Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 201917009

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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

Case Reference: 201917009

Listed Authority: Southern Health and Social Care Trust (the Trust).

I received a complaint concerning the actions of the Trust in relation to the care and treatment the complainant received. She experienced gynaecological symptoms (Post-menopausal bleeding – PMB) which she considered to indicate the presence of cancer. The complainant attended the Trust on 2 March 2020 for an ultrasound which showed fibroids.[1] She then had a hysteroscopy[2] on 30 April 2020 which did not identify that any further treatment was required. The complainant remains unsatisfied with the explanations the Trust provided and is insistent that her womb be removed. Similar discussions took place between the Trust and the complainant in 2018 and 2019 and she had had a previous hysteroscopy on 19 December 2018. The complaint also included the complainant's experience following a visit to the Trust's Emergency Department (ED) on 3 May 2020 complaining of sudden onset shortness of breath. The complainant associated this with the recent hysteroscopy and believed that she was not adequately assessed in the ED before leaving the hospital.

Following my investigation which included the receipt of independent medical advice I did not uphold the complaint or find any failure in the care and treatment provided. While I appreciate and understand the complainants anxiety and worry over the PMB that she experiences and accept that she may not fully accept my conclusions, I am satisfied on the basis of the independent medical advice which I have received that the appropriate investigations were carried out by the Trust in 2020 and that no evidence of cancer was found in the review of these scans. I hope that the complainant can take some reassurance from this.

THE COMPLAINT

[1] Non cancerous growths that develop in or around the womb (uterus)
[2] An examination of the inside of the cervix and the uterus using a thin flexible tube called a Hysteroscope

1. The complaint concerns the actions of the Southern Health and Social Care Trust (the Trust) when providing care and treatment to the complainant during the period March to May 2020. The complainant had been experiencing gynaecology symptoms which she believed indicated Ovarian Cancer. The complainant has a family history of hysterectomy[3] due to heavy period bleeding and illness. After medical investigations the complainant was advised that there was no evidence of cancer. She remains convinced however that she does have cancer.

Issues of complaint

2. The issues of complaint which I accepted for investigation were:

- **Issue 1:** The investigation of fibroids and the information the complainant was provided with.
- **Issue 2:** Information provided to the complainant before and after a procedure carried out on 30 April 2020 at Daisy Hill Hospital.
- **Issue 3:** The information provided to the complainant regarding the need or otherwise for a hysterectomy.
- **Issue 4:** The care and treatment received following an attendance at the Emergency Department on 3 May 2020.

INVESTIGATION METHODOLOGY

3. In order to investigate the complaints, the Investigating Officer obtained from the Trust documentation on the relevant guidance and policies relating to the care received by the complainant, together with comments on the issues raised by the complainant. The Investigating Officer also obtained a copy of the Trust's complaints files and medical records.

[3] A surgical procedure to remove the womb

Independent Professional Advice Sought

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

a) A Consultant Obstetrician and Gynaecologist (OB IPA) with many years' experience in general gynaecology.
b) A Consultant in emergency medicine (ED IPA) from 2007 whose clinical duties include attending acutely unwell or injured patients and providing supervision for doctors in training. He also oversees the care of patients attending the department with all types of major and minor presentation. This also includes patients who may present with concerns following an operative procedure.

5. I received clinical advice in my consideration of this case.

6. The information and advice which informed my findings and conclusions are included within the body of my report. The IPAs provided me with 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion. I should also state that in conducting an investigation under my legislation, I refer to Section 30 (6) under the heading, investigative procedure, which states 'the procedure for conducting an investigation is to be such as the Ombudsman considers appropriate in the circumstances of the case.' Therefore, I alone determine the significance of the various elements in a complaint and which areas are to be investigated. Neither a complainant nor those complained of can have the final decision in relation to the specific questions which are to be addressed, the manner and extent of the investigation, or be involved in determining my conclusions.

Relevant Standards

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[4]:

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

8. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the bodies complained of and whose actions are the subject of this complaint.

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.

THE INVESTIGATION

Background

10. The complaint against the Trust concerns the care and treatment provided to the complainant in 2020. The complainant is of the belief that the gynaecological symptoms she experiences indicate that she has cancer. She attended the Trust in March 2020 for an ultrasound which showed a small fibroid. She then had a hysteroscopy in April 2020 with nothing untoward found. Nonetheless the complainant remains unhappy with the investigations carried out and the explanations provided.

