Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Southern Health and Social Care Trust

NIPSO Reference: 201916340

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

TABLE OF CONTENTS

	Page
SUMMARY …………………………………………………………	4
THE COMPLAINT ……………………………………………….	5
INVESTIGATION METHODOLOGY ………………………….	6
THE INVESTIGATION …………………………………………..	8
CONCLUSION …………………………………………………...	23
APPENDICES …………………………………………………….	24

Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 22585 / 201916340

Listed Authority: Southern Health and Social Care Trust

SUMMARY

This complaint is about care and treatment the Southern Health and Social Care Trust (the Trust) provided to the complainant's mother (the patient) in 2017 and 2019 for hypothyroidism[1]. The complainant was concerned the Trust only considered blood tests when treating the patient's condition. He said it incorrectly adjusted the patient's medication, and raised concerns about the dosage of levothyroxine[2] prescribed. He raised further concerns about the Trust's failure to undertake genetic testing to diagnose Non-classic Congenital Adrenal Hyperplasia[3] (NCAH).

The investigation examined the details of the complaint, the Trust's response, clinical records, and relevant guidance. I also sought advice from an independent consultant endocrinologist (E IPA). The investigation established the Trust treated the patient in accordance with relevant guidance for both admissions. It also found the Trust tested the patient for NCAH in 2017 and 2018, producing negative results on both occasions. While the investigation established the Trust did not perform the genetic test the complainant requested, it found its decision not to do so appropriate. I did not uphold this issue of complaint.

The complainant also raised concerns about how the Trust dealt with his complaint. He said the Trust failed to provide clear reasons for its detention of the patient in October 2017. The investigation found the Trust sufficiently responded to this issue. The complainant also said the Trust failed to investigate why information in carer reports conflicted with statements in its own reports. The investigation found the Trust failed to make sufficient enquiries regarding this issue of complaint. I partly upheld this issue, finding it led the complainant to experience frustration and uncertainty. I recommended the Trust apologise to the complainant. I also recommended action for it to take to prevent the failure recurring. The Trust accepted my findings and recommendations.

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[1] When the thyroid gland does not produce enough hormones (also referred to as underactive thyroid).

[2] A medication used to treat thyroid hormone deficiency.

[3] A group of genetic disorders that affect the adrenal glands. The non-classic form is milder and more common, and may not become evident until childhood or early adulthood.

THE COMPLAINT

1. This complaint is about care and treatment the Southern Health and Social Care Trust (the Trust) provided to the complainant's mother (the patient). The complainant raised concerns with the patient's hypothyroidism[4] diagnosis and the Trust's treatment of the condition in 2017 and 2019. He said the Trust wrongly prescribed the patient high levels of levothyroxine[5] to treat the condition. He also said the Trust failed to appropriately test the patient for Non-classic Congenital Adrenal Hyperplasia[6] (NCAH). The complainant also raised concerns with how the Trust handled his complaint.

Background

2. The patient's community General Practitioner (GP) diagnosed her with primary hypothyroidism in 2005 and prescribed levothyroxine. In April 2016, the patient developed dementia. From July 2017, the complainant raised concerns about the effect levothyroxine had on the patient, specifically on her symptoms of dementia. In October 2017, the Trust detained the patient under the Mental Health (Northern Ireland) Order and admitted her to a Memory Centre within the Trust area. The complainant said that while detained, doctors increased the patient's levothyroxine medication and she became increasingly agitated.

3. The Trust admitted the patient to Craigavon Area Hospital (CAH) due to a knee complaint in January 2019. The complainant said that during her admission, Trust staff again increased the patient's levothyroxine medication.

4. The complainant considered the patient's diagnosis of hypothyroidism incorrect and believed she instead had NCAH. He said despite his requests, the Trust failed to appropriately test the patient for the condition. The patient sadly passed away in February 2020.

5. The complainant first raised concerns to the Trust about its treatment of the patient in December 2017. The Trust closed the complaint the same month, marking it as '*informally resolved*'. He raised two further complaints in May

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[4] When the thyroid gland does not produce enough hormones (also referred to as underactive thyroid).

[5] A medication used to treat thyroid hormone deficiency.

