Investigation Report

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

NIPSO Reference: 202001919

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

TABLE OF CONTENTS

Page

Case Reference: 202001919
Listed Authority: Northern Health and Social Care Trust

SUMMARY

I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust) in relation to the care and treatment provided to the complainant's late son (the patient) from 1 May 2019 to 13 June 2020.

The complainant raised concerns with the treatment Antrim Area Hospital (the hospital) Cardiology staff provided to the patient and, in particular the actions taken following the patient's echocardiogram (echo) result.

To assist with consideration of the issues the complainant raised I obtained independent professional advice from a Consultant Cardiologist and Consultant Psychiatrist

My investigation found failures in the care and treatment the Trust provided to the patient in relation to the following matters:

- Length of time the patient had to wait to have an echo carried out;
- Length of time taken to receive/review the echo report;
- Communication with patient and his GP about results of the echo;
- Failure to arrange an earlier Cardiology review appointment;
- Failure to request further tests, including an MRI;
- Failure to carry out baseline tests, and further monitoring, including an ECG, before prescribing anti-psychotic medication; and
- Failure of the Community Mental Health Team (CMHT) to proactively seek information from the Cardiology department about the patient's condition.

I concluded that these failures in care and treatment caused the patient to experience the loss of opportunity for, him and his GP to receive information about his echo result, a timelier follow-up cardiology appointment, optimal treatment options, (including, the request for additional tests, baseline tests including an ECG),

to have all relevant information conveyed to his CMHT, to have enhanced monitoring and reassessment of his prescribed medication by the CMHT. I also concluded the patient also experienced uncertainty and the complainant experienced uncertainty and upset.

My investigation did not establish a failure in the priority the Trust gave to the echo requested on 1 May 2019.

I recommended the Trust provided the complainant with a written apology for the injustice caused to the patient as a result of the failures in care and treatment identified. I also made recommendations for the Trust to address to prevent further reoccurrence of the failings identified.

THE COMPLAINT

1. I received a complaint about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's late son, (the patient) from 1 May 2019 to 13 June 2020.

Background

2. In February 2019 the patient's General Practitioner (GP) referred him to the cardiology[1] department of Antrim Area Hospital (the hospital) because of significant bradycardia[2]. A Consultant Cardiologist, Dr A, saw the patient on 1 May 2019 and ordered an echocardiogram[3] (echo). The echo, undertaken on 11 February 2020 queried the presence of features suggesting hypertrophic cardiomyopathy[4] (HCM) and Dr A requested a six month review. On 29 November 2019 the GP also referred the patient to community mental health team (CMHT) due to possible psychosis[5]. Between 6 December 2019 and 9 April 2020, a Consultant Psychiatrist, Dr B, reviewed the patient on several occasions. Dr B prescribed various medication including anti-psychotic medication[6]. The patient sadly passed away on 13 June 2020 following a fall off his motorbike. The patient's Report of Autopsy documented the cause of death as *'…1(a) Acute Left Ventricular Failure[7] due to (b) Myocardial scarring[8]…'* As result of the patient's sudden and unexpected death the Trust carried out a Serious Adverse Incident[9] (SAI) review.

Issue of complaint

3. I accepted the following issue of complaint for investigation:

Issue 1: Whether the patient received appropriate care and treatment from the Trust from 1 May 2019 to 13 June 2020

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[1] The branch of medicine that deals with diseases and abnormalities of the heart.
[2] A slow heart rate.
[3] A test of the action of the heart using ultrasound waves to produce a visual display, for the diagnosis or monitoring of heart disease.
[4] When the heart muscle cells enlarge and the walls of the heart chambers thicken. The heart chambers are reduced in size so they cannot hold much blood, and the walls cannot relax properly and may stiffen. Also, the flow of blood through the heart may be obstructed.
[5] When a person perceives or interprets reality in a very different way from people around them.
[6] Used to treat psychotic disorders.
[7] Occurs when the left ventricle is unable to adequately move blood through the left side of the heart and out into the body.
[8] The accumulation of fibrous tissue resulting after some form of trauma to the cardiac tissue.
[9] Serious Adverse Incident (SAI) reviews are initiated following unexpected and unintended incidents of harm. Their objective is to ensure service providers learn from harm and make improvements to services.

INVESTIGATION METHODOLOGY

4. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process. The patient's GP also provided relevant medical records.

