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

Report Reference: 202006317

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

TABLE OF CONTENTS

Page

Case Reference: 202006317
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

This case was about the Belfast Health and Social Care Trust's (the Trust) interpretation of a full spine MRI scan, carried out on 17 June 2023 at Musgrave Park Hospital. The complainant said the MRI report failed to identify dehydration of the disc between the Th5 and Th6 vertebrae, which a private MRI scan, carried out in Poland in 2020, had previously highlighted.

The investigation found no failures in care and treatment on the Trust's part. It found the Trust followed relevant guidelines in its interpretation of the MRI scan, and the contents of its report were reasonable and appropriate. I therefore did not uphold this complaint.

However, I made an observation about the Trust's communication with the complainant, which I encouraged the Trust to reflect upon going forward.

THE COMPLAINT

1. This complaint was about the Belfast Health and Social Care Trust's (the Trust) interpretation of the full spine MRI scan it carried out for the complainant on 17 June 2023 at Musgrave Park Hospital.

Background

2. The complainant had a road traffic collision in 2020 after which he experienced significant back pain, particularly in the thoracic spine[1]. The report of a private MRI scan[2] carried out in Poland, dated 1 August 2020, described disc dehydration[3] between the Th5 and Th6 vertebrae[4].

3. The complainant's GP referred him to the Orthopaedic Integrated Clinical Assessment and Treatment Service (ICATS) in Belfast in January 2023. ICATS carried out the MRI scan for the complainant on 17 June 2023 and produced its report of the scan on 25 June 2023. This report did not mention dehydration of the Th5/Th6 disc. ICATS discharged him on 29 June 2023. The complainant began Physiotherapy sessions in Belfast in March 2023. These ended in July 2023.

4. While waiting for the Trust to process his complaint about its interpretation of the June 2023 MRI scan, the complainant had a second private MRI scan in Poland. The report of this scan, dated 9 September 2023, also described dehydration of the Th5/Th6 disc.

Issue of complaint

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

Whether the care and treatment the Trust provided to the complainant following the MRI scan on 17 June 2023 was reasonable, appropriate and in line with relevant standards.

[1] The upper back and the middle back are referred to as the thoracic spine. It is located mostly between the shoulder blades, extending from the bottom of the neck to roughly the level of the waist. This part of the spine is connected to the ribcage and supports the upper body.

[2] MRI stands for Magnetic Resonance Imaging. An MRI scan uses strong magnetic fields, radio waves, and a computer to create detailed images of the inside of the body. MRI scans are useful for diagnosing conditions, planning treatment, and assessing if previous treatment has been effective.

[3] The spinal column is made up of bones called vertebrae. Between each vertebra, there is a disc known as an intervertebral disc. These are rings of cartilage which encircle a gel-like centre. Discs hold the vertebrae together and act as a shock absorber for the spine. Disc dehydration normally occurs when a part of the disc is damaged or injured. It causes spinal discs to lose their fluidity and become stiff and painful.

[4] The thoracic portion of the spine is made up of twelve vertebrae. Conventionally, these are numbered T1 or Th1 (closest to the skull) to T12 or Th12 (closest to the waist). The Th5 and Th6 vertebrae are therefore located in the central region of the thoracic spine.

INVESTIGATION METHODOLOGY

6. 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

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

    - A Musculoskeletal Radiologist, BA, MA (Cantab) MBChB, FRCR, with 5 years' experience and spinal centre fellowship.

    I enclose the clinical advice received at appendix two to this report.

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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

    The general standards are the Ombudsman's Principles[5]:

    - The Principles of Good Administration.

10. 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.

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

The specific standards and guidance relevant to this complaint are:

- The Royal College of Radiologists' "Standards for Interpretation and Reporting of Imaging Investigations", Second Edition, March 2018 (the RCR Reporting Guidance).

I enclose relevant sections of the guidance considered at appendix three to this report.

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

12. 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. I carefully considered any comments I received.

THE INVESTIGATION

Whether the care and treatment the Trust provided to the complainant following the MRI scan on 17 June 2023 was reasonable, appropriate and in line with relevant standards.

Detail of Complaint

13. The complainant said the MRI report of the scan carried out on 17 June 2023 omitted information about the dehydrated disc between the Th5 and Th6 vertebrae. This information was very important to him because his greatest pain comes from this region. The complainant felt ICATS discharged him with no information on what to do next to manage his back pain.

14. The complainant highlighted a private MRI scan, carried out in Poland in August 2020, showed this area was dehydrated. This was confirmed by a second private MRI scan he obtained in Poland in September 2023.

Evidence Considered

The Trust's response to investigation enquiries

15. The Trust stated it arranged for another Consultant Radiologist to review the 17 June 2023 MRI scan as part of the complaints process. The initial interpretation of the MRI scan *"was found to be accurate and no changes were advised"*.

16. The Trust stated it is the role of the referring clinician to act on the findings of the MRI scan, which was the complainant's GP on this occasion.

Relevant Trust records

17. I enclose a summary of the relevant records at appendix four to this report.

Relevant Independent Professional Advice

18. I enclose the independent professional advice at appendix two to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

19. The RCR Reporting Guidance states MRI reports ought to consider the patient's history and current symptoms, answer the clinical question posed by the referrer (in this case, the patient's GP), and advise on the possible next steps for the patient, if appropriate.

Complainant's history and current symptoms

20. The complainant's GP's referral to ICATS described a history of pain in the thoracic region after a road traffic accident. ICATS' subsequent assessment of the complainant noted *"neck pain, upper thoracic pain and lumbar pain, 3 years after road traffic collision… the upper thoracic pain is the worse and radiates across to the anterior chest wall"*. The report for the MRI scan the Trust carried out on 17 June 2023 described several clinical indications leading to the scan, including a road traffic collision three years ago and thoracic pain radiating to the anterior chest wall. The IPA advised this demonstrated the Trust's consideration of the complainant's medical history and condition. Having reviewed all relevant evidence, including the IPA's advice, I am therefore satisfied the report included appropriate consideration of the complainant's history and current symptoms, as per the RCR Reporting Guidance.

