SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Case ref: 201508365, An NHS Board
Sector: Health
Subject: Community Nursing & Support Services / Nurses / Nursing Care

Summary
Mrs C complained via an advocacy service in relation to her husband (Mr A) who was receiving end of life care at home. Mrs C had gone out one morning, expecting a visit from a district nurse (the nurse) to take place in her absence. When Mrs C returned, she found Mr A deceased and in an inappropriate position. Mrs C called her immediate family who lived within walking distance. Her daughter (Mrs B) covered Mr A up and the family contacted the emergency services.

Paramedics attended and confirmed that Mr A had died. A doctor from the family's GP practice attended to certify death. Mrs C complained to the board shortly afterwards, saying that she believed the nurse had left the property whilst Mr A was dying or after he was dead.

In response to the complaint the board conducted an internal investigation. They interviewed Mrs C, the nurse and other health professionals involved in the case. The nurse accepted that they had left the property without recording their visit properly, but stated they had intended to return. They denied strongly having left Mr A in an inappropriate condition.

The finding of the internal investigation was that the nurse's version of events was confused and contradictory. It concluded the nurse had breached professional guidelines in terms of record-keeping and that the care they had provided had fallen below an acceptable standard.

The internal investigation recommended a disciplinary hearing be held. Mrs C's advocate advised us that the family had not been kept informed of the board's actions. The advocate said there had been an extended and unexplained delay in the investigation and when a formal complaint was made about this, the board's complaint response was entirely inadequate.

The advocate said the family were told they could not be given any details of what had happened to Mr A, though they were told the board were satisfied that

the nurse had responsibility for the condition Mr A was found in. We reviewed all the interviews and information considered by the board's internal investigation. We also interviewed Mrs B, who said she felt she had been overlooked by the board's original investigation. We took professional advice on the standard of nursing care provided to Mr A and whether this met the professional standard expected of a nurse. We found that although it was not possible to determine exactly what took place, the likelihood was that the nurse performed some form of treatment on Mr A.

There was no suggestion this had contributed to his death, but the weight of the evidence pointed to Mr A being left in an inappropriate condition by the nurse. We found the board's investigation had failed to interview family members, and that the board had not provided the family with an adequate explanation for their actions. The advice we received was that the nurse's actions fell below acceptable professional standards and that the care provided to Mr A was unreasonable.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) consider a referral to the Nursing and Midwifery Council, in view of the concerns raised over the Nurse's conduct and that an explanation for any decision reached is provided to this office;	15 April 2017
(ii) review the procedures for the management of lone working in the community to ensure an adequate level of communication is sustained between staff and managers;	15 April 2017
(iii) remind staff of the importance of giving consideration to interviewing all individuals involved in an the incident under investigation;	15 April 2017
(iv) provide evidence that the actions identified in their review of the handling of Mrs C's complaint have been implemented;	15 April 2017
(v) provide evidence that all staff have been reminded of the need to identify and record complaints accurately; and	15 April 2017
(vi) apologise unreservedly for the failings identified in this report.	15 March 2017

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Given the extremely sensitive nature of the complaint and in order to ensure the individuals involved in the complaint are not identified, in accordance with the Act, the board is not named in this report.

Introduction

1. Mrs C complained to the Ombudsman via an advocacy service about the care and treatment provided to her husband (Mr A), who was found deceased following a visit from a district nurse (the Nurse). Mrs C was unhappy with the standard of care provided to Mr A, and the subsequent investigation into her complaint. The complaints from Mrs C I have investigated are that an NHS Board (the Board):

(a) failed to provide a reasonable standard of care when the Nurse attended Mr A's home on 31 December 2014 (*upheld*);

(b) failed to carry out a reasonable investigation into what happened when the Nurse attended on 31 December 2014 (*upheld*); and

(c) failed to respond to Mrs C's complaint in line with the NHS complaints procedure (*upheld*).

2. I note that the Board's investigation was conducted entirely as an internal disciplinary matter. This had implications both for the length of the investigation and the information shared with Mrs C. In this report my complaints reviewer has set out as much information as possible about the incident involving Mr A, based on the statements obtained from Board staff and the family. The powers available to my complaints reviewer under our governing legislation would have allowed them to interview all the members of staff interviewed during the Board's internal investigation, if necessary under oath. Given that interviews were already available, and that due to the passage of time, this was unlikely to produce a clearer recollection than that already available, the internal interviews are summarised instead in this report.

3. The report does not comment on either the conclusions reached by the Board's disciplinary panel, or the actions subsequently taken by them. I am satisfied that in making this distinction, the investigation has not considered either disciplinary or personnel matters, which are precluded by the primary legislation defining the powers of this office.

Investigation

4. In order to investigate Mrs C's complaint, my complaints reviewer has considered all the information submitted by both Mrs C and her family as well the information submitted by the Board. I have also taken advice from a nursing adviser (the Adviser). In this case, we have decided to issue a public report on Mrs C's complaints because of the serious failings identified during the

investigation and the significant injustice suffered by the family as a consequence.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Key Events

6. Mr A was a patient receiving palliative care for end stage Chronic Obstructive Pulmonary Disease (COPD – a disease of the lungs in which the airways become narrowed). He resided at home, receiving care from his family and from the district nursing service. The district nursing service monitored Mr A's international normalized ratio levels (a measurement used to assess the ability of a patient's blood to clot) and provided Mrs C with assistance as required with Mr A's other health needs. Care could be provided on an 'on demand' basis, which meant Mrs C would telephone in order to arrange care if it was required.

7. On the morning of 31 December 2014, Mr A informed Mrs C that his catheter (a thin tube used to drain and collect urine from the bladder) was causing him discomfort. Mrs C contacted the district nursing service in order to request assistance. Mrs C contacted the district nursing service at around 08:30. Mrs C informed them about the problem with the catheter, she also advised that she was planning to go out that morning to the shops. The front door would be left open to allow the Nurse allocated to attend.

