Neutral Citation No: [2020] NICoroner 5 ***Judgment: approved by the Court for handing down (subject to editorial corrections)****	***Ref:* [2020] NICoroner 5** ***Delivered: 22/10/20***

IN THE CORONERS COURT FOR NORTHERN IRELAND

Paul Aiden McKeown

IN THE MATTER OF AN INQUEST INTO THE DEATH OF

Before: Coroner Mr Patrick McGurgan

(1) The deceased, Paul Aiden McKeown, born on 14th January 1994, of 178 Dunclug Park, Ballymena, died on 13th August 2018.

(2) Mrs Susan Anne McKeown, mother of the deceased gave evidence to the inquest. She stated that on Monday 30th July 2018, the deceased informed her that he felt that he had pulled something on the right hand side of his body after turning suddenly when out walking. This continued to annoy him and he attended with his GP on 2nd August whom the deceased stated had informed him that he had pulled something. On Friday 3rd August, the deceased was meant to attend a wedding but his mother explained that he was in a lot of pain and did not look well. He was extremely cold and as a result his mother took him to the Accident and Emergency Department (A&E) at Antrim Area Hospital.

(3) Following triage, the deceased was examined by a doctor who considered that it could be a blockage in the bowel or appendicitis or a pulled ligament. Mrs McKeown stated that the doctor ultimately diagnosed a bowel blockage and a pulled muscle and prescribed naproxen and a laxative. Mrs McKeown also informed the doctor that she had a history of Crohn's disease and ulcerative colitis and a previous perforated colon and that the deceased had an underactive thyroid and was on levothyroxine. The deceased was advised to return if his symptoms did not improve.

(4) According to Mrs McKeown, the deceased felt slightly better over that weekend but on Monday 6th August he was unwell and in pain. The following morning, 7th August, he vomited, was sweaty and in a lot of pain.

(5) That same morning, he had a prearranged appointment with his GP to have his bloods checked for his underactive thyroid. On attendance at his GP practice, the GP noted that his temperature was raised and he sent the deceased to A&E at Antrim Area Hospital.

(6) On attending A&E, the deceased was triaged and his temperature was 39 degrees. He was given paracetamol and subsequently x-rayed. The doctor discussed constipation and appendicitis. The deceased was eventually admitted to ward C5 and reviewed by members of the surgical team. The deceased was to be kept overnight for observations.

(7) On 8th August, the deceased spoke to his mother by phone at 7.30am and advised her that he had a urinary tract infection. His mother spoke again with him at 10am and the deceased indicated that he was being discharged. Mrs McKeown again spoke with the deceased by phone at midday and he advised he was awaiting pharmacy and then he could leave. Mrs McKeown attended the hospital and the deceased left at 4pm once pharmacy had dispensed his medication.

(8) The following morning, 9th August, the deceased woke his mother between 5.30am and 6am. He explained that he had been sick and that his vomit was black in colour. He denied being in pain although he appeared restless throughout the day and did not seem to be able to get comfortable. Mrs McKeown took the deceased's blood pressure which was 88/64. She telephoned the GP and after discussing the deceased's symptoms, it was decided that as the hospital had just released the deceased, then the deceased should be observed for 24 hours but if symptoms got worse then he was to go to A&E.

(9) Between 5.30pm and 5.50pm on the 9th August, the deceased came downstairs and Mrs McKeown described him leaning his right shoulder against the wall with his hand on his chest and saying "mummy". Mrs McKeown knew there was

something wrong and the deceased collapsed in her arms. She proceeded to place the deceased in the recovery position and contact emergency services. The deceased was taken to Antrim Area Hospital.

(10) Mrs McKeown stated that whilst at the hospital she was informed by a member of the surgical team that they had reviewed the CT scan and that the deceased's appendix had ruptured two days prior in Antrim Area Hospital.

(11) The deceased underwent a laparotomy and remained in ICU. Unfortunately, the deceased continued to deteriorate and he was declared brain stem dead at 11.19am, at Antrim Area Hospital on 13th August.