[6] A group of genetic disorders that affect the adrenal glands. The non-classic form is milder and more common, and may not become evident until childhood or early adulthood.

2018 and February 2020. The Trust provided its final response to the complaint in April 2020.

Issues of complaint

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

   Issue 1: Was the patient's diagnosis of hypothyroidism and the prescription of levothyroxine, appropriate, reasonable and in accordance with relevant guidance and standards?

   Issue 2: Did the Trust investigate the complaint in accordance with relevant policy, procedures and standards?

INVESTIGATION METHODOLOGY

7. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

8. I obtained independent professional advice from the following independent professional advisor (IPA):

   - A Consultant Endocrinologist, MB ChB FRCP PhD, with over 20 years' experience in the field.

   The clinical advice received is enclosed at Appendix three to this report.

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

Relevant Standards

10. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[7]:

- The Principles of Good Administration
- The Principles of Good Complaint Handling

11. The specific standards and guidance I refer 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 relevant to this complaint are:

    - The General Medical Council's (GMC) Good medical practice, updated April 2014 (GMC Guidance);
    - The National Institute for Health and Care Excellence's (NICE) Clinical Knowledge Summary (CKS): Hypothyroidism, updated April 2016 and June 2018 (NICE CKS on Hypothyroidism);
    - The Royal College of Physicians' (RCP) Guidelines on management of primary hypothyroidism, 2011 (RCP Guidelines);
    - The British Medical Association's (BMA) and the Royal College of Physicians' (RCP) British National Formulary, relevant versions March to August 2017, September to February 2017, September 2018 to February 2019, and March to September 2019 (the BNF);
    - The Southern Health and Social Care Trust's Policy for the Management of Complaints, July 2018 (the Trust's Complaints Policy); and
    - The Department of Health's (DoH) Guidance in Relation to the Health and Social Care Complaints Procedure, revised April 2019 (DoH Complaints Procedure).

12. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

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

13. 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.

INVESTIGATION

Issue 1: Was the patient's diagnosis of hypothyroidism and the prescription of levothyroxine, appropriate, reasonable and in accordance with relevant guidance and standards?

Detail of Complaint

The hypothyroidism diagnosis

14. The complainant said the patient did not display signs or symptoms of hypothyroidism. He explained the Trust's medical team believed only thyroid function blood tests (TFT) will confirm a hypothyroid diagnosis. He also said they believed patients must take increasing doses of levothyroxine until readings are inside the reference range. The complainant did not consider this correct.

Treatment with levothyroxine

15. The complainant said the patient was more confused, more agitated, and had difficulty sleeping when taking levothyroxine. He raised concerns regarding Trust staff's decision to increase the patient's levothyroxine prescription during her admission to facilities in October 2017 and January 2019. For the latter admission, the complainant said staff increased the patient's prescription from '*effectively zero*' to 75mcg in under two weeks. He considered this contrary to relevant guidance.

Failure to test for NCAH

16. The complainant said he considered the patient had NCAH rather than hypothyroidism. He raised concerns with the Trust's failure to perform a 17-OHP test[8], which he requested.

Evidence Considered

Legislation/Policies/Guidance

[8] A genetic test to screen for congenital adrenal hyperplasia.

17. I referred to the following policies and guidance, which were considered as part of investigation enquiries:
    - The GMC Guidance;
    - NICE CKS on Hypothyroidism;
    - The RCP Guidelines; and
    - The BNF.

    Relevant extracts of the guidance considered are enclosed at Appendix four to this report.

The Trust's response to investigation enquiries

The hypothyroidism diagnosis

18. The Trust referred to the NICE CKS on Hypothyroidism and explained a diagnosis is '*suspected*' if a patient displays more than one of the listed clinical features. It explained the patient displayed six of these features.

19. The Trust explained that current guidelines '*refute that clinical features are required to diagnose primary hypothyroidism*'. It further explained that '*clinical symptoms and signs of hypothyroidism are not specific to this condition; therefore the diagnosis is based on laboratory testing of thyroid function tests*'.