8. Mrs C left the house before 08:40 and caught the 08:40 bus. The Nurse's arrival is estimated at between 09:10 and 09:15. It is recorded that a text was sent at 09:40 by the Nurse to their team leader, saying that they had visited the property. The Nurse arrived at their next patient who was in a nearby property at approximately 09:50.

9. Mrs C returned home at around 09:50. On entering the property she noticed that Mr A's nursing notes were on a ledge in the hall, rather than in his bedroom as normal. Mrs C said she knew that the Nurse had been and she called out to Mr A asking if he felt more comfortable, but did not receive any response.

10. As Mr A was not responding to her, Mrs C climbed the stairs to Mr A's bedroom. Mrs C said that when she entered the bedroom Mr A was lying on his bed, uncovered, with his boxer shorts around his knees, apparently lifeless. Mrs C said that at that point she telephoned her daughter (Mrs B), who lived in a neighbouring property. Mrs B went to the house with her two daughters and her husband.

11. Mrs B said that she and her family had entered Mr A's bedroom as soon as they came into the house. Mr A was lying with one leg in the bed and one leg hanging out of it. His covers were pulled back and he was exposed with his boxer shorts around his knees. Mrs B and her daughters all had experience of seeing deceased individuals through their work in a local nursing home. Mrs B's daughter had gone to check Mr A's pulse and Mrs B had put his legs back into the bed, before covering him. Mrs B works as an 'enhanced carer' and although not a registered nurse, she has had some nursing training. Mrs B said she was clear that Mr A's body was still warm, meaning that he had not been dead long.

12. Mrs B's husband had begun the process of calling for an ambulance but one of her daughter's had taken over the call. The Scottish Ambulance Service records show that an ambulance was dispatched at 10:17 and that it arrived on the scene at 10:24. The paramedics confirmed that Mr A's life was extinct and contacted the family's GP Practice. The GP certified death at 10:35.

13. At 10:47 the district nursing team leader received the text the Nurse had sent about the visit. The text said Mr A had been asleep, Mrs C was nowhere to be seen and that the Nurse would go back to the property later.

14. Mrs C recalled that when the paramedics attended, they asked to see Mr A's nursing notes. They commented that there was no entry for the 31 December 2014. The paramedics pronounced life extinct and contacted that GP and the police. The paramedics departed at 11:35.

15. The Nurse returned to the district nursing team office between 12:30 and 12:50, at which point they were informed that Mr A had been found deceased. The Nurse was contacted by the GP at 12:57 by text message. The GP also left a voicemail asking the Nurse to speak to them about the incident that morning. The Nurse's mobile telephone showed that the message was received at 13:02. The Nurse did not respond to the GP until 17:54, when they

sent a text message saying they were available to speak until 18:00, when they were going out for the evening. In the event, the Nurse did not speak to the GP until several days after the new year.

16. Mrs C contacted the district nursing service on 5 January 2015 to complain about the care and treatment provided to Mr A. The call was taken by the district nursing team leader, who then contacted the GP on 8 January 2015, before meeting with Mrs C later the same day. The team leader said Mrs C was convinced that the Nurse had left the property either whilst Mr A was dying, or shortly afterwards. Mrs C based her view on the condition she had found Mr A in.

17. The Nurse was suspended from duty on 12 January 2015, whilst the Board pursued its investigation. It should be noted this suspension was not an indication of the Board's view of their conduct, but a reflection of the serious nature of the incident being investigated.

18. The Nurse provided a written statement on 22 January 2015. The statement set out their previous experience and employment history. The Nurse set out their current role, noting a requirement for clear decision making in stressful situations and the need for good communication with colleagues, patients and their families.

19. The Nurse was told on 31 December 2014 that they were to visit Mr A. They were told he was in pain from his catheter, and that Mrs C would leave the front door open. The Nurse attended the property at 09:20 (approximately), they noted they had no previous involvement in Mr A's care and no knowledge of his clinical history.

20. The Nurse said on arrival they announced their arrival, but received no acknowledgement. An oxygen concentrator was located on the ground floor, with tubing running up to Mr A's bedroom. Mr A appeared to be asleep, and although he mumbled an acknowledgement when the Nurse shook his shoulder and spoke to him, he did not wake. The Nurse had taken his pulse, which was present but irregular and checked his catheter, which appeared to be draining, although the urine was dark. Mr A displayed no signs of pain.

21. The Nurse said they had read Mr A's notes and then taken the folder downstairs and left it in the hall. This would alert the family to their visit, they

had not documented their actions in the notes as they intended to return to Mr A very shortly. The Nurse said the intention was to revisit when Mrs C was there to gain more information about Mr A. They said they left the property and texted the team leader at 09:27.

22. The Nurse said they had intended to carry out a visit in the afternoon and had returned to the district nursing office at lunchtime. They were told Mrs C had contacted the office and stated she had found Mr A dead. The Nurse said that Mr A was alive during the visit.

Interview with the District Nursing Team Leader

23. The team leader was interviewed on 3 February 2015 by the Board's investigation team. The team leader provided some background to Mr A's care and noted that Mr A had undergone a catheter change on 19 December 2014. The team leader noted the morning had been very busy, and they had received a text from the Nurse at 10:47. The team leader said they had not been texted by the Nurse before and that the Nurse did not normally telephone during the day. The text stated Mr A was asleep and could not be roused enough to talk to. Mrs C was nowhere to be seen and the Nurse intended to return later in the day.

24. The team leader said it was unusual for the Nurse to provide an update on patients and it was unusual for the Nurse to inform them that a patient was asleep. If a patient could not be roused, the expectation was that as a trained nurse action should be taken, contact the patient's GP and establish what the situation was. If the Nurse had said they would return to the patient, the team leader said they had to trust the Nurse to do this.

