Investigation Report

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

NIPSO Reference: 202000636

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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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Listed Authority: Southern Health & Social Care Trust

SUMMARY

I received a complaint about the Southern Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment his newborn son (the infant) received from the Trust during the period 22 September to 25 September 2020. The infant was born on 22 September 2020 and the complainant said following his birth, he was not meeting his feeding requirement. When the infant did feed, he fed very slowly. The complainant said the Trust did not listen to his wife's concerns regarding the infant's feeds. The complainant believed the Trust discharged the infant and his wife prematurely from Craigavon Area Hospital, only for them to be readmitted hours later.

The investigation examined the details of the complaint, the Trust's response, clinical records, and relevant guidance. I also sought advice from an independent Midwife, and an independent Paediatrician.

The investigation found the omission in the medical records of some of the millilitres of formula milk the infant took, and the inaccurate recording of the infant's weight, did not have an adverse impact on his care and treatment. The investigation also established the Trust appropriately responded to the concerns of the infant's mother.

However the investigation found the Trust discharged the infant prematurely from hospital on 25 September 2020. This caused the complainant to sustain an injustice of upset and uncertainty.

I recommended the Trust apologise to the complainant and his family. I also recommended the Trust discuss the findings of this report with the relevant staff to prevent future failings recurring.

THE COMPLAINT

1. I received a complaint about the actions of the Southern Health and Social Care Trust (the Trust). The complaint relates to the care and treatment the Trust staff provided to the complainant's newborn son (the infant) in relation to his feeding, the staff's consideration of his wife's concerns and the recording of the infant's weight.

Background

2. The infant was born prematurely at 35 weeks on 22 September 2020. Within the first 24 hours of the infant's life, he began to encounter poor feeding. The complainant's wife expressed concerns to Midwifery staff about the infant's feeding and so a Midwife assisted with some of the feeds. The Trust discharged the complainant's wife and the infant on 25 September 2020. On arriving home, the complainant and his wife noticed a drastic change in the infant's feeding and phoned the Trust for advice. The infant attended Emergency Department (ED) Craigavon Area Hospital (the hospital) on 25 September 2020. The infant was admitted at 02.00 on 26 September 2020 and was subsequently tube-fed. The Trust discharged the infant from hospital on 2 October 2020.

Issue of complaint

3. The issue of complaint accepted for investigation was:

   Whether the care and treatment provided to the infant between 22 September 2020 and 25 September 2020 was appropriate and in accordance with relevant procedures and guidance.

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.

Independent Professional Advice Sought

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

    - Midwife IPA (MW IPA), RM RN BSc (Hons) PgCert MA. The IPA is a practising Midwife and her role ensures she has detailed knowledge of contemporary issues relating to midwifery practice.
    - Paediatrician IPA (P IPA), MBBS, MMedSC Paediatrics, DCH, MRCPCH, FRCPCH.

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

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 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 which are 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[1]:

    - 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:

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

- British Association of Perinatal Medicine Identification and Management of Neonatal Hypoglycaemia in the Full Term Infant April 2017 (BAPM Guidance);
- Nursing and Midwifery Council (NMC) The Code – Professional standards of practice and behaviour for Nurses, Midwives and Nursing associates 10 October 2018 (NMC Guidance);
- National Institute of Care and Excellence (NICE) Faltering growth: recognition and management of faltering growth in children NG75 27 September 2017 (NICE Guidance); and
- Neonatal Network Northern Ireland (NNNI) Criteria for Administration to and Discharge for Home from Neonatal Units Health and Social Care October 2019 (NNNI Guidance).

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

9. I did not include all the 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.

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 care and treatment provided to the infant between 22 September 2020 and 25 September 2020 was appropriate and in accordance with relevant procedures and guidance.

