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IN THE CORONERS COURT FOR NORTHERN IRELAND

IN THE MATTER OF AN INQUEST INTO THE DEATH OF

William James McGurk

Before: Coroner Mr Patrick McGurgan

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1. The deceased, William James McGurk, born on 5 June 1938, of Mullaghboy Private Residential Home, 88 Warren Road, Donaghadee, died on 7 May 2017.

2. In her evidence to the Inquest, Mrs Christine Cameron, daughter of the deceased, stated that the deceased became a resident of Mullaghboy Nursing Home ("the Nursing Home") around the end of 2014. She described the deceased as being frail, he had suffered a heart attack and was unable to look after himself. She would visit him on Monday each week and take him out. Mrs Cameron explained that he was unable to walk due to a bad hip and having arthritis but would manage a few steps.

3. In July 2016 the deceased fell from his bed in the Nursing Home as he tried to move from the bed to his chair and broke his hip in several places. He was taken to the Ulster Hospital, Dundonald, but according to Mrs Cameron, the surgeon stated that he was too old and frail to survive a hip replacement operation.

4. Mrs Cameron expressed a wish for the deceased to have a hip replacement but realised that was not an option. The deceased was returned to the Nursing Home around one week later and Mrs Cameron stated that, throughout 2016, she continually expressed her concerns to the Nursing Home staff about the deceased's pain.

5. The deceased was readmitted to the Ulster Hospital on 12 August after his GP, Dr Hiscocks, had seen him on 9, 10 and 12 August. At this time the

deceased was confused and, after speaking with Mrs Cameron, he was admitted to the hospital.

6. On 14 August the hospital spoke with Mrs Cameron regarding the discharge plan.

7. Mrs Cameron stated that, on Tuesday 11 October 2016, she contacted Ms Shirley Pyper, the deceased's social worker, to express her concerns regarding the deceased's health and care within the Nursing Home. Shirley Pyper was unaware that the deceased had fallen and broken his hip.

8. On 27 October 2016, according to Mrs Cameron, she was informed by the Nursing Home manager, Ms Anne Dugan, that the deceased had a sore on his right foot, due to him rubbing it with his other leg. It was the size of a 50 pence piece and, as time went by, Mrs Cameron explained that the open sore was getting larger. Ms Dugan explained that it was being treated with Manuka Honey, as per the instructions of the Tissue Viability Wound Specialist Team.

9. Mrs Cameron explained that, on 28 October 2016, she received a phone call from Dr Sloan GP, who advised that he was with the deceased and that the deceased had blood poisoning, he had prescribed a liquid antibiotic and the deceased was to be treated palliatively. Mrs Cameron asked for the deceased to be taken to hospital and, according to Mrs Cameron, Dr Sloan refused, stating that the deceased had no veins to receive intravenous antibiotics.

10. Mrs Cameron was referred to the GP notes and records at various times throughout her evidence. She accepted that the GP notes and records, which were made contemporaneously, would be more reliable than her recollection.

11. The entry in the GP notes for 28 October reads as follows:

> "Dr Chris Sloan at Nursing Home
>
> History- reviewed-remains frail++ ongoing diarrhoea. TVN saw this am and likely has ulcer on foot;
>
> Examination- infected ulcer on foot. Temp 37.4 responds to voice but drowsy and confused. Long chat with NOK Christine Cameron on phone- joint agreement to shift priority of care to palliative instead of curative. little to be gained by another referral to hospital- is almost certainly going to be managed conservatively for any condition. Christine feels in addition to this a hospital admission would cause him

to deteriorate further as it has done in the past. She understands that I don't feel Jimmy is likely to improve significantly. Plan therefore – staff will push oral fluids…

Medication- Flucloxacillin Oral solution."

12. Mrs Cameron stated that, due to her persistence, the deceased was admitted to hospital on 31 October 2016. The GP entry for this date, that is 31 October 2016, reads:

> "Dr Chris Sloan at third party consultation;
>
> Long chat with daughter Christine. Doesn't appear to have remembered much of our lengthy discussion on Friday. Asking for very specific prognosis of father- exact nature and site of infection/ whether or not he will improve or deteriorate and a time scale on whether or not this will happen.
>
> History- .. the fundamental question is whether or not to manage aggressively or conservatively/palliatively at home. She appears unsure at present but will discuss with other family members and get back to me if she is keen for a change to the management plan as agreed with her on the phone Friday."

13. In her evidence Mrs Cameron accepted that she did say she would discuss matters with her family and that she talked the issue over with her own children. She did, however, dispute other aspects of these entries and particularly, that she ever agreed a shift to palliative care. In essence, she stated that some parts of the entries were correct and some were not.

14. I am not persuaded by that argument.

15. Later, on 31 October, Mrs Cameron contacted the GP surgery and asked if the deceased could be admitted to hospital and Dr Sloan organised an ambulance accordingly.

16. According to Mrs Cameron, medical staff at the hospital voiced their concerns about the state of the deceased's health and condition and, in particular, she stated in evidence that a nurse told her that, if this was a child, then it would amount to child neglect.

17. On this point I understand that if nursing or medical staff have concerns regarding an individual's health condition then they are able to report same in a formal manner to a social worker. No such report was made in this case.

18. The admission note for 31 October did record; "family concerned re care he has been getting in NH…Daughter unhappy with the GP management of this."

19. According to Mrs Cameron, on 3rd November she spoke with a Professor Trinick, who explained to her that the deceased had been diagnosed with an extreme and severe case of MRSA and C.Diff. Professor Trinick was also concerned with the deceased's weight and loss of appetite. Professor Trinick advised that there was no evidence of a health plan set in place for the deceased whilst he had been in the Nursing Home.

20. Mrs Cameron stated that she was actively considering not sending the deceased back to this Nursing Home but, ultimately did, as she believed the Nursing Home would learn lessons from this, and Ms Dugan the Nursing Home manager accepted in her evidence that such a conversation may well have occurred.