25. The team leader said the GP had informed them of Mr A's death and the need to speak to the Nurse. The team leader said they were clear that the matter was urgent. The team leader had told the Nurse as soon as they returned to the office about Mr A's death and the need to call the GP urgently. The team leader had felt the Nurse was defensive in response to this information. The Team Leader did not ascertain if the GP was called, although they did remind the Nurse to do it several times during the day. At the time they believed the Nurse had contacted the GP's Practice and left several messages for the GP.

26. The team leader confirmed that some days later they had spoken to the GP. The GP had denied the Nurse had left messages at their practice trying to contact them. The GP had stated the call recording systems at their practice would have logged any telephone contact, and there were no records the Nurse had done this. When the Nurse had been in touch by text message, the GP felt the Nurse's attitude was surprising, since the Nurse indicated they did not have long as they were going out for a meal, allowing less than five minutes for the GP to contact them.

27. The team leader described her subsequent interactions with Mrs C. The team leader noted that Mrs C had been very angry initially, although Mrs C had been happier once she knew an investigation was to be undertaken. The team leader confirmed that they had informed the Nurse after her meeting with Mrs C on 8 January 2015 about the absence of nursing notes. The team leader said they would have expected the Nurse's actions to be documented.

The Board's Interview with Mrs C

28. Mrs C was formally interviewed, by the Board with Mrs B in attendance on 5 February 2015. Mrs C set out her recollection of the events of 31 December 2014. She recalled Mr A had spoken to her before she left the house, and had asked for his glasses so that he could read the paper. He had complained about his catheter, but had not wanted to bother the nursing service. Mrs C felt it was important that it was checked, and so had left a message asking for someone to attend. Mrs C had explained in the message she would not be in and that the door would be open.

29. On her return Mrs C had noted that Mr A's notes were downstairs, rather than their usual place in his room. Mrs C had called out, but received no answer. When she entered the room, Mr A was lying partially out of the bed. Mrs C said she had fetched her daughter Mrs B, as well as her granddaughters. One of her granddaughters had noticed a pair of discarded rubber gloves on Mr A's chest of drawers.

30. Mrs C said given Mr A's position when she found him she believed that Mr A had been being attended to by the Nurse when he had died, or a similar scenario. Mrs C did not believe Mr A could have achieved the position he was found in by himself. She noted Mr A had been unable to leave his bed by himself on 30 December 2014 and had required assistance from family members.

31. Mrs C said she had not touched Mr A, but had immediately sought help from family members. They had then telephoned for the paramedics. Mrs C said that she had suffered a terrible shock finding Mr A. The following day she had fainted from what she felt was the delayed shock.

32. Mrs B said that she had covered Mr A, prior to the paramedics' arrival. Mrs C added that Mrs B had also taken Mr A's pulse, but it could not be located. Mrs B had remarked at the time that Mr A was still warm. Mrs C also recalled that the paramedics had commented on the absence of any nursing record.

33. The interview then ran through the chronology of events with Mrs C. It noted that some days after her complaint the team leader had come out to see her. Mrs C emphasised that she and her family simply wanted to know what had happened to Mr A. Mrs C felt the Nurse must have panicked, but that this was inappropriate behaviour for a professional. Mr A should not have been left in the condition that he was for Mrs C to find.

34. The Board told Mrs C they understood her desire to find out what happened. They could not, however, guarantee what they would be able to tell her, given the possibility of disciplinary proceedings. They said they would let the area manager know about her request to be kept informed. They said they were not sure if a formal response could be provided, but they would ask for one.

35. Mrs C and Mrs B emphasised the family were looking for closure. Mrs C said she thought that if Mr A had been living on his own, he could have been left for an extended period after death, without being found. Mrs C was adamant that Mr A would not have been able to get out of the bed, or change position unassisted. She also noted that the catheter and the bag were as they were left on 30 December 2014; that is the bag had not been emptied. Mrs C said she understood that Mr A had been at the end of his life, and that the Nurse could not have prevented his death, but it was the lack of dignity the family had found so upsetting.

Interview with the GP

36. The GP was formally interviewed on 17 February 2015. The GP gave their perspective on Mr A's care. They noted he had been unwell and was considered to have end stage COPD. The GP was the duty doctor on

31 December 2014 and had been called to attend Mr A as the paramedics required the GP to certify death. The GP said they had been shown upstairs on arrival, and the paramedics had left. Mr A had been lying under the covers at that point.

37. The GP had spoken to a family member and then checked Mr A to ensure there were no injuries to him. They had then done the formal death certification. The GP said they recalled the family mentioning the nursing notes to them, but had assumed they were confused by a visit the previous day to test Mr A's blood. The GP had not pursued the issue as the family were naturally upset.

38. The GP had left the house and contacted the team leader. They had confirmed a visit had been scheduled for that morning and had given the Nurse's contact details to the GP. The GP said they felt they ought to establish if Mr A had been unwell that morning. The GP had called and left a voice message, as well as sending a text to the Nurse asking for a call back.

39. The GP said the Nurse had not contacted them until just before 18:00. The GP did not have time to speak to the Nurse before the Nurse had indicated they would be unavailable, so the matter had been left. The GP confirmed that any calls to their practice would have been automatically logged.

40. The GP said they had spoken to the Nurse in the new year. The GP felt this was important as she was aware Mrs C was unhappy with what had taken place. The GP said Mrs C had spoken to the practice nurse and so the GP was aware that Mrs C was very upset.

Interview with the Nurse

41. The Nurse was formally interviewed on 12 March 2015. It was made clear at commencement there were no suspicious circumstances around Mr A's death. The interview established the Nurse used their personal mobile, as they did not have a work telephone. It also established that the text sent by the Nurse on 31 December 2014 to the team leader was at 09:40, not 09:27. The Nurse explained they had begun calling the office at 09:27, but had not been able to get through. They had, therefore, finished inside the property by this time.

42. The Nurse said they had gone to see Mr A and then on to a neighbouring property to visit the next patient on their list. The Nurse estimated they had

arrived between 09:10 and 09:15, spending a short time in the property. The Nurse said they believed that Mrs C would be returning to the property shortly and if there were continuing problems, the Nurse would have been contacted and returned.