20. The Trust said that on multiple occasions, the patient's thyroid blood results were in keeping with a diagnosis of primary hypothyroidism. It explained that if left untreated, primary hypothyroidism '*can cause significant morbidity*[9]', including a patient's neuropsychiatric function[10]. The Trust further explained that '*in older patients who have cognitive decline, it is usual practice to assess thyroid blood tests and treat any thyroid dysfunction*'.

Treatment with levothyroxine

21. The Trust explained that levothyroxine replacement is required to '*normalise thyroid function, reduce morbidity and improve the patient's overall health and wellbeing*'. It said it is '*unlikely*' the medication caused the patient to become

[9] Suffering from a disease or medical condition.
[10] Relating to mental disorders attributable to diseases of the nervous system.

‘*agitated and confused*’ as she had been taking levothyroxine since 2005. It explained the patient’s dementia ‘*may have contributed to these symptoms*’.

22. The Trust explained that staff recommended the increased dose of levothyroxine for the patient as the ‘*untreated hypothyroidism was felt to be contributing to her mental state*’. It said that on 4 January 2019, the patient’s blood test results ‘*showed quite marked primary hypothyroidism*’. The Trust explained that on 10 January 2019, staff increased the dose of the medication to 75mcg. It said staff ‘*reintroduced [it] in the hospital setting where [the patient] was able to be observed for any side effects*’.

23. The Trust referred to NICE CKS on Hypothyroidism and the BNF. It explained the guidance recommends ‘*starting levothyroxine on a titrating dose*[11] *when it is a new treatment in an older person*’. It further explained the patient took the medication since 2005, and medical staff considered 75mcg a ‘*smaller than average dose*’. The Trust said that in April 2018, the patient was on the same dose, and her blood test results were normal. It explained this was the reason why the dose was reintroduced, and doing so ‘*over 10 days would not be unreasonable*’. The Trust said the patient’s GP reduced the dose to 25mcg following her discharge from hospital and blood test results show her condition was ‘*undertreated*’ during this time.

Failure to test for NCAH

24. The Trust explained a consultant endocrinologist reviewed the patient on 19 April 2018 and concluded, ‘*there appears to be no evidence of adrenal insufficiency with this lady*’. They further concluded that based on the patient’s blood test results, she had primary hypothyroidism. The Trust explained that based on the patient’s age and lack of clinical features, the consultant endocrinologist did not recommend further genetic screening. It said they considered it ‘*unnecessary and inappropriate*’, and the patient herself was ‘*unable to consent to genetic testing*’. The Trust explained staff discussed the outcome of the assessment with the complainant. It also said it referred the patient for four further independent medical opinions.

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[11] The process of adjusting the dose of a medication for the maximum benefit without adverse effects.

25. The Trust said the patient attended hospital for a synacthen test[12] to measure the patient's baseline adrenocorticotropic hormone[13] (ACTH). It said the results of these tests '*excluded adrenal insufficiency*'. The Trust explained that due to the complainant's dissatisfaction with the results, it referred the patient for further tests within the Belfast Health and Social Care Trust.

Relevant medical records

26. A summary of the relevant clinical records is enclosed at Appendix five to this report.

Relevant independent professional advice

The hypothyroidism diagnosis

27. The E IPA advised the patient's records show '*evidence of primary hypothyroidism with TSH [thyroid stimulating hormone[14]] greater than 10*'. He said the features of hypothyroidism are '*vague, and non-specific until the disease is very severe*'. Therefore, he '*would treat [the patient]…even in the absence of clear, definitive signs of hypothyroidism*'.

28. The E IPA explained that after starting treatment, thyroid function tests are '*typically checked every 2 months until the TSH lies in the normal range*'. He said it may '*take some adjustments in the dose of thyroxine to achieve*' levels in the normal range.

Treatment with levothyroxine – October 2017

29. I referred the E IPA to the patient's admission to the Memory Centre in October 2017. He advised doctors prescribed and administered '*25 micrograms of thyroxine*' for the patient on 3 and 4 October 2017. He advised doctors did not administer any thyroxine on 5 October 2017. However, they prescribed and administered '*50 micrograms thyroxine*' from 6 October 2017.