21. The deceased returned to the Nursing Home on 18 November.

22. On 21 November 2016, Mrs Cameron stated that she spoke with Dr Hiscocks, one of the deceased's GPs, and shared with him her opinion, that the medication which had been prescribed to the deceased did not work and caused him to contract C.Diff and MRSA.

23. According to Mrs Cameron Dr Hiscocks stated: "I'm sorry, I let your father down, but that's all you're going to get."

24. That same day, Mrs Cameron stated that she met with Ms Anne Dugan, and asked for the deceased's care plan, which she never received.

25. Mrs Cameron stated that she never received any care plan during the entire time that the deceased was a resident in the Nursing Home. However, she did accept that she had signed a document dated 30 March 2016, which indicated that she had read/seen a care plan.

26. It was explained that the policy within the Nursing Home was not to give out the care plan, but to allow the family/resident to read/review same and that any changes would be notified to the resident/NOK.

27. Mrs Cameron had no recollection of reviewing the plan despite the fact a cover letter to that effect bore her signature.

28. Again, on the same date, Mrs Cameron raised her concerns with Shirley Pyper and, on 29 November, she again spoke with Shirley Pyper, about wishing to make a formal complaint about the Nursing Home in respect of two matters; that they had not attended to the wound on the deceased's foot in a timely fashion; and the fact that the deceased had no skin on his bottom and; and also a complaint that Dr Hiscocks wanted to treat the deceased palliatively.

29. That same day, Mrs Cameron met with Shirley Pyper and Ms Anne Dugan and went through her list of concerns.

30. On 10 January 2017 Mrs Cameron phoned Dr Hiscocks to raise concerns regarding the deceased's foot and hip pain and about the catheter he was using. She said that Dr Hiscocks advised that the deceased had been assessed at the Ulster Hospital on 13 December 2016 and the decision had been taken to treat the deceased's foot palliatively and there was no point in having a physio plan, although he did then advise that he would ask for a physio team to visit the deceased. According to Mrs Cameron, this never happened.

31. It would appear from the GP notes that, on learning that the deceased had been assessed in hospital in December, Dr Hiscocks changed his mind regarding the necessity of a physio assessment.

32. Whilst it was not referred to in her statement, Mrs Cameron did accept, in evidence, that the deceased was readmitted to hospital from 8 February 2017 until 10 March 2017 and then again on 18 March and not 11 March as stated in her statement.

33. On 18 March 2017 the deceased was admitted to Ulster Hospital and Mrs Cameron expressed concern to the doctor that there was no care plan in place for the deceased.

34. The deceased underwent a hip operation and was placed on a six week course of antibiotics. Mrs Cameron accepted that this was not surgery to replace or "fix" the fractured hip but rather this was a washout and debridement of the pressure ulcer on his right hip.

35. Because of the wound on his foot, Mrs Cameron wanted the deceased's foot amputated, as she believed this would save his life. However, Dr Goa

advised that the infection in the foot was contained and the general source of infection was the bones in the deceased's right hip.

36. Mrs Cameron stated in her evidence that she disagreed with the conservative management plan for the deceased's hip.

37. Unfortunately, the deceased passed away on 7 May 2017.

38. In his evidence to the Inquest, Dr Chris Sloan stated that he was a GP with Donaghadee Health Centre. The deceased was a patient registered with this Practice.

39. He first saw the deceased at Mullaghboy Nursing home on 16 January 2015 and thereafter on various occasions throughout 2015, 2016 and 2017.

40. Following the deceased's fall and fracturing of his hip, a discharge letter, dated 3/8/2016, was sent to the GP surgery, advising that the deceased was to be reviewed at the fracture clinic in four weeks' time. Dr Sloan explained that, for this first review appointment, it would be for the GP to arrange transport to the hospital but, thereafter, it would be for the Trust/Nursing Home.

41. On 2 September 2016, a further orthopaedic review letter was sent to the GP surgery, advising that the fracture was suitable for ongoing conservative care and that the deceased was to be reviewed again in 8 weeks' time. Dr Sloan felt that this plan sounded very reasonable.

42. Dr Sloan stated that, on 28 October 2016, he had a long telephone conversation with Mrs Cameron while he was at the Nursing Home, as outlined above.

43. In his evidence, Dr Sloan stated that it was agreed, with Mrs Cameron, that it would be in the deceased's best interests to shift the focus and priority of his care to a palliative approach, instead of a curative approach.

44. Dr Sloan felt that there was limited benefit from another hospital admission and that any treatment would likely be conservative in nature. Indeed, his note records that Christine Cameron suggested that a further hospital admission would likely cause her father to deteriorate, as it had done in the past.

45. Again, as outlined above, Dr Sloan spoke with Mrs Cameron on 31 October 2016 and, according to Dr Sloan, she did not appear to have remembered

much of the conversation on 28 October. Dr Sloan felt that Mrs Cameron appeared unsure as to whether she agreed with a palliative approach. She advised she would discuss this with family members and revert. Mrs Cameron later phoned back and asked that the deceased be admitted to hospital and Dr Sloan arranged for an ambulance.

46. Dr Sloan confirmed that he made these entries in his notes within 30mins of returning from the Nursing Home to the surgery.

47. As regards Dr Sloan's conversation with Mrs Cameron about the deceased's elevated white cell count, he stated that he did not use the term blood poisoning but that there was evidence of an infection.

48. On 2 November 2016, a letter was sent from the Ulster Hospital to the GP surgery, advising that the deceased had informed the hospital that he no longer required a review appointment with Trauma and Orthopaedic Surgery. The deceased was in hospital at this time. Dr Sloan did not recollect seeing this letter and, although it was addressed to his colleague, accepted that this type of correspondence would normally be brought to the attention of the treating GP.

49. Dr Sloan advised that this cancelled appointment was never followed up and that it would have been important to follow it up.