Detail of Complaint

11. The issue of complaint is about the care and treatment the Trust provided to the infant from 22 September to 25 September 2020. The complainant raised the following concerns:
    - Following the infant's birth, he was very slow to feed and did not receive an adequate amount of formula milk;
    - The records do not accurately reflect the millilitres of formula milk the infant had taken;
    - Midwifery staff did not listen to his wife's concerns, and these concerns were not referred to the Paediatrician; and
    - The infant and mother were discharged prematurely from the hospital, only to be readmitted hours later.

Evidence Considered

Legislation/Policies/Guidance

12. I considered the following policies/guidance:
    - BAPM Guidance;
    - NMC Guidance;
    - NICE Guidance; and
    - NNNI Guidance.

Trust's response to investigation enquiries

Considerations of the Mother's Concerns

13. The Trust stated, *'the Consultant Paediatrician [B] was sorry to learn of [the complainant's] concerns and she apologises if there were communication issues regarding [the infant]'s care'*. The Trust said the infant's management plan was appropriate.

Feeding of the infant

14. The Trust stated, *'the Midwives have acknowledged that feeding was slow and the amounts of formula taken at each feed varied. Unfortunately, on occasions the volume of formula taken by [the infant] was not recorded and for this the Lead Midwife apologises sincerely'*. The Trust informed this Office it had spoken to the staff involved in the infant's care to ensure it will not happen again for another family.

Discharge - Feeding

15. Regarding the patient's readmission to hospital the Trust stated, although it was regrettable, *'the Consultant Paediatrician [B] has concurred that nothing could have been done to avoid this'*.

Discharge - Infant's weight

16. The Trust acknowledged there was an error in the recording of the infant's weight but stated the action plan to discharge the infant was appropriate. The Trust advised this Office it spoke to relevant staff and highlighted this issue so it would not occur for another family. The Trust stated, that despite the inaccurate recording of the infant's weight, the infant's percentage weight loss was correct. The Trust stated its action plan to discharge the infant was appropriate.

Relevant Trust records

17. A summary of the relevant clinical records is enclosed at Appendix four to this report.

18. I also included statements from Midwives which this Office received in response to our enquiries with the Trust. These statements are enclosed at Appendix five to this report.

Response to the draft Investigation Report

19. Both the complainant and the Trust were given an opportunity to provide comments on the draft Investigation Report. Where appropriate, comments have been reflected in changes to the report. Other comments are outlined below.

The complainant's response

20. The complainant understands the independent professional advice received is based on the infant's medical records. The infant was the complainant's second child. Her first child was born at 34 weeks and was admitted for treatment in the Neonatal unit. The complainant said, *'it is for this reason she understood the gravity of the situation with [the infant]'s feeding'*. The complainant said she felt her concerns were not addressed appropriately by the Trust, and this is evident by the infant's readmission to hospital (on 26 September 2020) and the need to receive NG tube feeding.

Relevant Independent Professional Advice

Consideration of Mother's Concerns

Midwifery Care

21. The MW IPA advised the Trust's records document that the mother raised concerns about feeding. The MW IPA also advised the records document that the Midwives provided reassurance to the mother and indicated that the behaviour of the baby was normal for a baby born at 35 weeks.

22. The MW IPA advised it may have been helpful for the Midwives to explain or show the mother how she might get the baby to take more milk at each feed. The MW IPA advised, *'this would have helped her to feel more confident in terms of ensuring that the baby was meeting his feeding requirements'*.

23. The MW IPA advised, *'there is evidence in the documentation that the midwives asked for paediatric review at appropriate times'*. The MW IPA advised she could not identify any failings about this matter.

Paediatric Care

24. The P IPA advised *'Paediatricians regularly reviewed the baby and examined and managed accordingly by doing septic screen, started IV antibiotics and gave advice about required amount of feeding which were appropriate actions'*.

Feeding of the infant

Midwifery Care

25. The MW IPA advised *'there are multiple records in the notes to indicate that the baby's feeding was being monitored'* by the midwifery staff. The MW IPA advised, *'overall the midwives provided appropriate care in terms of the baby's feeding and made appropriate referrals for Dr review'*.

