Investigation of a complaint against Belfast Health & Social Care Trust

Report Reference: 202001704

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Appendix 1 – The Principles of Good Administration

Case Reference: 202001704
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant between November 2020 and November 2022.

The complainant was concerned about the result of a MRI brain scan the Trust carried out in November 2020 and a subsequent CT venogram. She was also concerned the Trust showed her the result of someone else's MRI brain scan in August 2022. The complainant wanted a CT angiogram of her brain and was further concerned the Trust would not refer her to Liverpool for this procedure.

The investigation established a failure in how the Trust recorded and reported the outcome of a CT venogram it carried out in January 2021 to the complainant. I upheld this element of the complaint. The investigation also established the Trust showed the complainant her own brain scan in August 2022 and its decision regarding the Liverpool referral was reasonable, appropriate in line with relevant standards. I therefore did not uphold these elements of the complaint.

I recommended that the Trust provide the complainant with an apology in accordance with NIPSO 'Guidance on issuing an apology (July 2019) for the injustice caused as a result of the failure identified. I also recommended for service improvement and to prevent future recurrence the Trust discuss the contents of this report with relevant staff so they can reflect on the findings identified and to remind relevant staff of the importance of Standard 19 of the GMC Guidance.

THE COMPLAINT

1. This complaint was about care and treatment the Belfast Health and Social care Trust (the Trust) provided to the complainant between November 2020 and November 2022.

Background

2. The complainant has a diagnosis of epilepsy[1]. In 2015 the Trust referred her to the Walton Centre in Liverpool where she underwent brain surgery for her epilepsy.

3. In June 2020, the complainant told the Trust she was experiencing loss of power in her legs. Two doctors attended to her, Dr A, a Consultant Neurologist[2] and Dr B, a Consultant Ophthalmic Surgeon[3]. Dr A referred her for an MRI scan[4] of her brain which the Trust conducted in November 2020. Dr B referred her for another MRI brain scan which the Trust conducted in December 2020 and a CT venogram[5], which she had in January 2021.

4. A Consultant Neuroradiologist[6] (Dr C) reviewed the CT scan and noted an arachnoid cyst[7]. Dr B told the complainant about the arachnoid cyst at a review meeting in February 2021. The complainant complained to the Trust about the diagnosis. The Trust responded that the reference to an arachnoid cyst was an error and apologised.

5. In August 2022, the complainant attended a meeting with Dr C. She said Dr C showed her a MRI Scan image, but she believed this image was not of her brain as there was no evidence of the scar tissue from her brain surgery in 2015.

[1] Epilepsy -A neurological disorder that causes seizures or unusual sensations and behaviours.
[2] Neurologist - A medical doctor who specializes in diagnosing and treating diseases of the brain, spinal cord, and nerves
[3] Ophthalmic Surgeon - a clinical and surgical doctor who deals with the diagnosis and treatment of eye disorders
[4] MRI scan - a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
[5] CT venogram - is a contrast-enhanced examination with an acquisition delay providing an accurate detailed depiction of the cerebral venous system.
[6] Neuroradiologist - A neuroradiologist is a medical doctor (M.D. or D.O.) who specializes in diagnosis and characterization of abnormalities of the central and peripheral nervous system, spine, and head and neck using neuroimaging techniques.
[7]Arachnoid Cyst - a noncancerous fluid-filled sac that grows on the brain or spinal cord. Symptoms include headaches and seizures, but many arachnoid cysts do not cause symptoms.

6. The complainant experienced loss of power in her legs. The Trust referred her to the Walton Centre for a second opinion on the cause. A doctor there (Dr D) suspected it may be due to 'severe migraine'[8] .

7. Two of the complainant's close family members on her maternal side suffered brain haemorrhage[9] and stroke[10] (brain bleed). Whilst at the Walton Centre Dr D referred her for a CT Angiogram[11] to be conducted at the Walton Centre. The Trust decided not to fund her return visit to the Walton Centre for a CT Angiogram as this procedure is available in Northern Ireland. In addition, the Trust said it will not conduct a CT Angiogram as it does not consider the complainant to be at risk from a brain bleed.

