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IN THE CORONERS COURT IN NORTHERN IRELAND

BEFORE THE CORONER OF NORTHERN IRELAND
MARIA DOUGAN

IN THE MATTER OF AN INQUEST TOUCHING UPON THE DEATH OF TRIONA ROSE McNABB

FINDINGS

Introduction

[1] The inquest was held in Laganside Courthouse on 16, 17, 18 and 19 September 2024. During the proceedings, I received evidence from a number of witnesses, and I carefully considered several statements admitted pursuant to Rule 17 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963, along with voluminous medical notes and records. While it is not feasible to set out all the evidence in these findings, I wish to make clear that I have duly considered all evidence presented before reaching my conclusions.

[2] The deceased, Triona Rose McNabb of 26 Aughnamoe Road, Dromore, County Tyrone, died on 27 February 2017 in the South West Acute Hospital, Enniskillen.

Summary of evidence

Evidence of Mrs Maeveen Brown

[3] Mrs Maeveen Brown, sister of the deceased, gave evidence to the inquest. The deceased was the youngest of four girls. She is survived by her three sisters: Edel; Cathy; Maeveen and her parents Rosaleen and Patrick. Mrs Brown described her sister as a talented and wonderful young woman. She recounted how the deceased was kind and attentive, a great listener and how she knew instinctively to make people feel better. The deceased was very athletic and enjoyed sports when she was younger. She played ladies Gaelic football into her twenties and when she finished playing, she was involved in managing teams from junior to senior level. She was passionate about

football and about building and bettering the club for the community. After the deceased's death the club together with her family launched the 'Triona Jersey' in her memory.

[4] Mrs Brown told the inquest that the deceased had worked as a classroom assistant for a couple of years and loved it, as she had a natural ability working with children and teenagers. Mrs Brown stated that she was great with the children in her family and she was known as 'the cool auntie.'

[5] Mrs Brown told the inquest that the deceased had a wicked sense of humour and always had a witty remark or one liner at the ready to make people laugh. She used her many wonderful personality traits to make people feel loved and that they belonged. Mrs Brown described how, since her sister's death, the family have learned much more about her impact outside the family. She touched the lives of many and made an impression everywhere she went. Mrs Brown stated that her death has left a void which is felt deeply, not just by her family and friends, but by the entire community.

[6] Mrs Brown told the inquest that in 2000, the deceased began to have persistent health problems. She had been hospitalised on a couple of occasions that year and suffered with low iron. She was prescribed iron tablets and needed occasional blood/iron transfusions.

[7] In 2007, the deceased attended consultant gastroenterologist, Dr Simon Johnston, in the Ulster Independent Clinic. An initial diagnosis of small bowel Crohn's disease was made in view of the location of the inflammation in the bowel.

[8] From December 2007 until March 2008 the deceased continued to be treated by Dr Johnston as in-patient in Belfast City Hospital. After discharge, she slowly began to gain small amounts of weight and her potassium levels, haemoglobin and protein all showed small improvement.

[9] In February 2008, the deceased had a capsule endoscopic procedure. Mrs Brown stated that it was unsuccessful, and the medical team followed the capsule passing through her body for 12 months, until it became lodged in her small bowel. In July 2009, the deceased was scheduled to undergo a removal procedure, however, the capsule was no longer visible on x-ray.

[10] It was around this time, that the deceased admitted to taking Nurofen Plus and Codeine and in 2010 she was diagnosed with NSAID (Non-Steroidal Anti-Inflammatory Drugs) related enteropathy (small bowel damage).

[11] The deceased continued to suffer persistent ongoing 'gastro' problems including cramps, bloating and reflux. She had her bloods monitored regularly by her GP and Dr Johnston.

[12] In 2016, the deceased moved out of the family home and worked full time in an art gallery. Mrs Brown described the deceased's health to be the best it had been in a long time as she had gained substantial weight.

[13] In October 2016, the deceased started to feel poorly, she experienced varying degrees of sickness; from mild nausea and bloating to prolonged vomiting and bouts of diarrhoea with periods of severe constipation.

[14] On 30 December 2016 and on 6 January 2017 the deceased attended Belfast City Hospital and was assessed by Dr Johnston. On 23 January 2017, she received an iron transfusion. On 24 January 2017, she was due to attend Belfast City Hospital for a Barium Swallow but was unable to attend because of vomiting. Her GP prescribed medication.

[15] On 14 February 2017, the Barium Swallow was carried out and no abnormalities were discovered. On 16 February 2017 she had an endoscopy procedure and the deceased reported to her family that this found "nothing major only a hiatus hernia" in her oesophagus and a few "minor defects" in the stomach.

[16] On 21 February 2017 the deceased was too ill to attend an appointment with her GP and the GP suggested that she attend the South West Acute Hospital (SWAH). Mrs Brown told the inquest that her family asked if she could travel to Belfast City Hospital, as she was known there. They were told this was not possible. The deceased arrived by ambulance in SWAH at approximately 16.30 hours and she was admitted to ward one early the next morning.

[17] On Wednesday 22 February 2017, the deceased was assessed, firstly by a junior doctor and then a consultant, Dr Campbell. He explained to the deceased that he had a plan in place, and he mentioned a possible Vitamin K deficiency. Mrs Brown explained to nursing staff that the deceased was under the care of Dr Johnston in Belfast City Hospital and she provided contact details for Dr Ferguson, who was covering for Dr Johnston, as he was on leave. Later that day, the palliative care team attended to try and control the deceased's nausea and vomiting. A syringe driver was inserted and cyclizine administered. The deceased was then transferred to medical ward three.

[18] On Thursday 23 February 2017, the deceased's mother telephoned Dr Ferguson in Belfast City Hospital, asking if she could arrange a transfer from SWAH. Dr Ferguson advised that she was happy for the deceased to be treated by Dr Campbell and his team in SWAH.

[19] On 24 February 2017, the deceased told her family that her infection markers were up and that she may have an infection related to her kidneys or a kidney stone. Later that evening she was complaining that she had a lot of pain, and the anti-sickness medication was no longer working. Visits to the bathroom were facilitated by her family, rather than nursing staff.

[20] On Saturday 25 February 2017, a CT scan was ordered by Dr Campbell, although, he did not review the deceased in-person. The CT scan showed a small piece of metal in her bowel. Mrs Brown stated that the family considered this may have been a camera from an endoscopy or from dental work carried out in October 2016. They were told the CT scan showed a narrowing of the bowel, but the family were of the view that there did not appear to be any action taken following the CT.

[21] In the early hours of 26 February 2017, the deceased was continually vomiting, with Mrs Brown by her side, accompanying her to the bathroom. She was very weak and anxious and there did not appear to be any record kept of her output. She was eventually given anti-diarrhoea medication.

[22] On the morning of Sunday 26 February 2017, the deceased told Mrs Brown that she was frightened and that if she didn't "break the cycle I am stuck in, I am going to die." Dr Geoghegan, another consultant, attended the deceased and explained that there were two things wrong with her – a kidney stone and a piece of metal in her bowel, both of which could be resolved. At around 11.30 hours, a consultant surgeon, Mr Mullan attended the deceased, with her family present. He explained that he had looked at the CT scan and commented, along the lines "I am here for one reason only – to see if you need surgery today. Do you need surgery today? No. I cut out the bad bits, I don't fix things." The family understood that it was a kidney stone causing the issue and that this would be removed the next day.

[23] That afternoon, Mrs Brown stated that the deceased was not attended to regularly and her fluids were infrequently replenished. That evening, the deceased deteriorated and required oxygen. An anaesthetist arrived and advised that, at that time, there were no beds available in the High Dependency Unit (HDU)/ intensive Care Unit (ICU). Mrs Brown insisted that the deceased was "barely breathing" and that if she were not moved, they would take her to another hospital. At 23.55 hours the deceased was moved. During this time, she was very agitated and in a lot of pain.

[24] Mrs Brown told the inquest that at around 02.30 hours, the deceased was very distressed. She was constantly trying to take the oxygen line out and trying to move in the bed. She was trying to talk, but her voice was so faint it was hard to make out. She cried out, "please just let me die" at least once. The chaplain was called for and the deceased was anointed.

[25] At 03.30 hours, the anaesthetist told the family that there was nothing more they could do. Mrs Brown told the inquest that at no point were the family given the choice in relation to resuscitation. They did ask that the deceased be given morphine for the pain. At 03.55 hours, shortly after the deceased was administered morphine, she passed away surrounded by her family.

Evidence of Dr Paul Reilly

[26] Dr Paul Reilly, the deceased's GP, gave evidence to the inquest which was admitted by way of Rule 17. Dr Reilly outlined the deceased's past medical history which included: left renal calculus – December 2003; duodenal ulcer - diagnosed November 2006; Osteoporosis - diagnosed March 2010; NSAID induced enteropathy - diagnosed May 2010; recurring iron deficiency anaemia; right renal calculus – May 2015 and Opioid dependence for which she was treated by the addiction team with Subutex (last review was 28 September 2016).

[27] Dr Reilly described how the deceased presented at the surgery on 20 January 2017 complaining of ten days of vomiting and diarrhoea. It was recorded that she was clinically not dehydrated, and a sample was sent to the lab. She was prescribed cyclizine and loperamide. The deceased reattended on 24 January 2017 when she reported that the diarrhoea had resolved and had only recurred on the previous night following her iron transfusion in Belfast. It was confirmed there was no bacterial growth from the sample.

[28] On 21 February 2017, the deceased made an emergency appointment with Dr Reilly. Just before the appointment, the deceased cancelled, as she was too ill to attend. She had severe bilious vomiting, was very weak and unable to get out of bed. Dr Reilly stated that, knowing her history, she would need an urgent urea and electrolyte blood test with intravenous fluids/potassium and so an urgent admission to hospital was essential. Dr Reilly spoke with the deceased, and she was agreeable to being brought by ambulance to the SWAH.

Evidence of Dr Simon Johnston

[29] Dr Simon Johnston, consultant gastroenterologist, gave evidence to the inquest. He first met the deceased in September 2007 when she was an inpatient in Belfast City Hospital. She was admitted for elective investigations for a history of two and a half stone weight loss over a three-month period, iron deficient anaemia (low blood count due to low iron levels), hypoalbuminemia (low protein) and amenorrhea (absence of menstrual periods). She was also noted to have swelling of both legs due to the low albumin causing fluid retention.

[30] Dr Johnston explained that the presumptive diagnosis was small bowel Crohn's disease in view of the location of inflammation in the bowel. The deceased was commenced on oral steroids and a bowel anti-inflammatory and nutritional supplements.

[31] Dr Johnston described how the deceased had further admissions and investigations in 2007 and 2008, including a small bowel series, during which a wireless capsule endoscopy was performed. It was noted that, after a number of hours, the capsule had not exited. In January 2008, the deceased had required nasogastric (NG) tube insertion for administration of an elemental diet and

subsequently Total Parenteral Nutrition (TPN) for a period of two weeks. It was at this time that the Nutrition Support Team raised the possibility of NSAID related enteropathy (small bowel damage). Thereafter, the deceased admitted to taking Nurofen Plus (Ibuprofen (NSAID)) plus Codeine (Opiate). Subsequently the deceased had input from a clinical psychologist and regular review by dietetics. The initial diagnosis of Crohn's disease was therefore replaced by NSAID enteropathy, which, Dr Johnston stated, can be a mimic for Crohn's disease.

