Investigation of a complaint against Belfast Health & Social Care Trust

Report reference: 202004671

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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: 202004671
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

This complaint was about care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the patient between 13 and 16 April 2023. The complainant is the patient's daughter.

The complainant said the Trust did not identify or address her father's condition early enough. She questioned whether there was 'more going on' which could account for her father's rapid deterioration and death, and whether any medical conditions he may have had had gone undiscovered.

The investigation found the patient received appropriate care and treatment in both the Mater Hospital and Belfast City Hospital, and the Trust acted in accordance with relevant standards.

Therefore I did not uphold the complaint.

THE COMPLAINT

1. This complaint was about care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the patient between 13 and 16 April 2023. The complainant was the patient's daughter.

Background

2. The patient was a 75 year old gentleman with a history of diabetes[1] and congestive heart failure[2]. He attended the Mater Hospital by ambulance with Abnormal Kidney Function[3] on 13 April 2023, following the results of blood tests his GP Practice conducted that day.

3. The patient subsequently transferred from the Mater Hospital Emergency Department to the Belfast City Hospital on 14 April 2023 with a severe Acute Kidney Injury (AKI)[4], requiring emergency admittance and haemodialysis[5].

4. On 16 April 2023 the patient sadly passed away. The Trust recorded his cause of death as acute mesenteric ischaemia[6].

Issue of complaint

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

   Whether the care and treatment the Trust provided to the patient between 13 and 16 April 2023 was appropriate, reasonable and in line with relevant standards.

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 complaints process.

[1] A condition that causes a person's blood sugar level to become too high.
[2] A condition where the heart is unable to pump enough blood to meet the body's needs. The condition tends to get gradually worse over time.
[3] Abnormal kidney function means the kidneys aren't working properly. This can be either a temporary condition or a longer term issue, and can lead to the build up od waste products in the blood and fluid imbalances.
[4] Acute Kidney Injury is where the kidneys suddenly stop working properly. It can range from minor loss of kidney function to complete kidney failure.
[5] A treatment to filer wastes and water from the blood.
[6] An uncommon and serious medical condition that occurs suddenly, when parts of the digestive system don't get enough blood flow and oxygen.

Independent Professional Advice Sought

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

   - A Consultant in Emergency Medicine with over 25 years' experience (ED IPA); and
   - A Consultant Nephrologist with 20 years' experience treating patients with chronic kidney disease and acute kidney injury (N IPA).

   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 IPAs provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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[7]:

   - 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.

    The specific standards and guidance relevant to this complaint are:

    - Royal College of Radiologists Guidance on Indications for Plain Abdominal films from the Emergency Department, February 2016; and
    - National Institute for Health and Care Excellence (NICE) – Acute kidney injury: prevention, detection and management, December 2019 (NG 148).

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

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. Both the complainant and the Trust accepted my findings.

THE INVESTIGATION

Whether the care and treatment the Trust provided to the patient between 13 and 16 April 2023 was appropriate, reasonable and in line with relevant standards.

Detail of Complaint

13. The complainant said the Trust failed to identify and address her father's condition early enough. She questioned whether it missed the true cause of her father's death, whether there was 'more going on' which could account for her father's rapid deterioration and death. She queried whether any medical conditions he may have had were undiscovered. She questioned whether more timely assessment and treatment could have resulted in a difference outcome.

Trust's response to investigation enquiries

14. The Trust stated it completed a clinical review for the period the patient was under the care of the Mater Hospital. It stated the Consultant who completed the review confirmed staff assessed the patient and admitted him with an AKI and dehydration. He could not identify any issues with the care and treatment provided whilst the patient was in the Emergency Department at the Mater Hospital. The Trust stated the Consultant also commented there was no clinical indication the patient exhibited symptoms of Bowel/Gut Ischaemia during his time in the Emergency Department.

15. The Trust stated it conducted a second clinical review for the period the patient was under the care of Belfast City Hospital. It stated the Clinician concluded the patient had timely initiation of dialysis following referral, and that a number of medical staff

reviewed and re-assessed him during his admission, including an experienced consultant and senior registrars. The Trust stated the review identified that clinical assessments were appropriate, timely and of high quality, and the cause of death recorded was in keeping with clinical events. It explained the review concluded the care the renal team provided to the patient was satisfactory.

