctor in the Group in May 2013. The MRI report concluded *"there is no MRI evidence of significant previous endometriosis or evidence of an active*

lesion or chocolate cyst…" According to a review following the MRI, I note the record states *"This has not shown any signs of recurrence of active endometriosis which she was very worried about."*

Independent professional advice dated 7 June 2019

47. Due to the response from the complainant to the draft report and the new past medical records obtained, the Investigating Officer sought further advice from the IPA. In particular further advice was sought regarding the significance of the complainant's past history of endometriosis and whether this should have affected Dr A's clinical decision making. The IPA noted the discrepancies in Dr A's contemporaneous notes and subsequent statements and highlighted that there is simply no means to reconcile the accounts of the complainant and Dr A in a meaningful way. The IPA therefore advised that *'on the basis of contemporaneous information alone, there was no reason for Dr A to request additional information about the complainant's past medical history. Had this been requested, it would revealed that the complainant had a persistent right ovarian cyst of approximately the same size as was diagnosed by Dr A. It would have corroborated the account from the complainant that she was first diagnosed with endometriosis age 18 and that in 1995 she had undergone endometriosis laser treatment and that she had informed the doctors that bowel was found stuck to her uterus at this operation. There is no record of the actual operation in 1995 or any correspondence related to this.'*

48. In relation to the history taken and recorded by Dr A, the IPA advised *'Nevertheless, it the doctors responsibility to elicit (not the same as what is being conveyed) relevant medical history (not the same as requesting additional information) from the patient – had she done so, in all likelihood, she would have elicited information about the complainant's endometriosis, her previous operations, and, history of persistent right ovarian cyst. In making this judgement, I refer to the records from SE Trust, when Dr […'s] team had elicited similar information in 2010. I therefore conclude that Dr A's history taking was sub-optimal.'*

49. The IPA suggested that had Dr A requested this additional information, it would have resulted in a 3-6 month delay in her operation, although she would have avoided 2

operations. The IPA advised *"For the avoidance of doubt, I would not have expected Dr A to refer onwards based on the complainant's account of her medical history, but, to have offered to request her notes and review in clinic again for a definitive plan. Overall, given all of this, attempting to deal surgically with what appeared to be a simple ovarian cyst (as opposed to endometriosis) was not unreasonable. A competent gynaecologist should and would be able to deal with the cyst only irrespective of the extent of the endometriosis.'* The IPA did not think that Dr A ought to have advised the complainant of her surgical limitations if she was only dealing with an ovarian cyst.

50. The IPA concluded that *'Dr A missed diagnosis of a para-ovarian cyst at laparoscopy. Had she taken a detailed history as she claims she did, or had the complainant's past medical information been available, it would have been evident to her that the ovarian cyst in question had been present since 2010 i.e. not a new finding, and, that she was likely to encounter surgical difficulty both due to the complainant's BMI and self-reported surgical findings from her laparoscopy in 1995. Despite this, it was not unreasonable for Dr A to attempt removal of the cyst only, if she thought this aspect of the operation was within remit of her surgical competence.'*

The Group's response to IPA report

51. The Group stated Dr A did take a detailed history though, with the passage of time, cannot specifically recall exactly what the complainant listed as the specific findings at her laparoscopy 21 years previously. The decision of whether to recommend further investigation/treatment by a consultant following a consultation and detailed history is not dependent on the clinical history alone. Dr A also took into account what was recorded on the GP referral letter (which merely indicated a laparoscopy in 1995-21 years previously), abdominal and vaginal examination findings, ultrasound findings (which indicated a simple cyst as opposed to dense cyst with old blood which one would find in haemorrhagic endometriotic cysts) and inflammatory blood markers (CA 125[11] = 17; which one would expect to be much higher in advanced endometriosis). Dr A therefore felt that a laparoscopy and cystectomy was indicated.

[11] A CA 125 test measures the amount of the protein CA 125 (cancer antigen 125) in your blood

52. With respect to the history of endometriosis, Dr A would strongly contest that there was nothing to suggest severity and with the passage of time and treatment administered 21 years ago, that a clinician would expect the treatment to have made a difference. In relation to the previous MRI scan report in 2013, the Group confirmed Dr A did not have access to this which was carried out as a private patient of another consultant. The Group stated MRI's are not an effective tool for assessing severity of endometriosis and even if she had of accessed this report, it was normal. It would not have changed her decision making pathway. The Group was asked to clarify whether Dr A identified the presence of an ovarian cyst on 30 April 2016. The Group explained the presence of a simple ovarian cyst was identified by ultrasound however at laparoscopy the findings were contrary to what was expected. This is not a new phenomenon in endometriosis whereby clinical history and investigation findings do not correlate with laparoscopy findings. The Group stated a cystic structure (now confirmed to be a paratubal cyst) was amongst the adhesions and as previously explained Dr A did not intervene to avoid the risk of unnecessarily harming the complainant and instead referred her to another surgeon with the necessary experience in severe endometriosis.