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 Cardiologist, MD FRCP, with over 30 years' experience as a consultant cardiologist, looking after patients with general cardiac problems, and with arrhythmias, cardiomyopathies and those with implantable defibrillators. (C IPA); and
    - A Consultant Psychiatrist, BSc MB BS MRCP MRCPsych MD FRCP FRCPsych, with over 30 years' experience as a general and community psychiatrist (P IPA).

6. The information and advice which informed the findings and conclusions are included 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. 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[10]:

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

- The Principles of Good Administration

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:

   - The General Medical Council's Good Medical Practice, updated April 2019 (the GMC Guidance);
   - National Health Service England: (NHS England) Standards for the Communication of Patient Diagnostic Test Results on Discharge, March 2016[11] (NHS results on discharge guidance);
   - The Health and Social Care Board's (HSC) and Public Health Agency's (PHA) Commission Plan 2019/20 (2019/20 Commissioning Plan[12]);
   - The National Institute for Health and Care Excellence, (NICE), Clinical Guide 178 – Psychosis and schizophrenia in adults: prevention and management, 12 February 2014 (CG178);
   - The National Institute for Health and Care Excellence, (NICE), - Clinical Knowledge Summaries (CKS), Psychosis and schizophrenia, January 2020 (CKS Guidance); and
   - The Standard Operating Procedure (SOP) included as an Appendix within The Northern Health and Social Care Trust (the Trust's) Evaluation of the Pilot Physical Investigation at Ballymoney community Health Team, April 2019[13] (the SOP).

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

[11] Although produced by NHS England this guidance has been endorsed by the Royal College of Physicians.
[12] The Commissioning Plan sets out the priorities to be taken forward by Health and Social Care (HSC) and providers.
[13] Prior to a standard operating procedure being implemented by CMHTs in May 2021 the Trust advised that the CHMTs had adapted what was to be completed at a physical investigation clinic from a pilot undertaken at Ballymoney CMHT. This pilot was evaluated and rolled out across all the CMHTs within the Trust.

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.

THE INVESTIGATION

Issue 1: Whether the patient received appropriate care and treatment from the Trust from 1 May 2019 to 13 June 2020.

Detail of Complaint

11. The complainant raised concerns about the treatment cardiology staff provided to the patient. She queried Dr A's decision to refer the patient for a routine echo given his symptoms. The complainant also raised concerns about the actions taken following receipt of the echo result, including not informing the patient or his GP. She said there was no further monitoring of the patient and other clinicians could not take his echo results into consideration when providing care including the prescribing of medication which caused myocardial scarring[14]. The complainant believed that had the Trust diagnosed the patient in a timely manner and communicated the ongoing test and results to his GP and other clinicians then, his condition could have been monitored and managed and, he would still be here today.

Evidence Considered

Legislation/Policies/Guidance

12. I considered the following policies/guidance:
    - the GMC Guidance;
    - the NHS results on discharge guidance;
    - the 2019/20 Commissioning plan,
    - CG178;

[14] Myocardial scarring is the accumulation of fibrous tissue resulting after some form of trauma to the cardiac tissue.

- CKS Guidance; and
- the SOP.

Trust's response to investigation enquiries

13. In relation to the priority given to the echo request following the cardiology review on 1 May 2019 the Trust explained *'…No red flag symptoms were identified…which were indicative that an urgent ECHO was necessary. So, a routine ECHO was ordered. Thereafter the ECHO was reported on 03 March 2020 as showing changes suggestive, but not definitive, of hypertrophic cardiomyopathy (HCM)…There was no suspicion of HCM until the ECHO report became available some months later...'*

14. In relation to communication with the patient and his GP about the result of the echo the Trust identified a lack of communication *'…as part of the learning from the Serious Adverse Incident (SAI) review…'* It further explained it was *'…currently in the process of developing a Diagnostic Test Policy for all wards and departments in the [Trust], which will include the need for clear communication of test results.'* It went on to explain that the only way the community mental health team (CMHT) *'…would have been aware that [the patient] had undergone an echocardiogram or been aware of any result would be for this information to be communicated directly to the CMHT by the cardiology team / the GP/ or [the patient] (or his family)…'* However, '…*The treating psychiatrist was aware of the cardiology referral…. From a cardiology perspective…if a cardiologist is aware that a patient is attending a psychiatrist and the treatment of the psychiatric condition would have an impact on the cardiac diagnosis, it is likely that the cardiologist would copy the psychiatry team into correspondence. However, it is not always apparent that a patient is attending psychiatry as their records are not on ECR [electronic care record]. If the patient or the original GP referral letter does not let the cardiologist know, it is unlikely they would copy correspondence with any other professional.'*

15. The Trust acknowledged as part of the SAI review that *'...Additional investigations to assess [the patient's] arrhythmic risk were not organised upon*

receipt of the ECHO report…However, the SAI review team…were not certain an alternative management plan may have affected [the patient's] outcome. When considering this aspect, the SAI review team acknowledged certain difficulties, such as the diagnosis of HCM not being certain, the cardiac MRI[15] wait time being over 1 year at the time… and the fact that very few MRI's were being performed during the early stages of the pandemic…Based on wait times alone, it became apparent that even if further investigations had been requested they would not have been completed by the time of patient's death.'