30. The E IPA advised the records did not contain '*a biochemistry [blood] test or a medical assessment of the thyroxine dose*'. However, he advised that '*based*

[12] A special chemical to test how well the adrenal glands make a hormone called cortisol.
[13] Produced by the pituitary gland. Its key function is to stimulate the production and release of cortisol from the cortex (outer part) of the adrenal gland.
[14] A pituitary hormone that stimulates the thyroid gland to produce thyroxine.

on the other records available, it is likely that the dose of thyroxine is too low'. The E IPA referred to the patient's later medical records (from 2019), which document that '*75 micrograms thyroxine daily resulted in normal range TSH blood results*'.

31. I asked the E IPA if the doses prescribed were in accordance with relevant guidance. He advised they were '*typical of replacement doses used in primary hypothyroidism*'. He further advised '*the dose should be titrated against the TSH, and here we have evidence that on thyroxine treatment the patient had a normal TSH. Therefore, the doses used were optimal for the patient*'.

32. I asked the E IPA if doctors are required to monitor patients for side effects once they administered thyroxine. He advised, '*no. Thyroxine does not cause side-effects in the manner than some drugs do, as it is a natural hormone*'. He further advised that '*monitoring is focused on symptomatic response, and to the optimisation of the circulating TSH, which should be in the normal range*'. I asked the E IPA if staff monitored the patient for side effects. He advised '*the monitoring appeared very good to me, and I could not see any suggestion of any adverse effects from the thyroxine*'.

33. In summary, for this admission, the E IPA advised staff's care and treatment of the patient '*was exemplary*'. He further advised the '*endocrinology consultant appeared to be closely involved*', despite the reason for the patient's admission not being related to endocrinology. The E IPA advised that '*no effort was spared in trying to optimise the patient's care with respect to her thyroid, and in my view she was optimally managed*'.

Treatment with levothyroxine – January 2019

34. I referred the E IPA to the patient's admission to the Craigavon Area Hospital in January 2019. He advised that on 3 January 2019, the patient was hypothyroid[15] with a markedly raised TSH at 19[16], and with a low free thyroxine of 5[17]. The E IPA advised that the patient may not have taken the prescribed

[15] Suffering from abnormally low activity of the thyroid gland.
[16] A normal level is typically 0.5 to 5.0 mIU/L.
[17] Normal levels are typically 12 to 30 picomoles per liter (pmol/L).

thyroxine replacement, which '*explained the rise in TSH*'. He said medical staff restarted thyroxine '*at a very low dose of 25 micrograms daily*'.

35. The E IPA advised that an endocrinology registrar reviewed the patient on 9 January 2019. The registrar also discussed the plan with the endocrinology consultant. The E IPA advised they agreed to '*manage the patient with thyroxine in daily doses to maintain a normal TSH*'. The E IPA further advised that a consultant endocrinologist's review '*is an ideal outcome*'. However, it is not common for a consultant to '*resolve replacement doses of thyroxine*' for all primary hypothyroid patients.

36. I asked the E IPA if the levothyroxine dosage prescribed was appropriate. He advised the initial doses were '*very small*', which he considered was '*possibly over-cautious*' in this instance. However, he further advised that he did not consider it '*unreasonable*', as the patient was '*frail and elderly*'.

37. In relation to side effects, the E IPA advised that '*there is very little evidence that replacement doses of thyroxine cause side effects*'. He explained it is not necessary to monitor a patient for side effects. However, he advised that in the patient's case, staff '*carefully reviewed*' her, as there were '*many different processes and diseases at play*'. The E IPA reviewed the records and said he '*could not detect any features suggestive of thyroxine toxicity*' [poisoning]. He advised he considered staff's care and treatment of the patient '*very careful, and considered*', and '*excellent*'.

Failure to test for NCAH

38. The E IPA advised the patient did not have any '*clinical features suggestive of this disorder*'. He further advised that an endocrinology consultant assessed the patient in relation to a possible diagnosis of NCAH. However, the consultant did not note any clinical features.

