Neutral Citation No. [2010] NIQB 10

Ref:	**GIL7610**

Judgment: approved by the Court for handing down
*(subject to editorial corrections)**

Delivered:	**28/01/2010**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

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BETWEEN:

MARY BERNADETTE MAGILL AS PERSONAL REPRESENTATIVE OF THE ESTATE OF BRIAN MAGILL (DECEASED)

Plaintiff;

and

ROYAL GROUP OF HOSPITALS
First Named Defendant;

BELFAST CITY HOSPITAL TRUST
Second Named Defendant ;

DR PAMELA LOGUE

MARY BERNADETTE MAGILL AS PERSONAL REPRESENTATIVE OF THE ESTATE OF BRIAN MAGILL (DECEASED)
Plaintiff;

and

ULSTER INDEPENDENT CLINIC
First Named Defendant;

and

DR JOHN COLLINS
Second Named Defendant;

and

MR THOMAS DIAMOND
Third Named Defendant;

and

DR P K ELLIS
Fourth Named Defendant;
and

PROFESSOR R A J SPENCE
Fifth Named Defendant;

MARY BERNADETTE MAGILL
Plaintiff

and
ULSTER INDEPENDENT CLINIC
First Named Defendant;
and

DR JOHN COLLINS
Second Named Defendant;
and

MR THOMAS DIAMOND
Third Named Defendant;
and

DR P K ELLIS
Fourth Named Defendant;
and

PROFESSOR R A J SPENCE
Fifth Named Defendant;
and

ROYAL GROUP OF HOSPITALS
Sixth Named Defendant;
and

BELFAST CITY HOSPITAL TRUST
Seventh Named Defendant;
and

DR PAMELA LOGUE
Eighth Named Defendant.

GILLEN J

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[1] **Paragraph** **Topic**

The Cause of Action

[2] In these three cases the plaintiff, a personal litigant , is the widow of Brian Magill who died on 30 December 1999 (the deceased). There has been a wealth of pleadings, amended pleadings and interlocutory orders in these actions but in essence there are two separate claims. First a claim by the plaintiff as personal representative of the estate of the deceased on foot of the negligence of the defendants and each of them in and about the provision of medical and nursing care, treatment and advice for the deceased. The case

has also been pleaded as a matter of breach of contract in addition but this has not added materially to the issues to be determined. Secondly there is a claim by the plaintiff for nervous shock and damage sustained by her by reason of the same negligence and breach of contract of the defendants. This action came to include a claim against Dr Collins the second named defendant for assault and false imprisonment. The claims against Dr Logue were discontinued shortly prior to the commencement of this trial. It was agreed by all parties at the outset that only the issue of liability would be determined at this stage and that in the event of the plaintiff succeeding a further hearing to deal with quantum would be fixed.

[3] Since in the event it was not a matter of much contention and had no bearing on the substantive issues in this trial, I briefly mention that after hearing submissions on behalf of all parties, I made an order amending certain of the pleadings in the actions to reflect the fact that the plaintiff sued not only in her personal capacity but also in her capacity as administratrix of the estate of the deceased. The full terms are set out in an Order of 23 September 2009.

[4] Mr Elliott QC appeared with Mr Lavery on behalf of Dr Ellis, the Royal Group of Hospitals and the Belfast City Hospital Trust (BCH). Mr Millar appeared on behalf of the Ulster Independent Clinic (UIC) and Professor Spence in relation to private medical care provided by him to the deceased between 9 December 1999 and 17 December 1999 (and thus not in Professor Spence's capacity as an employee of the BCH Trust where he acted as a NHS consultant). Mr Park appeared on behalf of Dr John Collins and Mr Diamond. The plaintiff represented herself throughout the proceedings before me. The trial lasted approximately 45 days.

[5] I take the opportunity at this stage of my judgment to note that a very large number of medical experts, other than the defendants with whom I shall deal separately, were called by all parties. I observe that without exception I found all of these experts to be of the highest calibre professionally. The multiplicity of such witnesses has not allowed me to accord to them individually the professional credit that each merited for the skill, thought and time that they, individually and collectively invested in the issues in this case. Rarely has a court been privileged to have assistance from such a wide array of distinguished international consultants. I add a particular note of judicial gratitude for those who travelled long distances across international borders—in the case of Dr Rauws from Amsterdam on three separate occasions - to attend in order to further the interests of justice in this case. That in some instances I have preferred the evidence of one over another is no adverse reflection on their professional expertise but rather an indication on my part of the need to consider this case in the context of differing bodies of professional opinion in specific medical disciplines.

Background Information

[6] Although in some instances there was a serious division of opinion between reputable experts both as to the findings and the interpretation of matters that occurred over 10 years ago, the following background material was either uncontentious or ,where it was, I have made a finding of fact to this effect.

[7] The deceased, a retired bank manager aged 66 years at death, has been described by his wife the plaintiff as a reasonably fit man prior to his admission to the Ulster Independent Clinic in December 1999. In 1999 he had suffered from an itch and rash on his trunk/back/legs and arms requiring medication. He subsequently developed jaundice. On 7 December 1999, having sought medical attention at Portrush Medical Centre for a blood sample, his general practitioner Dr Logue diagnosed inflammation/bile duct stones or a serious malignant state. Consequently the plaintiff telephoned Professor Roy Spence (Professor Spence) who arranged an appointment at the outpatients' clinic at the Ulster Independent Clinic (UIC) on 9 December 1999. The deceased had previously been under the care of Professor Spence in 1996 with rectal bleeding when a diagnosis of diverticulitis was made, a condition which can cause constipation, diarrhoea, cramps and occasional bleeding. Professor Spence alleged in evidence that on examination in 1999 the deceased looked unwell, jaundiced and had an enlarged liver. I accept the evidence of Professor Spence that obstructive jaundice can be caused, inter alia, by cancer of the head of the pancreas, gallstones in the bile duct (these two causes account for about 90% of jaundice in middle aged men) and the remaining 10% include a stricture of the bile duct which can be benign or malignant. In the event it proved to be the case that this man did have a malignant stricture of the bile duct namely a cholangiocarcinoma (hereinafter described as "CC").

[8] Professor Spence thereafter remained in overall charge of Mr Magill's care between 9 December 1999 and 17 December 1999 overseeing his care as an inpatient at the UIC and coordinating the investigation of his condition by various other experts, He was sufficiently concerned that he immediately arranged the patient's admission to UIC. An ultrasound scan (USS) was carried on the evening of 9 December 1999 by a radiologist Dr Crothers and subsequently, after his admission to UIC on 10 December 1999, a CT scan (CTS) of the abdomen on 13 December 1999 was performed by Dr Crothers. According to the note made by Dr Crothers, this revealed a dilated common hepatic duct with marked intra hepatic biliary dilatation on both lobes of the liver. The head of the pancreas was reasonably well visualised and no obvious mass was identified. Even though the head of the pancreas did not seem to be a difficulty, USS is not an infallible guide to the condition and so the CT scan was arranged.

[9] Professor Spence then referred Mr Magill to Dr Collins, Consultant Gastroenterologist at the Royal Victoria Hospital (RVH). Dr Collins considered that an endoscope retrograde cholangio-pancreaticogram (ERCP) was necessary to define the cause of the obstructive jaundice which he duly performed on 14 December 1999. The process involves the patient being sedated, an endoscope then being introduced through the mouth and inserted past the oesophagus, stomach etc and eventually into the bile duct. Contrast is then introduced therein. The endoscopist sees these events in real time on a monitor during the course of what has been described as a dynamic process. As occurred in this case some spot films may be taken (3 in this case) but these spot films are said by Dr Collins to be no substitute for what the endoscopist views on the monitor during the process. The procedure was carried out with prophylactic intravenous antibiotics.

[10] According to Dr Collins the ERCP confirmed a stricture in the upper common hepatic duct involving the bifurcation of the left and right hepatic ducts. It was his contention that the most likely diagnosis was that of a hilar cholangiocarcinoma tumour.

[11] It was Dr Collins' evidence that due to the tightness of the stricturing only small biliary stents for the purpose of drainage could be inserted namely a 5 and 7 French stent in the right hepatic duct. He was unable to drain the left side due to the stricture.

[12] Both the need for an ERCP and the manner in which it was carried out were matters of dispute in this case It was the plaintiff's contention that infection occurred into the biliary tree at the time of the ERCP when the drainage was not provided. The infection deteriorated in the absence of appropriate treatment causing the consequences which led to his death according to the plaintiff's case.

[13] The condition of Mr Magill after the ERCP procedure has been a matter of contention in this case, with the defendants alleging that nothing of undue concern arose until 21/22 December 1999 whereas the plaintiff alleges that matters of concern were ignored from a much earlier stage. Dr Collins asserted that he had discussed the ERCP findings with Dr Ellis, a consultant interventionist radiologist before conversing with a surgeon, Mr Diamond.

[14] Following the ERCP, Professor Spence consulted the only hepato-biliary surgeon at that time in Northern Ireland namely Mr Diamond of the Mater Hospital who saw the deceased on 15 December 1999. Mr Diamond asserted that, having had the benefit of the deceased's UIC notes records and scans and subsequently Dr Collins' opinion (and thus that of Dr Ellis)on the ERCP findings his view that the lesion was an inoperable type IV hilar CC tumour. He recommended palliation through the insertion of drains placed

by a trans-hepatic approach using a technique called percutaneous trans-hepatic cholangiography (PTC).

[15] This classification and conclusion was challenged by the experts on behalf of the plaintiff who broadly asserted that it was a type 3A tumour on the universally acknowledged Bithmus scale which was operable.

[16] Save for the visits to the RVH for the CT scan on 13 12 99 and the ERCP on 14 December 1999, the deceased remained a patient in the UIC between 10 December 1999 and 17 December 1999. The UIC is an independent hospital with charitable trust status, which opened in 1979. Patients are referred by their GP for consultant care in the clinic. It is not a clinic equipped to carry out ERCP/PTC procedures and does not have an Intensive Care Unit (ICU). The competence of the consultants and nursing staff from that clinic was an issue in the case. In 1999 UIC did not employ medical staff and the patient care was consultant led. If illness arose, the consultant in charge was contacted directly and overnight a consultant was on call.

[17] Between 17 December 1999 and 24 December 1999 the deceased was a patient in the RVH. Subsequent to the ERCP Mr Magill underwent PTC procedures carried out by Dr Ellis on both 17 December 1999 and 20 December 1999 . The delay between the ERCP on 14 December 99 and the first PTC was a matter of contention between the parties. That procedure was described in detail to me by Dr Ellis, consultant interventionist radiologist. It was carried out in a special room suitable for interventional radiology with a sterile atmosphere where air is exchanged between 11/20 times per hour. There is at least one radiographer to ensure good imaging, movement of the image intensifier and the lowest radiation possible. The interventionist radiologist concentrates on the procedure, watching images as they develop on the screen. The patient is placed on a specially designed table where x-rays pass through him and the table into a detector and then on to a TV screen to be witnessed by the consultant. The patient is given at least three medications including an antibiotic, sedative and heavy duty pain killer. This is a very invasive and potentially very painful procedure as access is obtained through the rib cage and interior abdominal wall. There are three reasons for pain. First, there is capsular pain for several hours where the insertions have been made. This in itself needs heavy duty analgesia. Secondly, the drain is inserted through the soft tissue walls and chest. There is no anaesthesia effect after 2 to 3 hours. Thirdly, there may be bile leaks around the catheter which are irritant to the skin and may cause excoriation. Regularly, according to Dr Ellis, a patient will require codeine type drugs and strong paracetamol for two to three days thereafter.

[18] An ultra sound scan with a covered probe to ensure its sterility is employed to choose where the best duct is sited and after application of local

anaesthetic at the site the consultant then attempts to insert a relevant instrument deeply into the liver capsule.

[19] Dr Ellis exhibited to me the various instrumentation used to enter the body. They include a 21 gauge needle (a chiva which has a hollow core), a mandaril guide wire, dilators which pass over the wire and make the insertion hole a little bigger, a sheath which gives access to the bile duct and has a valve which only allows flow in one direction, catheters which are placed through the sheath and which are in various pre shapes to allow the consultant to change direction. The guide wire is passed through the catheter and once the wire is through the stricture, the catheter is then passed over the wire beyond the stricture thus allowing the stents to be inserted. Access is gained through the gap between the eighth and ninth ribs on the right and on the left side just below the sternum. Attempts are then made to get past the stricture on both sides.

[20] The aim was to put in two parallel stents and release them at the same time to form a Y configuration if possible, remaining as permanent features in the bile ducts. Dye is then inserted on both sides into the bile duct and down into the duodenum to allow observation to the consultants. There is a post procedure cholangiogram.

[21] On 17 December 1999 an initial cholangiogram demonstrated obstruction of the right main hepatic duct extending into the origins of the anterior and posterior sectoral ducts. There was also occlusion of the left main duct. A metal stent was placed into the right ductal system and an external drain placed on the left. It was impossible according to Dr Ellis initially to get a stent through the lesion on the left side and therefore an external drain was placed on the left side for drainage.

[22] Over the next 24-48 hours it was a matter of dispute as to how much, if any, bile Mr Magill's external drain produced and thus how successful the PTC had been.

[23] On 20 December 1999 a further metal wall stent was placed across the tumour to achieve drainage from both sides of the liver. This second metal stent was placed across the left hepatic duct stricture into the first metal stent in a T configuration rather than the usual Y configuration because it had proved impossible to put a parallel metal stent on the left side. The aim was therefore to place the stent on the left side across the blockage so that it could drain into the right stent and then drain down into the intestine. It was the defendants' case that these PTCs did achieve some measure of drainage from both lobes of the liver.

[24] It was the plaintiff's case that this procedure had a number of errors and did not drain well or at all. It was contended that the bile, unable to

escape through that stent on the left side, escaped into the peritoneal cavity (the space in the abdomen which allows the organs to move) through the puncture site at the liver causing peritonitis i.e. inflammation in the lining of the abdominal cavity leading to pancreatitis. The infection of the biliary tree amounted to sepsis or ecoli infection of the blood. The plaintiff's case was that the deceased deteriorated thereafter. There thus had been inadequate ERCP management with no alternative method of drainage for 3 days, no recognition of post ERCP symptoms followed by inadequate biliary drainage at the PTCs on 17 and 20 December 1999.

[25] The plaintiff further contended this condition was not treated until 23 December 1999, despite clear signs of infection, with aggressive intravenous fluids and antibiotics i.e. 9 days after the original ERCP. The plaintiff's evidence was that the defendants at various stages ignored symptoms such as the deceased suffering severe abdominal pain, fever, rigors, lack of appetite, nausea and passing black tarry stools all of which were indiciae of infection, peritonitis, septic shock, pancreatitis, multi-organ failure etc.

[26] The nature and degree of a number of allegedly rancorous verbal exchanges between the plaintiff and medical staff and nurses at the RVH during this period was a matter of much dispute during the case and included an allegation by Mrs Magill that Dr Collins had assaulted and falsely imprisoned her on 24 December 1999. I shall deal with the salient exchanges during this judgment.

[27] According to the defendants it was only from 22 December 1999 onwards that more serious symptoms started to emerge in the light of a report from the bacteriology department showing that his blood cultures revealed an ecoli gram negative rod infection. His condition deteriorated on 23 December 1999. An intensive care opinion was obtained and the matter discussed with the specialists in the renal department of BCH but neither haemodialysis nor immediate transfer to the ICU was required at that time according to the defendants. A central venous line was inserted by an anaesthetist. An unfolding pattern of non improving blood pressure and poor urinary output emerged.

[28] The treatment the deceased received from medical and nursing staff in the RVH, and in particular the events surrounding 23 and 24 December 1999 were much in dispute during the trial.

[29] Following the breakdown in relations between Mrs Magill and medical and nursing staff at the RVH and with Dr Collins in particular on 24 December 1999, Mr Magill was transferred to the High Dependency Unit of the Belfast City Hospital under the care of Professor Spence. He remained at the BCH between 24 December 1999 and his death on 30 December 1999. The

reasoning behind the transfer and the medical advisability of doing so was a matter of contention.

[30] On arrival at BCH it is clear that Mr Magill at that stage was suffering from renal difficulties, sepsis, hypotension and lack of urinary output. His renal function was deteriorating, he was still jaundiced, and his abdomen was distended. He was given fluid intravenously, drugs and antibiotics to deal with the very low blood pressure and to stabilise his condition. Once again the treatment that was given to the deceased at this time was a matter of dispute between the parties. The defendants contend that initially he improved somewhat but by 26 December 1999, Dr McNamee, a nephrologist at BCH, found him to be confused, lacking in coherence, jaundiced with continued renal failure indicating the sepsis had re-established.

[31] On 28 December 1999 an ultrasound scan and CT scan were performed. Dr McNamee's assertion was that this was to fulfil the need to try and search for the on-going sepsis. The defendants' case was that a CT guided drainage procedure was undertaken and bile stained fluid was aspirated. It was Mrs Magill's assertion that the purpose of this procedure was in fact to replace a metal stent which she alleged had been voided per rectum by the deceased on the 27 December 1999 in her presence and that of a nurse and that this procedure contributed to his demise.

[32] It soon became clear however that the deceased was suffering multi organ failure. Over the few days in the BCH he underwent haemodialysis for his renal failure but despite the support of therapy and continued antibiotics his condition deteriorated as his jaundice worsened and his coagulation deteriorated. On 28 December 1999 Professor Spence considered that owing to rapid deterioration he was not fit for a general anaesthetic to undergo any surgical procedure for example to perform peritoneal toilet. Following discussions with the surgeons, nephrologists and an anaesthetist it was agreed that his continuing care should be palliative. Mr Magill died on 30 December 1999.

[33] A post-mortem examination was undertaken by Professor Crane on 31 December 1999. Professor Crane's report, and his evidence before me, evinced his view that there was an infiltrating CC in the area of the bifurcation of the common hepatic duct. He alleged he sought the view of a histopathologist at the RVH, Dr Sloane, to confirm the presence of a CC tumour. This was a source of complaint from Mrs Magill who challenged not only Dr Sloane's role and the independence of the post-mortem but suggested Dr Collins had tried to influence the outcome. According to Professor Crane, histologically there was acute haemorrhagic pancreatitis with widespread destruction of the glandular tissue and foci of fat necrosis. Professor Crane concluded that following stent insertion, Mr Magill developed septicaemia,

which was further complicated by renal failure and it was these conditions that were eventually responsible for his death.

[34] Before turning to the salient issues to be determined in this case it may be helpful if I set out the legal principles which have governed my considerations.

Legal principles

Clinical Negligence

[35] The general principles of law applicable in clinical negligence cases are rarely in dispute in modern cases. The test set out by McNair J in Bolam v Friern Hospital Management Committee (1957) 1 WLR 582 at 586 has stood the test of time and is so well known that it does not require detailed recitation by me. To all the defendants in this case there is to be applied the standard of the ordinary skilled man or woman exercising and professing to have the skill of a consultant, doctor or nurse as the case may be. They must act in accordance with the practice accepted at the relevant time as proffered by a responsible body of medical and nursing opinion; see also Sidaway v Bethlem Royal Hospital Governors (1985) 1 AER 643 at 649.

[36] The standard of care must reflect clinical practice which stands up to analysis and is not unreasonable. It is for the court, after considering the expert medical evidence, to decide whether the standard of care afforded to this deceased put him at risk.

[37] Given the division of expert opinion in this case, it is appropriate to draw attention to the views expressed by Lord Scarman in Maynard v West Midlands Regional Health Authority (1984) 1 WLR 634 where he said:

> "It is not enough to show that there is a body of confident professional opinion which considers that there was the wrong decision, if there also exists a body of professional opinion, equally confident, which supports the decision as reasonable in the circumstances … Differences of opinion in practice exist, and will always exist in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other but that is no basis for a conclusion of negligence."

[38] That reflects the views expressed in Hunter v Hanley (1955) SC 200. In that case Lord President Clyde dealt with the question of different professional practice in these terms:

> "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty if acting with ordinary care."

[39] In Sidaway's case, Lord Scarman said:

> "In short, the law imposes a duty of care (but) the standard of care is a matter of medical judgment."

[40] The overall situation is well summarised in Jones (Medical Negligence) 2003 4th Edition at paragraph 3-030 where the author states:

> "It will be rare for the courts to condemn as negligence a commonly accepted practice. Only where the risk was, or should have been, obvious to the defendant so that it would have been folly to disregard it will the courts take this step. This point was stressed by Lord Browne-Wilkinson in Bolitho v City and Hackney Health Authority (1998) AC 232 … It would seldom be right, said his Lordship, for a judge to reach the conclusion that views generally held by competent medical experts were unreasonable. It would be wrong to allow the assessment of medical risks and benefits, which was a matter of clinical judgment, to deteriorate in to seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported (3-030). (See also Marriott v West Midlands Health Authority (1999) Lloyd's Rep. Med. 23)."

[41] I was acutely aware during the course of this trial that it was a fairly specialised field of medicine under scrutiny. Accordingly it was likely that the specialists in each area under consideration were few in number and, as far as the UK and Ireland are concerned, in all likelihood they knew each other, having met up at various conferences etc. In such circumstances the court must rigorously guard against the danger of sympathy for a familiar colleague, however unconscious that may be, overriding a detached judgment on his or her performance. I have refreshed my memory several

times during this trial with the cautionary words of Lord Browne-Wilkinson in Bolitho v City and Hackney H.A. [1998] AC 232 at p240:

> "…the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice …the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion had a logical basis. In particular in cases involving…the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have demonstrated a defensible conclusion on the matter."

[42] Many claims arise because of an alleged error in diagnosis which can arise for a variety of reasons. But an error of diagnosis is not necessarily negligence. Ultimately that has to be determined by the requirements of the Bolam test and whether the defendant has acted as a reasonable doctor or nurse in the circumstances. It will depend to a large extent upon the difficulty of making a diagnosis given the symptoms presented, the diagnostic techniques available such as tests or instruments and the dangers associated with the alternative diagnosis (see Jones at para. 4-013). At the same time in arriving at a diagnosis, where there are several doctors involved with one patient, failure to properly communicate with each other will be negligent. See Hucks v Cole [1993] 4 Med L R 393.

[43] In Holmes v Board of Hospital Trustees of the City of London (1977) 81 DLR (3D) 67, the court emphasised that a diagnosis must be judged in the light of facts known at the time to the practitioner when he provided his professional opinion. There is always a danger of "reading history backwards" and judging the events with the benefit of knowledge acquired subsequently. At the same time, despite the passage of time, the practitioner must not be careless, jump to over hasty conclusions (Hess v Erwyn Bissell (1988)45 D.L.R621) or be unprepared to reassess diagnoses where appropriate (Dale v Munthali (1978)D.L.R.388).

