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

Report reference: 202400815

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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: 202400815

Listed Authority: Northern Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's mother (the patient) during a visit to the Emergency Department at Antrim Area Hospital on 17 April 2024. The complainant said she was unhappy that Trust staff did not refer the patient for an emergency MRI scan for her abdominal pain.

My investigation found that the care and treatment the Trust provided was reasonable, appropriate and in line with relevant standards. The investigation found there were no medical grounds at the time to refer the patient for an emergency MRI. I therefore did not uphold the complaint.

THE COMPLAINT

1. This complaint was about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's mother (the patient) on 17 April 2024 during a visit to Antrim Area Hospital Emergency Department (the ED).

Background

2. The patient attended the ED on 17 April 2024 with lower abdominal pain. At the time of this attendance, the patient was awaiting a planned MRI[1] scan on her pelvis, due to a fall in July 2023. The patient did not have a date for this at the time of her ED attendance. The complainant believes the ED Doctor should have referred her mother for an emergency MRI scan or had the pre-planned scan fast-tracked, during this visit.

Issue of complaint

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

   Whether the care and treatment the Trust provided to the complainant's mother on 17 April 2024 was reasonable, appropriate and in line with relevant guidance. In particular this will consider:

   - **Whether the ED should have arranged an urgent MRI scan for the complainant's mother.**

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 advisor (IPA):

   - A Consultant in Emergency Medicine MD PhD FRCEM FRCSEd DIMC RCSEd, with 28 years' experience in the role (IPA).

[1] Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

I enclose the clinical advice received 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 IPA provided 'advice'; how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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

The general standards are the Ombudsman's Principles[2]:

- The Principles of Good Administration

8. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Good Medical Practice, updated January 2024 (the GMC Guidance);
- Antrim Area Hospital (AAH) Emergency Department (ED) Out of Hours Pathway for MR Investigation for Cauda Equina Syndrome (CES) for Next Day MR Scanning Monday to Friday, issued January 2024 (AAH Pathway).

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

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

9. 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.

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: Whether the care and treatment the Trust provided to the complainant's mother on 17 April 2024 was reasonable, appropriate and in line with relevant guidance. In particular this will consider:

- **Whether the ED should have arranged an urgent MRI scan for the complainant's mother.**

Detail of Complaint

11. The complainant said her mother should have had an MRI scan or had the pre-planned scanned fast-tracked during her ED attendance on 17 April 2024. She said that the doctor told the patient that she did not need an MRI scan *'as it would not show anything'.*

12. The complainant said that this has made her mother feel like she didn't deserve medical care, and the patient feels like she would not receive proper treatment if she ever had to back to hospital.

Trust's response to investigation enquiries

13. The Trust stated that during the ED doctor's assessment of the patient the doctor noted she had been having pain in her lower abdomen and pelvic area following a fall the previous July. Following assessment, it stated the *'working diagnosis was no abnormality detected',* and the ED doctor advised the patient to use pain relief and follow up with her GP.

14. The Trust stated the ED Doctor noted the patient's GP had referred her for an MRI scan of her pelvis on 8 January 2024. The ED doctor determined that there was no

'indication from an emergency department point of view for arranging an urgent or emergency MRI of [the patient's] pelvis'.

15. The Trust also stated the ED doctor would only refer a patient for an emergency MRI *'to rule out cauda equina syndrome'.*[3] It stated the patient did not have suspected cauda equina syndrome. In addition, it stated a *'patient with ongoing abdominal pain for months with normal examination and bloods, presenting overnight, already with an outpatient MRI requested by their GP would not warrant emergency MRI scanning'.*

16. The Trust also stated that during an earlier visit to the ED the patient *'had a previous CT scan [4] of the abdomen and pelvis on 8 November 2023 which indicated no acute abdominal or pelvic pathology'.*

Relevant Trust records

17. I reviewed relevant Trust records which included the patient's medical records from the period 1 July 2023 to 17 April 2024 and the complaint file.

Relevant Independent Professional Advice

18. I enclose the IPA's 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. I note the medical records confirm that the patient attended the ED with ongoing lower abdominal pain. I note also that the patient reported normal bowel movements, no urinary symptoms, no chest pain or shortness of breath and no fever or sweating.

20. I note that the ED doctor ordered blood tests for the patient, which the Trust stated were *'unremarkable'*. The IPA advised that *'appropriate blood tests were sent for*

[3] Cauda equina syndrome is a rare and severe type of spinal stenosis where all of the nerves in the lower back suddenly become severely compressed.
[4] A computerized tomography scan, also called a CT scan, is a type of imaging that uses X-ray techniques to create detailed images of the body.

analysis'. He advised that the blood tests *'revealed a marginally elevated amylase as the single abnormality'* but advised that *'in isolation, would not have been a concern.'*

21. The IPA advised that he could not find any fault or omission in the care the Trust provided to the patient in the ED. He advised the *'assessment and care provided to [the patient] in the Emergency Department were appropriate for her presentation'*. He also advised that he was *'unable to identify the need for any additional investigations'.*

22. I note the Trust's response that the only circumstance that ED staff would refer for an emergency MRI would be to rule out cauda equina syndrome, a rare condition that can have a devastating impact on a patient's life. I reviewed the AAH Pathway and note that MRI scanners are not routinely available for emergency scanning outside normal working hours (Monday to Friday 9-5) unless a patient has suspected cauda equine syndrome. This is primarily due to staffing restrictions.

23. The IPA advised that *'emergency MRI scans are undertaken for acute spinal conditions, sometimes also in acute neurological conditions'.* The IPA also advised that *'the scan of choice for abdominal conditions is the CT scan'* but advised that in the patient's case *'there was no indication to request an urgent CT scan'.*

24. I reviewed the patient's medical records prior to the date of the ED visit and note the results of a CT scan conducted on 8 November 2023 concluded that there was *'no acute abdominal or pelvic pathology'*.

25. I reviewed GMC guidance which states that doctors must *'provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with them to assess their needs and priorities. The investigation or treatment you propose, provide or arrange must be based on this assessment, and on your clinical judgement about the likely effectiveness of the treatment options'*.

26. I accept the IPA's advice that *'appropriate bloods tests were sent for analysis'* and there were *'no additional investigations'* that the ED doctor should have undertaken.

27. In light of this guidance, and the IPA's advice that the *'assessment and care provided to [the patient] in the Emergency Department were appropriate for her presentation',* I find that the care and treatment provided to the patient was reasonable, appropriate and in keeping with relevant standards. I further find the Trust's decision not to refer

the patient for an emergency MRI scan was in keeping with relevant protocols, and does not amount to a failure in care and treatment. I therefore do not uphold this complaint.

CONCLUSION

28. I received a complaint about care and treatment that the patient received during a visit to the Antrim Area Hospital Emergency Department (ED) on 17 April 2024. While I acknowledge the complainant's disappointment that the patient did not have the requested MRI test, I did not find any failures in the care and treatment the ED doctor provided. I therefore do not uphold this complaint.

MARGARET KELLY
Ombudsman

July 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.