Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 201914805

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the care and treatment provided to the complainant in July 2015 when she attended the Royal Victoria Hospital Emergency Department (ED) complaining of a severe headache. The complainant was diagnosed with a benign brain tumour and complained that following surgery, there was a delay in making a diagnosis of acquired (structural) brain injury. The complainant also said there was a failure to adequately investigate and treat the pain she was experiencing following the surgery.

I obtained all relevant information, including the complainant's clinical records, the Trust's response to each element of the complaint and relevant policies and guidance. I also obtained independent professional advice from a Consultant in Emergency and Critical Care Medicine, a Consultant Neurosurgeon, a Consultant in Rehabilitation Medicine and a Consultant Neuropsychologist.

The investigation found that when the complainant attended the ED and subsequently the Medical Consultant Decision Unit (MCDU), she should have had a CT brain scan. There was also a failure to carry out an appropriate assessment in the ED. The investigation also found that the cognitive assessment undertaken when she was referred to rehabilitation, was inadequate and there was a failure to review the complainant earlier following an MRI scan. Further, there was a failure to diagnose the complainant's structural brain injury at an earlier stage and a delay in commencing her assessment in the Community Brain Injury Team. I was satisfied that as a result of these failings, the complainant sustained the injustice of distress, frustration and there was a loss of opportunity for her to understand and accept her ongoing symptoms.

I concluded that there were no failures in the ED's consideration of the complainant's fluctuating white blood cell count, or in the investigation and management of post-operative pain.

I recommended that the Chief Executive of the Trust apologise to the complainant and made a recommendation for service improvements to prevent recurrence of the issues identified. The Trust accepted my findings and recommendations.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant said that she did not receive appropriate care and treatment in the Emergency Department (ED) of the Royal Victoria Hospital (RVH) on 7 July 2015. The complainant also said she did not receive appropriate treatment following surgery she had for a brain tumour in August 2015 and that her acquired brain injury should have been diagnosed earlier.

Background

2. On 7 July 2015, then aged 50 years, the complainant attended the ED of RVH via ambulance with symptoms including severe headache, vomiting, diarrhoea and a feeling of slow speech. She was assessed and discharged with a diagnosis of a viral headache. She was dissatisfied with this diagnosis and made a decision to cancel an upcoming holiday that necessitated long haul air travel. She attended a different ED outside of the Trust on 8 July 2015, whereupon a CT scan of her head was carried out. The CT scan showed a large parafalcine meningioma[1]. The complainant was discussed at the Regional Neuro-Oncology Multi-Disciplinary meeting (MDM) on 10 July 2015 and surgery was undertaken on 10 August 2015. Following surgery, the complainant was referred to the Regional Acquired Brain Injury Unit (RABIU)[2] where assessments were undertaken. A deterioration in the complainant's presentation resulted in a referral to mental health services. The complainant was diagnosed with an acquired (structural) brain injury in June 2017.

Issues of complaint

3. The issues of complaint accepted for investigation were:

Issue 1: Was the care and treatment provided to the patient at the Royal Victoria Hospital Emergency Department (ED) on 7 July 2015, appropriate and reasonable?

Issue 2: Was the care and treatment provided to the patient in the management of symptoms following neurosurgery, appropriate and reasonable?

[1] A tumour, arising from the membranes that surround the brain and spinal cord, located in the middle third of the brain

[2] Located at Musgrave Park Hospital within the Trust

INVESTIGATION METHODOLOGY

4. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling the complaint.

Independent Professional Advice Sought

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

- A consultant in emergency and critical care medicine with over ten years' experience (ED IPA);
- A consultant in Neurological Rehabilitation Medicine with over eighteen years' experience (R IPA);
- A consultant Neurosurgeon with over thirteen years' experience (N IPA), and
- A Chartered Consultant Clinical Neuropsychologist (Adult) and Clinical Psychologist, registered with HCPC, with twenty five years clinical experience (NP IPA).

6. I included the information and advice which informed my findings and conclusions within the body of this report. The IPAs provided 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. 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. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[3]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling

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

8. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- Ionising Radiation (Medical Exposure) (Northern Ireland) Regulations 2018 ('the IRMER regulations');
- NICE Clinical Knowledge Summary 'What features indicate a serious cause of headache?' (updated October 2019), ('the NICE CKS');
- General Medical Council (GMC) 'Good Medical Practice', 22 April 2013, ('the GMC guidance');
- Regional Acquired Bain Injury Implementation Group (RABIIG) 'Acquired Brain Injury Adult Community Care Pathway'[4] ('the RABIIG Pathway'), and
- NICE guidance on cancer services 'Improvising outcomes for people with Brain and other CNS[5] Tumours' June 2006 ('the NICE tumour guidelines').

9. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that I took into account everything that I consider to be relevant and important in reaching my findings.

10. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. I took into account all comments received and amended the report for clarity and accuracy. I include extracts from the clinician's responses at appendix six.

[4] Published by the Health and Social Care Board and Public Health Agency
[5] Central Nervous System

THE INVESTIGATION

Issue 1: Was the care and treatment provided to the patient at the Royal Victoria Hospital Emergency Department (ED) on 7 July 2015, appropriate and reasonable?

Detail of Complaint

11. The complainant said when she attended the ED in RVH on 7 July 2015 with symptoms of a severe headache, Trust staff failed to record that she had mild right sided weakness and '*slurring of speech'*. The complainant also said she should have had a CT scan of her brain. She said the reason provided by the Trust for not carrying out a CT scan of her brain, was unsatisfactory. The complainant said as a result, the Trust failed to diagnose her brain tumour.

12. The complainant said she read her notes in the RVH ED on 07 July 2015 and saw the words "?SAH/?STROKE". She does not believe that the notes that she received from the Belfast Trust are the same notes that she saw during her attendance. She believes it was possible at that time to print off a duplicate flimsy[6] containing the original registration details taken during admission such as name, address, GP, next of kin, time of registration and time and date of triage. She believes this reprinted flimsy would not have included any hand-written notes and could therefore be rewritten and rescanned and the original destroyed

13. The complainant also said that fluctuations in her white blood cell count were not properly investigated.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the NICE CKS which is contained at Appendix two of this report.

[6] ED record

15. I also considered the IRMER regulations which place an obligation on the Trust to ensure that exposure to radiation in each instance is justified and any benefits outweigh the risk to the patient.