16. The Trust stated that, in the absence of a CT Angiogram[8], it could not establish the definitive diagnosis of mesenteric ischaemia pre-mortem. However, it stated '*death certification is a difficult process in such situations with a complex interplay of potential causes. The cause of death given is consistent with the clinical event*s'.

Documentation and records examined

17. I completed a review of the copy documentation the complainant provided, and those the Trust provided in response to my investigation enquiries. I outlined my consideration of this evidence in my analysis and findings below.

Relevant Independent Professional Advice

18. I enclose both IPA's full advice at Appendix two to this report. I outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

Care and treatment provided in ED at the Mater Hospital

19. The complainant questioned whether the Trust provided appropriate and timely investigations and treatments to the patient upon his admittance to hospital.

20. I reviewed the patient's medical records. I note he attended hospital urgently via ambulance at, his GP's request, following blood test results which showed a deterioration in his kidney functioning. I note the Trust triaged the patient within 42 minutes of arrival. The ED IPA advised the time taken to triage the patient was '*reasonable*'.

21. The records show the patient saw a doctor five and a half hours after registration at the hospital. The ED IPA advised this was '*far beyond a reasonable timeframe*'. However, he has also advised that whilst this is '*disappointing'*, it was unlikely to have had a significant bearing on the outcome for the patient, or the care and

[8] A scan to evaluate blood vessel disease or related conditions such as aneurysms or blockages.

treatment he received. I acknowledge it is disappointing the patient had to wait that period of time to see a doctor in the ED. However, I also acknowledge the pressures EDs are under in hospitals across Northern Ireland which means patients often have to wait longer to see a doctor than would be preferable. In light of this, and the ED IPA's advice regarding the impact of this wait on the patient, I am satisfied this wait did not constitute a failure in the care and treatment the Trust provided.

22. The doctor examined the patient at 22:40, and the plan was to admit him and provide intravenous fluids.

23. The ED IPA advised the examining doctor took a reasonable history, performed a reasonable examination, and that the working diagnosis of acute kidney injury due to dehydration because of the patient's recent vomiting and diarrhoea was also reasonable. Having reviewed the patient's medical records, I accept this advice.

24. In terms of whether the patient's symptoms should have prompted further investigation into potential abdominal causes, I reviewed the Royal College of Radiologists Guidance on Indications for Plain Abdominal films[9] from the Emergency Department. It states clinicians should consider plain abdominal films where there is clinical suspicion of obstruction[10], acute exacerbation of inflammatory bowel disease[11], palpable mass[12], constipation[13], acute or chronic pancreatitis[14], a foreign body[15], or a blunt or stab abdominal injury.[16] The ED IPA advised none of these conditions were indicated

25. The ED IPA further advised that, in hindsight, intermittent bowel ischaemia could have caused the patient's gastrointestinal symptoms. However, at the time he attended ED there was no indication from his medical history or test results that this was more likely to be the cause than the working AKI diagnosis.

26. The ED IPA therefore advised it would not have been apparent to any doctor examining the patient at the time that this was the cause of his symptoms, as

[9] Also known as an abdominal X-ray. Used to help a doctor assess potential problems in the abdominal cavity, stomach, and intestines.
[10] A blockage or impediment, particularly in a body passageway, that prevents normal movement or flow.
[11] Inflammatory Bowel Disease involves recurrent episodes of inflammation in the gastrointestinal tract. The two main types are ulcerative colitis and Crohn's disease.
[12] A lump or swelling that can be felt through the skin during a physical examination.
[13] A condition characterized by infrequent bowel movements, hard stools that are difficult to pass, and a feeling of incomplete evacuation.
[14] The swelling of the pancreas.
[15] Any object or material that is not naturally part of the body and is found within it.
[16] A blunt abdominal injury occurs from a blow or impact to the abdomen without a penetrating object. A stab abdominal injury is caused by a sharp, penetrating object.

established bowel ischaemia is expected to cause a massive acidosis[17], which was not apparent on blood tests taken within the Emergency Department.