26. The MW IPA advised the omission in the medical records of some of the millilitres of formula milk the infant took *'did not impact the care and treatment given to the baby'*. The MW IPA advised, *'there is regular documentation that the baby was feeding and no concerns were documented about the amounts being taken by the baby, which were initially above its requirements'*.

27. The MW IPA advised, *'failings identified are in relation to record keeping where the amounts given to the baby are not documented. This may have impacted on the mother's confidence that the baby was taking appropriate amounts of feed'*.

Paediatric Care

28. The P IPA advised Paediatrician B appropriately monitored the feeding of the infant. The P IPA advised, *'I would not say the omission of some of the millilitres of formula taken by the infant had impact on this case management. However it is a good practice to record an amount of milk taken, duration of feed and any signs of feed intolerance'*.

Discharge – Feeding

Midwifery Care

29. The MW IPA advised the Midwife carried out a full Newborn and Infant Physical Examination[2] (NIPE) assessment of the baby before discharge and *'weighed the baby and noted the weight loss which was within normal limits. The midwives also appropriately requested a paediatric review before discharge*

[2] The Newborn Infant Physical Examination (NIPE) must be performed with8in 72 hours of birth by a qualified practitioner. The purpose of the examination of the new-born is to screen for congenital abnormalities.

which was undertaken and the paediatrician assessed the baby as fit for discharge following discussion with the Registrar[3]'.

30. The MW IPA advised, *'the baby was examined by the midwife prior to discharge and a review by a paediatrician was appropriately requested as the baby was pre term'*.

Paediatric Care

31. The P IPA advised that normally Paediatricians review a new-born infant prior to their hospital discharge. The P IPA advised, *'in this case, the discharge was premature in view of baby was not fed adequately which was evident in the volume of milk baby took'*. The P IPA also advised, *'in addition to that baby was still slow to feed and maternal concern about feeding as well as high PCV[4] which is one of the markers of dehydration'*. The P IPA advised the infant's PCV level was 62, which is the upper range of the normal limit. The P IPA advised, a newborn's *'feeding should be adequate and tolerant'* prior to hospital discharge. The P IPA advised the Trust's decision to discharge the infant was *'not appropriate'* and was '*premature'*.

Discharge - Infant's Weight

Midwifery Care

32. The MW IPA advised *'a 9% weight loss […] is within normal limits'*. The MW IPA also advised when the Trust readmitted the infant to hospital on 26 September 2020, the baby weighed 3610g which was *'within normal range'* of percentage weight loss.

33. The MW IPA advised, *'the documentation of the wrong weight by the paediatrician did not have any effect on the care and treatment of the baby'.* The MW IPA explained this was because, *'the baby's weight loss was within normal limits prior to discharge'*. Regarding the infant's weight, the MW IPA advised, *'it was appropriate to discharge the baby'*. The MW IPA advised, *'the midwives recorded the right weight and calculated the correct weight loss*

[3] A middle ranking hospital doctor undergoing training as a specialist.
[4] Packed Cell Volume (PCV) Is a test used to diagnose dehydration.

percentage and appropriately assessed the baby as fit for discharge'. The MW IPA also advised the midwives appropriately asked for Paediatric review prior to the infant's hospital discharge and *'there was no other indication that the baby was unwell […] so discharge was appropriate'* in relation to midwifery care and treatment.

Paediatric Care

34. The P IPA advised the inaccuracy of the recording of the infant's weight, *'did not effect on the patient's care as percentage of weight loss was correct'*. The P IPA also advised the inaccuracy of the recording of the infant's weight did not have an impact on the infant's discharge. The P IPA advised, *'in general rules, baby can lose weight 10% within first 10 days, in this case the baby's weight was not contraindication for discharge on that day'*.

35. The P IPA advised, the infant's readmission to hospital *'did not impact on the infant as the baby was readmitted for feeding support but it caused emotional stress to the family'*.