39. I asked the E IPA what tests, if any, staff undertook for the patient. He advised the medical team checked '*an early morning plasma cortisol*' in 2017. This measured 653nmol/l, which he advised is '*completely normal*'. The E IPA advised that in his experience, this result normally '*ends further testing of the*

adrenal'. He further advised that with a result above 350nmol/l, tests showed there was a 100% success rate in subsequent short synacthen testing. However, the E IPA advised that in this instance, the patient proceeded to short synacthen testing. He said this was '*probably in response to requests from the patient's son*'. He advised it is '*arguable that this testing was unnecessary*' and '*results of the further testing were also normal*'.

40. The E IPA advised that treatment of the disorder is '*confined to managing hirsutism*[18] *in younger women*'. Therefore, it was '*clear that no further testing, or treatment would be indicated in an elderly, frail woman with multiple morbidities, and taking many drugs already*'.

41. I referred the E IPA to the Consultant Endocrinologist's letter they wrote to the complainant in April 2018. I asked him if their conclusions were appropriate. He advised that the letter provided an '*excellent summary of the position, and the plans are very clear, and well-justified*'.

Analysis and Findings

The hypothyroidism diagnosis

42. The complainant said the patient did not display signs or symptoms of hypothyroidism. He also said Trust staff believed only TFTs will confirm a hypothyroid diagnosis. I note the patient's GP diagnosed the patient with hypothyroidism in 2005. Therefore, as the patient had an existing diagnosis at the time of the events in this complaint, my investigation did not seek to establish if the Trust correctly diagnosed the patient with the condition. I note the Trust treated the patient for hypothyroidism intermittently between October 2017 and February 2019. My investigation considered if it was appropriate for the Trust to do so based on its own consideration of her presentation and blood test results.

43. I note the Trust disagreed with the complainant's view and said it identified the patient displayed six clinical features of hypothyroidism. However, it refuted that they are required to be present to diagnose the condition. I note NICE CKS

[18] A condition where women have thick, dark hair on their face, neck, chest, tummy, lower back, buttocks or thighs.

refers to clinical features. However, it states doctors should only consider them when suspecting [my emphasis] hypothyroidism. By October 2017, doctors had treated the patient for the condition for 12 years. Therefore, I consider it was not necessary for the Trust to use clinical features to suspect hypothyroidism during the patient's admissions starting in October 2017 and January 2019, as it was already diagnosed.

44. I note the RCP Guidelines state that identification of clinical features alone is '*insufficient to make a diagnosis of hypothyroidism'.* It also states, '*the only validated method of testing thyroid function is on blood'.* Therefore, I consider the guidance clearly states the importance of blood tests when diagnosing and/or treating hypothyroidism. I note from the patient's clinical records, the Trust tested her blood on multiple occasions between October 2017 and February 2019, which it said showed '*evidence of primary hypothyroidism*'. I also note the E IPA's advice that based on the patient's blood results, it was appropriate to treat her for hypothyroidism '*even in the absence of clear, definitive signs of hypothyroidism'*. I accept his advice. I consider the Trust did rely on blood test results to reaffirm the patient's diagnosis and to direct its treatment of her. I consider in doing so, the Trust acted in accordance with relevant guidance.

45. The complainant also said the Trust believed patients must take increasing doses of levothyroxine until readings are inside the reference range. He did not consider this correct. I refer to the NICE CKS on Hypothyroidism, the RCP Guidelines, and the BNF. I note the guidance states that doctors ought to base treatment on the patient's TFT results. The guidance also states that doctors should monitor the patient's response regularly, and adjust the prescription level until the patient is in a *'euthyroid*[19]*'* state.

46. I also refer to the E IPA's advice. I note he advised that a patient's response to treatment is '*typically checked every 2 months until the TSH lies in the normal range*'. He also advised it may '*take some adjustments in the dose of thyroxine to achieve*' levels in the normal range. I accept his advice. I consider the Trust

[19] Having a normally functioning thyroid gland.

did adjust the patient’s prescription until her readings were inside the reference range. I consider that in doing so, the Trust acted in accordance with relevant guidance. I do not uphold this element of the complaint.