27. Having reviewed all relevant evidence, including the ED IPA's advice, I find the care and treatment the Trust provided to the patient in the Mater Hospital ED on 13 April 2023 was reasonable, appropriate and in line with relevant standards. Whilst I acknowledge that bowel ischaemia could have been the ultimate cause of the patient's symptoms, I accept the ED IPA's advice this condition would not have been apparent to the treating clinicians at that time. I have not identified any failings in the care and treatment provided to the patient while under the care of the Emergency Department at the Mater Hospital.

28. I therefore do not uphold this element of the complaint.

Care and treatment provided on the ward at the Mater Hospital

29. The Trust admitted the patient onto a ward at the Mater Hospital at 23:45 on 13 April 2023, prior to transferring him to the Belfast City Hospital on 14 April 2023 at 17:20.

30. The N IPA advised the care and treatment the Trust provided during this time was appropriate. He advised the decision to provide intravenous fluids, whilst not done under the specific directions of a Nephrologist, was appropriate to improve the patient's kidney health.

31. The N IPA identified the length of time the patient spent on the ward in the Mater Hospital, before his transfer to Belfast City Hospital for additional treatment. He advised if the Trust had transferred the patient earlier, further renal management may have started earlier. However, he advised the treatment pathway, including the decision to begin dialysis, would have been the same. He ultimately advised the time taken to complete the transfer had very little impact on the patient or his overall care and treatment.

32. Whilst I acknowledge the Trust could have transferred the patient more timeously, I note the transfer still took place within 24 hours. I accept the N IPA's advice that he received appropriate care during that wating period, and that this passage of time did not have any impact on the overall care and treatment the patient received. I have

[17] A condition in which there is too much acid in the body fluids.

therefore not identified any failings in the care and treatment provided to the patient while on the ward at the Mater Hospital.

33. I therefore do not uphold this element of the complaint.

Care and Treatment provided in the Belfast City Hospital

34. I note NICE guidance (NG 148) states the Trust should refer patients for renal replacement therapy[18] if the patient is fluid overloaded and not responding to medical management.

35. The N IPA advised that upon transfer on 14 April 2023, the Trust correctly diagnosed the patient with an AKI, requiring dialysis to remove waste products and excess fluids. He advised the Trust appropriately inserted a central line[19] and commenced haemodialysis in a timely manner. The N IPA advised this treatment was appropriate in the circumstances, and that dialysis was the key intervention. He advised at that time there were no indications for further investigations. I accept this advice. I am satisfied, therefore, that the Trust's decision to commence this treatment was reasonable and appropriate in the circumstances.

36. The records show on 15 April 2023 a senior doctor, and then a consultant, reviewed the patient. The doctors decided he required further dialysis as he was fluid overloaded. However, I note the patient was not able to tolerate this, and he developed chest pain and breathlessness.

37. The N IPA advised patients with AKI who have excess fluid, but do not tolerate the dialysis required to remove it, are in a '*perilous clinical state'*. He advised if the Trust did not consider the patient to be a candidate for Intensive Care because of his overall state and co-morbidities, he was unlikely to survive at ward level care.

38. The N IPA advised the consultant decided the patient should remain at ward level care, because of his complex co-morbidities and poor tolerance of dialysis. The N IPA advised the Trust gave appropriate consideration to the option of Intensive Care, and ultimately made a reasonable and appropriate decision on his ceiling of care. I

[18] A medical treatment that replaces the normal kidney function when a person's kidneys are not working well.
[19] Also known as a central venous catheter, it is a thin, flexible tube inserted into a large vein, typically near the neck or chest, for long term access to the bloodstream.

accept this advice. I am therefore satisfied the care and the treatment the Trust provided to the patient in determining his ceiling of care was reasonable and appropriate in the circumstances.

39. The patient's medical records show the Trust noted the patient started to experience abdominal pain on 15 April 2023 at 22.30, which settled before reoccurring at 01:45 on 16 April 2023.