16. In relation to monitoring of the patient's heart before being given and while on anti-psychotic medications, the Trust explained that such medications '…*carry an increased risk of arrhythmia provocation (abnormal heart rhythms), but [the patient's] particular medications carried a lower risk. With regards to the antipsychotic medications (Aripiprazole[16] and subsequently Olanzapine[17]), current NICE guidelines, [stipulate] that monitoring is required if there are other risk factors for arrhythmia. The absence of written communication on the echocardiogram report and any interpretation of the findings therein, may have denied the opportunity for enhanced monitoring.'* The Trust went on to explain that the SAI also identified '…*A baseline ECG[18] should have been performed before starting the antipsychotic medication. The suggested diagnosis from the echocardiogram may have warranted further follow up ECG's [sic] with any dose changes of the antipsychotic medications.'*

Relevant Trust records

17. I completed a review of the relevant Trust and GP records. I also reviewed the patient's Report of Autopsy.

[15] Magnetic resonance imaging (MRI) is a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues in your body.
[16] A second generation (sometimes referred to as 'newer' or 'atypicals') antipsychotic. It is also known by the trade names Abilify and Abilify Maintena.
[17] An atypical antipsychotic used to treat bipolar disorder, schizophrenia and psychosis.
[18] An electrocardiogram (ECG) records the electrical signal from the heart to check for different heart conditions.

Relevant Independent Professional Advice

C IPA

18. The C IPA advised that *'…The patient presented to his GP with an episode of palpitation and breathlessness. This was clearly stated in the GP referral letter, although the "headline" of that letter was "sinus bradycardia*"…*The patient was assessed by cardiology on 01/05/19...The cardiologist does not appear to have addressed the issue of palpitations during the consultation, focussing on the chest pain and bradycardia...A 24 hour ECG monitor or a cardiac event monitor might have been requested, as an investigation of palpitation. Requesting one or other of these would have been reasonable practice, given the history of a single episode of palpitation. However, it is likely that neither would have shown any abnormality. Palpitation does not seem to have recurred, so not investigating the palpitation will not have had any impact. Otherwise the investigation was appropriate.'*

19. The C IPA further advised that during the assessment on 1 May 2019 '…*An ECG was performed, and showed sinus bradycardia (rate 54 beats per minute)…The automatic computer interpretation concludes that the ECG is borderline. My interpretation of this ECG is that the tall R wave in V1 is unusual, but is non specific. This ECG may therefore be within the normal range, and once right sided abnormalities (eg pulmonary stenosis, right ventricular hypertrophy) have been excluded (as they were subsequently by echocardiography) this ECG did not suggest any specific diagnosis.'*

20. The C IPA also advised that following the initial assessment *'…An echo was requested. This echo was performed on 11/02/20…As no significant cardiac disease was suspected clinically, there was no urgency that this echo be done…However…This patient waited over nine months to have a routine echocardiogram, which is clearly in breach of the Trust target of 26 weeks, and clearly is not good clinical practice. If the echo had been performed in a timely way, and the report seen by the consultant soon afterwards, a cardiology review appointment should have been made, so that further diagnostic tests (eg magnetic resonance imaging, MRI) could have been arranged. Had the cardiologist reviewed the patient, the patient may have told him that he was*

attending mental health services, and the cardiologist should have then repeated the ECG, to assess the QT interval[19]. He also would have communicated with the mental health team, who might also have considered the underlying cardiac disease as an additional risk factor for arrhythmias in association with the psychotropic drugs prescribed.'

