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**IN THE CORONERS COURT FOR NORTHERN IRELAND**

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**IN THE MATTER OF**

**AN INQUEST TOUCHING UPON THE DEATH OF**

**MR GARY WILLIAM BRIGGS**

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**Before: Coroner Patrick McGurgan**

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[1] The Deceased, Gary William Briggs, of 53 Halfpenny Gate Road, Moira born on the 26th June 1971, died on the 23rd December 2012.

[2] The Deceased suffered from diabetes and hypertension and was on home dialysis for renal failure due to underlying Type 1 diabetes and Hypertension. Several days prior to the 23rd December 2012, the Deceased had been feeling unwell. He was short of breath and had a cough. He was unable to undergo his dialysis on 22nd December due to his ill health. He had been suffering from vomiting and diarrhoea and was complaining of tightness in his chest.

[3] As a result of his continued ill health, the Deceased's wife contacted the out of hours doctor, Doctor Gallagher, in the early hours of the morning of the 23rd December. Following a telephone conversation it was agreed that the Deceased would attend the Out of Hours centre at Lagan Valley Hospital.

[4] Dr Gallagher, the Out of Hours GP, gave evidence to the Inquest. He stated that he saw the Deceased at 5.22 am and that he was complaining of shortness of breath, coughing since the preceding Friday and that his oxygen saturation levels were 82%. Dr Gallagher told the Inquest that he was querying whether or not the Deceased may have been having a cardiac issue but that he was a good colour and he was not clammy. Dr Gallagher further indicated that he learned that the Deceased was diabetic from taking a history and that he was Insulin Dependent. He accepted that he should have taken a BM test, for his blood sugar level, but that his main

concern was the Deceased's oxygen levels and the desire to get the Deceased to hospital as soon as possible. Dr Gallagher stated that he did not telephone for an emergency ambulance as his experience was that they did not always arrive expeditiously and that transport by car would have been the fastest method of transfer to the hospital.

[5] Dr Gallagher further accepted that although he wrote a referral letter for the Deceased (said letter and any copies of same have since gone missing) to give to the hospital staff, he did not phone the Emergency Department to alert them to the Deceased's intended attendance. His reasoning was that calls were not always answered in the department and that in all likelihood he would have been told that the Deceased would be triaged on arrival.

[6] Dr Gallagher also advised the Inquest that he was unaware that there was a phone number for a Renal Registrar that could be contacted for dialysis patients, such as the Deceased, all year round and at any time of the day. He also advised that there was a cardiac monitor available to him but that he did not use it as he would not be confident in reading the results and that he could not recall if he had taken the Deceased's blood pressure.

[7] Dr Gallagher indicated that the consultation with the Deceased ended in or around 5.46 am and that he gave the Deceased a referral letter to take with him to the Royal Victoria Hospital as he felt that the Deceased should have a chest x-ray and further investigations.

[8] In a subsequent statement to the Inquest, Dr Gallagher accepted that on reflection he should have sent the Deceased to hospital by way of ambulance and that he should have tried to telephone the Emergency Department irrespective of what difficulties there may have been in getting to speak to someone.

[9] I find that Dr Gallagher did not appreciate how seriously ill the Deceased was. I find that this lack of appreciation, the decision not to call for an emergency ambulance (a blue light ambulance) and the failure to perform a BM test, all represented a loss of opportunity in respect of the care and treatment of the Deceased.

[10] The Deceased arrived at the Accident and Emergency Department of the Royal Victoria hospital at 5.58 am on the 23rd December 2012. He was initially triaged by a Band 5 Staff Nurse, Nurse Miller. The Deceased's wife was not present at this time as she had gone to park her car after leaving the Deceased off at the front door of the Department.

[11] Nurse Miller gave evidence to the Inquest. She explained that she brought the Deceased to the triage room at 6.05 am. The Deceased provided her with the GP referral letter and she also took a history from the Deceased. According to Nurse

Miller she did not enquire from the Deceased if he had vomiting or diarrhoea nor when the Deceased had last had his dialysis treatment.