Analysis and Findings

Consideration of Mother's Concerns

36. The complainant said the Trust's Midwifery staff did not listen to the mother's concerns about the infant's feeding, and the Midwifery staff did not refer these concerns to the Paediatrician.

37. The Trust stated the staff Midwife, *'advised and offered reassurance that this can be normal for a 35 week gestational age baby to be slow to feed and perseverance is required'*. The Trust advised the infant's management plan was appropriate.

38. I note the Trust's medical records document on 24 September 2020 at 16.45 the mother raised concerns about the infant's feeding. On 25 September 2020 at 10.20 the records document the mother was *'anxious about baby being slow to feed – reassurance given this can be normal for 35 week baby'*. The Midwifery staff provided statements to this Office to assist in the investigation.

Midwife A acknowledged in her statement that: *'Mum had expressed concerns about how slow baby was to feed'*.

39. I refer to the NMC Code which requires Nursing staff to *'recognise when people are anxious or in distress and respond compassionately and politely'*. I note the NMC code also requires Nursing staff to refer matters to their colleagues when appropriate.

40. I note the MW IPA advised, *'the midwives offered reassurance to [the mother] on a number of occasions and helped with feeding the baby as needed which was appropriate care'*. The MW IPA advised the medical records document that the Midwives asked for Paediatric review *'at appropriate times'*.

41. I considered all the available evidence, including the advice of the IPAs. I accept the advice of the MW IPA that the Midwifery staff *'offered reassurance to [the mother] on a number of occasions and helped with feeding the baby as needed which was appropriate care'*. I note the Midwifery staff acknowledged the mother's concerns within their statements to this Office.

42. I also accept the MW IPA's advice that Midwifery staff referred the infant for Paediatric review *'at appropriate times'*. I note the P IPA's advice that the *'paediatricians regularly reviewed the baby and examined and managed [the infant] accordingly'*. I consider the Trust provided the mother and the infant with the appropriate care and treatment following the mother's concerns. I do not uphold this element of the complaint.

43. Although I did not identify a failing about this matter, I wish to highlight the advice of the MW IPA: *'it may have been helpful for the midwives to explain to or show [the mother] how she might get the baby to take more milk at each feed'*. The MW IPA advised this would have assisted the mother to *'feel more confident in terms of ensuring that the baby was meeting his feeding requirement'*. In response to the draft Investigation Report the Trust informed this Office it will reflect on this advice.

Feeding of the infant

44. The complainant said the infant was very slow at feeding and not meeting his feeding requirement. The complainant also said some of the millilitres of formula milk the infant took were omitted from the records.

45. The Trust stated, *'the Midwives have acknowledged that feeding was slow and the amounts of formula taken at each feed varied. Unfortunately, on occasions the volume of formula taken by [the infant] was not recorded and for this the Lead Midwife apologises sincerely'*.

46. I note Midwife A's statement that the infant was slow to feed on some occasions. The Midwife explained this can be normal for a 35 week baby. Midwife A also said the Paediatricians were aware of the infant's feeding.

47. I note the Trust's medical records document the Midwives measured the infant's blood sugar levels pre-feed, which were within normal limits. The medical records also document the number of millilitres of formula milk the mother and the Midwifery staff fed the infant, however the Trust acknowledged there were some omissions of these millilitres of formula milk in the medical records. The medical records also document the Trust's Paediatrician B regularly reviewed the infant.

48. The BAPM Guidance states, *'there should be regular assessment of the baby when awake'*. The Guidance also requires these assessments to *'include assessment of feeding behaviours'*. The BAPM Guidance also states, *'Practitioners need to be skilled in the clinical assessment of effective feeding and reluctant feeding'*. The Guidance states infants that *'are reluctant to feed should be given an active feeding plan'*.

49. I refer to the NMC Code which requires Midwifery staff to *'keep clear and accurate records relevant to your practice'*.