(12) The deceased's family consented to his organs being donated and I commend them for this.

(13) In his evidence admitted under Rule 17, Dr Nigel Ruddell, Medical Director of Northern Ireland Ambulance Service, stated that on 9th August NIAS received a 999 call from the deceased's mother at 17:45:57 hrs. The deceased had collapsed. On further questioning, the call was categorised as a patient aged below 35 years who had passed out but who is now completely alert and has no known history of cardiac problems. This was a category C response with an expected response time of within one hour.

(14) Dr Ruddell stated that NIAS operates a Clinical Support Desk staffed by paramedics to engage with those patients initially categorised as lower priority. This was considered such a case and at 17:53 a call was made to the now deceased. The female who answered stated that the deceased "was hardly conscious at all now" and that he was "barely breathing here" and that he was bringing up "black bile". As a result, the call handler/paramedic upgraded the call to a category A. The paramedic remained on the line with the deceased's mother until arrival of the RRV paramedic.

(15) The RRV paramedic arrived at 18:04:13 after being tasked at 17:56:56. An A&E ambulance was allocated at 18:07:11 arriving at 18:23:58. The crew and the deceased

left scene at 18:50:18 arriving at Antrim Area Hospital at 19:04:31, a standby call having been made en route.

(16) In his evidence to the Inquest, Dr J McFarland GP, stated that the deceased had been his patient since birth. He suffered from Hypothyroidism and was prescribed medication for this. Dr McFarland explained that the deceased attended with him on 2nd August 2018 complaining of a vague pain over the right hand side of his pelvis for the previous week. On examination, the deceased had slight tenderness of this area but no abdominal tenderness. Dr McFarland stated that he felt that this was muscular in origin. It was agreed that the deceased would continue to observe his condition and if it did not improve then he was to return to Dr McFarland.

(17) Dr McFarland subsequently received communication from Antrim Area Hospital, A&E, indicating that the deceased had attended on 3rd August 2018 and had been diagnosed with a sprain/ligament injury on lumbar spine with constipation and had been discharged with analgesia and laxatives.

(18) Dr McFarland told the Inquest that the deceased then re-attended with him on 7th August with his mother. The deceased had felt that his initial symptoms had resolved but that he had developed worsening abdominal pain with vomiting the previous night. On examination, his temperature was 37.9 degrees, he was very pale and had generalised tenderness all over his lower abdomen. Dr McFarland referred the deceased immediately to A&E at Antrim Area Hospital with a letter for urgent re-assessment. Dr McFarland was concerned that the deceased was developing acute abdominal pathology.

(19) On 9th August, the deceased's mother spoke by telephone with Dr McFarland. She advised that he had been discharged from hospital and that there was no improvement in his symptoms. It was agreed that she would continue to observe her son's symptoms but that he may need re-admitted if symptoms worsened.

(20) I find that Dr McFarland acted appropriately.

(21) In his evidence to the Inquest, Dr Matthew McKee stated that the deceased presented to A&E at Antrim Area Hospital on 3rd August 2018 at 8.31am and Dr McKee saw him at 10.30am. The deceased's triage note indicated "RIF pain for 1/52" meaning pain in his lower side of his abdomen for 1 week. The deceased had been streamed to minors and bloods and urine collected at triage.

(22) The deceased was with his mother and he had a history of right iliac fossa pain from Sunday. He had no nausea or vomiting and he advised Dr McKee that he had strained himself, hurting his right side and shoulder. Dr McKee felt that he looked clinically well and was able to hop onto the bed with no discomfort. All observations were within normal limits although his blood pressure was slightly low, which Dr McKee explained would not be uncommon in young adults.

(23) On examination, the deceased had mild pain in RIF but it was soft with no rebound or guarding. The abdomen was dull to percussion. Blood and urine tests were normal.

