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IN THE CORONERS COURT FOR NORTHERN IRELAND

IN THE MATTER OF

AN INQUEST INTO THE DEATH OF

Melanie Catherine Evans

Before: Coroner Patrick McGurgan

[1] The deceased, Melanie Catherine Evans, born on the 12th October 1979, of 45 Knockmore Road, Stratore, Derrygonnelly, Enniskillen, died on the 18th October 2015.

[2] In his evidence to the Inquest, Dr Michael McCavert, Out Of Hours (OOH) GP, stated that the deceased attended with him on the 13th October 2015 at 8.23pm. She had initially attended the Emergency Department (ED) of the South West Acute Hospital (SWAH) Enniskillen and was referred to the OOH doctor. She had a label of sore throat and difficulty swallowing.

[3] The deceased informed Dr McCavert that she had onset sore throat from around 4pm that afternoon with difficulty swallowing. The deceased denied any allergies to drugs or foods and was on no medication.

[4] On examination Dr McCavert noted that the deceased found it sore to speak and swallowing her saliva was painful and her voice was affected. There was no drooling noted at that time. The deceased's neck was tender on the right side, at the front, with no obvious lumps and Dr McCavert thought that the deceased's uvula was swollen. He diagnosed throat oedema "presumably allergic" and prescribed loratadine and prednisolone orally.

[5] In his evidence, Dr McCavert stated that he was not absolutely sure what was wrong with the deceased and that her presentation was outside the norm of sore

throats that he would examine. As a result, he referred her back to ED having examined the deceased for some 28 minutes himself. Dr McCavert explained that epiglottitis is extremely rare and that he had never encountered a patient before with same.

[6] I find that Dr McCavert acted appropriately and timely as regards his involvement with the deceased.

[7] In his evidence to the Inquest, Dr Ian Crawford, Consultant in Emergency Medicine stated that the deceased had initially been triaged at 7.57pm by the triage nurse and referred to the GP Out Of Hours, Dr McCavert.

[8] Dr Crawford advised that the deceased was re-triaged at 9.01pm and seen by a locum Emergency Department Doctor Weigang at 10.17pm. Dr Crawford himself at no time encountered the deceased but having reviewed the notes and records he noted that the deceased was noted to be complaining of a sore throat and right ear with difficulty swallowing and a swollen uvula. Dr Weigang treated the deceased as having an anaphylactic reaction and prescribed various medications. Dr Weigang referred the deceased to the medical unit for admission at 10.39pm and the deceased was subsequently transferred to Ward 1 on 14th October at 12.10am.

[9] I find that Dr Weigang acted in an appropriate and timely manner.

[10] Dr Crawford explained to the Inquest that he himself had experienced a patient with epiglottitis on one previous occasion whilst in Manchester Royal Infirmary. This condition would historically be mostly seen in children although a vaccine now being administered is eradicating its occurrence in children and consequently in those children as they move into adulthood. Dr Crawford was aware of the guidelines drawn up by SWAH in the aftermath of this tragedy. He was of the opinion that the guidelines as drafted could be further refined so that there can be little ambiguity as to what would trigger a referral to ENT in Altnagelvin. He was further of the opinion that there was nothing that could have been done differently here as the deceased's presentation to hospital could have been due to a variety of causes and indeed some of the initial treatment would have treated some of the symptoms of epiglottitis even though they were administered for the incorrect reason. Dr Crawford was unaware of any guidelines existing prior to this tragedy.

[11] Dr Omar Ben-Khiaron gave evidence to the Inquest. He stated that he first encountered the deceased on the 14th October 2015 at 8.15am during the post-take ward round. A history was recorded and systemic review showed that she had PV bleeding for a few weeks; otherwise she was fine. There were no respiratory,

neurological, cardiac or gastrointestinal tract symptoms. There was mild tenderness on the right side of the neck, mild tenderness in the abdomen but no rash.

[12] According to Dr Ben-Khiaron the working diagnosis was that of a throat infection with query allergic reaction. Blood tests showed a mild elevation of inflammatory markers.

[13] The deceased wished to be discharged and treated with oral antibiotics but Dr Ben-Khiaron indicated to her that he wished for her to have more intravenous antibiotics which she had been commenced on and wanted further observations to be performed first. This was Dr Ben-Khiaron's only involvement with the deceased on the 14th October 2015. I will return to this evidence.