[44] Even where a particular condition cannot be diagnosed, the symptoms may be such as to indicate that the claimant is suffering from something serious which needs further investigation, or indeed the difficulty of making a diagnosis may in itself suggest that the doctor or nurse should take

additional precautions for observation or conducting further testing. I respectfully borrow the approach adopted by Bingham LJ in Eckersley v. Binnie [1988] 18 Con. L.R. 1 at p 79 when he gave the following summary of the Bolam test:

> "From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members of his profession in knowledge of new advances, discoveries and developments in his field. He should have such an awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinary competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet".

[45] On the topic of witnesses in such cases a cautionary note is recorded in Jones at paragraph 3-151 as follows:

> "The court must be satisfied that the experts' view constitutes a 'responsible body of professional opinion, experienced in the particular field of medicine concerned.' Thus, on questions of liability it is important to obtain expert opinion in the appropriate speciality …. Where conflicting bodies of opinion are not 'equally competent' or responsible the court is entitled to prefer the evidence of one body of professional opinion over another."

[46] Nursing staff owe a duty of care to the patients in their care. The principle relating to the liability of doctors applies equally to nurses. The nurse must thus attain the standard of competence and skill to be expected from a person holding her post. Very often the nurse's duty is in practice discharged by bringing any concern she has in relation to a patient to the attention of the medical practitioner caring for the patients.

[47] A nurse who fails to take note and act on instructions given her by the attending medical practitioner will be liable for any consequent injury to the patient. See Smith v. Brighton and Lewis HMC, The Times May 2 1958.

[48] In the majority of torts the plaintiff must show that the defendants' wrongdoing caused him actual damage. Accordingly the plaintiff must establish that the defendants' conduct did in fact result in the damage of which the plaintiff complains and the damage is not in law too remote a consequence of the defendants' wrongdoing. Proof of causation is crucial to success. A helpful definition of causation is found in Clerk and Lindsell on Torts 19th Edition at paragraph 2-02 where it is stated:

> "The term 'causation' should be approached with caution. Judges tend to shy away from both scientific and philosophical formulae of causation, preferring to adopt what is said to be a broad commonsense approach. Although in many cases scientific evidence may be absolutely essential in deciding the causation question, the legal method is very different from the scientific method since the lawyer wants to know not simply what events or occurrences contributed to a particular outcome, but whether the defendant should be held liable for that outcome. In the law of tort causes assume significance to the extent that they assist the court in deciding how to attribute responsibility for the claimant's damage."

[49] Thus, in this case if any of the defendants or any servant or agent of the defendants was guilty of negligence, I have to ask myself what evidence exists to link the defendant's wrongdoing to the damage alleged and whether it is sufficient to persuade the court that causation is established. The burden of proving causation rests with the plaintiff. The plaintiff must adduce evidence that it is more likely than not that the tortious conduct of the defendant in fact resulted in the damage of which she complains. If the judge is not able, on the evidence, to resolve the causation issue, but concludes simply that he is not persuaded that the deceased's symptoms were caused by the defendant's breach of duty, he is not required to go further and make a positive diagnosis of the injured party's symptoms. In these circumstances the action fails on the burden of proof. I have to ask if the defendant has caused or substantially contributed to the injury alleged on the balance of probabilities.

[50] In Gregg v Scott (2005) 2 AC 176 at p. 231 Baroness Hale summarised the position as follows:

> "But damage is the gist of negligence. So it can never be enough to show that the defendant has been negligent. The question is still whether his negligence has caused actionable damage."

[51] An issue that was raised in this case was that of a loss of a chance of a better medical outcome for the deceased.

[52] The most recent leading authority on this matter is Gregg v Scott (see above). In that case due to the negligence of his general practitioner, there was a nine month delay in the plaintiff receiving treatment for cancer and this significantly reduced his chances of survival from 42% to 25%. In a split 3:2 majority decision, the House of Lords held that a claim for damages for clinical negligence required proof on a balance of probability that the negligence was the cause of the adverse consequences complained of. An exception would not be made to that requirement so as to allow a percentage reduction in the prospects of a favourable outcome as a recoverable head of damage. Accordingly, absent any argument as to entitlement to damages for extra pain and anxiety referable to the additional treatment made necessary by the delay, the finding that the plaintiff could not show as a matter of probability that the delay in treatment was the cause of his likely premature death he was precluded from an award of damages.

[53] An analysis of the five judgments in Gregg v Scott in Clerk and Lindsell on Torts 19th Edition at para. 2-68 led the authors to the conclusion that in a medical negligence claim it was arguable that a plaintiff could claim for loss of a chance of a better medical outcome only where:

(1) There was significant medical uncertainty about the outcome at the time of alleged negligence (per Lord Nicholls).

(2) The injury which affected the plaintiff's prospects lay in the future at the time of the alleged negligence

(3) The outcome is known

[54] Baroness Hale seemed to contemplate that a modest claim for reduction of life expectancy could arise where the delay in starting treatment had shortened the claimant's life expectancy compared to patients in the claimant's position who received prompt treatment, even if with prompt treatment the patient would probably have died i.e. a modest claim in respect of "lost years" (see paragraph 207 of the judgment).

[55] In short, one of the issues that I might have had to determine was whether or not the deceased's treatment at the hands of the defendants or any of them affected the course of his illness or his prospects of survival.

[56] In the course of the case, largely in order to assist the unrepresented plaintiff I set out in writing some basic tenets of law which would govern the legal principles in the matter. I gave the parties some days to consider the matter and to direct me to any other legal issues. The case, other than the assault and false imprisonment issue, was approached by all parties as one of medical negligence. The represented defendants made some helpful submissions on the issue of negligence. The plaintiff informed me at that time that she had nothing to add. Accordingly it did not surprise me that the closing written submissions by the defendants were confined to the issue of negligence. The plaintiff however, having been granted an extension of time to make her submissions, raised the issue of breach of contract against some of the defendants.

[57] I share the view of the authors Jackson and Powell on "Professional Negligence" 4th Edition at paragraph 6-03 that "most medical treatment is now undertaken under the NHS scheme and there is probably no contract between the patient and those against whom he is treated. Where a medical practitioner is privately engaged he owes a contractual duty to attend and treat the patient and to exercise reasonable skill and care in so doing."

[58] I do not consider those acting in a private capacity here e.g. Professor Spence etc at the UIC faced a greater responsibility than normally fell upon them in the course of the exercise of their ordinary care and skill under the NHS. See Morris v Winsbury –White (1937)4 Aii.E.R.494. Accordingly I respectfully adopt the words of Lord Donaldson M.R. in Hotson v East Berkshire Area Health Authority (1987)1 AC 750 at 760Bwhen he said:

> "I am quite unable to detect any rational basis for a state of the law ,if such it be ,whereby in identical circumstances ,Dr A who treats a patient under the NHS, and whose liability therefore falls to be determined in accordance with the law of tort, should be in a different position from Dr B who treats a patient outside the service, and whose liability therefore falls to be determined in accordance with the law of contract."

[59] No evidence was produced before me to establish that any contractual term imposed on any doctor or nurse in this case was more onerous than the tortious duty. Accordingly in determining this case on the basis of tort I have dealt with all contractual terms arising.

Assault and False Imprisonment

[60] An assault is an act which causes another person to apprehend the infliction of immediate and unlawful force on his person (see Collins v Wilcock (1984) 1 WLR 1172 at 1178). Although in popular language an assault includes a battery, a person may be guilty of an assault without being guilty of a battery. In Cobbett v Gray (1849) 4 Ex. 729 at 744 Pollock C.B. said:

> "… If you raise your fist, within those limits which give you the means of striking, that may be an assault: but if you simply say, at such a distance as that at which you cannot commit an assault, 'I will commit an assault', I think that is not an assault."

[61] Threatening words alone do not amount to an assault. It is not an assault for one person to stand in front of another and refuse to move without touching or threatening him or merely to obstruct his movement as a door or wall could (see Innes v Wylie (1844) 1 C and K 257 and Squires v Botwright (1972) RTR 462. This however only applies if the measures are entirely passive. It is an assault to take active measures to block or obstruct another. In Hepburn v Chief Constable of Thames Valley Police (2002) EWCA Civ 841 Sedley LJ said:

> "While it is not an assault simply to get in someone's way, it is a technical assault to obstruct him in circumstances which make it clear that if they go on they will be stopped forcibly."

[62] To be liable in false imprisonment, it must be demonstrated that the defendant had the necessary intention, as well as the ability, to detain the claimant. It must be shown that had the claimant attempted to leave premises controlled by the defendant, the defendant would have taken steps to stop him. False imprisonment is the "unlawful imposition of constraint on another's freedom of movement from a particular place" (See Collins v Wilcock (1984) 1 WLR 1172 at 1178).

[63] The tort of false imprisonment is established on proof of the fact of imprisonment and the absence of lawful authority to justify that imprisonment. Imprisonment is complete deprivation of liberty for any time, however short, without lawful cause. Any restraint within defined bounds which is a restraint in fact may be an imprisonment (see Meering v Grahame-White Aviation Company (1919) 122 LT 44.

[64] This has been an extremely lengthy trial with a multitude of witnesses. The issues raised have been numerous. As one would expect in a case where pleadings have been drafted by a personal litigant with no legal

qualifications, those issues have not always matched the pleadings and some of the matters pleaded have not been pursued. From an early stage in this case I attempted to crystallise the main thrust of the plaintiff's case in writing for all parties to comment on. Again towards the end of the case I caused to be circulated to the parties a suggested approach to the salient issues to be determined together with the law applicable and set aside a day to discuss the matter. All the parties broadly adopted my suggestions and accordingly I shall now turn to deal with each of the main issues in turn albeit necessarily from time to time there may be a measure of overlap. In each instance, I have relied on the legal principles set out above. I have asked myself whether the plaintiff on the balance of probabilities has proved that the defendants or any of them personally or through their servants or agents have been guilty of negligence applying the Bolam test. Where they have been so guilty, I have gone on to consider whether the act of negligence caused or materially contributed to the deceased's condition and eventual demise.

[65] I shall deal initially with a number of discrete medical issues which were of cardinal importance in this case before assessing the remaining matters against the defendants.

Did the deceased suffer from a cholangiocarcinoma?

[66] This was not really in dispute in the case. In any event I was completely satisfied from the evidence of Professor Burt, the Head of Clinical Services at the Department of Cellular Pathology at Newcastle-upon-Tyne Hospitals that the deceased had suffered from a CC at the hilum with evidence of perineural infiltration. For this conclusion he relied on the histological samples from the liver and biliary system. I am satisfied that the radiological evidence was sufficient to determine that there was a cancer.

[67] I also accept the unchallenged pathological evidence of Professor Spence that one of the chilling aspects of this type of tumour is that its extent can be very difficult to determine. Under microscopic examination it can skip areas as it progresses up or indeed outside the bile duct. What is seen on X-ray may not be the full extent of the tumour. Thus even if the patient was opened up by the surgeon the extent of the tumour might still not be seen.

[68] Any doubt that may have arisen on this issue in earlier times may have its genesis in the conversation which Mrs Magill had with Professor Crane, the State Pathologist on or about the 10 February 2000. Although it had little to do with the main issues in the case given that there was no real dispute about the presence of CC it required to be ventilated because of Mrs Magill's assertion that this episode revealed misfeasance at least on the part of Dr Collins. In view of the tenor of her cross examination of Professor Crane it is appropriate that I deal with this matter now.

[69] It was her evidence that after the death of her husband on 4 January 2000 she telephoned the State Pathologist to find out the cause of death. At that stage he informed her that he found no perforation and that he could not tell her what happened. He asked her to telephone him again on 10 February 2000 which she did. On that date Mrs Magill said that Professor Crane told her he had opened the bile duct and whilst there was an inflammatory state and toughened tissue there was no tumour. She said she was clear that he indicated to her that the diagnosis was as a result of microscopic examination. He asked her to telephone him back again and when she did so, he told her on this occasion that he had found pin pricks of cancer. She asked him if anyone else had been involved and he had said no.

[70] Professor Crane was called to give evidence. He had prepared a report of the post mortem which he had carried out. He said that his procedure is to examine the bile duct grossly, take a section and look at it under the microscope. The naked eye is not always enough for a diagnosis even if he is able to make a provisional diagnosis. He asserted, and I accepted, that this is standard pathological procedure. The dissection occurs at a later date, not at the autopsy, and thus the organ is retained for further dissections. Only then, after the laboratory tests under a microscope, is the final report prepared. In this case for the purposes of dissection and examination under the microscope, Professor Crane said he took 80 slides from the liver after his naked eye examination. The slides showed some degree of autolysis i.e. tissue breakdown which can obscure cellular detail. However he did find some cells that he could not interpret. He examined these and saw infiltration of what he believed was adinocarcinoma i.e. cancer from glandular type tissue. This showed a desmoplastic (i.e. formation of scar tissue) reaction which a tumour will evoke.

[71] Notwithstanding that having formed a view that it was a cholangiocarcinoma, he did not regard himself as a liver expert and he felt it important to have his diagnosis confirmed by someone who was more expert than him. Accordingly he invoked the assistance, for this one issue, of Dr James Sloane who was a histopathologist from the RVH and was an acknowledged expert on liver pathology. He had done this in the past in other cases – possibly two to three times over the previous year. Professor Crane contended that this is standard good practice regularly carried out by his colleagues. Accordingly he brought a tray of slides including the slides that he had looked at to Dr Sloane and in order not to influence him in his diagnosis, asked him to look at them blindly. Dr Sloane knew nothing of the individual or the background of the case. Having examined the slides under a microscope, Dr Sloane concluded that the condition was consistent with CC and commented on the desmoplastic reaction. Dr Sloane suggested that Professor Crane carry out immunohistochemistry testing which is a marker for tumours and helps in diagnosis. That test was done in the hospital laboratory because the State Pathologist did not have those facilities available.

Accordingly the tests were carried out and CEA positivity was established indicating again carcinoma.

[72] Professor Crane accepted that when he spoke to Mrs Magill initially he would not have seen any evidence of the tumour because it had been purely a naked eye examination. There had been no microscopic analysis at that stage. Contrary to Mrs Magill's assertion, he insisted he did not give a definitive diagnosis and did not say he had examined the matter microscopically at that stage. According to him he had simply said that he had not seen any evidence grossly of tumour but could not rule it out. In so far as his evidence differed from Mrs Magill's, I preferred that of Professor Crane. I can see no reason why he would have withheld information from her about the tumour or misled her as to Dr Sloane's involvement. It is common case that this patient did have cholangiocarcinoma. Why would Professor Crane have told Mrs Magill that he had examined the situation under a microscope when in fact he had not? I have not the slightest doubt that there has simply been a misunderstanding on Mrs Magill's part as to what Professor Crane said.

[73] Mrs Magill also took exception to the examination by Dr Sloane on the basis that his connection with the RVH amounted to a lack of independence in the carrying out of the post mortem. I fear this betrays a misunderstanding by Mrs Magill as to what would constitute the "carrying out "of a post mortem. I am satisfied that Professor Crane carried this out properly and independently. The fact that he sought some independent corroboration from Dr Sloane on one matter, without having told him anything of the background of the deceased, does not prima facie flaw the independence of the examination that he carried out. Similarly the presence of Dr Collins at the post mortem – he being the consultant caring for the patient - strikes me as prima facie unobjectionable and does not flaw the process.

[74] Dr Sloane was called to give evidence before me and I found him to be a thoroughly reliable and honest witness in whom I could repose complete trust. He freely admitted the part he had played. I believe him when he told me that he did not know who the patient was when he was carrying out this test and had no contact with Dr Collins at that stage. Mrs Magill cross examined him on the basis that he was a close colleague of Dr Collins with the implied innuendo that this somehow influenced his decision. I regard this allegation as utterly without foundation and I find not the slightest evidence to impugn the integrity of either Dr Sloane or Professor Crane or the independence of the decision making process at the post-mortem .

The classification of hilar cholangiocarcinoma tumours

[75] The classification of the tumour was a major issue during the entirety of this case and requires careful analysis. These tumours are found at the

hepatic bile duct confluence. Attention was first drawn to this group of tumours in a report of 13 patients by Klatskin and accordingly cholangiocarcinoma at the hilum continues to bear his name. Hence throughout the reports before me these were referred to as Klatskin tumours.

[76] Central to the arguments was the classification of such tumours by an internationally renowned hepatobiliary surgeon in Paris Professor Bismuth. He described his classification as early as 1975 and modified it in 1988, as published in 1975 (Surgery, Gynaecology & Obstetrics 1975, volume 140, page 171-8), with added minor changes published in 1988 (Wold Journal of Surgery, 1988; 12: pages 39-47) by Prof. Bismuth et al. This scheme describes type 1 tumours as being entirely below the confluence, type 2 tumours affecting the confluence, type 3 tumours extending to the first order right or left intrahepatic ducts and type 4, added in 1988, as "consisting of type 3A and 3B lesions in which the tumour invades the second bile duct branches involving both segmental ducts." It was common case that if the classification was 1- 3A or 3B the patient was generally able to be explored surgically but if type 4, in general the condition was not operable. A great deal of time was spent in this case dissecting the nature of this classification.

[77] The plaintiff's case was clear. It was crystallised first by Dr Rauws, a very distinguished gastroenterologist from the Academic Medical Centre, Amsterdam, who for over 20 years was mainly involved in treatment of all kinds of hepato-pancreatico-biliary diseases, performing about 600 ERCPs and 400 endoscopic ultrasounds yearly. He has written and contributed to a great number of medical papers in this field. Secondly the plaintiff relied on Professor Lameris, a distinguished radiologist of 30 years standing who was professor of interventionist radiology at the same centre (a teaching hospital) as Dr Rauws in Amsterdam and whose main area was hepatobiliary disease.

[78] In the opinion of these 2 experts, only a type 4 lesion i.e. involving segmental involvement on the left and right ducts made this tumour irresectable. Whilst it was common case that there was segmental involvement of the ducts on the right side, there was no evidence of segmental involvement on the left side. It was the evidence of Dr Rauws that even if there was 1 centimetre of intrusion of the tumour into the left duct it did not intrude into the segmental portions. According to the correct Bismuth classification Mr. Magill's hilar tumour should be staged as Klatskin type 3A which means primary confluence obstructed with extension to right secondary confluence only.

[79] Mr Diamond who it is alleged by the defendants was responsible ultimately for the decision not to resect the deceased's tumour, was a consultant since 1992 in general and hepatobiliary surgery and a senior lecturer in surgery at Queen's University Belfast. Between August 1990 and July 1999 he had been a chef du clinique or senior registrar at the Hepato-

Pancreato-Biliary Surgery and Liver Transplantation Hospital, Paul Brousse in Paris where he had trained with Professor Bismuth. Whilst there, he had co-authored a number of papers with other experts including Professor Bismuth. Four papers which he co-authored with Professor Bismuth were contained in the curriculum vitae of this witness.

[80] Upon Mr Diamond's return to Northern Ireland liver resections were being established in the province and throughout the United Kingdom in cancer patients. Mr Diamond performed the first liver resection for colon cancer metastasis in late 1992 in Northern Ireland. Between 1992 and 1999 as his reputation built up as a hepatobiliary surgeon, he was carrying out 10-12 cases of resections of the liver per year. There are now three hepatobiliary-biliary surgeons in the Mater and last year 38 liver resections between the three of them were carried out. The vast majority of these are as a result of colorectal metastasis.

[81] Mr Diamond thus was a surgeon whereas Dr Rauws was a gastroenterologist and Professor Lameris a radiologist. This surgeon was adamant that it was appropriate to classify the tumour in this instance as a class 4 tumour where it had extended, on the evidence before him emanating from Dr Ellis, 1 centimetre into the trunk of the left duct. Once it had extended so far into the trunk of the left duct, this prevented the surgeon having a sufficiently tumour free margin clear of the segmental area for resection to take place. He contended that radiological assessment could not reveal the full extent of the growth of this tumour and there must be at least clearance of 5 mms beyond where the tumour ends radiologically from the segments to permit appropriate resection to be carried out. Only this method can address the fact that the tumour tends to spread along the wall of the duct. If this is not achieved, it simply means that the tumour will be left after the resection and the procedure will have been unavailing.

[82] Secondly, he asserted that there has to be sufficient bile duct left after the resection to join with a loop at the small intestine in order to provide a route for the bile to flow from the liver down into the intestine—the process of anastomosis . Mr Diamond illustrated this with a diagram from a text book "Surgical Management of Hepatobiliary and Pancreatic Disorders" by Poston and Blumgart 2003 edition (exhibit D15 in this case) which illustrated diagrammatically the need to make a join between the intestine and the bile duct. Self evidently in order to stitch the bile duct to the intestine, a stump – suggested to be 3 mms by Mr Diamond – of the bile duct needs to be free and available.

[83] The test, according to Mr Diamond, is not what is seen radiologically but what the surgeon can achieve. In short, Mr Diamond asserted that Dr Rauws as a Gastroenterologist and Professor Lameris as a radiologist would look at the x-ray images of the ERCP or PTC to make decisions, while a

surgeon such as Mr Diamond would be acutely aware of the practicality of what he had to do and the necessity of ensuring that there was a free margin beyond the x-ray imaging microscopically. Thus what may appear on macroscopic examination not to be a type 4 tumour but rather a type 3A may well be classified as a type 4 by a surgeon after considering the combination of macroscopic spread, microscopic spread and the additional requirement of tumour free length beyond both where the tumour ends radiologically and for the purpose of anastomosis.

[84] Mr Diamond, who had worked with Professor Bismuth, asserted that Bismuth himself emphasised the need for a clear resection margin and he personally had heard him say this on a number of occasions.

[85] I have to determine if Mr Diamond's view accords with a body of competent professional opinion despite the difference in opinion from the plaintiff's experts.

[86] The school of thought outlined by Mr Diamond in distinguishing between the radiological and surgical assessment, found support from a number of sources. First, from Mr Parks, a highly qualified senior lecturer in surgery and general consultant surgeon specialising in hepato-biliary surgery practising in the Royal Infirmary in Edinburgh. This is a tertiary referral hospital closely associated with liver transplants in Scotland and the significant hepato-biliary unit for Scotland. He had a number of extremely distinguished post-graduate honours and awards including the James Four Travelling Fellowship under which he travelled widely worldwide to hepato-biliary units. He has contributed to the leading textbook by Professor Gardiner on hepato-biliary surgery as well as a number of other textbooks including the widely read textbook by Professor Farquarson which is highly regarded in Asia. He has published approximately 120 peer reviewed articles virtually always on hepato-biliary disease.

[87] This witness emphasised the need to ensure a complete oncological clearance before contemplating resection. Mr Parks shared the view of Professor Spence and Mr Diamond that CC is a spreading infiltrating tumour and spreads at the microscopic level. It spreads along the mucosal layer (i.e. the lining of the cells of the duct). The risk in his opinion of leaving a positive resection margin and not obtaining oncological clearance is a vital factor. He added:

> "It should be remembered that the radiological appearance of macroscopic involvement of the biliary ducts often underestimates the microscopic involvement as the tumour spreads along the mucosa and sub mucosa for a distance beyond the radiological level of complete obstruction."