43. The Nurse had been shocked to hear of Mr A's death. The Nurse acknowledged they had failed to document their visit properly. The Nurse said they had moved the notes to the bottom of the stairs to indicate they had visited, but the Nurse had thought Mrs C would be back any minute, would call the office and the Nurse would then return to the property.

44. The Nurse said they had not clinically 'done' anything, so they did not consider it necessary. The Nurse added they knew nothing about Mr A and they intended to return and speak to Mrs C. The Nurse acknowledged they had checked Mr A's pulse and his catheter.

45. The Nurse said they would contact the team leader if they had concerns about a patient. The Nurse said they had had no reason to believe Mr A was unwell. He was not dead or dying, but responsive, although not alert.

46. The Nurse said they had lifted the covers to look at the catheter and they believed it had been draining into a basin on the floor. It had seemed fine. Mr A was not cyanosed (blue lips and/or skin caused by low blood oxygen levels or poor circulation) and had nasal cannulas in. He was hard to rouse and the Nurse had the impression he was exhausted. The Nurse had not used any personal protective equipment (PPE), such as disposable gloves or an apron when checking the catheter and the blue disposable gloves mentioned by the family had been lying there when they arrived.

47. The Nurse said Mr A had been lying in the bed propped up by a few pillows. The Nurse had not attempted to move him in any way. They could not comment on his ability to mobilise independently as they knew so little about the patient.

48. The Nurse said they left immediately after checking the catheter. The Nurse's concern was that Mr A's presentation did not match the information provided. The catheter appeared to be draining well and Mr A did not appear to be in pain. The Nurse had no concerns and they were categorical that he was alive when they left.

49. The Nurse said they had not returned because they were so busy as the office was short staffed on Hogmanay. The Nurse could not explain why they had not returned immediately, given her next patient was in a neighbouring property. The Nurse was adamant they had not moved Mr A's legs, or removed any of his clothing.

50. The Nurse maintained they had attempted to telephone the GP following Mr A's death. The Nurse was informed there was no record of the calls, but stated that they had definitely telephoned and spoken with the receptionists. The Nurse said the receptionists did not have good spoken English, and believed they were foreign.

51. The Nurse said they had texted the team leader at 16:52 on 31 December 2014, stating that they had not been called by the GP. The Nurse acknowledged they had received a text from the GP at 13:02 that day, but said they had called the surgery and left messages for the GP. The Nurse had then texted the GP at 17:54, as there had been no contact.

52. The Nurse could not recall the date they had spoken to the GP, but it was after the public holidays. They said the GP had assured her that Mr A's health was very fragile and that he had been at risk of passing away.

53. The Nurse said they felt terrible for the family and that they did not believe the incident should have been dealt with by the Board in the manner it had been.

54. The Nurse was asked again about the level of assessment they had carried out, it was noted that the Nurse seemed to have drawn conclusions about Mr A's clinical status. They said although they had come to conclusions about Mr A's level of cyanosis, manner and behaviour, this was automatic as an experienced nurse.

55. The Nurse was asked why they thought it appropriate to wait for a call back from Mrs C, rather than making a decision. The Nurse was asked whether they felt they had been wrong to state Mr A was at no risk, when they had noted an irregular pulse and he was difficult to rouse.

56. The Nurse said again that they had intended to return. The Nurse had, however, been so busy that they had not done so. The Nurse could not explain why they had not completed the notes for Mr A. The Nurse said they had been able to see the insertion point of the catheter without removing Mr A's clothing and that they had made no physical contact with him whilst carrying out a visual check of the catheter's position.

57. The Nurse denied having panicked due to Mr A's death. The Nurse said they were experienced and had dealt with deaths previously in the course of their work.

Statement from Healthcare Support Worker

58. The meeting on 19 March 2015 confirmed that the healthcare support worker (the Support Worker) had seen Mr A on 30 December 2014. He had been talkative and had asked after his usual nurse, who was on leave.

59. The Support Worker confirmed Mr A could not get up and down stairs. He had last managed a few days previously, by going up and down on his bottom. The Support Worker said Mr A would have been in bed the whole day on 30 December 2014, they did not think he was fit enough to get himself out of the bed. Mr A had not been able to sit up in bed to have his blood tests taken and had been using his oxygen.

60. The Support Worker said there was no way Mr A could have removed or put on clothing by himself. Although he might have been able to move his duvet, the Support Worker believed it would have been impossible for him to swing his legs out of the bed independently. The Support Worker said in their experience his room was usually tidy, there were not items of discarded equipment like gloves left lying around.

The Board's Investigation Report

61. The Board's report set out the background and the process followed in investigating the complaint, as well as the records and policies accessed.

62. The report identified inconsistencies in the Nurse's statements which they considered concerning. The Board noted the Nurse had stated they had no concerns about Mr A, and that their practice was only to contact the team leader when they had concerns.

63. The Nurse's statements appeared to indicate they had spent thirteen minutes attempting to contact the team leader, even though they had no concern about Mr A's well-being.

64. The Board noted that a registered nurse had a professional duty to keep clear and accurate records. The Nurse had said they intended to return to the property and update the notes, which was a contravention of the Nursing and Midwifery Council (NMC) guidance in itself.

65. The report said there were further issues with the Nurse's stated intention to return. The Nurse had failed to give a clear explanation for leaving the property and not returning. The Nurse had said that they expected Mrs C would call the district nursing office if there was a problem with Mr A, as the Nurse had assessed Mr A as not being in pain. The Nurse had also said they intended to return shortly as they were seeing a patient in a neighbouring property and planned to see Mr A, but had been too busy to do so before lunchtime, even though the Nurse would have passed Mr A's property after leaving the neighbouring property.

66. The report found the Nurse did not appear to have adhered to the correct procedure for assessing a catheter. It also noted the contradiction between the Nurse's first claim they had not done anything clinical, with their subsequent qualification that they had done clinical work, but not recorded it.