11. Following the Hysteroscopy, carried out on 30 April 2020, the complainant attended the ED of Craigavon Area Hospital on 3 May 2020 complaining of sudden onset shortness of breath which she associates with the hysteroscopy. The complainant considered that she was not adequately assessed in the ED before leaving the hospital.

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

12. The complainant remains unsatisfied with the explanations the Trust provided and is insistent that her womb be removed. Similar discussions took place between the Trust and the complainant in 2018 and 2019 and she had had a previous hysteroscopy on 19 December 2018.

Issue 1: The investigation of fibroids and the information the complainant was provided with.

Detail of Complaint

13. The complainant said that that a Trust Consultant Obstetrician and Gynaecologist (Consultant A) advised her at an appointment on 2 March 2020 that she had fibroids, however, she also advised her on 2 January 2019 (Trust stated this was 2 January 2020) that she did not have fibroids.

The Trust response

14. The Trust advised that a small fibroid was visible on the ultrasound scan of 2 March 2020. The Trust further stated that on 2 January 2020 Consultant A informed the complainant that there were no fibroids within her uterine cavity. The Trust stated that Consultant A explained to the complainant the different types of fibroids. Fibroids projecting into the cavity of the womb are visible during hysteroscopy and fibroids within the wall of the womb and projecting outside of the womb are not.

Relevant Independent Professional Advice

15. The OB IPA informed me that the complainant underwent an ultrasound scan which is appropriate first-line intervention for a complaint of PMB.

Analysis and findings

16. It is evident from an examination of the medical records (and correspondence with the complainant as a result of previous complaints on this issue) that the complainant has had longstanding concerns regarding PMB. There have been previous referrals to the Trust and investigations carried out from at least 2018 with a previous scan and a hysteroscopy and biopsy being carried out. The complainant

has been consistent in her belief that she may have cancer and in her desire to have a hysterectomy. I shall give my consideration on the issues raised, however at this stage I should state that I am in agreement with, and accept, the medical advice which I received ,which is that the investigations and procedures carried out in 2020 were appropriate and reasonable for her presentation and symptoms. No evidence of cancer was found. I hope that the complainant can take some reassurance from these findings.

17. The complainant had investigations carried out in 2018 and 2019. Her GP referred her back to the Gynaecology clinic on 2 March 2020 following a further period of post-menopausal bleeding. She was seen again by Consultant A. As the complainant had previously disagreed with this consultants findings, she was offered the option of another appointment with a different doctor however the complainant declined this offer.

18. An ultrasound was carried out which revealed a small anterior wall fibroid. I note a detailed letter from the Trust to the complainant following previous procedures, dated 9 January 2019, explained the differing types of fibroids and the effect these can have with regard to post-menopausal bleeding. No abnormalities were detected as a result of the ultrasound on 2 March 2020 and the complainant was reassured by Consultant A that no signs of ovarian cancer were detected or of a prolapse. After discussion with the complainant she was booked for further investigation in the form of a hysteroscopy.

19. The independent professional advice which I received from the OB IPA is that the complainant underwent an ultrasound scan which is appropriate first-line intervention for a complaint of PMB. He also stated that the complainants interactions with the Trust and explanations received, as detailed in the clinical notes and in response to previous correspondence with regard to complaints, dated 9 January 2019, 21 February 2019, 26 May 2020 and 16 June 2020 were reasonable and appropriate. I accept this advice and as a result I do not uphold this element of complaint.

Issue 2 - Information provided to the complainant before and after a procedure carried out on 30 April 2020 at Daisy Hill Hospital

Detail of Complaint

20. The complainant was concerned about the level of information which was provided to her before and after the hysteroscopy being carried out on 30 April 2020 and the fact that no review appointment was arranged to discuss its findings.

The Trust response

21. The Trust, in its response to this issue of the complaint, referred to a letter to the complainant, from the Trust dated 7 August 2020. In this letter to the complainant, the Consultant Obstetrician and Gynaecologist (Consultant B) who carried out the hysteroscopy stated that he took particular care to keep the complainant informed as he was aware that she had been investigated previously for the same complaint. Consultant B stated that he explained the procedure in detail when he reviewed the complainant after the operation. The complainant had made it clear to him that she needed a full explanation, so he took the time to provide this. He also stated that he had showed the complainant the intraoperative operation photographs to demonstrate that there was no problem with the uterine cavity, that there was no abnormality from the biopsy results and that there was nothing for the complainant to worry about. In summary, the Trust and Consultant B's response stated that the bleeding is likely to be 'Postmenopausal Atrophy', that there was no evidence of cancer and that the complainant was offered treatment for this and refused. As a result of this complaint Consultant B had again reviewed the clinical notes and had nothing further to add.