[32] Dr Johnston explained to the inquest that, "it's widely acknowledged that NSAIDs cause damage to the stomach and duodenum because those are readily accessible areas for investigation. It is not so widely known that NSAIDs cause damage to the small bowel, but when you do capsule endoscopy of patients who are on chronic NSAIDs, about 70 per cent of them will have damage to the small bowel. This may take the form of erosions, inflammation or ulcers in the small bowel. In advanced cases, NSAID enteropathy may develop into so-called diaphragm disease with these fibrotic web segments in the small bowel, as in the case…" of the deceased. He went on to say that "over a ten-year period, we have a case series of 16 patients with NSAID enteropathy, in which we have tried to highlight this condition. It is rare, but if you look for small bowel damage, it is there. I recall Triona being the only patient that I have met with diaphragm disease itself. This series of 16 patients over a ten-year period was collected in the Belfast Trust and really served to highlight the significant impact that the condition has on those patients." Dr Johnston talked about the treatment of NSAID enteropathy, including early identification and a referral to a community addiction service with the potential of a substitute Subutex being prescribed to reduce the craving for Codeine.

[33] Dr Johnston told the inquest that, over the succeeding years, the deceased developed iron and folate deficiency and a low albumin associated with oedema of the legs, which Dr Johnston assumed to be due to protein losing enteropathy. He believed this was due to damage to the small bowel due to NSAID related enteropathy. In April 2008, the deceased developed an episode of subacute small bowel obstruction due to capsule retention. She was commenced on TPN and regularly reviewed in the months that followed. The small bowel obstruction settled spontaneously with conservative management following a CT scan. An abdominal x-ray was conducted with a view to trying to remove the capsule, however, the capsule was no longer present, and it was believed it had passed out of the intestine through the rectum.

[34] In 2009, the deceased was noted to be engaging well with 'Addiction Services' at the Tyrone and Fermanagh Hospital. Throughout 2011, the deceased attended Dr Johnston for further investigations, in view of her persistent and recurrent anaemia which was documented at his Gastroenterology Outpatient Clinic. In 2012, Dr Johnston convened a multi-disciplinary meeting with Addiction Services to discuss the deceased's denial of her problematic addiction and cover up, as she had ongoing consumption of NSAIDs, as urine test samples tested positive. Dr Johnston

continued to review the deceased throughout, with the deceased attending Addiction Services and an eating disorder clinic, from which she was discharged in 2015.

[35] On 30 December 2016, Dr Johnston assessed the deceased at the Gastroenterology Clinic. She described new onset of dysphagia (difficulty swallowing) at the upper sternal level (above the breastbone), particularly for meats, associated with nausea and episodes of vomiting. Her weight was down nine kilograms since the last review, associated with poor appetite. The deceased admitted to recent Nurofen ingestion for a four-month period, but, at the time of the clinic in December 2016, she was back on Subutex. Dr Johnston stated that "his thoughts at the time in terms of the nausea and vomiting and weight loss, would have been around the fact that the ulceration most likely was affecting the stomach and duodenum in the upper gastrointestinal tract."

[36] An oesophago-gastro-duodenoscopy (OGD) was performed on 6 January 2017, which appeared to show an oesophageal web and the deceased was referred for a barium swallow. Dr Johnston's last contact with the deceased was on 27 January 2017. Dr Johnston agreed that further investigation of the bowel, such as a CT scan, could have been considered at this time, but he explained "we wanted to clarify, first of all, the cause of the swallow difficulty with the barium swallow and then to proceed to gastroscopy to ensure that we have examined the stomach and the small bowel to see if there's mucosal inflammation there or ulceration which may be causing her symptoms."

[37] The barium swallow took place on 14 February 2017 and showed no evidence of oesophageal web. Dr Johnston explained that the barium was designed to delineate the oesophagus, stomach and duodenum - the first part of the small bowel and that it does not necessarily give valuable information regarding the distal small bowel. Further tests were undertaken and showed mild gastritis but were otherwise normal. Dr Johnston went on annual leave from 13 February until 6 March 2017.

[38] Dr Johnston was asked, having read through the deceased's notes and records, if he had not been on leave and the deceased had come to be treated by him in Belfast, was there anything he would have done differently or investigated more rapidly than what transpired in SWAH. He stated that whilst the Western Health and Social Care Trust's (the Trust) Serious Adverse Incident (SAI) Report identified delays, in terms of investigation, such as the timing of the CT scan, the process was similar to what he would have conducted and he commented "I think for any patient who's acutely unwell, medical advice would be to go to your nearest hospital with an emergency department. I think it was appropriate for Ms McNabb to be treated in SWAH." He did state that a dietetic assessment about her nutritional intake would be helpful at an early stage and a NG tube to decompress the stomach and provide intravenous fluids should be a consideration. Furthermore, if a total bowel obstruction is prolonged then TPN would be required.

Evidence of Dr Heather Ferguson

[39] Dr Heather Ferguson, specialty doctor gastroenterology, gave evidence to the inquest. She first met the deceased on 16 October 2007 when she was an inpatient in Belfast City Hospital, under the care of Dr Johnston. Dr Ferguson worked as a specialist registrar in gastroenterology under the supervision of Dr Johnston. Dr Ferguson reviewed the deceased on routine ward rounds during this admission and admissions and appointments throughout 2008, 2010 and 2011.

[40] Dr Ferguson reviewed the deceased again on 13 June 2016, when the deceased admitted to the use of Ibuprofen (a NSAID) after dental work three weeks earlier.

[41] On 25 January 2017, the deceased contacted Dr Johnston's secretary. As he was on leave, Dr Ferguson spoke with her over the telephone. The deceased reported that over the past three weeks she had diarrhoea up to ten times per day, with some improvement over the preceding week. For the past eight weeks she had intermittent vomiting, although she was tolerating liquids. She felt that she was losing weight. Dr Ferguson arranged an urgent appointment at Dr Johnston's outpatient clinic in Belfast City Hospital on 27 January 2017, where she was subsequently seen by Dr Johnston.

[42] On 13 February 2017, the deceased contacted Dr Johnston's secretary and as he was on leave, Dr Ferguson spoke with her. The deceased informed her that recent bloods checked by her GP showed a low potassium level for which she was being prescribed potassium. Dr Ferguson advised her to complete the course, and she wrote to her GP asking for repeat bloods to be carried out.

[43] On 21 February 2017, the deceased again telephoned Dr Johnston's secretary. Dr Ferguson spoke with her, and she reported ongoing intermittent vomiting and diarrhoea for the last six to eight weeks. Dr Ferguson noted that she had been assessed by Dr Johnston on 20 December 2016 and 27 January 2017 and had a recent OGD. Dr Ferguson wrote to her GP to prescribe Omeprazole and to repeat stool cultures to rule out an infective cause for diarrhoea. She also arranged an appointment for Dr Johnston's next clinic on 6 March 2017. Dr Ferguson told the inquest that the deceased did not request, during this telephone call, to be admitted to the Belfast Health and Social Care Trust (the Belfast Trust) that day and she recalled that the deceased appeared satisfied with the treatment plan and date for the next review.

[44] On 22 February 2017, the deceased's mother contacted Dr Johnston's secretary and as he was still on leave, Dr Ferguson spoke with her. Mrs McNabb informed her that the deceased had become unwell in the late afternoon on 21 February 2017, was assessed by her GP, admitted via ambulance to SWAH and that she was under the care of Dr Eugene Campbell. Dr Ferguson's recollection of the telephone call was that Mrs McNabb asked whether she thought the deceased should be treated in Belfast. Dr Ferguson stated that she did not specifically ask her to have the deceased transferred to the Belfast Trust. She reassured Mrs McNabb that Dr Campbell would

be providing the same level of care as she would have in the Belfast Trust. She stated that all the information from Dr Johnston's clinic would be available on Northern Ireland Electronic Care Record (NIECR) and that she would be happy to discuss the deceased's case further if contacted by Dr Campbell's team. As she was going on leave, Dr Ferguson discussed the deceased with Dr Michael Mitchell and Dr Gerard Rafferty (consultant gastroenterologists in the Belfast Trust). Dr Rafferty felt that the deceased's treatment would be the same in the SWAH as in the Belfast Trust and was happy to discuss her case if contacted. Dr Ferguson was not contacted by the SWAH, and she subsequently went on leave until 27 February 2017.

[45] Dr Ferguson explained to the inquest that protein losing enteropathy, which was Dr Campbell's initial view, is a result of NSAID enteropathy. NSAID enteropathy is inflammation and ulceration in the small intestine, caused by overuse of NSAIDs or non-steroidal anti-inflammatory drugs. As a result of that, inflammation and ulceration results in protein loss from the small intestine, so-called protein losing enteropathy. She explained the records on the NIECR for the deceased went right back to her first admission under Dr Johnston in 2007 and included in-patient discharge summaries, out-patient clinic letters from Dr Johnston's clinic. In relation to the deceased's diagnosis in SWAH, she commented "looking back through those, I think it would have been clear that the underlying cause for the protein losing enteropathy was NSAID enteropathy."

Evidence of Dr Marek Oshodi

[46] Dr Marek Oshodi, consultant cardiologist and general physician, gave evidence to the inquest. The deceased had attended the Emergency Department (ED) in SWAH at 16.27 hours on 21 February 2017, with a history of vomiting and diarrhoea. Dr De Wolf assessed her in the ED at 18.26 hours and referred her for admission to the medical team. She was assessed by Dr Zuhair Ahmed, Staff Grade doctor in gastroenterology, at 22.00 hours. He obtained a history of recurrent vomiting and diarrhoea since the start of the year and since Sunday she had been feeling unwell, with poor appetite, vomiting six to seven times a day and diarrhoea five to six times a day. A history of ibuprofen abuse and protein losing enteropathy was documented. Dr Ahmed admitted the deceased under the care of the medical team and ordered an abdominal x-ray.

[47] At 06.15 hours on 22 February 2017, Dr Oshodi attended the deceased as part of the ward round in the acute medical unit. He was the consultant physician on call for the day. He noted that the deceased had a history of recurrent diarrhoea and vomiting, loss of appetite and weight loss, several months in duration. He noted that her medical notes recorded a background of Nurofen misuse, recurrent anaemia, a low albumin, and nutritional deficiency.

[48] Dr Oshodi stated that, on examination, the deceased appeared pale, under nourished and cachectic, however she was haemodynamically stable, lucid and coherent.

[49] Dr Oshodi reviewed the x-ray ordered by Dr Ahmed, which was formally reported at 08.41 hours. A note made in the deceased's medical notes stated, "abdominal x-ray–dilated loop of small bowel." Dr Oshodi stated this may have been made by Dr Ahmed who was with Dr Oshodi. The x-ray report stated "The gas pattern is unremarkable. Please correlate with the clinical features." Dr Oshodi believed the note was written by Dr Ahmed. Dr Oshodi told the inquest that the radiologist did not think that there was anything particularly abnormal about the x-ray appearance", however his view and Dr Ahmed's at the time, was a dilated loop of the small bowel.

[50] The fact that the deceased tended to feel more unwell after eating, made Dr Oshodi consider the possibility of malabsorption or dumping syndrome which, he explained, can happen when food is poorly digested or poorly absorbed in patients who have been undernourished for a lengthy period of time. He also thought there might be an element of small bowel dysfunction or brush-border enzyme dysfunction and this may have been causing bloating and diarrhoea. He told the inquest that, at that time, a potential obstruction was not a differential diagnosis. When asked if he made any connection between the history of NSAID misuse and the deceased's symptoms, Dr Oshodi replied "I genuinely can't say at this point in time, but I don't think it was the major thing, I just felt that the small intestine wasn't working."

[51] Dr Oshodi directed the deceased's vitamin D levels be checked and he sought an abdominal ultrasound and a surgical review to rule out the possibility of an underlying surgical problem or intrabdominal pathology. He then assigned the deceased to the gastroenterology team for further care. The ultrasound was reported at 10.51 hours and stated, "large volume ascites noted with bilateral pleural effusions…moderate right hydronephrosis." Dr Oshodi did not review this ultrasound, even though he ordered the ultrasound, as the deceased had moved under the care of Dr Campbell. He explained that had he viewed the report of hydronephrosis he would have wanted to explore that further by way of CT scan.