67. The report did not consider the Nurse's account of how they checked Mr A's catheter to be credible.

68. The report also considered that the Nurse had failed to use PPE appropriately and noted the unexplained presence of used rubber gloves in Mr A's room. The Support Worker had confirmed that the room was usually tidy, and that all used PPE equipment was placed in a bin.

69. The report noted Mr A was described by Mrs C, Mrs B and other health workers as unable to move from his bed unaided. It also noted Mrs C's comment that Mr A had been left with his boxer shorts removed. Mrs C believed this is because he was being examined when he died. The Nurse denied they had made any physical contact with Mr A that involved moving him, or removing clothing. The report noted it was this lack of dignity in the way that Mr A was found which had particularly distressed the family.

70. The report's conclusion was that the Nurse had not made a clinically accurate assessment of Mr A's condition. This was based on the information provided by a COPD specialist. The Nurse had said Mr A was not cyanosed, however, the COPD specialist had confirmed he was, in fact, always cyanosed and this would have been apparent on visual inspection.

71. The report also noted that if the Nurse did not speak to the patient, and had no knowledge of him, as the Nurse claimed, then it would not have been possible for them to assess whether Mr A's condition was 'normal'. The Nurse could not have found Mr A both 'hard to rouse' and 'responsive', especially if he was so deeply asleep that they had not been able to wake him.

72. The report considered it likely that the Nurse had put the gloves on that were found in the room. This had been done because the Nurse intended to assess the catheter and possibly change it.

73. The report considered the failure to make any record in the notes was suspect. It observed this made it impossible to assess the Nurse's practice on 31 December 2014. Although it was not possible to give an exact time, the report said the Nurse could have been with Mr A for anything up to 40 minutes.

74. The report felt the Nurse had actively avoided telephoning the GP. The practice records did not support the Nurse's claim to have repeatedly called looking for the GP. Additionally, by texting the GP at 17:55, the Nurse did not give the GP time to speak to them before the Nurse became unavailable.

75. The report felt the Nurse had minimised their role and had failed to accept responsibility for their actions. It observed the Nurse had referred to the disciplinary investigation as unnecessary and focussed solely on the failure to record their visit in the notes.

76. The report identified failures in the Nurse's clinical practice and a failure to follow the correct procedures. In particular the Nurse had failed to follow the correct record keeping procedures or communicate properly with the family or other fellow professionals.

77. Following the Board's investigation, a disciplinary hearing was held on 1 September 2015.

The Board's Complaint Response

78. The Board responded to Mrs C's complaint on 14 October 2015. The Board said they had investigated the matter fully and they apologised for the distress the investigation process had caused her.

79. The Board said they had taken action on the lessons learnt during their investigation. The investigation had included several discussions with the Nurse about their actions on 31 December 2014. The Board said the Nurse was certain they had left Mr A in an appropriate situation following their visit. In the absence of any other witness or evidence, the Board could only accept the Nurse's version of events.

80. The Board said that deficiencies in the Nurse's practice had been identified in terms of compliance with Board policy and record-keeping, as well as other areas of practice which related to their work. The Board said these were not directly related to the clinical care the Nurse provided to Mr A. The failings had been raised formally and the appropriate action taken with the Nurse.

81. The Board said they were sorry for the length of time the investigation had taken, in particular the difficulty they had had in concluding the investigation process and feeding back the findings to Mrs C. This had been due to long term illness on the part of a member of staff. The Board said this had already been discussed with Mrs C when she had been visited by the area manager and lead nurse on 4 September 2015. In view of Mrs C's comments about the distress this delay had caused her, the Board had initiated a further review into the management processes surrounding the handling of Mrs C's initial concern.

Interview with Mrs B

82. As part of this investigation, my complaints reviewer conducted a telephone interview with Mrs B. Although she was present at the interview Mrs C had given to Board staff as part of their investigation, Mrs B was not asked questions about her recollection of events and her role in what unfolded on 31 December 2014.

83. Mrs B said she had attended Mrs C's interview primarily to provide moral support. She had not been asked for a separate interview and no request had been made to any other family member.

84. Mrs B said Mrs C had telephoned her house, she lives in a neighbouring property, on the morning of 31 December 2014. Her husband had answered the telephone and the family members in the house had immediately gone to Mrs C's house.

85. When they went to Mrs C's house, she and her family went immediately upstairs to the bedroom. Mrs B said Mr A had been lying on the bed, with one leg on it, and the other resting on the floor. Mrs B said the immediate impression was of someone trying to get up, but this was impossible. Mrs B had seen Mr A the previous evening and Mr A had been unable to raise his head from the pillow. Mrs B said it was unlike Mr A not to be able to lift his head, but she emphasised Mr A had been both lucid and capable of holding a clear conversation.

86. Mrs B was very clear about her recollection of Mr A's condition when she entered the bedroom. Mr A was not covered by the bedding and his boxer shorts were around his knees. Mrs B's daughter had checked Mr A's pulse and Mrs B had lifted his legs back into bed, before pulling the covers over him. Mrs B said she had known that Mr A was dead as soon as she entered the room. Mrs B worked in a nursing home with enhanced duties. She was not a registered nurse, but had undergone some nursing training, and carried out additional duties, such as administering medication to residents. Mrs B said Mr A had still been warm to the touch, and had not been dead for very long.

87. Mrs B's husband had called the paramedics, but he had started to panic, and her daughter had taken over the call. Mrs B said the family had gone downstairs to wait for the paramedics, and had remained there whilst they determined that life was extinct. They had been followed into the bedroom by the police who had been called by the paramedics following their assessment of Mr A.

88. Mrs B said it was perfectly clear to the family the Nurse had visited Mr A. Mrs B believed that the only rational explanation for the condition Mr A had been found in, was that the Nurse had done something to him, before leaving hurriedly. Mrs B emphasised that the family only wanted to know what had taken place in the house on the morning of 31 December 2014 so that they could achieve some closure.