16. I considered the GMC guidance and noted the following relevant extract contained in paragraph 15:

***'15** You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*

a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient
b. promptly provide or arrange suitable advice, investigations or treatment where necessary
c. refer a patient to another practitioner when this serves the patient's needs

***19** Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards'*

Trust's response to investigation enquiries

17. In response to investigation enquiries, the Trust said *'on arrival and following handover from ambulance staff, the presenting symptoms are consistent and accurately documented from the time of triage through to discharge'*. The Trust further said *'the ambulance staff record in their notes a GCS (Glasgow Coma Scale)[7] 15/15 with a record of normal power in the motor response of all limbs. This is consistent with the triage note that states FAST[8] negative and again [ED Consultant] records on his examination the power was 5/5 in all four limbs'.*

18. The Trust also said '*based on the presenting features, a CT scan would not have been indicated as part of the ED assessment and therefore [the complainant] was*

[7] A scoring system used to reflect the level of consciousness of patients with an acute brain injury
[8] The FAST (Face, Arms, Speech, Time) test can be performed to help recognise stroke symptoms

admitted for reassessment and review the following morning.[9] There were no new neurological symptoms and [ED Consultant] outlined the specific indicators for a CT scan at the time of [the complaints] meeting…'

19. In relation to the recording which the complainant stated she saw within her clinical notes, the Trust said the complainant '*stated at the meeting she remembers seeing the words "?SAH/?Stroke" on the ED paperwork and this was fully discussed at the meeting. Both [ED Consultant] and [staff nurse] confirmed to [complainant] that there is no mention of "SAH" (refers to subarachnoid haemorrhage) or "Stroke" in any of the documentation and that there is nothing missing from her notes. All patient ED records are electronically scanned into an I.T. system that holds the clinical notes evident of what is recorded by all staff at the time of attendance. The electronic copy also supports that there is no record of SAH or Stroke in any ED documentation and neither are there any missing notes.'*

20. On further enquiry the Trust stated:
'While a blank copy of an ED record (flimsy) can be reprinted, this is fully auditable on the symphony system. The ED record was printed at 00:38 hrs on the 07 July 2015 by the Triage Nurse (no future copies were printed), this was then scanned with the clinical information documented at 17:03 hrs by administration staff. There have been no amendments / reprinting of the clinical record. The system has been in interrogated, a second clinical record was not created, there are digital fingerprints of each user.'

21. In relation to the complainant's white blood cell count, the Trust said '*all patients discharging from hospital have a letter sent to their GP for any further follow up care required. [Complainant] was given advice on discharge; however, the Trust apologises if any information regarding her blood test was not given at the time she was leaving.'*

[9] The ED assessment includes a period of observation within MCDU (Medical Consultant Decision Unit with the Royal Victoria Hospital) in the early hours of 7 July 2015, prior to discharge

Clinical records

22. The complainant's clinical records were examined and a chronology of care and treatment was prepared. The chronology is contained at Appendix four of this report. Relevant extracts from the clinical records are also contained in Appendix five of this report.

Complaints records

23. On 30 August 2019, a meeting between ED staff and the complainant took place as part of the Trust's complaints process. The Trust provided this Office with meeting notes prepared following this meeting. The following entry is relevant to this issue of complaint:

'[ED Consultant] advised again of certain criteria to be followed when requesting a CT scan given it was 1.00 am when he had reviewed her. [complainant] said that she believed she did fit the criteria to have a CT scan at that stage, that it could have be done at any time in ED and should have been done in MCDU… [ED Consultant] went through the criteria for CT in the out of hours period'.

Relevant Independent Professional Advice

24. The ED IPA was asked about the complainant's presenting symptoms and advised '*the patient is recorded by the ambulance service to have complained of sickness, pain in the head and slow speech. At triage it is recorded that the patient had a sudden onset headache with vomiting, that she felt her speech to be slow. FAST was recorded as negative at triage. The clinical record documents a feeling of tiredness and lethargy. This had been present since waking that morning. There was an acute headache in the evening associated with an onset of vomiting just after the headache'*.

25. The ED IPA advised that the clinical record noted 'headache' in relation to diagnosis. The ED IPA advised '*there is no documented evidence of brain tumour as a possible cause for the patient's symptoms. Patients presenting with headache to an emergency department are only rarely found to have undiagnosed brain tumours. In the patients that do, concerning 'red flags' for consideration of the diagnosis include patients over 50 years of age. As [the complainant] had this 'red flag' a brain tumour should have been considered. It is*

reasonable to not document that consideration as long as the history and examination are adequately conducted and recorded.'

26. The ED IPA referred to the IRMER regulations and further advised '*based on the documented ED notes I think the patient met the criteria for a CT scan. The red flags of concern for me are a 50 year old presenting with a sudden onset headache associated with vomiting who also complained of slow speech (symptom). There is also the mild right upper limb weakness recorded at 0110hr in the observations chart. From the information recorded in the ED notes I would have requested a CT scan. My indication would have been to diagnose a subarachnoid haemorrhage rather than to identify a tumour'.* The ED IPA was asked to advise on the impact on the complainant, of the decision not to carry out a CT brain scan. The ED IPA advised '*given that there were only 2 days between her attendance at RVH ED and the diagnostic imaging I would struggle to believe there was any impact on her prognosis physically*'.

27. The ED IPA also advised '*a FAST test is a simple screening tool to help patients and carers to identify high risk features associated with a potential stroke. The documentation at triage simply says FAST negative. It does not record the individual features of the tool. A negative result implies that the patient could raise and hold both arms in the air and that the patient could speak clearly and understand what the triage nurse was saying. Slow speech is not a feature. If either assessment had been positive that should have prompted a clinical assessment to consider a stroke. As it occurred a clinical assessment had already been carried out at 0030 (prior to triage). My opinion on whether a CT should have been carried out is not based on the triage note but the documented clinician history and examination. Importantly, in of itself, the FAST test is not a gateway to a CT scan'.*

28. In relation to the complainant's account of what she saw written in her clinical records, the ED IPA said there was no such entry within the records. The ED IPA also advised that there was no evidence that SAH or stroke was considered by clinical staff as a possible diagnosis. The ED IPA repeated his previous statement that these should have been considered.

29. Further, in relation to the complainant's white cell count, the ED IPA provided a breakdown of the blood test results and advised **'***there is fluctuation. On the attendance at RVH emergency department the initial figure was 20.8 reducing to 10.5 approximately 9 hours later… This was noted at the 1415hr medical review where the patient was discharged. Both the high count and fluctuation were not of importance at that admission. It was noted in the general medical documentation that the count was high in the long term. The direction of fluctuation (down to 10.5) was noted. In the context of their working diagnosis of viral headache this is reassuring and normal. I do not think that any further action should have been taken'.*

30. In concluding, the ED IPA advised '*the emergency department assessment does not document some of the standard medical enquires about pain and also social history (did any people she lived with also have the same symptoms to assess carbon monoxide poisoning for example?) and family history (which is a strong association with aneurysmal subarachnoid haemorrhage). There is no record of a cranial nerve examination or fundoscopy*[10]*. This information may well have been elicited but is not recorded. Fundoscopy is not recorded in the general medical assessment either at initial assessment or discharge.'*

31. The Investigating Officer asked the ED IPA to consider the responsibility of the MCDU clinicians in the decision making process. He advised:

'I have already reported that I believe there was enough patient information available from the assessment in the Emergency Department to prompt a CT brain. This information was also available to the MCDU consultant. They also had available to them another 7 hours of observation, prescription records and the opportunity to re-examine the patient. It is unclear to me from the record (page 83 of ED IPA advice package) whether a physical examination took place or the patient was [as recorded] *"off ward to smoke". On the basis of the information provided I believe that both parties are separately responsible for (not) requesting the CT.'*

[10] An examination that uses a magnifying lens and light to assess the fundus of the eye (the area at the rear of the inside of the eye)

Analysis and Findings

32. I note the complainant had concerns about the care and treatment she received at the ED RVH on 7 and 8 July 2015. I will address each of the concerns raised by the complainant in turn.