Evidence of Dr Mary McCaffrey

[52] Dr Mary McCaffrey, staff grade doctor, general medicine, gave evidence to the inquest. At 08.30 hours on 22 February 2017, she commenced her shift on ward one, the medical and surgical assessment unit. She noted that the deceased had been admitted to the ward the night before and a post-take ward round was conducted by Dr Oshodi at 06.15 hours. From the post-take notes, there was a concern of intestinal malabsorption or pancreatic insufficiency and the plan included ultrasound scan of abdomen. Dr McCaffrey requested this ultrasound within the first hour of work and the deceased underwent the ultrasound at approximately 10.00 hours. The deceased was reviewed by Dr Campbell mid-morning and was to be moved wards.

[53] Before the deceased moved wards, at around 13.00 hours, Dr McCaffrey conducted a review of the deceased's notes and test results. She looked up her chest

x-ray, abdominal x-ray and ultrasound scan which was reported at 10.51 hours. Given her very low albumin result and ultrasound findings, which included a large volume of ascites (fluid) noted with bilateral pleural effusions, together with hydronephrosis, she contacted Dr Campbell to discuss.

[54] Following their discussion, Dr McCaffrey documented the discussion in a detailed note and recorded that the deceased was not for surgical review at that present time. The deceased was transferred to medical ward three that evening. Dr McCaffery told the inquest that she wanted to specifically check with Dr Campbell whether a surgical review was required and to discuss the ascites and low albumin level. She recalled they discussed the ultrasound results on the ward. She stated that Dr Campbell felt that with the dietician and palliative care input, symptoms may settle, so that would be the first plan of treatment. She stated "I cannot recall the full detail of that discussion and how much I discussed the ultrasound. I'm pretty sure I would have mentioned the ascites and the albumin because those were my concerns."

[55] Dr McCaffrey explained to the inquest the importance of fluid monitoring in a patient such as the deceased. She stated that she would be watching for input and output monitoring for any patient, especially the deceased, given that she was having episodes of vomiting and diarrhoea and given that her weight was low, there was ascites and fluid within her bowel. She stated that she had already had some intravenous fluids on the 21 February into the 22 February and it would be very important to see what she was managing to take herself orally and what was being passed out and how that was balancing as there would be a risk of fluid building up within the body and perhaps her ascites or oedema worsening. There was a fluid chart completed for 22 February 2017 when Dr McCaffrey was on duty and she could not comment on why fluid monitoring was not conducted on other days during her admission.

Evidence of Dr Eugene Campbell

[56] Dr Eugene Campbell, consultant gastroenterologist, gave evidence to the inquest. Dr Campbell told the inquest that whilst he was in the SWAH he was assisted by a junior doctor, whom he shared with Dr Geoghegan, the other gastroenterology consultant. He did not have a registrar. He explained that, at the time, he did not consider the staffing levels in SWAH to be adequate. In 2015, he submitted a clinical incident report (known in the Trust as 'a Datix', a tool to highlight any patient safety concerns), outlining how the Gastroenterology Department in SWAH was understaffed. At one point Dr Campbell had nearly 40 in-patients for him and half a junior doctor to treat. He repeated his concerns in 2016 to the manager for Acute and Unscheduled Care in SWAH and the medical director. He produced a piece of work which showed that SWAH had more patients and fewer doctors than other hospitals. As a result, they received a locum staff grade, which was a temporary post. At the time, this was filled by Dr Ahmed.

[57] Dr Oshodi had requested an ultrasound abdomen and handed the deceased's care over to the gastroenterology team. Dr Campbell attended the deceased on the morning of 22 February 2017, as the on-call medical consultant. The deceased had just returned from the Radiology Department after an ultrasound scan, but no result was yet available.

[58] Dr Campbell noted that NIECR recorded the deceased having attended a gastroenterology team in Belfast and they had labelled her as 'non-steroidal addiction.' Dr Campbell noted an OGD conducted on 16 February 2017 did not show anything sinister and was suggestive of reflux. No issues were highlighted following a barium swallow.

[59] During his assessment of the deceased, she informed him that she had not taken much food for nearly a month and that her issues were nausea, vomiting and diarrhoea. She strongly denied an eating disorder, and she denied taking any non-steroidal since October 2016. Her C-Reactive Protein (CRP) marker was slightly elevated and albumin very low.

[60] Dr Campbell recorded in his notes "looks like protein losing enteropathy to me" meaning the lining of the bowel has been scraped raw by NSAIDs and the proteins within the body leech out into the gut and then are excreted, resulting in a low protein level or albumin.

[61] When asked whether he considered liaising with Dr Johnston who was treating the deceased in Belfast City Hospital, Dr Campbell replied "My involvement was one day. I'd like to think that if I had not been on leave that I would have rang because I do know Simon Johnston. But, on the first day of seeing her, I thought no obstruction, nutrition, control symptoms, vitamins, I thought we had a plan. Obviously, I'd like to think - and everything's great with hindsight - that when we saw the plan wasn't working or wasn't working as good as we wanted that we would have done a CT earlier."

[62] Dr Campbell told the inquest that an abdominal x-ray, ordered by Dr Ahmed, did not look in keeping with bowel obstruction. He documented that it looked like a protein losing enteropathy. He stated that, at the time, he did not have any suspicion of small bowel obstruction. It was put to him that, an earlier note (made by Dr Ahmed, who was with Dr Oshodi), documented "dilated loop of small bowel", which proved to be correct. He replied, "with hindsight and with the passage of time, yes, that is correct, I am sad to say." Dr Campbell explained to the inquest that, as the deceased was having diarrhoea, this was indicative of something passing, to go against a complete blockage and he also stated that he was "lulled also by the OGD in the City [(Belfast City Hospital)] and the barium contrast" and there was nothing to suggest an obstruction. When asked again, given her symptoms recorded by Dr Ahmed, why he did not consider a small bowel obstruction, he replied "But was it there when she came in? It was progressing, I would say. Did I not think of it? No, I didn't think of it and for that I'm very sad. Would I have thought of it? Well, then we're into

conjecture and guesswork." He stated that if he had a query of bowel obstruction at this time, the investigation of choice would have been a CT scan, with surgical review, nil by mouth and possible NG tube insertion, known as the 'drip and suck' method.

[63] When asked whether NSAID misuse linked to gastro issues crossed his mind at any time, Dr Campbell replied: "At this time, no, it was not in my consciousness."

[64] Dr Campbell queried a vitamin K deficiency, prescribed intravenous vitamin K and asked the palliative care team to review the deceased, as she had little effective nutrition for many weeks. He recorded 'dietitian vital' in her notes. This was Dr Campbell's last physical contact with the deceased. She was then reviewed by Dr McCaffrey later that afternoon.

[65] The deceased was reviewed by a dietitian at 14.50 hours. The dietitian recorded the deceased's BMI as 17.2 and suggested pabrinex, forceval capsule and fortijuice together with food record charts. She was subsequently reviewed by palliative medicine, and the recorded plan was for the administration of a syringe driver with cyclizine, to be reviewed and monitored as necessary.

[66] Dr Campbell accepted that his management plan did not request a check of the ultrasound ordered by Dr Oshodi, nor did he go back and check on the deceased before he finished his shift at 22.30 hours.

[67] In relation to the ultrasound, which was ordered by Dr Oshodi and reported at 10.51 hours, Dr Campbell stated that whilst he accepted Dr Oshodi believed it to be a gastroenterology issue, he did believe that Dr Oshodi, who was on-call for 24 hours, should have reviewed the ultrasound report, commenting "I think this was missed opportunities by both of us is the best way to say it."

[68] On 23 and 24 February 2017, Dr Campbell was off on study leave. During this time, Dr Geoghegan covered his patients.

[69] On the morning of Saturday 25 February 2017, Dr Campbell attended the hospital to catch up on patients. He was not on-call. He noted from NIECR that the deceased's CRP had climbed and that the ultrasound, requested by Dr Oshodi and performed on the morning of 22 February 2017, showed moderate right hydronephrosis, as well as ascites and bilateral pleural effusions. These findings concerned Dr Campbell and so he telephoned Dr Lucyna Samiecova who was the on-call radiology consultant. He ordered and she agreed to perform a CT abdomen/pelvis later that day. He was also concerned that the CRP was raised to 180, which was a measure of infection. On the Tuesday/Wednesday the CRP level was 24.

[70] Dr Campbell told the inquest that he had no recollection of being contacted by Dr McCaffrey in relation to the ultrasound report. Dr McCaffrey told the inquest that, at 13.00 hours on 22 February 2017, she "…contacted Dr Campbell to discuss results

and to check regarding surgical review as this was also part of the post-take plan around the management. From this discussion, I documented that this lady was not for surgical review at the present time." He stated in evidence that he had no recollection of this and that is why he ordered the CT scan on the Saturday. He commented "that is just highly improbable of me to hear about hydronephrosis and ascites and not say get a CT." He stated that it was his recollection that the first time he saw the ultrasound was on the Saturday and had he seen it earlier he would have ordered a CT. He accepted that the ultrasound result should have been considered, interpreted and acted upon prior to 25 February 2017, "that would have been optimal and a much better plan."

[71] Dr Campbell then went to ward three and spoke with Dr Geoghegan and Dr Eanna Coffey, the on-call senior house officer (SHO). He explained his concerns and informed them that he had ordered a CT scan of the abdomen/pelvis. He did not record any of this in the deceased's notes. He then left the hospital at around 11.20 hours. Dr Campbell stated that he expected the CT scan to be conducted more rapidly than the five hours that it took after he requested it. It was reported at 19.45 hours that evening and reviewed by Dr Geogehan at 10.00 hours the following day (26 February 2017). Dr Campbell stated that he would have assumed it would have been done more rapidly.

[72] In relation to a comment made in the SAI Report, that the "Review of actions and results from previous ward rounds [were] lacking. The notes from medical ward rounds should include reference to abnormal investigations and outstanding tasks from previous rounds. This may have led to an abnormal ultrasound scan and bloods being acted upon sooner", Dr Campbell replied that, in relation to the notes, the most likely explanation was that junior doctors were looking at 'what was the latest thing happening.' That they were not going back to the very start, reading through all the notes in order to make their assessment of a patient, due to pressure of work. Dr Campbell commented that "we were doing our best and in Triona McNabb's case this was not good enough" and "there were multiple areas where things slipped and didn't get done speedily."

[73] Dr Campbell agreed that there was not a formal handover between him and Dr Geoghegan, that it was effectively an understanding between the two senior doctors: "When I'm off, you cover me and vice versa." The SAI Report recounted the Royal College of Physicians standard that states there ought to be a written note of a handover and Dr Campbell accepted this.

[74] Dr Campbell concluded by stating "I think there were missed opportunities, and I put myself firmly in the camp of missing things."

Evidence of Dr Helen Maguire

[75] Dr Helen Maguire, SHO in general medicine, gave evidence to the inquest, which was admitted by way of Rule 17. In his evidence, Dr Campbell explained that,

as Dr Maguire was the junior doctor, she had to work to two consultants – Dr Campbell and Dr Geoghegan and her workload was "onerous" compared with other junior doctor roles.

[76] Dr Maguire first reviewed the deceased at 10.00 hours on 23 February 2017. She was stable, had started to eat, and her diarrhoea was improving. Her National Early Warning Score (NEWS)was between three and four and she scored for hypotension and tachycardia. The plan was to treat her for a urinary tract infection, commence IV pabrinex and check re-feeding bloods. There was ongoing palliative care input for nausea and dietician input for nutritional needs.