(a) Failed to provide a reasonable standard of care when the Nurse attended Mr A's home on 31 December 2014

Concerns raised by Mrs C

89. Mrs C believes that Mr A was not provided with a reasonable standard of care on 31 December 2014. Based on what she found when she returned to the property, Mrs C believed that the Nurse had begun to work on Mr A's catheter, before stopping and leaving the property. Mrs C thought that this might be because the Nurse had panicked, but the end result had been that Mr A had been robbed of his dignity in his final moments. Mrs C had been traumatised by the shock of finding him. Mrs C made it clear throughout the investigation that her primary concern was finding out what had happened to Mr A.

The Board's response

90. The Board said their investigation had identified areas of deficiency in the Nurse's compliance with Board policy and record-keeping as well as other areas of their practice which were related to her work. These were not, however, directly related to the clinical care provided to Mr A on the day in question.

Nursing advice

91. I asked the Adviser to provide a summary of what would be expected of a district nurse visiting a patient like Mr A. The Adviser said the standards expected of a registered nurse were contained within the NMC Code for nurses and midwives (the Code).

92. The Adviser said the key issues were ensuring that patients were treated as individuals and that their dignity was upheld. The patient should be treated with kindness, respect and compassion and the fundamentals of care should be delivered effectively. Assumptions should be avoided and treatment, assistance or care should be delivered without undue delay. The Adviser said they would have expected a qualified, registered nurse to have completed a full nursing assessment, document this and then decide on a plan of care. The Adviser felt in this case, the Nurse had made a judgement about Mr A's condition which failed to take into account his care needs.

93. The Adviser added the Nurse had failed to consult or refer to their colleagues. They would have expected the Nurse to have spoken to either a colleague or the team leader for guidance, given the unusual circumstances. The Adviser said although district nurses were expected to work autonomously,

close team working was paramount, including discussing patient progress and providing updates on the care being provided.

94. The Adviser said in their view, there was a clear breach of the Code by the Nurse in her failure to keep accurate and contemporaneous records of her actions whilst visiting Mr A.

95. Additionally, the Adviser noted the Code required nurses to work 'within the limits of their competence'. This required the Nurse to accurately assess signs of normal or worsening physical health in the person receiving care. If necessary, a timely referral should be made to another practitioner when it was in the best interests of the individual receiving care and that if any action or procedure lay beyond the limits of a nurse's competence, then help should be requested.

96. The Adviser said they would have expected a district nurse who recognised the limits of their competence should have the insight to identify when a patient's condition required them to ask for assistance. Situations which were unfamiliar or unusual should alert a nurse that advice was required. This was key for registered nurses who worked autonomously. The Adviser said it was possible the Nurse had not recognised how sick Mr A was and had failed to respond appropriately. In the Adviser's view, the Nurse had not acted in a professional or competent manner.

97. The Adviser said that district nurses were expected to act autonomously and would not be in constant contact with their manager throughout the day. That said, the Adviser felt the lack of information held by the district nurses office about individual staff member's work each day was a concern. Managers should be aware of which individuals staff intended to visit and in what order. The Adviser said given the failings in this case it would be appropriate for the Board to review arrangements in place for the support and supervision of district nurses.

(a) Decision

98. In reaching a decision, I have considered first what can be established as fact in terms of what happened on the morning of the 31 December 2014. The evidence is not clear but it can be estimated that the Nurse did visit the property at or around 09:10 and had left by 09:40, when they sent the team leader a text message.

99. The Nurse has given contradictory accounts of their actions with Mr A on 31 December 2014. The Nurse initially denied any clinical interactions with him. When interviewed, however, they accepted they had taken Mr A's pulse, which was erratic but present, as well as lifting the covers to check on the catheter. The Nurse's description of their interactions with Mr A varies, the Nurse said he was asleep and could not be roused, but also said that Mr A had responded to them when they shook his shoulder, although he was not able to speak clearly.

100. The advice I have received is that the Nurse failed to follow the procedure expected of a registered nurse working in a community setting. In doing so, the advice felt the Nurse was in breach of a number of areas of the Code. If they were uncertain about his condition, the Nurse should have produced a plan of care for Mr A. If required the Nurse should have sought help, either from Mr A's GP, or from the district nursing team. I note the Nurse stated they would normally only contact their team leader about cases of concern. They later contradicted this, however, by stating they had had no concerns about Mr A and that they expected Mrs C to contact the district nursing team if further assistance was needed. What is clear, is that by their own account, the Nurse acted in breach of the Code, by leaving a patient who they were unable to speak to without ascertaining his condition, or seeking guidance or further information.

101. The Nurse was in the property for at least ten minutes, and possibly up to thirty minutes, given that she arrived around 09:10 and did not text the team leader until 09:40. The Nurse has not been able to provide a coherent or consistent explanation of their actions whilst in the property. Additionally, it is unclear why, having left the property, the Nurse did not return immediately. The next patient the Nurse visited was in a property in close proximity to Mr A's. If the Nurse did require a conversation with Mrs C, it seems illogical not to have returned to the property at this point.

102. What cannot now be ascertained is exactly what occurred when the Nurse visited Mr A. I do not consider that the available evidence supports the Nurse's claim that she did not touch Mr A in any way. The Nurse's descriptions of their actions inside the property are inconsistent and contradictory and their account of Mr A's condition when they left him is directly contradicted by the accounts of the family members who found him. I note that the health support worker who knew Mr A well did not consider him capable of independent movement.

103. In normal circumstances, the primary source for determining the actions taken by the Nurse would be the patient's medical records. As there are no records, the investigation has had to balance the available evidence sources and decide how much weight they can be given. It is accepted the description of Mr A when he was found by the family is accurate. When commenting on a draft of this report, the Board noted that it was possible for patients in the final hours of life to attempt to move, particularly if alone and confused. For Mr A to have achieved the position he was found in, he would have had to remove his bedclothes, partially remove some of his clothing and raise himself at least partially from his bed. These are not actions that he was considered physically capable of. I note the family's view that Mr A could not alter his position or his clothing independently is supported by the Support Worker's statement given to the Board's investigation.