50. I note the MW IPA advised, *'there are multiple records in the notes to indicate that the baby's feeding was being monitored by both midwifery and medical staff'*. The MW IPA advised that overall, the Midwifery staff *'provided*

appropriate care' to the infant. Regarding the infant's slow and reluctant feeding, the MW IPA advised the Midwives made the *'appropriate referrals for [Doctor] review'*.

51. The MW IPA advised the omission of the number of millilitres of formula milk did not impact on the care and treatment given to the infant. The MW IPA advised, *'there is regular documentation that the baby was feeding and no concerns were documented about the amounts being taken by the baby, which were initially above its requirement'*.

52. The P IPA also advised, *'I would not say the omission of some of the millilitres of formula taken by the infant had impact on this case management'.*

53. I considered all the available evidence, and I note the medical records document that both the Paediatrician and Midwifery staff monitored the infant's feeding. I accept the MW IPA's advice, that overall in terms of feeding, the Midwives provided the infant with the *'appropriate care'*. I also accept the MW IPA's advice that the Midwives '*made appropriate referrals for [Doctor] review'*. I am also satisfied the record keeping failing identified did not impact on the care and treatment in relation to the infant's feeding. I do not uphold this element of the complaint.

54. Nonetheless I am concerned that the Midwifery staff did not maintain accurate medical records for the number of millilitres of formula milk the infant took. I would expect the Trust staff to maintain records as required by the NMC. I acknowledge the Trust recognised this failing as part of local resolution and informed the complainant it has spoken to the members of staff involved in the infant's care to prevent this error happening again for another family.

55. In response to the draft Investigation Report, the Trust wished to provide assurance to both our Office and the complainant that the requirement to record feeding volumes within an infant's medical records is embedded within Midwifery practice.

Discharge - Feeding

56. The complainant said the Trust discharged his son and wife prematurely from the hospital only to be readmitted hours later. When readmitted the complainant said the infant required a NG tube[5] for feeding and treatment for jaundice and remained in hospital until 2 October 2020.

57. Regarding the infant's remittance to hospital the Trust stated, although it was regrettable, *'the Consultant Paediatrician [B] has concurred that nothing could have been done to avoid this'*.

58. The NNNI Guidance states that in order for medical staff to discharge an infant from hospital it must be on *'full enteral feeds for 48 hours. If going home on tube feeds, stable and parents trained'*.

Nursing Care

59. I considered all of the available evidence and I accept the MW IPA's advice that, *'the midwives […] appropriately requested a paediatric review before discharge'*.

Paediatric Care

60. I note the NNNI Guidance requires the Trust to discharge an infant following 48 hours of enteral feeds[6]. I accept the P IPA's advice that, *'the feeding should be adequate and tolerant before baby is discharged'*.

61. The P IPA advised Paediatrician B's decision to *'discharge was premature in view of baby was not fed adequately which was evident in the volume of milk baby took'*. The P IPA further advised, *'the feeding should be adequate and tolerant before baby is discharged'*. I note the P IPA advised *'the baby feed was advised to increase due to PCV 62 which is upper range of normal although still in normal limit'*.

[5] Nasogastric intubation is feeding through a thin, bendy plastic tube which goes through the patients nose all the way down to their stomach.
[6] Intake of food via the gastrointestinal tract. Often referred to as tube feeding.

62. The P IPA advised that although Paediatrician B examined the infant, *'the decision for discharge of the baby was not appropriate and premature'*. I accept this advice. I consider the decision to discharge the infant on 25 September 2022 a failure in care and treatment. I uphold this element of the complaint.

63. In response to the draft Investigation Report the Trust accepted the infant was discharged home prematurely, and this was a result of the Paediatric Team's error in judgement. I welcome this acknowledgment.

Discharge - infant's weight

64. The complainant said the Trust's error in the recording of the infant's weight impacted on his discharge on 25 September 2020, and the subsequent readmission to hospital on 26 September 2020.