[12] Nurse Miller attempted to carry out some initial investigations and observations. She recorded the Deceased's oxygen saturation levels to be 86% on room air. He was given oxygen therapy. She attempted to take blood samples but could not cannulate the Deceased's arm. Nurse Miller advised that she intended to test the Deceased's blood glucose level by way of a finger prick blood sample but was distracted by his oxygen levels and forgot to test the blood glucose.

[13] I find that the failure to perform a BM test represented a loss of opportunity in respect of the care and treatment of the Deceased.

[14] Nurse Miller followed the Manchester Triage policy. The Deceased's vital signs had not significantly deteriorated in the interim between the GP assessment and Triage, and following triage, the Triage Nurse was also of the opinion, that immediate medical assessment was not required at that time. The Deceased was categorised as a category 3 patient, which meant that he was to be seen by a doctor within 60 minutes. In fact the Deceased was not seen by a Doctor for some two hours seven minutes post triage. This was also after the Deceased had been re-triaged as a Category 2 patient at 7.50 am. I will return to this point later.

[15] If the systems in place had been working correctly, the Deceased should have had IV access secured, bloods collected, blood sugar measured, an ECG taken and regular observations in the interim whilst awaiting the doctor to see him; this would have provided an opportunity for any deterioration or evolving issues to be identified and addressed.

[16] I find that the systems in place were not working correctly and that this represented a further loss of opportunity in respect of the care and treatment of the Deceased.

[17] With the benefit of hindsight and the experience Nurse Miller has acquired since this incident she accepted that the Deceased should have been triaged initially as a Category 2 which would have meant that the Deceased would have been expected to have been examined by a Doctor within 10 minutes.

[18] I find that the initial categorisation of 3 represented a further loss of opportunity in respect of the care and treatment of the Deceased.

[19] Nurse Miller described an overwhelming situation in the Department on the morning in question. She described ambulances queuing to off load patients and the entire department corridors full with patients on trolleys. In fact, between 8.30 pm on the 22nd December and 7.45 am on the 23rd December she and another nurse had triaged a total of 79 patients. In her evidence Nurse Miller accepted that for a patient

to get seen by a doctor it was more or less a case of "he who shouted loudest", got attended to.

[20] I find that this situation also led to a loss of opportunity to properly diagnose, treat and care for the Deceased. I find that there were insufficient staff available to deal with the influx of patients and given that the Emergency Department of the Belfast City Hospital had been closed one year earlier, this increase in patient numbers was foreseeable and proper systems should have been in place.

[21] Nurse Miller also explained that she was not surprised by the fact the original GP referral letter could no longer be located. She advised that the letter would normally be placed within the patient's "flimsy". This is the paperwork created by the triage nurse in relation to the patient and that given it was only a folded sheet of paper, letters etc. would regularly fall out and effectively get lost.

[22] The evidence suggests that there could be a better way to ensure that patient's records/letters/notes/results etc. are kept together and securely.

[23] In his evidence to the Inquest, Dr Peter Ingram, Assistant State Pathologist, advised that he performed a post mortem of the Deceased on the 24th December 2012. He found severe narrowing of the coronary arteries that is, coronary atheroma. He also discovered a coronary thrombus, [ruptured plaque] and an enlarged heart.

[24] Dr Paul McGlinchey, Consultant Cardiologist, gave evidence to the Inquest. He accepted that earlier medical intervention in relation to the Deceased may have increased the Deceased's chances for survival but that it may not have changed the ultimate outcome.

[25] Dr McGlinchey agreed with Dr Ingram in relation to the cause of death.

[26] In his evidence to the Inquest, Dr Paul Glover, Consultant in the Regional Intensive Care Unit, advised that he became involved with the Deceased after 10.20 am whenever the Deceased had been transferred to ICU. At this stage the Deceased had suffered a cardiac arrest when he was transferring himself from a trolley to a bed. CPR was commenced but ultimately proved futile and life was pronounced extinct at 11.00 am on the 23rd December 2012 at the Royal Victoria Hospital, Belfast.

