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IN THE CORONERS COURT FOR NORTHERN IRELAND

IN THE MATTER OF AN INQUEST INTO THE DEATH OF

Elizabeth Joyce Thompson

Before: Coroner Mr Patrick McGurgan

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1. The deceased, Elizabeth Joyce Thompson, born on 25 June 1951 of 30 Southland Dale, Belfast, died on 20 August 2017.

2. In her evidence to the inquest, Ms Nicola Smyth, daughter of the deceased stated that her mother had suffered from abdominal pain, cramping, intermittent constipation and diarrhoea for in excess of one year prior to her death.

3. The deceased attended with her GP on numerous occasions and according to Ms Smyth her complaints were put down to Irritable Bowel Syndrome (IBS).

4. On 13 August 2017, she attended the Emergency Department (ED) A&E at Ulster Hospital, Dundonald. Ms Smyth was in daily telephone contact with the deceased and each day she would complain of being in pain.

5. According to Ms Smyth, the deceased felt that things were going around in circles and she was in so much pain that she stated that she was "at the end of her tether."

6. Ms Smyth stated that she could not understand why, from the 13 August, nothing was picked up by medical staff and why there was no review by senior staff or a surgical team while her mother was in hospital.

7. In his evidence to the inquest, Mr Darren Thompson, son of the deceased, stated that the deceased had been on medication for both arthritis and severe

back pain over a long period of time, namely 5+ years, and this pain relief gave her a quality of life.

8. Around one week prior to the deceased's attendance at hospital on 13 August 2017, she would moan in pain, especially when trying to move. Mr Thompson noticed the deceased become increasingly worse and she became bedridden by 15 August.

9. Leading up to the attendance on 17 August, Mr Thompson stated that the deceased was writhing in extreme pain and still bed ridden. He felt that she should have been admitted to hospital.

10. On the night of 17 August Mr Thompson received a distraught telephone call from the deceased. Mr Thompson drove to the deceased's home and found her wailing in her bed. The deceased informed him that an ambulance was on its way.

11. Mr Thompson stressed to the ambulance crew that the deceased's complaining and contacting an ambulance were totally out of character and he requested that this information be passed to the receiving doctors, as the deceased was adamant that she travel alone to the hospital.

12. Mr Thompson collected the deceased from hospital on 18 August and later that day she reported that, "I feel slightly better son. Very little, but only a little." Mr Thompson felt that the deceased did not seem herself.

13. According to Mr Thompson, the deceased remarked to him that she felt that, while in the hospital, she was not being taken seriously and it was possibly assumed that she was being grumpy or exaggerating.

14. In his evidence to the inquest, Dr Shaun Finlay, General Practitioner, stated that during 2015 and 2016, the deceased had multiple contacts with the Practice mainly regarding her musculoskeletal pains and her COPD. She had pains in her neck, back with sciatica, hands and shoulder. Dr Finlay explained that the deceased had been prescribed numerous different analgesics to try and control her pains, all with limited effect. She had also received three intra-articular steroid injections to her hands.

15. Dr Finlay noted that the deceased had been reviewed on 10 November 2016 by Dr Aileen McSorley, Consultant Physician in Care of Elderly, Ulster Hospital, having been referred there with dizziness. Dr McSorley suggested a gradual reduction in analgesics, as it was felt the polypharmacy was contributing to the deceased's symptoms.

16. On 23 November 2016, Dr Finlay discussed this advice with the deceased and she was commenced on Butec patches for pain relief. The deceased declined a physiotherapy referral.

17. Dr Finlay stated that he next discussed the deceased's pain and analgesics on 22 December 2016 when it was noted that she had loose frequent motions possibly starting around the time she commenced the Butec patches.

18. On 16 February 2017 Dr Peter Topping spoke with the deceased by telephone and as she reported local skin reactions to the Butec patches, it was agreed to recommence Tramadol.

19. Dr Finlay saw the deceased on 22 February 2017 and again discussed analgesics. Instead of Tramadol, he prescribed Morphine Sulphate SR tablets (MST), 10mg twice daily which she could increase to 20mg twice daily after 1 week, if required.