Issues of complaint

8. I accepted the following issues of complaint for investigation:

Issue 1: Whether the care and treatment the Trust provided to the complainant between November 2020 and November 2022 was reasonable and appropriate?

In particular -:

The information the Trust communicated to the complainant after her scans

Issue 2: The need for a CT Angiogram

INVESTIGATION METHODOLOGY

9. 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

10. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors IPAs:

[8] Migraine - A migraine tends to be a very bad headache with a throbbing pain on 1 side of the head.

[3] Stroke - a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off.
[4]CT Angiogram - an imaging test to view blood vessels and tissues.

- A Consultant Neurosurgeon with 11 years' experience FRCS(SN) (N IPA); and
- A Consultant Neuroradiologist with 12 years' experience (MBBS,MSc,FRCR) (R IPA).

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

11. I included the information and advice which informed the findings and conclusions 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

12. 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[12]:

- The Principles of Good Administration

13. 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 April 2019 (the GMC Guidance); and
- ACR-ASNR-SPR Practice Parameter for the Performance and Interpretation of Cervicocerebral Computed Tomography Angiography (CTA) 2020 (CTA Guidance).

[12] 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 four to this report.

14. 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.

15. 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 have carefully considered the responses I received.

THE INVESTIGATION

Issue 1: The information the Trust communicated to the complainant after the MRI brain scan performed in November 2020

In particular -:

The information the Trust communicated to the complainant after her scans.

Detail of Complaint

16. The complainant was concerned the Trust said it discovered a large arachnoid cyst on the right side of her brain. She said the Trust later informed her it was arachnoid granulation, and it had informed her about a cyst in error. She said this caused her to lose faith in the organisation, so she is not sure which diagnosis is correct. The complainant is also concerned that in August 2022 the Trust showed her a brain scan image which was not of her brain as there was no scar from brain surgery carried out in 2015.

The Trust's response to investigation enquiries

17. As noted in the Trust's correspondence of 21 December 2022 to the complainant, the letter relating to her attendance at Dr B's clinic on 23 February 2022 describes a large arachnoid cyst. At a meeting on 17 November 2022 the Trust explained to the complainant that arachnoid granulation is a normal finding and regrettably the clinic letter mentioned a cyst in error. The Trust

confirmed Dr B is sincerely sorry for any distress this confusion caused the complainant.

18. The Trust stated it acknowledged the inaccurate reference to an arachnoid cyst in the complainant's records caused her some distress and it reiterated its sincere apologies to her in this regard. The Trust stated it will continue with its efforts to ensure appropriate care and attention in relation to documentation and the accuracy of record keeping.

19. The Trust wishes to reassure the complainant the MRI Scan it showed her was of her brain.

Relevant Trust medical records

20. I attach relevant extracts from the Trust Medical Records at Appendix three.

Independent Professional Advice

21. I enclose the N IPA and R 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

22. The complainant was concerned the MRI scan carried out in November 2020 revealed a large arachnoid cyst on the right-hand side of her brain.

Diagnosis of arachnoid cyst or granulation in November 2020.

23. I reviewed the medical records, and I note that in relation to the November 2020 MRI scan the Principal Interpreter found '*Appearances likely to represent an arachnoid granulation*'. He concluded *'likely arachnoid granulation in the lateral most aspect of the right transverse sinus'.* The N IPA advised this was a reasonable interpretation of the scan result.

24. Taking account of the IPA advice and the findings and conclusions of the Trust's Principal Interpreter I am satisfied the MRI Scan taken in November 2020 did not reveal an arachnoid cyst but arachnoid granulation.