Clinical notes

22. I note this extract from the clinical notes of 30 April 2020.

23. 'post op home today, no routine hospital review…she does not want to use any HRT or Vagifem…..(Consultant B) came to review patient post-op, explanation given, all normal, no biopsy, no more results to come….discharge letter and post op

information given and explained…patient assisted down to front door to be collected by husband for home.'

Relevant Independent Professional Advice

24. The OB IPA informed me that a hysteroscopy was the appropriate procedure for the complainant's presentation and past history and that the results were normal. He also advised that the information and explanations provided to the complainant were reasonable and appropriate. With regard to the complainant being informed that there would be no follow up unless the situation changed. The IPA agreed with this on the basis that complainant declined topical oestrogen treatment. However the IPA did note that it did not appear that complainant was asked to refer again in case of recurrent PMB after 6 months as is the standard of care.

Analysis and Findings

25. The complainant raised concerns about the level of information she was provided with both prior to and after the hysteroscopy was carried out on 30 April 2020.

26. I accept the independent medical advice which I received. On this basis and from the evidence of the clinical record, I am satisfied that a hysteroscopy was the appropriate procedure for the complainant's presentation, that it was clinically appropriate that it be carried out and that the results of the procedure did not disclose any abnormality and were normal. I am also satisfied that this was explained to the complainant post operation. Additionally I note the clinical record documents that the complainant did 'not want to use any HRT or Vagifem' despite the complainant's current contention that she was not offered this. As a result I do not uphold this issue of the complaint. Nonetheless I hope that the complainant is reassured by this confirmation that the results of the hysteroscopy were normal and the content of the independent medical advice received.

Issue 3: The information provided to regarding the need or otherwise for a hysterectomy

Detail of Complaint

27. The complainant believes she should have her womb removed. Her sister had ovarian cancer and the complainant has had several breast cancer scares, which she believes increases her risk.

The Trust response

28. The Trust stated this has been discussed with the complainant previously in 2018, 2019 and by letter dated 2 March 2020 about the indications for hysterectomy and the associated risks. The Trust stated that it was explained to the complainant that if she had concerns about her family history of ovarian cancer that a referral to genetics would be prudent before making any decision regarding surgery.

Relevant Independent Professional Advice

29. The OG IPA informed me that there was no indication for the removal of the womb and/or ovaries based on the complainants symptoms/signs. He advised that the complainant had appropriate management of PMB which is a marker for risk of endometrial cancer. Whilst breast and ovarian cancer are related, a hysterectomy is a major operation with risks and therefore it is appropriate that benefits are assessed by clinical genetics as proposed.

Analysis and findings

30. The complainant evidently has a longstanding fear that she either has cancer at the moment or that she will develop cancer in the future. She is of this belief both through her own personal history of post-menopausal bleeding but also because of a family history. A reading of the medical record and correspondence between the complainant and the Trust evidences that the complainant brought up the issue of her desire to have a hysterectomy with both Consultant A and B. Previous correspondence from 2018 and 2019 shows that the clinicians involved with the complainant's treatment all advised against the complainant having a hysterectomy. This advice is consistent with more recent advice provided by the clinicians treating

her in 2020. Consultant B advised that he would be against having a major abdominal operation as the complainant had significant other risk factors which would not justify the clinical risk to the complainant in having a hysterectomy. Even when the complainant suggested to him that she and her husband were considering having the operation carried out privately, he advised against that approach and despite the complainants insistence he stated that he would not plan a hysterectomy in these circumstances. Consultant A expressed similar sentiments explaining that while cancer can run in families, surgery would only be performed where the risk was thought to be especially high. This doctor did suggest that if the complainant was concerned about her family history she could attend her GP who could consider a referral for genetic testing.

31. The independent medical advice I received agrees with the advice given to the complainant. This is that there is no clinical indication or justification for carrying out a major operation such as a hysterectomy on the complainant based on her current symptoms. I am of the opinion that all surgery, even minor, carries with it risks and that for the wellbeing and safety of the complainant such action should be clinically justified weighing up the risks against the potential benefits. On the basis of the advice which I received I am satisfied that such clinical justification does not exist currently. I would suggest that should the complainant still desire a hysterectomy that she contact her GP to consider genetic referral for proper assessment of her future risk.