20. In a telephone encounter with the deceased on 27 February, the deceased advised Dr Finlay that she had increased the morphine sulphate dose to 20mg twice daily on 23 February. She complained of being in agony with pain and said the analgesics were only giving her temporary relief. As a result, it was agreed to increase the morphine sulphate dose to 30mgs twice per day and to replace Solpadine and Co-codamol with paracetamol.

21. On 28 February Dr Finlay received a message that this pain relief regime was helping the deceased.

22. Dr Finlay reviewed the deceased on 22 March, she was still struggling with her musculoskeletal pain and wanted to increase the morphine sulphate dosage. This request was declined by Dr Finlay due to opiate toxicity concerns. Dr Finlay referred the deceased to Dr Neville McMullan, a doctor in the practice who had a special interest in pain. The Pregabalin dosage was increased back to 75mg twice per day.

23. Dr Finlay explained that he engaged in a process of negotiation with the deceased as regards her pain relief and said that at all times he was striving to achieve a balance between providing the deceased with a quality of life and limiting the amount of pain relief prescribed.

24. Dr Finlay told the inquest that the deceased first complained of chronic constipation during a telephone encounter with Dr Mark Coghlan on 7 April 2017. She was looking for advice regarding laxatives. The deceased stated that she had been struggling with constipation for a long time while previously taking Tramadol but that it was worse since starting MST. Dr Finlay

explained that constipation would be a frequent side effect of strong opioids such as MST. She advised that none of the laxatives were giving her "a normal poo". She described her belly as being hard, uncomfortable, and sore on sitting. Her laxative was changed to Movicol sachets and Dr Coughlan discussed a rectal examination and treatment with an enema if her symptoms did not settle.

25. Dr Finlay explained that Dr Neville McMullan saw the deceased on 2 May 2017 at which time he noted her widespread musculoskeletal pains. A previous MRI scan of her head and neck in October 2016 was normal. Dr McMullan prescribed Duloxetine, Capsaicin cream and Pregabalin.

26. Dr Finlay saw the deceased on 1 June 2017 for a review of her chronic widespread degenerative musculoskeletal pains. At this consultation she complained of constipation, with a lot of abdominal cramps, relieved by passing a motion. She reported an approximate 30% improvement in her pain and 50% improvement in her paraesthesia symptoms. She was prescribed Bisacodyl 5mg tablets one to two tablets per night. A planned review was intended for two months, when consideration would be given to reducing her morphine sulphate dosage.

27. On 21 July Dr Nicola Topping discussed the deceased's constipation problems with her by telephone. The deceased indicated that her constipation had improved while taking the laxative Bisacodyl but that her symptoms had significantly deteriorated with bad cramps in her stomach, and sore on toileting, after she herself had stopped taking this medication. Dr Topping arranged a clinical review that afternoon with Dr Coghlan.

28. Dr Coghlan recorded as follows:

> "Not new symptoms, cramps seem to be relieved by motion being passed and felt a lot better when taking Bisacodyl. No overt loading palpable this afternoon. I do not think needs to attend A&E for AXR at present….Clear safety netting re need to attend A&E for AXR if worsening abdo pain/not passing flatus/vomiting/distension. All bowel symptoms date to starting MST but keep review in a couple of weeks to ensure improved again with regular laxative."

29. Pulse and temperature were normal her abdomen was soft, generally slightly tender to deep palpation, no guarding/rebound.

30. Dr Finlay next spoke with the deceased by telephone on 7 August 2017 at which time she continued to complain of abdominal cramps related to her

taking Movicol and Bisacodyl. She also related that she was not eating due to nausea. Dr Finlay switched her to Lactulose solution 15mls twice daily as required.

31. Dr Finlay again spoke by telephone with the deceased on 10 August 2017, at which time she complained that her abdominal cramps were getting worse, she hadn't been able to pass a motion and was scared to eat. Dr Finlay felt that there was a change in her presentation and so an appointment was arranged for later that day with his colleague Dr McGuckian

32. The entry in the GP notes reads:

> "History lower abd cramps getting worse. Hasn't really passed motion. Not eating as scared.
>
> Comment- apt for exam and prt. May need enema…"

33. Dr Finlay explained that the reference to PRT was a typographical error and should have read 'pr' that is "per rectum".

34. No rectal exam was performed nor was an enema given as these were only thoughts/suggestions for his trainee staff, in this case Dr McGuckian.