[77] Dr Maguire reviewed the deceased with Dr Geoghegan at 09.15 hours on 24 February 2017. She had no further vomiting or diarrhoea. Later that day, at 15.00 hours, Dr Maguire reviewed her bloods and explained that, at the time, her impression was an acute kidney injury. Her plan included replacing her electrolytes and to monitor inflammatory markers as she felt the deceased appeared to be improving and that her increased CRP of 181 was likely 'lag.'

Evidence of Dr Michael Geoghegan

[78] Dr Michael Geoghegan, consultant gastroenterologist, gave evidence to the inquest. He is still working in SWAH. In relation to the staffing levels, which was raised in evidence by Dr Campbell, Dr Geoghegan stated that, "Dr Campbell is a very diplomatic doctor. I mean the staffing levels are very very poor. I don't think Dr Campbell would have mentioned that. When you come into work on a Monday and then you come back on a Tuesday, you may have a different SHO. They simply swap and change. It's very poorly staffed." In relation to staffing levels in SWAH at present, he acknowledged there has been "some improvements but they have been offset by COVID [(the COVID-19 pandemic)]. So, in other words, we're still struggling."

[79] As Dr Campbell was on leave on Friday 24 February 2017, Dr Geoghegan reviewed the deceased on his ward round. He told the inquest that Dr Campbell did not provide any advance information in relation to any of his patients, including the deceased. Dr Geoghegan accepted that the process whereby he covered Dr Campbell's patients during leave and vice versa, without a formal handover, was subject to Royal College of Physician standards. This required that a formal note be made of transfer of patients between consultants.

[80] When asked why he did not mention that Dr Campbell was also off on Thursday 23 February and whether he knew he was off then, Dr Geoghegan replied that he would have known. He did not review the deceased on 23 February 2017, even though he was the consultant in charge of her care that day. She was reviewed by SHO, Dr Maguire.

[81] During the morning ward round, at 09.15 hours, Dr Geoghegan noted that the deceased had been seen by the palliative care team and dietician and had been given a syringe driver with cyclizine. On review, the deceased reported feeling better and she denied any vomiting or diarrhoea. Her appetite had improved a little. Her NEWS was three, which was the same score for the previous two days. Dr Geoghegan requested regular blood tests and stool samples. Dr Geoghegan stated that he could not recall whether an ultrasound report was available, which was requested by Dr Oshodi and reported on 22 February 2017. He told the inquest that, in the deceased's notes, Dr McCaffrey made a detailed note of the ultrasound results and recorded that there was a discussion between her and Dr Campbell and that the conclusion from the discussion was that the deceased did not need surgical review.

[82] Dr Geoghegan was of the view that it was likely he had seen that note and at that point, considered that there was no further action to be taken on foot of the ultrasound. He believed that it was the combination of the ultrasound allied with the high CRP on Saturday 25 February 2017, that then prompted urgent action from Dr Campbell. Dr Geoghegan accepted that the deceased's rising CRP should have been monitored from 22 February to 25 February 2017. The deceased's CRP rose to 181 at 15.00 hours on 24 February 2017 and Dr Geoghegan stated that Dr Maguire should have contacted him at this stage. He stated that he may have ordered a CT scan at this stage but could not be certain.

[83] Dr Geoghegan took the view, that, from the outset, the deceased should have been treated as a surgical patient, rather than a medical patient. He explained, "the medical team led themselves up the garden path here. We convinced each other that this was a medical patient. But she wasn't a medical patient. This was a surgical patient." He went on to clarify, "At no stage am I saying that this patient needed an operation, but it's still a surgical problem. Bowel obstruction, a stone in the kidney, these are all surgical problems. These are not medical problems. Why did we manage to make so many mistakes, so many misdirection's, because we are looking after a patient that we assume has a protein losing enteropathy or assume has a urinary tract infection, but that was not the problem. And one doctor convinced the next and nobody really drew a line under it and reassessed." Dr Geoghegan stated that had this been recognised, the deceased would have been nil by mouth, with TPN administered.

[84] At around 10.30 hours on Saturday 25 February 2018, Dr Geoghegan met Dr Campbell during the ward round. Dr Campbell informed him that he was going to organise a CT abdomen scan for the deceased. Dr Geoghegan told the inquest he got the impression that the CT scan was to check they were not missing anything. At around 11.00 hours, Dr Geoghegan reviewed the deceased, and she was stable with a NEWS of three.

[85] At around 10.00 hours on Sunday 26 February 2018, Dr Geoghegan reviewed the deceased and explained that she was stable, but her NEWS had increased to four. He explained that she had a bout of diarrhoea overnight and appeared more anxious.

He told the inquest that he noted her CT scan report, which was reported the evening before at 19.45 hours. He explained that he did not look at it earlier due to the pressures of work.

[86] The CT scan showed "several distended (up to 5cm) small bowel loops in the left abdomen with several short sections of luminar narrowing. Due to marked ascites assessment of wall thickening at those sections is difficult. Small bowel loops are filled with fluid." He discussed the findings with the consultant radiologist, Dr Samiecova and they agreed the best way forward was for surgical review. When asked whether he picked up on the significance of the small bowel loops filled with fluid, he stated that he knew it was "big, big trouble."

[87] The patient was reviewed by Mr Mullan, Consultant Surgeon on call, at 13.00 hours. He documented a non-tender abdomen with a plan for conservative management. At inquest, Dr Geoghegan highlighted that whilst it may not have been a complete blockage, a fairly severe narrowing of the bowel is a serious surgical problem. He added, "if the surgeons want to manage it conservatively, and bring this patient to intensive care unit and we can all work together on getting TPN feeding and nil by mouth. But if you stretch the medical team beyond their boundaries, you are going to end up in a hospital whereby the medical team are completely run off their feet and unable to cope and the surgical team are not doing enough to justify their work in the hospital on that day." He continued to believe that the deceased was a surgical patient, claiming "she was the most unwell patient in A and E that month. And yet the decision by the A and E team was to refer this patient to a medical doctor, which was the wrong decision. This patient should have been referred to the surgeons who would have then got their CT scan on Tuesday evening." He explained that whilst the deceased may not have needed an operation immediately, this does not mean they are not a surgical patient, "I think people have fallen into the trap here of believing because the patient does not need an operation right now, they say therefore it's a medical problem. But that is wrong." He stated that now, the surgical team are based in Altnagelvin Area Hospital (Altnagelvin), so if someone attends the ED in SWAH, there is still pressure on the medical team to admit the patient as Altnagelvin is 60 miles away.

[88] Dr Geoghegan accepted that the absolute minimum that should have been offered to the deceased, before she rapidly deteriorated on 26 February 2017, was the drip and suck method of nil by mouth and the insertion of a NG tube.

[89] At around 20.20 hours, Sister Gemma McGoldrick spoke to Dr Geoghegan about the deceased. She explained that the deceased was shorter of breath and desaturating. Dr Geoghegan was told the plan on the ward was to give some IV furosemide as the feeling was fluid overload. She was also given tazocin antibiotic, together with albumin.

[90] At around 21.30 hours, SHO Dr McKendry, informed Dr Geoghegan that the deceased was unwell. She was hypotensive with a blood pressure of 86/60.

Dr Geoghegan informed Dr McKendry that the deceased needed to be transferred to the HDU. Dr McKendry then requested for an urgent anaesthetic assessment.

[91] At around 22.30 hours, Dr Geoghegan attended the deceased along with Dr Beata Iwanicka, consultant anaesthetist, and they agreed that the deceased would be moved to intensive care. Dr Geoghegan accepted that this was the first time he attended the deceased since that morning and at this stage the deceased's NEWS was nine. During the evening, she was reviewed by two very junior doctors. He explained that SWAH took the decision not to have medical registrars, which other hospitals have. He explained they are "the fulcrum of any hospital" and they, as experienced clinicians, may have made different decisions in relation to the deceased.

[92] At around midnight, Dr Geoghegan telephoned Mr Mullan to inform him that the deceased had deteriorated and that she was being transferred to ICU. Mr Mullan replied that there was nothing more he could do.

[93] At around 02.50 hours on 27 February 2017, Dr Geoghegan was contacted by Dr McGourty, SHO, who informed him that the deceased continued to deteriorate, her blood pressure was unrecordable despite maximal strength noradrenaline and that the intensive care team felt there was nothing more that could be done. A short time later, the deceased passed away.

[94] Dr Geoghegan explained that he did not agree, at any time, that the deceased should not be resuscitated. The form was completed by Dr McGourty, and his name was put down as the authorising consultant. The medical notes recorded, "Further deterioration noted. Remains extremely unwell. Distressed. Discussed with Dr Geoghegan. Discussed with family. DNAR [/DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)."] Dr Geoghegan expressed a strong view that Dr McGourty should not have been placed in this position and that it should have been the ICU consultant, Dr Iwanicka or indeed himself, who had these discussions and completed the form.

Evidence of Dr Samiecova Lucyna

[95] Dr Samiecova Lucyna, consultant radiologist, conducted a CT scan of the deceased's abdomen and pelvis at 18.33 hours on 25 February 2017, following Dr Campbell's request. Her report noted, amongst other findings, "several distended (up to 5cm) small bowel loops in the left abdomen with several short sections of luminar narrowing. Due to marked ascites [,] assessment of wall thickening at those sections is difficult. Small bowel loops are filled with fluid. There is rather well defined mildly hyper dense 3cm lesion present in the small bowel loop in the left flank (FB- foreign body?). A 12cm x 6mm metallic FB in the small bowel loop in the level of the pelvic inlet on the right."

[96] Dr Samiecova also reported on a chest x-ray conducted at 19.39 hours on 26 February 2017. She commented, "bilateral patchy air space shadowing likely in

keeping with current infection. No cardiomegaly. Mild pleural effusion. Increased bowel gas within several distended bowel loops."

[97] Dr Samiecova reported on another chest x-ray conducted at 02.07 hours on 27 February 2017. It showed, "marked progression of bilateral air space shadowing when compared with yesterday's film. No cardiomegaly. Moderate left pleural effusion. Right-sided central line with its tip within the lower SVC. Distended bowel loops."

Evidence of Dr Eanna Coffey

[98] Dr Eanna Coffey, locum SHO, gave evidence to the inquest which was admitted into evidence under Rule 17. At around 11.00 hours on 25 of February 2017, Dr Coffey reviewed the deceased in the company of Dr Geoghegan. He stated that the deceased was symptomatically stable when reviewed. She remained slightly tachycardic (heart rate 110) and hypotensive (blood pressure 95/55) despite antibiotic and fluid therapy to date. In view of the indeterminate origin of her symptoms, a CT scan of her abdomen and pelvis which was performed and reported that evening. She was subsequently reviewed by the 'foundation year one' doctor on-call overnight in view of a recurrence of her diarrhoea.

[99] Dr Coffey and Dr Geoghegan subsequently reviewed the deceased the following day, 26 February 2017, around midday. They noted her CT report and in view of these findings, they arranged for two referrals - one to the urology team and one to the general surgical team.

[100] The general surgical team in SWAH agreed to a review and she was seen at 13:00 hours by Mr Mullan. His plan was that he would discuss the findings with the radiologist and subsequently with Dr Campbell or Dr Geoghegan. No further changes to management were advised at that time.

[101] Dr Coffey spoke with a urologist in Altnagelvin who advised that no acute action was necessary for the deceased's renal calculus beyond a referral to Urology Outpatients Department.