40. The records show the doctor who attended the patient overnight discussed his condition with their specialist registrar, and concluded no further investigations were indicated at the time. At 09.10 on 16 April 2023 the records show the patient experienced abdominal pain and his white blood cells count and inflammatory markers were elevated. The N IPA advised the treatment plan was to try a further session of dialysis, add broad spectrum antibiotics and complete a plain abdominal X-ray after dialysis.

41. The N IPA advised radiology investigations using CT scan with intravenous contrast would have been more useful than an abdominal X-ray in diagnosing the gut ischaemia. However, the contrast can be toxic to already damaged kidneys and worsen or prolong an AKI. He advised the Trust therefore had to consider both the benefits and risks of that procedure for the patient.

42. The N IPA advised the records also show the patient had elevated lactate[20] and blood acid[21] at this time. I note he advised the elevated blood acid could be accounted for by the AKI. However, the elevated lactate may have been a signal of bowel tissue not receiving sufficient oxygen. The N IPA ultimately advised that, in the context of the patient's co-morbidities and an AKI, there was no clear point at which a CT scan should have been considered. Additionally he advised a definitive diagnosis of an abdominal issue at that stage was '*highly unlikely*' to have changed the outcome, given the patient's advanced stage of illness.

43. The N IPA further advised that, in his experience, ischaemic bowel in patients who are dialysis dependant is almost always fatal. Anaesthetic and surgical colleagues are reluctant to plan extensive surgery as the patient is unlikely to survive the anaesthetic/surgery. He advised that if a diagnosis of gut ischaemia was made at this

[20] A naturally occurring substance produced in the body during metabolism, particularly when cells don't have enough oxygen.
[21] High levels of acid in the blood, known as acidosis, can occur when the body either produced too much acid or is unable to effectively remove it from the blood.

point, it was likely care would have switched from active treatment with dialysis and antibiotics to supportive end of life care.

44. In summary, there was no indication a reasonable doctor would have identified the patient's condition related to bowel ischaemia before 15 April 2023. Additionally, the treatment the Trust provided for the condition it had reasonably diagnosed prior to 15 April 2023 was appropriate. I further consider the Trust gave appropriate consideration to abdominal scans once the abdominal pain began. However, it was reasonable not to progress these further because of the patient's co-morbidities, and AKI. Even if bowel ischaemia had been confirmed, it was unlikely to have changed the outcome for the patient.

45. I am therefore satisfied that the care and treatment provided to the patient in the Belfast City Hospital was reasonable and appropriate in the circumstances.

46. As such, I do not uphold this element of the complaint.

Cause of death

47. The complainant said she is unclear why the cause of death is detailed as Gut Ischaemia, as she believed her father's cause of death related to kidney failure.

48. I note the patient's cause of death was recorded as Mesenteric Ischaemia[22] due to (or as a consequence of) chronic kidney disease, Ischaemic heart disease, Hypertension, Chronic obstructive pulmonary disease and Type 2 diabetes. Other significant conditions are listed as acute renal failure requiring dialysis.

49. The N IPA advised the cause of death on the death certificate was a '*reasonable estimation*'. He advised cause of death cannot be proven without a post mortem or CT scan in life. The N IPA advised the cause of death was *'a reasonable estimation'* because the patient was known to have large artery blood vessel vascular disease[23] and had risk factors for blocked blood supply to the bowel such as type 2 diabetes and high blood pressure. I accept this advice.

50. The N IPA advised the decision to make an informed estimation of the cause of death was appropriate, and it allowed registration of the death in a timely fashion.

[22] Reduced blood supply to the bowel via the connecting mesenteric arteries

[23] This term encompasses conditions which affect the large blood vessels, including the aorta and its major branches.

51. Based on the advice provided, I have not identified any failings with respect to the cause of death as detailed on the death certificate.

52. I therefore do not uphold this element of the complaint.

CONCLUSION

1. I received a complaint about the actions of the Belfast Health and Social Care Trust and the care and treatment it provided to the patient in April 2023. I did not uphold the complaint for the reasons outlined in this report.

2. I offer through this report my condolences to the complainant for the loss of her father. I hope this report provides the complainant with some reassurance regarding the care and treatment that was provided to her father by the Trust.

MARGARET KELLY
Ombudsman **September 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.