35. Dr Finlay stated that part of the difficulty was the fact that the deceased would stop taking the laxatives herself, when she was supposed to be taking them regularly as prescribed, which made a differential diagnosis difficult.

36. Dr Finlay did not believe that the deceased was being "fobbed off" with laxatives and he was of the opinion that the deceased appreciated that the practice was working with her.

37. Dr Finlay explained that following this tragedy, his practice carried out a Serious Event Audit ("SEA"). Flowing from that, one of the action plan points was "remind all clinicians to do a rectal examination as part of assessment of constipation."

38. Dr Finlay went on to explain that the doctors in the practice did not agree with this but rather believed that a rectal exam should be considered, on a case by case basis. This was not reflected in the SEA form, nor in Dr Finlay's statement to the Coroner. Dr Finlay also made available to the staff an article from the "BMJ" entitled "Pharmacological therapies for opioid induced constipation in adults with cancer". He explained that he summarised the relevant parts for the doctors within the practice.

39. In concluding his evidence Dr Finlay explained that, if the same set of circumstances arose with a patient of the practice today, there is no policy in place to deal with the scenario but rather each patient would be assessed individually and a management plan made, as has always been the case, but with this tragedy in mind.

40. In her evidence to the inquest, Dr Niamh McGuckian stated that at the relevant time she was working as a GP Registrar in Cherryvalley Group Practice.

41. She encountered the deceased on 10 August 2017. This was the first and only time she met with the deceased.

42. The deceased had been telephone triaged by Dr Finlay and asked to attend the surgery for an assessment. Dr McGuckian explained that this would not be unusual.

43. Dr McGuckian could not recall if she read the deceased's notes on EMIS prior to seeing the deceased but she explained that it would be her usual practice to do so.

44. Although the note of Dr Finlay's telephone encounter with the deceased stated "apt for exam and prt. May need enema." Dr McGuckian explained that she interpreted this as simply Dr Finlay's thoughts and that treatment of the patient was subject to her performing her own assessment and examination. She also confirmed that she understood that "prt" had been a typographical error, intended to refer to 'pr' i.e., a rectal examination.

45. The deceased reported 2-3 months of constipation, she complained of nausea and that her diet was not great. On examination Dr McGuckian found the deceased to be uncomfortable, soft abdomen, tender in her lower abdomen and tender in her left hip. She had passed a small amount of liquid stool that morning, she had not vomited and had passed flatus.

46. The deceased reported that she was scared to take laxatives in the past and that she had not taken any laxative medication at the time of this appointment nor had she collected the prescription for lactulose. The deceased also reported feeling there may be a hard stool in her rectum.

47. Dr McGuckian explained to the deceased that her medication namely MST could cause constipation.

48. Dr McGuckian stated that she did not perform a rectal examination as she believed that the deceased's symptoms did not warrant same and, she felt that the issue was the deceased's failure to take her laxatives.

49. Dr McGuckian was also of the view that the deceased's symptoms that day did not warrant a referral to ED and there were no red flag factors.

50. Dr McGuckian suggested Senna, Lactulose and Glycerol suppositories.

51. Dr McGuckian explained that suppositories were an alternative to an enema.

52. The deceased was advised to return for review if symptoms did not improve and Dr McGuckian prescribed Senna 7.5 milligram tablets and Glycerol Suppositories 4mg.

53. In her evidence Dr Louise Douglas GP Partner at Cherryvalley Group Practice stated that she spoke with the deceased by telephone on 18 August 2017.

54. The transcript of the telephone call was read at the inquest.

55. Dr Douglas could not recall if she had reviewed the deceased's notes prior to speaking with her but said it would be her usual practice to do so.

56. The deceased informed her that she had attended the Ulster Hospital on Tuesday 13 August with severe constipation and nothing appeared to be shifting same. That report was not available to Dr Douglas at that time.

57. The deceased informed Dr Douglas that the hospital had given her an enema but that she could not hold it. It was suggested that she reduce her MST medication. She was encouraged to continue with the Laxido regimen as prescribed to her.

58. Dr Douglas believed that the deceased was only 24hrs into taking her laxatives as prescribed by the hospital and she advised the deceased that it usually takes up to 48hrs for them to work.

59. Dr Douglas was content with the hospital plan and she took reassurance from the fact that the deceased had been in hospital twice as she was aware from her training in ED that a second attendance in particular would trigger more scrutiny and investigations.