[88] Mr Parks strongly asserted that the need for a tumour free margin of plus 5 mms before resection can be contemplated is a commonly accepted concept amongst surgeons. It was his view that surgeons not only consider the biliary involvement, but also consider the vascular involvement, and the liver remnant that will be there after removal of part of the liver. An emphasis is on not only the quantity of liver left but also the quality.

[89] This surgeon further accepted the assertion by Mr Diamond that 3 mms of bile duct needed to be available in order to connect this to the gastrointestinal tract in order to be able to form a proper seal. Typically 10 to 14 stitches are inserted and these are in individual stitches. He described the requirement "to take an adequate bite" of the bile to ensure that "cheese cutting" does not occur and the stitches simply cut through the bile duct. In other words a surgeon requires an oncology aspect of 5 mms and the additional 3 mms in order to carry out the surgical technique. He contended that this tumour cannot be visualised macroscopically by the naked eye or by the radiologist on the cholangiogram. In his opinion a competent body of surgeons would most definitely take the same view as that of Mr Diamond and the references hereinafter set out in paragraphs 94 et seq in the consensus guidelines in GUT and in Professor Gardiner's textbook.

[90] On the issue of the Bismuth classification, it was Mr Parks' opinion that this is simply a guide or an aid to communications between clinicians and to the establishment of data. It is also of some help in diagnosis. He cautioned however that it is now less commonly used because the original description by Bismuth has evolved into a variety of matters which have changed some of the original criteria. He asserted that there was a body of opinion in North America and the United Kingdom which have moved away from a strict use of the Bismuth classification. Surgeons need to take into account four criteria: first, the resection margin; second, the surgical anastomosis margin; third, the need for vascular support and finally the residual element of liver which is left. In his view a competent body of surgeons act on what they see and not on a strict analysis of the Bismuth classification. In his opinion he had no doubt that a competent body of surgeons, being told that there was a 1 cm involvement of the left hepatic duct in this instance, would have concluded that this was not resectable and came within the type 4 tumour.

[91] I pause to observe that I found Mr Parks to be an astute and incisive witness who in my view gave his evidence honestly and genuinely. I reject entirely the less than veiled suggestion by Mrs Magill that he was biased because Mr Diamond had been one of his supervisors during his undergraduate and postgraduate work and had worked with him for a short time as a colleague. I saw nothing representing bias in his evidence before me since all that he said was backed up by references in the literature and

textbooks. Whilst he has personally undertaken 8/10 klatskin tumour resections, he is part of a team which has undertaken 20/25 per year over a large number of years. I found this witness to be highly expert in his field and someone in whom I could repose confidence and weight when deciding if there was a competent body of surgeons who would have acted as Mr Diamond did on this occasion.

[92] Dr McEniff, the interventionist radiologist from St James Hospital in Dublin, indicated in the course of his evidence that whilst he was a radiologist and not a surgeon, he had attended in recent years many multidisciplinary meetings and had heard the standard view expressed on many occasions that a 5 millimetre tumour free area is required together with 2 to 3 mms in order to permit connection between the duct and the intestine.

[93] He also made the point that this CC invariably grows up the side of the duct and will be much more infiltrative than the scan will show. PTCs, in his experience, regularly "under-size the tumour". In his opinion if it was 1 cm macroscopically on the left side into the left duct, this tumour would undoubtedly be classified as a class 4 tumour by surgeons in his hospital in Dublin. He asserted that in both Ireland and the United States, the GUT guidelines (see next paragraph) are adopted and once there is involvement of the left side of the duct, it is classified as a type IV.

[94] A further source of support for the view of Mr Diamond is found in 2002 "Guidelines for the Diagnosis and Treatment of Cholangiocarcinoma: Consensus Document" published GUT 2002 51 (hereinafter called the "GUT guideline") which deals with the development of guidelines for the optimal diagnosis and treatment of CC. Paragraph 4.11 records:

> "4.11 Resectable tumours –
>
> - Patients' suitability for major surgery should be guided by medical risk factors rather than the age.
> - For Klatskin tumours the Bismuth classification is a guide to the extent of surgery required (aim is tumour free margin of more than 5 mm).
>
> . . .
>
> Survival depends on staging with tumour free margins with the absence of lymphadenopathy being the most important positive prognostic indicator."

[95] The GUT guideline records the extent of duct involvement by tumours as classified by Bismuth and includes the following definition of type 3 and type 4:

> "Type III: tumorous occluding the common hepatic duct and either the right (IIIa) or left (IIIb) hepatic duct;
>
> Type IV: tumorous that are multicentric or that involve the confluence and both the right and left hepatic ducts".

It is not without significance that the reference to the type IV does not refer to the need for segmental involvement.

[96] Dr Rauws asserted that not only were these guidelines published after 1999 but that they were in error in not adhering to his strict interpretation of the Bismuth classification type IV. The fact of the matter is of course that these were guidelines drawn up because there was no clear national consensus for the optimal diagnosis and treatment of cholangiocarcinoma. It is impossible to ignore the distinguished genesis of these guidelines as is evidenced by the description of their development at paragraph 1.1 as follows –

> "The need for these guidelines was highlighted following the annual meeting of the British Association for the Study of Liver in September 2000. During their development these guidelines were presented at a BASL liver cancer workshop in January 2001. They were also circulated to BASL members and the Liver Section of the British Society of Gastroenterology (BSG) committee members, including gastroenterologists, hepatologists, gastroenterological surgeons, pathologists, radiologists and epidemiologists for comments before the final consensus document was drawn up."

[97] The extensive peer reviewing of these guidelines therefore dilutes materially Dr Rauws' criticism of them. It is difficult to see how these authors and reviewers could be classed other than as a body of competent, professional opinion which has approved these guidelines.

[98] Hence I was not surprised to hear the evidence of Professor O'Connor, a consultant gastroenterologist since 1989. He had trained in Dublin, Leeds and Birmingham and is now a consultant gastroenterologist and Professor of Gastroenterology at Adelaide/Meath Hospital and Naas General Hospital.

He has published approximately 70 papers and contributed eight text book chapters on the topic gastroenterology. His special interest is ERCP.

[99] It was his evidence that the GUT guidelines are not only excellent, but reflect the clinical approach by any reasonable group of gastroenterologists to diagnose and manage CC. He regarded them as commonsense guidelines widely used in clinical practice. I observe at this stage that the point made by the plaintiff that these did not apply in 1999 since they were published in 2002 ignores the fact these guidelines purport to be a synthesis of practice that was operating in earlier years.

[100] The need for a tumour free margin of over 5 mm is set out in the leading textbook "Hepatobiliary and Pancreatic Surgery" edited by Professor Garden at page 228:

> " en bloc resection of the supraduodenal common bile duct . . . and extra hepatic ducts . . . is recommended for bismuth type I and II tumours without major vessel involvement. A tumour-free proximal margin of at lest 5 mm is required. Type III tumours require additional hepatic resection. Type IV tumours may require an extended right or left hepatectomy in addition to local resection . . ."

Mr Parks was understandably adamant that this reference to tumour free area referred to all Bisthmus classifications.

[101] I am satisfied that the evidence of independent experts and peer reviewed medical literature of high standing indicate that a responsible body of surgical medical opinion would classify a type 4 Bismuth tumour as Mr Diamond did in this instance namely one materially involving the confluence and the right and left hepatic ducts without the necessity for segmental involvement especially where a substantial intrusion of tumour into the ducts is microscopically visible given the need for a 5mm tumour free margin for resection and an additional 3mms for anastomosis .

Was this tumour resectable?

[102] Mr Diamond concluded that this tumour was not resectable. I have to determine if a reasonable competent body of surgeons would have come to a similar conclusion.

[103] On behalf of the plaintiff Dr Carr-Locke gave evidence on this matter. He was the director of endoscopy at Brigham and Women's Hospital and Associate Professor of Medicine at Harvard Medical School. He was a gastroenterologist with 29 years experience in pancreatic and biliary disease

and who has written extensively in his field. In his opinion there was no evidence there was a cancer which was untreatable on 14 December 1999. He felt that the early conclusion by the defendants that there was such a cancer influenced their decisions throughout the treatment thereafter. Dr Carr-Locke felt it was operable because the CT scan of 13 December 1999 showed that there was no great mass in the area and the tumour had not extended into the blood vessels. There was a 10-15% chance of resectability i.e. 10-15% of the time surgeons will decide to resection in cases such as this. The prospect of success giving five years of life would be in 10-15% of the procedures. In other words 1-2% will survive 5 years if it is resected. It was common case that there is less than 2% chance of success with such tumours.

[104] The view of Dr Rauws was that although better estimations can be made of the length of the tumorous stricture after magnification of the X-rays, the tumour extension did not reach segment 4 and was thus a Klatskin type 3A tumour on the Bismuth scale for which curative resection was indicated.

[105] In his view and that of Professor Lameris, even if tumour was found during surgery to extend to segment 4 resection was still possible by an extended right sided hemihepatectomy with surgical anastomosis made in segments 2-3 of the liver, there being 8 liver segments. Whilst he accepted that an extended right sided hemihepatectomy with surgical anastomosis made on the segments 2-3 was not easy regular surgery, nonetheless this type of extensive surgery was already performed in the units of Professor Bismuth and Professor Blumgart in the early 1980s. He asserted that in Amsterdam this type of surgery was started in the late 1980s - early 1990s. Even in retrospect, after reviewing all pictures and magnifying the PTC pictures, Dr Rauws concluded that Mr. Magill should be staged as a Klatskin type 3A.

[106] Prof. J. Lameris, interventional radiologist, had also concluded that this was a type 3A tumour. He insisted there was no evidence of segmental involvement on the left side in the ERCP. A decision not to resect should not have been taken on the basis of these images. Accordingly he felt there should have been a surgical exploration and a consideration of liver resection if there was a large amount of healthy tissue.

[107] The defendants' case was that it had to be borne in mind that Dr Rauws was a Gastroenterologist and Dr Carr-Lock was an Endoscopist. The decision to proceed to surgery is one for a surgeon to determine. He will of course rely upon the evidence of others but ultimately it is his decision. This was one of a series of occasions in this case where I concluded that it was important that experts did not stray beyond their own area of expertise. It is essential that judges exercise some measure of quality control when assessing on what areas experts are entitled to comment.

[108] A crucial piece of evidence in this regard was the assertion by Dr Ellis that he had taken steps to measure the length of the stricture into the left duct on the ERCP. He did this by taking a reference point of the scope being used (which was 16 mms) and compared that in terms of length with the stricture into the left duct. Using this measured approach, he estimated the length of the stricture on the cholangiogram as amounting to 1 centimetre. He had already informed Dr Collins of his view having originally seen the ERCP and Dr Collins in turn said he passed this on to Mr Diamond on 15 December 1999. Whilst Dr Ellis firmly denied ever having discussed resectability with anyone in this case (it was not his area of expertise as a non surgeon) this was important information for Mr Diamond and I accept it reached him on the 15 December 1999. Dr Ellis was able to confirm the length of this stricture on the left side with the cholangiogram of 20 December 1999 following the PTC procedures.

[109] The evidence of Dr McEniff, the interventionist radiologist called on behalf of the defendants, unequivocally corroborated this measurement. Dr McEniff had taken the cholangiogram and, using the PACS system, had magnified it and brightened it. This became an exhibit in the case. Dr McEniff illustrated to my satisfaction that this improved imaging illustrated definite involvement of the left duct. Adopting as his measuring tool a 10 mm wall stent in the normal duct on the right side, he concluded that there was definitively a 9-11 millimetre incursion into the left duct of the tumour. He checked this by adopting a computer measurement of the 10 millimetre wall stent which provided a pixel measurement of 79.3. He compared that measurement to the length of the tumour appearing in the left duct and found a pixel measurement of 78.8. In other words he was able to say they were in terms the same length i.e. 1 centimetre.

[110] Dr McEniff went further in his evidence to this degree. Looking at the segmental area on the left hand side, he observed narrowing at the branch of the first segment and, further up the left biliary tree, he noticed that the first segment area was narrow and ragged which suggested to him "strongly" that there in fact was segmental involvement in the left side. He was able to illustrate to me the difference in outline between that area of the segmental involvement i.e. narrow and ragged as opposed to other segmental areas which were clear and smooth. This narrowing and irregularity could conceivably be due to infection but he felt that this would be secondary to the tumour. By the time the cholangiogram of 20 December had been taken, the left system had been drained externally for three days and there ought to have been clearance of the swelling and infection. Contending that these tumours are infiltrative and always worse than the imaging shows, it was his belief that this cholangiogram revealed segmental involvement on the left side. Whilst this seemed plausible I confess that I was not convinced by this assertion in the absence of a suggestion to that effect by Dr Ellis or Professor Lameris having the opportunity to comment but my doubt about this

assertion did not in any way deflect me from my complete satisfaction that the measurement of the tumour in the left duct macroscopically was 1 centimetre and not the 1 millimetre originally suggested by Dr Rauws.

[111] Mr Parks also commented on the cholangiogram of 20 December 1999 taken by Dr Ellis. In his opinion this clearly showed filling of the left hepatic duct with a bullet head appearance of the duct which illustrated the tumour spreading up the edge. He describes segment four as being the critical branch. Assessing the width of the stent which was present on the cholangiogram, he assessed that the extent of the tumour had all the appearances of approximately 1 cm. In his opinion, allowing the tumour free area and the anastomosis margin would have taken the necessary free area well beyond segment four. In terms he was satisfied on his own assessment of the cholangiogram that there was significant involvement of the left hepatic duct.

[112] I am satisfied that this amounted to further clear evidence that this tumour was within the category which a competent body of surgeons would have considered to be a type 4 Bismuth classification. That in itself would have been sufficient to persuade me that a competent body of surgeons would have shared the view of Mr Diamond that this tumour was not resectable.

[113] As a more general point, Mr Parks borrowed from a leading and standard hepatobiliary and pancreatic textbook in the UK namely "Hepatobiliary and Pancreatic Surgery" edited by Professor Garden which was first published in 1997 and has now recently been published in its 5th edition. In that book there was a chapter written by Professor Irving Benjamin entitled "Benign and Malignant Lesions of the Biliary Tract". That chapter records that the worldwide experience of resection for hilar carcinoma at that time remained relatively small. Professor Benjamin, who in the 1990s probably had the largest experience of management of cholangiocarcinomas in the UK according to Mr Parks, had only undertaken a relatively small number of hepatic resections. Mr Parks goes on to record:

> "There were a number of reasons for the low numbers of resections, but a major factor was the associated high peri-operative mortality rate which even in highly specialist centres was reported between 10-30% but could be as high as 70%. One of the reasons for this was because of the extent of non tumour liver tissue that must be removed to obtain oncological clearance of the tumour and secondly because of the impaired function of the liver remnant due to the biliary obstruction. Most hepatic resection for biliary cholangiocarcinoma usually involved removing somewhere between 60-80% of the liver volume leaving a small residual

liver which may lead to liver insufficiency and ultimately liver failure."

It is thus a major operation attended by an extremely high mortality rate which should not be undertaken lightly unless the precautions outlined by the surgeons in this case are in place. All of this heightened in the case of Mr Magill the significant risk of not leaving a positive resection margin and not obtaining an oncological clearance.

[114] Mr Parks indicated that matters have improved over the last 10 years with technical improvements occurring with the advent of MRCP scans which in themselves have provided a revolution in the staging of CC. That was certainly not the position in 1999. Further improvements over the past 10 years from a surgical point of view have also been seen in the wake of portal vein immobilisation which allows intervention to block off the blood supply to the liver sections which then atrophy and which in turn encourage hypertrophy or growth of the remaining segments. That is a procedure that arrived in Edinburgh in 2005 and would not have been available for consideration in Belfast in 1999. In Mr Parks' opinion a reasonable body of competent surgeons would have deemed that this would not a resectable case. On the other hand palliation, if that was the judgment call of the surgeon, could well produce 15-18 months of life without the risk of peri-operative death or the impaired quality of life which would be attendant on attempting a resection.

[115] It is important therefore that in considering this case I take what steps I can to ascertain the appropriate standard of treatment by a competent group of practitioners in 1999 and relate this to the care provided to the deceased.

[116] Mr Parks' evidence conformed with the evidence of Mr Diamond who emphasised that it was crucial to ensure that a surgeon does not leave behind too little liver when he has carried out his resection of the liver. Dr Diamond too emphasised the advances in surgical management of this condition over the past 10 years including the use of portal vein immobilisation, the generally improved peri-operative care of patients undergoing major hepatic resection and the improved radiological imaging with the arrival of MRCP. The fact of the matter is that surgery nowadays for this condition may be more aggressive because of modern techniques than was the case in 1999. I must be careful not to invest surgeons in 1999 with knowledge which has been accumulated over the last 10 years or assume that a practice of resectability carried on in Amsterdam was the practice in the UK or Ireland.

[117] I was satisfied therefore that –

- a competent body of interventionist radiologists would have come to the conclusion that there was a tumour 1 centimetre in length extending into the left duct evident on the ERCP and on the cholangiogram of 20 December 1999.
- a competent body of surgeons faced with this conclusion would have determined as Mr Diamond did that no step should be taken to resect this tumour but rather to turn to palliative steps .

[118] Before leaving this topic I have asked myself whether the deceased should have been referred to a more specialist cancer centre e.g. Hammersmith in London on the 13 December 1999 before the ERCP was carried out. In this case I believe that it was reasonable not to do so I accept the evidence of Professor Price and Professor Spence that inevitably any such request would have been refused in the absence of further information to be obtained in an ERCP. No diagnosis was clear from the USS or the CT scan and the evidence of an ERCP would have been insisted on by any such hospital before any consideration of a transfer was given.

Should there have been a multi disciplinary team (MDT) conference

[119] It was the contention of Dr Rauws and Professor Lameris that prior to the decision being taken not to resect the tumour there should have been a multi disciplinary team conference involving a discussion at least between the surgeon, the gastroenterologist and the radiologists pre the ERCP. Dr Rauws gave evidence that he has chaired a MDT meeting since 1992 to consider cases in the Netherlands and to arrive at team decisions. He considered that there was miscommunication in this instance which led to purely palliative treatment for a tumour which should have been resected. Dr Rauws argued that it must have been obvious that it was more likely that the jaundice was a malignancy with high suspicion of hilar lesion once the CT scan/USS had been carried out initially. With that high suspicion of hilar lesion, the matter should have been referred to a joint expert meeting. In the event he contended that Mr Diamond had come to an erroneous conclusion without viewing the ERCP and on the basis of a discussion with Dr Collins.

[120] It was the defence case that in 1999 it was not the practice to have routine MDT discussions . That practice has developed in later years . I found this dispute a largely sterile one given my conclusions as to what in the event happened in this instance. I was satisfied that Professor Spence did coordinate the medical involvement. After seeing the patient on 9 December, his first step was to arrange for Dr Crothers to carry out a USS. The patient was admitted by Professor Spence the next day. A gastro-enterologist, Dr Collins was brought in on 10 December and on 13 December a CT scan is carried out by Dr Crothers. It is clear to me that the possibility of malignant lesion was in the mind of Professor Spence. An ERCP is a well recognised procedure as evidenced by the GUT guidelines. It was necessary to carry out

this ERCP to attempt to diagnose what the problem was and if possible deal with the firm suspicions and preliminary views that were held by Professor Spence as to the presence of a tumour.

[121] Once that had been done, there is clear evidence that Professor Spence then invoked the assistance of a hepato-biliary surgeon, Mr Diamond, who did discuss the matter with Dr Collins. Dr Collins had the benefit of his own assessment of the ERCP as well as of the interventionist radiologist, Dr Ellis, and passed these comments on to Mr Diamond. Professor Spence was therefore carefully following the advice of the other experts that he had involved.

[122] It was the decision of Mr Diamond that this tumour was not resectable and Professor Spence accepted that opinion. I am satisfied therefore that there was sufficient discussion between the experts in this case before the final decision was taken.

[123] Dr Ellis recorded that there are now multi-disciplinary meetings in which he is involved virtually every Friday whereas that was not the practice in 1999. It is an efficient way of gathering together various opinions and expedites treatment. At such meetings the radiologists may describe their findings on the scans at ERCP/PTC, the gastro-enterologist will record his findings and the surgeon will decide if surgery is necessary. This is probably more a product of the greater number of experts now available in the relevant fields. However this is not a forum where, according to Dr Ellis, everyone gives their view on every topic. The radiologists confine themselves to the radiological findings, the surgeon to surgery issues etc. Each discipline must be aware of the dangers of straying into areas outside their own. The fact of the matter is that whilst there was no multi-disciplinary meeting – it was not the norm in 1999 – Mr Diamond had the benefit of all the necessary information before he, and he alone, formed the opinion that this tumour was not resectable.

[124] In the opinion of Dr Ellis, Mr Diamond could not be criticised for not looking at the ERCP because he is not trained in deciphering these whereas Dr Collins and Dr Ellis are the experts. There was a meeting between Dr Ellis and Dr Collins at which they were in complete agreement according to both these witnesses. Dr Collins had told Dr Ellis that he had seen a stricture involving both ducts. Dr Ellis then considered the three images of the ERCP. On the second image he observed stricture involvement on the right hand side and on the left duct a stricture with the presence of contrast beyond that stricture. He demonstrated to me on the ERCP images of 15 December 1999 the presence of contrast within the left duct. As I have earlier indicated he had made a measurement of the stricture on the left side. I accept the evidence of Dr Ellis that he was absolutely certain that there was a presence of a tumour in the left duct, he having seen literally hundreds of ERCPs at an

average of 5-6 every week. It is a common occurrence for Dr Ellis to be asked to perform this task. I am also satisfied that Dr Collins would not be fully au fait with reference points for imaging and that it was not surprising that his analysis of the extent of the tumour into the left duct was less precise than that of Dr Ellis.

[125] The information that Dr Ellis imparted to Dr Collins about the length of the tumour was passed on to Mr Diamond in a manner that would not have radically differed even if there had been a MDT meeting. I considerate inconceivable that Mr Diamond would have challenged the measurement of Dr Ellis or come to any other conclusion.

[126] Dr Ellis emphasised again and again that he did not have any knowledge as to the operability of this tumour because he is not a trained surgeon. Even had there been a MDT meeting he would not have strayed outside his own area. Whereas of course he would have intervened if Mr Diamond had acted against his own radiological findings, but that did not occur in this case.