(24) Dr McKee was of the opinion that the deceased had injured his abdominal wall muscles along with his shoulder and that he had become constipated as a result of slower movement due to pain which is why he was dull to percussion. Dr McKee prescribed Naproxen, an anti-inflammatory and a laxative. Although Dr McKee did consider appendicitis as a differential diagnosis he did not feel that the deceased had appendicitis in light of his examination and the test results.

(25) Dr McKee discussed his findings with the deceased's mother and explained that if pain got worse, or if he was unwell or not settling then he was to return to the hospital.

(26) I find that Dr McKee acted appropriately throughout.

(27) In her evidence to the Inquest, Nurse Stephanie Linton stated that she was a registered nurse on duty on 7th August 2018. Prior to her contact with the deceased, he had been triaged as increasing pain and vomiting, having been discharged 4 days earlier with Laxido and bloods were taken. Nurse Linton assessed the deceased at

12.30pm and his NEWS was 5 as he had a high respiratory rate, high temperature, low blood pressure and raised heart rate. The deceased had been given paracetamol in triage at 11.45am. 400mg of Ibuprofen was prescribed by Dr Christopher Irwin and Nurse Linton administered this at 12.45pm. The deceased said his pain was an 8/10 before the paracetamol and it had since eased but he was sore on touch. His bowels were noted to be variable between constipated and normal and he felt he couldn't relieve himself fully due to the pain.

(28) The deceased was then seen by surgeons whose note documented that he was "not feverish" and the diagnosis as unlikely appendicitis query inflammatory bowel disease. Surgeons had requested a chest and abdominal x-ray and their plan was for discharge if this x-ray was normal. Nurse Linton stated that she took issue with both the noted observation that he was not feverish and the plan for discharge as the deceased had a previous high temperature and appeared to be in a lot of pain. Nurse Linton raised this with Dr Christopher Irwin and surgeons advised they would review him again.

(29) Whilst waiting on a bed, Nurse Linton completed a further set of observations at 2.50pm. NEWS was 6 as his respiratory rate was still high at 23, his blood pressure had dropped lower 88/58 and heart rate was still raised. Dr Irwin then cannulated the deceased and the deceased remained in A&E until a bed was available and at 3.20pm Nurse Linton recorded his NEWS at 3, as respiratory rate was still high at 23 although his BP had come up to 117/64. The deceased was then transferred to a bed.

(30) I find that Nurse Linton acted appropriately at all times and I commend her action in querying the initial discharge plan for the deceased.

(31) In his evidence to the Inquest, Locum Consultant Surgeon, Mazin H Farhan-Alanie stated that he was on-call in Antrim hospital on 9th August 2018 when he was contacted by his associate specialist to advise that the deceased had presented with collapse and cardiac arrest at home and that CPR had lasted about 40 minutes. The deceased was critically ill with a Glasgow Coma Scale 3/15.

(32) Mr Farhan-Alanie attended the hospital and the deceased was sent for CT scan as he was unhappy with the initial scan report. He contacted the on-call Radiologist and the deceased was diagnosed with a perforated appendicitis with sepsis and ARDS (Acute Respiratory Distress Syndrome). CT brain showed severe global anoxic changes.

(33) The deceased went straight to theatre and a laparotomy was performed. The deceased had a gangrenous perforated appendix with an abscess, ischaemic posterior wall of the caecum and there was ischaemia of last 4 inches of terminal ileum. An ileocaecal resection was performed with an ilestomy. The deceased remained critically unwell and developed multi-organ failure and he was transferred to ITU. The deceased continued to deteriorate and he passed away on 13th August 2018.

(34) Mr Farhan-Alanie was of the opinion that whilst acute appendicitis was difficult to diagnose he believed the deceased's appendix had ruptured at least 48 hours prior to him seeing the deceased due to the presence of fibrous adhesions. As regards the blood test results that had been obtained, he opined that to diagnose inflammation there would need to be a series of tests performed over a number of days in order to look for a pattern and that one set of blood tests would be insufficient. He further stated that plain abdominal x-rays would be of no benefit in helping to diagnose appendicitis but that a CT scan would be useful. He commented that diagnosis of appendicitis required consideration of the whole clinical picture and benefited from experience.