[14] At 1.15pm the deceased was reviewed by Dr Azhar Ayob, Speciality Doctor in General Medicine, as she continued to complain of a sore throat. Dr Ayob stated in his evidence to the Inquest that he had been tasked by nursing staff to review the deceased in order to confirm that she could be discharged. He entered her side room and noted that the deceased appeared well with no signs of respiratory compromise. The deceased was able to swallow oral antibiotics and had tolerated some soup at lunchtime. The deceased continued to complain of a sore throat. Dr Ayob suggested the use of mouthwash for soothing effect and simple oral analgesia. He also suggested that the deceased be reviewed later that day probably to be discharged home if she was able to eat and drink normally.

[15] Dr Ayob told the Inquest that he had not considered a diagnosis of epiglottitis and that his review was really an ad-hoc review to essentially confirm if the deceased could be discharged. There was no mention of such a diagnosis in the deceased's notes from the morning ward round when Dr Ben-Khiaron had examined the deceased. He had never encountered an adult with epiglottitis before but he had known about it from medical school. At that time in SWAH he was unaware that there was a pathway for patients such as the deceased but he was now aware of such a pathway. If he had considered epiglottitis then he would have referred his concerns back to Dr Ben-Khiaron.

[15] I find that in the circumstances Dr Ayob acted appropriately.

[16] According to Dr Ben-Khiaron, from the notes and records, the deceased was reviewed at 4.30pm and was noted to be settled and asleep. At 5.00 pm the deceased had become very anxious and tearful, was in severe pain and complaining of difficulty in swallowing with a temperature of 38. A nurse was informed to review the patient and to consider blood culture. At 5.50pm a nurse entered the deceased's room in order to obtain the blood culture and noted that the deceased

was struggling to breathe, was very blue grey in colour and the medical team was called and CPR commenced. There followed a successful return of circulation and the deceased was then intubated and transferred to ICU. Dr Ben-Khiaron again saw the deceased at 10.15am in ICU on 15th October where she was sedated and on a ventilator. She was subsequently transferred that day to ICU in Altnagelvin Hospital.

[17] Dr Ben-Khiaron explained to the Inquest that he had never before encountered epiglottitis nor indeed had he heard of it. At the time a person presenting with the deceased's symptoms was admitted to the general medical ward as there was no ENT ward and indeed there continues to be no ENT ward in SWAH. Now, according to Dr Ben-Khiaron if the deceased was to present with the same symptoms ED would contact the on-call ENT doctor in Altnagelvin and transfer the patient to that hospital. A patient presenting with throat symptoms would either be considered for discharge by ED home or transferred to Altnagelvin. Such a patient would no longer be admitted to the general medical ward.

[18] Given that the deceased had no symptoms of drooling nor had a fever at the ward round, but had mild pain, a red throat and slightly enlarged tonsil, Dr Ben-Khiaron felt that the deceased was suffering from a throat infection rather than something more sinister.

[19] Dr Ben-Khiaron accepted in his evidence that the deceased became progressively worse from his encounter with her at the 8.15am ward round. In fact he was of the view that the deceased should have been referred to ENT at 1.15pm as she had not improved. He was further of the view that at 5pm when she was discovered to be in distress with a high temperature she should have been assessed by a doctor and that a delay of 50 minutes from 5pm until 5.50pm was too long.

[20] Dr Ben-Kbiaron was not aware of any guidelines being in place prior to this tragedy. I find that Dr Ben-Khiaron in the circumstances acted appropriately.

[21] In his evidence to the Inquest, Dr William Holmes, Speciality Anaesthetist, stated that on the evening of 14th October 2015 he was summoned to Ward 1 in SWAH to attend to the deceased who was in extremis. Dr Holmes found the deceased to be comatose and cyanosed but with a weak pulse that soon disappeared. She was intubated with great difficulty because of massive swelling in her throat, in fact, so much so that he could not identify the larynx. Dr Holmes managed to pass the endo-tracheal tube and ventilate the lungs. Some spontaneous respiration returned but the deceased remained unconscious. The deceased was then transferred to ICU where her lungs were ventilated with 50% oxygen. Dr Holmes

stated that he had never encountered epiglottitis in an adult throughout his extensive medical career.

[22] I find that Dr Holmes acted both timely and appropriately and displayed immense skill in being able to place the endo-tracheal tube in the circumstances.

[23] In his statement to the Inquest admitted under Rule 17, Dr D T McGahey, Consultant ENT Head and Neck Surgeon, stated that at the time he was the ENT on call Consultant for Altnagelvin when he received a phone call from Professor Ronan O' Hare, Consultant Anaesthetist at SWAH with regards to the deceased. At that point the deceased was stable and it was agreed that she would remain in SWAH that night on broad spectrum antibiotics and then transfer to Altnagelvin the following day.