Diagnosis of arachnoid cyst or granulation in January 2021

25. The medical records indicate the Trust conducted a CT venogram scan in January 2021. The R IPA independently reviewed the CT venogram scan. He advised '*There is an arachnoid granulation at the junction of the right transverse and sigmoid sinus.* The *'CT scan does not show an arachnoid cyst.'* He also advised '*The CT report states that 'on the right side a large arachnoid cyst is seen, sinus system is otherwise patent'. This is incorrect'.*

26. The R IPA advised *'The CT venogram report incorrectly referred to an arachnoid granulation as an arachnoid cyst. Typographical errors are common (particularly when using voice recognition software) and it is good practice to separate the process of dictation and proof reading*.' I accept the advice of both the N IPA and the R IPA, and therefore find the complainant's scan results both showed arachnoid granulation, and not an arachnoid cyst. I further accept the R IPA's advice that the diagnosis stated on the CT venogram report was incorrect, which I note the Trust acknowledged. I also welcome the Trust's apology to the complainant for this error. I note the complainant said she remains unsure about her diagnosis, and I hope this will bring her reassurance about the exact nature of her scan results.

27. Regarding record-keeping, Standard 19 of The GMC Guidance says *'Documents you make (including clinical records) to formally record your work must be clear, accurate and legible.* I reviewed the medical records in relation to the CT venogram. In his report of the findings of the CT venogram Dr C recorded '*arachnoid granulation*.' However, I note in his conclusion to the report he referred to *a 'large arachnoid cyst*.' Given his previous conclusions and taking account the R IPA's advice that there is no evidence of arachnoid cyst I consider this to be an inaccurate record which was not in accordance with the guidelines. This is a failure in record keeping.

28. On the foot of Dr C's conclusion, Dr B advised the complainant, by letter, in February 2021 of the presence of the arachnoid cyst but said *'it is not causing a blockage and was of no concern'.* The IPA advised *'although the complainant*

might have felt distressed at the mix-up, there was no actual consequence. I accept that whilst there was no clinical consequence in this instance, Dr C's failure to accurately record the findings of the CT venogram influenced the diagnosis Dr B made and relayed to the complainant. Whilst I am satisfied, on foot of the R IPA's advice, this error did not have any impact on the complainant's care and treatment on this occasion, Dr C's failure to make an accurate record caused the complainant to sustain the injustice of uncertainty and upset. I uphold this element of the complaint.

Brain Scan shown to complainant in August 2022

29. Dr C held a meeting with the complainant in August 2022 where the complainant states he showed her the Trust's November 2020 MRI scan of her brain. The complainant was concerned this image did not relate to her brain, as she said it did not show scar tissue from her brain surgery in 2015. The N IPA advised this MRI scan *shows scar tissue, that is entirely consistent with the medical records, at the site of previous brain surgery.* The R IPA also observed '*evidence of previous surgery in the left temporal lobe and overlying temporal bone'*

30. The complainant did not explain how she reached the conclusion scar tissue from her previous brain surgery was not evident on this MRI Scan. However, I accept the N IPA and R IPA's advice. I am therefore satisfied the MRI scan the complainant examined at the meeting in August 2022 was the November 2020 MRI scan of her brain. I therefore do not uphold this element of the complaint.

Summary

31. On foot of my above findings, I partially uphold issue one of this complaint.

Issue 2: **The need for a CT Angiogram**

Detail of Complaint

32. In September 2021 Dr A referred the complainant to the Walton Centre. Dr A did not advise Dr D that this was for a one-off second opinion consultation. Dr D

advised the complainant he wished to see her again and made an appointment for December 2021.

33. The complainant contacted the Trust's complainant travel team to arrange this, who told her the medical board only recommended she attend for one appointment. The complainant said she wants the Trust to fund further appointments for her at the Walton Centre.

34. She is concerned her neurologist at the Walton Centre has not discharged her. She said Dr D wants to see her again as that is where she had her brain surgery.

35. The complainant is dissatisfied with the way the Trust has dealt with her as it is sending other patients to specialists outside of Northern Ireland. She is concerned the Trust is treating her differently.

The Trust's response to investigation enquiries

36. The Trust stated it referred the complainant to the Walton Centre in September 2021, who saw her in November 2021. The Trust stated it subsequently re referred her in September 2022, but she declined several appointments. It then discharged her. The Trust stated it became aware of this in May 2023.

37. The Trust stated it referred the complainant to the Walton Centre again in May 2023, where she was seen in July 2023.