21. She went on to advise *'…I assume that this wait for the echo to be performed represents the waiting list for routine echocardiography at the time…The echo was reported the day it was done. The result was date stamped as received by the cardiologist on 03/03/20, a delay of 4 weeks, which seems rather long. This is an additional unnecessary delay, causing a further delay in arranging follow up. It is not clear why this particular delay occurred. It may be related to a variety of factors, such as delivery of results in the post, the consultant being on leave etc. The Trust should have arrangements in place for timely review of results (eg when a consultant is on leave etc).'*

22. In relation to the findings of the echo the C IPA advised '*The echocardiogram…did not…give a definitive diagnosis. As there was no definite diagnosis made by echocardiography, further tests, including magnetic resonance imaging (MRI) should have been requested. This test should have been done within the time frame specified in the Trust's response (By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test, By March 2020, no patient should wait no longer than 26 weeks for a diagnostic test). Usually if further tests are required it would be appropriate to arrange an early review (within weeks) to discuss this with the patient, specifically to explain the result of the echocardiogram, and to explain the rationale for requesting further tests. The patient had been appropriately reassured at the time of the first cardiology consultation; the echo result suggested that this reassurance was not supported by the findings, so the change in opinion should have been discussed with him in person (rather than, say, by letter)…'* She went on to advise that *'…Additional tests eg exercise stress testing and 24*

[19] The section on the ECG that represents the time it takes for the electrical system to fire an impulse through the ventricles and then recharge. It is translated to the time it takes for the heart muscle to contract and then recover.

hour ambulatory monitoring were also required to undertake a risk assessment (for sudden cardiac death).'

23. In relation as to who should have been informed about the results of the echo the C IPA advised *'…The GP and the patient should have been informed of the result of the echocardiogram… and that further tests, including MRI were required to try and reach a definitive diagnosis…The patient was not receiving psychiatric care either at the time he was referred to cardiology or at the time he was seen by cardiology. The cardiologist could not have been expected to anticipate the subsequent psychiatric problems and referral. The patient was receiving psychiatric care at the time the echo was performed and reported. The cardiologist could not have been expected to know this, as the Trust has stated in its response that psychiatric records are not available on the general electronic record system. He therefore could not have been expected to copy any correspondence about the echo to the mental health team.'*

24. In relation to the six month review appointment the C IPA advised that *'…This was not appropriate. It probably did not however impact the patient, as a definitive diagnosis might still had not been reached[sic]…Ideally the patient should have been given a much earlier review, so that the echo findings could have been discussed with him, and further investigation…planned.'*

25. The C IPA advised on the Trust's SAI review conclusion that there was no evidence to suggest the patient's outcome would have been any different had the Trust implemented an alternative management. She advised '…*We must remember that*
    - *no definitive diagnosis (of hypertrophic cardiomyopathy) was made, either in life or after death. The echo report is inconclusive…The post mortem examination was also inconclusive, the expert second pathologist stating that the pattern of patchy fibrosis observed was not typical of hypertrophic cardiomyopathy*
    - *Although hypertrophic cardiomyopathy has not been confirmed, it remains a possibility. Other causes of unexplained hypertrophy should be considered, as should other causes of fibrosis.*

- *There was nothing detected in the initial cardiology consultation to suggest a potentially serious condition...the abnormalities were non specific…*
- *Given the waiting times described in the SAI report, further investigation could not have been undertaken and completed between the date of the echo and the date of the patient's death.*
- *If a diagnosis of hypertrophic cardiomyopathy had been made, a risk assessment for sudden death should have been undertaken. This is routine in patients with hypertrophic cardiomyopathy. This risk assessment includes factors recorded in the history from the patient (eg has he had blackouts), factors measured by echocardiography,…and a 24 hour ambulatory ECG (Holter)…'*

26. The C IPA went onto advise using the information available *'…on the balance of probability, this patient would have had a sudden cardiac death risk of less than 3% related to a diagnosis of hypertrophic cardiomyopathy (if that diagnosis had been conformed)[sic]… The risk generally considered as an indication for consideration of an implantable primary prevention implantable cardioverter defibrillator[20] (ICD) is 5%. The decision to implant an ICD can be difficult, both for the doctor and for the patient, as there are many additional factors to be taken into account, over and above the risk of sudden death, given the long term nature of this treatment, and its many complications over subsequent years. Co morbidities need to be taken into account, and in particular psychiatric morbidity, in particular severe anxiety, may be a relative contraindication.* She further advised '…*Therefore, it is not likely, on the balance of probability, that this patient would have fulfilled guidelines for primary prevention ICD implantation, and, even if he had fulfilled guidelines, it is not likely that he would have received one, given his psychiatric comorbidity.'*

27. The C IPA went onto advise '…*even if the echo had been performed in a timely way, and the diagnosis of hypertrophic cardiomyopathy had been confirmed,*