(35) In his evidence to the Inquest, Mr Garth Beattie explained that he had been employed as a Consultant by the Northern Health and Social Care Trust from 2007. Following time spent in Perth, Australia, where he underwent some of his training he incepted a policy/working practice in Antrim Area Hospital whereby his Registrar would commence the post take ward rounds in the morning, or triage ward rounds, as he referred to them and then he would attend at a later time and discuss each patient with his Registrar to establish who was a priority patient.

(36) Mr Beattie explained that a fundamental element of this policy/ working practice was that no patient was to be discharged until he himself had seen the patient. On this particular aspect of his evidence, he initially stated that he had told his Registrar this but then stated that she should have known this as she had been working with him for the previous 6 months. In addition, when asked if his employers knew that this was his approach he suggested that he may have informed his appraiser in 2015/2016, Dr Moen, a Cardiologist, but accepted that it was unlikely that this information would have filtered back to his employers. He stated that no issue had ever been raised about this policy/working practice.

(37) Mr Beattie stated that he was the on-call Consultant Surgeon between 1pm on 7th August 2018 and 1pm on 8th August. On-call on the 7th August was quiet. On the 8th August, Mr Beattie stated that he arrived at the hospital at around 10am and spoke with his Registrar, Miss Victoria Graham, Staff Nurse Davies, the F1 and CT doctor.

(38) He was not in the hospital before this time as he was at home trying to complete his 2017 appraisal, which was long overdue. He was however available by phone if needed. Mr Beattie went on to say in his evidence that he felt that his appraisal and the fact that his back was on the ropes in relation to having it completed clouded his judgement as regards attending the hospital on time.

(39) Mr Beattie noted that the deceased was not on the take sheet for discussion and he noticed his name above an empty bed. According to Mr Beattie, Miss Graham assured him that she had assessed the deceased in A&E the previous afternoon and had admitted the deceased for observation. The impression Mr Beattie had was that the deceased had not really needed to be admitted and he was further advised that the deceased's bloods were normal and that his abdominal pain had disappeared. Mr Beattie was not informed that the deceased had previously attended on the 3rd August with the same complaint. Miss Graham informed Mr Beattie that the deceased was keen to get home and he was sent home before Mr Beattie had an opportunity to assess him.

(40) Mr Beattie asserted that this was the first time in 11 years that a patient of his had been discharged during the post take ward round by his Registrar without him having seen the patient. He did not recall questioning Miss Graham about this decision and the fact that it was contrary to his policy/working practice as he did not want to undermine her.

(41) Mr Beattie was informed that the deceased had been commenced on an antibiotic as he had protein and white cells in his urine. The plan was to arrange a flexible sigmoidoscopy at an out-patient clinic which Mr Beattie asked to be changed to a colonoscopy and he said that he would review the deceased in six weeks. Mr Beattie was assured that there was no need for a scan prior to discharge. On the morning of Tuesday 14th August, Mr Beattie received a text message from Miss Graham informing him that the deceased had been admitted a number of days later extremely unwell and underwent a laparotomy which revealed a gangrenous appendix.

(42) Mr Beattie accepted that if he had assessed the deceased and if he had considered all of the evidence which was available to him at the time, then he would not have discharged the deceased.

(43) Mr Beattie stated that as a direct consequence he has changed his practice in that he now does an initial Consultant led post take ward round.

(44) I will return to Mr Beattie's evidence in due course.

(45) In his evidence, Dr Christopher Irwin stated that on 7th August 2018 he was working as a locum doctor in Antrim Area Hospital A&E whenever he encountered the deceased. Dr Irwin stated that he reviewed the deceased at 12.15pm on 7th August. The deceased was presenting with abdominal pain for the previous week and had been seen in A&E on 3rd August with the same pain that was felt likely due to constipation. On this occasion, the deceased complained of pain in the right lower quadrant of his abdomen made worse on walking or going over speed bumps in the car. He reported several vomits and feeling feverish the previous night.