Clinical question posed by referrer

21. The report of the MRI scan carried out on 17 June 2023 noted the purpose of the scan was to *"exclude sinister pathology in thoracic pain"*. I reviewed the GP's referral and note it stated *"thoracic pain radiates to anterior chest wall"* as a symptom. The IPA advised *"most radiologists would interpret this as asking the question 'is there any disc abnormality which is compressing a nerve in the thoracic spine'".* The IPA explained *"this is because nerve compression in the thoracic spine produces radiating chest wall pain as described in the request".* He advised *"as such, the report stating that there is 'no disc herniation in the thoracic spine' answers this clinical question"*. Having reviewed all available evidence, I accept this advice. I am therefore satisfied the MRI report of the 17 June 2023 MRI scan addressed the complainant's GP's clinical question, as per the RCR Reporting Guidance.

Discrepancy between reports of private MRI scans and Trust report of 17 June 2023 MRI scan

22. The report of the private MRI scan carried out in Poland, dated 1 August 2020, noted *"intervertebral disc dehydration Th5/Th6"*. I note this was also identified in the report for the complainant's second Polish scan, dated 9 September 2023. However, the Trust's report of the 17 June 2023 MRI scan did not note this dehydration. The IPA advised there is very slight dehydration of the Th5/Th6 disc in the 17 June 2023 scan, adding: *"The level of degeneration of this disc is extremely minimal and well within what would normally be expected for the patient's age… Overall given normal spine degeneration changes with age, the patient's spine is better preserved than average"*.

23. The IPA provided an explanation for why the Trust's MRI scan report did not note this dehydration, stating the management of spine pain does not change, even if degenerated discs are identified. He advised *"this is now almost universally treated conservatively (non-surgically) in the first instance"*. Therefore, the IPA advised, *"the majority of radiologists do not report all degenerative disc changes as this may give a false sense of a 'positive finding' of an imaging feature that is the 'cause of pain' when this can be a normal age related finding"*. As such, he advised *"it is entirely possible for both the Polish radiology report and the Belfast radiology report to be correct and this would not affect the patient's management pathway and both would be within what would be expected for a spine imaging report"*. I accept this advice. I am therefore satisfied the Trust's decision not to note dehydration of the Th5/Th6

disc in the report of the 17 June 2023 MRI scan was in line with good practice and did not represent a failure in care and treatment.

Observation – The Trust's communication with the complainant

24. However, the IPA identified a lack of sensitive communication with the complainant about this apparent discrepancy as a possible cause of the escalation of his complaint to the present level.

25. In its written response to the complainant, the Trust simply stated, *"a second Consultant Radiologist performed an independent review of the MRI scan. The report was found to be accurate and no changes were advised"*.

26. The records show ICATS was aware the complainant's main concern related to the lack of reference to dehydration of the Th5/Th6 disc in the report of the 17 June 2023 MRI scan. The IPA observed, *"it may have been more sensitive and helpful for the imaging review to take the Polish MRI results into consideration during this review to acknowledge that they were accurate but contextualise these findings to allow the patient to see that the two sets of imaging were not at odds"*. Having reviewed the correspondence between the Trust and complainant, I agree with the IPA's observation. I consider in its review the Trust could have expanded upon why its report did not refer to disc dehydration. I encourage the Trust to consider this observation in its practice going forward.

Possible next steps

27. The RCR Reporting Guidance places emphasis on *"actionable reporting"*. This means MRI reports ought to advise on the next steps of patient management, if appropriate and *"when an abnormality is detected"*. For example, by suggesting further investigations or referral to another speciality. The report of the 17 June 2023 MRI scan concluded *"normal appearances of the whole spine for age"* and *"no concerning marrow or cord pathology"*. As such, it did not detect any abnormalities and did not suggest any further investigations or onward referral to another speciality. ICATS subsequently sent the complainant a letter on 29 June 2023, explaining no orthopaedic treatment was required, and discharged him back into the care of his GP. The IPA advised, as the complainant did not require surgical intervention, the guidance ICATS offered the complainant was appropriate. I accept this advice. I am

therefore satisfied the report's omission of suggestions for further investigation or onward referral did not constitute a failure in care and treatment.

28. In addition, the records evidence the complainant attended Physiotherapy sessions with the Trust between March 2023 and July 2023 (before and after input from ICATS). Upon discharge, the Physiotherapy Service referred the complainant to the *"healthwise"* scheme and suggested onward referral to a pain clinic to help manage his pain going forward. The IPA advised the guidance the Physiotherapy Service offered the complainant was appropriate. I accept this advice. I am therefore satisfied the Trust provided the complainant with several appropriate channels of support, and that these were ongoing after his discharge from ICATS.

Summary

29. Having reviewed all relevant evidence, including the IPA's advice, I find the Trust's interpretation of the 17 June 2023 MRI scan followed the RCR Reporting Guidelines. I find the care and treatment it provided to the complainant was reasonable and appropriate. Therefore, I have not identified any failings in care and treatment, and I do not uphold the complaint.

CONCLUSION

30. I received a complaint about the Belfast Health and Social Care Trust. I did not uphold the complaint for the reasons outlined in this report.

31. However, I made an observation about the Trust's standard of communication with the complainant, and I encourage the Trust to reflect upon this going forward.

MARGARET KELLY
Ombudsman **March 2025**

Appendix 1 – PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.