[20] A cardiac device implanted under the skin of the chest, which monitors every heart beat; if a cardiac arrest due to a very fast heart beat, such as occurs in ventricular fibrillation, is detected by the device, it will deliver a life saving shock which corrects the abnormal heart rhythm.

and an indication for an ICD demonstrated...Given the waiting times described in the SAI report, it is unlikely that this patient would have received a primary prevention ICD within the time available…' She further advised that *'…Risk stratification[21] in hypertrophic cardiomyopathy (if that diagnosis had been confirmed) would not have prevented the sudden death.'*

28. In relation to further monitoring of the patient during the time the CMHT prescribed anti-psychotic medications the C IPA advised '*The patient was receiving psychiatric care when the echo was done; the cardiologist presumably would have identified this at cardiac review, and if he had, should have copied his letter to the psychiatrist, with an additional discussion of the ECG, and in particular the QTc interval, and the recommendation for ECG monitoring. The mental health team (consultant psychiatrist and community mental health nurse) were aware of the patient's cardiac referral; they should have sought cardiac advice regarding any diagnosis made. The mental health team should have requested a baseline ECG…Initiating monitoring was their responsibility and not that of the cardiologist…Baseline ECGs and ECG monitoring should be available in mental health with cardiology input in interpretation of ECGs…'* However, she concluded that *'…ECG monitoring probably would not have prevented the sudden death.'*

P IPA

29. The P IPA advised that as far as he could tell *'…no baseline investigations…'* as set out in CG178 *'...were requested by the psychiatrist before [the patient] was started on Aripiprazole. Some tests had been requested by the GP. However, the results of these do not seem to have been available to the psychiatric team, although overall responsibility for the completion of baseline tests lies with the psychiatric team.'* He went on to advise as the patient *'…had a history of heart disease in childhood and he had been referred to cardiology, both of which were known to the psychiatry team, an ECG as in NICE Para 1.3.6.2 , was mandatory.'*

[21] Method of calculating an individual risk estimate that contributes to the clinical decision-making process.

30. The P IPA disagreed with the Trust's assertion that *'…"With regards to the antipsychotic medications (Aripiprazole and subsequently Olanzapine), current NICE guidelines do not suggest the need for ECG monitoring in services users on these medications as the risk of QT prolongation is low."…In [the patient's] case he did have heart disease diagnosed at birth and was being seen by a cardiologist and in my view this meets the NICE criterion "there is a personal history of cardiovascular disease." Moreover, available guidance at the time indicated that both Aripiprazole and Olanzapine did in fact carry some risk of cardiac effects, although the effect was "low":*

31. The P IPA advised that the medications, *'…were prescribed in line with BNF (NICE) guidance*[22]*.* However, he went on to advise he did not find a record to suggest that the psychiatry team had been informed of the patient's echocardiogram result *'…but if they had been informed, the correct treatment would be a reassessment and considering withdrawing the antipsychotic drug…'* The P IPA also advised that the patient's *'…Antipsychotic medication was increased to the maximum advised without any further physical investigations. NICE guidelines advise regular monitoring…'*

32. The P IPA further advised *'The pathologist has given the view that the primary cause of death was heart failure. However, the pathologist also gives the opinion that death may have been due to a cardiac arrhythmia, contributed to by the drugs he was taking. The apparent lack of initial testing and the lack of monitoring combined with a decision to increase Aripiprazole to the maximum recommended may have contributed to [the patient's] suffering an arrhythmia and this may have contributed to his death…'*

Complainant's response to draft report

33. In response to the draft report the complainant said she felt very strongly that had the Trust carried out the patient's echo within it's target of 26 weeks and, there been no delay in Dr A receiving/reviewing the result of the echo with

[22]British National Formulary - Organisation which provides key information on the selection, prescribing, dispensing and administration of medicines.

further timely tests organised that, the patient would be here today. She said that a delay of over 40 weeks to complete the patient's echo was totally unacceptable and not good clinical practice. The complainant also raised very critical views in relation to Dr B and considered that he had seriously failed to follow proper procedures especially as he knew that the patient had attended Cardiology and believed that he had *'…failed in his duty of care to the [patient]…'*

Trust's response to draft report

34. The Trust acknowledged that the failures identified resulted in uncertainty and loss of opportunity for the patient to have further timely investigation and review and advised work was ongoing to implement the recommendations.