60. Dr Douglas asked the deceased to keep in close contact with the practice and to phone out of hours over the weekend if she had any concerns or to contact the practice first thing Monday morning if she had concerns.

61. I was particularly impressed by Drs Douglas and McGuckian. I also note that Dr Coughlan made an extensive record of her encounter with the deceased on 21 July with a clear plan and both the plan and note are to be commended.

62. I commend Dr Finlay for performing an SEA and the evidence suggests that this practice should be mandatory across GP practices where appropriate.

63. I find that all the GPs acted appropriately and in a timely manner as regards the care and treatment of the deceased.

64. The deceased self-referred to the Ulster Hospital on 13 and 17 August.

65. A then locum Senior House Officer at Ulster Hospital, Dundonald, Dr Emma Moffitt, gave evidence to the inquest.

66. Dr Moffitt confirmed that she had attended the induction training provided by the Trust on 2/3 and 4 August 2017, which included training in relation to high-risk patients in ED and those presenting to ED with abdominal pain.

67. She stated that she reviewed the deceased in the RATU area of the department on 13 August 2017. Dr Moffitt explained that RATU was for walk-ins and those with abdominal pain were regularly seen there.

68. The deceased was complaining of two weeks of abdominal pain and stated that she had not opened her bowels properly for 2 weeks. She was now having watery stools and had tried various over the counter medications for constipation. She was also complaining of nausea and had vomited five times over the previous two days. She had a reduced appetite.

69. On examination, Dr Moffitt noted that the deceased appeared in pain, her abdomen was mildly distended but soft, tender centrally and bowel sounds were present. A per rectum examination was performed and a hard stool was felt in the rectum. No other abnormalities were detected. The deceased's observations were recorded as normal and an abdominal x-ray was performed, which was normal.

70. Dr Moffitt explained that, as part of her investigation of differential diagnoses, she ordered an abdominal and chest x-ray, in order to check for an obstruction/perforation.

71. Although the triage nurse had ticked the box on the ED flimsy that suggested blood tests were indicated, no blood tests were ordered. Dr Moffitt felt that blood tests were not clinically indicated, as she felt that the diagnosis was constipation.

72. Dr Moffitt stated that, in light of this tragedy, she would now order blood tests.

73. It was put to Dr Moffitt that, as part of her induction training, she had been told that obtaining a full blood picture was mandatory for a patient presenting with moderate abdominal pain.

74. Dr Moffitt was of the view that this was only guidance and that it depended on how different patients presented. In other words, the training was just that and not a strict set of criteria to follow.

75. Dr Moffit stated that whilst peritonitis was part of her differential diagnosis, she was reassured that the deceased did not have an infection, due to the normal observations.

76. Dr Moffitt advised that the deceased be treated with oral and rectal laxatives, she said that the deceased refused the rectal enema. Dr Moffitt discussed the case with her senior colleague, Dr George Graham, who agreed that she should maximise the oral laxative therapy. In addition, Dr Moffitt ticked the box on the ED flimsy headed "Red Flags Explained" that indicated that she had explained to the deceased what symptoms should trigger a re-attendance at ED or seeking further medical advice. I observe that no note of what was discussed was made by Dr Moffitt, although her training directed her to note the red flag symptoms discussed with the patient.

77. On the ED flimsy there is a box headed "Cons [Consultant] sign off" with abdominal pain inserted and a space left for a Consultant to sign and date.

78. It was explained to the inquest that this would be inserted by the nurse at triage. As part of the induction training, junior doctors are instructed to ensure they have a consultant or a senior doctor on the floor, sign off the discharge plan before discharge of high-risk patients. Patients presenting with abdominal pain are categorised as high risk.

79. Dr Moffitt accepted in her evidence that she did not do this notwithstanding the fact that it was clear to see that same was required on the front of the ED flimsy and that she had received her induction training less than 2 weeks prior.

80. Dr Moffitt advised the deceased to return if her symptoms worsened and that she should attend with her GP.

81. I find that Dr Moffitt did not make a sufficient record of her interaction with the deceased. I find that she should have ordered blood tests and reviewed

same before the deceased was discharged. This is what her training had directed her to do. By not doing so, Dr Moffitt did not have a complete clinical picture of the deceased when she took the decision to discharge her.