50. Dr Sloan last visited the deceased on 12 April 2017, at the request of Nursing Home staff, as he had just been discharged from another hospital admission. Dr Sloan noted a Do Not Resuscitate Order (DNR) was in place and the deceased appeared extremely frail with minimal oral intake and little urinary output. He was pale and bedbound, although he did state that he was comfortable.

51. The deceased's abdominal and chest examinations were unremarkable and Dr Sloan felt that this was a terminal deterioration and he advised staff in the Nursing Home to keep the deceased as comfortable as possible and to observe the DNR.

52. On 25 April Mrs Cameron phoned Dr Sloan, stating that she felt Nursing Home staff were not feeding the deceased on the basis of poor swallow and she queried whether Dr Sloan had "ordered" staff to do this. Dr Sloan said that he had not discussed this with the staff and he advised that, if there was a concern around poor swallow, then he could make a referral to Speech and

Language, if the Nursing Home requested same, which they did on 28 April 2017.

53. In his evidence to the Inquest, Dr Gareth Hiscocks stated that he was a GP partner with Donaghadee Health Centre. He detailed his encounters with the deceased, his first being on 9 August 2016 when he visited the deceased in the Nursing Home. This was some 3 weeks post a right hip fracture. He was confused and disorientated with decreased appetite and urinary output. He was observed for 48 hrs and, as he did not improve, he was sent to A&E on 12 August 2016.

54. Dr Hiscocks noted that the deceased had pinpoint pupils, a sign of possible opiate overload, and he felt that the opiates should be stopped. He accepted that he was performing a balancing exercise between pain relief and preventing opiate overload.

55. I find, on the balance of probabilities, that this was the correct decision in the circumstances.

56. In his evidence Dr Hiscocks said he believed that the Orthopaedic Surgeons had decided to pursue a conservative path, due to the deceased's co-morbidities. The outworking of this approach was, he believed, to set the deceased on a palliative path and not one of recovery and, one where the deceased would inevitably end up bed bound.

57. Dr Hiscocks accepted that, in August 2016, he did not discuss this with the deceased's daughter, Mrs Cameron.

58. I find that there should have been a proper and fulsome conversation between Mrs Cameron and Dr Hiscocks/Dr Sloan at this time.

59. On 21 November 2016 Dr Hiscocks spoke with Mrs Cameron regarding the deceased's C.Diff and ongoing management. Dr Hiscocks denied that he apologised to Mrs Cameron for letting the deceased down and said that he had no reason to apologise.

60. I do note however, that one-week later Mrs Cameron informed Ms Shirley Pyper that Dr Hiscocks had apologised to her and this was recorded by Ms Pyper.

61. Dr Davis, from the practice, visited the deceased the following day and a physiotherapy referral was advised. A referral was made, but did not happen, as the deceased was in hospital and was unwell.

62. Dr Hiscocks did not believe that the deceased needed to be admitted to hospital earlier than 31 October 2016, which admission was as a result of Mrs Cameron contacting the GP practice and requesting admission.

63. I will return to this aspect of the evidence later.

64. On 28 November 2016 Dr Hiscocks spoke with Mrs Cameron, when she phoned about the deceased's catheter. His discharge letter was reviewed and it stated same was to remain in place for 3 months.

65. On 29 November 2016 Mrs Cameron again contacted Dr Hiscocks, to discuss C.Diff, and she was advised that the stool sample had not yet been processed and clinically, as he did not have diarrhoea, he was free of C.Diff.

66. According to Dr Hiscocks, the deceased was reviewed at the Vascular Clinic at the Royal Victoria Hospital on 13 December 2016 and he was deemed unfit for any surgical intervention.

67. On 10 January 2017 Dr Hiscocks had a telephone encounter with the deceased's daughter, whereby removal of the deceased's urinary catheter was discussed, as well as physio. A trial removal of the catheter was agreed.

68. Dr Hiscocks accepted in his evidence that he had suggested a physiotherapy referral but, on speaking with Ms Dugan from the Nursing Home, Dr Hiscocks learnt that the deceased had been assessed by physio in early December and so he did not make the referral.

69. Dr Hiscocks did not inform Mrs Cameron of this change in plan and he accepted, and I find, that he should have done.

70. In relation to the letter from the Ulster Hospital, dated 2 November 2016, cancelling the orthopaedic review, Dr Hiscocks agreed that the deceased could not have done this and that this should have been followed up.

71. Whilst I find that nothing turns on this missed review, I find that this was more by luck than design, and I find that this cancellation should have been pursued by the GP practice.

72. Dr Hiscocks stated that he had no issue with the care or treatment of the deceased in the Nursing Home, that he had numerous patients resident there and that he had a long relationship with the Nursing Home.

73. In his evidence to the Inquest Mr Lee Edmonds stated that he was a Clinical Nurse Facilitator with the South Eastern Health Social Care Trust ("SEHSCT")

within the field of tissue viability and wound care. On 26 October 2016 he received a referral for the deceased, regarding pressure on his right foot.

74. He called with the Nursing Home to assess the wound on 28 October. He noted that the deceased had a recent history of necrosis to his metatarsus of his right foot. The deceased was bedbound. The wound was 2cm x 2cm. There were no major signs of local wound infection and there was no pain coming from the wound. The deceased had weak or missing pulses in his right foot and he was therefore vulnerable to pressure damage.

75. He advised the Nursing Home how to dress the wound, of the need for an urgent onward podiatry referral and that they should discuss, with his GP, the need to obtain a vascular surgery opinion.

76. Mr Edmonds gave the Nursing Home his original tissue viability assessment and discharged the deceased from his care.

77. In her evidence to the Inquest, Ms Shirley Denise Pyper stated that she was a Monitoring Officer and qualified nurse with SEHSCT. Her role is to assess and review services provided by Care Homes to the Older People who reside within those facilities.