Analysis and Findings

Actions of Cardiology Department

i. Initial Cardiology assessment and request for echo

35. The complainant queried Dr A's decision to refer the patient for a routine echo given his symptoms. I considered the Trust's records and noted Dr A assessed the patient on 1 May 2019, following a request from the patient's GP. He made a referral for an echo the same day. I further note the Trust carried out the echo on 11 February 2020. I note the Trust's comments that during the patient's initial assessment *'…No red flag symptoms were identified…which were indicative that an urgent ECHO was necessary…'*

36. The C IPA's advised the patient's GP referred him to Cardiology due to significant bradycardia but, he had also presented to the GP with '…*an episode of palpitation and breathlessness.* She also advised during the Cardiology assessment on 1 May 2019 Dr A focussed on the patient's '*chest pain and bradycardia...'* However, given the history of a single episode of palpation, requesting '…*A 24 hour ECG monitor or a cardiac event monitor…would have been reasonable practice…'* I also note the C IPA's advice that '…*Palpitation does not seem to have recurred, so not investigating the palpitation will not have had any impact. Otherwise the investigation was appropriate.'* While I acknowledge the C IPA's advice about reasonable practice in relation to

investigating the patient's episode of palpitation, I also accept her advice that not investigating this would not have had an any impact on the patient. However, I would ask the Trust to reflect on the advice of the C IPA in relation to this reasonable practice.

37. I considered the C IPA's advice that '*…As no significant cardiac disease was suspected clinically, there was no urgency that this echo be done…'* I accept the C IPA's advice that it was appropriate for Dr A to request a routine echo.

38. However, I further note the C IPA's advice '*This patient waited over nine months to have a routine echocardiogram, which is clearly in breach of the Trust target of 26 weeks, and clearly is not good clinical practice...'* I refer to the 2019/20 Commissioning plan which states that '*75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks…'* I am very concerned that in this case it took almost 41 weeks for the Trust to carry out a routine echo on the patient. I consider this delay in completing an echo a failure in the patient's care and treatment. I will deal with injustice to the patient as result of this failure at paragraph 47. Therefore, I partially uphold this element of complaint. I would highlight that the breach of waiting times is a recurring theme in my investigations and this case highlights the potential risks of breaching waiting times to patients and ultimately to the National Health Service as a whole.

ii. Actions taken after echo findings

39. The complainant raised concerns in relation to the actions taken following receipt of the echo result, particularly in relation to communication of the echo result and further monitoring. I considered the Trust's records and note the findings of the echo report dated 11 February 2020. I also note Dr A stamped the report on 3 March 2020 and proposed a six month review of the patient.

40. I considered the Trust's comments that it had identified a lack of communication with the patient and his GP about the result of his echo and it was developing a Diagnostic Test Policy for all wards and departments as result. I also considered its comments that it would not always be apparent to Cardiology

'…*that a patient is attending psychiatry as their records are not on ECR…'* and '…*it is unlikely they would copy correspondence with any other professional…'* unless advised by the patient or referring GP that they were attending psychiatry. I further the note the Trust acknowledged that *'...Additional investigations to assess [the patient's] arrhythmic risk were not organised upon receipt of the ECHO report…However, the SAI review team…were not certain an alternative management plan may have affected [the patient's] outcome…'* due to the factors detailed in paragraph 15.

41. I note the C IPA's advice in relation to the time taken for the cardiologist to receive/review the echo result from the date of reporting and that '…*This is an additional unnecessary delay, causing a further delay in arranging follow up…The Trust should have arrangements in place for timely review of results (eg when a consultant is on leave etc).'*

42. I also considered the C IPA's advice that as the echo did not give a definitive diagnosis '…*further tests, including MRI should have been requested. This test should have been done…'* in accordance with the 2019/20 Commissioning plan and *'…Additional tests eg exercise stress testing and 24 hour ambulatory monitoring were also required to undertake a risk assessment (for sudden cardiac death).'* I note the IPA's advice that the plan for a six month review was *'...not appropriate. It probably did not however impact the patient, as a definitive diagnosis might still had not been reached…Ideally the patient should have been given a much earlier review, so that the echo findings could have been discussed with him, and further investigation…planned.'*

43. I note the C IPA's advice that *'…The GP and the patient should have been informed of the result of the echocardiogram… and that further tests, including MRI were required to try and reach a definitive diagnosis…'* I further note her advice that at the time the echo was carried out, the patient was receiving psychiatric care but the '…*cardiologist could not have been expected to know this…'* as '...*psychiatric records are not available on the general electronic record system…'* However, I also note her advice that '…*the cardiologist presumably would have identified [the patient was receiving psychiatric care] at*

cardiac review, and if he had, should have copied his letter to the psychiatrist, with an additional discussion of the ECG…and the recommendation for ECG monitoring.'