82. In his evidence to the inquest, Dr Conor Brown stated that at the time he was a foundation year 2 doctor working in ED at Ulster Hospital, Dundonald.

83. Dr Brown agreed that he had undergone the induction training, as outlined by Dr Moffitt, at the same time as her. This was some 13-15 days prior to his encounter with the deceased on 17th August.

84. He accepted that, as part of that training, he was shown a slide regarding high risk patients. The deceased fulfilled two of the requirements to be categorised as high risk, she presented with abdominal pain and as an unplanned re-attender.

85. Unlike Dr Moffitt, Dr Brown was of the view that the points/lessons raised in the training he underwent were mandatory and not just thinking points. He was further of the view that obtaining blood tests was mandatory.

86. He assessed the deceased at 2.20am on 17 August 2017 in the ED. He noted that she had previously been seen in the ED on 13th August, with a similar presentation of abdominal pain and constipation and had been discharged on 20mls Lactulose BD.

87. The deceased informed Dr Brown that she had been to see her GP in relation to constipation prior to attending ED and she had been prescribed Laxido and Bisacodyl. She also advised that she had attempted, and failed, a colonic irrigation on 12 August.

88. The deceased was complaining of abdominal pain, back pain and constipation. She stated that she had been unable to pass a solid motion for two weeks and was having watery diarrhoea. The deceased described stabbing, crampy pains in her abdomen, sweating and had vomited en-route to ED. She indicated that a lot of her pain originated in her back and that this was a long-term issue.

89. Dr Brown noted her past medical history. She was alert, in pain and looked uncomfortable on the bed. Observations were within normal ranges. Dr Brown arranged an abdominal x-ray which he and the middle-grade doctor on the floor (Dr Purdy) both perceived to show extensive faecal loading. On examination she appeared to be mildly dehydrated. Her abdomen was soft and bowel sounds were present. She was tender in her lower abdomen and also in her lumbar spine.

90. Dr Brown was taken through the contents of the ED flimsy for 17 August 2017. I noted that under the heading "Cons [Consultant] sign off" it states:

"Patient will be treated as NOT REQUIRING Consultant Sign Off".

Despite stating this, which I find completely erroneous, Dr Brown stated that he knew that the deceased would require a consultant sign off, as he had learnt that from his training. In this case, the sign-off would be provided by Dr Purdy as he was the senior doctor on the floor that evening.

91. Dr Brown explained that, after recording the deceased's history and examining her, he made a plan which is properly recorded on the flimsy. It states as follows: "PLAN- Chase bloods, AXR (Abdominal x-ray), IVF (Intravenous fluids), IV Buscopan, Phosphate Enema".

92. He went on to explain that, once he formulated part of the above plan, he spoke with Dr Purdy to discuss the x-ray findings and that Dr Purdy had suggested the phosphate enema and also reminded him to chase the bloods.

93. Pausing here, I note that I put Dr Brown over his evidence on this point. Dr Brown confirmed that not only did he himself write "chase bloods" in his treatment plan, but Dr Purdy had also reminded him to do so. In other words, Dr Brown twice forgot to chase the blood results, notwithstanding his belief that obtaining blood tests was mandatory for a patient such as the deceased.

94. Dr Brown explained that he was extremely junior at the time, that night was particularly busy and he had a difficult patient with mental health issues who was taking up a lot of his time.

95. Dr Brown reviewed the deceased at 4am, when her IV fluids and Buscopan had been administered. The deceased was still in pain but had improved significantly. A discharge plan was devised and Laxido and Buscopan were prescribed.

96. I note that the deceased was not discharged until 5.20am and the bloods were reported on at 4.50am. Dr Brown confirmed that, barring the results having to be revalidated, which I find was not the case, these results would have been available to him almost immediately by electronic means.

97. The results indicated a high white cell count of 29.5 when the normal range is 4-10. In addition, the CRP or C reactive protein result was available from 2.56am. This had a reading of 346.9 when the normal range is 0-5.

98. Dr Brown explained that both these results are evidence of inflammation/infection and if he had been aware of them, he would have arranged for admission, contacted the surgical team and he, or most likely they would have ordered an emergency CT scan of the abdomen.