78. Ms Pyper explained that her role was to ensure that a patient was properly placed, review their care, assist family with issues they may have and link in with the GP, Tissue Viability Nurse and other professionals. She stated that, if a Nursing Home had no care plan in place for a resident, then she would address that, although she had never encountered that before.

79. Ms Pyper was passed the deceased's file on 2 September 2015. She outlined her various contacts with both the deceased and Mrs Cameron.

80. She further outlined the concerns raised by Mrs Cameron, regarding the deceased's care, to include his general physical condition, bed sore on his foot, C-Diff infection and the use of incontinence products.

81. Ms Pyper discussed the concerns with her Primary Care Manager on 23 November 2016. The manager informed Ms Pyper that she had spoken with Mrs Cameron about whether or not the deceased wished to move homes and the potential financial implications of this.

82. Ms Pyper stated that a meeting took place on 28 November 2016 between herself, Mr and Mrs Cameron and Ms Anne Dugan, and a number of issues were discussed to include ongoing diarrhoea, who was responsible for

wound care regarding the deceased's foot, unhappiness with the GP for not offering more treatment regarding the ulcer on the foot and communication.

83. Ms Pyper further stated that, if a nurse, or medical staff, had any concerns regarding issues of neglect/abuse, then she would fully expect them to report that to the patient's Social Worker. No such concern was relayed to her in relation to the deceased.

84. Ms Pyper had no concerns as regards the deceased's care in the Nursing home.

85. On 25 April 2017 Ms Pyper was advised, by the acting Primary Care Manager, that the deceased was now nursed in bed and was terminally ill.

86. Mr Andrew Adair, Consultant Orthopaedic Surgeon, gave evidence to the Inquest.

87. He detailed how the deceased was brought to the A & E department of the Ulster Hospital on 23 July 2016 by ambulance. He had a significant medical history and was diagnosed with a fracture of the right proximal femur. Mr Adair explained that the deceased had suffered a complex comminuted fracture which meant, in this case, that he had sustained a three part fracture.

88. The deceased was admitted to a ward under Mr Adair's care. On review by a number of medical practitioners, it was initially felt that the deceased would require surgical intervention. However, at an X-Ray meeting (as referred to by Mr Adair) which would have up to 6 Consultants present, it was decided that, in the best interests of the deceased, the plan would be for conservative management, and this was the course that was pursued.

89. There were no notes or minutes recorded of this meeting.

90. Mr Adair explained that the decision for conservative management is relatively rare, but that the decision was one of risks versus benefits and, in this particular case, the surgery would have been particularly challenging and there was an increased risk of wound breakdown and infection post-surgery.

91. Mr Adair's hope and expectation, with conservative management, was that the deceased would experience a reduction in pain and return to his pre-fall level of mobility which was quite limited. Mr Adair felt that this was a realistic outcome.

92. Alternatively, Mr Adair stated that, if the deceased did not experience a reduction in pain, then he would have considered a Girdlestone procedure or perhaps reconsidered fixation of the fracture, but it would have been a difficult decision.

93. Mr Adair accepted that he did not discuss the conservative management plan with Mrs Cameron but said that, if asked, he would have been happy to do so.

94. Mr Adair found it hard to believe that there would not have been a discussion with the deceased at the time but there was no note of any such discussion and I find, in the absence of any note, that there was no such discussion.

95. I find that good communication is imperative and that it should not be left entirely to a family member to ask about decisions.

96. The deceased was nursed on the ward with analgesia and progressive physiotherapy. He was discharged on 3 August.

97. An x-ray, taken on 12 August, indicated marked diastasis (a gap) and displacement at the fracture site. Mr Adair explained that, as the fracture had not been fixated, then he fully expected there to be movement. In addition, whilst it would not be unreasonable to suggest that the radiologist reviewing this x-ray should have touched base with the orthopaedic team, the radiologist would have been aware of the conservative management plan and any such referral would not have altered this plan.

98. Mr Adair reviewed the deceased at his fracture clinic on 2 September. The deceased was noted to be in no pain, he had a fixed flexion of the hip and knee and an x-ray confirmed there had been no further displacement at the fracture site since the x-ray on 12 August.

99. Mr Adair was of the view that the deceased was suitable for on-going conservative care, with an 8 week review planned, and that matters were going in the right direction.

100. Mr Adair explained that the deceased was re-admitted on 1 November 2016 with pyrexia and foot pain. He had a right foot ulcer and cellulitis. He was discussed by the vascular surgeons at the RVH and his ulcer was treated by the Podiatric service.

101. Mr Adair could not offer any explanation as to why the deceased's review in November was cancelled but, given the fact that the deceased had been in

hospital for periods between November and March, and no issues had been raised regarding the hip, it is likely that no different method of treatment would have been warranted in November.

102. Mr Adair also noted that, between November and February, there were no entries in the GP notes and records referencing the right hip, which again lent support to his view that the conservative management plan was getting somewhere.

103. At the beginning of March 2017, the deceased was admitted to the care of the elderly unit. He was being treated with antibiotics for an infected foot ulcer. There was a pressure sore over the right hip with bone protrusion. His x -ray at this time showed a similar picture to that in September, which further reinforced Mr Adair's view that, had he been reviewed in November, there would have been no change to his treatment plan.

104. The deceased was taken to theatre on 3 March for a wash out and debridement of the wound on the right proximal femur. This procedure was undertaken the day after confirmation of osteomyelitis and thus there was no delay.

105. Mr Adair explained that the hip had ulcerated due to the non-union of the proximal femur, the increasing frailty and weight loss of the deceased and gradual progression of the proximal femur to create a pressure area with skin breakdown.

106. The deceased was discharged from hospital on 10 March.

107. In his evidence to the Inquest, Professor T R Trinick, Consultant Physician and Consultant Chemical Pathologist with the SEHSCT, stated that the deceased was admitted to ward 20 Ulster Hospital, on 1 November 2016. He had a history of a painful right foot for a number of weeks and diarrhoea for the previous week. He was noted as having underlying conditions. He was on antibiotics for the right foot ulcer and his diarrhoea was confirmed as C-Diff which was treated. MRSA was grown from a sample taken from the foot. There were concerns regarding the blood supply to the legs.