44. I note the C IPA's advice in relation to the conclusion of the SAI review that there was no evidence to suggest the patient's outcome would have been any different had the Trust implemented an alternative management, '…*even if the echo had been performed in a timely way, and the diagnosis of hypertrophic cardiomyopathy had been confirmed, and an indication for an ICD demonstrated...Given the waiting times described in the SAI report, it is unlikely that this patient would have received a primary prevention ICD within the time available…Risk stratification in hypertrophic cardiomyopathy (if that diagnosis had been confirmed) would not have prevented the sudden death.'*

45. Given the available evidence it is clear there was '…*unnecessary delay…'* in Dr A receiving/reviewing the echo report. I am satisfied Dr A should have informed both the patient and his GP of his echo result in accordance with the NHS Results on Discharge Guidance. I consider this delay and the lack of communication with the patient and his GP are failures in patient's care and treatment.

46. I acknowledge the Trust's comments about waiting times for MRIs at the time of the echo result, and the resulting impact of Covid 19. However, I accept the C IPA's advice that Dr A should have arranged an earlier Cardiology review and requested '…*further tests, including…MRI…'* Although, I also acknowledge her advice that even given an earlier review *'…a definitive diagnosis might still had not been reached [sic]…'* I consider the failure to arrange an earlier cardiology review appointment and to request further tests, including an MRI, as failures in the patient's care and treatment. It is my view these failures were also compounded by the failure already identified in paragraph 38 in relation to the delay to carrying out the initial echo.

47. I acknowledge and accept the C IPA's advice that had a diagnosis of HCM been confirmed, risk stratification would not have prevented the patient's

sudden death. However, I consider, that as a consequence of the failures identified in paragraphs 38, 45 and 46 the patient and his family experienced uncertainty. I further consider the patient experienced the loss of opportunity for a timelier follow-up cardiology appointment, optimal treatment options (which should have included the request for additional tests eg MRI) and for him and his GP to receive information about his echo result. I also consider the patient experienced the loss of opportunity to have all relevant information conveyed to his CMHT. This is because an earlier review appointment would have given Dr A the opportunity, via the patient, to identify he was receiving psychiatric care and share information with the CMHT. I also consider that this in turn caused the patient the loss of opportunity to have enhanced monitoring and reassessment of his treatment, including the appropriateness of the prescribed antipsychotic medication by the CMHT. Therefore, I uphold this element of complaint.

48. The failures identified also highlight the need for appropriate communication systems between specialisms and I will refer to this in my recommendations.

Actions of CMHT

49. I am considering the treatment the CMHT provided based on available clinical information it had on the patient at the time of his referral to the CMHT. The complainant said that after the completion of the echo there was no further monitoring of the patient's condition and therefore other clinicians could not take his condition into consideration when providing care including the prescribing of medication. I acknowledge the complainant's strongly held view that if the Trust diagnosed the patient in a timely manner and communicated the ongoing test and results to his GP and other clinicians then, his condition could have been monitored and managed, and he would still be here today. I also note the complainant's comments in relation to Dr B.

50. I considered the Trust's records and note the occasions the CMHT reviewed the patient including the medication prescribed. I also noted the Report of Autopsy for the patient. I considered the Trust's comments that the patient's particular anti-psychotic medications carried a lower risk of '…*arrhythmia*

provocation (abnormal heart rhythms)…' and '…*A baseline ECG should have been performed before starting the antipsychotic medication. The suggested diagnosis from the echocardiogram may have warranted further follow up ECG's with any dose changes of the antipsychotic medications.'*

51. I note the P IPA's comments that *'…no baseline investigations…were requested by the psychiatrist…'* and that while the GP had completed some tests *'…the results of these do not seem to have been available to the psychiatric team, although overall responsibility for the completion of baseline tests lies with the psychiatric team.'* He also advised given the CMHT was aware of the patient's childhood history and that he had been referred to cardiology*, '…an ECG…was mandatory…'* as *'…this meets the NICE criterion "there is a personal history of cardiovascular disease"…'* I also note his advice that the patient's *'…Antipsychotic medication was increased to the maximum advised without any further physical investigations. NICE guidelines advise regular monitoring…'* I further note the P IPA's advice that had the CMHT been informed of the echo result '…*the correct treatment would be a reassessment and considering withdrawing the antipsychotic drug…'*