104. On balance, therefore, I agree with the conclusion of the Board's investigation, that the Nurse's explanation of their actions during her visit to Mr A is not credible. There is an accumulation of evidence suggesting that Mr A must have been being treated by the Nurse during their visit and that the Nurse chose not to record their actions. In the absence of contemporaneous written records, my view is the available evidence supports the family's belief that Mr A was being actively treated by the Nurse during their visit and that the Nurse left him in an inappropriate condition. I note this was also the conclusion reached by the Board's own investigation.

105. I consider the Nurse's conduct fell well below that set out by the Code of practice from the NMC, which as a health professional, they would be expected to adhere to. As a consequence the care and treatment provided to Mr A was of an unacceptable standard. In particular the Nurse's failure to clearly document their actions greatly increased the distress experienced by the family. The Board have conducted their own internal disciplinary investigation, however, my view is that the concerns raised by the Nurse's conduct are serious enough that the Board should consider a referral to the NMC for further investigation.

106. Whilst the Board have considered this solely as a disciplinary matter, based on the failings of one member of staff, I am concerned that the investigation has raised wider issues around the way the district nursing team works. The Board's investigation revealed the Nurse in question normally

provided no feedback during the working day on their engagement with patients. Additionally managers were unclear whether staff saw patients on their way into the office in the morning.

107. I am concerned that in an emergency, such as occurred on 31 December 2014, the Board had no way of knowing where the relevant member of staff was, or when they were likely to return to their office. In this case the Nurse did return to the district nursing office at lunchtime, however, it is not clear if this was planned. It would also appear from the statement by the team manager that the Nurse had not been contacted by the office, even though Mr A's GP had telephoned informing them of his death and the need to speak to the Nurse. As a result, the Board were not able to ensure that the Nurse spoke to the GP on the day of the incident and it is unclear what would have been done had the Nurse not returned to the office at lunchtime. This made it more difficult for the Board to determine what had occurred at Mr A's property. Additionally, this would appear to represent a risk to staff working alone, as conceivably, should anything occur, the Board would not be aware of the incident until the following day. I note the advice received comments on the need for the Board to review the procedures in place to support and supervise district nursing staff.

108. I uphold the complaint and make the following recommendations:

(a) Recommendations

109. I recommend that the Board:	*Completion date*
(i) consider a referral to the NMC, in view of the concerns raised over the Nurse's conduct and that an explanation for any decision reached is provided to this office; and	15 April 2017
(ii) review the procedures for the management of lone working in the community to ensure an adequate level of communication is sustained between staff and managers.	15 April 2017

(b) Failed to carry out a reasonable investigation into what happened when the Nurse attended on 31 December 2014

110. Mrs C did not consider the Board's investigation into her complaint to have been adequate. She felt the Board had failed to tell her anything about what had happened to Mr A. Mrs C was particularly upset by the Board's statement

that there was a lack of witnesses or evidence to contradict the Nurse's statements about what had happened and that consequently her version of events had not been accepted by the investigation.

111. Mrs C felt her statement had been overlooked. She also noted that a number of her family members had seen Mr A in the state in which she had found him. Mrs C disputed there was a lack of evidence, suggesting that, instead, evidence which contradicted the Nurse had simply been ignored. Mrs C said that this, coupled with the length of time it had taken for her to receive a response had greatly increased the distress the family had experienced as a result.

The Board's response

112. The Board said they had acknowledged that there had been issues with the investigation. They intended to address these. The Board also referred to the complaint response, in which the investigative process was made clear, and which had involved interviewing the staff involved, as well as reviewing the available records.

(b) Decision

113. This investigation was clearly challenging for the Board. It involved subject matter of great sensitivity, combined with potentially serious disciplinary issues for a member of Board staff. The decision to progress a disciplinary investigation as well as a formal complaint investigation was an appropriate one for the Board to make.

114. The Board did interview all the relevant Board staff who were involved in Mr A's care and treatment on 31 December 2014. I am, however, critical that the Board did not attempt to interview more of Mrs C's family. From Mrs C's account, this meant statements were not taken from at least three potentially significant witnesses. Mrs C's account, which is not disputed, is that Mrs B, her two daughters and husband all arrived at the house a matter of minutes after Mr A's body was discovered.

115. The statement made by the Board in their formal complaint response was:

> 'The Nurse who visited [Mr A] is certain that [they] left [Mr A] in an appropriate situation following [their] visit and, in the absence of any other witnesses or evidence. The investigation team can only accept [their] version of events.'

I consider this statement is factually inaccurate. It may be that the Nurse's recollection was preferred to the alternatives, but this is not the same as an absence of alternative witnesses. The Board had the statement from Mrs C about the condition Mr A was found in, and they could have confirmed this with other family members. Additionally, they had the statement from the Support Worker, which supported the family's belief that Mr A could not have moved without assistance. Furthermore, the Board's own investigation had concluded that the Nurse's statements were contradictory and lacked credibility.

116. It is not disputed that the Board had the discretion to decide how much weight to give the available evidence, but in this key area I consider the Board's complaint investigation did not obtain relevant evidence by interviewing more widely. I consider the Board should have interviewed the family members who attended the property immediately after Mr A was found and before the arrival of the paramedics. This would have provided all family members with the opportunity to contribute meaningfully to the Board's investigation and ensured their voices were heard as part of the Board's subsequent deliberations as well as ensuring that the internal investigation's conclusions were based upon all the available evidence. As a result I believe the Board's complaint response failed to properly take into account all the available evidence.

117. On balance, due to the importance given to the weight of evidence in the Board's decision letter to the family, I consider the failure to interview more widely amongst family members was significant.