Recording of symptoms

33. I note the complainant said that Trust staff did not record that she had right sided weakness and slurring of speech as additional symptoms. I reviewed the clinical records relating to the complainant's attendance at the RVH, which included both Northern Ireland Ambulance Service (NIAS) and Trust documentation. I noted a single reference to mild right sided weakness at 01.10. However, no such weakness was noted in the clinical review at 01.40. I note the Trust stated that the complainant's presenting symptoms are consistent and accurate. I also note from the clinical records that staff did note mild right sided weakness on one occasion. I am therefore satisfied that the complainant communicated this to Trust staff and it was recorded appropriately. I therefore do not uphold this element of the complaint.

34. I note the complainant also said that she had 'slurred speech' when she attended the ED. A review of the clinical records revealed that the ED record and the record made by the ST3 doctor noted the complainant felt her speech was slow. The investigation found no evidence of Trust staff recording that the complainant's speech was slurred. I note and accept the advice of the ED IPA regarding the FAST test, in that slow speech is not a feature of the test. I also note that the complainant's FAST test was negative and accept the ED IPA's advice that a positive test should have prompted consideration of a stroke rather than a CT brain scan. Similarly, whilst I have no reason to doubt the complainant's account regarding slow or indeed slurred speech, the absence of independent evidence means I am unable to conclude if the complainant had this symptom. I do however note that the ED letter from the Ulster Hospital reflects that the complainant had right sided weakness but does not mention any restrictions to the complainant's speech.

CT Brain Scan

35. The complainant also said that she should have received a CT brain scan in ED or MCDU given her presenting symptoms and this was not carried out. The complainant said when she attended a different ED on 8 July 2015, a CT brain scan was carried out which identified her brain tumour.

36. The clinical records reflect a CT brain scan was part of the complainant's management plan if her symptoms did not improve. However, the complainant was discharged from MCDU later on 7 July 2015 without a CT brain scan being performed. I note the Trust said that a CT scan '*would not have been indicated as part of the ED assessment'* and staff repeated the account provided to the complainant at the complaints meeting that there was no requirement to carry out a CT brain scan.

37. I note and accept the advice of the ED IPA that he considers a CT scan should have been carried out, in consideration of the complainants age and the sudden onset of symptoms as being 'red flags' and a brain tumour should have been considered by clinical staff. The ED IPA referred to NICE CKS in reaching this conclusion. I also accept the ED IPA's advice that SAH and stroke should also have been potential diagnoses considered by clinical staff which warranted CT scanning.

38. I acknowledge that the IRMER regulations place obligations upon Trust staff to ensure that each exposure to radiation is necessary. However, having carefully considered the clinical records, and the ED IPA's advice, I conclude that the complainant should have received a CT brain scan on 7 July 2015. I consider that this is a failure in the care and treatment provided to the complainant. I note that following her discharge, the complainant attended a different ED on 8 July 2015, whereupon a CT brain scan was carried out and her brain tumour diagnosed. I note the ED IPA's advice that given the short period of time involved, it is unlikely that the delay in CT scanning had an impact on the complainant's clinical prognosis. However, I recognise the difficulty that the failure to identify the brain tumour, placed upon the complainant to monitor her own symptoms and the potential for deterioration in her prognosis, had she not

taken the prompt action she did. She immediately cancelled a planned trip abroad in order to seek further medical assessment. I am therefore satisfied that the failure to carry out a CT brain scan before discharge from MCDU caused the complainant to sustain the injustice of distress and inconvenience.

39. In providing advice in relation to this issue, the ED IPA raised concerns regarding the record of the assessment carried out in ED. In particular, the ED IPA advised there was a lack of documentation of pain, social history and family history and there was '*no record of cranial nerve examination or fundoscopy'*. In consideration of the record of the assessment, I took account of paragraphs 15 and 19 of the GMC guidance and in light of the concerns raised by the ED IPA, I am not satisfied that the relevant standard has been met. I find this is a failure in the care and treatment provided to the complainant. However, given the short timeframe between the examination and the complainant's subsequent diagnosis, I am satisfied that the failure to appropriately record an assessment did not have an impact on the complainant's diagnosis. I therefore uphold this element of the complaint.

Recording of potential diagnosis

40. I note the complainant said that she viewed her clinical records and saw ?SAH/?stroke' noted. A careful examination of the clinical records did not reveal such reference. Further, the investigation did not reveal any missing or amended records. I also note the Trust was unable to explain the complainant's account in the complaints meeting. In response to enquiries made by this Office, the Trust interrogated the system again and confirmed that there was no evidence that a second clinical record was created.

41. I note and accept the ED IPA's advice that there was no evidence within the clinical records that Trust staff were considering either SAH or stroke as diagnoses. As previously outlined, this investigation concludes that was not appropriate. However, I am unable to draw any conclusion in relation to the complainant's steadfast account that she saw these words recorded in her clinical records. I recognise that the complainant will be disappointed that I am unable to make a finding in relation to this issue.

White cell count

42. Further, I note the complainant had concerns about fluctuations in her white cell count (WCC) and that this was not further investigated by the Trust before her discharge. An examination of the clinical records showed an overnight fluctuation in the complainant's WCC from 20.8 to 10.5. I note the fluctuation was not recorded in the complainant's discharge note. I note and accept the advice of the ED IPA that in the context of the complainant's symptoms, the fluctuation was *'reassuring and normal'* and that no further action was required. I find there was no failing in the Trust's actions in relation to the complainant's WCC. I therefore do not uphold this element of the complaint.

Issue 2: Was the care and treatment provided to the patient in the management of symptoms following neurosurgery, appropriate and reasonable?

Detail of Complaint

43. The complainant said that following neurosurgery to remove her brain tumour, she experienced symptoms such as decreased cognitive ability and reduced independence, which she reported to Trust clinicians. The complainant said that these symptoms were inappropriately attributed to her mental health, she was referred to mental health services and her acquired brain injury was not diagnosed at the earliest opportunity. The complainant also said she should have been referred to neuropsychology services earlier. The complainant further said that despite her mentioning pain at appointments, post-operative pain was not investigated and treated appropriately by the Neurosurgery department. The complainant said she was subsequently diagnosed with neuropathic pain.

44. For ease of the reader, I will consider each of the concerns raised by the complainant, in turn.

i. Diagnosis of acquired brain injury / Referral to neuropsychology

Evidence Considered

Legislation/Policies/Guidance

45. I considered the RABIIG Pathway and the NICE tumour guidelines. Relevant extracts from these documents are contained in Appendix two to this report.