[27] Dr Glover explained that a patient with 82% oxygen saturation levels needed oxygen and the cause identified. He would also be concerned with 86% levels and that an urgent assessment by a doctor would be warranted with a patient exhibiting these levels.

[28] Dr Glover was of the opinion that there was a very significant likelihood that the Deceased would not have survived even with earlier intervention although he did accept and I find that earlier intervention may have improved the Deceased's chances of survival.

[29] Mr Colin Holburn, Consultant in Accident and Emergency Services, was engaged on behalf of the Coroner to provide expert opinion. He was of the opinion that the Deceased fell within either Category 3 or 2 and that it was essentially a matter of judgement for the Triage nurse. He indicated that Triage required experienced nursing staff. He also believed and I find that to have no further observations of the Deceased performed for some 1 hour and 50 mins was unacceptable.

[30] In her evidence to the Inquest, Dr Jennifer Hanko, Consultant Nephrologist, explained that she first met the Deceased in November 2011. She advised that the Deceased underwent home dialysis 3.5 hours per session on alternate days and that this was subsequently increased to 4 hours per session. She would not be overly concerned if a patient missed a dialysis session, as occurred here. The Deceased was last assessed by an associate specialist doctor in her clinic on the 20th December 2012 and his clinical condition was reported as stable.

[31] Dr Hanko indicated that she believed that initiation of the Deceased's terminal illness was a problem with his heart. She further advised that the Deceased, on presentation to the Emergency Department, would have required dialysis in order to get his potassium levels lowered. Without any disruption or distractions this would have taken a minimum of one hour from presentation to set up with a further hour for the dialysis to work.

[32] Dr Hanko did not believe that the administering of an insulin and dextrose mix to a patient with already high glucose levels would have had any adverse effect on the Deceased as the administering of the insulin was the priority and the "hyperkalaemia kit" comes pre-prepared with instructions to mix insulin with 50% dextrose.

[33] Dr Hanko confirmed that there was an on call Renal Registrar who could be contacted at any time, via the hospital switchboard, to discuss patients such as the Deceased and that if they had have been contacted by Dr Gallagher on the morning in question then the dialysis nurses could have been alerted and arranged to see the Deceased. The evidence suggests that this particular fact pertaining to the availability of an on call Renal Registrar to be contacted at any time could be made more widely known amongst medical practitioners to include General Practitioners.
In his evidence to the Inquest, Dr Duncan Redmill, Consultant in Emergency Medicine, advised that he came on duty in the Emergency Department at 9 am on the morning of 23rd December 2012. On becoming aware of the Deceased he quickly recognised that he was grossly unstable with renal failure and severe hyperkalaemia with respiratory difficulty.

[34] Dr Redmill accepted, and I find, that the seriousness of the Deceased's condition was not recognised by hospital staff until 7.50 am and that the Deceased

should have been initially triaged as Category 2. This would have meant that the expectation would be that the Deceased would see a doctor within 10 minutes.

[35] Dr Redmill was of the opinion, and I find that, Triage Nurses need to be senior members of nursing staff given the judgement calls required at Triage and that to have a junior nurse in the department under the pressures being experienced at that time was unsafe.

[36] Dr Redmill described the Emergency Department in the Royal Victoria Hospital as the most stressful environment he had ever worked in and that staffing quotas at that time were not being regularly met.

[37] Dr Redmill accepted that opportunities were missed in relation to the care of the Deceased. I find that the extraordinary pressures, which were foreseeable and preventable, pertaining at the time in the Department contributed to the loss of opportunities in respect of the care and treatment of the Deceased.

[38] Dr Charlotte McAfee gave evidence to the Inquest. She advised that on the morning in question she was a Foundation Year 2 (FY2) Doctor and first came into contact with the Deceased at approximately 8.05 am. She had come on shift at 8 am and described the Emergency Department as being very busy. Dr McAfee described the Deceased as presenting very short of breath and unable to speak in full sentences. Dr McAfee accepted that due to the chaotic nature of things at the time she did not perform a blood sugar test.