Evidence of Mr Michael Mullan

[102] Mr Michael Mullan, consultant general surgeon, gave evidence to the inquest. On the weekend of 24 to 26 February 2017, he was the consultant surgeon on-call in SWAH. At 13.00 hours on Sunday 26 February 2017, he reviewed the deceased following a request from the medical team in relation to a CT scan which was conducted the day before and suggested possible obstruction. Mr Mullan reviewed the deceased's notes, including clinical letters from the Belfast City Hospital (which were on NIECR). He noted the deceased's past medical history of codeine misuse and previous care under the gastroenterology team in Belfast.

[103] Mr Mullan told the inquest that the deceased reported that her bowels had opened nine to ten times that morning. He stated that this indicated that there was not a complete blockage, as something was able to pass through, though there may still be narrowing. Mr Mullan explained that an abdominal examination revealed that it was not distended, it was non-tender and bowel sounds were normal. He then spoke with Dr Samiecova, and they discussed the deceased's CT scan. The CT scan revealed a large amount of ascites in the abdomen, a metallic foreign body in the small bowel, which was not causing an obstruction, and a further foreign body in the left abdomen. There appeared to be strictures (narrowing of the bowels). The foreign body in the left abdomen had areas of collapsed and dilated small bowel on either side. There was no evidence that this was causing an obstruction, and it appeared to be transiting through the small bowel. Whilst there were areas of strictures reported, it was unclear if these were acute or chronic. He agreed that distended (up to 5cm) small bowel loops were clinically significant, as he explained "the small bowel is generally about 2 to 3cm in size and once it gets over 4cm there's certainly a problem with it" meaning, obstruction and "I would say 5cm, would suggest that there has been certainly a holdup there and it's been going on for a long time." He agreed that small bowel loops filled with fluid is in itself one of the classic signs of an obstruction.

[104] Mr Mullan recorded in the notes "no definite transition point." He explained that a transition point means "where it goes from a dilated bowel to a collapsed bowel, then we will go in and see if we can do something. If the patient is fit for an operation, of course." He and Dr Samiecova did not see a transition point in the deceased's case, though he accepted that there are cases, like the deceased's, where a transition point is not identified but there is more than a suspicion of sufficient bowel narrowing.

[105] Mr Mullan told the inquest that it was his feeling the deceased did not require an emergency operation at that time. He considered "do we need to do something now. And my assessment from that was no. Do we need to do something after further investigations or further consideration? And I'm not talking about later today. Maybe later next week - that's where Triona would have been. She would have been in that second box."

[106] Mr Mullan opined that the deceased was severely malnourished, her albumin (protein) was low, and he felt that she would need some nutritional support, and it would require careful consideration before any operation. However, this was not recorded in his notes of the assessment. He believed that she needed further bowel investigations to work out what was going on.

[107] In relation to the discussion whether the deceased was a surgical or medical patient, Mr Mullan stated that on some occasions patients who he has assessed as 'wait and see' are moved to the surgical team, but in the deceased's case "that just never came up." He explained that 'if patients need a procedure done, that's the part we [surgeons] do for them.' A gastroenterologist has knowledge and skills that I don't have and I felt probably [the deceased] needed some nutritional support and that can

be done by the gastroenterologist. That's not exclusively the realm of surgeons. Now when it comes to an operation, that is the realm of surgeons."

[108] Mr Mullan's note of his assessment concluded with "Plan – Mr Mullan will discuss with Dr Campbell/Dr Geoghegan." He clarified in evidence that he meant he would discuss with Dr Campbell on Monday morning, rather than immediately or later than day. He chose Dr Campbell as he was the consultant in charge of her care, despite Dr Geoghegan covering that day. He accepted that that the deceased "deteriorated quite suddenly and to an extent which was not appreciated on the Sunday. And with the benefit of hindsight, of course, I accept that I should have given Dr Geoghegan a call." He told the inquest that had he had that conversation, he would have advised that the deceased needed nutritional support. He explained that no dieticians were available on medical wards at weekends, but there was a dietician in ICU on a Sunday afternoon. He stated that if nutritional support were required over the weekend, that decision would have to be made on the Friday morning.

[109] At around midnight, Mr Mullan received a call from Dr Geoghegan, informing him that the deceased had become extremely ill and he enquired about his assessment earlier that day. Mr Mullan explained that there were no abdominal findings on examination.

[110] At inquest, Mr Mullan explained that he was taken back by the findings of the post-mortem, when the pathologist had found that the deceased died of a bowel obstruction. He stated that there was "not the clinical picture that we had at one o'clock on the Sunday." He added, "if I would have thought an operation was the right thing to do at that time on Sunday afternoon, I would have done it."

Evidence of Dr Orla McKendry

[111] Dr Orla McKendry, 'foundation year two' doctor in general medicine, gave evidence to the inquest, which was admitted by way of Rule 17. At approximately 18.30 hours on 26 February 2017, she was contacted by Dr Loughran who advised that the deceased had deteriorated. Dr Loughran stated that the deceased was requiring high levels of oxygen and had a CT scan which showed dilated loops of small bowel and the general surgical team had concluded that it was not a small bowel obstruction. Dr McKendry recommended an urgent portable chest x-ray and arterial blood gas to investigate the drop in oxygen levels.

[112] Dr McKendry reviewed the chest x-ray which showed fluid overload in the lungs and dilated loops of bowel. She then discussed the deceased with Dr Geoghegan who advised that further furosemide and albumin be administered and requested that the surgical team review the deceased again due to the dilated loops of bowel on the chest x-ray.

[113] Dr McKendry reviewed the deceased. On examination her blood pressure was low, and heart rate was high. She had extensive peripheral oedema, and she looked

very frail and cachectic. She reviewed the surgical team's input, and they had advised that there was no acute bowel obstruction, and no surgical action was required. She did not request another review by the surgical team. Both Dr McKendry and Dr Geoghegan agreed the deceased should be discussed with ICU. She was then reviewed, and Dr McKendry handed the deceased's care over to Dr McGourty.

Evidence of Dr Christine Loughran

[114] Dr Christine Loughran, foundation year one doctor, gave evidence to the inquest which was admitted by way of Rule 17. At 18.30 hours on 26 February 2017, she reviewed the deceased. On examination she could hear fine crackles on both sides of her lungs. She had a high heart rate, low blood pressure and a low BMI, with a documented weight of 48.6kg. She had fluid in her tissues from her feet to her sacrum. Dr Loughran prescribed a dose of IV furosemide to remove some fluid on the lungs to see if this helped with her breathing and to remove some of the fluid in her legs. She then contacted Dr McKendry requesting a further review of the deceased. They both noted the deceased's white cell count (WCC), a marker of infection, was raised slightly along with her CRP, a marker of inflammation. They agreed a course of antibiotics be administered and a chest x-ray conducted along with an arterial blood gas sample.

[115] The chest x-ray showed fluid in the left lung, together with several distended (inflated) loops of bowel. Dr McKendry agreed to speak to Dr Geoghegan and Dr Loughran spoke with the SHO who reviewed the deceased alongside Mr Mullan, earlier that day. He advised that this was "not an acute bowel obstruction" and there was "nothing to do at present." He stated that he would discuss the case with Dr Geoghegan and Dr Campbell in the morning.

[116] Despite all the senior doctor's involvement, Dr Loughran described how she still had a degree of concern regarding the deceased. She and Dr McKendry provided a detailed handover to colleagues at 21.00 hours.

Evidence of Sister Gemma McGoldrick

[117] Sister Gemma McGoldrick, clinical co-ordinator - hospital at night, gave evidence to the inquest, which was admitted by way of Rule 17. At 18.20 hours on 26 February 2017, she received a 'bleep' from a staff nurse informing her that the deceased was complaining of shortness-of-breath and feeling unwell. She and Dr Loughran attended. From 18.30 hours to 20.00 hours, Dr Loughran assessed the deceased, and Sister McGoldrick implemented her treatment plan, which included: an ECG; obtaining arterial blood gas; reviewing blood results; tazocin and furosemide administration and chest x-ray. SHO Dr McKendry was contacted for review.

[118] At 20.20 hours, Sister McGoldrick met Dr Geoghegan and informed him of the blood results and the recent chest x-ray. He advised that albumin be administered and that he would discuss the case with Dr McKendry. During handover, at 21.00 hours,

Dr McKendry informed Sister McGoldrick that Dr Geoghegan advised that ICU should be contacted and at 21.34 hours Dr McKendry along with Sister McGoldrick spoke to the staff grade anaesthetist.

[119] At approximately 22.45 hours, Sister McGoldrick requested an urgent review of the deceased. Thereafter Dr Iwanicka reviewed the deceased, and the deceased was moved to ICU at 00.25 hours.

Evidence of Dr Kevin McGourty

[120[Dr Kevin McGourty, at the time a foundation year two doctor, gave evidence to the inquest. On the evening of 26 February 2017, he was the SHO for SWAH. Dr McKendry handed over that the deceased was extremely unwell and that she needed an overnight urgent review and ICU team review, on the advice of Dr Geoghegan. Dr McKendry requested the review. Dr McGourty found out she had been accepted and transferred to ICU for critical support. At around 03.00 hours he was 'bleeped' to attend ICU as the deceased had deteriorated and unfortunately, they could not offer any further treatment options.

[121] Dr McGourty discussed this situation with Dr Geoghegan, although he could not recall the detail of the conversation. He believed, by this stage, Dr Iwanicka had spoken with the family and morphine had commenced. Dr McGourty brought the deceased's mother and sisters into a private room and informed them that she was deteriorating and that consultants had told him that there was nothing else that could be done for the deceased. He stated that the family agreed that comfort measures were in the deceased's best interests and a DNACPR form was completed by Dr McGourty. He stated that he did not feel forced to complete this form, but he was aware that Dr Iwanicka had commenced a morphine infusion. He stated that it was in this context, he felt it was appropriate to complete the form. He agreed that the deceased's family may have given implied consent, rather than a direct answer to a direct question about resuscitation.

Evidence of Dr Beata Iwanicka

[122] Dr Beata Iwanicka, consultant anaesthetist, gave evidence to the inquest. She was the consultant anaesthetist on call for the weekend of 25 and 26 February 2017. At around 22.00 hours on Sunday 26 February 2017, Dr Subhani Shalk, staff grade anaesthetist, was asked to review the deceased. Dr Iwanicka later joined Dr Subhani Shalk for the assessment.

[123] Dr Iwanicka noted that the deceased's condition had deteriorated in the afternoon of 26 February 2017, as her NEWS rose from four to nine. Upon examination, Dr Iwanicka noted that the deceased was alert but very pale, cachectic and frail. She was receiving oxygen via a face mask, had reduced air entry at both lung bases and her abdomen looked distended. She was receiving cyclizine and albumin. Dr Iwanicka told the inquest that she was very concerned about the

deceased and the fact that she had been given no TPN even though she had not been able to eat properly for about a month. Dr Iwanicka agreed that the deceased be admitted to the ICU for invasive monitoring and organ support.

[124] Dr McKendry recorded in her notes that initially the deceased was refused admission to ICU due to a lack of beds. Dr Iwanicka told the inquest that both HDU and ICU were full that night. In those circumstances, there is a possibility of swapping patients from HDU and medical wards depending on the needs of those patients. She clarified that Dr McKendry may have been told there were no beds in ICU, which was correct, but that was not a refusal of admission, "we didn't refuse. We can't refuse" and "our duty is to review the patient and see what we can do" and "I think there was a miscommunication."