Trust's response to investigation enquiries

46. The Trust said following surgery, the Consultant Neurosurgeon referred the patient *'to Rehabilitation Medicine for assessment'*. The Trust said '*when [the complainant] attended the Outpatient Clinic in the Regional Acquired Brain Injury Unit (RABIU), her history was reviewed and her concerns as to alterations in concentration and memory post-surgery were noted. At this appointment, she reported no behavioural change at that time. A cognitive assessment was carried out subsequently and this confirmed functions to be in the average to superior range. At that time, the assessment using self-reported scales, identified her as having moderate depression, moderate anxiety and hopelessness, which was felt to be related to her perceived lack of progress and concerns as to whether she would be able to return to work in the future. [RABIU Consultant]'s view was, while there was reported decrement in her cognition this could be accounted for at least in part by mood disorder arising from the totality of circumstances surrounding the diagnosis and management of her tumour.'*

47. The Trust also said '*a subsequent MRI of brain, organised by [Consultant Neurosurgeon] in April 2016 did show encephalomalacic scarring*[11] *of the brain substance but as there was also a query as to the possible residual tumour, [RABIU Consultant] deferred to Neurosurgical review and opinion. In August 2017, repeat MRI of brain confirmed scarring of frontal lobes and [RABIU Consultant], at that stage, confirmed to [the complainant] that she had structural brain injury. [RABIU Consultant] therefore accepts this represents a delay in his confirmation of structural brain injury as discussed at the previous Trust meeting of RABIU on 8 May 2019'*. The Trust further stated the RABIU Consultant *'accepts an earlier confirmation of structural brain injury should have been made*

[11] Encephalomacic scarring is a localized softening of the substance of the brain, due to bleeding or inflammation

and in hindsight, agrees that referral to Community Brain Injury Team would have been appropriately made earlier than it was'.

48. Further, the Trust said *'[Consultant Neurosurgeon] has noted the delay in the diagnosis of brain injury following her surgery and it was only following review by Psychiatry Services, that it was felt [the complainant] did not have depression…As a learning point, [Consultant Neurosurgeon], will be more cognitive of the issue of encephalomalacia documented on an imaging report. [Consultant Neurosurgeon] acknowledges it would be worthwhile highlighting this to patients and what it means in terms of subsequent follow up and surveillance. [Consultant Neurosurgeon] has noted that once [the complainant] was advised of evidence of brain injury following surgery, she was able to reconcile her symptoms with this diagnosis and felt in a better place emotionally and psychologically.'*

49. The Trust also provided an overview of neuropsychology services and indicated that services within RABIU and CBIT[12] were open for the complainant to be referred to. Specific to the complainant's care, the Trust also said *'of note, consistent with the ABI Framework, referral for outpatient cognitive assessment (OT and/or Neuropsychology) in a specialist rehabilitation centre (RABIU) occurred following [complainant] attendance for routine follow-up following hospital discharge. This pathway is open to adult patients following traumatic brain injury (TBI) or acquired brain injury (ABI). In addition, patients may also be referred to their local community brain injury service (Discharge and Leaving Hospital Leaflet No. 3) for assessment and planned rehabilitation. It is noted that in this case, [complainant] was also referred to her local community brain injury service by [Consultant Neurosurgeon] in November 2016. [Complainant] underwent further cognitive assessment in April 2018 (Report dated: 24.05.18)'.*

50. The Trust was asked to provide clarification in relation to the complainant's CBIT referral. The Trust said the complainant was referred to CBIT on 25 November 2016 and was discharged on 30 June 2018. The Trust further stated *'the Department of Health, Social Services & Public Safety (DHSSPS) has set*

[12] Community Brain Injury Team

standards for response times within ABI (Acquired Brain Injury) Services and the current maximum waiting time from referral to assessment is 13 weeks.
In this case, [complainant]'s initial assessment was commenced by Social Work within CBIT on 28 April 2017. The Trust regrets the 13 week maximum waiting time was breached as a consequence of staff shortages and staff sick leave at this time.'

Complaints records

51. Following a complaints meeting held on 8 November 2018, the Consultant Neurosurgeon prepared a note for the Service Manager. The following extract is relevant to this issue of the complaint:
'[Patient] felt there was delay in the diagnosis of brain injury following her surgery and it was only following review by [Neuro-psychiatrist] and after some difficult times following apparent drug overdoses of her analgesic control and following review by psychiatry services it was felt that she did not have depression.
[Patient] herself felt this all along that she did not have depression and a lot of her symptoms were due to her surgery and the brain injury that she had acquired as a consequence of her large tumour resection. I think once she was told that she had evidence of brain injury following surgery she herself was able to reconcile her symptoms with this diagnosis and felt she was in a better place emotionally and psychological... there is very little in scientific literature about encephalomalacia following craniotomy for tumour resection and I suppose it would be similar to scarring from any surgery anywhere in the body nevertheless it is something that probably should be reflected on and highlighted to patients on review so that patients are aware of'.

52. On 8 May 2019, a meeting was held with the complainant and clinicians from the RABIU. The minutes of the meeting reflect that the Consultant in Rehabilitation Medicine said '*at 6 months post-surgery he had discussed the scan in detail with [the complainant] and identified scarring/ encephalomalacia/ gliosis. He apologised again that he had not made the referral to the CBIT at an earlier stage…'*

Clinical records

53. The chronology contained in Appendix four is relevant to this element of the complaint.

Relevant Independent Professional Advice

Consultant in Rehabilitation Medicine IPA (R IPA)

54. The R IPA advised in relation to this element of the complaint, stating *'the patient was referred to RABIU on 29/10/15 by [Consultant Neurosurgeon], for advice on rehabilitation and return to work. In that referral letter he noted, "I have no doubt she will probably have some frontal lobe issues if more formally tested"*".

55. The R IPA advised that the April 2016 MRI scan was requested by the neurosurgery team, however the results were available at the complainant's RABIU review on 5 May 2016. The R IPA advised at that appointment *'the RABIU consultant documented a discussion on the results of the MRI scan as raising a question about tumour recurrence and that the neurosurgery consultant was looking to repeat this. There was no comment about the frontal lobe changes on the scan, and in the context of the concern about recurrence, it was in my opinion reasonable not to focus on this at this appointment… it was reasonable for the RABIU consultant to defer to the neurosurgical consultant on what could potentially have been a serious finding on the scan*.'