(46) On assessment, Dr Irwin noted the deceased to have a fever of 38.5 degrees but other observations were normal. He was tender in his right lower quadrant but without guarding or rebound tenderness which are signs of inflammation within the abdomen.

(47) Dr Irwin referred the deceased for surgical admission as he suspected appendicitis given the site of the pain, new onset of fevers and vomiting. He also prescribed painkillers and intravenous fluids.

(48) Nurse Linton made Dr Irwin aware of the documented surgical review and plan at 2pm which was to discharge with an outpatient appointment for flexible sigmoidoscopy as Miss Graham (Surgical Registrar) was concerned the deceased may have inflammatory bowel disease.

(49) It was noted that Miss Graham had written in the deceased's record that he was "not feverish". As a result, Dr Irwin stated that he contacted Miss Graham to highlight that he did have a fever and that he felt he may have acute appendicitis and would require surgical admission. Miss Graham advised someone from surgical team would attend and review the deceased. Dr Irwin described this telephone encounter as possibly being the one Mrs McKeown felt was heated as he felt that the surgical team did not think that the deceased had appendicitis.

(50) Dr Irwin assessed the deceased again at 2.50pm at the request of nursing staff, due to the deceased's blood pressure being low, although Dr Irwin did not make a note of this. Dr Irwin commenced a bolus of IV fluids, which caused the BP to return to 117/64. Dr Irwin again contacted the surgical team and Dr Dwyer (surgical FY2) agreed to attend to re-assess the deceased which she did at 3.40pm. Dr Irwin advised that he thought that the deceased had an acute appendicitis and should be admitted for surgical review.

(51) After review, Dr Dwyer informed Dr Irwin that the deceased was going to be admitted and the deceased was moved to the surgical ward.

(52) Whilst it is of the utmost importance that notes are accurately completed, I find that Dr Irwin acted appropriately at all times and I commend him for his persistence as regards having the deceased admitted.

(53) In her evidence to the Inquest, Dr Laura Dwyer FY2 trainee in surgery at Antrim Area Hospital stated that on 8th August she received a referral from an SHO in A&E about the deceased who it was felt might be presenting with appendicitis. Dr Dwyer explained that she got the surgical pro-forma ready and she went to see the deceased accompanied by Miss Victoria Graham, Surgical Registrar. Both reviewed the deceased's bloods and noted that his haemoglobin was below normal range but had been for some time. Dr Dwyer acted as scribe during the clinical encounter and noted the history including that the deceased had attended A&E four days prior with abdominal pain. Miss Graham examined the deceased while Dr Dwyer watched from the foot of the bed. Miss Graham thought the cause of pain may be constipation and felt that he could go home if his x-rays which had been ordered were normal.

(54) On the pro-forma, both Dr Dwyer and Miss Graham have completed sections. Although on this occasion nothing turns on it, Dr Dwyer accepted that she should have signed the part completed by her.

(55) Pausing here, although Dr Dwyer's statement reads as though by the time this assessment was being performed the x-ray results were to hand, I find that this was not the case.

(56) In addition, her statement also sets out the observations made in relation to the deceased, to include his temperature, but I find that these had also not been considered by Dr Dwyer at the time of her discussion of the deceased with Miss Graham, because had she been aware of his recorded temperature of 38 degrees she would have known that the description of the deceased as 'not feverish' was incorrect.

(57) Dr Dwyer stated that she was later bleeped by A&E regarding the deceased. He had a drop in blood pressure and IV fluids had been commenced. Dr Dwyer

returned to re-assess the deceased. His history remained unchanged and on examination he was tender in the right and left iliac fossa.

(58) Dr Dwyer discussed admitting the deceased with Miss Graham for overnight observation which Miss Graham agreed with.