[125] It was put to Dr Iwanicka, that on 24 February 2017, the deceased had a CRP of 181 and she was asked what that indicates and whether the deceased should have been moved to HDU sooner than 26 February 2017. She replied that 181 was very high and indicative of infection. In relation to admission to HDU sooner, she stated "I think even on admission, on the Wednesday or Thursday, I think the ICU staff should have been made aware of her. It should have been discussed that there is a patient, with such a severe malnutrition, that there was a potential of her getting worse because she will have no reserve and her immune system [will be] compromised, so she will not be able to fight any infection properly. That should be addressed, and the anaesthetist should be asked to put in a central line to provide the parenteral nutrition." Dr Iwanicka was of the view that TPN should have been commenced, explaining that where there was an issue with the bowels the source was unknown and that nutrition should be prioritised.

[126] At 00.28 hours on 27 February 2017, the deceased arrived in ICU. Dr Iwanicka explained that the one-and-a-half-hour delay in admission was due to the fact she had to review and discharge a patient to a ward to make a bed available for the deceased. She stated that a bed was available at around midnight, then a porter had to move her and a one-hour delay for admission to ICU is not considered a significant delay.

[127] On admission, the deceased was alert but looked very tired, very pale and her blood pressure was low. She was put on high flow 100% oxygen and central venous line and arterial line were inserted, after which a chest x-ray was conducted, which showed remarkably distended bowels, which was pushing her lungs up. This was a clear sign that chest problems were secondary to an abdominal condition. Dr Iwanicka wished to ask for another surgical review, however she was informed that earlier that day, Mr Mullan had not found anything requiring surgical intervention.

[128] Dr Iwanicka told the inquest that, from 02.30 hours, the deceased's condition was deteriorating rapidly. Dr Iwanicka described the deceased as being very frail, malnourished, in a critical condition, with low blood pressure, with no cardiopulmonary reserve and the metabolic acidosis she suffered from was

worsening. Her bowels, lungs, kidneys and liver were failing. Dr Iwanicka spoke to the deceased's family and explained that the deceased was too weak and frail to overcome septic shock. Dr Iwanicka told the inquest that a DNACPR was signed by the medical team and acknowledged by the ICU team.

[129] When it was put to Dr Iwanicka that, as she was the treating consultant at the time, would it not have been more appropriate for her as a senior doctor to complete this form rather than leave it to Dr McGourty a foundation year two doctor, Dr Iwanicka replied, "I didn't want to fill [in] this form. I accepted it when it was - because I thought it was discussed with Dr Geoghegan, and it was a medical team opinion. So, I accepted it" and "I was like a bit passive in this case."

Evidence of Dr Subhani Shalk

[130] Dr Subhani Shalk, staff grade doctor, gave evidence to the inquest which was admitted by way of Rule 17. Dr Subhani Shalk completed the verification of life extinct record sheet. She pronounced life extinct at 03.55 hours on 27 February 2017.

Expert evidence

Evidence of Mr Jonathan Wilson

[131] Mr Jonathan Wilson, consultant general and colorectal surgeon, instructed on my behalf, provided a report and gave evidence to the inquest.

[132] Mr Wilson told the inquest that prior to the rapid deterioration on 26 February 2017, the deceased, who was a complex patient, had been under the care of three different consultants since her admission on 21 February 2017. In his view, there was no clear documentation of handover between teams detailing relevant results and pending investigations to chase, such as CT results. He stated that this would have contributed to the delay in appreciating the deceased's condition and acting on the deceased's rising CRP and the abnormal ultrasound report. This had been performed on 22 February 2017 but was not fully appreciated until 72 hours later during the weekend (25 February 2017), which then prompted the CT request and further management being coordinated by busy on-call teams during the weekend.

[133] Mr Wilson stated that the deceased was persistently hypotensive (systolic <100 throughout admission) and tachycardic (>110/minute throughout admission), which did not appear to concern the clinical teams involved prior to the rapid deterioration on 26 February 2017.

[134] Mr Wilson told the inquest that this delay was avoidable, and a CT scan could have potentially been performed three days earlier, thus highlighting a complex patient with several significant evolving problems: potential subacute small bowel obstruction with ascites; an obstructed right kidney with potential proximal infection; and unexplained rising inflammatory parameters, prior to the weekend. Had this

occurred, Mr Wilson stated that the clinical teams would have been able to involve general surgeons (to manage small bowel obstruction conservatively earlier and to address fluid/electrolyte/nutritional deficiencies earlier), urologists, and potentially discuss with the Belfast City Hospital team the deceased's complex history and possible transfer of care to them. Furthermore, HDU could have been involved earlier, prior to the deceased's rapid deterioration. Mr Wilson opined that it was possible the rapid deterioration on the 26 February 2017 and death on 27 February 2017 was preventable. He went on to say that due to the deceased's low BMI and chronic nutritional deficiency, she may not have had the same physiological reserve as healthy patients of her age and therefore had the potential for a more precipitous deterioration once she had started to decompensate.

[135] Mr Wilson explained that there was a further delay of more than 12 hours between the urgently requested out-of-hours CT report being made available and the clinical team documenting the CT findings in the notes, along with an action plan. This further delay, in his view, was preventable.

[136] At inquest, the evidence of Dr McCaffery was put to Mr Wilson, specifically that she recorded in the medical notes that she did discuss the ultrasound report with Dr Campbell on 22 February 2017. It appeared to Mr Wilson that the 25 February was the first time anyone appreciated the magnitude of the report, and it warranted an urgent CT scan, which Dr Campbell directed on 25 February. Dr Campbell's explanation, that it was the report in combination with a rising CRP that led to the CT scan being ordered, was put to Mr Wilson and he commented, "this was a highly complex patient that had perplexed a tertiary unit [in the Belfast City Hospital] for many many years. She was tachycardic, hypotensive and her albumin was very low at 13. It's rare to see such a low albumin in my experience, with significant ultrasound findings. So, I don't think it's a grey area. I think we would want more definitive granular information than an ultrasound and that is by today's standards a CT scan, abdomen, pelvis, probably chest as well given the pleural effusions."

[137] Mr Wilson commented on the delay in acting on the ultrasound performed on 22 February 2017, showing right renal hydronephrosis. This was confirmed on a CT scan on 25 February 2017 and showed a large 16mm stone obstructing the renal pelvis. In the context of a rising and significant CRP and falling eGFR (a blood test that estimates how well your kidneys are functioning), proximal infection and an obstructed system should have been considered. Consequently, urgent drainage of the kidney should have then also been considered. Due to the delay in the CT, this discussion happened with the weekend urology on-call team on 26 February 2017, who advised that there should be an urgent outpatient referral and no need for acute intervention. Although the autopsy report did not reveal macroscopic, histological or microbiological evidence of pyelonephritis, this, in Mr Wilson's view, may still have contributed materially to some extent to the deceased's deterioration. Therefore, earlier appreciation and intervention may have been beneficial.

[138] Mr Wilson noted that the Trust's SAI Report included an external review of general surgical management by Mr W J Campbell, which concluded that conservative management of the small bowel obstruction and the initial observation had been appropriate. This was due to the deceased's generally poor condition at the time of her referral to the general surgeons, with electrolyte imbalance, AKI, hypoalbuminemia, tachycardia and hypotension. Furthermore, the deceased required optimisation prior to any thoughts of surgical intervention.

[139] Mr Wilson stated that the review did not mention the absence of a NG tube in the management of the small bowel obstruction, which would be the standard of care. Mr Wilson could not see any documentation regarding a NG tube in the notes. He explained to the inquest that this would have provided decompression of the stomach and small bowel, consequently reducing intra-abdominal pressures. This potentially would have improved splanchnic perfusion, reduced bacterial translocation and provided better respiratory function. He added that it also stops uncontrolled vomiting and the risk of aspiration pneumonitis. He stated that drip and suck "would be the only treatment really available and drip and suck would be implemented immediately if someone is identified as having either full high grade small bowel obstruction or as near as your de-facto bowel obstruction" as in the deceased's case and consequently should have been directed.

[140] Mr Wilson opined that TPN would have been the only way of addressing the deceased's nutritional deficit. He agreed with Dr Iwanicka that there should have been TPN early in the deceased's admission, as he explained: "the admission bloods with an albumin of 13, the knowledge that was available from the inter-hospital link that this patient had protein losing enteropathy, I think it was always going to be a massive challenge to try and manage the fluid balance and the nutritional deficit. And there should have at least been a conversation about total parenteral nutrition." In relation to whether Mr Mullan should have suggested TPN during his review, Mr Wilson commented: "I would have expected there to be direct instruction from the surgical team to insert a nasogastric tube with immediate aspiration and the frequency of that aspiration, four to six hourly aspiration but, also, yes, the nutritional picture in front of him would usually be discussed. But on a weekend on-call, it's more and more pressing to deal with the immediate bowel obstruction picture. TPN is not available over the weekend in the vast majority of hospitals, so it wouldn't have been something they would have been able to implement on a Saturday or a Sunday. So, it might not have been a high priority for Mr Mullan."

[141] Mr Wilson did agree with Mr Campbell's comment in the SAI Report, that the CT scan demonstrated the passage of contrast through the small bowel and into the colon. It also demonstrated that while there was a dilated small bowel present, "…it is likely, therefore, that this is a chronic dilation and a subacute obstruction." He stated that there was not absolute constipation, however, Mr Wilson went on to say that that the autopsy did find solid stool facealisation above the level of the points of obstruction, which suggested chronicity and that this had been on-going for some time. Furthermore, "the history from the notes is that the patient was vomiting from

Christmas, so there had been almost a two-month history of probable, with the benefit of hindsight, subacute bowel obstruction going on two months prior to the admission."

[142] Mr Wilson explained to the inquest that there was suboptimal recording of fluid balance in the deceased's medical notes. He described how the deceased had significant diarrhoea and vomiting on admission, with marked hypoalbuminemia and peripheral oedema. The patient was hypotensive and tachycardic throughout her entire admission. Fluid balance would therefore have been challenging in the deceased and consequently a strict input/output chart would be essential, and this was poorly documented in the medical notes. Indeed, the SAI Report highlighted that this was sub-optimally recorded with the deceased self-toileting.

[143] Mr Wilson noted that there was a suggestion that the foundation year one doctor involved in the deceased's care, in the early hours of 26 February 2017, was uncertain of the management and there was no evidence of escalation or senior review documented.

[144] In relation to the lack of escalation for a critical NEWS (seven or above), Mr Wilson commented that despite the deceased having a NEWS of nine at 18.10 hours on 26 February 2017, which signalled a marked and rapid deterioration, the deceased was not directly seen by a doctor above foundation year two seniority until the anaesthetic review over four hours later at 22.45 hours. It was only then that the patient was accepted for ICU, however, the deceased had already deteriorated significantly by then and, in Mr Wilson's opinion, an earlier input from a more senior member of team or intensivists/ICU, may have had a positive influence on the outcome.

[145] In Mr Wilson's opinion, communication between the medical and ICU doctors was suboptimal. He stated that there appeared to be sub-optimal communication between the medical staff, the anaesthetic staff grade doctor and consultant anaesthetist prior to their ultimate review on the ward. He agreed with a comment in the SAI Report that a much earlier anaesthetic/ICU ward review would have identified a critically unwell patient and expedited the process. He went on to say that it was also possible that the intensivists could have implemented some treatment on the ward which was not implemented until the deceased arrived in ICU several hours later. He stated that this delay in treatment may well have contributed to the deceased's ultimate outcome.

[146] Mr Wilson told the inquest that early discussions with Dr Johnston's team at Belfast City Hospital for joint decision-making and advice, would have been helpful. Whilst Dr Johnston stated that the deceased would have received the same level of care, Mr Wilson commented: "I think probably with the benefit of hindsight we can see that maybe there would have been a benefit to admission to Belfast City Hospital… given that's where the patient had been managed for 10 years, they knew her very

well…So just from a logistical point of view, it would have been much easier to look after her there."