[127] Professor Spence had thereafter orchestrated Dr Ellis' involvement having given him a brief history of the deceased's condition, discussed the CT scan with him, indicated that Mr Diamond had taken the final decision on surgery namely that his condition was inoperable and had dictated that the role of Dr Ellis was to perform palliative treatment. I find nothing out of the ordinary about this and I do not believe that a MDT meeting would have advanced the matter any further.

[128] Obviously had a multi-disciplinary meeting occurred Dr Ellis would have seen the CT reports from Dr Crothers rather earlier than he did but the CT report from Dr Crothers did not mention a tumour and the presence of the CT scan would have made no difference to the decision as to operability made by Dr Diamond. The CT scan had been seen by an experienced radiologist who saw an obstruction at the helium but that was as far as the matter had gone.

[129] In short I am satisfied that there was an adequate substitution for the absence of a multi-disciplinary agency namely the opinion of experts dealing with the original CT scan/USS namely Dr Crothers, experts on the ERCP namely Dr Collins and Dr Ellis, an expert on surgery namely Mr Diamond and the overarching orchestration by Professor Spence.

[130] Dr Ellis was correct to refuse to stray outside his own field since he would not be sufficiently equipped to know precisely what evidence Mr Diamond would require to make a decision about operability. Consequently the decision not to resect was taken without an opinion from Dr Ellis on that surgical issue. He was told that the process was to be palliative and I find no

evidence that a competent body of interventionist radiologist would not have acted exactly as he did and determined to take palliative steps in the PTC even had there been a MDT.

[131] My preliminary conclusions in this regard were reinforced by the view of Mr Parks. In Edinburgh the concept of MDT did not occur until 2005. There was no management decision making forum before that time. That of course coincides with the evidence that I have had in this case about the practice in Belfast. Prior to 2005 in Edinburgh, there was a system of one to one referrals precisely as happened in this instance according to Mr Parks.

[132] This witness specifically approved of the procedure whereby Mr Diamond gathered in evidence about the possibility of resection from conversations he had with Dr Collins who in turn had spoken to Dr Ellis about the significance of the ERCP and in particular the length of the tumour. He emphasised that the ERCP is a dynamic process where the clinician gathers most information at the time and summarises information for other disciplines such as the surgeon. He did not find it at all unusual that there had been no specific note of the 1 cm intrusion into the left duct by Dr Ellis. He considered this was typical of the manner in which consultants in different fields communicated with each other in 1999.

[133] In the course of his reports Dr Parks had relied on the handwritten and typewritten note of the endoscopist Dr Collins who had carried out the procedure and he was of the view that this was the appropriate practice for competent surgeons to do. Dr Diamond was therefore perfectly entitled to form a provisional view on the basis of the note and typewritten report made by Dr Collins which thereafter became definitive once he had discussed the matter with Dr Collins in light of his conversation with Dr Ellis. In terms Mr Parks rejected the suggestion that there was insufficient information on the ERCP or that there was no evidence of left sided involvement as suggested by Dr Rauws.

[134] Dr McEniff, the interventionist radiologist called on behalf of the defendants from St James Hospital in Dublin indicated that in his opinion it was "absolutely normal" for Dr Collins to have spoken to the interventionist radiologist to discuss the ERCP findings. Dr McEniff said that "we review ERCPs with gastroenterologists all the time".

[135] This witness asserted that an interventionist radiologist would not usurp the surgeon's function and determine the question of operability. It was his experience also that there were no multi disciplinary team meetings in his hospital in Dublin in 1999 and that the advent of multi disciplinary meetings did not come until 2004/2005.

[136] Dr O'Connor also confirmed that the concept of MDT did not arrive until the early part of this decade. He asserted that in 1999 it was perfectly normal for the gastroenterologist and the interventionist radiologist to discuss what had been seen and then to contact the surgeon often over the telephone. Indeed it is his experience the concept of telephone contact to resolve problems still continues notwithstanding the advent of MDT meetings.

[137] I am satisfied that the lack of a formal MDT in Belfast in 1999 conformed with current competent medical practice and in any event the absence of such formal meetings was superfluous in this case given the measure of contact there was between the experts.

Were the US scan of 9 December 1999 and the CT scan of 13 December 1999 of Dr Crothers wrongly interpreted? Was an ERCP necessary?

[138] The plaintiff's evidence on this issue of the early scans was as follows:

- after the US scan occurred on 9 December 1999, Dr Crothers, the radiologist responsible, informed her that "things look good" and Professor Spence also said that it was good except that there was slight inflammation in the bile ducts and that her husband would be admitted for this on 10 December 1999.
- on 13 December 1999 at the RVH a CT scan was carried out. According to Dr Crothers everything seemed clear except for inflammation in the bile ducts. The deceased told Mrs Magill that he later saw Dr Collins who gave him a leaflet about ERCP and warned that it was a risky procedure. The plaintiff encouraged him to undergo this test on the basis that Professor Spence thought it necessary.
- much more should have been made of these US scans and if Mr Diamond had spoken to Dr Crothers the absence of portal vein, arterial , vascular or lymph node involvement and lack of evidence of tumour to the liver would have been revealed.
- Dr Rauws asserted that a reading of the scans would have indicated that the most likely diagnosis was a CC and this should have persuaded the clinicians to proceed to a PTC rather than the risky ERCP procedure.

[139] The defendants drew attention to the following extracts from these scans:

- the US scan of Dr Crothers of 9 December 1999 records inter alia:
  "Conclusion – obstructive jaundice. Cause unknown. Further follow up with a CT scan has been arranged."
- the CT scan of 13 December 1999, again carried out by Dr Crothers, records, inter alia:

> "Overall appearances are consistent with obstructive jaundice, the cause of which is not determined. Further follow up with ERCP is required."

[140] The evidence of Professor Spence was that the US scan is useful to reduce the differential diagnosis e.g. no gallstones were present in the gall bladder (a possible cause of jaundice) and it made cancer of the head of the pancreas less likely. However in his opinion the US scan does not provide the best imagery and a CT scan is required. For example the US scan might not pick up a gallstone in the common bile duct. Moreover the findings at this stage could have been consistent conditions other than CC such as a Mirizzi syndrome, which is a migrated gallstone that causes significant scar tissue and obstructive jaundice. Similarly a small stone or tumour on the bile duct may be hard to see on such procedures in the absence of an ERCP. In terms, whilst such procedures did initially help and provided good news so far as the possibility of cancer of the pancreas was concerned, they did not afford the opportunity to make a final diagnosis. These scans determine the existence of an obstruction. They did not provide the level of the cause of the obstruction or the cause itself definitively.

[141] That this was the approach that would be accepted by a competent body of medical opinion was established by the evidence of Dr McEniff, a distinguished interventionist radiologist practising in the leading tertiary referral hospital at St James in Dublin. This was another witness who had an extremely distinguished curriculum vitae, having trained in leading hospitals in the north eastern area of the United States and being currently the President of the Irish Society of Interventional Radiologists. He has extensive experience of PTC procedures and of CC. It was his view that notwithstanding that the USS and CT scan of Dr Crothers revealed the absence of gallstones, vascular or lymphatic involvement, thus indicating a reasonable likelihood or 70%/80% certainty that the deceased was suffering CC, nonetheless it would have been too big a leap to have unequivocally concluded at that stage that he was suffering CC. Other possibilities still existed e.g. duodenal tumour, pancreatic cancer or even stones in the common duct which can be missed on a USS. It was the regular practice of his hospital to invoke the process of USS, CT, MRCP but thereafter almost always followed by ERCP before a PTC. He could not remember a single instance in his 12 years in St James where there had not been an ERCP before the PTC was carried out.

[142] Professor O'Connor added further weight to this proposition contending that one could not assume CC by virtue of the CT scan and USS. Bile duct stones might often be the cause of obstruction and the USS is not sensitive to bile duct stones through the biliary system. The presence of absence of the CT scan does not take away from the need for a cholangiography. Whilst the presence of the obstructive jaundice and the

abdominal ultrasound illustrated clear evidence of bile duct obstruction with marked intra-hepatic bile duct dilation, these scans provided no obvious cause for this obstruction or its location the level in the biliary tree. ERCP is vital in order to perform this task and it was standard practice to move on to this procedure before invoking the assistance of Mr Diamond. From the surgical point of view, the ERCP was necessary to provide further information before taking a view as to resectability. The ERCP is a dynamic investigation which the endoscopist can well visualise. These are much more important than the ERCP pictures which are merely snapshots. Those images can also be reported on helpfully by the interventionist radiologist. Often the ERCP can provide sufficient information as indeed it did in this instance for Mr Diamond to come to a conclusion.

[143] Dealing with the criticism of Dr Crothers for not including in his procedures reference to the absence of involvement of lymph nodes, liver, portal vein, artery involvement or spread to the liver of any problem, Professor O'Connor refuted this indicating that it was a matter for the discretion of the expert radiologist to include them or not. The fact of the matter is that irrespective of their mention a CT scan would not indicate the cause or the level of the obstruction and thus a further procedure was vital.

[144] Further independent evidence favouring the need for ERCP and PTC for a definitive diagnosis is found in the GUT guidelines at paragraph 3.3.4 where it is recorded as follows:

> "3.3.4 Cholangiography (MRCP, ERCP and PTC)
>
> - Essential for early diagnosis of cholangiocarcinoma and assessing resectability."

[145] I have therefore come to the conclusion that there is a competent body of medical opinion to the effect that in circumstances such as this, the US scan and the CT scan would have been insufficient to make a definitive diagnosis of CC. I find no basis for any suggestion that there was any misinterpretation of the US scan and CT scan. In all the circumstances it was appropriate for Professor Spence to invoke the use of further procedures.

Should the ERCP procedure have been carried out in preference to a PTC? If so was the ERCP carried out in a competent manner?

[146] Dr Rauws boldly asserted that the ERCP procedure ought not to have been invoked instead of the PTC procedure because of the risk of infection in the biliary tree from bacteria introduced by the endoscopy and the use of contrast itself. He considered that the PTC is safer for drainage of this type of patients and indeed he went so far as to state that in the future ERCP will not

be carried out because of the risks attendant upon it. It was his contention that the complication of post ERCP pancreatitis in this case had led to the death of the deceased.

[147] Dr Carr-Locke made a somewhat different point namely that whilst the use of ERCP might be useful for diagnosis it should not be used for therapy as the latter involves passing stents through the stricture and thus introduces infection beyond the stricture. It was this that triggered the development of sepsis leading ultimately to the death of Mr Magill in his view.

[148] It was common case that that the ERCP procedure does carry risk. Not only does the literature make this clear but the evidence of Dr Rauws was that complications occur in about 10% of the cases. The risk of mortality is ½%. In his view the most feared consequence was pancreatitis following from the operation whilst perforation, infection, peritonitis, respiratory/cardiac complications are also risks.

[149] Dr Ellis opined that indirectly the sphincterotomy - a necessary cut at the lower end of the bile duct at the commencement of an ERCP – does introduce the real possibility of reflux of bowel contents into the bile duct and thus the presence of bugs/bacteria. In some instances e-coli from the GUT can infect any poorly drained segments. It was Dr Ellis' view that the sepsis in this instance may well have derived from the necessary risk which was carried out at the ERCP. By its very nature therefore ERCP introduces contamination whereas the PTC procedure is more sterile.

[150] This view was echoed by Dr McEniff who suggested that the primary cause of death may have been due to the development of sepsis following the gram negative ecoli infection which did occur in this case and which may have been due to the procedures. E. coli originates in the bowel/GUT and the ERCP could have been the trigger for its introduction. Over 10 days the patient developed septicaemia/septic shock. This he stressed is wholly separate from the issue of whether there were any signs or symptoms of these conditions which were not detected in time or at all.

[151] I am satisfied that those involved in the ERCP procedure and the later PTC procedure in this case were all well aware of these risks. It is possible according e.g. to Dr Ellis, Dr Fogarty, Dr McEniff and Dr McNamee that the ERCP may have been the source of the ecoli infection which was able to migrate from the GUT to the upper reaches of the incompletely drained biliary system and which led ultimately to the sepsis, renal failure and pancreatitis which caused death. This does not establish that the ERCP procedure was negligently carried out or that those responsible for it were unaware of the risk. Equally Professor Spence and Professor Spence were wedded to the opinion that the genesis of the infection may have been the

PTC procedure. That did not establish that the PTC procedure was negligently carried out. None disputes that PTC carries a high mortality rate in its wake with a 2009 paper (to which I shall refer when dealing with the PTC procedure) suggesting a mortality figure of almost 20%.

[152] Notwithstanding the risks I do not accept that use of the ERCP procedure was not in accordance with practice accepted by a responsible body of gastroenterologists and radiologists at that time. In the "Guidelines for the diagnosis and treatment of cholangiocarcinoma: consensus document" published in GUT 2002 setting out the development of guidelines for this condition there is clear authority for the proposition that ERCP is the favoured approach. At paragraph 3.3.4 it states:

> " . ERCP, when available, is usually favoured above PTC. However, ideally, facilities for PTC should always be available to deal with cases where attempts at ERCP have failed.
>
> . There is no clear evidence that PTC should generally be favoured over ERCP on the basis of the level of obstruction. However, PTC may be the modality of choice depending on local expertise and anatomical considerations."

[153] My attention was drawn to the standard text book published in the year 2000 by Nezam H. Afdhal dealing with "Gall Bladder and Biliary Tract Diseases". At paragraph 3 of page 852 below the heading "Management of Hilar Malignant Biliary Obstruction", the following extract appears:

> "Stenting of malignant hilar strictures can be achieved by either endoscopic or percutaneous routes. (*The latter of course refers to a procedure through the skin which is PTC whereas the former is the ERCP route*.) It may be difficult to place a stent across a proximal biliary stricture by endoscopic techniques because of the distance of the lesion from the papilla. In some patients, it is not possible to gain access to both left and right hepatic ducts when approaching the strictures from the common duct. Selective entrance into one of these dilated intra hepatic ducts may be more reliably attained by separate puncture to either lobe of the liver via a percutaneous approach. Nonetheless, the endoscopic route is preferred as the initial approach, as it is considered less traumatic and is associated with less patient discomfort, fewer procedure sessions, and shorter hospitalisation. In cases where ERCP fails to result in drainage of the desired

biliary system, the percutaneous approach is usually successful."

[154] Moreover in a very recent publication by the British Society of Interventional Radiology entitled "First Biliary Drainage and Stent Audit Report 2009" published by the British Society there was evidence based on data collected prospectively between 1 November 2006 and 18 August 2009. It included analysis based on the largest published data base of collated procedure records on percutaneous biliary intervention worldwide with 833 patients submitted by 62 operators from 44 centres across the United Kingdom (including the RVH). At page 23 a table records that in the case of the vast majority of patients with malignant disease, 42.1% underwent an ERCP. Even the more modern introduction of MRCP only has 16.8% of patients undergoing this. It is noteworthy that 86% undergo ultrasound and 86% undergo a CT scan also. This paper was introduced by Dr Ellis in the course of his evidence.

[155] In my view these extracts fully justify the conclusion that the competent and proper practice of adopting ERCP as the first preference was deployed in this instance.

[156] Dr Ellis and Dr Collins both asserted that ERCP is not only less invasive than PTC but it involves the patient usually in a short hospital stay. According to Dr Ellis in the RVH there are approximately 500/600 ERCPs performed each year whereas only 50/60 PTCs are performed.

[157] Mr Parks, the expert on surgery called on behalf of the defendant, asserted that both ERCP and PTC were available in 1999 and the choice as to which was adopted often depended on local expertise. In his hospital in Edinburgh the majority of patients underwent ERCP before PTC for a number of reasons. First because it provided easier access, secondly because there was more availability and thirdly because in 1999 PTC was not as well established as ERCP. Even though in Edinburgh they had an outstanding interventionist radiologist, PTC was only carried out in selected cases. Finally, both procedures in his opinion had risks, but PTC was regarded as slightly higher risk even in expert hands.

[158] On the decision to invoke the use of ERCP, Dr O'Connor relied on the GUT guidelines mentioned in above. It was this witness' assertion also that PTC is more invasive and more risky than ERCP albeit ERCP carries risks as well. An additional advantage of ERCP is that it can provide the facility for brushings or biopsy material which is not available in PTC.

[159] I therefore consider that the decision to invoke the use of ERCP initially in preference to PTC was in accord with a reasonable and competent

body of medical opinion. The decision that the plaintiff required an ERCP, to which the plaintiff consented, was entirely appropriate.

[160] I turn now to the ERCP procedure. I commence by outlining Dr Collins' account of the background and the procedure itself

[161] It was Dr Collins' evidence that Professor Spence had referred the patient to him, as he often does, to carry out an ERCP. He had met Mr Magill and discussed the procedure with him in some detail over about 30 minutes warning him that in 5/10% instances there could be serious complications which would include pancreatitis, bleeding, and infection in the biliary system. Risk of a really serious complication was 0.1%. The procedure had to be carried out at the RVH as there is no ERCP facility on UIC. He described the procedure as being diagnostic but it can be therapeutic as well if it is necessary to insert stents.

[162] In light of the US scan Dr Collins was aware that there was obstruction probably in the bile ducts but gallstones were not the cause. The ERCP would define the level of obstruction.

[163] On the day of the ERCP, but prior to it occurring, a note from the ward sister Warwick recorded that the deceased was administered ciproxin, a prophylactic antibiotic. Dr Collins asserted that in 1999 there was no consensus view about the giving of antibiotics. There was a school of thought that no purpose was served but it was his view that such antibiotics ought to be given.

[164] The conventional approach was adopted at the ERCP itself with the endoscope deployed. Dr Collins indicated that there are two screens available for him so that he can observe the images whilst the procedure is carried on. In the course of the procedure he injected a radiological sterile solution of dye into the bile duct and could see the bile duct outlined on the screen. He was able to see a stricture in the right hepatic duct and also some filling in the left duct. It was important to note that Dr Collins asserted that his interpretation was based on real time imaging, an advantage which no other witness in the case had.

[165] On the left side he found a rock hard stricture which caused the guideline wire to bend back. He was unable to effect any drainage. On the right hand side due to the stricture he was unable to place the conventional 10 mm French stent or indeed the 8.5 mm French gauge stent. Accordingly he put in a 7 mm stent but the structure was so rigid he was not sure if the stent had gone above the stricture. Accordingly he used a small 5 mm French stent. Such a stent is only used in about 5% of cases but it is better to use a small stent that none at all. It was his evidence that this was one of the most difficult strictures he had ever encountered in the course of many hundreds

of ERCPs which he had performed. He was confident however that the 5 gauge stent had crossed the stricture mainly because he was able to observe this on the real time imaging. He did not think that the 7 stent gauge had passed the stricture and therefore he recorded that it was not optimally placed.

[166] It is common case that this is a very complicated procedure. Dr Rauws was of the opinion that this should be performed only by the most experienced endoscopists.

[167] Dr Rauws and Dr Carr-Locke made a number of criticisms of the ERCP procedure in this instance.

- The 5 FG stent in the right hepatic ductal system was too small and inadequate to drain the biliary tree. Dr Carr-Locke did not consider even the 5 French gauge (FG) stent had crossed the stricture.
- There was no evidence whatsoever of any incursion of contrast into the left side of the biliary tree.
- Dr Rauws felt that the sequence of events should have been to preserve the function of the left liver lobe by draining the left hand side to enable the jaundice to be dealt with and then proceed to resection of the tumour. In any event it had not been possible to adequately drain the biliary system because there was no stent on the left and on the right it was inadequate.
- The introduction of the stent in itself then induces infection growing and cholangitis of that area. It was Dr Rauws' view that it was the ERCP which led to the development of pancreatitis.
- That intra venous antibiotics pre the ERCP were necessary and were not provided in this case.
- Dr Carr-Locke asserted that the deceased should have been given antibiotics post ERCP.

[168] I am satisfied that Dr Collins found it impossible to dilate the stricture enough to pass a bigger or 10 FG adequately. He was doing the best he could in the circumstances to drain the right side. I find that Dr Collins was an experienced and highly skilled endoscopist who was perfectly competent to perform an ERCP in this instance. Although Dr Carr Locke and Dr Rauws were critical of the use of a 5 FG stent in the ERCP, I believe that this is simply a matter of choice for the endoscopist in the individual case and that a competent body of physicians would have acted exactly as Dr Collins did in inserting the smaller stents when the conventional 10 mm stent was not plausible. He placed the 5 mm and the 7 mm against each other in a proper manner in my view. He did not think that the 7 mm stent was past the structure – hence the reference in his note of the operation to it not being "optimally placed". I accept his evidence that this was one of the most

difficult strictures that he had encountered and that he did his best in the circumstances.

[169] I am satisfied that the 5 mm gauge had crossed the stricture because Dr Collins had the benefit that Dr Carr-Locke and Dr Rauws did not have, namely that he was able to view the matter on the real time imaging whilst they were restricted to the three pictures which are only a spot check at a moment in time.

[170] On the issue of the left side, I found Dr Collins to be frank and forthcoming. He candidly admitted that he could not see from the ERCP if the stricture had gone into the segments of the left upper duct in circumstances where he must have known that this had become a major issue in the case. He frankly admitted on a number of occasions that he was not a radiologist and that it was not his role to determine this. The ERCP gave information about the confluence but not upstream on the left side. He could not inject contrast into the left side because of the rock hard stricture.

[171] Dr O'Connor carefully considered the procedure carried out by Dr Collins. He is a consultant gastroenterologist since 1989 currently practising in the Adelaide and Meath Hospital in Dublin and the Naas General Hospital. He has authored approximately 90 papers and 8 book chapters in leading textbooks on gastroenterology. His special interest is ERCPs.

[172] This witness asserted that he would have done exactly the same as Dr Collins. An effort would be made to get as large a stent as possible to maximise the drainage, but where the stricture was as hard and as difficult to negotiate as in this instance, he said it was perfectly standard practice to have used a Five FG stent only and indeed he had been in exactly the same position himself during the course of ERCPs and had used a Five French stent. He insisted that Dr Carr-Locke was incorrect to say that the Five French stent had not gone above the structure. Having looked at the ERCP he was absolutely satisfied that it had moved beyond the stricture whereas the Seven French stent had not and was not providing any drainage. I find this to have been a competent operation and was entirely in line with what a competent gastroenterologist would have done in the circumstances.

[173] I am satisfied that nurse Warwick's note can be relied on and sufficient antibiotics pre- the procedure were given. Both Dr O'Connor and Professor Spence asserted that continuation of antibiotics after ERCP is a controversial area. The danger in continuing to give antibiotics is that the body builds up immunity to them and the patient can develop antibiotic diarrohea or infection. It is therefore a matter of surgical choice and I accept that to be a competent medical opinion .

[174] Having heard the evidence of Professor O'Connor, Dr Ellis, Dr McEniff and for that matter Professor Lameris, and having had them demonstrate to me on the ERCP photographs the presence of contrast on the left hand side, I believe that there was clear evidence of contrast on the left side and that Dr Rauws was simply unable to properly interpret these scans when he first opined that the contrast was simply "shadow".