56. The R IPA advised that at the next RABIU review appointment on 25 August 2016, the neurosurgery opinion on the previous MRI scan was known '*however, neither the RABIU consultant nor the neurosurgical consultant commented on the frontal encephalomalacia, which was clinically significant for this patient in view of the two alternative explanations of structural brain injury or mood-related impairment for her ongoing cognitive and executive symptoms… in the original referral to RABIU, the neurosurgical consultant indicated that he expected some frontal deficits due to the nature of her tumour and surgery. Thus, in my opinion, the RABIU consultant should have had a high index of suspicion that this patient had suffered structural brain injury as an explanation of her symptoms, even*

though she had a history of mental health issues, and the findings of both the 11/4/16 MRI scan and in fact the previous 21/9/15 CT scan confirms this suspicion.' The R IPA advised the review on 25 August 2016 represented *'a missed opportunity to review the scan findings in the context of ongoing symptoms… and either reach a diagnosis of acquired brain injury at that appointment or request a further opinion. In my opinion, this would not however have changed the patient's final functional outcome but it would have assisted her in achieving a clearer understanding of her problems sooner.'*

57. The R IPA also advised that the RABIU team arranged for cognitive and mental health assessments in March 2016. The R IPA advised these assessments were '*comparable…and essentially reasonable'*. However the R IPA advised that the results of these assessments were made known to the RABIU Consultant and if '*the ongoing patient complaints of decline in cognitive functioning had been reviewed in the context of the finding of structural frontal lobe injury, then the conclusion reached subsequently on 24/5/18 by the Community Brain Injury consultant neuropsychologist of executive function impairments due to brain injury, could have been achieved sooner'.* The R IPA raised concerns about the lack of direct involvement from a neuropsychologist and advised '*it is unclear why the patient was not referred directly to the Community Brain Injury Service'*.

58. The R IPA also advised *'in my opinion, there was evidence that the patient had sustained a brain injury which was available to the RABIU consultant at the time she was first seen in clinic on 17/12/15'* and provided reasons for reaching this conclusion.

Consultant Neurosurgeon IPA (N IPA)

59. The N IPA reviewed the scan images and in relation to the MRI scan dated 11 April 2016 provided the following advice:
'The MRI head scan report dated 11/04/2016 has been reported as revealing postoperative cystic encephalomalacic changes in the frontal lobes with mild postoperative dural enhancement and most likely nodular scar tissue within the surgical defect in the medial right frontal lobe. I agree with the report and would like to point out that the radiology report is not required to state whether there has

been an acquired brain injury or not. It was reasonable for the Consultant Neurosurgeon to conclude that the scan image did not show recurrence of the tumour / most likely graft.'

60. The N IPA further advised that following review of the scan images, the Consultant Neurosurgeon wrote to the complainant on 20 April 2016 '*stating that the recent MRI scans had been reported and did not reveal any obvious tumour residuum or recurrence and simple revealed mild enhancement of the dural region. The Consultant Neurosurgeon conveyed that the scans were quite reassuring and that he was going to review [the complainant] in the outpatients in the coming months…the letter to the patient detailing the salient points of the MRI scan findings was appropriate and reasonable. The plan to review her in clinic in due course was also appropriate and reasonable. My only criticism is that perhaps the patient should have been reviewed in the clinic sooner i.e. by May June 2016 rather than the eventual clinic appointment in November of 2016. An earlier review within 6 weeks after the scan would have been preferable in order to explain the scan findings in greater detail in person (not feasible or advisable over the phone or in a letter) and to assess the patient clinically. However, an earlier review would not have altered the outcome or prognosis'.*

61. Referring to the detail within the letter dated 20 April 2016, the N IPA advised *'it was also reasonable not to mention the postoperative encephalomalacic changes on the scans as this would have needlessly worried the patient, would have been difficult to explain satisfactorily and appropriately in a letter and were expected postoperative findings… The clinical diagnosis of acquired brain injury is made by the clinicians looking after the patient, in this case, the Consultant Neurosurgeon. The condition is however, managed more appropriately by Consultants in neuro-rehabilitation'.*

Consultant Neuropsychologist IPA (NP IPA)

62. Due to the concerns raised by the R IPA and the N IPA in relation to the role of neuropsychology, advice was sought from the NP IPA in relation to those aspects of the complaint. Advising generally about the role of the neuropsychology team, the NP IPA advised that there was '*very limited involvement'* and *'in this case the*

neuropsychology team received a referral to assess the patient and provide support. A trainee clinical psychologist carried out a joint assessment with an occupational therapist. A joint report was prepared and the results fed back to the patient, possibly via the Consultant in Rehabilitation Medicine…the patient continued to report cognitive problems in outpatients and so she was referred to another neuropsychologist, who felt that as there was no regrowth of the tumour, the patient would best be seen by the CBIT, who could carry out an assessment and provide care as part of a multidisciplinary team. A neuropsychologist in the CBIT subsequently carried out a more comprehensive assessment'.

63. The NP IPA provided advice in relation to the assessments which were carried out at the request of the RABIU team in March 2016. The NP IPA advised: *'The core test within the cognitive assessment was the RBANS, a neuropsychological screening measure with a limited emphasis on so-called executive functions, i.e. those abilities most often associated with frontal lobe functions. We know the patient had a bifrontal resection and was aiming to return to a demanding and responsible job, therefore a robust comprehensive assessment would have been more appropriate, akin to that carried out later in the CBIT. This would include premorbid ability and executive functions (as indicated in the previous section). Executive functions were barely assessed in this report and not mentioned…'* The NP IPA referred to a later *'neuropsychological assessment report dated 24th May 2018, relating to an assessment the patient had had through the CBIT, Consultant Clinical Psychologist. This was a more comprehensive assessment than the one carried out in March 2016 and highlighted considerable difficulties with executive functioning.'*

64. The NP also advised '*the conclusion of the report placed a great emphasis on psychological reaction, and there seems to have been a view that should the mood improve, then so would the cognition. Whilst that can occur, dysexecutive syndrome adds complexity, for example, this is associated with emotional dysregulation. Had the executive problems been more actively considered, there may well have been a plan for neuropsychiatry involvement, and further neuropsychology sessions for some psychoeducation around the issues with*

rehabilitation sessions to help manage the cognitive and emotional sequalae'.

65. In relation to the recommendations following the assessment, the NP IPA advised '*while the trainee and [Consultant in Rehabilitation Medicine] both noted some decrement in memory and attention and reactive low mood the patient did not seem to have been offered any rehabilitation strategies. It was also not clear from the report which tests the psychologist carried out and which tests the occupational therapist carried out. It is assumed both agreed with the recommendations.'*

66. The NP IPA also advised a psychiatry referral '*may have been more timely and considered as a recommendation from the March 2016 neuropsychology / neurorehabilitation intervention'.* The NP IPA advised on the referral to Clinical Psychology in November 2016, and advised that the decision to refer to the CBIT *'appears to have been made to not see the patient merely because she had been seen in March 2016, rather than considering the current referral and the previous report – which could have resulted in another assessment, which hopefully would have been more adequate'*. The NP IPA further advised *'the mere fact that [the assessment] had been carried out seems to have influenced [CP B[13]]'s decision to not review the patient and another opportunity to consider the impact on executive functions was missed. The CBIT would have been an appropriate service to see her, however there was a long delay between referral and assessment, during which the patient deteriorated in her mental state…'*

67. In relation to the impact on the complainant's prognosis, the NP IPA advised the inadequacy of the assessment undertaken '*caused delay in the in the understanding and management of her neuropsychological condition, in that it seems to have limited the patient's access to neuropsychological rehabilitation. It is difficult to say whether that would have prevented subsequent distress and return-to-work / retirement planning, but one of the aims of rehabilitation would be to ameliorate the impact of such problems'.*

[13] CP B is s second Consultant Clinical Psychologist who reviewed the Consultant Neurosurgeon's referral in November 2016

Analysis and Findings

68. I note the complainant said that her post-surgical symptoms were not considered appropriately and as a result she was referred to mental health services and her structural brain injury went undiagnosed. The investigation established that the complainant was referred to a Consultant in Rehabilitation Medicine on 15 October 2015, following a review by the Consultant Neurosurgeon. The clinical records indicate that this referral was prompted by the complainant's enquiry regarding returning to work and not by any clinical need. I note at the outset that there is limited guidance in relation to this clinical area.