108. Mr Baker, vascular surgeon, was contacted and he undertook to see the deceased within two weeks.

109. A CT angiogram was carried out to assess the blood supply to the lower limbs. The abdominal aorta was heavily calcified and part of his femoral

artery was heavily diseased on the left side with the right being occluded through most of its length.

110. Professor Trinick explained that, in effect, the blood vessels to the lower limbs were heavily diseased, which in turn had implications for how the deceased would have responded to the fracture.

111. As regards his encounter with Mrs Cameron, Professor Trinick explained that he did meet with her a number of times and that he was concerned about the deceased's weight and loss of appetite and he may have mentioned that he had not seen a health plan. He clarified however that his comments were not meant as a criticism of the Nursing Home.

112. Professor Trinick stated that he was not concerned about how the deceased was being managed in the Nursing Home and the deceased is noted as saying that he was happy to be returning there.

113. As regards the deceased's admission on 31 October, which had been at the request of Mrs Cameron, Professor Trinick explained that the deceased was very unwell and, if he had not been admitted to hospital at that time, then it was likely things would have ended badly for him, that is, he would have passed away.

114. He was able to discharge the deceased back to the Nursing Home on 19th November but Professor Trinick explained that, at that time, the deceased had a limited life expectancy and was, in fact, approaching end of life.

115. In his evidence to the Inquest, Mr Liam Convie, stated that, at the time, he was a Registrar in the Department of Vascular Surgery at the Royal Victoria Hospital. He first met the deceased on 13 December 2016 at Mr Baker's clinic. His past medical history was noted and, at the time, he had been prescribed antiplatelet and a statin as a secondary prevention for cardiovascular disease. He was holding his right leg in fixed flexion at the hip. It was not possible to straighten the leg. There was no evidence of sepsis and x-rays of the right foot did not demonstrate any evidence of osteomyelitis.

116. As the deceased's foot was not septic, he had multiple serious co-morbidities and a fixed flexion of his right hip, Mr Convie decided to initially pursue a course of conservative management to manage his right foot ulcer. Mr Convie explained that, due to the deceased's leg being in fixed flexion, access to his groin would have been impossible in order to perform stenting of the arteries in the leg and, even if blood flow had been improved above the knee, this

would not necessarily mean the blood flow would have improved below the knee.

117. Because of the condition of the deceased, he would likely have required a number of procedures to attempt surgical improvement of his blood flow.

118. Further vascular surgery outpatients appointments were also made for February and March 2017, although it was unclear what had happened in relation to the intended February appointment and the notes recorded that the March review was cancelled, but not how or why it had been cancelled. In any event, Mr Convie was of the opinion that reviews in February and March would not have altered the conservative management approach at that time.

119. I find that the conservative management approach adopted by Mr Convie was the correct one at that time.

120. In his evidence to the Inquest, Mr Luke Ogonda, Consultant Orthopaedic Surgeon stated that the deceased was referred to him on 22 March 2017. That same day he was seen by an associate specialist in orthopaedics.

121. Mr Ogonda noted, from the A&E flimsy of 18 March 2017, that the deceased was a Nursing Home resident with minimal communication and poor oral intake.

122. On 20 March 2017 he had a discussion with Mrs Cameron and a DNAR was put in place. Mrs Cameron wanted aggressive treatment to be pursued and Mr Ogonda agreed to consider a surgical approach, but only if the deceased was fit for surgery. The surgery contemplated at that time was a mid-foot amputation.

123. Notes made on 21 March recorded that the deceased was not for theatre but rather would be discussed at the x-ray meeting the following morning. Mr Ogonda gave evidence that the deceased was a complex case and hence, his care was discussed at that meeting with a number of orthopaedic surgeons. An ulcer approximately 2cms in diameter was noted over his right fifth metatarsal head with the underlying bone exposed. He had multiple scabs over both legs and, on his left foot, it was noted that he had fixed flexion of his metatarsal phalangeal joints. Antibiotics were continued

124. Mr Ogonda reviewed the deceased on 27 March and he was noted to be confused and frail. His ulcer had improved and, as he did not have features of systemic sepsis, continued conservative management, with regular dressings and antibiotics, was advised.

125. Mr Ogonda determined that surgery was not in the best interest of the deceased. This was agreed with Mrs Cameron.

126. Mr Ogonda reviewed the deceased again on 3rd April and he was improving, although he remained frail and confused. Given the chronic nature of his condition, Mr Ogonda explained that he felt the deceased was likely to deteriorate over time.

127. He was reviewed again on 5 April and his condition remained stable.

128. The deceased was discharged back to the Nursing Home on 11 April 2017.

129. Mr Ogonda stated that the source of the osteomyelitis was the hip. It was caused by the bone protruding through the skin and thus becoming contaminated. As regards the foot ulcer, Mr Ogonda believed that, although the bone here was exposed, it represented a localised infection and, although chronic, it was stable and therefore less likely to have been the source of systemic infection.

130. Mr Ogonda explained that the osteomyelitis developed, not as a result of the deceased sustaining a fracture, but due to the bone penetrating the skin and becoming exposed.

131. I find that Mr Ogonda's decision not to perform surgery was the correct one.

132. In her evidence to the Inquest, Ms Anne Dugan stated that she was the Nurse Manager of Mullaghboy Private Nursing Home, having taken up that position in May 2003.

133. The Nursing Home had 32 residents and the deceased initially entered same in September 2014 for respite care and then became a permanent resident.

134. A pre-admission assessment was performed by her in the Ulster Hospital, where the deceased was an in-patient. He had a history of alcohol dependency and withdrawal symptoms, confusion, frequent falls, chronic obstructive airway disease, heart failure and stroke.