Treatment with levothyroxine

47. The complainant raised concerns about the Trust’s decision to increase the patient’s levothyroxine prescription during her admissions in October 2017 and January 2019. He considered this contrary to relevant guidance. I note that for patients starting levothyroxine, both the NICE CKS for Hypothyroidism and the BNF recommend starting doses of 25 to 50mg daily, and increasing it in steps of 25mg every four weeks depending on the patient’s response. However, I consider it important to note that the patient’s GP first prescribed levothyroxine in 2005. Therefore, she did not commence the medication in October 2017.

48. I refer to the patient’s Memory Centre records from her admission in October 2017. I note the complainant informed staff he did not administer levothyroxine to the patient ‘*every other day over past 10 day’s approx. [sic]*’. Therefore, the patient did not take her normal prescription during that period. The records document staff took a blood test on 4 October 2017, which showed abnormal TSH and T4 levels. As a result, doctors prescribed the patient 25mg levothyroxine on 3 October 2017. They increased the prescription to 50mg from 6 October 2017.

49. I note the patient’s blood results continued to show abnormal TSH and T4 levels on 30 November 2017. In response, doctors increased the patient’s levothyroxine prescription to 75mg daily. I note that blood tests taken four weeks later (28 December 2017) showed the patient’s TSH and T4 returned to normal. I note the E IPA’s advice that 75mg was therefore the ‘*optimum*’ dose for the patient. I consider the doses prescribed during this time were in accordance with the aforementioned guidance.

50. I also refer to the patient’s clinical records from her admission to CAH in January 2019. The records document the patient did not take levothyroxine for one month prior to her admission. As a result, her TSH and T4 levels were again abnormal. I note doctors initially prescribed the patient 25mg of

levothyroxine. While this was in accordance with the starting doses outlined in the guidance, the E IPA advised this was *'over cautious'* given 75mg was already established as the optimum dose for the patient. I note that following input from an endocrinology registrar on 9 January 2019, doctors increased the prescription to 75mg.

51. I acknowledge the prescription increased from 25mg to 75mg within the period of a week. I also acknowledge this is not in accordance with the guidance. However, the guidance relates to <u>starting</u> [my emphasis] doses. By this time, the patient had taken levothyroxine over a period of 14 years, and the Trust's endocrinologists already established that 75mg was the optimum dose for the patient. Therefore, I accept the E IPA's advice that the dose was appropriate, and the doctors' actions were '*careful and considered*'. I consider the Trust's treatment of the patient with levothyroxine during her admissions in 2017 and 2019 appropriate.

52. I note the complainant's concern about the effect the increased medication had on the patient. Having reviewed the patient's clinical records, I accept the E IPA's advice that the records evidence staff closely monitored the patient during her admissions in 2017 and 2019. I also accept his advice that there is no evidence the patient experienced any adverse effects of the levothyroxine medication during her admissions. I do not uphold this element of the complaint.

Failure to test for NCAH

53. The complainant said he believed the patient had NCAH rather than hypothyroidism. He raised concerns about the Trust's failure to perform a 17-OHP test, which he requested.

54. I note the complainant raised the question of NCAH with Trust staff on several occasions from 2017, and they referred his concerns to a Consultant Endocrinologist. I note the Trust performed a cortisol test for the patient in October 2017, and a synacthen test in September 2018. However, neither result supported an NCAH diagnosis. I note from the records the Consultant Endocrinologist did not consider further testing '*necessary or appropriate*' given

the patient's age and morbidities. I also note that following the complainant's disagreement, the Trust referred him to another Trust area for a further opinion.

55. I note the E IPA's advice that he did not consider the patient displayed any clinical features of NCAH. I also note his advice that based on the cortisol and synacthen test results, staff excluded an NCAH diagnosis for the patient, and further tests were not necessary. I accept his advice. I am satisfied the Trust did not perform a 17-OHP test as the complainant requested. However, given the patient's age and morbidities, I do not consider it was necessary or appropriate to do so. I do not uphold this element of the complaint.

Summary of findings for Issue One

56. I do not uphold this issue of complaint for the reasons outlined previously. I note the E IPA's advice that the staff's care and treatment of the patient since October 2017 was '*excellent*'. I accept his advice. I acknowledge the difficulties in this case, particularly the differing views between the complainant and Trust staff. However, it is clear from the records that staff listened to and considered the complainant's concerns, taking action to explore them further. While they did not always agree with the complainant, it is clear they considered the patient's best interests when deciding on her care. I commend the staff for this.