69. The investigation also established that the first appointment with the Consultant in Rehabilitation Medicine in the RABIU was on 17 December 2015. The record of this review reflects it was determined that an Occupational Therapy (OT) and psychology assessment were appropriate. The record of the review does not note any concerns raised by the complainant in relation to symptoms. I note the psychological assessment was carried out by a Trainee Clinical Psychologist under the supervision of a Clinical Psychologist on 14 March 2016. Further, I note and accept the advice of the R IPA and the NP IPA that this assessment concluded that the complainant was within the average range in terms of her memory, attention, concentration, language construction and visuo-spatial construction skills. The assessment also indicated '*moderate depression and anxiety*'.

70. The investigation established that this assessment played a significant role in the events leading to the delayed diagnosis which is subject of the complaint. I note and accept the advice of the NP IPA that the core test adopted in the assessment was the RBANS, which was not considered appropriate by the NP IPA due to its limited assessment of executive functions and absence of premorbid assessment. The investigation found no guidance to determine the type of testing and assessment to be adopted in such cases. Moreover, the NP IPA advised that this is within the clinical judgement of the treating Psychologist given the circumstances of the case. I note the advice of the NP IPA that they

could find no reason why a more comprehensive assessment was not carried out, particularly given that the Consultant Neurosurgeon had highlighted to the Consultant in Rehabilitation Medicine the strong possibility of frontal lobe issues. Further, the Consultant in Rehabilitation Medicine noted in his clinic letter following review on 21 February 2021 that the purpose of the referral to RABIU was for cognitive assessment. I consider it a failure in the care and treatment provided to the complainant that a more appropriate, comprehensive method of assessment was not undertaken in this case.

71. I also note and accept the NP IPA's advice that the assessment did not offer any rehabilitative strategies or goals to deal with her symptoms, and that a psychiatry referral was not recommended, both of which the NP IPA advised would have been appropriate. I note the Trust stated that only after the review by Psychiatry services was it determined that the complainant did not have depression. I consider had an appropriate assessment been carried out in March 2016, this conclusion could have been reached at an earlier point. I consider that this assessment appears to 'stand alone' rather than form an integral element of the complainant's recovery. I find that the failure to make appropriate recommendations following the assessment constitutes a failure in the care and treatment provided to the complainant.

72. Further, the NP IPA advised that it was inappropriate that the result of the assessment was communicated back to the complainant by the Consultant in Rehabilitation Medicine and not as part of a review by the Psychology Team. I make an observation to the Trust to consider this as part of the learning from this complaint.

73. I find that the failure to carry out an appropriate assessment, and make appropriate recommendations caused the complainant to sustain the injustice of frustration and represented a missed opportunity to identify underlying issues with the complainant's cognitive functioning, and to aid her understanding of her symptoms. The NP IPA advised on the impact of the inadequate assessment undertaken. I note and accept the advice of the NP IPA that it is uncertain what impact understanding her symptoms better would have had on

the complainant. I also note and accept the advice of the NP IPA that a more appropriate, comprehensive assessment was carried out in May 2018 when the complainant was referred to CBIT.

74. The investigation determined that on 11 April 2016, the complainant had a further Brain MRI Scan which was requested by the Consultant Neurosurgeon. I note the report of this scan stated '*nodular and linear enhancing material is likely to reflect scar tissue, but it is difficult to exclude residual tumour, and follow up scanning is therefore advised'.* When the complainant was reviewed by RABIU on 5 May 2016, this result was available to the Consultant in Rehabilitation Medicine, together with outcome of the March 2016 assessment. I note from the clinical records dated 5 May 2016 and the R IPA's advice that the results of the assessment and the MRI scan were communicated to the complainant. I note and accept the advice of the R IPA that it was reasonable for the Consultant in Rehabilitation Medicine to refer to the opinion of the Consultant Neurosurgeon in relation to the scan findings.

75. I note from the clinical records and the N IPA's advice that the Consultant Neurosurgeon sent a letter to the complainant on 9 May 2016 outlining his review of the scan images/report. I accept the N IPA's advice that the opinion of the CN that the scan images were reassuring and *'did not reveal any obvious tumour residuum or recurrence',* was reasonable. I also accept the N IPA's advice that providing the complainant with this information via letter and arranging a clinic review, was also reasonable. However, the N IPA advised that an expedited review, within six weeks of the scan, would have been 'preferable' however it would not have altered the outcome or prognosis.

76. I note and welcome the Consultant Neurosurgeon's comments in a further response to the draft report in which the findings are accepted. He states that he realises the distress and anxiety this finding caused the complainant in this instance and in hindsight would have offered an earlier review appointment to discuss this. He explains that he now has a greater awareness of post-surgical findings such as encephalomalacia on a scan and to communicate these to the patient in a timely manner.

77. I consider that the decision to await the later review date in November 2016, deprived the complainant of the opportunity to seek further information about the scan findings, and notably how she might be clinically impacted by it. I note this was envisaged by the Consultant in Rehabilitation Medicine in the clinic letter following his review on 5 May 2016. I also accept the advice of the N IPA that an earlier review would have allowed a further clinical examination of the complainant, whereupon her cognitive functioning issues could have been highlighted. I am also pleased to note that the Consultant Neurosurgeon accepts that whilst the information available on encephalomalacia is limited, patients should be informed of the potential for occurrence. I conclude that the failure to offer an earlier review constitutes a failure in the care and treatment provided to the complainant. I am satisfied that as a result of this failure, there was a missed opportunity to identify her structural brain injury and also for her to understand her condition and symptoms better.

78. I note from the clinical records and the R IPA's advice that the next review of the complainant took place in RABIU on 25 August 2016. I note from the clinical records and the R IPA's advice that the Consultant in Rehabilitation Medicine did not address the April 2016 scan findings with the complainant at this review appointment. The investigation did not uncover any evidence that the complainant's symptoms (with the exception of headaches) were discussed during this review. I accept the R IPA's advice that given the indication by the Consultant Neurosurgeon, the Consultant in Rehabilitation Medicine '*should have had a high index of suspicion'* that the complainant had suffered a structural brain injury as an explanation for the symptoms identified within the cognitive assessment. I therefore consider the failure to evaluate this assessment, with the complainant's symptoms and the scan findings, represents a further missed opportunity to make the diagnosis of structural brain injury at an earlier stage. I am satisfied that the complainant now also sustained the injustice of frustration regarding the failure to reach this diagnosis sooner. I consider the delay deprived the complainant of the opportunity to better understand her symptoms and condition, and may have allowed her access to the supports provided for within the RABIIG guidance, particularly those provided by the CBIT which she did later receive. However, I accept the

R IPA's advice that there is no evidence that an earlier diagnosis would have changed the clinical outcome for the complainant.