38. The Trust stated it is aware the complainant was keen for it to refer her to the Walton Centre for a CT angiogram. However, the referral was for consideration of epilepsy surgery and a *'CT angiogram would not be indicated for epilepsy surgery workup.'* The Trust stated it sought clarification from the Extra Contractual Referral (ECR) team regarding funding for investigations outside Northern Ireland. The ECR team advised '*These ECRs are approved with the expectation that if diagnostic tests are available (Bloods/MRI's/Video/EEG etc) locally these should be organised by the Trust and results forwarded to the tertiary centre to negate the need for multiple unnecessary travel trips.*

However, if there are diagnostics/tests that must be done in a tertiary centre for clinical reasons then travel for this purpose is appropriate.' The Trust stated that, to avoid confusion, Dr A informed the Walton Centre about this at the time of referral.

39. The Trust is unable to organise a CT angiogram for intracranial screening for the complainant as she already saw a specialist (Dr C), who stated this is not indicated.

Relevant Trust medical records

40. I attach the relevant Trust Medical Records at Appendix three.

Relevant Independent Professional Advice

41. I enclose the N 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

42. I note the complainant was keen to have a CT Angiogram of her brain given her family history of brain bleeds. She wished to have this in the Walton Centre as this was where she underwent her previous brain surgery. The Walton Centre agreed to carry out a CT Angiogram. The complainant was concerned the Trust will not fund this.

The need for a CT Angiogram

43. I note in December 2021 Dr A wrote to Dr C saying the complainant was '*understandably concerned about her risk of SAH at age 39.'* In that letter Dr A asked Dr C to see the complainant '*to discuss whether any further investigation is indicated'.* By letter dated January 2022 Dr C advised the complainant's GP '*I have explained to the complainant that one first degree relative[13] does not meet screen criteria for intercranial aneurysm[14] screening. I have explained that given the complainant is not a smoker her likelihood of having an aneurysm is*

[13] First degree relative – parents, children and brothers/sisters
[14] Intercranial aneurysm – Brain Aneurysm. An aneurysm is formed when there is a weakness in the blood vessel (artery) causing a ballooning or 'out-pouching' that fills with blood.

roughly similar to the rest of the female population her age. For this reason, we will not be offering aneurysm screening.' Dr C continued *'I will be writing to her consultant neurologist in this hospital who will decide on further onward referrals and / or further imaging concerning her ongoing leg problems.'*

44. I note Dr A wrote to a Trust Consultant Neurosurgeon (Dr E) in April 2022 asking that he review the Strategic Planning and Performance Group's (SPPG) decision not to send the complainant to the Walton Centre for a CT Angiogram. In May 2022 Dr E responded that he '*reviewed Dr C's clinical letter and would be completely in agreement with his assessment in regard to screening as this complainant is not fulfilling the criteria for screening for intercranial aneurysm, I do not think she is eligible for the screening process*'.

45. I reviewed the medical records, and I note after the meeting with the complainant in August 2022 Dr C wrote to the complainant's GP. In that letter Dr C explained discussions had taken place with the complainant regarding the need for a CT Angiogram. Dr C stated he had advised the complainant:-

- *An intercranial aneurysm is unlikely to be the cause of her new symptoms*
- *A CT Angiogram involves x rays which have to be justified on clinical grounds*
- *An MRI angiogram would be a preferable alternative and probably have more accurate results; and*
- *[Dr C] had offered to have the MRI imaging carried out by the Trust but reported by a consultant elsewhere*

46. At paragraph II of the CTA guidelines it states *'INDICATIONS 1. Arterial aneurysms or pseudoaneurysms, venous varices, and dissections'*

47. The N IPA referred to the guidelines and advised '*the clinical guidelines for offering a complainant a CT angiogram are suspected cerebral aneurysm or other vascular abnormalities which is not the case here''.* He advised the Trust was correct to not have offered the complainant a CT Angiogram as '*CT*

delivers a dose of ionising radiation and should only be done when there is a clinical suspicion of the relevant pathology.'