99. As a direct consequence of Dr Brown not checking these results, none of the above took place.

100. Again, like Dr Moffitt, Dr Brown had ticked the "Red Flags Explained" box but had not completed any entries regarding his conversation with the deceased on this issue.

101. The evidence suggests that there is a training need on this point. Junior doctors are being trained to record the red flag symptoms that they outline to patients, but neither Dr Moffit nor Dr Brown had done so.

102. I also note that the box headed "Clinical Note audit/X-Ray Report Outcome" is blank despite an abdominal x-ray having been obtained.

103. In addition, Dr Brown stated that he would have advised the deceased to return to the ED and not just the GP, if she needed to. Whilst Dr Brown took the time to record his advice to see "GP for review if there was no bowel opening," he did not record any advice about returning to the ED. Again, he put this down to being very busy that evening.

104. I am not persuaded by that explanation, as I find that it would have taken very little time to also write 'ED' when he was already recording 'GP' as a source of review for the deceased.

105. Dr Brown accepted that he should have checked the deceased's bloods prior to discharge and that he had been falsely reassured by the improvement in the deceased's condition. He further accepted that he should have sought Dr Purdy's sign off prior to discharge.

106. I find that by doing neither, this represented a loss of opportunity as regards the care and treatment of the deceased.

107. The inquest heard evidence that since this death an IT solution has been devised which would alert doctors attempting to discharge a patient that the patient's blood results had not been reviewed, which I will return to.

108. In his evidence to the inquest, Dr David Purdy ST1 in Emergency Medicine, stated that he worked as a locum middle-grade doctor at the Ulster Hospital between August 2017 and July 2018.

109. On 17 August 2017 at 3am he was approached by Dr Conor Brown in ED to discuss the deceased. She had presented with a two-week history of constipation and abdominal discomfort. Oral laxatives had not improved things and she had long standing back pain, for which she took Co-codamol and morphine. On examination by Dr Brown, the deceased's abdomen was soft, bowel sounds were present and her observations were within normal limits. They reviewed her abdominal x-ray which they believed showed faecal loading and no evidence of bowel obstruction. At that time, no blood results were back.

110. Dr Purdy and Dr Brown both accepted that the x-ray did not in fact show faecal loading.

111. Dr Purdy advised Dr Brown to treat the deceased with IV Buscopan and Phosphate enema, chase her blood results and reassess the deceased later. Dr Brown was advised to re-discuss the deceased with Dr Purdy and to admit the deceased under the care of the surgical team if he had any further concerns.

112. In his evidence, Dr Brown stated that although he could not recall all the details of his conversation with Dr Purdy, he did not disagree with Dr Purdy's evidence.

113. The deceased re-presented to ED at 4am on 19 August by way of ambulance.

114. In her evidence to the inquest, admitted under Rule 17, Dr Catherine Johnston stated that she was a Consultant Surgeon at the Ulster Hospital, Dundonald. At the morning handover on 19 August Dr Johnston was informed that the deceased required a laparotomy having presented to ED with an acute abdomen. A CT scan reported at 7am suggested a large bowel obstruction and pneumoperitoneum in keeping with a perforation.

115. Dr Johnston found pus throughout the abdomen, a large bowel obstruction originating from a mass/presumed perforation, sigmoid colon/upper rectum with densely adherent small bowel mesentery, appendix and fallopian tube, caecal dilatation and necrosis of rectum/mesorectum to pelvic floor. A total abdominal colectomy with end ileostomy was performed.

116. The deceased was transferred to ICU but despite maximal treatment the deceased continued to deteriorate and life was pronounced extinct at the Ulster Hospital Dundonald on 20 August 2017 at 4.30am.

117. In relation to the abdominal x-ray which Dr Brown had reviewed, Dr Johnston was of the view that same would not support a diagnosis of faecal

impaction. In the context of the deceased re-presenting, Dr Johnston was of the opinion, and I find, that an alternative diagnosis or surgical opinion should have been sought and she opined that, following appropriate investigation and treatment, it was possible that the outcome may have been different here.

118. A review of the blood tests that were taken on 17 August revealed markers of inflammation or infection. Dr Johnston believed that these results should have prompted senior review, urgent investigation and admission together with an urgent CT scan of the deceased's abdomen as well as broad spectrum antibiotics.