79. The investigation also uncovered on 9 November 2016, the complainant was again reviewed by the Consultant Neurosurgeon. The clinical records reflect at this appointment, it was noted that she '*continues to suffer a lot*' of various symptoms including difficulties with cognitive functioning. The Consultant Neurosurgeon noted that it would be '*very helpful'* for her to be seen by one of the Neuropsychologists and she was referred accordingly. I consider the necessity for the referral to Neuropsychology is further evidence that the March 2016 assessment, was inappropriate and if appropriate recommendations had been made on foot of that assessment, the second referral may not have been necessary. I note the key role played by neuropsychology and neuropsychiatry in the management of such patients as outlined in the NICE tumour guidelines.

80. I note that following receipt of the referral, CP B sent a letter to the Consultant Neurosurgeon on 28 November 2016 indicating that the Community Brain Injury Team (CBIT) may be a more appropriate referral for the complainant and cited reasons for this. The NP IPA noted the one of the reasons cited was that the complainant had previously undergone a cognitive assessment, and advised that the suitability and adequacy of that previous assessment was not considered. I note and accept the advice of the NP IPA that this represented a further missed opportunity to consider the complainant's cognitive functioning. However, I also accept the NP IPA's advice that the CBIT was an appropriate service to review the complainant, and this may have been an appropriate referral in March 2016 had the cognitive assessment been adequate and appropriate. A CBIT referral at that point may have allowed the complainant to avail of the RABIIG pathway services.

81. In response to the draft report, the Consultant Clinical Psychologist explained his rationale for his decision and accepts the findings in the report that a comprehensive assessment was required. I note and welcome that he states that he will reflect on learnings from this case, and will discuss with neuropsychological services for brain injury. I include his response to the draft

report at appendix six of this report.

82. The NP IPA also referred to the CBIT referral, and advised that there was a '*long delay between referral and assessment*'. I note from the clinical records that the complainant was referred to CBIT on 25 November 2016 and accepted for assessment on 29 November 2016. The Trust informed the investigation that the complainant's assessment commenced on 28 April 2017, some 22 weeks after the referral was made. I note the Trust also stated it regretted the 13 week target time was not met. I accept the advice of the NP IPA that during this waiting period, the complainant suffered a deterioration in her mental health. I consider the delay in commencing the assessment represented a failure in the care and treatment provided to the complainant, and was heightened by the possibility that a referral may have been appropriate sooner. I consider that the failure of the CBIT to commence the process sooner caused the complainant to now sustain the injustice of frustration. I also accept the advice of the NP IPA that during the time spent awaiting the assessment, the complainant experienced a deterioration in her mental health. I therefore uphold this element of the complaint.

ii. Post-operative pain

Evidence Considered

Trust's response to investigation enquiries

83. In response to investigation enquiries, the Trust said *'in [Consultant Neurosurgeon]'s experience, it is unusual for a patient to experience post-craniotomy neuropathic pain[14]. As indicated in his letter dictated 9 November 2018 following his meeting with [complainant] on 8 November 2018, his standard analgesia regimen to manage post-operative wound pain is initially simple analgesics such as paracetamol followed by stronger opioid-based analgesics (e.g. codeine, tramadol) should the pain be more refractory. In some cases, a short-acting opioid may be required to manage the pain in the first week or so*

[14] Neuropathic pain is caused by damage or injury to the nerves that transfer information between the brain and spinal cord from the skin, muscles and other parts of the body. The pain is usually described as a burning sensation and affected areas are often sensitive to the touch

after surgery.

Sometimes, a non-steroidal anti-inflammatory analgesic such as Ibuprofen may be required and the anti-inflammatory effects of steroid medication (many brain tumour patients will already be on dexamethasone) may also help manage post-craniotomy wound pain. It may take some months for wound pain to eventually settle down.'

84. The Trust also said '*should a patient have persistent pain 6-12 months after surgery, [Consultant Neurosurgeon] would consider referring them on to a pain specialist. [Consultant Neurosurgeon] would also consider seeking the help and advice of a neurologist in diagnosing and managing neuropathic pain. [Consultant Neurosurgeon] continued to monitor [complainant]'s progress following surgery and she was reviewed in his outpatient clinic in October 2015…'* The Trust referred to the review carried out by the Consultant Neurosurgeon on 9 March 2016 and said *'she still had ongoing headaches and a lot of discomfort around the site of previous surgery, but she had managed to come off the morphine. From this, [Consultant Neurosurgeon] inferred that [complainant]'s pain requirements were reducing.'*

85. The Trust further said '*when [Consultant Neurosurgeon] next reviewed [the complainant] in November 2016, she was still struggling with the pain but she had already been referred to her local pain clinic at the Ulster Hospital by her GP. [Consultant Neurosurgeon] did not feel there was anything further he could suggest at that stage, as the appropriate referral had been made for pain management.'*

86. The Trust referred to the review carried out by the Rapid Access Neurology Team on 25 September 2015. The Trust said it was '*noted [complainant] had indicated she was much improved and felt back to baseline. [Consultant Neurologist] referred to the CT scan of 21 September, which showed an improvement of the previous findings; in particular, there was no evidence of acute haemorrhage or any other acute abnormality… A few weeks later, on 15 October 2015, [the complainant] was seen at [Consultant Neurosurgeon]'s Outpatient clinic. [Consultant Neurosurgeon] has documented how pleased he*

was that [the complainant] was making a good recovery following her surgery; her wound had healed well and she had had no further neurological issues since surgery. [The complainant] had enquired about returning to work at this stage.'

87. Referring to the subsequent reviews, the Trust said '*an appointment at RABIU was arranged for 17 December 2015. [Consultant in Rehabilitation Medicine] has noted [complainant] suffered from pressure-like headaches immediately after surgery, which have now improved markedly… At his clinic at the Ulster Hospital on 4 January 2016, [Consultant in Pain Management] recommended [complainant] reduce the Epilim to stop. He did not think [complainant] had a predominantly evident cognitive deficit and suggested she should discuss a phased return to work with her occupational health service. There was no mention of headaches in [Consultant in Pain Management]'s clinic letter. [Consultant Neurosurgeon] has noted [complainant] still had ongoing headaches and some nausea when he reviewed her at his clinic on 9 March 2016. He also mentioned she had a lot of discomfort around the site of previous surgery…'*

88. Finally, the Trust said *it 'is truly sorry [complainant] suffered from a significant level of pain in her head, despite various medications being prescribed to control the pain. In the notes of the meeting on 8 November 2018, [Consultant Neurosurgeon] has mentioned issues with an undiagnosed neuropathic element of pain and apologised for the delay in advising [complainant] of this.'*

89. In the Consultant Neurosurgeons letter dated 9 November 2018, I note the following extract relevant to this element of the complaint:

'*Wound pain: [complainant] felt that there issues in relation to an undiagnosed neuropathic element of pain in relation to her wound. This was not (sic.) delayed until quite sometime after her surgery and may well be due to some neuropraxia*[15] *of the scalp subcutaneous nerves possibly supraorbital nerve. She attended a Pain Clinic and I understand she was referred in December 2016 by her GP…'.*

[15] Neuropraxia is a mild form of traumatic peripheral nerve injury

Clinical records

90. The chronology contained in Appendix four is relevant to this element of the complaint.

Relevant Independent Professional Advice

91. The N IPA provided an overview of the references to pain within the complainant's clinical records. The N IPA also advised:
'It appears that by October 2015, [complainant] had managed to come off the morphine and by March 2016, the headaches had been recognised and were being managed effectively with the help of p.r.n[16] medication. However, by November 2016, according to the Consultant Neurosurgeon's clinic letter, it appears that [complainant] had been referred to the pain team at Ulster Hospital for management and I think this is appropriate'.