[147] Mr Wilson disagreed with Dr Geoghegan's view that the deceased should have been under the care of the surgical team from admission. He stated that the evidence that the doctors had on the 22 February 2017 was heavily balanced towards gastroenterology and medical problems. Namely, a very low albumin, diarrhoea and vomiting but without a diagnosis of bowel obstruction. Whilst the deceased did have bilateral pleural effusions, peripheral oedema and a history being exclusively managed by medical gastroenterologists at Belfast City Hospital for 10 years previously, he did not see anything that the surgeons would have been able to add at that point, and it probably would have been an inappropriate location for the patient to go to at that stage.

[148] In relation to the cause of death provided at postmortem, Mr Wilson, commented that the "causes of death that are described in a postmortem often oversimplify the actual picture, the cause of death being bowel obstruction. I think it was multifactorial. This patient had multi-organ failure, as a consequence of severe malnutrition [and] severe hypoproteinaemia, leading to multiple organ dysfunction both respiratory, cardiovascular [and] gastrointestinal."

[149] Mr Wilson concluded by summarising that the deceased was known from the onset to have a complex past medical history and the receiving medical team in the SWAH should have anticipated the need for attention to detail, timely review of investigations and robust handovers between teams (consultant-led). However, in Mr Wilson's view, there were significant delays in reviewing and acting upon abnormal clinical signs and test results. These delays resulted in urgent referrals and the involvement of other sub-specialities. He added that the involvement of 'out-of-hours over the weekend' occurred at least three days later than it should have, which resulted in delays in treatment and the deterioration of a complex patient.

[150] Mr Wilson opined that other concerning clinical parameters, such as persistent and significant hypotension and tachycardia, were documented but not seemingly appreciated or considered by the medical team prior to decompensation. The magnitude of the problem was therefore underappreciated going into the weekend and it was not until the patient decompensated and became critically unwell that senior escalation and ICU involvement were requested. However, he added that escalation was slow, with further avoidable delays and the deceased was moribund upon arrival in ICU. Furthermore, the deceased died within four hours of arrival on ICU, which suggested that the deterioration on the ward was too advanced and therefore irreversible.

[151] Mr Wilson told the inquest that it was entirely possible that had the cumulative avoidable delays not occurred and had the deceased been transferred to a higher level of care or tertiary referral unit in a timely fashion, prior to the significant deterioration, she may have survived. When asked whether he thought the deterioration the

deceased suffered on the 26 February 2017 was likely to have been preventable, had there been an earlier recognition of how critically unwell she actually was, Mr Wilson replied: "Yes, it's a difficult question and my gut instinct is that it was avoidable." He explained that "objective information like persistent tachycardia, persistent hypotension and blood levels with albumin of 13, the very significant ultrasound findings and so on, and for me the big driver would be the complex history, all paint a picture of someone that was always going to be very difficult to look after."

[152] When asked whether, in his view, on balance, the deceased's death was preventable, Mr Wilson replied that "I think if I paint what perfect management would look like and again of course with the benefit of hindsight, early discussions with tertiary centre who know the patient well, consideration of a transfer, urinary catheter, nasogastric tube to decompress the stomach and the small bowel, which would have helped gut profusion and reduce bacterial translocation from a distended obstructed gut. TPN consideration, to take the pressure off the oral intake and get good nutritional input and, as soon as decompensation had started during the day on the 26, earlier involvement of the intensivists for at least advice, if not implementation of different strategies on the ward and getting to a high dependency environment much earlier may have avoided the rapid decline."

Evidence of Dr Andrew Bodenham

[153] Dr Andrew Bodenham, consultant in anaesthesia and intensive care medicine provided an expert report on behalf of Dr Iwanicka and he gave evidence to the inquest.

[154] Dr Bodenham told the inquest that the cause of the deceased's initial admission to hospital appeared to be some combination of worsening small bowel obstruction or other gut pathology, causing many days of vomiting and diarrhoea. This ultimately led to reduced fluid and nutritional intake. A urinary tract infection relating to an obstructing stone in the right kidney was also possible, in his opinion. Her clinical deterioration occurred within the background of severe and longstanding poorly characterized gastro-intestinal (GI) tract problems, anxiety and drug addiction and other significant medical problems.

[155] Dr Bodenham told the inquest that the true extent of the deceased's nutritional deficits and severity of illness may not have been fully appreciated by her, her family and the admitting clinicians. Her admission BMI was recorded as 17.2 by a dietician, but he stated that this may be an overestimate if the fluid retention in her trunk and limbs from her underlying nutrition problems or heart failure was not factored in. He explained that the complications of severe malnutrition (protein, calories, vitamins and others), irrespective of cause, are well established and lead to immunocompromise, diminished physiological reserve, cardiac failure, cardiac arrest, low blood pressure, brady/tachycardia and other problems in the body. It carries significant mortality and morbidity in short and longer term.

[156] Dr Bodenham told the inquest that the deceased needed urgent replacement of vitamins, calories, fluid losses and electrolytes. In addition to the treatment she did receive, he opined that the only additional elements of care potentially available were: the provision of TPN (all fluids and nutrients provided intravenously); placement of a NG tube to decompress the upper gut; insertion of a stent or drainage tube to the obstructed kidney, surgical intervention to relieve upper GI obstruction; different antibiotic prescribing or referral to the Belfast City Hospital where she was well known to gastroenterologists.

[157] Dr Bodenham explained to the inquest his view, in relation to the question, would earlier admission to HDU/ICU have altered the overall outcome? He told the inquest that admission to an intensive or critical care unit is not a therapy in its own right. Earlier admission can allow administration of higher (or lower) volumes of IV fluids, more sophisticated patient monitoring, earlier use or higher doses of vasopressor support, earlier assisted ventilation, either non-invasive or invasive or earlier hemofiltration. He stated that whilst earlier interventions can be lifesaving, if the patient has deteriorated sufficiently to be near the point of respiratory or cardiac arrest, the evidence for planned earlier or prophylactic use of such interventions is cited as weak. Unfortunately, even when correctly identified, deteriorating patients often have delayed admission to ICU for multiple reasons. For example, a lack of staffed ICU beds in the NHS. He was of the view that an admission to HDU/ICU was not indicated any earlier than 26 February 2017. He stated: "One can discuss all the other interventions that might have been offered, like, earlier surgery, earlier nasogastric tubes, earlier intravenous nutrition and so on, but those interventions don't require admission to HDU or ICU to be carried out."

[158] Dr Bodenham told the inquest that earlier admission to ICU would not have halted or altered the speed of her clinical deterioration and clinicians would have been still left with the same difficult decisions to make in a patient in a rapidly developing peri-arrest situation.

[159] In relation to the discussion and decision surrounding DNACPR and whether further escalation in care (primarily tracheal intubation and assisted ventilation plus hemofiltration/dialysis) and cardiopulmonary resuscitation was not in the deceased's best interests, Dr Bodenham discussed how this is a very difficult decision to make in the case of a 34-year-old patient, with the uncertain prospects of reversible medical conditions. However, in his opinion, Dr Iwanicka was correct in stating that there was a high probability of cardiac arrest on induction of anaesthesia to enable tracheal intubation and assisted ventilation, plus she was very unlikely to be stable enough to undergo hemofiltration or to survive the illness.

[160] Dr Bodenham stated that, overall, in his opinion, decision-making was reasonable, and a reasonable body of clinicians would have made the same decisions and recommendations to the family, about not escalating care. Furthermore, the same decisions and recommendations regarding a DNACPR order and moving towards comfort/palliative care. He agreed with a finding from the SAI Report, that such

decision-making should have included the referring medical team, but it was unlikely that this would have altered decisions made at the time.

[161] In relation to communications with families, Dr Bodenham explained that many patients and families believe that it is their choice as to whether further escalations in care or resuscitation are carried out, but ultimately clinical staff are not obliged to provide such interventions if they believe they are not in the patient's best interests or very unlikely to be successful.

[162] In Dr Bodenham's opinion, on balance of probabilities, she would not have survived even with different management from the ICU team.

Pathology evidence

Evidence of Dr Christopher Johnson

[163] Dr Christopher Johnson, the then Assistant State Pathologist for Northern Ireland, gave evidence to the inquest. He performed an autopsy on the deceased on 1 March 2017 and thereafter produced a report.

[164] Dr Johnson confirmed that at autopsy, he found a few metallic foreign bodies within the deceased's stomach. He presumed these were the same as those found on the CT scan on the 25 February 2017. He stated that they were very small, only 0.1 millimetres in diameter. He did not see any large foreign bodies anywhere and he stated that this may have been because it had transited through the deceased's system. He could not say exactly what the cause of the small metallic foreign bodies were.

[165] Dr Johnson explained that the most compelling feature at autopsy was the presence of small bowel obstruction. The small bowel that was proximal to the areas of obstruction was dilated and contained liquid, gas and hard bowel content. He stated that the presence of small bowel obstruction would account for the deceased's clinical symptoms of vomiting, diarrhoea and abdominal cramps and is considered to be the cause of death. Dr Johnson described how small bowel obstruction can interfere with absorption of fluids and nutrients and lead to dehydration, hypovolaemia (low volume of fluid in the body) and severe metabolic disturbances.

[166] Dr Johnson told the inquest that the cause of the bowel obstruction in the deceased's case was likely to be related to the misuse of NSAIDs. The deceased's consultant, Dr Simon Johnston, informed Dr Christopher Johnson that the deceased had a long history of abusing medications containing NSAIDs. Dr Johnson explained that the appearances within the bowel of circumferential, band like strictures, were the same as what has been described within the medical literature as arising as a result of excessive use of NSAIDs and is called 'NSAID enteropathy.' In the deceased's case, the strictures were at 4 to 5cm intervals and 0.4cm in width. Dr Johnson explained that NSAID enteropathy is a rare complication of NSAID use and is thought to arise due to disruption of the mucosal and cellular integrity of the bowel wall (the lining of

the bowel wall becomes damaged), due to the effects of the NSAID. This leads to scarring and the formation of strictures.

[167] Dr Johnson explained to the inquest that the strictures had scar tissue on them and in his opinion were therefore chronic, meaning they were ongoing for a period as opposed to acute, which is something that occurs quickly. So, in his opinion, they "would have been there for a while."

[168] Dr Johnson stated that he did not find any evidence of another bowel condition to suggest there was an alternative diagnosis, other than NSAIDs.

[169] Dr Johnson advised that there was no histological evidence of pyelonephritis or traumatic injuries that could have caused or contributed to the deceased's death.

[170] Dr Johnson concluded by stating that, in summary, the deceased was a 34-year-old woman who was admitted to hospital with diarrhoea, vomiting and abdominal pain and died. The cause of her presentation and death was small bowel obstruction, which was caused by strictures within the small bowel. The strictures resulted from NSAID enteropathy.

Conclusions on the evidence

[171] On the balance of probabilities, I find that the death of the deceased on 27 February 2017 was preventable. Had there been early engagement and discussion with the gastroenterology team at Belfast City Hospital who were familiar with the deceased's clinical history and timely consideration of transfer to that facility; the insertion of a urinary catheter; earlier surgical review; the insertion of a NG to decompress the stomach and small bowel; the early commencement of TPN and earlier involvement of the intensive care team, whether for the purpose of providing advice or the implementation of alternative management strategies on the ward; I find, on the balance of probabilities, that the deceased's rapid clinical deterioration could have been avoided and that her death on 27 February 2017 thereby prevented.

[172] On the evidence before me, there were a number of missed opportunities, in the care and treatment of the deceased. I outline these below. Each of my findings I make on the balance of probabilities.