135. Upon admission, care plans were drawn up in relation to the deceased, and daily reports would be compiled, covering any issues that would arise during the day. There would also be monthly evaluations of the care plans, and any changes to a resident's needs would be recorded and signed by the named nurse.

136. Ms Dugan explained that the care plans are voluminous documents and are available for review by family members, and that a discussion about the Care Plan would take place with family members.

137. In addition, Ms Dugan explained that the SEHSCT appointed a care manager, who would visit the Nursing Home, as would inspectors from RQIA.

138. RQIA did not raise any issues as regards the deceased's care plan.

139. The deceased also had a tissue viability nurse who provided advice on how to care for his fragile skin. Dieticians, his GP and a podiatrist all visited the deceased at times during his stay in the Nursing Home.

140. According to Ms Dugan, no member of the multi-disciplinary team ever expressed any concern about the deceased's care whilst he was within the Nursing Home.

141. On 23 July 2016 the deceased broke his hip when, as Ms Dugan explained, he was trying to move from his bed to his bedside chair, which he did daily, and slipped, landing on the floor.

142. An ambulance was subsequently called, the deceased was admitted to hospital and, one week later, he was readmitted to the Nursing Home with a prescription that included paracetamol and butrans patches.

143. In August 2016 Mrs Cameron expressed concern at a care management team meeting, that the deceased was not receiving physiotherapy and rehabilitation.

144. According to Ms Dugan, the reason for this was that the deceased had been assessed for such treatment whilst in hospital and there had been a joint decision, made by the Consultants within the hospital, that such treatment was not going to be of any benefit at this stage in his life, and he was going to remain in bed constantly.

145. In evidence, Ms Dugan could not account for the source of this information but suggested that it may have come from a hospital nurse to a Nursing Home nurse at a handover, who in turn, must have informed Ms Dugan and that she must have recalled the information after a considerable passage of time.

146. I am not persuaded by that explanation and, if that important information had been conveyed at a nursing handover, I would fully expect to have seen a record of such an important conversation.

147. On 16 August 2016, a physiotherapy assessment stated, "unable to give physiotherapy as patient is not compliant with recommended positioning to prevent contractures."

148. Following this assessment, the physiotherapist stated that the Nursing Home was to discuss pain management with the GP.

149. Ms Dugan accepted that there were no entries in the Nursing Home notes to suggest that this had happened and I find that it did not.

150. On 27 October 2016, Ms Dugan informed Mrs Cameron that the deceased had a sore on his right foot due to him rubbing his foot with his other leg whilst he lay in bed. The wound was being treated as per the directions of the tissue viability nurse.

151. Ms Dugan was of the view that the deceased was approaching the end of his natural life and she agreed with Dr Sloan that another hospital admission would be of no benefit. The deceased was treated palliatively as per his GP's directions, with which Ms Dugan agreed.

152. However, following a phone call from Mrs Cameron to Dr Sloan, the deceased was re-admitted to hospital on 31 October 2016, returning on 4 November 2016.

153. In her evidence Ms Dugan stated that Dr Sloan, "eventually gave in and authorised the deceased's transfer to hospital."

154. At this juncture I remind myself of Professor Trinick's evidence that, if the deceased had not been admitted at that time, he would have passed away.

155. Ms Dugan was of the view that Mrs Cameron made all the professionals involved in the deceased's care feel as though they were not doing enough for him.

156. Ms Dugan was aware that the deceased's skin was breaking down in areas and she attributed this to the fact that he was incontinent in urine and sometimes faeces. The deceased had a catheter fitted and this was removed at Mrs Cameron's request, but had to be reinserted after 10 days, as the deceased was unable to advise when he had to toilet.

157. As regards follow up review appointments, Ms Dugan explained that normally the Nursing Home would receive the appointment letters, as they have to organise the transport. She was unaware of the fracture review planned for November, nor the fact that it had been cancelled.

158. The deceased tested positive for both C.Diff and MRSA, although no other resident did and I find that these were not contracted in the Nursing Home. On 7th May staff at the Nursing Home contacted Mrs Cameron to advise that the deceased was deteriorating and he passed away later that same day, at 3.30pm, at the Nursing Home.

159. In his evidence to the Inquest, Mr Robert Duncan, owner of the Nursing Home, stated that his family have operated this Nursing Home since it was established in 1986. Mr Duncan took over control of the three nursing homes that his family owned and operated in 2008. He did not have any specific qualifications relevant to nursing care.

160. Mr Duncan explained that, as the "Registered Person," he monitors the quality of the services in accordance with the Home's written procedures, to ensure the organisation is being managed in accordance with legislation and the Care Standards for Nursing Homes.

161. During his unannounced visits, he would speak with residents, staff and visitors to the Home, to ascertain their level of satisfaction with the care provided, although he stated that he never encountered Mrs Cameron throughout the time that the deceased was a resident.

162. Mr Duncan stated that, on a number of occasions, he spoke with the deceased and the following comments were recorded on the monthly monitoring reports:

> 29th July 2015- Resident A (the deceased) has been in the home for almost a year and speaks very fondly about all of the staff. He says he is happy in the home, enjoys the view and sitting in his room and says that the food provided is very nice. He says he has no concerns about the care being provided;
>
> 1st February 2016- Resident B (the deceased) says that he is very happy in the home and that the staff are all very good to him. He says he enjoys spending time in his room as he enjoys the view of the sea from his chair. He says that he has nothing but good to say about the staff and the home and he has no concerns about any aspect of his care;

March 2016- Resident C (the deceased) says he is happy in Mullaghboy and enjoys spending time in his room because it has a nice view of the sea. He says all the staff are "brilliant" and that they are always "very good" to him. He says he has improved enormously since he has come to Mullaghboy and that he has no concerns about the quality of the care;

27th June 2016- Resident D (the deceased) was enjoying watching television in his room. He said that he is happy in the home, the staff are all good to him and he has no complaints about anything.