[175] I am also satisfied, from the evidence of Dr McEniff, that there was a clear separation of the left duct from the right which represented the presence of tumour on the left hand side. The cholangiogram of the ERCP on 14 December 1999 showed the presence of tumour extending into both sides and revealed the presence of a complex bile duct stricture at the halum of the liver involving the common hepatic duct and extending into the right and left hepatic ducts. The cholangiograms of 17 December 1999 and 20 December 1999 (following the PTC) confirmed this.

[176] I was not persuaded that the post ERCP procedures were negligent or fell short of a proper and appropriate standard of medical and nursing care. During the course of this trial there was detailed scrutiny of the medical and nursing notes for this period between 14-17 December 1999.

[177] I observe in passing that Mrs Magill accused Professor O'Connor of bias because he and Dr Collins were both members of the Irish Society of Gastroenterologists (both serving on the board) and that he had a close working knowledge and association with Dr Collins. The fact of the matter is that there are a limited number of gastroenterologists in the Republic of Ireland and the United Kingdom and they are bound to meet at professional groups and societies. I do not believe that this constitutes a basis for actual or implied bias. The courts regularly hear solicitors in Northern Ireland giving evidence on behalf of other solicitors. Membership of the Law Society does not disqualify one professional from criticising or praising another. I therefore dismissed any suggestion of bias in this instance. I found Professor O'Connor to be a highly qualified well experienced consultant who gave his evidence in my view in a detached and informed manner.

[178] I therefore do not accept that it was incorrect to approach this matter via the medium of ERCP followed by PTC and I am satisfied the procedure was carried out in accordance with the opinion of sound medical practice at the time.

Were there signs or symptoms of infection post ERCP in the UIC and RVH which were ignored ?

[179] It was the plaintiff's case that the deceased became ill following the ERCP and sepsis and pancreatitis were undetected. I shall deal separately

with the issue of pancreatitis but confine this section to the issue of infection. She relied on the following evidence:

- Dr Rauws contended that the drainage having failed in the ERCP, close attention should have been shown to symptoms that were in evidence after the procedure. Perusal of the nursing records post ERCP in UIC revealed the following entries inter alia:

  (a) A temporary rise (spike) in his temperature at 10.00am on 15 December 1999.

  (b) "Crampy windy abdominal pain AM ?? constipated." 15 December 1999.

  (c) Nausea.

  (d) Refused his evening meal as not hungry and had cup of tea only at 5.30pm on 15 December 1999.

- It was Dr Rauws' contention that knowing that there had been a failed drainage operation and that pancreatitis is the most feared complication after an ERCP, the temperature spike and the abdominal crampy pain ought to have sounded alarm bells. Whilst the nurses may not have realised this doctors should have known better. His concerns would not have been assuaged by the fact that the amylase reading of 105 on 17 December 1999 was normal because it can go up and down in his view. In Dr Rauws' opinion abdominal imaging by a radiologist ought to have been carried out and the doctors ought to have been informed of these symptoms.

[180] The defendants note that in the RVH records on 18 December 1999, four days after the ERCP, the white cell blood count was normal at 9.89 and on 19 December it was also normal at 8.99. In their view this was a strong indicator that there was no onset of sepsis at this stage. The CRP tests recorded a reading of only 16 which would be 100 + if pancreatitis or septicaemia was present, according to the defendants. Dr Carr-Locke answered that the patient was on antibiotics during this time but he did concede there was a paucity of any recorded evidence of sepsis occurring earlier. In essence Dr Carr-Lock agreed that the steps taken on 17th to 20th December in the RVH were correct. His argument was that the appropriate steps had been taken but not at the right time.

[181] It was the view of Dr McEniff, interventionist radiologist from St James Hospital in Dublin called on behalf of the defendants, that a short term

temperature spike at this stage does not present a problem unless it remains high. It is certainly not evidence of the patient being in septic shock or suffering sepsis. For that, according to Dr McEniff, there would have to be raised blood pressure, a pulse rate which was racing up or pyrexia. He was absolutely satisfied from reading the notes that the deceased was in a stable condition between 14 December 1999 and 17 December 1999. He would have seen nothing on the records that would have persuaded him that the standard gap of three days between the ERCP and PTC procedures should be shortened. Patients suffering from jaundice regularly do not feel like eating.

[182] Although there is a risk of infection from ERCP, Dr Ellis gave evidence that he saw no signs of the sepsis present until 22 December 1999 i.e. 2/3 days after the PTC final procedure had been carried out. Hence in his opinion there was no need to take any blood cultures between 15 December 1999 and 21 December 1999. The single spike in temperature at 38.2 degrees on 15 December in his opinion made "not a jot of difference" and would not have changed his mind in the slightest. It was not sustained and was therefore of no relevance in the context of sepsis. He also asserted that the high bilirubin reading was not evidence of infection but rather of bile duct obstruction. Again and again this witness emphasised that he applies the five criteria mentioned above and none of the criteria of sepsis were present in the three days between the ERCP and the PTC.

[183] Whilst I shall deal in more detail with the nursing care in the UIC and RVH later in this judgment, I make it clear at this stage that I found that no significant signs or symptoms had gone undetected post ERCP in these hospitals.

Did the plaintiff have pancreatitis in the aftermath of the ERCP which was not noticed? If not when was the likely onset of pancreatitis?

[184] The autopsy recorded that necrotising pancreatitis had been a cause of death. The real issue was whether the condition developed in the immediate aftermath of the ERCP in UIC and RVH or, as the defendants asserted, not until circa 26 or 27 December 1999 in the BCH. It was the plaintiff's case that this condition went undetected at a time when it could have been reasonably dealt with by staff in UIC and RVH.

[185] Mrs Magill relied mainly on the following evidence:

- That condition was not treated before 23 December 1999, according to Dr Carr-Locke and Dr Rauws, with aggressive inter venous fluids and antibiotics i.e. 9 days after the original ERCP. Dr Carr-Locke felt that the necrotising pancreatitis was probably the cause of his renal failure. He has lost a lot of fluid and if it not replaced the kidneys will not work. The autopsy reveals a particular type of kidney damage which

is usually a consequence of losing fluid quickly. He considered that the final factor was the bleeding from the duodenum. As the blood passes through the intestine it becomes black. ERCP may involve a cut at the papilla. One consequence can be bleeding and this may contribute to pancreatitis.

- Dr Rauws emphasised that pancreatitis was the most severe complication of ERCP. It had commenced in his opinion during the ERCP procedure. The amylase level was measured only once on 17 December 1999, 3-4 days after the ERCP and it was not measured otherwise during the crucial period 14-16 December 1999. He indicated it is difficult to treat pancreatitis apart from giving lots of intra-venous fluids (6 litres or more).
- A major source of dispute was the interpretation of the CT scan of 23 December 1999. Dr Carr-Locke and Dr Rauws both claimed that there was evidence of pancreatitis on this scan. The former felt there was swelling of the head and the latter felt there was general swelling. Professor Lameris was more circumspect in his conclusions indicating that there were some factors pointing to the presence of a mild pancreatitis on the scan whilst recognising that a diagnosis of the condition required clinical evidence as well .He conceded that it would be difficult to make such an assertion absent a raised amylase level.
- A further issue arose as to the amount of fluid in the abdomen representing leakage from the liver. Dr Rauws suggested the presence of fluid there indicated infection and pancreatitis. However he was unable to glean from the scans how much fluid there was. The autopsy revealed 1 ½ litres at 31 December 1999 but that does not mean that such amounts of fluid were there on or prior to 23 December 1999.
- What was the cause of pancreatitis? Dr Carr-Locke contended it was either due it the ERCP catheter entering into the duct canal on 14 December or it occurred against a background of his ongoing sepsis, shock and multi-organ failure which developed from 22/23 December 1999 onwards. Dr Carr-Lock agreed that the symptoms would normally occur within a few hours albeit some instances occur later. However in cross examination he conceded the view that the ERCP was a *possible* cause of pancreatitis and not a probable one.

[186] It was the defence case that there were no signs of pancreatitis prior to 24 December 1999 at the earliest which would have led a competent doctor or nurse to conclude that the condition was being suffered. In particular it was asserted that there were 9 specific symptoms to be expected in the condition of pancreatitis, none of which were present in this case. These were:

- Acute /severe abdominal pain which was constant and which was not crampy. Dr Rauws conceded that it was not uncommon to have severe pain with this condition although it was not always constant. When it

was put to him that "crampy" suggested the very opposite of constant, he said this was a subjective description. This of course referred to the plaintiff's complaints on 15 December 1999 in the UIC in the nursing notes However he recognised that pain with pancreatitis can be so severe that it needs morphine and often cannot be relieved by oral medication. I came to the conclusion that there was no evidence that this man was suffering the acute severe abdominal pain of a constant nature which is resonant of pancreatitis and that the description of the pain that the deceased was suffering contained in the notes would not have been sufficient to alert a competent doctor or nurse that he was suffering from such a condition. As Professor Price indicated, ERCP is an uncomfortable procedure and abdominal cramps are not unusual after such condition. Whilst there is no doubt that the patient was receiving zydol(pain killers) regularly over his period in the RVH, Professor Price and Dr Ellis asserted this is fairly standard for someone undergoing the pain of 2 PTC procedures .

- Professor O'Connor, the gastroenterologist expert called on behalf of the defendants, indicated that whilst it is difficult to say when the pancreatitis did commence, there was no clinical evidence in the wake of the ERCP. He asserted that acute pancreatitis is a well known clinical entity. The symptoms include severe upper abdominal pain going through to the back of the abdomen, the abdomen is very tender with the patient not wanting it to be palpitated and often is accompanied by vomiting. Patients are bedridden. This contrasted markedly with the evidence of the RVH from Nurse McQuillan of 21 December 1999 that the deceased was self caring and able to attend to his own hygiene and of Nurse Belshaw that on 20 December he was able to pass urine into the toilet i.e. he must have risen from his bed and travelled to the toilet on both 19 and 20 December.
- In acute pancreatitis, which has the potential to progress to necrotic pancreatitis (a ½% will do this), pain will rise to a peak. Dr Rauws accepted that this is correct but again it simply does not fit the pattern of this case in the aftermath of the ERCP according to the notes and records of UIC or RVH.
- Loss of appetite would be indicative but there was no evidence in the nursing notes of this man refusing an evening meal until well over 24 hours after the procedure at 5.30pm on 15 December 1999.
- Dr Rauws accepted that pancreatitis can often be associated with a fast heart rate. This man's heart rate was normal. This is another factor that favours the defendants' case.
- There is often a reduction in blood pressure in the presence of pancreatitis. This man's blood pressure was normal in the days after the ERCP.
- It was strongly asserted by the defendants that the amylase readings were crucial. This is an enzyme produced by the pancreas. The level of amylase is measured in blood serum by the laboratory RVH regards

normal range as being 25-125 units of amylase in an adult. The relevant readings were 105 on 17 December 1999 and on 24 December 1999 less than 30. If there is pancreatitis amylase readings will be outside the normal range and would be as high as the 100s or 1000s whereas they were never other than normal on the two occasions – 17 December 1999 and 24 December 1999 - when they were taken in this instance. Dr Rauws felt that a patient could have mild clinical symptoms and have a normal amylase reading although he accepted that he would not make a firm diagnosis of pancreatitis in the absence of an abnormal amylase. Dr Carr-Lock conceded that if that is all one had to rely on then it would be "a cause for thought "as to whether or not the man had pancreatitis.

- Professor O'Connor asserted that inevitably pancreatitis prompts high amylase reading. In his view a reasonably competent body of medical practitioners would say that if the amylase level was not raised, then the patient did not suffer pancreatitis. The normal readings mentioned above contrasted with the readings in the BCH on 28 December 1999 of 91 and 92 which subsequently rose to 272 and 549. This illustrates in his view that the pancreatitis had developed towards the end of his illness.
- Professor O'Connor said that such a complication of ERCP would usually present within a few hours with severe upper abdominal pain radiating through to the back requiring frequent injections of narcotics, nausea and vomiting. If the pancreatitis was severe, there would in addition be respiratory difficulties.
- Dr Rauws accepted that one would expect a man in this condition suffering from pancreatitis to be complaining of symptoms, look ill, and that medical practitioners if watching closely should be aware of these symptoms. The fact of the matter is that this man was seen at 8.00pm on 14 December 1999, the evening of the ERCP by Dr Collins, on 15 December by Mr Diamond who spent 30 minutes with him, Professor Spence on 16 December 1999 and Dr Ellis on 17 December 99. The records show that there were no problems being evinced at that stage. All of these consultants averred that they had many years of experience seeing patients with acknowledged pancreatitis and would not have missed signs and symptoms of such a condition I simply cannot accept that if this man was suffering from pancreatitis between 14-17 December that these experienced consultants would not have observed some symptoms. Dr Rauws answered this by saying that acute pain can be symptomless for a number of days but I found this difficult to accept in the face of close scrutiny by these three consultants.
- The CRP-reactive protein level would be much higher than the 16 that was found in this case if it was acute pancreatitis. Dr Rauws felt this was not always the case but sometimes would be so. Professor Lameris indicated that the combination of this and normal amylase readings

perhaps made pancreatitis unlikely at 24 December 1999. The white cell blood count was normal at 8.90 on 18 December 1999 and at 8.99 on 19 December 1999. Professor O'Connor asserted that in the presence of pancreatitis, the pulse will quicken and white cell and CRP levels will be very high. The evidence of the records in the UIC was that these were all normal. Hence Professor O'Connor contended that these symptoms could not be equated with the development of pancreatitis post ERCP.

[187] The CT scan of 23 December 1999 was the subject of careful dissection in this context. The defendant evidence was that it is normal for the pancreas to be slightly enlarged having regard to the procedures but that there was absolutely nothing about the CT scan which would have indicated pancreatitis. The following points were made:

- Evidence called by the plaintiff from Professor Sebaldus Lameris an interventionist radiologist from the distinguished teaching hospital AMC in Amsterdam, who had examined that CT scan, drew a concession from him that the head, body and tail of the pancreas were all proportional to each other and within normal range. He remarked that if this was the only evidence before him he would agree that it by itself did not provide evidence of the existence of pancreatitis. He did emphasise however that he had not seen any earlier scans and that if the patient had constant abdominal pain he could still have pancreatitis despite the apparent normal view of the pancreas on the CT scan.
- Dr McEniff, also a Consultant Intervention Radiologist, concluded that the CT scans of 23 December 1999 did not show any evidence of pancreatitis and he expressed astonishment that Dr Rauws was offering an expert opinion in a field on medical imaging in which he is clearly not an expert. The pancreas was not swollen and it had not lost its normal fat surrounding. The fat planes were preserved which would not be the position if there was evidence of pancreatitis. Even if this CT scan had been taken in the very early stages of pancreatitis, where conceivably there might not have been swelling, elevation of the CRP and amylase readings would be manifest .

- This coincided with the evidence of Dr Ellis who in the course of detailed examination in chief took this court through the various scans available on 13 December 1999, 17 December 1999, 23 December 1999 and 28 December 1999. By contrasting that of 23 December 1999, where it was asserted there was no evidence of pancreatitis or swelling of the pancreas, with the CT scan of 28 December 1999 where it is common case that the plaintiff had pancreatitis and was exhibiting a swollen pancreas, it was fairly clear even to my unpractised eye that there was a major difference in size between the two. Dr Ellis also

contended that he had made measurements of the pancreas on 13 December 1999 (where it is common case there was no pancreatitis present) and that the measurements he made on 23 December 1999 were the same. I fear that Dr Rauws' confidence that there was swelling at the head of the pancreas is an illustration of my concern that at times this distinguished gastroenterologist was too ready to stray outside his own field of expertise and to make bold assertions which were subsequently controverted by expertise from the appropriate field of radiology. Indeed it seems to me that on this occasion there may well be merit in Dr Ellis' assertion that Dr Rauws had mistaken the duodenum for the head of the pancreas when coming to his conclusions. The duodenum is of course adjacent to the pancreas and easily mistaken. In short it was Dr Ellis' assertion that the pancreas – the head, tail and body – should be reasonably in proportion if it was not swollen. Having viewed both scans of 23 December and 28 December, I was satisfied that there was a reasonable argument to be made that all parts of the pancreas were clearly in proportion in the earlier scan but not in the later.

- Professor Price gave evidence that even if the symptoms described by the plaintiff in the UIC constituted evidence of pancreatitis, it had to be a very mild form and since by 20 December 1999 there was evidence from Dr Lee SHO in RVH that his urea level was normal and he was not dehydrated, it must have resolved by 20 December 1999.
- Dr Ellis also gave evidence that to diagnose pancreatitis one would expect to find infection of the fat planes surrounding the pancreas. Once again on the CT scan of 23 December 1999 the fat planes were clearly outlined whereas they were blurred on 28 December 1999. I was shown the fat planes by Dr Ellis. I am satisfied that there is a reasonable case to be made that the CT scan of 28 December 1999 ,where it is accepted that he had pancreatitis, revealed a blurred outline where one could scarcely see the margins of the pancreas. In contrast on 23 December 1999, the pancreas clearly has retained its outline shape. Dr Ellis also contended that if the pancreas is inflamed, the fat planes have a grey appearance (this was the case when I observed the scans of 28 December 1999) but this was not the appearance on 23 December 1999.
- Turning to the presence of fluid as a sign of infection on the CT scan of 23 12 99 Dr Ellis made the following case. The scan of 13 December 1999 taken by Dr Crothers revealed no fluid around the gallbladder. There are only small collections of fluid on 23 December 1999 which contrasts sharply with the collection of fluid on 28 December 1999. I conclude this aspect of the case by indicating that it was again clear to my unpractised eye that the CT scan of 28 December 1999, where it is admitted that there was pancreatitis present, was very different indeed from the picture of 23 December 1999.

[188] I concluded that the entire weight of the radiological and clinical evidence was very much against Dr Rauws and Dr Carr-Locke. It amounted to a clear indication against the presence of pancreatitis either prior to the CT scan of 23 December 1999 or the normal amylase reading of 24 December 1999 at the earliest. I found this to be another troubling example of where I considered these two distinguished physicians were straying outside their areas of expertise and thus diminished the strength of their evidence.

[189] I was satisfied from the evidence of the defendants and their expert witnesses that the plaintiff had failed to establish that on the balance of probabilities a reasonable competent body of medical opinion would have concluded that there were signs or symptoms of pancreatitis post ERCP or PTC or at all prior to late in this man's condition. It seems to me much more likely that this pancreatitis did develop at a later stage after the signs of septicaemia were evident on 22 December but not before the normal amylase reading of 24 December 1999. Indeed Dr Rauws accepted that if he was wrong in his interpretation of the CT scan of 23 December 1999 his proposition was entirely unfounded. Consequently I am not satisfied that this condition was missed by the defendants at any material time.

Did the deceased suffer meleana in the aftermath of the ERCP

[190] This issue was important as it was common case that the presence of melaena or large tarry stools would have represented a strong indication of bleeding from the upper gastro-intestinal area.

[191] The plaintiff dilated on this issue on a number of occasions throughout her evidence. It first surfaced she claimed in the UIC on the 14 December 1999 after the deceased had returned from the ERCP. Some time after 8.00 pm, her husband, who had been in a little bathroom attached to the room, called her and showed her large tarry stools he had passed. Later that evening the toilet was blood filled. The plaintiff said she requested a nurse to look. The nurse put her head round the door and said not to worry as it was the after effects of the ERCP.

[192] Some time after 11.00 am the plaintiff spoke to the Sister in the hospital and asked to see Professor Spence on his own. This was arranged and she saw Professor Spence. Mrs Magill did not mention this condition to him.

[193] On the morning of 15 December 1999 in the UIC the plaintiff said that her husband complained of abdominal pain as the morning progressed. He refused lunch and his evening meal. He was leaning forward and supporting his abdomen. He was given medication several times that day and again passed large tarry stools. The plaintiff believed that this was as a result of the ERCP in view of what she had been told. There was also bleeding – not as much as on 14 – of bright red blood when passing stools accompanied by an

obnoxious smell. The deceased complained of feeling sick, retching and shivering at times. She recalled him holding on to the window on an and being by the Sister to practise deep breathing exercises. He asked for blood tests as he was worried about infection. Accordingly therefore over 14/15 December 1999 he was prescribed medicine for abdominal pain/nausea/itch and jaundice.

[194] In the RVH the plaintiff alleges she expressly drew attention to the issue of melaena with both Dr Lee SHO who was asked to arrange tests on stools the plaintiff had left in a side room in a bedpan with the patient's name for testing and with Nurse McQuillan. I shall deal with the individual instances of such allegations later my judgment when assessing the allegations against the hospitals.

[195] Mrs Magill lent on Dr Collins' statement to the Coroner of April/May 2000 where, specifically referring to "the concerns in Mrs Magill's letter "(*i.e. to the Coroner),*he stated –

> "Internal bleeding. Tarry stools were noted and his blood count closely watched. He did not develop serious bleeding at any time …."

[196] I consider that there was no medical basis in the evidence for the existence of melaena for the reasons in the following paragraphs.

[197] There were just too many opportunities for these tarry stools to have been noted or mentioned, and where in the event the contrary was the evidence, for me to accept that this was occurring. Meleana is by all accounts a very obvious condition with a highly distinctive smell. I do not believe that a wide variety of witnesses both nursing and medical staff in both hospitals all missed this feature or were lying about it before me to maintain a wall of silence on this discrete issue.

[198] One illustration of this is the fluid balance chart in RVH which recorded that his bowels had opened on 19 and 22 December 1999. These bowel movements, according to Nurse Belshaw, would have been recorded as a result of direct questioning of the deceased. Here was a perfect opportunity for reference to be made to dark tarry stools. I have not the slightest doubt that reference to dark tarry stools during this period would have triggered a note and concern at least in some of the nurses who were attending to him. The absence of the slightest reference in any note to such stools during this period satisfies me that such a complaint was not being made.

[199] What possible motive could there have been for the wide variety of witnesses on this issue so doing? It was not only the evidence of the

individual nurses at all 3 hospitals in this case but also that of the two nursing experts Ms Edy and Ms Kidd that dark tarry stools would be an alarm call for all nurses. I do not believe that they all have flagrantly ignored something that was a clear matter of concern.

[200] Dr Lee on 21 December 1999 made a medical note of "bowel movement yesterday—Dark "blue"+ large motion. Passing wind only today". Her evidence, which I accepted, was that this was not a reference to the dark tarry stool characteristic of meleana but a description of what the patient told her. If the patient had described the condition she would instantly have recognised it. I also accept that Dr Collins' coronial statement in turn referred to Mrs Magill's reference to dark tarry stools in her letter and Dr Collins tying this in with Dr Lee's note. What possible reason would there be for Dr Lee deliberately concealing on 20 December 1999 that she was aware of dark tarry stools – a serious medical condition of which she must have been aware – and fabricating a note referring to" dark blue" to cover up her knowledge of the meleana? Why make a note at all if she wanted to conceal the matter?