(59) The following morning, the deceased was seen on the post take ward round. By this time Dr Dwyer had been on the surgical team for 7 days. Present at this ward round were Dr Dwyer, Miss Graham, a nurse and the surgical nurse practitioner and an F1. Dr Dwyer explained that the deceased's recent NEWS score was 2 but that his previous 24 hour scores were not discussed. No further notes were considered. The deceased mentioned an uncomfortable sensation on passing urine so he was prescribed an antibiotic. The clinical impression remained one of constipation requiring outpatient flexible sigmoidoscopy or colonoscopy. He was then discharged and Dr Dwyer wrote his discharge note.

(60) In her evidence, Dr Dwyer accepted that in light of all the information that had been collated by staff pertaining to the deceased he should not have been discharged. She further explained that she expected the deceased to have been assessed by the Consultant Mr Beattie as that was her experience of all other Consultants she had worked under. When questioned about this, she accepted that it would have been better if the deceased had not been discharged prior to Mr Beattie assessing the deceased rather than being discharged and then hopefully assessed by Mr Beattie prior to leaving the hospital. Dr Dwyer further accepted that she did not question Miss Graham's decision to discharge the deceased but that she would have if she had had any concerns. She did not believe that the deceased presented with symptoms typical of appendicitis and that his symptoms were more akin to inflammatory bowel disease.

(61) As regards Mr Beattie's practice of allowing his Registrar to conduct the post take ward rounds in his absence, Dr Dwyer stated that this continued for the next 3 months that she was on that team following the passing of the deceased.

(62) In her evidence to the Inquest, Miss Victoria Graham stated that at the time she was working as an ST4 (Speciality Registrar) in the general Surgical Department of Antrim Area Hospital. Miss Graham stated that she first met the deceased at 1.20pm on 7th August in the A&E Department. FY2 Dr Laura Dwyer had been asked to review the patient by the A&E Locum Doctor, Dr Irwin and she was the Registrar on-call for emergencies. The deceased complained of crampy abdominal pain for the last 8 days and had issues with his bowels. He was accompanied throughout by his mother. Miss Graham did not recall being informed that the deceased had previously presented to A&E on 3rd August. The deceased said that his pain was constant and he rated it at 4/10 in severity. He advised that he had been eating and drinking well with no vomiting or nausea.

(63) On the issue of vomiting, although Miss Graham stated that the deceased told her he had no vomiting, there is no note regarding vomiting in the surgical pro-forma section that she completed. There is an entry however made in the same pro-forma by Dr Dwyer under the section "History of Presenting Complaints" which states "vomiting overnight."

(64) The deceased denied any heartburn or reflux. He last passed a motion on 4th August but was passing flatus. The deceased advised that he was prone to constipation over the preceding few months and had been having episodes of rectal bleeding. The deceased's mother advised that she had Crohn's disease and suspected that the deceased had also.

(65) On examination his abdomen was soft, minimal tenderness over his suprapubic region, and was Rosving's sign negative which Miss Graham explained was a test used to indicate peritoneal irritation possibly due to appendicitis.

(66) According to Miss Graham, she asked Dr Dwyer about the deceased's observations and was informed that they were stable. She herself never checked the NEWS scores as her and Dr Dwyer were working as a team and she expected Dr Dwyer to alert her to any issues with the observations.

(67) She said that the deceased's inflammatory markers were within normal limits and no abnormalities were noted on his blood tests. Urine dipstick revealed + protein but nil else. Miss Graham stated that she later became aware that his temperature was 38.1 degrees at 12.30 on 7th August but said that it never spiked above 37.4 degrees after that singular recording.

(68) As regards the issue of the deceased's temperature, Miss Graham accepted in her evidence that the deceased's temperature was in fact initially recorded in A&E at 39 degrees, then 38.5 degrees and then 38.1 degrees, which in effect represented three high temperature recordings, each one of which would have constituted a fever.