Analysis and Findings

53. The complainant asserted that Dr A was inappropriately qualified to have undertaken surgery on 30 April 2016 and that she was unnecessarily subjected to two procedures. She also complained that Dr A was unable to remove a simple ovarian cyst and did not accept her explanation that as access to her uterus was difficult, the procedure was abandoned for her own safety.

54. In relation to whether Dr A was competent to have undertaken the surgery on 30 April 2016, the IPA has not identified any concerns in relation to her preparation and treatment plan in advance of the surgery. Although the complainant expressed concern at Dr A's admission that she only deals with stage one-two endometriosis, the decision to operate was based on a 5cm simple ovarian cyst that had been identified by ultrasound and not the presence of endometriosis. I therefore accept the advice of the IPA that Dr A was qualified to carry out the surgery and there was no

prior indication of the need to make a referral to a specialist in advance of the surgery.

55. In response to the draft report, the complainant stated that as she gave Dr A a detailed history of the extent of her endometriosis, this should have resulted in a referral to another surgeon with the expertise to deal with advanced endometriosis. The Group stated Dr A did take a detailed history but could not specifically recall what the complainant listed as the specific findings from her previous laparascopy. I note Dr A recorded a history of *'ovarian cyst, PCOS/endometriosis'* in her note of the consultation on 29 February 2016. Although I have no reason to dispute the complainant's assertion that she communicated her detailed past history to Dr A, I can find no corroborating evidence to support her view. I therefore cannot make a definitive finding on whether Dr A took a detailed history from the complainant.

56. I also note from the previous Trust medical records that a more detailed history is evident from the complainant's previous consultations with various Consultants over the years. Due to the lack of detail in Dr A's notes of the relevant past history, I accept the advice of the IPA that it is the doctor's responsibility to elicit relevant medical history from the patient [and therefore] Dr A's history taking was below the standard required. The General Medical Council (GMC) guidance on 'good medical practice' states that clinical records must be clear, accurate and legible. I conclude that Dr A's failure to record an adequate history during her consultation on 29 February 2016 does not meet this standard and therefore constitutes a failure in care and treatment.

57. In relation to the consequences of this failure, despite Dr A's subsequent statement that she intended to treat any endometriosis present there is no evidence to support this. Her contemporaneous records following the consultation make no reference to her intentions regarding endometriosis and only refer to her plan to remove the cyst. Therefore the severity of the complainant's endometriosis did not appear to have impacted on the decision to proceed to a laparoscopy. I accept the advice of the IPA that *'even if Dr A reviewed/been aware of the full medical history, I support her decision to proceed with surgery if she thought she was competent in managing the ovarian cyst which was the intended aim…'* I therefore conclude there was no injustice to the complainant caused by the failure to record an adequate history.

58. In relation to the potential use of a surgical assistant during the procedure, the Group has explained that Dr A did not request one and it is the clinical responsibility of the surgeon to bring a surgical assistant themselves. I note the IPA welcomed the Group's response that it has the capacity for surgical assistants and therefore retracted his previous criticism in relation to this. I will therefore accept the IPA's finalised view on the use of surgical assistants and will not consider this issue any further as it is outside the remit of this investigation.

59. In relation to the laparoscopy performed by Dr A on 30 April 2016, I am satisfied that she had identified a right sided ovarian cyst following an ultrasound scan. Her operation notes of 30 April 2016 recorded a normal right ovary and a multi-loculated left ovary that was adhesed to the left pelvic sidewall. In a referral letter to Dr B, Dr A confirmed that she was unable to identify the presence of an ovarian cyst. However this statement has been subject to some conjecture due to the subsequent contradictory statements provided by Dr A. In response to the complaint to the Group, Dr A stated she identified a right sided ovarian cyst. This is clearly contrary to her contemporaneous surgical findings and correspondence of the procedure she conducted on 30 April 2016 which state the right ovary was normal and no evidence of a cyst was found. In subsequent correspondence with this Office, Dr A has maintained that she found a left sided ovarian cyst. This statement is contrary to both her contemporaneous records and her response to the complaint which states she identified a cyst on the right side.

60. I consider these conflicting statements have been less than helpful in establishing the facts of this case, in particular whether or not Dr A identified the presence of an ovarian cyst on 30 April 2016. Although I am unable to explain or reconcile the contradictory nature of Dr A's statements, I note the IPA advised that a multiloculated ovary does not necessarily equate to an ovarian cyst. The IPA also advised that her statement to Dr B that she did not find evidence of an ovarian cyst *'supports her contemporaneous recording of the notes and accompanying letters to GP and referral to Dr B.'* Based on the balance of the evidence, I am satisfied that Dr A did **not** identify the presence of an ovarian cyst despite having observed one in advance via an ultrasound scan. Therefore I consider she provided the correct information in her referral to Dr B. Furthermore, Dr A acknowledged during interview

that she had labelled the diagram incorrectly and therefore her findings should be reversed. However I accept the advice of the IPA that the surgical diagram and findings were correctly labelled.