92. The N IPA was asked about the impact of any delayed diagnosis on the complainant's prognosis. The N IPA advised:
'Postoperative neuropathic pain though a rare condition is notoriously difficult to treat and I do not think it has had any impact on the patient's overall condition and prognosis. It is usual practice to manage postoperative pain with paracetamol, NSAIDs or opioid-based analgesics such as codeine or tramadol. When the Consultant Neurosurgeon met up with the patient in March 2016, six months after the surgery, even though she still had headaches and discomfort around the wound site, it can be a common finding and it is usual practice to carry on oral analgesics.
However, when he reviewed her in November 2016 and she was still struggling with pain, that is the time when we would escalate it to the pain team but by then [complainant] had already been referred to the pain clinic by her GP. This was an appropriate referral. At this point, the Neurosurgery team, could not have done anything more apart from waiting to see the outcome of the pain management advice from the Pain Clinic. Apart from the pain that the patient experienced, I do not feel that she came to any harm.'

[16] Pro re nata – as and when required

Analysis and Findings

93. The Consultant Neurosurgeon further explains the amendments to current standard practice since 2016 with the inclusion of relevant information booklets to patients. He outlines the changes and the introduction of a keyworker for patients. I note the complainant said that the pain she was experiencing in her head after her surgery was not fully investigated by the Neurosurgery department. The complainant said she was subsequently diagnosed with neuropathic pain and this is accepted by the Trust. I note at the outset that the investigation did not find specific guidelines in relation to this area of clinical practice. I also note the Trust commented that neuropathic pain post surgery is '*unusual'* and the N IPA's advice that it is a '*rare condition'* and '*notoriously difficult to treat'*

94. The examination of the clinical records with reference to pain noted by the complainant revealed that following attendance at the ED on 21 September 2015, complaining of pressure headaches, she was reviewed by the Neurology Team on 25 September 2015. The Trust indicated that at that appointment, the complainant '*felt back to baseline'*, however what that baseline was, was not noted. I also note pain was reported at the first review by Neurosurgery in October 2015, but that she had discontinued some of her pain medication. I note and accept the advice of the N IPA that pain at this time could be expected. I also note it was recorded in the March 2016 review that the complainant was continuing to experience pain and the records reflect that the pain medication was continued. I note and accept the N IPA's advice that it is 'usual practice' to carry on oral painkillers in such cases.

95. I also note that when the complainant was reviewed in November 2016, she reported pain to the Consultant Neurosurgeon. The Trust said that at that stage, it would be the Consultant Neurosurgeon's practice to seek input from the pain clinic, however the complainant had already been referred by her GP to that team. I note the Consultant Neurosurgeon commented on the length of time taken for the complainant to be reviewed by that team. However, this was

not an issue accepted for investigation by this Office.

96. I note and accept the advice of the N IPA that at this stage, the Neurosurgery team could not have done anything more for the complainant and that it is not felt the complainant came to any harm as a result. I therefore conclude that there is no failing in the care and treatment provided to the complainant in relation to this issue and I do not uphold this element of the complaint.

CONCLUSION

97. I received a complaint about the care and treatment provided to the complainant by the Royal Victoria Hospital ED, when she was diagnosed with a viral headache. The complainant was diagnosed with a benign brain tumour two days later and underwent surgery the following month. The complainant also said that following surgery, there was a delay in making a diagnosis of acquired (structural) brain injury. She complained that symptoms were wrongly attributed to depression. The complainant also said there was a failure to adequately investigate and treat the pain she was experiencing following the surgery. She states that these failings caused her emotional and psychological trauma.

98. The investigation identified the following failures in care and treatment:

- Failure to carry out a CT brain scan in the ED or MCDU;
- Failure to carry out an appropriate cognitive assessment;
- Failure to make appropriate recommendations following psychology assessment;
- Failure to carry out an earlier neurosurgery review;
- Failure to diagnose structural brain injury at earlier stage, and
- Delay in commencing assessment in CBIT

I am satisfied the failures caused the complainant to sustain the injustice of distress, frustration and loss of opportunity.

99. The investigation also identified that there was a failure to carry out an appropriate assessment in the ED. However, it was determined that no injustice resulted from this failure.

100. The investigation did not find failures in the following issues raised by the complainant:

- actions regarding fluctuation in WCC, and
- Investigation and management of post-surgical pain.

Recommendations

101. In my draft report I recommended that the Trust's Chief Executive provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified. However the complainant has indicated that she would not accept an apology from the Chief Executive.

102. As a result of the findings in this report and bearing in mind the accuracy principle of the General Data Protection Regulation (GDPR)[1], I recommend the Trust reviews the complainant's records and takes appropriate action in line with ICO guidance to ensure that the records are compliant with this principle in relation to the incorrect assertion in 2016 of anxiety and depression. This is to ensure that those reviewing the complainant's medical records are aware that this diagnosis was incorrect and has been superseded

102. I further recommend the Trust take the following steps for service improvement and to prevent future recurrence:

[1] Article 5(1)(d) of the UK GDPR states
1. Personal data shall be: (d) accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay ('accuracy')"

a. Ensures that all ED clinicians involved in the complainant's care have the opportunity to consider the findings in this report, and demonstrate that those individuals whose actions have been criticised have reflected on how they can improve their practice in future;
b. Provides evidence that the Consultant Clinical Psychologist had the opportunity to reflect on learnings and discuss with neuropsychological services for brain injury in accordance with the intention noted at appendix six.
c. Ensures that all RABIU staff involved in the complainant's care have the opportunity to consider the findings of this report, and demonstrate that those individuals whose actions have been criticised have reflected on how they can improve their practice in the future;
d. The relevant team within the RABIU should review its practice in line with the R IPA's conclusion: '*I have recommended that the RABIU team as a whole review their processes in light of this case'*, and
e. Provides evidence of use of the information pack now provided to patients following neurosurgery (as described in appendix six).

103. The complainant has stated that an apology alone is not sufficient to provide redress for the trauma she has suffered. I therefore recommend that the Trust implements an action plan to incorporate my recommendations and provides me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken including, where appropriate, records of reflective accounts, relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies.

Margaret Kelly
Ombudsman **8 June 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers 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.