Issue 4: The care and treatment received following an attendance at the Emergency Department on 3 May 2020

Detail of Complaint

32. Following the hysteroscopy, carried out on 30 April 2020, the complainant attended the ED of Craigavon Area Hospital on 3 May 2020 complaining of sudden onset shortness of breath which she associated with the hysteroscopy. The complainant believed that she was not adequately assessed before leaving the hospital.

The Trust response

33. The Trust stated that the complainant was examined by a Senior Emergency Department Doctor and it was noted that she was short of breath at rest and had a cough since arriving. It was noted her chest was clear of 'auscultation' [5]and chest x-ray was normal. An arterial blood sample was also taken to check her oxygen levels. The Trust believe that appropriate assessments were carried out and the complainant was advised on discharge that if her condition worsened she should return.

Relevant Independent Professional Advice

34. The ED IPA advised that the complainant self-presented to ED three days after a hysteroscopy with painful chest and abdominal symptoms. She was assessed promptly and had initial screening investigations undertaken to identify what was troubling her as well as to try and rule out serious pathology which would have included complications of surgery. Appropriate analgesia was provided, and the investigation results were reviewed and recorded. Following reassessment, the complainant was discharged with treatment for what was considered the most likely condition identified.

Whilst there are minor details from the history and examination omitted from the records, the ED IPA did not consider these omissions would have altered the outcome of the presentation in anyway on the day. He considered that the medical records represent a full and appropriate assessment of the complainant's condition on the day of the presentation.

Analysis and findings

35. The complainant attended the ED of Craigavon Area Hospital three days after undergoing a hysteroscopy complaining of shortness of breath, chest pains and abdominal discomfort. She associated these symptoms with the procedure carried out a few days earlier. She complained that she was not assessed adequately in the ED prior to her discharge later that same day. The complainant has not specified in her complaint exactly what she considered to be deficient in her treatment. I

[5] The action of listening to the heart, lungs or other organs typically with a stethoscope.

therefore sought independent medical advice to cover the totality of her experience while attending the ED on 3 May 2020.

36. The detailed medical advice which I received and which I accept, is clear that the investigations undertaken were carried out promptly, were appropriate for the complainant's presentation and were recorded properly. While the ED IPA did identify minor administrative omissions he did not consider that these would have altered the outcome for the complainant in any way. I accept and agree with this. I do not consider there to have been a failure in the care and treatment experienced by the complainant on this occasion and I do not uphold this issue of complaint. While I do not consider it to represent a failure in the care and treatment received, I would however bring to the attention of the Trust the comments of the ED IPA, with reference to the recording of a NEWS score, as a learning point.

CONCLUSION

37. I received a complaint concerning the actions of the Trust regarding the care and treatment provided to the complainant in the early months of 2020. I did not find there to have been a failure in the care and treatment provided.

38. I fully recognise and understand the worry and anxiety experienced by the complainant and her desire to seek reassurance concerning the symptoms she experiences. I hope that my report will go some way to address her concerns over the care and treatment she received and will provide some of the reassurance she seeks. I am satisfied that the investigations undertaken as a result of the complainant's symptoms were both reasonable and appropriate and professionally carried out. Neither the ultrasound nor the hysteroscopy revealed the presence of cancer. I recognise that the complainant may not agree with all of my conclusions but I wish to assure her that I have reached them only after the fullest consideration of all the facts of this case.

39. Following receipt of a copy of this report in draft form the complainant stated that she was still hugely concerned about the risk of cancer. She stated that she did not recall having been shown photographs following the procedure on 30 April 2020 or the explanation received on that date as disclosed in the Trust's letter to the

complainant of 7 August 2020 and the clinical notes dated 30 April 2020. She asked if a meeting could be arranged with the Trust whereby she could be shown these photographs again and a further explanation provided. While I am conscious that I have not made a finding of a failure in the care and treatment provided to the complainant, I would ask that the Trust give some consideration to acceding to the complainants request for a meeting in order to provide her with the additional reassurance that she seeks.

MARGARET KELLY
Ombudsman **29 March 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.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and 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 learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on 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.

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 co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

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.

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 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.

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.

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 the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.