[201] Dr Andrew Fitzsimmons who was a junior house doctor in the Royal Victoria Hospital who saw the deceased on admission on 17 December 2004 was potentially an important witness in this regard. He had no recollection of the deceased and was relying entirely on his note. However he had all the hallmarks of a conscientious witness who had manifestly taken great care in the preparation of his notes.

[202] His admission note recorded, inter alia, that since the end of October the patient had noticed increasing dark urine, pale stools *(my emphasis)*, jaundice and an itch. On direct questioning he indicated to Dr Fitzsimmons that his appetite was fine and that he had had some diarrhoea over the past 4 weeks but he had no bleeding per rectum.

[203] Dr Fitzsimmons said that during the gastro-intestinal tract questions, he would have specifically asked the patient about any nausea, vomiting , blood discharge and the colour of the diarrhoea in order to ascertain if he was passing blood.

[204] Whilst this witness acknowledged that there was a possibility the patient was discussing the matter pre-ERCP I nonetheless find it extraordinary that if he had been passing dark tarry tools that this would not have emerged at some stage during the questioning of Dr Fitzsimmons. I therefore found this witness' evidence inconsistent with the case made by the plaintiff of the patient's condition in the period prior to his admission to the RVH when the plaintiff alleged he had been suffering, inter alia, from black tarry stools, nausea, retching.

[205] I further do not believe that Dr Caroline Lee (SHO) in the RVH and for whom Mrs Magill allegedly left out specimens of such stools, would have failed to recognise the importance of such matters. What reason would there be for ignoring such requests and for not having tests carried out on the stools when she had clearly orchestrated the carrying out of a raft of other tests in a plethora of other areas.

[206] Dr Ellis, Dr Collins, Prof. Spence ,Professor O'Connor and Dr McEniff all gave evidence that melaena would be evidence of bleeding high up in the ducts. Such bleeding inevitably has a laxative effect entirely inconsistent with the record of constipation at UIC on 15 December 1999 and on 16 December 1999 a note of bowels not opening for 3 days. Moreover the CT scan of 23 December 1999,well illustrated to me in court by Dr Ellis , showed substantial faecal loading on the right side and transverse colon. i.e. constipation. Far from being constipated the patient would be passing frequent loose motions if he suffered melaena.

[207] I also accept the evidence of e.g. Professor Spence, Dr Collins, Dr Ellis and Dr Lee that if there was such bleeding, particularly over a lengthy period it would be evidenced in the haemoglobin (hgb) levels and urea readings of the patient. On the contrary the hgb and urea readings of this patient were static during the periods under scrutiny. On 14 December 1999 the hgb count was recorded by Professor Spence as 14.1 (normal) and on 18 December 1999 as 13.8 (normal) by Dr McCarty SHO. How could this possibly be the case if he had been suffering meleana since 14 December 99?

[208] I found no reason to reject the evidence of e.g. Professor Spence and Dr Collins that the patient with meleana would be noticeably pale and ill looking. How could this have bee missed by the various consultants and nurses who saw him prior to 21 December 1999?

[209] It was clear to me that Dr Collins' coronial note was a response to the specific allegation of Mrs Magill in her letter to the Coroner and a passing reference in that context to the note made by Dr Lee about dark blue motions mentioned to her by the deceased to her.

[210] I have concluded that the plaintiff has not satisfied me that there was any material evidence before any of these defendants that the deceased was suffering from melaena.

The delay between the ERCP and the PTC

[211] The ERCP was performed on 14 December 1999. The PTC was not carried out until 17 December 1999. The plaintiff argued that the delay was too long and injurious to the deceased. She relied on the following evidence in support of her contention:

- Dr Rauws made the case that the longer the delay between the two procedures, the more the deceased was at risk. Drainage had not been properly secured with the former procedure and accordingly the bacteria would have been multiplying during this 3 day period causing cholangitis.
- Dr Carr-Locke was of the view that infection had been introduced by the bacteria in the catheter and the introduction of dye when the obstruction was passed during the ERCP In his opinion this commenced a chain of events that followed on from the cholangitis or infection of the biliary system - a recipe for septicaemia. The temporary spike of temperature on 15 December, the nausea, the abdominal crampy pain, loss of appetite, and inadequate drainage all indicated contamination. The 3 day delay until the PTC exacerbated this. Doctors should have known better even though the nurses may have thought it was regular.

[212] The defendants gave evidence as follows –

- Dr Ellis asserted that in his 12 years as an interventionist radiologist, the 2-3 day delay in this instance between the two procedures was standard practice. In his experience he had never come across a patient where infection had occurred due to the delay that had occurred.
- Had he detected any sign of sepsis he would have cancelled PTC. The crucial point upon which he relied was that he was the only person in this entire case who had actually witnessed the bile coming from the right duct during the course of the PTC procedure. He asserted that he had seen bile on countless occasions including infected bile. Infected bile has a purulent appearance being whitish/creamish in appearance and contained sediment (e.g. he had observed this condition in another patient no later than one week before he had given evidence in this case). There was no question of this bile being in such condition. This was a greenish/yellow clear fluid as you would expect in normal bile. This was proof positive that the delay between the ERCP and PTC had not occasioned any spread of infection. He did not record that the bile was normal because this is the case in virtually 95% of the PTCs he carries out and he would only make a record if it was unusual/infected.
- In addition Dr Ellis recorded that he had found no clinical sign of sepsis or indication of infection. He asserted that on 17 December 1999 at 11.00 am he had spoken to Mr Magill and found him in good spirits not complaining of abdominal pain, tarry stools, loss of appetite or anything else of note save for an itch. Dr Ellis claimed that he saw from notes (either nursing notes or the

houseman's notes) that his blood pressure, temperature, white cell count, pulse and coagulation were all normal. He claimed there were five criteria for the presence of sepsis namely increased temperature, raised blood pressure, raised white cell count, appearance of the bile and raised pulse. Not one of these criteria were present in the three days after the ERCP and immediately prior to the first PTC. I found this all coincided with the general thrust of the nursing notes which essentially did not record any evidence of sepsis until at the earliest 5pm on 21 December 1999.

[213] I now consider the expert evidence called on behalf of the defendant. It was the evidence of Professor Price that there was nothing untoward about the delay of three days between the two procedures. She felt it was important to plan the PTC. Surgeons may well wish to leave the matter for a day or thereabouts after the ERCP to afford an opportunity for the inflammation to subside and for some drainage to occur. It was her experience that usually 2 or 3 days are given between the two procedures. Indeed she saw no evidence of infection up to 22 December 1999. It was her evidence that "bugs do not stay around" and that it was unlikely that they would not create infection until 7 days later. She had not seen a delayed incidence of septicaemia. It was much more likely that infection would manifest itself at the time and with the absence of any low grade infection until 22 December 1999 – he was in relatively good health according to the notes and records except for that period – there is no evidence that the delay caused any problem at all. In her opinion the septicaemia was caused post the PTC on the 20 December for three reasons. First because this is a recognised complication of PTC, secondly because the timescale is right, and thirdly it often takes 2 days for the bugs to enter the system and get worse. She was 95% certain septicaemia was triggered post PTC of 20 December 1999 and not 14/15 December 1999 as Dr Carr-Locke and Dr Rauws suggested.

[214] Professor O'Connor's evidence was similar. He said that in his hospital, a three day delay between ERCP and PTC is perfectly acceptable. The situation would be different if there was evidence of illness through septicaemia or cholangitis. Cholangitis i.e. bacterial infection of the biliary tree has a triad of key symptoms namely fever, rigors and jaundice. He also defined septicaemia as a condition which can complicate cholangitis with toxins produced getting into the bloodstream. These conditions can be indistinguishable one from another. He found no evidence of cholangitis or septicaemia post ERCP. These two conditions occur quickly and would provide very distinct symptoms. They would never be diagnosed in the absence of severe illness. The symptoms suggested by Mrs Magill of crampy abdominal pain, loss of appetite, nausea, a temperature spike on 15 December 1999 and her allegation of tarry stools would not in his opinion have amounted to the triad of symptoms to which he had referred. The ERCP process does introduce gas/air into the system and a non specific pain such

as this would certainly not suggest septicaemia, cholangitis or pancreatitis. Similarly nausea and loss of appetite are both regular post ERCP complaints. In terms he found no evidence of any complications of ERCP in the days before the PTC. In the absence of such symptoms there was no need to prioritise the PTC.

[215] Professor O'Connor noted the white cell count (WCC) on 18 December 1999 which stood at 9.89 and on 19 December 1999 which stood at 8.99. In his opinion it was inevitable that an inflammatory response to cholangitis would give rise to an increase WCC and it would be highly unusual to have a normal WCC in those circumstances creating a definitive indication that there was no cholangitis, septicaemia. Similarly the C reactive protein (CRP) levels respond to inflammation. One would expect the level to be in the thousands if these conditions were present. On the contrary on 16 December 1999 the CRP level at 16 would have been a strong contraindication.

[216] This witness opined that ascending cholangitis would be attended by abdominal tenderness in the upper quadrant where the liver is. He referenced the examination on admission by Dr Fitzsimons at the RVH on 17 December 1999 when no such symptoms were found. Moreover, following the PTC, his abdomen was found to be soft

[217] In so far as the allegation of melaena has any relevance to this topic I have dealt with it at paragraph 190 et seq.

[218] It was the evidence of Dr McEniff that the three day delay between the ERCP and the PTC was standard in his hospital and in his experience in the USA where there is no evidence of sepsis and the patient is stable.

[219] Mr Parks, the expert called on surgery by the defendants, echoed the sentiments of Professor Price, Dr O'Connor and Dr Ellis in terms of this delay. His experience in Edinburgh is that they aim to complete the PTC within 48 hour to 72 hours of the ERCP but even that sometimes is difficult because of the pressure on lists. Pragmatically in his opinion three days was perfectly acceptable. He recognised that the procedure of PTC can take several hours and is technically very challenging. To perform it outside the normal schedule is difficult and was even more difficult in 1999 with less personnel available.

[220] I have concluded that the 3 day gap between ERCP and PTC was a standard delay consistent with competent medical practice in the absence of evidence of septicaemia /cholangitis /pancreatitis etc.

Was the PTC procedure competently carried out?

[221] Dr Ellis gave evidence that he had been requested by those responsible for the deceased's treatment to carry out a palliative PTC procedure. The decision had been taken by Mr Diamond that this patient was not a candidate for surgery because the tumour was a Bismuth type 4. The best option was a palliative PTC. He asserted it was outside his competence to question such a determination and stoutly denied that it was his role to second guess the decisions which had been taken by the team that was treating the plaintiff and in particular that of the surgeon Mr Diamond. Dr Ellis had only come into the case according to him at the request of Professor Spence to carry out a palliative PTC after the ERCP had been completed. He considered it appropriate that he should carry out that task.

[222] I have already described the basic tenets procedure at paragraph 5 et seq of this judgment. Dr Ellis declared it is a risky procedure with a 20% mortality outcome for PTC procedures, the possible outcome involving e.g. sepsis, renal failure or multi organ failure. The intention on Friday 17 December 1999 was to bypass the stricture on the left and right sides and achieve drainage. Dr Ellis' evidence was that this was one of the two most difficult tissue masses he had come across. He could not get the wire through the left hand side because the tumour was so tough. Accordingly a left external drain was placed with the intention of coming back for another effort on 20 December 1999. This would have allowed time for swelling on the left side to have settled, the external drainage would have relieved pressure and the liver could perhaps excrete bile making the left duct smaller and easier to direct the wire into. Consequently over 1 ½ hours he concentrated on the right side. In the event the wire was inserted and a metal stent placed on the right hand side without any penetration on the left.

[223] Dr Ellis contended that there were two schools of thought in the medical literature as to whether two stents would be used for palliation or whether only the right side would have been sufficient. He observed that it is impossible to drain the whole of the liver. There are eight segments in the liver and some of them will not be drained. In his opinion it had to be borne in mind that the left system had been opacified with dye being introduced to it at the ERCP which was not sterile and therefore it was necessary to drain the left system as well. There would be a high risk of sepsis if that area remained undrained. It was therefore important to attempt to drain the left side as well.

[224] Dr Ellis contended that it was entirely appropriate to attempt to insert the metal stents on both the right and left sides. He had struggled for over 1½ hours to insert the drain into the right hand side on 17 December. In his view to have then inserted an external drainage on the right side would have involved taking the wire out which he had passed through the stricture, with the attendant risk that he would not be able to get it back in again leaving two external drains i.e. left and right for the purpose of palliation. He had

substantial experience of double external drains in the USA when he had practised there. His experience was that the drains become infected, leaks of bile occur, it is painful for the patient, the bile makes the skin irritable and excoriates the skin and the drains can be dislodged. In his view no one would palliate with external drains. Dr Ellis indicated that he had never seen external drainage left in for 7-10 days as suggested by Professor Lamaris over his many years of practice.

[225] Accordingly he attempted to try the left side again on Monday 20 December. He could not perform the parallel stenting. The head of the wire wanted to link up with the other part of the Y. Therefore he had to perform a T configuration rather than a Y i.e. the left stent was placed through the right stent into a T configuration. Although it is not optimal it was a standard procedure.

[226] It was Dr Ellis's evidence that he did achieve a flow of bile by the T configuration on 20th with the left side was draining into the right and then down into the stent placed on the Friday. A crucial piece of evidence in this case was the assertion by Dr Ellis that he had observed evidence in real time of a degree of drainage after the PTC had been performed by watching the injected dye descending into the right duct system, down the common biliary duct and into the duodenum. In other words he saw a passageway through which bile was descending into the duodenum from the left moving across into the right duct system and down. He stressed that he alone of anyone in the entire case had the opportunity to watch in real time the draining of the bile through the stent system. The drainage of the bile in his opinion was better than adequate at this time.

[227] The CT scan of 23 December 1999 was also significant in this regard. Dr Ellis said that Dr Collins had requested him to carry out the CT scan because Mr Magill was not doing well, his blood pressure had dropped, there were concerns that perhaps he was bleeding or that he was suffering sepsis because of the possibility of a large bile leak or the ducts were not draining satisfactorily. Hence he was looking for a leakage of bile. This x-ray amounted to salami cuts from the top of the liver to the upper pelvis. Dr Ellis recorded that the stents were clearly in position in a T-shape. On the right hand side the bile ducts have narrowed down well, confirming a good drainage on the right side and on the left they were somewhat less so since clearly some segments had not drained.

[228] Dr Ellis drew attention to the bilirubin levels. The liver works to excrete bilirubin from the blood. Failure to do so builds up the levels and can drain other organs of the body including the cornea etc. The only way to reduce bilirubin levels is to provide drainage. It can take several weeks for bilirubin levels to reduce to the extent that the jaundice is clear. Nonetheless such levels are always measured to check drainage and the fact of the matter

is that there had been a substantial drop in bilirubin levels within one week from the PTC procedure being invoked. The records revealed bilirubin levels as follows were as follows:

- 17 December – 450
- 19 December – 452
- 21 December – 447
- 22 December – 431
- 23 December – 494
- 24 December – 391
- 26 December – 344
- Autopsy -- 316

[229] It was Dr Ellis's view that the fall in levels between 450/344 does show that bile is being drained. The fact of the matter is that he would have left the left external drainage in situ if he had not been satisfied that there was adequate drainage whereas he took the specific decision to remove the external drainage. He posed the question as to why he would have done this if he had not thought there was some reasonable drainage. Consequently, for three reasons Dr Ellis stated that he was satisfied there was adequate drainage. First because he had witnessed it in real time during the PTC process, secondly because he observed it on the cholangiogram (the cholangiogram of the 20 December showed, he claimed , the left stent inside the right stent and clear drainage of contrast through the left and right ducts) and thirdly because the bilirubin levels were falling.

[230] The plaintiff criticised the performance of Dr Ellis in the following respects –

- Dr Carr-Locke asserted that the stent on the left was kinked and not functioning as it passed through the right stent and in the event did not drain that side at all. Consequently the bile, unable to escape through that stent on the left side, instead escaped through the puncture sites at the liver into the peritoneal cavity (the space in the abdomen which allows the organs to move). In other words the bile had exited the liver causing peritonitis i.e. inflammation in the lining of the abdominal cavity. The biliary tree was already infected from the time of the ERCP when the drainage was already inadequate. Untreated and unrecognised in the 3 days between the ERCP and the subsequent PTC the infection took root and with the bile leakage making things even worse caused the consequences which led to his death.
- Professor Sebaldus Lameris an interventionist radiologist from the distinguished teaching hospital AMC in Amsterdam challenged that procedure adopted by Dr Ellis on the 17 12 1999 and asserted that it was not in accord with any recognised practice at that time. In the first

place Professor Lameris contended that Dr Ellis should not have accepted that only a palliative procedure was appropriate. He ought to have realised that the ERCP was a poor diagnostic tool upon which to base such a decision. The ERCP had not revealed sufficient information about the left hepatic duct to justify a decision that the tumour was of the Bismuth class four type. Accordingly it was the view of this witness that Dr Ellis ought to have gone back to the team responsible for his treatment and questioned the decision to carry out a palliative PTC procedure. This echoed the view of Dr Rauws.

- Professor Lamaris criticised the procedure carried out in the first PTC of 17 December 1999. He asserted that it was common practice in Europe in 1999 to insert dual catheter drains in such situations rather than metal stents and thereafter to await the effect on the clinical situation for several days during which the bilirubin or the effects of cholangitis could be monitored.
- The witness and Dr Rauws also criticised the decision to remove the external drainage rather than to leave in situ for 7 days as being rife with danger and liable to lead to leakage of bile into the abdominal cavity through the hole where the metal stent had been inserted in the absence of a drain. Inserting this drain for 7 days would allow an opportunity for a fibrous tract to develop to the outside without leakage.
- Use of the metal stent on 17 December 1999 rendered any decision to resect impossible. It is extremely difficult to remove a metal stent once they have been inserted. The decision whether or not to resect should have been postponed until the period of 7 to 10 days had passed after the insertion of the catheter drainage.
- It was Professor Lameris's contention that the decision to insert the metal stent on the right hand side in the first PTC at too early a stage in the process necessarily created a situation in which the second procedure ended up with the left stent going through the meshes on the right stent i.e. a stent within a stent which created a barrier. Drainage was therefore poor.
- Dr Rauws also criticised the decision on the part of Dr Ellis to insert a stent on the right-hand side on Friday 17 December 1999. In his opinion it should have been the left-hand side that was drained. Dr Rauws criticised the attempt to make a T formation of the mental stent on the right and mental stent on the left. Only the right side is observed in the PTC on 17 December 1999. However the most important side was the left system in his view because there was no evidence of segmental involvement on that side in the ERCP. Stents should not have been inserted on the right-hand side if it was intended to insert a further stent on the left-hand side on the following day, 20 December 1999. He described this approach as "indefensible" because leaving the stent on the right-hand side made it impossible to put a stent into the left-hand side and provide adequate drainage on that left

side. He described the approach adopted on 20 December 1999 – whereby a T formation of stenting was introduced – as an attempt to get out of the problem on Monday which he had created the previous Friday. He claimed he had not seen a T formation in his department. In short the PTC should only have been used to inject contrast into the left system.

- Dr Rauws criticised the number of puncture holes in the liver which had been caused in the course of the PTC. He asserted that no explanation had been given as to this number. In his opinion the consultant carrying out the PTC should insert the needle on the first occasion into a dilated bile duct and whilst it is possible in his opinion to miss on the first occasion it should not require several attempts.
- Dr Rauws asserted there had been ineffective drainage as a result of the PTC procedure carried out by Dr Ellis. He saw no effective drainage after the PTC. The bilirubin readings were a matter of contention in this regard. It was Dr Rauws' opinion that once the bilirubin reached over 400 because of the patient's jaundice it can take up to 4-6 weeks to reduce especially after long standing obstruction and infection. Bilirubin will be high even if there is adequate stenting. Dr Rauws therefore indicated that he would not even measure the bilirubin levels in the few days after the PTC whereas the presence of fever or positive blood cultures would be much more important.
- Mrs Magill claimed that Dr Ellis exhibited a lack of experience or knowledge of his own limitations.

[231] I commence my review of this issue by observing that Dr Carr-Locke and Dr Rauws are gastroenterologists who are not technically skilled to perform PTCs albeit Dr Rauws contended that he has dealt with this type of patient for 24 years and has seen hundreds of them performed. I consider this diminishes to some extent the strength of their evidence in this highly specialised field.

[232] I shall deal first with the allegation that the T formation was not standard practice to the extent that Dr Rauws asserted he had not come across it before. This assertion surprised me somewhat in that this is precisely the operation described in a paper co-authored, inter alia, by Dr Rauws entitled "Endoscopic Palliation of Patients with Biliary Obstruction caused by Non-Resectable Hilar Cholangiocarcinoma", published in volume 56 (No. 1) 2002 of Gastrointestinal Endoscopy where it records at paragraph 34:

> "When insertion of two wall stents was required at the same session, our preference was to place two guide wires before consecutive insertion of the delivery systems. In some patients however the guide wire had to be advanced through the mesh of the first wall stent deployed into the opposite main hepatic

> duct, followed by dilatation of the mesh with a dilating balloon before insertion of the second deliver system."

This appeared to be precisely what Dr Ellis had done in the instant case.

[233] In a further article found in Vasc Interv Radiol 2004(hereinafter called VIR 204) entitled "T-Configured Dual Stent Placement in Malignant Biliary Hilar Duct Obstruction with a Newly Designed Stent" published in 2004, it records the following at page 717:

> "We can assess some of the advantages of the T-configured dual stent for the treatment of malignant hilar obstruction. This technique is feasible for the interventional radiologist. It allows bilateral internal drainage of the right and left ductal systems via a single percutaneous approach in most cases."

[234] My attention was drawn to a paper entitled "Percutaneous Placement of Biliary Metallic Stents in Patient's with Malignant Hilar Obstruction: Unilobar versus Bilobar Drainage" ("Percutaneous Placement "). This was published by a group of Turkish interventionist radiologists in what I was given to believe was one of the most widely read journals in this area namely Das. Interv. Radiol. 2003: 14: 1409-1416. In this article at page 1410, there was a schematic representation of stent deployment configurations which had emerged in the study illustrating that approximately one half of the studies had used one stent, and the other half had used two stents, the latter groups mixing a Y configuration with a T configuration in the event that the Y configuration could not be obtained.

[235] Further support for the use of the T configuration is found in the text book edited by Afdhal page 853 where it states:

> "Metallic stents may be particularly useful for treatment of proximal malignant obstructions (*this of course is the present case*). The open mesh design permits bile flow through the sides of the stent and side branches of the intrahepatic are not obstructed. Furthermore, a second stent can often be placed through the mesh work and directed to the opposite lobe when bilateral drainage is desired."