119. I find that not reviewing the blood tests and misinterpreting the abdominal x-ray represented a loss of opportunity in respect of the care and treatment of the deceased.

120. In her evidence to the inquest, Dr Claire Jamison, Consultant in the Intensive Care Unit at the Ulster Hospital, stated that the deceased was referred to her by the theatre team.

121. The deceased was admitted to ICU on 19 August at 2pm following a laparotomy where she had undergone a total abdominal colectomy.

122. The deceased remained intubated and received mechanical ventilation alongside sedation to facilitate this and her inotropic support was continued.

123. Dr Jamison described the deceased's prognosis as grim and her underlying COPD made it less likely that she would make a good recovery from ICU.

124. Dr Jamison explained that further surgical options were ruled out as a return to theatre was not viable and her condition continued to deteriorate.

125. Dr Jamison kept the deceased's son and daughter continually updated and there was clearly a high level of communication which I commend.

126. Dr Jamison agreed with the cause of death as recorded in the Post-Mortem report.

127. In his evidence to the inquest, Mr Sydney Marshall, Consultant in General Surgery at the Ulster Hospital, Dundonald from 2006 until 2019 now retired, stated that he was Consultant "Surgeon of the Night" from the period Friday to Sunday 18 – 20 August 2017.

128. The deceased's case was initially discussed via telephone at 7am on 19 August with Mr Marshall by Mr Al-Saudi, Surgical Registrar.

129. The deceased had presented to ED at 4am on 19 August critically unwell with clinical evidence of an abdominal emergency.

130. The deceased underwent resuscitation and an emergency CT scan showed evidence of obstruction and perforation of the large bowel.

131. As noted above, emergency surgery in the form of a laparotomy was undertaken by Ms Johnston.

132. Post-surgery, the deceased was transferred to ICU and at the request of Dr Jamison in ICU, Mr Marshall assessed the deceased at 8.15pm on 19 August.

133. According to Mr Marshall, the deceased remained critically unwell, had shown no improvement in the hours since surgery and her condition had in fact deteriorated.

134. The deceased's features of a generalised mottling throughout the body and a dusky ileostomy colour indicated a peripheral and central vascular shutdown with hypo-perfusion and acidosis.

135. Mr Marshall described the outlook at this stage as increasingly grave.

136. Further surgery was considered but Mr Marshall explained that same at that point would have been pointless and surgical removal of the small bowel would have been non-survivable.

137. Mr Marshall explained that despite ongoing maximal ICU treatment the deceased continued to deteriorate and following a discussion with her son and daughter her treatment was changed to palliative, comfort care.

138. Mr Marshall agreed the cause of death as given by the pathologist. He further agreed that the colonic irrigation which was attempted on 12 August had no bearing on this matter.

139. Whilst I acknowledge that Mr Marshall was not appearing as an expert witness, I did allow him to be questioned as to his opinion on what had happened here. Mr Marshall explained that the pathology of abdominal pain is very difficult to interpret and that is why such patients are considered high risk by the ED. He was of the view that, having read the papers, to include the pathology and histology reports, surgical findings and documented history of crampy pain for several weeks, there was evidence of pathology, strongly suggestive of an abscess/collection beside the bowel, which developed over several days. The picture was in keeping with a localised collection and then same leaking out into the abdomen. There was an initial leak from the bowel

which the body managed to wall/close off, but eventually it leaked into the abdomen over the 12, 24, or 36 hours prior to surgery. Mr Marshall felt that the deceased had diverticular disease but said that this is a common occurrence in lots of people aged over 40/50 years, due to diet, and that most do not know they have it.

140. Mr Marshall explained that the earlier the deceased underwent surgical intervention the better although, with her underlying COPD, it still would have been high risk surgery. By 19 August the position was essentially irrecoverable. He did not think Dr Moffitt's clinical findings on 13 August were suspicious.

141. I found Mr Marshall to be an impressive and diligent witness, who had clearly given much thought to this matter and I accept his views on the likely unfolding of events.

142. In his statement, admitted under Rule 17, Mr Ian McAllister Consultant Colorectal Surgeon, was of the opinion, and I find, that the colonic hydrotherapy which the deceased failed to tolerate on 12 August had very little influence on the outcome of this matter.

143. A post-mortem was performed and it records, and I find, that death was due to:

I(a) Intestinal Perforation Associated with Diverticular Disease and Intestinal Ischaemia (Clinical Diagnosis).