118. I uphold the complaint.

(b) Recommendation

119. I recommend that the Board:

	Completion date
(i) remind staff of the importance of giving consideration to interviewing all individuals involved in an incident under investigation.	15 April 2017

(c) The Board failed to respond to Mrs C's complaint in line with the NHS complaints procedure

120. Mrs C complained that the Board's complaint investigation took an unreasonable length of time. During this period, she was unaware of what was happening. Mrs C met with the Board on 5 February 2015 to discuss her

concerns. She heard nothing following that meeting for several months, but Mrs C said she was eventually told there were 'five discrepancies' in relation to Mr A's care, but that she could be told nothing further as the matter was confidential.

121. Mrs C then raised a complaint through an advocate and received a final response from the Board. Mrs C did not agree with the Board's conclusions and did not feel the response accurately represented the available evidence.

122. Mrs C felt she had endured months of stress due to not knowing what had happened to Mr A. She had lost weight and was having difficulty sleeping. Mrs C felt the Board had not investigated her complaints properly, or apologised adequately for the failure to communicate with her following Mr A's death.

The Board's response

123. The Board said they accepted the investigation could have been handled better and that the experience had been distressing and frustrating for Mrs C and her family. They had undertaken a review of the complaint investigation in order to identify how the service could improve.

124. The Board's review noted an absence of timescales within the disciplinary investigation process. As a result the length of time the investigation was taking was not scrutinised as closely as it might have been. It was also noted there was a lack of oversight of the appointment of investigators. As a result, the investigation had been significantly delayed when the lead investigator had been taken ill, as no mechanism was in place for substituting an alternative member of staff in.

125. The review identified several points in the investigation when Mrs C could have been updated, or the matter could have been diverted into the formal complaints process. The Board felt that the managers involved were clearly taking the issues raised very seriously, but dealing with them through local resolution. Had the concerns been put through the formal complaints process, then the Board would have been able to respond more appropriately.

126. The Board acknowledged there were lessons for staff to learn. The expectations of service users needed to be recognised when a confidential investigation was being undertaken and staff needed to ensure they fully

engaged with them to clearly understand what complainants expected in terms of feedback.

(c) Decision

127. It is accepted by the Board that they did not follow the NHS complaints procedure when investigating Mrs C's complaint. The Board have acknowledged that this increased the distress experienced by the family and had the investigation been handled better, Mrs C may have felt less disappointed by the outcome.

128. I consider the decision to carry out a disciplinary investigation into the Nurse was reasonable, given the potential significance of any failings, the impact on Mrs C and her family of Mr A's death and the very obvious concerns around the conduct and professionalism of a member of the Board's nursing staff. This decision, however, caused the Board's investigating staff considerable difficulty. Great consideration was given to the confidentiality of the investigation and the rights of the staff member involved. This appears to have overshadowed any considerations about the right of the family to know what happened to Mr A whilst he was receiving care from the Board. It also showed little concern for the effect on the family of finding Mr A in such traumatic circumstances.

129. When Mrs C was interviewed during the Board's investigation, the investigators were unclear about what information she could be provided with and what the limitations would be on information sharing. The impression the transcript of this interview gives is that Mrs C's distress was not a consideration for the Board and nor was her wish to know what had happened to Mr A. I am critical of the Board's approach for showing a significant lack of empathy to a recently bereaved family.

130. The Board have carried out an internal management review of the process. They have acknowledged that there was a lack of information provided to Mrs C during the investigative process and that there was an unreasonable delay, due to a sudden staff absence through ill health.

131. The Board's review indicates it did not consider Mrs C had made a formal complaint until 14 September 2015. I am critical of this and consider it to be a clear failing on the part of the Board. Mrs C expressed her concerns and dissatisfaction by telephone to the district nursing service within days of Mr A's

death. The Board's records describe her as being intensely angry and from Mrs C's own account, it is clear she regarded the meeting she had with the Board on 5 February 2015 was held to record her complaint. Not to have recorded these contacts as a formal complaint represents a significant failing on the part of the Board.

132. Local resolution is intended to allow frontline staff to resolve complaints quickly, without the need for formal investigation. This case was clearly not suitable for local resolution, regardless of how committed staff may have been to achieving this. I am concerned that staff considered this appropriate, but I note the review contained as one of its actions work to try and ensure the complaints process was appropriately signposted.

133. Had Mrs C's concerns been correctly investigated as a formal complaint from the outset, she could have been provided with the Board's response sooner and been given a more complete explanation of the investigation the Board was undertaking. Additionally it would not have required Mrs C to make a second complaint via an advocate in order for her to receive a written explanation of the Board's findings. I uphold the complaint.

(c) Recommendations

134. I recommend that the Board:	*Completion date*
(i) provide evidence that the actions identified in their review of the handling of Mrs C's complaint have been implemented; and	15 April 2017
(ii) provide evidence that all staff have been reminded of the need to identify and record complaints accurately.	15 April 2017

In addition I make the following general recommendation.

(c) General Recommendation

135. I recommend that the Board:	*Completion date*
(i) apologise unreservedly for the failings identified in this report.	15 March 2017

136. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these

recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr A	the aggrieved
the Nurse	a district nurse
the Board	an NHS Board
the Adviser	an adviser to the Ombudsman who specialises in nursing
COPD	chronic obstructive pulmonary disease
Mrs B	Mrs C and Mr A's daughter
GP	general practitioner
PPE	personal protective equipment
the Support Worker	a healthcare support worker
the NMC	the Nursing and Midwifery Council
the Code	the NMC Code for nurses and midwives

Annex 2

Glossary of terms

catheter	a thin tube used to drain and collect urine from the bladder
chronic obstructive pulmonary disease (COPD)	a disease of the lungs in which the airways become narrowed
cyanosis (cyanosed)	blue lips and/or skin caused by low blood oxygen levels or poor circulation
personal protective equipment (PPE)	items such as gloves, aprons, gowns, masks etc worn by nursing staff for health and safety reasons