(69) Miss Graham accepted in her evidence that there was poor communication between her and Dr Dwyer as regards the entries in the surgical pro-forma. In addition, the pro-forma is signed by Miss Graham and she was the Registrar and therefore I find that it was her responsibility to ensure that she was fully acquainted with its contents.

(70) Miss Graham explained to the deceased and his mother that she did not believe that appendicitis was the most likely diagnosis and nor did she believe that the deceased required an operation at that point. She felt that in light of the deceased's altered bowel habits and PR bleeding he would require endoscopic investigation. Miss Graham advised the deceased that once x-rays were obtained of his chest and abdomen and if they were satisfactory then he would be discharged for out-patient follow-up and investigation.

(71) At approximately 2pm that afternoon, Miss Graham believed that Dr Dwyer received a phone call from Dr Irwin who advised that he felt the deceased should be admitted given the earlier high temperature. Miss Graham stated that at no time did she speak on the phone with Dr Irwin as Dr Dwyer held the emergency bleep and she, Dr Dwyer, would have responded to the bleep. Dr Dwyer contacted Miss Graham later that afternoon after having reviewed the deceased. She explained that the deceased remained in a similar state as to when she had examined the deceased.

The X-rays showed some mild faecal loading and the deceased was admitted for observation. The deceased was then transferred from A&E to ward C5.

(1) Miss Graham explained that she had no further contact with the deceased that day and no concerns were voiced to her at any time that day.

(72) Miss Graham emphatically disputed the suggestion by Mr Beattie that the only reason the deceased had been admitted was to assuage the A&E doctor, or that she had intimated such a thing to Mr Beattie.

(73) On 8th August, Miss Graham arrived at the hospital at 8am to attend surgical hand-over. Dr Beattie was not in attendance which was his usual practice. As per Mr Beattie's instructions, Miss Graham commenced the ward round in his absence. Miss Graham explained that Mr Beattie never informed her that she was not to discharge a patient until he assessed the patient, nor had she ever heard of the phrase "triage ward round" until she had read Mr Beattie's statement for the Inquest. She advised that when she had previously worked as a SHO she had witnessed Registrars under Mr Beattie discharge patients. She had never experienced Mr Beattie take issue with such discharges. According to Miss Graham, Mr Beattie never commenced a post take ward round and his usual practice was to arrive into the hospital at 10.30am. She indicated that everyone within the surgical team in this hospital knew that to be the case and that Mr Beattie had a reputation for being absent that was known even within the hospital she later moved to.

(74) Miss Graham reviewed the deceased. Miss Graham assumed the nurse who was in attendance at the ward round was the nurse in charge of the deceased's care when in fact it was not. She described him as sitting upright in the bed. He was not experiencing any pain, had a comfortable night and stated that things had resolved. On examination, his abdomen was soft and less tender than previously. Observations were stable. His inflammatory markers were normal. Again Miss Graham explained to the deceased that she felt that he did not have appendicitis. She further explained that his clinical history was suggestive of urinary infection and as a result she prescribed a course of antibiotics. Neither the deceased nor the nurse in

charge raised any concerns at that time. Miss Graham then advised that the deceased could be discharged once the paperwork was in place.

(75) Miss Graham stated that she had fully expected Mr Beattie to assess the deceased before he was discharged as that was her practice. She did not expect the deceased to have been moved into the discharge lounge so quickly and prior to Mr Beattie's arrival.

(76) I find that this was inappropriate. Whilst Mr Beattie reviewing the deceased prior to discharge may have been her intention, knowing that Mr Beattie's practice was to be late, I find that Miss Graham ought not to have directed the discharge of the deceased until the deceased had been assessed by Mr Beattie.

(77) Mr Beattie arrived at 10.30am and Miss Graham discussed the deceased with him outlining her findings and diagnosis with which Mr Beattie agreed although he directed a colonoscopy rather than a flexible sigmoidoscopy. Miss Graham subsequently asked Dr Dwyer to ensure a colonoscopy was requested. At no time did Mr Beattie question Miss Graham's decision to discharge the deceased nor did he advise her that she was not to discharge patients until he had assessed them.