61. In responding to the complaint, Dr A stated that she found the presence of endometriosis extending beyond stages one-two. In responding to the IPA, the Group and Dr A have maintained that she found evidence of advanced endometriosis at laparoscopy. Dr A's surgical notes record *'2-3 spots of endometriosis'* and her letters to the GP and Dr B refer to small amounts of endometriosis. I have therefore found no contemporaneous evidence that supports a diagnosis of advanced endometriosis. I accept the advice of the IPA that the presence of severe endometriosis is not supported by the clinical records as documented at either of two surgical operations. In considering this issue, I have had regard to the GMC Good Medical Practice guidelines (2013) on record keeping. Standard 21 states *'Clinical records should include: a) relevant clinical findings b) the decisions made and actions agreed, and who is making the decisions and agreeing the actions c) the information given to patients d) any drugs prescribed or other investigation or treatment e) who is making the record and when.'* I consider Dr A failed to have recorded the presence of severe endometriosis in the clinical records in keeping with GMC standards, which constitutes a failure in care and treatment.

62. I note Dr A's letter to the complainant's GP and in her referral to Dr B on 30 April 2016 refer to *"very small spots of endometriosis"* and therefore does not state the presence of advanced endometriosis as she has subsequently suggested. I therefore consider this failure in record keeping caused the complainant the injustice of uncertainty and confusion regarding the extent of her endometriosis and the reasoning behind the clinical judgement made.

63. In relation to whether Dr A ultimately ought to have discovered the presence of a right sided paratubal cyst that was subsequently removed by Dr B, Dr A has provided a fresh explanation as to her actions on 30 April 2016. It is unclear why this explanation was not previously offered and I note the IPA's advice that it is not supported by her own contemporaneous records nor Dr B's operation notes. I accept the consolidated advice of the IPA that although Dr A's recent statement is unhelpful and confusing, the documented surgical difficulties Dr A encountered on the day

provide a reasonable explanation as to why the diagnosis of a right sided paratubal cyst was missed. I therefore do not consider this constitutes a failure in care and treatment. I am also satisfied that the decision to abandon the surgery and refer to Dr B was appropriate and in accordance with clinical standards.

64. In concluding this issue, I have found that Dr A's attempt to have located and removed the cyst on 30 April 2016 does not constitute a failure in care and treatment. I am also satisfied that the decision to abandon the procedure and refer to another specialist was appropriate and in accordance with clinical standards. However I have found a failure in care and treatment in relation to the record keeping regarding the extent of the endometriosis detected at laparoscopy. I also consider that Dr A should review her recent statement and also reflect on her responses to this investigation. Overall, I consider the care and treatment provided to the complainant by the Group was appropriate and reasonable. **I therefore do not uphold this issue of complaint.**

CONCLUSION

65. A complaint was submitted to me about the actions of the Group for treatment of a suspected ovarian cyst at Kingsbridge Private Hospital.

I have carefully investigated the complaint.

I have identified a failure in care and treatment in respect of the failure of Dr A to have recorded the presence of severe endometriosis in the clinical records. I am satisfied that the maladministration I identified caused the complainant the injustice of uncertainty and confusion regarding the extent of her endometriosis and the reasoning behind the clinical judgement made. I have also identified a failure in care and treatment in respect of Dr A's failure to record an adequate history during her consultation on 29 February 2016. However I did not identify any injustice arising from this failure.

Recommendations

66. I recommend that the Group:

i. Provides a written apology in keeping with NIPSO 'Guidance on issuing an apology' dated June 2016 to the complainant for the injustice identified in this report. I consider this apology should provide details on the lessons learned from this investigation and a commitment that the Group has taken action to implement my recommendations. The Group should provide the apology to the complainant within one month of the date of my final report;

ii. Provides confirmation to my office that Dr A has reflected upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report. These include the importance of accurate record keeping and providing clear and accurate information in responding to a complaint. An anonymised copy of the complaint, together with this report and her reflection on them, should be retained on her appraisal file, which will then be further discussed with her Appraiser and will be retained within the permanent appraisal database. This action should be provided to me within three months of the date of my final report.

iii. Provides the complainant's GP with a full and comprehensive report detailing the exact nature of her endometriosis. This report should be provided to the complainant within three months of the date of my final report.

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public bodies means:

1. Getting it right

- Acting in accordance with the law and 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.