52. The C IPA advised given the CMHT was aware of the patient's Cardiology referral *'…they should have sought cardiac advice regarding any diagnosis made... Initiating monitoring was their responsibility and not that of the cardiologist…'* and the CMHT should *'…ensure that that they have a system for baseline ECGs and ECG monitoring in place…'* She also advised '…*ECG monitoring probably would not have prevented the sudden death.'* However, I also note the P IPA *'…The apparent lack of initial testing and the lack of monitoring combined with a decision to increase Aripiprazole to the maximum recommended may have contributed to [the patient's] suffering an arrhythmia and this may have contributed to his death…'*

53. I refer to CG 178 and the Trust's SOP that require baseline investigations to be competed, which includes an ECG, as well as ongoing monitoring at least every 12 weeks. Given the available evidence, I am satisfied that the CMHT failed to carryout out baseline assessments before prescribing the patient anti-psychotic

medication and failed to carry out any further monitoring. I consider this a failure in the patient's care and treatment.

54. I also refer to paragraphs 38 and 45 to 47 which highlight the Cardiology department's failures and the subsequent loss of opportunity to the patient. Alongside these failures, I am also satisfied that CHMT could have taken a more proactive approach to seeking additional information about the patient's Cardiology referral. I consider the failure to proactively seek information from the Cardiology department a failure in the patient's care and treatment.

55. As a consequence of the failings identified in paragraphs 53 and 54, I consider the patient experienced uncertainty and the loss of opportunity to have optimal treatment options, which should have included baseline tests, further monitoring and the reassessment of his prescribed medication.

56. Given the available evidence of the C IPA, P IPA, and the Report of Autopsy, I cannot conclude whether the lack of an initial ECG, ongoing monitoring, reassessment of the patient's prescribed medication caused the patient's sudden death. However, there is evidence that these may have been a contributory factor. Although it is not possible to say definitively whether the appropriate care and treatment would have altered the sad outcome for the patient, it is clear to me that the failings identified meant the patient did not receive the care and treatment that he should have. Unfortunately, this means that the complainant experienced uncertainty and upset because there will always be an element of doubt in relation to the circumstances surrounding the patient's death.

CONCLUSION

57. I received a complaint about the actions of the Trust in relation to the care and treatment provided to the patient from 1 May 2019 to 13 June 2020.

58. The investigation established failures in the patient's care and treatment in relation to the following matters:

- Length of time the patient to had to wait to have an echo carried out;
- Length of time taken to receive/review the echo report;
- Communication with patient and his GP about results of the echo;
- Failure to arrange an earlier Cardiology review appointment;
- Failure to request further tests, including an MRI;
- Failure to carry out baseline tests, and further monitoring, including an ECG, before prescribing anti-psychotic medication; and
- Failure of the Community Mental Health Team (CMHT) to proactively seek information from the Cardiology department about the patient's condition.

59. I am satisfied that because of these failures the patient experienced the loss of opportunity for, him and his GP receive information about his echo result, a timelier follow-up cardiology appointment, optimal treatment options, (including, the request for additional tests, baseline tests including an ECG), to have all relevant information conveyed to his CMHT, to have enhanced monitoring and reassessment of his prescribed medication by the CMHT. I am also satisfied the patient also experienced uncertainty and the complainant experienced uncertainty and upset.

60. The investigation did not establish a failure in relation to the following matter:

- The priority given to the echo requested on 1 May 2019.

61. I offer through this report my condolences to the complainant for the sad loss of her son.

Recommendations

62. I recommend within one month of the date of this report the Trust:

i. 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; and

ii. Discusses the findings of this report with the clinicians (in both Cardiology and the CMHT) involved in the patient's care.

63. I further recommend for service improvement and to prevent future recurrence the Trust:

i. Reviews the current waiting times for routine echoes and provides evidence as to how it has improved/or continues to improve waiting times for such tests;

ii. Provides evidence of the developed Diagnostic Test Policy which includes the need for clear communication of test results with patients and GPs;

iii. Reviews the current communication arrangements between Cardiology and CHMTs with a view to implementing an information sharing framework to enable Cardiologist and CHMTs involved in a patient's care to have sight of the relevant information that may impact on a patient's care and treatment; and

iv. Carries out a random sampling audit (for the 12 months prior to the issuing of the final report) of patients prescribed anti-psychotic medication by the CHMT, to ensure relevant baseline tests and appropriate ongoing monitoring have been completed. Take action to address any identified trends or shortcomings. The Trust should include any recommendations identified in its update to this Office.

64. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

65. The Trust accepted my findings and recommendations.

MARGARET KELLY
Ombudsman **26 June 2023**

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.