[24] Following her transfer on 15th October to Altnagelvin, Dr McGahey saw the deceased in the ICU where he carried out an endoscopy of her upper airway. This showed generalised swelling of her pharynx. A CT scan of her neck and brain were performed and there appeared to be no localised abscess or fluid collection in the neck although there was a significant hypoxic brain injury at this stage.

[25] Brain stem death was subsequently confirmed at Altnagelvin Area Hospital on 18th October 2015 at 11.14am and at 12.05pm.

[26] Mr Keith Trimble, Consultant Otolaryngologist was instructed as an expert on behalf of the Coroner. Dr Trimble stated that the deceased's symptoms were in keeping with epiglottitis with severe discomfort on swallowing, laryngeal tenderness and latterly progressive difficulty in breathing.

[27] Dr Trimble explained that epiglottitis is an acute inflammatory condition that in untreated cases can lead to airway obstruction and death. Rapid onset of a sore throat and painful swallowing are the commonest presenting symptoms. According to Dr Trimble subtle signs present in this case included subjective shortness of breath, tachycardia and rapid symptom onset over 24 hours but he further stated that ENT doctors would be alert for these symptoms and be aware of epiglottitis unlike general medical doctors. In fact Dr Trimble explained that it is very uncommon in adults; affecting approximately 12 adults in Northern Ireland each year.

[28] Dr Trimble was of the view that it was understandable and reasonable for a generalist doctor such as Dr Ben-Khiaron, on the deceased's presentation, to consider a wide range of possible diagnoses and he could understand why epiglottitis was not considered. He stated that at the l.15pm assessment by Dr Ayob the symptoms

were falsely reassuring for the doctor, however, he was further of the view that once difficulty swallowing saliva was noted then this warranted a telephone referral to ENT in Altnagelvin Area Hospital. At 5pm if an urgent medical review by a doctor had been requested, Dr Trimble was of the view that there wold have been a better outcome for the deceased.

[29] Professor Ronan O'Hare, Consultant Anaesthetist and Assistant Director of Acute Services (Medical) at SWAH gave evidence to the Inquest. He explained that prior to this tragedy there were a number of undocumented guidelines for various medical disciplines. Following this tragedy there was a set of guidelines drawn up in respect of patients presenting with sore throats to ED. In effect if a doctor believes that a patient's condition is such that it would warrant admission then a referral is made to ENT in Altnagelvin and the patient is admitted to that hospital as opposed to being admitted to the general medical ward at SWAH.

[30] I acknowledge the difficulties in trying to develop a rigid set of guidelines for a condition such as epiglottitis but I commend those guidelines that have been produced and I am reassured that they are effectively a living document.

[31] The evidence does suggest that it is imperative that those doctors working particularly in ED are made aware of the condition and symptoms, some of which can be quite subtle.

[32] The evidence further suggests that there is a lack of understanding regarding this condition and its symptoms both among GPs and those who are not ENT doctors. The evidence suggests that there needs to be training on this issue, both at undergraduate level and thereafter as part of on-going training.

[33] Professor O'Hare explained to the Inquest that SWAH operate, and did so at the time, HAN which means hospital at night. He described how in an effort to relieve pressures on junior doctors some 10 years ago a system was developed in that at 4.30pm senior nursing staff come onto the wards and review those patients considered to be the most ill. They then are in a position to highlight these particular patients to doctors coming on duty at 9pm.

[34] In this case, a nurse reviewed the deceased at 4.30pm and noted that she was sleeping. Professor O'Hare pointed out that prior to this the deceased had been administered tramadol which would have a strong sedative effect and in hindsight should not have been given to a patient with the deceased's symptoms. He further stated that at 5pm a nurse reviewed the deceased and noting her symptoms recorded a NEWS score of 3. However, she did escalate the matter in that blood cultures were requested and by escalating the matter the deceased would have been

monitored more and brought to the attention of the doctors at 9pm. Professor O'Hare accepted that the nurse could have sought an urgent medical review at 5pm and the fact that this did not occur represented a loss of opportunity in respect of the care and treatment of the deceased. In his evidence to the Inquest, Dr Peter Ingram, Assistant State Pathologist for Northern Ireland, stated that in his extensive career as a Pathologist he had never encountered epiglottitis before. His post-mortem records and I find that death was due to:

1 (a) Cerebral Hypoxia;

Due To:

(b) Upper Airways Occlusion (Clinical Diagnosis) Associated with Epiglottitis.

[35] I find that the deceased should have been assessed by a doctor at 5pm on 14th October 2015 and that not doing so represented a loss of opportunity in respect of the care and treatment of the deceased. Although I find that epiglottitis is an extremely rare condition I find that if the deceased had been assessed at 5pm then on the balance of probabilities I find that the proper treatment would have been commenced immediately and the outcome would have been different.