65. The Trust acknowledged as part of investigation enquiries that a trainee Paediatrician (Paediatrician A) recorded an error in the infant's weight. The Trust explained that despite the inaccurate recording of the infant's weight, the percentage weight loss of 9% was correct. The Trust stated the action plan to discharge the infant was appropriate.

66. The NICE Guidance states, *'It is common for infants to lose weight during the early days of life'*. The Guidance explains that this is because it usually relates to body fluid adjustments. I note the NICE Guidance states that an infant's weight loss of under 10% is within normal limits

67. The MW IPA advised the infant had a 9% weight loss which is within normal limits. The MW IPA advised, *'the documentation of the wrong weight by the paediatrician did not have any effect on the care and treatment of the baby'*.

68. The P IPA advised the inaccuracy of the recording of the infant's weight, *'did not effect on patient's care as percentage of weight loss was correct'*. The P IPA advised this is because the infant's percentage weight loss was *'within normal parameter'* for discharge. I accept this advice. I consider, in relation to weight loss, the Trust's decision to discharge the infant was appropriate.

69. I remain concerned about the inaccuracy of the Trust's records. The GMC Guidance requires medical staff to *'record your work clearly, accurately and legibly'*. Therefore I consider this a service failure. However, I hope the findings of this report go some way to reassure the complainant that the inaccurate recording of the infant's weight did not affect the decision to discharge the infant on 25 September 2020. The Trust has acknowledged Paediatrician A's error in the records and issued an apology to the complainant and his wife. I note as part of local resolution the Trust spoke to Paediatrician A in order to ensure this error will not happen again for other families. However, I referred to failings about the discharge of the infant in paragraphs 58 to 60 above.

Injustice

70. The findings of this report established the Trust discharged the infant prematurely, as he was not adequately feeding, and the infant's PCV level was within the higher normal limit. I note the P IPA advised, *'premature discharge of the baby caused readmission of the baby on the next day and also need tube feeding for one week in hospital'*. I consider this failing caused the complainant and his wife to suffer the injustice of uncertainty and upset. The complainant's wife believed the Midwifery staff did not take her concerns seriously about the infant's feeding, and he subsequently was readmitted to the hospital and received a NG tube to provide adequate feeding. I note the P IPA advised the infant's readmittance to hospital caused *'emotional stress to the family'*. I hope the P IPA's advice, *'it did not impact hugely on the infant as the baby was readmitted for feeding support'*, goes some way to reassure the complainant and his wife.

71. I accept the IPAs' advice that the inaccurate records did not have an impact on the infant's care and treatment, and I hope this also offers some reassurance to the complainant and his wife.

CONCLUSION

72. I received a complaint about the care and treatment provided to the infant in September 2020. I upheld elements of the complaint for the reasons outlined in

this report. I considered the Paediatrician B's decision to discharge the infant constituted a failure in the infant's care and treatment.

73. I recognise the impact the failures had on both the complainant and his wife. I especially recognise the upsetting situation of the infant's readmission to hospital for treatment. I note the infant's health and feeding improved upon his second admission to hospital and was discharged within a week after these events.

74. I acknowledge the Trust advised this Office and the complainant that it has taken forward learnings on the inaccurate records by speaking to the staff involved with the family's care.

75. In response to the draft Investigation Report the Trust advised this Office it will raise awareness amongst paediatric staff in relation to:
    - Any preterm infant <36 weeks would have a low threshold to consider feeding support; and
    - Large for dates babies born to type 1 diabetes mothers can provide to be slow to establish feeds that may require feeding support.

Recommendations

76. I recommend 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 failures identified within **one month** of the date of this report.

77. I recommend the findings of this report are shared with Paediatrician B in a supportive manner that encourages learning. This should be evidenced with records of information sharing and the Trust should provide this Office with an update within **three** months of the date of my final report.

Margaret Kelly
Ombudsman **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.