144. While I acknowledge the pressures doctors find themselves under, especially junior doctors in the ED, I find that the standard of record keeping in this matter by the junior doctors was poor. This is especially concerning given that they were junior and therefore not long out of training, when the importance of good record keeping should have been fresh in their minds.

145. I find that both Dr Brown and Dr Purdy misread the X-ray as same clearly did not show any faecal impaction. This highlights a further training issue.

146. Furthermore, the evidence suggests that in a tragedy such as this, where it should be obvious that there is likely to be an investigation, either internally or by the Coroner, statements should be made as soon as the medical personnel involved learn of the death.

147. I find that, whilst it may not have changed the outcome, if Dr Brown had checked the full blood picture that he had ordered and that was available, prior to the deceased's discharge, then she would have been admitted and

undergone surgery. By not chasing the blood results, the deceased was deprived of a "fighting chance" of survival.

148. However, this finding should be placed within the following context. The Royal College of Emergency Medicine "Consultant Sign-Off" Document 2016 states:

> "The ED is an excellent training area for junior doctors, because they are required to see a large number of acutely ill and injured patients and make important clinical decisions. This provides effective training, but it also has the effect of matching very inexperienced staff with very sick patients, creating high levels of clinical risk."

149. Dr Brown was effectively two weeks into his first unsupervised role in ED. He was therefore extremely junior. I also had the benefit of observing and listening to Dr Brown give evidence. I have absolutely no doubt that this tragedy has weighed heavily upon him over the last 3 years and, as he stated, he has altered his practices for the better following same.

150. Whilst I find that Dr Moffitt should have taken bloods on 13 August I am not persuaded, on the balance of probabilities, that this would have altered the outcome.

151. Dr Paul Faulkner, Emergency Medicine Consultant, gave evidence to the inquest. He explained that he was involved in undertaking a Level 1 Serious Adverse Incident (SAI) review on behalf of SEHSCT.

152. The SAI reported that routine blood investigations were ordered from triage but not performed on 13 August, no senior opinion was sought in relation to the deceased's presentation on 17 August 2017 one week after her initial presentation, the abdominal x-ray was interpreted as showing faecal impaction, which it did not, and her blood tests were not checked prior to discharge.

153. Dr Faulkner stated that, whilst he would not describe the contents of the training slides shown at induction as being mandatory per se, he would have ordered blood tests on 13 August 2017, given the deceased's presentation, and he felt that in this particular case, blood tests were in fact mandatory. He further stated that a consultant/senior doctor should have signed off the patient and, if he had been asked to do so, he would have requested blood tests first.

154. Dr Faulkner stated that he had reviewed the X-ray which had been reviewed by Drs Brown and Purdy, and he could not see any faecal impaction. His view

was that this may have been a case of "diagnosis anchoring", in that the doctors have decided what the diagnosis is and they look for something to support their diagnosis.

155. Following this tragedy, Dr Faulkner explained that the SEHSCT initiated changes to the electronic Emergency Medicine System (eEMS). There is now a mandatory field that alerts doctors attempting to discharge a patient on eEMS that the patient's blood results had not been reviewed and would prevent them from removing the patient from the eEMS system until the blood result had been studied and signed off electronically.

156. There is now also a specially designed ED sheet with diagonal lines to alert a doctor to the fact that a patient is an unplanned re-attender within 30 days from a previous attendance.

157. Dr Faulkner also explained that learning points from this tragedy were distributed regionally by the Health and Social Care Board and that a new training regime has been implemented which requires the trainee to undergo an exam at the end of each course with a 75% plus pass mark required.

158. In addition, consultant sign-off conditions have been reinforced with all staff.

159. I commend these changes. I also wish to place on record that I found Dr Faulkner to be a most impressive witness who clearly had invested a lot of his time in both undertaking the SAI review (which he advised was his first) and in preparing for the inquest. His evidence was of a great assistance to me and it underscored the value and importance of properly conducted SAIs.

160. The evidence suggests that the ED flimsy needs to be amended to incorporate a specific box to allow doctors to record the red flag symptom advice that they give patients and that the drop-down box, which includes an option requiring a consultant sign off, should be a mandatory field. These adjustments should be undertaken regionally forthwith.