48. The N IPA advised that both a CT Angiogram and an MRI Angiogram '*look at the blood vessels. MRI is harmless. I'd have no objection to performing a MRI if it provided the complainant with reassurance there is nothing wrong.'*

49. Neither the Trust or the N IPA consider the complainant's '*suspected cerebral aneurysm or other vascular abnormalities'* require further investigation by way of a CT Angiogram. Both indicated the risks associated with a CT Angiogram and identified a MRI Angiogram as a suitable alternative means of investigation.

50. I understand the complainant is concerned about her family history of brain bleeds, and how upsetting it is for her to suffer the new symptoms of loss of power to her legs. However, I am satisfied that the Trust has thoroughly assessed her risk of intercranial aneurysm and offered her a more suitable alternative means of investigation to reassure her that her risk is low. However, I note she has refused this offer. I accept the Trust's position and the N IPA's advice that a CT Angiogram is not necessary at this time. I therefore do not uphold this element of the complaint.

Referral to the Walton Centre

51. The Transfer for treatment by the SPPG who regulate the ECR scheme states *'Transfer for treatment by SPPG is known as ECR and occurs when the SPPG approves a consultant's request to transfer a complainant to a provider outside Northern Ireland for assessment or treatment which the consultant considers necessary, but which is not available through NHS facilities locally.'*

52. I reviewed the medical records: In September 2021 Dr A referred the complainant to the Walton Centre for *'Epilepsy Opinion.'* Funding was agreed on 30 September 2021, and I am satisfied the purpose of this referral was for further epilepsy investigations only and not investigations into a possible brain aneurysm.

53. At the epilepsy referral appointment in November 2021 the Walton Centre offered the complainant a CT Angiogram. The complainant informed Dr A about this offer and contacted the complainant travel team regarding funding of this procedure. By letter dated 16 November 2021 Dr A advised the complainant that '*funding approval for the Walton Centre was for a one off second opinion **only**'*. In a letter dated 23 November 2021 Dr A advised Dr D of this decision. The reason being that HSBC [now called SPPG] have '*indicated that they will not fund investigations in Liverpool that could be performed locally'.* In a follow up letter dated 6 December 2021 Dr A further advised Dr D *'I note that you had planned to organise a CT angiogram for the complainant in view of her family history of subarachnoid haemorrhage. This can be performed locally within Northern Ireland.'*

54. I appreciate the Trust's decision was frustrating for the complainant, particularly in light of the Walton Centre's offer. However, as the particular investigation the complainant requested is available in Northern Ireland, and noting SPPG's advice, I consider the actions Dr A were in accordance with the guidelines. I consider that each case must be determined on its own merits. I have no evidence the Trust has treated the complainant differently from other patients in Northern Ireland who wish to be referred to the Walton Centre for a CT Angiogram. I therefore do not uphold this element of the complaint.

Summary

55. On foot of my above findings, I do not uphold issue two of this complaint.

CONCLUSION

56. I received a complaint about the care and treatment received form the Belfast Health and Social Care Trust between November 2020 and November 2022.

57. In respect of Issue one the investigation found:
    - The Trust correctly recorded the result of the MRI Scan in November 2020. The Trust incorrectly recorded the result of a CT Venogram in

January 2021. This was not in accordance with the GMC Guidelines. The Trust shared this error with the complainant, which caused her to sustain the injustices of uncertainty and upset. I was satisfied, however, in the circumstances, this did not impact on the care and treatment she received. I therefore upheld this element of the complaint.

- The Trust showed the complainant the correct MRI scan of her brain. I did not uphold this element of the complaint.

58. In respect of Issue two the investigation found;

- The Trust's decision to not undertake a CT Angiogram of the complainant 's brain was appropriate. I did not uphold this element of the complaint.
- The Trust's decision to withhold funding for a CT Angiogram in the Walton Centre was in accordance with the appropriate guidelines. I did not uphold this element of the complaint.

Recommendations

59. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (August 2019), for the injustice caused as a result of the failure identified within **one month** of the date of this report.

60. For service improvement and to prevent future recurrence I also recommend the Trust:

i. discusses the findings of this report with all staff involved and allows them to reflect on the findings;
ii. reminds all staff of the importance of maintaining proper and appropriate records in accordance with Standard 19 of the GMC Guidance.

MARGARET KELLY

Ombudsman **December 2024**

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.