[173] I find that the medical team responsible for the deceased's care from her admission on medical ward three on 22 February 2017 until 26 February 2017, failed to adopt a holistic and proactive approach to her assessment and treatment. An open-ended and non-directive approach appeared to have been taken to her management. This was without decisive clinical decision-making by senior clinicians, timely review of the NIECR (which contained relevant information that the underlying cause of her protein-losing enteropathy was NSAID enteropathy) or formulation of a clearly defined management plan with set parameters for re-evaluation and reassessment of her condition.

[174] I find that insufficient consideration was given to the provision of effective nutritional support throughout the deceased's admission to SWAH. It was repeatedly recorded that she was malnourished, with a dietitian noting on 22 February 2017, that she had a BMI of 17.2 and had experienced an 11% weight loss since November 2016. A further review on 24 February 2017 recorded that she was "not meeting nutritional requirements at present." As this was a Friday, there was no further dietetic review, nor was there subsequent consideration by medical staff of her nutritional needs, including the potential commencement of TPN. I find that her nutritional reserves were severely depleted, rendering her unable to withstand further physiological stress.

[175] I find that Dr Campbell and Dr Geoghegan should have contacted Dr Johnston or Dr Ferguson at Belfast City Hospital for background information and discussion regarding the deceased's treatment, management and possible transfer to Belfast City Hospital.

[176] I find that there was a lack of timely review of investigations, inadequate continuity and robustness in handovers between consultant-led teams and significant delays in reviewing and acting upon abnormal clinical findings and test results. These delays necessitated urgent out-of-hours referrals to other subspecialties, at least three days later than should have occurred, contributing to a deterioration in the condition of an already complex patient.

[177] I find that, by 24 February 2017, there was sufficient and compelling clinical evidence (including blood results, inflammatory markers, physical presentation and the overall clinical course) to give rise to significant concern regarding the deceased's lack of clinical improvement. Persistent and marked hypotension and tachycardia were documented, however, these findings do not appear to have been appropriately appreciated, interpreted or acted upon by the medical team prior to the deceased's subsequent decompensation. It is evident that the seriousness and developing nature of the clinical picture were not fully recognised in the period leading into the weekend. It was only upon the occurrence of acute deterioration and critical illness that senior medical escalation and intensive care involvement were sought.

[178] I find that there was an absence of adequate written documentation in respect of clinical decision-making and handovers, particularly among consultants and junior medical staff. I find that there was no clear documentation of handover between teams, detailing ward rounds, relevant results, and pending investigations to chase. For example, ultrasound and CT results, which contributed to the delay in appreciation and acting upon the deceased's rising CRP and abnormal ultrasound report. The ultrasound having been performed on 22 February 2017.

[179] I find that Dr McCaffrey did discuss the ultrasound findings with Dr Campbell on 22 February 2017, although it was not until 25 February 2017 that Dr Campbell fully appreciated the significance of the ultrasound report. The findings on the ultrasound

warranted an urgent CT scan on 22 February 2017, which may have in turn, prompted earlier surgical review and the insertion of a NG tube for decompression of the stomach and small bowel. This would have addressed the fluid/electrolyte/nutritional deficiencies with commencement of TPN.

[180] I find that the delay in acting on the ultrasound performed on 22 February 2017, which showed right renal hydronephrosis (which was confirmed on a CT scan on 25 February 2017, with a large 16mm stone obstructing the renal pelvis, in the context of a rising and significant CRP), led to a discussion with the weekend urology on-call team on 26 February 2017, rather the than consideration of an infection, an obstructed system or urgent drainage of the kidney on 22 February 2017. I find that this delay may have contributed, to some extent, to the deceased's deterioration and earlier appreciation and intervention may have been beneficial.

[181] I find that there was an inappropriate delay of over 12 hours between the urgently requested out-of-hours CT report being made available on 25 February 2017 and Dr Geoghegan documenting the CT findings and requesting a surgical review the following day.

[182] I find that it was appropriate for the deceased to remain under the care of the gastroenterology team upon admission, however, as a minimum, the treatment plan should have included earlier surgical review. The deceased should have been made nil by mouth and there should have been the insertion of a NG tube to provide decompression of the stomach and small bowel to reduce intra-abdominal pressures.

[183] I find that although no acute surgical intervention was indicated at the time of the surgical review on 26 February 2017, consideration could have been given by Mr Mullan to an immediate discussion with the consultant on-call, Dr Geoghegan and conservative measures such as NG decompression of the stomach for immediate aspiration.

[184] I find that consideration should have been given to seeking early input from the ICU team, either for the purpose of obtaining clinical advice or for the implementation of alternative management strategies on the ward. As was accepted by Dr Iwanicka in her evidence, the ICU team should have been alerted to the condition of the deceased on the Wednesday or Thursday, given her severe malnutrition and compromised immune status. An anaesthetist ought to have been requested to insert a central line to enable TPN, as nutritional support should have been prioritised where bowel dysfunction of uncertain origin was present.

[185] I find that there was no formal handover of the deceased's care, despite her being under the responsibility of three different consultants between admission on 21 February 2017 and her transfer to ICU on 26 February 2017. There were no record of a handover process or key clinical discussions in her notes, amounting to poor medical record-keeping.

[186] I find that fluid balance recording was poorly documented in the deceased's notes. The deceased had significant diarrhoea and vomiting on admission, with marked hypoalbuminemia and peripheral oedema and was hypotensive and tachycardic throughout her admission. Fluid balance would therefore have been challenging in the deceased and consequently this heightened the need for accuracy, and a strict input/output chart was essential.

[187] I find that the deceased's NEWS of seven required a clinical review by a registrar or staff grade at ST3 or above. On 26 February 2017, a NEWS seven prompted attendance by a foundation year one doctor, followed by a foundation year two doctor, but at 18.10 hours the NEWS had risen to nine, signifying marked deterioration. The deceased was not reviewed by a senior doctor above foundation year two doctor level until 22:45 hours, when an anaesthetist attended — a delay of approximately four and a half hours. I find that an in-person review by a senior doctor should have occurred without delay.

[188] I find that there was insufficient discussion among senior medical and anaesthetic staff and a lack of clarity surrounding decision-making in respect of the DNACPR decision. There should have been a clearly documented discussion concerning the deceased's overall clinical trajectory with the deceased's family. This responsibility should not have been delegated to a junior, inexperienced foundation year two doctor. It lay within the remit of the ICU consultant who was present. However, I find that this would not have altered the eventual outcome.

[189] I find, as identified by Dr Campbell and Dr Geoghegan, there were significant staffing issues within SWAH at the relevant time, with two gastroenterology consultants sharing one junior doctor. I find that the level of staffing in SWAH was inadequate to meet the clinical needs and safety of patients.

[190] Having carefully considered all the evidence, both oral and written, I find that the medical cause of death was multi-factorial, arising from the complications of NSAID enteropathy, exacerbated by severe malnutrition and physiological decompensation.

[191] It is evident that the deceased was a much-loved daughter, sister and aunt, whose untimely death has caused deep and enduring grief to her family. The circumstances of her death stand as a reminder of the serious and potentially fatal consequences associated with the misuse of over-the-counter opiate medication and the gastrointestinal complications arising from NSAID use. It also underscores the importance of timely clinical assessment, clear documentation, continuity of care, and effective multidisciplinary communication in the management of these complex patients.

[192] A post-mortem was performed and it records, and I find, that death was due to:

1(a) small bowel obstruction

due to
1(b) small bowel strictures

due to
1(c) non-steroidal anti-inflammatory drug enteropathy.

[193] The above findings should be placed in the following context. At inquest, I heard evidence from Professor Ronan O'Hare, consultant in anaesthetics and intensive care medicine and the deputy medical director of the Trust, in relation to a number of changes made by the Trust following the deceased's death.

[194] Following the SAI Investigation and report, the Trust took forward a number of learning points and recommendations.

[195] The SAI report recommended the development of a SWAH Critical Care Outreach (CCO) Team. Professor O'Hare told the inquest that, in the intervening period with the COVID-19 pandemic, the change to the functionality of the hospital services and increase in anaesthetic staffing levels since the deceased's death, the need for an CCO service has not been developed.

[196] In relation to the recommendation that the Trust needs to ensure that the escalation policy (in Altnagelvin and SWAH), ensures that patients with a critical NEWS of equal to seven or more are reviewed by appropriately experienced clinicians at tier two (registrar equivalent), Professor O'Hare advised this action was completed in November 2019.

[197] The SAI Report recommended that the Trust should undertake regular planned audits of medical record keeping as a baseline for quality improvement projects, to improve record keeping standards. Professor O'Hare explained to the inquest that when care is transferred from one consultant to another, it should be clearly documented in the patient's notes. This should include an audit of legacy work to see if routine work is being completed in a timely fashion or if tasks are being left to out of hours and weekends. He stated that with Encompass (a health and social care software programme), the internal audit process is incorporated.

[198] The SAI report recommended that a senior nurse should accompany the medical team on the ward round (as recommended in the Royal College of Physicians Safe Medical Staffing 2018). If, due to staffing levels, this is not possible, then senior nursing input should form part of a board ward round prior to the medical ward round and nursing concerns should be documented. Furthermore, the report recommended that the Trust develop a mechanism for recording which members of the multi-disciplinary team are present at ward rounds and the recording of nursing concerns. Professor O'Hare stated that board ward rounds in all wards have been occurring since February 2020 as part of a quality improvement project. Practice

educators have been appointed and 'Hospital at Night' continues to identify the sickest patients in the hospital and focuses care toward those patients.

[199] In relation to the recommendation that foundation year one doctors should not be on duty without resident senior cover, as they are preregistration and always need support, Professor O'Hare advised that this recommendation has been actioned by the Trust, and a middle tier of medical cover is now provided. In addition, there are now two medical consultants present at the weekends, with an increase in Anaesthetic/ICU staff.

[200] In relation to a recommendation that there should be a documented consultant to consultant discussion in relation to DNACPR decisions, Professor O'Hare stated that there is a requirement to document conversations on the DNACPR communication sheet and these decisions are taken in conjunction with the patient themselves and with the family.

[201] In relation to the issue of staffing, namely the SAI report recommendation that the Trust should undertake a review of on-call medical staffing requirements to ensure that there are sufficient clinicians to provide a safe service, Professor O'Hare advised that staffing levels have changed since the SAI report was published.

[202] Professor O'Hare commented that the level of staffing in Northern Ireland is a documented risk on the risk register, and this is due to the lack of availability of doctors in the NHS and is common to all hospitals. He stated that this SAI report was used as a stimulant to improve staffing levels across the SWAH and Professor O'Hare stated that they have gone from "a funded establishment of nine consultants/physicians to in or around 22." Also, SWAH has since employed the middle grade rota of registrar level doctors.

[203] In relation to the evidence of Dr Campbell and Dr Geoghegan, Professor O'Hare stated the current position in gastroenterology is that they only have one substantive consultant and two locum consultants employed. That would be also a similar pattern in Altnagelvin. He explained that getting doctors is the issue, rather than funding. He agreed that the same issues exist today that existed in 2017.

[204] Professor O'Hare opined: "I came into my position in 2016. Before Ms McNabb's death, there was only one consultant on for the whole 170 patients, plus 20 admissions a day. So, they had to see all those patients coming in new and then they only had a junior doctor. Since then, we have changed that to two consultants on at the weekends and there will be significantly more juniors, probably another three or four. And, again, in anaesthetics now there is two juniors on during the day at weekends, but because of the change of the profile of the hospital there would be no emergency surgery. So, they would be a lot freer then to attend any of the wards."

[205] In relation to the deceased's diagnosis of NSAID enteropathy following codeine misuse, Professor O'Hare stated:

"I don't think there is an appreciation [of the consequences], as these are medicines that you can buy over the counter…it was a very rare complication, and I have not seen anything like that since or before."