[39] Following assessment, Dr McAfee asked Dr Jonathan Millar, Clinical Research Fellow, to assess the Deceased. Dr Millar was the middle grade doctor on duty at the time. Treatment was commenced for hyperkalaemia. This treatment was a mix of insulin and glucose. Dr McAfee accepted that she was unaware until the day of the Inquest of the GAIN guidelines which recommend not giving glucose to a patient already presenting with high glucose.

[40] The evidence suggests that doctors could be made more aware of the GAIN guidelines.

[41] In his evidence to the Inquest, Dr Nick Morse, Consultant in Emergency Medicine, advised that since this incident staffing levels both as regards medical staff and nursing staff has vastly improved and that there is now in place an escalation policy in respect of surges in patient attendances in the Emergency Department.

[42] A Serious Adverse Incident Review (SAI) was conducted by the Belfast Trust following this incident. Although it commented upon the actions of Dr Gallagher, he was neither invited to participate in same nor did he receive a draft of the report for consideration. In addition, Nurse Miller advised that she was not spoken to directly by the SAI team.

[43] The evidence suggests that an SAI should seek comment and or participation from all those involved in the matter under review.

[44] Dr Morse further advised that once Dr Gallagher discovered that the Deceased's oxygen saturation levels were 82% then an ambulance should have been called. A patient such as the Deceased should have an oxygen saturation level of approximately 96%. He explained that an ambulance crew would perform an assessment of the patient, including taking a blood sugar reading.

[45] I find that if an ambulance had have been tasked, that a blood sugar reading would have been taken and that this combined with the oxygen saturation level of 82% would have resulted in the Deceased being Triaged and seen by a Doctor more expeditiously. The decision by Dr Gallagher not to call an ambulance represented a loss of opportunity in respect of the care and treatment of the Deceased.

[46] In addition, Dr Morse explained that ambulance crews have access to a stand by phone which connects them directly to the Emergency Department which can be used in the event of a patient requiring immediate assessment/attention by a doctor. The evidence suggests that GP surgeries should have a similar system implemented. Dr Morse also indicated that the flimsy created by the nursing staff in the Emergency Department remains as it was in 2012, that is, a folded sheet of paper. He explained that patients are usually instructed to hold onto any letters or paperwork as they would usually be moving between departments.

[47] The evidence suggests that consideration should be given to the appropriateness of this type of flimsy and that a more secure method of retaining paperwork should be considered.

[48] Dr Philip O'Connor, Consultant in Emergency Medicine and Intensive Care Medicine, gave evidence to the Inquest. On the morning in question he was the "Short Stay Consultant", that is he would see patients admitted into the A & E Department Short Stay Ward and manage their conditions.

[49] At approximately 9.25 am on the 23rd December 2012, he was approached by Dr Redmill seeking assistance to stabilise the Deceased. Dr O'Connor recognised that the Deceased was critically ill and needed organ support. Dr O'Connor felt that the Deceased had severe pulmonary oedema probably secondary to a cardiac event superimposed on a background of dialysis dependent renal failure. Intensive treatment was provided and the Deceased's ECG complexes remained narrow. The Deceased was then transferred to ICU.

[50] In his evidence, Dr O'Connor accepted that at the time in question the Emergency Department was unsafe but that significant improvements had been made since. He further advised that he believed that the Deceased should have been triaged as a Category 2 patient and in all likelihood this would have meant that the

Deceased would have been examined by a Doctor within the 10 minute time frame expected. Dr O'Connor agreed that it was important to have an experienced nurse in Triage.

[51] In relation to the issue of giving a patient already high in glucose, additional glucose, Dr O'Connor was of the view that no real harm would have been caused by this and that the most important issue was the administering of insulin. He was further of the view that given how critically unwell the Deceased was and with the underlying heart issues the outcome here may not have been any different but he believed and I find that the Trust did not give the Deceased the best chance to survive.

[52] I find on the balance of probabilities that the cause of death was:

1 a) Coronary Thrombosis,

Due to;

b) Coronary atheroma, Congestive Cardiac Failure, End Stage renal failure,

Due to;

c) Type 1 Diabetes Mellitus and Hypertension.