(78) Miss Graham accepted in her evidence that if she had been aware of all of the available evidence regarding the deceased and in particular the fact that he had attended A&E on the 3rd August, she would not have discharged the deceased but would have ordered further investigations.

(79) Ms Margaret O'Hagan, Director of Surgery and Clinical Services within the Northern Health and Social Care Trust, gave evidence to the Inquest. Ms O'Hagan explained her understanding of where the on-call consultant surgeon should be and the changes made. Ms O'Hagan explained that there is a requirement to have a consultant surgeon available for emergency surgical cases every hour of the day, seven days per week. From 9am-5pm, the expectation is that the on-call consultant is within the hospital. In addition, she would expect the consultant to undertake at least one post take ward round at 9am after on-call to see the new patients and to determine the treatment/intervention required by the patient. Once it was identified

that this was not the understanding /practice of Mr Beattie, a memorandum was circulated to all consultant surgeons to ensure their practice complied with this expectation. In addition to this, there is now a job plan which sets out a daily timetable for each Consultant.

(80) Ms O'Hagan stated that she had never been aware of Mr Beattie's "triage ward round" but she did state that Mr Beattie had been spoken to in March 2018 about his poor time keeping in relation to out-patient clinic. Following this meeting, Mr Beattie did improve his time keeping but unfortunately no enquires were made as regards his timekeeping when he was the on-call surgeon. In addition, Ms O'Hagan stated that not only was Mr Beattie's 2017 appraisal overdue but so was his 2016 appraisal.

(81) I find that the lateness of Mr Beattie's appraisals combined with the need to address his timekeeping in out-patients in March 2018 should have raised serious concerns on the part of the Trust which warranted a much closer examination of Mr Beattie's practices.

(82) Ms O'Hagan spoke to the action plan that has been instigated by the Trust following this tragedy which I commend. In addition, a level 3 SAI was conducted by the Trust which was completely appropriate. Although the Inquest did not deal with all the aspects considered by the SAI, I have considered that document in its entirety and again commend all of the recommendations made by the SAI team.

(83) I find that Mr Beattie as the on call Consultant should have been in the hospital at 9am taking the post take ward round with his team. I find that on this particular occasion he prioritised completion of his appraisal over his patients.

(84) I find that it was a regular occurrence for Mr Beattie not to take a post take ward round and instead he fully expected this or, as he described it, a "triage ward round" to be conducted by his Registrar. In fact, Mr Beattie at one stage during his evidence stated: "Occasionally I turn up on time." I find this approach and attitude totally unacceptable.

(85) I find that he had not specifically addressed his team as to the workings of his policy/working practice and he assumed that they and in particular Miss Graham, picked it up as they worked together. I further find that his employers/superiors were oblivious to this approach, which in itself raises questions as regards supervision of Consultants within the hospital setting, particularly in light of the fact that it was ongoing for some 11 years and that Clinical Directors had to speak to Mr Beattie about his time keeping in out-patients.

(86) I find on the balance of probabilities that the approach adopted by Mr Beattie of not being present throughout the post take ward round and his reliance on his Registrar represented a loss of opportunity in respect of the care and treatment of the deceased.

(87) I find that the information that would have caused the medical staff dealing with the deceased to direct further tests rather than discharging him, was available in the A&E emergency department admission note, the Observation charts and the Surgical proforma had they been adequately considered.

(88) I find that whilst it was Miss Graham who made the decision to discharge she should never have been placed in this position by Mr Beattie and his approach meant that the deceased was never actually assessed/reviewed by a Consultant throughout the entire time he was in hospital between 7th and 8th August.

(89) I find on the balance of probabilities that this was death was preventable.

I find that the cause of death was:

I(a) Hypoxic Brain Injury

Due to

(b) Cardiac Arrest

Due to

(c) Intra-abdominal Sepsis

Due to

(d) Appendicitis

II Hypothyroidism