[236] I therefore accept on the basis of the literature before me that the decision of Dr Ellis to employ metal stents in a T configuration was consistent with competent medical practice at that time. The T-shaped reconstruction was entirely standard practice in the circumstances and there was nothing untoward in what he had done.

[237] That was a view shared by the other experts called by the defendants. On the issue of the T-share biliary reconstruction, Dr McEniff asserted that this is a well known and well documented procedure, illustrated in multiple

well-reviewed peer papers. Dr McEniff found it "extraordinary" that Dr Rauws had indicated that he had never come across a T shape biliary reconstruction. Dr McEniff recorded in his report:

> "This is truly incomprehensible. The T shape reconstruction is a well recognised bail out position and is frequently performed. Some authors actually prefer this approach as it can negate the need for a second puncture site. There are numerous references in the literature to this well established reconstruction technique."

[238] Whilst I would not choose to echo the note of incredulity expressed by Dr McEniff, I did consider that Dr Rauws' dismissal of the T configuration concept was perhaps anther example of him failing to fully appreciate the full extent of the expertise involved in interventionist radiology and served to trouble me about the strength of his evidence in general.

[239] On the issue of the use of bilateral external drainage—advocated by the plaintiff's experts, as opposed to bilateral or parallel stenting – advocated by Dr Ellis, I have again considered some of the medical literature put before me. VIR 204 supports the contention by Dr Ellis that bilateral drainage was appropriate when it records at page 716:

> "Percutaneous palliation of biliary obstruction caused by hilar malignancy can be accomplished in a variety of ways. Although it is still controversial whether all segments of the liver should be drained, bilateral drainage is more physiologic than unilateral drainage. Chang et al showed that the best survival rate in patients with bifurcation tumours was noted in those who underwent bilateral drainage and a worse survival rate was seen in those with cholangiographic filling of both lobes but drainage of only one."

[240] I was directed to a very recent paper from the British Society of Interventional Radiology (BSIR) outlining results in a range of hospitals over the United Kingdom including the RVH. This report was based on data collected prospectively between 1 November 2006 and 18 August 2009. It included analysis based on the largest published database of collated procedure records on percutaneous biliary intervention worldwide. Data was submitted on 833 patients submitted by 62 operators from 44 centres across the United Kingdom. Page 36 of that paper records as follows:

> "Stent configuration: the majority of patients had a unilateral stent placed from a right sided approach.

> Bilateral and kissing stents (*i.e. stents placed side by side*) were used for treating lesions involving the more proximal biliary tree, usually near the liver hilum (17.4%). In many cases of proximal obstructions at the junction of the right and left hepatic ducts (*this of course is the example of Mr Magill*), it is usually sufficient to drain the right sided ducts for the purpose of palliation. In the literature patency of single stents generally appears to be better. However, it is recognised that if both duct systems are seen during cholangiography (*and of course both were seen in the ERCP*) and only one side is stented, there is a higher septic complication rate."

[241] At page 85 of that article it reveals that in the biliary stenting procedure, "the stents deployed were overwhelmingly bare metal stents (96.6%) with only a tiny minority of operators using plastic stents. Primary stents (i.e. without a drain) were placed in 62.8% and staged stenting i.e. draining the matter first, was performed in only 25% of cases."

[242] In the Percutaneous Placement paper at page 414 the following extract appeared:

> "Some authors defend complete drainage and other advocate incomplete drainage. Supports of complete drainage emphasize the risk of cholangitis and inadequate drainage in incomplete drainage. Others advocate incomplete drainage because of the expected lower risk of complications and because adequate palliation can be achieved by drainage of only 25% of the liver……. Endoscopic studies focusing on the outcome of unilateral verses bilateral liver lobe drainage have yielded conflicting results."

[243] It was also interesting to note that Professor Lameris had co-authored an article published in Eur Radiol (2008) 18: 448-456 entitled "Percutaneous Drainage and Stenting for Palliation of Malignant Bile Duct Obstruction". In the course of that paper he said at page 449/450:

> "Adequate drainage and stenting of one complete liver lobe is usually sufficient to relieve the obstructive jaundice but draining only several segments of one lobe is usually not enough. …. Stenting both the right and left lobes is preferred in Grade III and Grade IV hilar lesions as it leaves the option to choose the most appropriate lobe for drainage when a repeat procedure is necessary."

[244] In a further article entitled, "The Role of Endoscoptic Treatment in Palliative Care of Hilar Malignant Strictures" by Kapsoritakis et al published in the Annals of Gastroenterology 2005, the summary of the article records:

> "Malignant Hilar Strictures (MHS) are caused by a heterogeneous group of tumours. They have an extremely poor prognosis with the vast majority of patients dying in the first year after the diagnosis. Palliation of patients with MHS is a difficult clinical problem with little consensus regarding the optimal treatment approach. The choices for palliation of jaundice in these patients include surgical bypass and percutaneous or endoscopic drainage".

[245] Once again this article makes clear that endoscopic stenting is an acceptable palliative approach for patients with MHS. It emphasises the lack of consensus regarding the optimal treatment approach. This article further serves to satisfy me that there is clear room for differing opinions as to the appropriate method of carrying out these PTCs.

[246] I am satisfied that these papers indicate that what Dr Ellis performed i.e. an additional procedure to insert the left stent on 20 December 1999 was consistent with competent medical practice at that time. Hence whilst it may have been reasonable to place the right stent for palliation by itself according to some medical opinions other equally respectable opinion favours the course adopted by Dr Ellis. Dr Ellis chose to introduce the left stent at a later procedure because of the presence of potential infection in the dye introduced on the left side at the ERCP which required to be drained. I consider this to have been in conformity with competent practice.

[247] My conviction based on the literature was confirmed by the expert evidence called by the defendants. Dr McEniff, a Consultant Interventionist Radiologist contended that it was appropriate and common practice to carry out such a dual stenting procedure in PTC operations in 1999 and said that this was regularly done when he had been at the renowned Massachusetts General Hospital in Boston earlier in his career.

[248] It was the witness' evidence that the key factor here was that Dr Ellis had been tasked to carry out a palliative procedure. If the attention is palliative, placing the primary stent is a preferred method at that stage. Whilst obviously is it better to have two stents inserted at the one time, it is often not possible in his experience to drain both sides at the first sitting due to the infiltration of the tumour. Once Dr Ellis had been unable to drain both sides, he was left with two choices. First, he could take out the guide wire which he had spent 90 minutes attempting to get in, without any guarantee

that he would be able to replace it again, and then place external drainage. His second choice was to do what he did and place the metal stent on the right hand side. It was Mr McEniff's experience, echoing that of Dr Ellis, that patients do not like external drains. This was relevant to the decision not to place an external drain on the right side. Moreover interventionist radiologists in his experience are not willing to give up the advantage of having managed to get the guide wire through the tumour because of the risk of being unable to achieve that a second time. The plastic stents put in during the course of the ERCP would be inadequate to provide palliation being simply five FG and seven FG stents. Moreover the right hand side of the liver provides two thirds of the drainage and it is necessary to try and achieve drainage at least on this side. Having opacified (i.e. injected dye into the right side) he had to take steps to drain it. In short Dr McEniff asserted that he was not satisfied that Dr Rauws fully appreciated the difficulties of interventionist radiology given that his discipline is gastroenterology.

[249] Before leaving this topic I observe that whilst Dr Ellis accepted that a metal stent would not be used if he had been told that the deceased was a candidate for surgery or if there was evidence he was suffering from sepsis it was not strictly relevant to the issue of whether or not the tumour was resectable, that decision having been taken by Mr Diamond by 15 December 1999. Nonetheless Mr Parks did support the view of Mr Diamond that in any event the insertion of metal stents in the PTC procedure did not rule out surgery by way of resection had that been the option. Mr Parks made precisely the same point that Mr Diamond had made about the metal stents namely that they are not difficult to remove at least during the first three/four weeks after the PTC although thereafter they do become rather more difficult, involving at times pulling the strands of wire out bit by bit. I am satisfied that there is a competent body of practitioners who would have shared the view of Dr Ellis in this regard.

[250] I turn now to consider whether the puncture holes caused by Dr Ellis were in conformity with standard practice. Once again I shall first consider the medical literature on the topic. BSIR , outlining results at a range of hospitals over the United Kingdom including the RVH on such procedures, records at page 84 a wide variety of instances where 1 to 5 passes are made before the relevant duct is found.

[251] I was introduced to a standard text book entitled "Interventional Radiology: A Practical Guide" edited by Anthony Watkinson and Andreas Adam with a foreword by Peter Muller, all distinguished interventionist radiologists practising in the United Kingdom and USA. Mr Ellis asserted that this text book is used by all interventionist radiologists. At page 61 it records:

> "The number of needle passes required for a successful puncture depends on the degree of ductal dilation. Commonly, 1-3 are required in very dilated systems However, an undilated biliary tree will often require more. No correlation has been demonstrated between the number of passes and the frequencies of complications."

[252] A further paper in an American journal from the Department of Radiology in the University of Pennsylvania recorded at page 2:

> "PTC of dilated bile ducts is almost universally successful but may require as many as 15-20 transhepatic needle passes."

[253] Dr McEniff strongly disputed Dr Rauws' criticism of the number of puncture holes in the liver during the PTC. In his experience it is well accepted that three to five passes are necessary to puncture a dilated system and indeed in the case of undilated systems they can take ten to twelve passes. A chiba needle is used which is a small flexible needle being 22 gauge and is deliberately designed to do the least damage.

[254] This was yet another area where it was not the discipline of Dr Rauws and I feared again that he was straying uncomfortably outside his area of expertise. Hence I am satisfied that there is a competent body of opinion which takes a view different from that of Dr Rauws and would hold that Dr Ellis acted appropriately in effecting the entry via the liver in the manner he did.

[255] I also conclude that after he had completed the two PTC procedures there were grounds for Dr Ellis concluding that his task had certainly secured a measure of success. In the presence of a klatskin tumour it is never going to be possible to get full drainage of the liver. The aim is to get good enough drainage. I was impressed by the evidence of the cholangiograms of 17th and one on 20 December 1999. This is a system of injecting a dye process after the stenting procedure. In my opinion they demonstrate some drainage on 17 December on the stented side. There were four images on 20 December at least consistent again with a measure of biliary flow.

[256] This was followed by a CT scan on 23 December which showed the two stents in position. The right duct system had decompressed and the left one had partially decompressed. In other words I am satisfied there was evidence that the right drainage procedure had achieved some success and that the left was partially successful.

[257] That this is the case is corroborated by the clinical picture that I am satisfied emerged in the course of the evidence. Dr Collins saw the patient on 18 December 1999 within a reasonably short time of the first stenting procedure by Dr Ellis (albeit this is disputed by Mrs Magill) and there was nothing of significance recorded. On 18 December, Dr McCarthy also saw him and recorded nothing of note. There was no rise in temperature at this stage. The hgb was 13.8 and if one was losing blood over many days for example from 14 December, it would be expected to be lower. On 18 December 1999 the white cell blood count was normal at 9.89 and on 19 December it was also normal at 8.99. The evidence of Dr Caroline Lee, the Senior House Officer to Dr Collins, was that on 19 December 1999 there were nursing notes of 200 mls drainage in the left external drain. That led her, in my view understandably, to conclude that the drainage was working and that she was content with the degree of drainage then flowing from the left external drain.

[258] On 20 December 1999 Dr Lee again made a detailed and, in my view, characteristically careful note about this man. In particular on this date she recorded his urea level as normal. This is a good guide as to whether or not he was dehydrated and bleeding from his intestine. If so it would be raised as would his hgb level which was also normal. His white cell count and creatine level – which deals with his renal function – were similarly normal. His C-reactive protein level (CRP) at 16 was not entirely normal but was not indicative of infection. It was her evidence that her interpretation of the notes of this man of 18/19 December were not materially different other than she recorded on 20th that there was some improvement of his itch.

[259] Repeat stenting was carried out by Dr Ellis on 20 December 1999 after Dr Ellis had seen him and I would not have expected Dr Ellis to have performed the PTC if he had given the appearance of being unwell.

[260] On 21 December 1999 about 9.00 am Dr Lee found normal temperature and blood pressure. It was her evidence that if there was any sign of infection, it would have been reflected in a raised temperature, blood pressure level reduced and pulse elevated whereas all of these were normal. She recorded that his appetite had improved. A significant entry at this stage was to "dark blue large motions, passing wind only today". Her evidence on this was that she clearly had information from him that he had a bowel motion the previous day but no bowel motion on that day. It was highly significant however she thought that the hgb/urea levels were normal suggesting that there was no internal bleeding.

[261] By 5.30 pm on 21 December 1999 he had a spike in temperature which in light of the laboratory blood cultures taken as a result and the other developments of 22 December 1999 and 23 December 1999 depict a picture emerging at some stage of a developing sepsis. That development is in my

view no indication that the PTC was carried out in any manner other that in complete compliance with standard practice.

[262] That a competent body of medical experts would have concluded that there was no evidence of septic shock until late in the morning of 23 December 1999 is backed up by the evidence of Dr McNamee the consultant nephrologist from the BCH. He was at pains to emphasise that the presence of gram negative rods discovered on the blood culture by the bacteriologists at 5pm on 22 December 1999 may happen in many instances and septic shock will not ensue in all or even most of the cases. Unfortunately this is one of those where it did occur but that was not until at least 11.30am/12.15pm on 23 December 1999. Thereafter in his opinion he was treated appropriately, I find no connection between this and any alleged incompetence in the carrying out of the PTC procedure.

[263] I found no basis for the suggestion by Mrs Magill that Dr Ellis exhibited a lack of experience or knowledge of his own limitations. Not only did I find Dr Ellis' curriculum vitae strewn with marks of academic excellence and high achievement but Dr McEniff, having carefully analysed his role in this matter, expressly refuted the suggestion. He asserted that the steps which Dr Ellis had taken were well thought out and in a logical sequence.

[264] I believe that this issue is a classic case of a situation where differences of opinion in practice in the medical profession have emerged. The question is not which body of opinion I prefer. That is no basis for a conclusion of negligence. The question I have to ask is whether there existed in 1999 a body of professional opinion which supported the approach taken by Dr Ellis. I must recognise that there can be ample scope for genuine difference of opinion. A doctor is not negligent because his conclusions differ from that of other medical professionals. I have to decide whether Dr Ellis has been proved to be guilty of such failure as no Interventionist Radiologist of ordinary skill would have been guilty if acting with ordinary care.

[265] The passage of time has not aided the plaintiff in this regard. Stretching the memories of practitioners back to the state of knowledge 10 years ago is not an easy task.

[266] Accordingly whilst I have no doubt that Drs Carr-Locke and Rauws and Professor Lamaris are genuinely convinced that a wrong approach was taken by Dr Ellis, I am not so persuaded on the balance of probabilities. On the contrary I am satisfied that the approach he adopted throughout his PTC procedures did conform with good medical current practice which then existed.

Was there bile duct perforation and was there bile stained material in the peritoneal cavity at post mortem ?

[267] It was the plaintiff's case that there had been perforation of the bile duct during the ERCP/PTC procedures ,that this had introduced bile into the abdominal cavity and had materially contributed to the demise of her husband.

[268] She relied principally on the evidence of Professor Van der Valk, a very distinguished professor of pathology at the Vrije University Centre, Amsterdam who made the following points:

- Nursing and medical notes from the BCH indicated that fluid aspirated from the abdominal cavity on 28 December 1999 during a CT scan procedure by Dr Shiels and Dr Foster was demonstrated as free flowing bile. Dr Fogarty had recorded on 29 December 1999 :

  > "USS/CT yesterday - Free fluid – aspirated and demonstrated as bile. Presumed diagnosis is bile duct injury secondary to the carcinoma in the stenting."

- Sister O'Kane on 28 December 1999 ,when the deceased had been returned to the ward, recorded:

  > "On return to ward at 9.10 pm – no tube inserted due to difficulty – free bile in abdominal cavity. Professor Spence informed of same by radiologist – may come in later to see patient."

- There is no other way that bile can enter the peritoneal cavity unless there has been a perforation of the bile duct. The setting of the narrowed ducts and the difficulties with the insertion of the stenting in the ERCP made it almost certain that this was what occurred. Professor Van Der Valk could only speculate when the perforation had occurred. One possibility was a perforation of any stent. A second possibility was the erosion of the wall of the bile duct over some time by the placement of the stents. It is common case that the plastic stents of the ERCP were unlikely to cause perforation though again this would depend on the element of pressure applied. In Professor Van Der Valk's opinion the metal stents would have been more likely to be responsible.
- Given the very irritating nature of bile in the peritoneum, a perforation would have caused sepsis/ septic shock which in turn caused organ failure and ultimately the death of Mr Magill.
- Perforations are often small and the area in which to look for the perforation is not the most accessible of areas. Moreover the area must have been compromised by the necrotising pancreatitis and the acute sepsis that was reported. Accordingly it did not surprise him that

> Professor Crane at post mortem might miss a perforation particularly if he was cutting the bile duct in order to examine to it.

[269] The plaintiff also relied on conversations she allegedly had with nursing and medical staff at the BCH. They were as set out in the following paragraphs.

[270] First, possibly with Dr Fogarty, in the BCH on 27 December 1999. When Mrs Magill initially gave evidence she identified this doctor as Dr McNamee. Having seen him in the witness box she was subsequently certain it was not him and instead thought it probably was D Fogarty but she could not be sure. On 27 December 1999 her husband's pain had been becoming progressively worse according to the plaintiff. She said that she was restraining him, that he was pulling at the central line and essentially he became very disturbed. On that date she observed Sister O'Kane remove a metal stent that the plaintiff had passed per anum in his bed. Some time after this, Dr Fogarty asked to speak to her, according to the plaintiff. He asked would she give consent to an operation. The plaintiff asked what the purpose would be because her husband was dying and it was now too late. Dr Fogarty said "Mrs Magill, I want to apologise to you and your husband for the treatment you have had at the hands of my colleague". The plaintiff assumed this meant Dr Collins. He went on to say "It is correct that there has been a perforation. Please give your consent." She gave her consent. Dr Fogarty informed her that he was going to aspirate the fluid. He invited her to go down and to join them if she wished. The plaintiff explained to her husband that they had accepted that there had been a perforation and that they were going to do the right thing and find out what had happened. He indicated his agreement and she followed him down to the theatre.

[271] Dr Fogarty gave evidence that he had absolutely no recollection of such a conversation and indeed he did not believe that he had been in the hospital on 27 December 1999 although he could not be certain. He had young children and the usual procedure was that doctors such as him would be allowed off at or about the Christmas period. In any even he asserted that it was not his "style" to speak to relatives in this manner. It would not have been his job in any event to seek consent for the procedure as this would be a matter for a radiologist. He was adamant that he would not have criticised care in another hospital i.e. a junior doctor choosing to criticise another consultant. For my own part I think it highly unlikely that Dr Fogarty was the doctor involved in this exchange or, if he was, that he spoke in this fashion. He struck me as someone who would take his duties extremely seriously and conscientiously and thus would be unlikely to engage in the kind of loose conversation or lack of deference adumbrated by Mrs Magill. In the absence of her being able to identify who the doctor definitely was and him having an opportunity to refute the matter, I am not prepared to accept her version in this instance. For reasons that I shall set out later in this

judgment I have had cause to doubt Mrs Magill's credibility about a number of conversations she alleged took place and considering the objective evidence against the likelihood of a perforation ,I reject her account of this conversation.

[272] Secondly, the plaintiff then alleged that Sister O'Kane said "Who's a clever girl. It wasn't until he passed it that they knew what had happened. Dr George was coming in each morning and looking at Brian and saying something is terribly wrong". Sometime later the deceased came back from the aspiration shaking. He seemed close to death according to the plaintiff. At some point the plaintiff alleged that Sister O'Kane told her they had found bile. The plaintiff asked her how much and she said "They couldn't drain it. Professor Spence said this is because they'd hit the bowel".

[273] Thirdly, at about 11.00pm on 28 December 1999 Sister O'Kane informed the plaintiff that Professor Spence wished to speak to her. The plaintiff told him that they had found bile but Professor Spence was reluctant to admit it. He said "I am still willing to operate. I don't want blamed if he dies on the table." The plaintiff informed him that he was dying anyway and Professor Spence told her that Dr George was standing by, he was an excellent anaesthetist and that he would be in at 8.00am.

[274] Finally, on 29 December 1999 at 10.30am, Dr George arrived and according to the plaintiff was in a tearful state. He said he had sat all night and asked himself what he would do if it was his father and his daughter. He said "I will bring him through but he will be on a life support machine. He will be on dialysis. Allegedly Dr George said "If we had got it (i.e. *perforation the plaintiff presumed)* or realised in time, we could have done something about it". The plaintiff advised Dr George to make her husband comfortable, palliative care was set up and he died at 3.30am in the morning.

[275] The defence case was that there had been no perforation. The following points were made;

- There was no direct evidence of a perforation clinically or radiologically. The ERCP procedure used plastic stents so that was unlikely to be a source of perforation Dr Ellis asserted that it was highly improbable that the hole for the drain through the liver was a source of leakage because during the PTC process he was able to check on the cholangiogram, observe the bile and see it flowing down into the duodenum. There was no leak through the percutaneous tract. The autopsy did not record a perforation even though Professor Crane carrying out the dissection of the bile duct had been looking for such a perforation, albeit Professor Crane accepted that if there was a small pinhole perforation he might miss it.