163. Mr Duncan outlined the various RQIA inspections the Nursing home underwent and said that any areas of improvement identified were satisfactorily met and none were restated at the next inspection.

164. Mr Duncan explained that any areas of improvement identified would not have impacted the deceased. At the RQIA care inspection on 17 May 2017 there were no recommendations or requirements identified by RQIA.

165. In his evidence Mr Duncan was asked about complaints made by Mrs Cameron, regarding the deceased's care in his Nursing Home. Mr Duncan was unable to recall whether or not he had seen or been made aware of any such complaints. He stated that he had not considered the Complaint records in advance of giving evidence to the Inquest, despite the fact that he had listened each day remotely to the evidence and was not asked to give evidence until day 3 of the Inquest.

166. He could not recollect Mrs Cameron writing to him, he could not recollect responding to her, after RQIA had contacted him, and he appeared to have forgotten that he wrote an email to the RQIA in June 2018, a copy of which formed part of the Nursing Home's disclosure of documents to the Inquest.

167. I found Mr Duncan to be an unimpressive witness, whose failure to properly examine his own records, in preparation for giving evidence, spoke to the seriousness with which he viewed his role as a witness to an Inquest.

168. Dr Amanda Crawford, specialist registration in Geriatric Medicine and General Internal Medicine 2014, gave evidence to the Inquest. She explained that she had been retained on behalf of the Coroner in order to consider all of the papers in the matter and to review the treatment, care and management of the deceased, from his time of admission to the Nursing Home, to his death.

169. Dr Crawford noted that the deceased had an extensive past medical history. Alcohol dependency was first registered in his GP records in 1999 and remained an active issue until his acute admission in October 2014.

170. The deceased's health deteriorated during 2014, resulting in two acute admissions. A coronary angiogram noted significant disease in the circumflex artery and confusion was also noted. A CT scan of his brain showed chronic ischaemia and an old stroke.

171. The deceased became housebound and there were family concerns of self neglect. Confusion continued and he was discharged to the Nursing Home on 19 September 2014.

172. His swallow improved, as did his weight. He had a number of falls within the Nursing Home, which Dr Crawford viewed as being understandable, given the deceased's irreversible medical issues.

173. The deceased sustained a comminuted intertrochanteric right neck of femur fracture as a result of sliding out of bed on 23 July 2016.

174. At this time the deceased was admitted to Ulster Hospital under the care of Mr Adair.

175. Dr Crawford was of the opinion that it evidenced good practice for Mr Adair to discuss the proposed management of the deceased's fracture at an X-ray meeting. She was advised of the factors that Mr Adair took into account when deciding on conservative management or surgery and agreed that they were all reasonable factors to have weighed up.

176. Dr Crawford noted that:

> "there was a clear orthopaedic review plan which I believe was to ensure that conservative management continued to be in Mr McGurk's best interests and to monitor for non-union complications."

177. Dr Crawford had never before come across a fracture, such as this, treated conservatively but she said that, even if the deceased had undergone surgery, the prognosis would still have been poor, and the 30-day mortality rate high.

178. Dr Crawford stated that, following the decision to treat the fracture conservatively, it was likely the deceased would be bed bound or sitting out in his chair. She was also of the opinion that it was reasonable for the GP to

think that the deceased was on a palliative pathway and that he would not recover.

179. Dr Crawford noted that Dr Sloan had spoken at length on the telephone with Mrs Cameron, regarding moving to a palliative approach, and she agreed that it was very important to have such a discussion with family members and to try and have an agreement. However, she advised that treatment is ultimately a medical decision.

180. Dr Crawford also noted the GP's assertion that Mrs Cameron appeared not to recall a lot of this conversation several days later and she said that this would not be unusual, given the level of shock and upset one can incur on hearing a poor prognosis in respect of a loved one. The deceased was again admitted to hospital on 12 August 2016 and, following his discharge back to the Nursing Home, there was ongoing confusion, intermittent agitation and variable oral intake. There was a concern from Nursing Home staff and GP about possible opiate toxicity.

181. The deceased had been discharged on an opiate patch. The GP reduced this and Dr Crawford was of the opinion that both the Nursing Home staff, and the GP, had the deceased's best interests in mind when making decisions regarding his analgesia.

182. The deceased was admitted to the Ulster Hospital on 31 October 2016 and was treated for an infected right foot ulcer and C.diff diarrhoea.

183. A Vascular review decided on conservative management in light of the fact that the deceased was not fit for surgical intervention. Podiatry input was recommended.

184. Dr Crawford was of the view that there was no reason, at that time, for the Nursing Home to consider MRSA as causative for the ulcer infection. Dr Crawford stated that the choice of Flucloxacillin was appropriate and in line with antibiotic guidelines. She noted that the Nursing Home records evidenced appropriate use of a wound chart.

185. A GP review on 28 October 2016 advised further oral antibiotics and palliative care, which Dr Crawford believed was appropriate in light of the deceased's escalating frailty.

186. The deceased developed diarrhoea and was diagnosed, whilst in the Ulster Hospital, with C.Diff. In January 2017 he again developed diarrhoea. A stool sample was sent by the NH on 23 January 2017 with a history of 3-5 days

diarrhoea. C.Diff was confirmed on 24 January and Vancomycin was commenced. He was then admitted to the Ulster Hospital on 8 February 2017.

187. Whilst I find that there was a delay, as regards the management of the C.Diff, on this occasion I find, on the balance of probabilities, that it had no bearing on the outcome.

188. During this hospital admission the chronic right foot ulcer was noted to be sloughy and an x-ray confirmed osteomyelitis. MRSA was isolated and antibiotics commenced. The tissue viability nurse reviewed the deceased, regarding the broken skin around his right hip Mr Ogonda then took over his care.