Issue 2: Did the Trust investigate the complaint in accordance with relevant policy, procedures and standards?

Detail of Complaint

57. The complainant raised his concerns to the Trust in December 2017, May 2018, and February 2020. He said his concerns related to the Trust's reasons for the patient's involuntary admission to hospital in October 2017. The complainant explained that despite receiving written responses to his complaints, the Trust's reasons remain unclear.

58. The complainant also referred to statements Trust staff made about both him and the patient, which he said were '*incorrect*'. He explained staff made these statements in a risk assessment and safeguarding reports for the patient. The complainant said he told Memory Services staff that the statements conflicted

with information recorded in carer reports. He explained he provided four months of carer records to demonstrate the disagreement. The complainant said the Trust '*ignored*' this and failed to fully investigate his concern.

Evidence Considered

Legislation/Policies/Guidance

59. I referred to the following policies and guidance, which were considered as part of investigation enquiries:
    - The Trust's Complaints Policy; and
    - The DoH Complaints Procedure.

    Relevant extracts of the guidance considered are enclosed at Appendix three to this report.

The Trust's response to investigation enquiries

Failure to provide reasons for the patient's involuntary admission

60. The Trust said it endeavoured to address all of the complainant's concerns '*on a number of occasions*'. It explained that staff made the complainant aware of reasons for the patient's detention on 13 October 2017, 10 November 2017, 13 December 2017, 7 February 2018, and 21 March 2018.

61. The Trust explained its staff also met with the complainant on 14 November 2018. It said it arranged the meeting to try to resolve the complainant's ongoing concerns. The Trust referred to the meeting minutes and explained the Approved Social Worker involved in the patient's detention on 3 October 2017 reiterated the '*reasons and rationale for the assessment and subsequent detention*'. It explained it also provided to the complainant a redacted version of the Mental Health Risk Assessment completed at the time of admission. The Trust said it redacted the assessment as the complainant did not provide consent for staff to share her personal information. It explained the risk assessment was only one of the information sources staff referred to as part of the patient's assessment.

Failure to investigate inaccurate information

62. The Trust explained the complainant disputed information it received from the care company on 19 September and 25 October 2017. It said the complainant raised this concern during the meeting on 14 November 2018. He also provided copies of the care records which did not detail the carers' concerns. The Trust said staff informed the complainant that carers will rarely document their concerns in their notes and will instead pass them to their line manager, which it said occurred in this case.

Relevant records

63. A summary of the relevant complaint records is enclosed at Appendix five to this report.

Other information considered

The Trust's response to the draft report

64. The Trust explained it aims to provide the '*highest possible standard of care, working in close partnership with service users, carers and their families and continually strives for improvement*'. It said it listens to those who observed or experienced their services. This helps it '*learn and improve*'. The Trust said it welcomes the views of patients, service users and carers.

Analysis and findings

Failure to provide reasons for the patient's involuntary admission

65. The complainant said the Trust failed to provide clear reasons for its detention of the patient in October 2017. My investigation did not seek to establish if the Trust's reasons for detaining the patient were appropriate. My role is to conclude whether or not the Trust responded to this element of the complaint in accordance with relevant guidance.

66. I note the efforts the Trust made to explain its reasons to the complainant both in written form and verbally during meetings with him. I note the meetings occurred both during the patient's admission and after the Trust discharged her from the facility, up until November 2018.

67. I note the Trust's Complaints Policy and the DoH Complaints Procedure both require the Trust to provide a full response that is *'clear, accurate, balanced, simple and easy to understand'*. Having reviewed the letters and notes of the meetings, I consider the Trust fully responded to the complainant regarding this issue. I also consider its response sufficiently clear and easy to understand. Most notably, the minutes of the Trust's meeting with the complainant document it detained the patient because she was '*mentally impaired, her cognition was severely compromised on the day in question and she was unable to look after herself'*. They further document the Trust *'assessed [the patient] under this [Mental Health Order] legislation due to the concerns raised regarding her presentation and as she was unwilling to go to hospital'*. The minutes also referred to an occasion in which the patient displayed aggression towards a social worker. I note the Trust provided a copy of these minutes to the complainant. Therefore, I consider it responded to this issue of complaint in accordance with its Complaints Policy and the DoH Complaints Procedure.

68. I acknowledge the complainant disagreed with the reasons the Trust outlined to him. However, his disagreement is not evidence that the Trust failed to provide clear reasons. I do not uphold this element of the complaint.

Failure to investigate inaccurate information

69. The complainant said the Trust failed to investigate his complaint that the patient's risk assessment (from October 2017) and safeguarding reports contained incorrect statements relating to both him and the patient. I note the patient said the Trust relied on information contained within these reports when making its decision to detain the patient in October 2017. My investigation did not seek to establish if these statements were correct. My role is to conclude whether or not the Trust appropriately considered this issue of complaint in accordance with relevant guidance.

70. I note the complainant said he provided to the Trust carer reports; the content of which he said conflicted with statements contained in the risk assessment and safeguarding reports. He asked the Trust to investigate why there was a discrepancy between the sets of documents.

71. I note the Trust explained it based the information in the reports on emails it received from the patient's carers, who were employees of a third party organisation. The Trust also explained to the complainant that carers will report concerns to their line manager, and will '*very rarely document concerns they have in the carer notes*'. I note that in its response to this issue, the Trust acknowledged the complainant's disagreement with the information contained within the reports. However, it said it could not amend this information, and it would append his comments to the report.

72. I acknowledge the Trust explained to the complainant the reasons why it could not change the content of the report, and offered a solution. However, the complainant wished to understand why statements in the reports differed to information the carers documented on the same dates. I do not consider the Trust provided any evidence to suggest it investigated this particular issue.

73. I note the DoH Complaints Procedure states that *'not all complaints need to be investigated to the same degree'.* I do not consider this issue required a comprehensive investigation. However, I would have expected the Trust to at least have contacted the third party organisation to enquire why the information in its emails conflicted with that in the carers' reports. This would have allowed the Trust to provide a reason to the complainant and fully respond to this issue of complaint. There is no evidence to suggest it made these enquiries. I consider that by not doing so, the Trust failed to act in accordance with this section of the DoH Complaints Procedure.

74. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with relevant guidance. The Fourth Principle of Good Complaint handling, 'acting fairly and proportionately', requires bodies to ensure complaints are investigated thoroughly. I consider that in not appropriately investigating this issue, the Trust failed to act in accordance with these principles. I uphold this element of the complaint. I consider that as a result of this failure, the complainant experienced the injustice of frustration and uncertainty.

CONCLUSION

75. The complainant raised concerns about care and treatment the Trust provided to the patient regarding diagnosis and treatment of her hypothyroidism. I do not uphold this issue of complaint for the reasons outlined previously in this report.

76. The complainant also raised concerns about how the Trust handled his complaint. I partly uphold this issue of complaint for the reasons outlined previously in this report. I consider the complainant experienced the injustice of frustration and uncertainty.

77. I shared the draft report with the complainant and he responded with his comments. I reviewed his response and corrected a factual error he identified. After careful consideration of the complainant's additional comments, I did not make any further amendments.

Recommendations

78. I recommend within **one** month of the date of this report:
    i. The Trust 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 maladministration identified; and
    ii. The Trust's Chief Executive reminds relevant staff of the importance of making relevant investigation enquiries to ensure it meets its obligations outlined in the DoH Complaints Procedure.

79. I understand the issues in this complaint are a great source of concern for the complainant. I hope the findings outlined in this report provide answers to some of his outstanding concerns. I also wish to offer my condolences to the complainant on the sad loss of his mother in February 2020.

MARGARET KELLY
Ombudsman **6 December 2021**

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.

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

- Publishing service standards for handling complaints.

- Providing honest evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.

- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

- Ensuring that decisions and actions are proportionate, appropriate and fair.

- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.

- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.

- Providing prompt, appropriate and proportionate remedies.

- Considering all the relevant factors of the case when offering remedies.

- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.

- Having systems in place to record, analyse and report on learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.