189. On 18 March 2017 the deceased was readmitted, remaining an inpatient until 11 April 2017. Conservative management of the foot ulcer and hip bone was advised.

190. Dr Crawford was of the view, and I find, that this was appropriate in the circumstances. In fact, Dr Crawford was of the view that palliative care should have been decided earlier in his demise.

191. Dr Crawford concluded that, from the time the deceased sustained his hip fracture, his mortality and morbidity were inherently impacted. There were multiple factors contributing to his decline, namely, the level of frailty, hip fracture, non-union of hip fracture, osteomyelitis and recurrent infections.

192. Dr Crawford advised that there is no procedure in place for elderly patients who sustain fractures to be screened for Osteomyelitis and that such a procedure would not be necessary, it would be unhelpful, and would be too difficult to operate, as Osteomyelitis has no definitive timeframe in which it occurs. In any event, same is picked up on X-ray.

193. I find on the balance of probabilities that, given the deceased's co-morbidities and his frailty, the decision to treat his fracture conservatively was the correct one. I also find that the decision not to amputate his foot was the correct decision, as was Mr Convie's decision to treat the vascular issue conservatively.

194. I find that the Nursing Home did treat and care for the deceased appropriately and that the deceased was happy and content in the Nursing Home.

195. I find that Ms Dugan did contact the GP on numerous occasions when the clinical picture required it.

196. However, I find that Ms Dugan had formed the opinion, following the fracture, that the deceased was on a palliative care pathway and that this did influence her at the end of October 2016, whenever the deceased needed admission to hospital, at Mrs Cameron's request.

197. I find that there was a lack of communication between the Orthopaedic Team and Mrs Cameron surrounding the decision to treat the fracture conservatively. If there had been proper communication, I find that Mrs Cameron would have had a much clearer understanding of the reasons for conservative management, what that actually meant for the deceased, what outcome was expected for him, and that this might have assisted her interaction with other health care professionals subsequently.

198. Although Mr Adair believed that the deceased might be expected to recover towards his limited, pre-accident, baseline position, I find that this was more a hope than an expectation and I find that Drs Sloan and Hiscocks equated the decision to treat the fracture by conservative management with a decision by the hospital doctors to place the deceased on a palliative care pathway and that this coloured their approach to how they dealt with the deceased.

199. Again, I find that, whilst there were numerous contacts between Mrs Cameron and Drs Sloan and Hiscocks, the communication was, at times, of a poor quality. Whilst there is a well-documented note regarding the conversation on 28 October 2016 and again on 31 October 2016, I find that there needed to be a face-to-face consultation and a difficult conversation was required.

200. This lack of communication led to difficulty on all sides, contributed to Mrs Cameron's upset and belief that her father was being neglected and perhaps to a perception that Mrs Cameron, in turn, was pestering the health care professionals. This was reflected by Ms Dugan's statement that, on 31 October, the deceased was admitted to hospital as a result of Dr Sloan 'giving in' to Mrs Cameron. This was at a time when Professor Trinick told the Inquest that the deceased was very unwell and required hospital admission.

201. I find that Mrs Cameron did initially agree with Dr Sloan to "shift priority of care to palliative…." as recorded by Dr Sloan in his notes on that date, and I find that Mrs Cameron, after giving the matter much thought, changed her

mind and that, as soon as she asked Dr Sloan to admit the deceased to hospital, he immediately acted upon that request.

202. I find that the deceased needed admission to hospital, and that the admission was made only at the request of Mrs Cameron.

203. I find that, even though the deceased was admitted to hospital on 31 October as a result of a request from Mrs Cameron, the GPs had correctly viewed the deceased as palliative around this time and this time frame was supported by Dr Crawford.

204. There was a failure in communication also between the Trust's Orthopaedic Department doctors and the GPs, which left the deceased discharged by Mr Adair in the belief that reasonable recovery was possible, back to a low baseline, while the GPs felt that he had been placed on a palliative pathway.

205. I find that the cancellation of the November orthopaedic review should have been followed up by Dr Sloan, and Dr Hiscocks, and that Mrs Cameron should have been informed of the decision not to seek a physiotherapy referral in January, again symptomatic of poor communication.

206. The evidence has shown the importance of making good notes and records. These have been to the assistance of the medical, nursing and GP witnesses in supporting their evidence. However, the absence of notes pertaining to the x-ray meetings as described by Mr Adair is difficult to justify particularly when it is in these meetings that fundamental decisions are taken regarding the most difficult cases.

207. The evidence suggests that notes of these meetings such be made and that such a policy should be incepted forthwith.

208. Notwithstanding these findings, I find they did not have any impact on the outcome.

209. I find that all of those involved in the care and treatment of the deceased acted at all times in the best interests of the deceased.

210 The deceased was undoubtedly a very unwell individual. He was unsuitable for surgical fixation of his hip fracture and he was unsuitable for vascular surgery to improve the poor blood flow to his lower limbs.

211. Notwithstanding Mr Adair's hope that he might make a measure of recovery, I find that the deceased was a man with limited reserves in terms of health.

He was weakened by the effect of the hip fracture, compounded by a series of infections, a foot ulcer caused by poor vascular condition to his lower limbs, reduced mobility, confusion caused by medication to control his pain, and reduced consumption of nutrition and fluids.

212. I find that Mrs Cameron understandably did not wish to confront or accept the reality of how seriously ill the deceased was following his fracture and, whilst she believed that the deceased was entitled at all times to "a fighting chance", I find that a robust and timely conversation with the medical professionals involved may have brought the reality of the deceased's extremely poor prognosis into sharp focus. This may have assisted Mrs Cameron in her decision making.

213. Osteomyelitis represented a final insult that the deceased could not survive. This chain of events flowed from the hip fracture in spite of, and not because of, the efforts of those seeking to care for the deceased.

214. I find that the cause of death as already registered is:

I(a) Osteomyelitis;

II. Fracture Right Neck of Femur, Peripheral Vascular Disease.