- Dr Ellis asserted that a sound test as to whether or not there was perforation was the evidence of the cholangiogram on 20 December 1999. This shows the right and left ducts and the biliary system. It clearly illustrates the left stent junction into the right stent, the left and right ducts and drainage occurring. Of high significance according to Dr Ellis was the fact that there was absolutely no evidence of dye/contrast going into any of the peritoneal tissues e.g. the cystic duct, etc. The PTC involves injecting contrasting material under pressure. One would have thought that if there was a leakage, the pressure of this procedure would have revealed it.
- The CT scan of 23 December 1999 was also significant in this regard. Dr Ellis said that Dr Collins had requested him to carry out the CT scan because Mr Magill was not doing well. His blood pressure had dropped, there were concerns that perhaps he was bleeding or that he was suffering sepsis because of the possibility of a large bile leak or the ducts not draining satisfactorily. Hence he was looking for a leakage of bile. Dr Ellis observed in that CT scan no free fluid in the abdomen and a normal pancreas. There was some fluid surrounding the gall bladder fossa but in his opinion no more than a few ccs which would be well in keeping with the normal very small amount of bile leakage in a PTC. Dr Ellis asserted that the liver would be producing one litre of bile per day. After three days there would be far more than a few ccs of fluid. He contrasted the CT scan of 23 December 1999 with the scan of 28 December 1999 carried out by Dr Shiels where there was far more fluid surrounding the liver because by that time it is agreed that the patient clearly had pancreatitis and low albi levels which would both constitute reasons for free fluid in the abdomen. These pictures as illustrated to me by Dr Ellis made compelling observation.
- Dr McEniff, the interventionist radiologist expert called on behalf of the defendants, was equally adamant that the CT scan of 23 December 1999 showed no evidence of any bile leak. There was a very little amount of fluid present in contrast with the scan of 28 December 1999 when there had been the intervening septic shock and multi organ failure and where there would inevitably be a large amount of fluid which may be bile stained as the bilirubin levels were still high. Dr McEniff was certain that if there had been a bile leak at the time of the PTC procedure, it would have been visible on the CT scan on 23 December 1999.
- The colour of the fluid – "reddish brown " - as described by Professor Crane was of some importance. Dr Ellis asserted he regularly sees bile which illustrates to him that he has entered the bile duct and that bile is green or yellow and viscous in nature. Dr Damien Fogarty, who is now a consultant nephrologist in BCH since February 2002 but at the relevant time on 29 December 1999 was a senior registrar in Nephrology at BCH asserted he had seen pure bile on a number of occasions. It was a viscous thick green yellowish substance often

found in the gallbladder and which he had seen during the course of dissections, surgical procedures and biliary drainage. When his attention was drawn to the reference to 1,500 mms of "reddish brown watery fluid" in the post mortem, he said that this suggested to him watery fluid stained with blood from the aspiration and not bile.

- The evidence of Professor Crane was that at the autopsy, upon examination of the abdomen, he discovered 1500 mls of reddish brown watery fluid. He recorded:

> "Abdominal cavity: contained 1500 ml. of reddish-brown watery fluid. It was crossed by fibrous adhesions. There is a large partially necrotic inflammatory mass crossing the upper half around the pancreas gland making removal of the organs difficult."

[276] It was his experience that normally little fluid is found in the abdominal cavity after death whereas in this instance there was a large amount which was dark in colour. He did not find this unexpected for two reasons. Firstly, because inflammation of the pancreas gland is associated with bleeding. As it breaks down, bleeding will occur from the gland. Therefore the fluid around it will be bloodstained. Secondly, if there is a high level of bilirubin in the body fluid, the fluid in the abdominal cavity will be dark because of the presence of bilirubin i.e. staining the bile fluid. Professor Crane sent a sample of this fluid to the biochemistry laboratory and a bilirubin level of 316 was found.

[277] In a view he shared with Dr Ellis and Dr Fogarty he contended that if it had been pure bile, the material would have been thick and viscous and the bilirubin level would have been considerably higher. In his opinion this was water fluid stained with bile and blood. The inflammation of the pancreas gland would itself accumulate fluid in the abdominal cavity. Effectively in multi-organ failure involving the kidney, the kidney will not produce urine and therefore the fluid will accumulate in the abdominal cavity. Fluid leaks out from the tissue. Professor Crane tested the blood post mortem and his urea level i.e. the waste product in his bloodstream was high. The kidney would normally dispose of that material. Therefore the urea and other waste products had built up in the bloodstream causing again a significant amount of fluid. This fluid in his opinion had built up from not a single source but from a number of sources due to the multi organ failure e.g. kidney failure, pancreas, etc.

[278] This echoed the views of Dr O'Connor the consultant physician/gastroenterologist called on behalf of the defendants. It was his view that there were a number of reasons for bile stained fluid within the abdominal cavity. In a patient such as Mr Magill who has developed

septicaemia, shock, multi-organ failure and haemorrhagic pancreatitis it would not be at all surprising that the patient developed ascites (fluid on the abdomen) and as he was a deeply jaundiced person then one would expect the ascites to be bile stained. At post mortem the concentration of bilirubin in the abdominal fluid was found to be 316 which was considerably less than the concentration of bilirubin (400) in Mr Magill's blood. It was Dr O'Connor's view that if there were significant quantities of bile leaking into the peritoneal cavity then the bilirubin concentration in the abdominal fluid would have been as high if not higher than that in his blood.

[279] Interestingly this all tied in with some other evidence from Dr Fogarty. That witness, on 29 December 1999, recorded the jugular venous pressure (JVP) in the neck at the earlobes as increasing. He could actually see the earlobes moving with the circulation. The amount of fluid in the autopsy shows that the deceased had extra fluid in the vascular tree i.e. intravascular volume which can contribute to various cavities and spaces between the vessels themselves. The raised JVP is consistent with increase in the volume of the watery fluid i.e. ascites. This man had acute renal failure and therefore he was not passing urine. Consequently the fluids he was getting from the drip were not being removed by kidney function and would go elsewhere. In addition the serum albumin – which is protein in the blood vessels – serves to keep liquid in the vessels and not extrude through the walls. If, as in this instance, the albumin level is low, then there will be further oedema in the cavities and the fluid will escape. The combination of reduction of albumin and the increase in pressure in the venous system in draining the gastro intestinal tract (the portal venous system) would all contribute to ascites. In short, it was Mr Fogarty's view, that if there was presence of ascites, as he suspected there was, 1,500 mls in the fluid would be perfectly standard amount to find. It was his experience that patients often have higher amounts than this consistent with ascites.

[280] In cross examination Professor Van Der Valk made a number of important concessions He accepted that if there was a bile leak from ERCP one would expect the white cell blood count three days later to be abnormal and increase whereas it was normal i.e. 9.8 on 18 December and 8.99 on 19 December. Similarly the CRP level on 17 December was close to normal at 16. These matters all made it less likely that the deceased had peritonitis at this stage. The lack of contrast showing a perforation in the cholangiogram on 20 December also made it less likely. The CT scan on 23 December showing very little fluid again was significant.

[281] He accepted that if there was a post ERCP bile leak it would cause significant pain within hours, be persistent and increase in intensity until the pain was relieved by analgesia albeit pain can be variable from patient to patient. One would expect peritonitis as a result of bile into the abdominal cavity giving inflammation of the peritoneal cavity. The abdominal cavity

can generate fluid to dilute this bile. However one would expect discomfort and it is unlikely that the patient would be able to go for a bath although much would depend on the amount of bile. He accepted that the notes in the UIC claimed that the deceased was up and walking, mobilising between rooms and corridors. This would usually inconsistent with peritonitis.

[282] On the issue of the notes from the BCH upon which Professor Van der Valk relied, Dr Damien Fogarty asserted that his note of 29 December 1999 was based entirely on a note from Dr Shiel who carried out the aspiration procedure. He readily admitted now that he had absolutely no evidence to suggest that it had been bile and if he was writing the same note today he would have written "bile stained fluid". It was an error for which he now accepted responsibility. At the time he did no see the importance of a distinction between bile and bile stained fluid in the case of Mr Magill. I was not impressed by the use of the phrase "free flowing bile" by Sister O'Kane. She is not a clinician. She admitted herself that her interpretation of this as free flowing bile derived from the note made by Dr Shiel. Dr Shiel was the expert and she certainly did not describe this as free flowing bile. I felt this was a classic example of a nurse, not being well versed in the essential distinction between bile and bile stained material, drawing a wrong conclusion. Dr Shiel's note, the genesis of the whole matter, was an unequivocal reference to bile stained fluid and not bile.

> "We therefore attempted to drain fluid from the right para colic Gutter to assess its content and some bile stained fluid was identified. It was not foul smelling and no pus was identified. The fluid was similar when aspirated from the left and right sides of the pelvis."

[283] Nurse O'Kane had no recollection of any such conversations with the plaintiff as she alleges .I consider it very unlikely that she would have had sufficient expertise to engage in an informed conversation about the presence of bile and even if she had done so I would have placed little or no weight on it because of that very lack of expertise. Dr George is now deceased and so I heard no evidence from him. However given the paucity of the evidence available to substantiate an allegation of bile perforation and the weight of the evidence outlined above against the proposition I consider it highly unlikely that he would have been sufficiently incautious to have ventured the opinion alleged by the plaintiff.

[284] The preponderance of the evidence clearly favours the defence case in this instance. I therefore have come to the conclusion that there was insufficient evidence to satisfy me that there had been a perforation of the bile duct or incursion of material amounts of bile into the abdominal cavity during these procedures.

Was it correct to transfer the deceased form RVH to BCH on 24 December 1999

[285] Mrs Magill took issue with the decision to transfer her husband from the RVH to the BCH on 24 December 1999 on the basis that he was not well enough to be transferred and it was detrimental to his wellbeing. Whilst Dr Carr-Locke stressed the benefits of continuity of medical care, I state immediately that on the issue of causation I found no acceptable medical evidence that this transfer had any detrimental effect on his condition or any causative connection with his death.

[286] In any event I am satisfied that it was a proper decision to conclude that there had been a complete breakdown in the relationship between the plaintiff and the nursing and medical staff at RVH and in particular with Dr Collins by 24 December 1999. It was appropriate that that practitioner should no longer be involved in the patient's treatment. I shall deal with the factual position vis a vis that breakdown later in this judgment in relation to the RVH staff and Dr Collins in terms of the allegation of assault and false imprisonment on 24 December 1999("the incident") etc but it is sufficient at this stage to indicate that there is no doubt in my mind that relationships between Dr Collins and the nursing and medical staff at RVH on the one hand and Mrs Magill on the other had reached an unacceptably low point by 24 December 1999. There had been unfolding a picture of deteriorating relations and the transfer of treatment in my view was timely, proper and a solution within the appropriate band of decisions to be taken by a competent consultant and medical director Dr Carson.

[287] It was clear during the course of the meeting between Dr Carson the medical director of RVH and Mrs Magill in the aftermath of the unfortunate incident between Dr Collins and Mrs Magill of 24 December 1999 that Mrs Magill did lack confidence in the management of Dr Collins and that professional relationship was not going to be restored. Both parties recognised this and agreed to the transfer of care to another clinician. I have no doubt that Dr Carson was being accurate when he recalled this and that Mrs Magill was well aware of what was going to happen. Properly in my view, at this point Dr Carson decided to visit the ward and make his own professional judgment so as to ensure that proper care was being given to the patient, that he was fit to transfer and to satisfy himself if the patient was in need of intensive care.

[288] Dr Carson's background was that of a consultant anaesthetist between 1975 and 2002 before being seconded as Deputy Chief Medical Officer between August 2002 and May 2006. He was a consultant who had practised for 24 years as such, had trained in the United Kingdom and the USA, had managed acute and critically ill patients and therefore had, as he indicated,

learned to make quick and rapid assessment of the physical condition of patients in order to ensure the necessary care.

[289] Despite Mrs Magill's assertions to the contrary, I am fully satisfied that Dr Carson was clinically competent to make an assessment of Mr Magill's condition and to conclude that Mr Magill could understand what was going on. I am satisfied that there was no evidence at that stage that he was in sceptic shock e.g. his pulse and blood pressure were stable. He was fit to be transferred.

[290] His conclusion was shared by Professor Spence who asserted that the patient's main problem at that stage was renal failure and the main renal unit was in BCH. The breakdown in relationship was undoubtedly another factor in favour of the transfer. Professor Spence made a very detailed note of the deceased's condition on his arrival at the BCH.

[291] That coincides with the view expressed by Dr McNamee the nephrologist at the BCH who saw him at 7.45 pm that evening in BCH with the benefit of the note made by Dr George upon admission. Dr McNamee's evidence was that whilst the patient was unstable on 24 December 1999 he would not have been moved to the Intensive care Unit in the RVH because only patients requiring ventilation (which he did not) would be so moved. He required support because his blood pressure had to be stabilised. It is perfectly normal in his experience to move patients in this condition to the BCH. The renal unit in BCH provides consultation for patients in RVH. In the event Professor Spence, after speaking to Dr Carson telephoned Dr McNamee asking that the patient be transferred to the Belfast City Hospital to the High Dependency Unit and it was agreed that transfer be effected.

[292] I thus reject entirely the suggestion by Mrs Magill that it was negligent to conclude that the deceased should be transferred to the Belfast City Hospital where he would be under the care of Professor Spence. Dr Carson's judgment was solely related to the nature of continuing care and who should be responsible for that care. Not only had Mrs Magill in my view agreed to her husband's care being transferred to another consultant but Professor Spence was the appropriate person to be in charge thereafter. Whilst obviously continuity of treatment is preferable, confidence had been lost in the nurses and doctors in Wards 9 and 10 of the Royal Victoria Hospital, whereas Professor Spence was the person who had originally referred Mr Magill for treatment and he was perfectly competent to decide what other experts would be required. Once Professor Spence had accepted responsibility for ongoing management he would take all responsibility for who was going to treat Mr Magill. I find it inconceivable that Mrs Magill would have objected to Professor Spence taking over all control once again at the Belfast City Hospital and I reject her suggestion that she was opposed to the move to Belfast City Hospital.

[293] I find no substance to the plaintiff's complaint in this context.

Should the deceased have been surgically investigated on or around 24 December 1999 upon his admission to BCH? In particular should the laparotomy contemplated on or around 28 December 1999 have been carried out on or around 24 December 1999?

[294] It was the plaintiff's case that there was evidence of bile leakage and consequential peritonitis when Dr George (now deceased) saw the deceased on admission to the BCH on 24 December 1999 and thereafter. She asserted that Dr George had brought her to see an x-ray and said there was something gathering but he could not work out what it was.

[295] She developed her case against the medical staff at the BCH by asserting that on or about the 24/ 25 December 1999 a decision should have been taken to investigate the peritoneal cavity, wash it out and provide a surgical remedy as suggested on 28 December 1999 by Professor Spence or that some other medical step should have been taken. In short a window of opportunity was missed to investigate. In particular it should have been obvious from the X ray of 25 December 1999 that the left stent was in an inappropriate position. Other than the evidence of Dr Rauws on the X ray of 25 December 1999 with which I have dealt earlier in this judgment, Mrs Magill produced no credible medical evidence to back up this aspect of her case .

[296] I commence my review of this wide ranging criticism by reiterating my finding that there was no substance in the claim that the metal stent had been improperly placed during the PTC or that there was any credible evidence on any scan or X-ray that it had been so misplaced. As I will shortly outline I am also satisfied that the stent did not migrate from where it had been located by Dr Ellis, it was not extruded on the 27 December 1999 and was not replaced by the aspiration exercise of 28 December 99. Hence there was no question of steps being taken to address this.

[297] I approach the matter thereafter by a general review of what was done medically in the BCH and a consideration as to whether there is any evidence that the medical path followed in the BCH medical team was other than that which a competent body of medical practitioners would have pursued.

[298] Dr Fogarty, a consultant nephrologist since February 2002 in the BCH and who was a senior registrar in December 1999 gave evidence on this matter. Whilst he had not been present on 24 December 1999, he was aware from the records that upon his admission Mr Magill was suffering acute renal failure and required urgent dialysis. Dr Fogarty asserted that there was no evidence on 24 December 1999 that there was any inter-abdominal problem

which required surgery. Fluid accumulated much later and as it transpired the deceased developed pancreatitis but again at a later stage. Dr Fogarty asserted there were however a number of conditions from which the plaintiff was suffering and which eventually contributed to his death. He had an aggressive tumour leading to obstruction in the bile ducts and developed gram negative E. coli which led to acute renal failure. The witness was adamant that the bile was not the cause of the acute renal failure and indeed the biliary tree was structurally normal on the post mortem. He saw no evidence of any missed opportunity to retrieve this man from his condition.

[299] Dr Fogarty indicated that it was quite a normal procedure to aspirate the patient as occurred on 28 December 1999 even if he was dying. Active treatment will still be offered to such a patient and it was his experience that that is frequently done for patients even who are suffering terminal illness. Aspiration is not a major procedure and it is done for patients even rather more ill than Mr Magill was.

[301] Dr McNamee gave evidence in some detail on this aspect of the case. He was a nephrologist in the BCH having been appointed a consultant in 1989. He had trained in Canada and had been appointed to the Northern Ireland Renal Unit in the BCH in December 1989. The background to the deceased's admission to BCH on 24 December 1999 is revealing and throws light on the condition that was being addressed on his admission it the BCH. Dr McNamee indicated that essentially the reason why he was being considered for transfer to the BCH from the RVH was because of renal function deterioration. In so far as Mrs Magill voiced a concern that dialysis was not embarked on in time Dr McNamee gave a number of reasons for dialysis therapy, none of which was present in this case during 24 /25 December 1999 . These are:-

- If the potassium level is too high, this will slow the heart. Dialysis will remove the potassium. It was not the case at this time that the potassium level was high.
- Fluid overload, which is due to the tendency to retain salt in the water and becomes overloaded. Again this was not the case at the time of his admission to BCH.
- Urea creatine levels may be too high. Again dialysis will lower the urea level and deal with the excessive salt in the water. These levels did not require to be addressed at this time of admission.

[302] The deceased had been seen coincidentally by two specialist renal registrars in RVH shortly prior to being transferred to BCH namely Dr Cunningham, who had seen the deceased unaware that Dr McCarroll, another specialist registrar, had also seen him.

[303] Dr Cunningham's note of 24 December 1999 revealed a high white cell count indicative of sepsis, very low urinary output and low blood pressure. Dr McNamee indicated that the clear impression here was sepsis/hypertension/possibly leading to kidney damage. The recommendation of micro-biology consultation was in Dr McNamee's opinion was a good step. The symptoms revealed no current need for dialysis.

[304] In short it was Dr McNamee's view that at that stage the high dependency unit or the intensive care unit were better that the dialysis unit. He spoke with Dr Collins at 1.00 pm on that date and told him of his view. Dr Collins was distressed and wanted something done. At 4.00 pm Dr McNamee was contacted by Professor Spence who said that he had organised a transfer to the high dependency unit of BCH and asked Dr McNamee to see him when he arrived there.

[305] Upon his admission to BCH, Dr George had seen him as already indicated. A full history was recorded by Dr George including the very low urinary output, and low blood pressure. Dr George had recommended blood cultures and IV fluids. Dr McNamee saw him later that day at 7.45 pm and, with the benefit of Dr George's note, agreed with the plan with the reassessment to be made the following morning.

[306] Dr McNamee saw him at 8.30 am on 25 December, Dr George already having seen him earlier that morning. He was reasonably alert, his chest X-ray had been clear but he was still jaundiced. Dr McNamee arranged for him to be transferred to the transplant ward where he would require intensive monitoring. At that stage Dr McNamee felt that he was better than he had been the day before. He discussed with Sister O'Kane, who was in charge of the ward, how he had been overnight and was reassured that there had not been any problem. He continued on antibiotics and intravenous fluids. Dr McNamee decided that dialysis would commence the next day if there was no improvement.

[307] On 26 December 1999, when Dr McNamee visited him Mr Magill was not well. The patient was confused, jaundiced, and had required sedation overnight albeit his blood pressure was satisfactory. Dr McNamee concluded that whilst for the first three days it appeared that the sepsis may have been resolving he was now deteriorating. A central line was now set up to facilitate dialysis therapy and he now handed over his treatment to other colleagues on that date and did not see him again. Thereafter on 28 December 1999 a US scan and CT scan were carried out by Dr Shiels and Dr Foster to discover if there was an abscess which could be drained.

[308] I find no evidence to suggest that this treatment was other than what a competent consultant would have directed for this patient. He was afforded

care at the highest level with input from a number of senior consultants. The important issue in the opinion of Dr McNamee was to treat the sepsis and to attempt to stabilise his condition upon being admitted to BCH. I find no evidence to challenge that assertion on a medical basis. Within two days however his sepsis appeared to have been re-established. The decision to carry out the US scan and the CT scan was to discover if there was an abscess which could be drained. The initial treatment therefore and management was with intravenous fluids, antibiotics and introbic supplements. The fact that these did not manage to control the sepsis and therefore the question of abscess formation arose leading to the aspiration on 28 December 1999 i.e. looking for the source of the sepsis is no indication that the treatment given was incompetent or other than a competent body of doctors elsewhere would have done.

[309] Dr McNamee emphasised that sepsis simply means infection. Septicaemia is a virus in the blood. These are separate concepts from septic shock. Septic shock arises when organisms produce toxins in the cell wall. If endotoxin is released septic shock will ensue. This is very dramatic. The blood pressure will fall sharply, the patient is unable to sit or walk and will collapse on the bed, cardiac output will be insufficient to keep the blood flowing to the vital organs e.g. the kidney, bowel and brain, and pancreatitis may occur, etc. Dr McNamee describes the development of septic shock as a very dramatic development where a patient can be well at 9.00 am and critical at 9.15 if septic shock ensues. Dr McNamee has great experience of this condition seeing it monthly in his practice. He was certain that the deceased had not suffered this before his admission to BCH and challenged Dr Rauws assertion that the patient had been in septic shock from any earlier date.

[310] It was Dr McNamee's opinion that what had happened in this case was that the deceased's underlying condition of biliary obstruction had predisposed him to infection and sepsis. Antibiotics had given temporary respite. However if parts of the liver were still obstructed, inevitably the organisms in the obstructed area will continue to proliferate, burst out and cause catastrophic sepsis. The PTC had not been able to give 100% drainage and had led to this condition.

[311] The attempt to find an abscess in the course of the sepsis was not successful. There was a raised amylase on 28 December 1999 which revealed to Dr McNamee that the pancreas had become inflamed and therefore it was right to suspect pancreatitis at that stage. The approach on 28 December 1999 to consider operative treatment was in the opinion of Dr McNamee a desperate move to find some focus but by 29 December 1999 with his blood pressure having fallen and his white cell count now over 1000 indicating active infection and septicaemia the position was hopeless.

[312] In parallel with this evidence is that of Professor Spence. I find no medical reason not to accept the evidence of Professor Spence that in any event this man was not fit for surgery when in the BCH and by 27 December 1999 the outcome was becoming inevitable. Difficult though it obviously is for any despairing relative to accept, the fact remains that Professor Spence was unchallenged in asserting that consideration has to be given to the futility of putting a patient through an operation where he may well die on the operation table or shortly afterwards.

[313] Mrs Magill questioned Professor Spence as to why surgery was not performed on 25 December 1999 by him which would have recognised in her view the advent of necrotising pancreatitis .Once again I can understand the difficulty in comprehending the evidence given by Professor Spence and others including Dr Rauws in this case that there is no proven treatment for pancreatitis other than supportive care in the absence of an abscess. Supportive care was being given i.e. fluid, antibiotic cover and renal treatment. Dr Shiels and Dr Foster had found no evidence of such an abscess even in the aspiration procedure as late as 28 December 1999.

[314] I believe that even at the eleventh hour , Professor Spence properly discussed with Dr George the possibility of an operation to clear out the bile stained fluid as "a last ditch stand". At that stage Mr Magill was in multi-organ failure, ongoing sepsis and renal failure with increasing poor coagulation and again Professor Spence in evidence raised the spectre of putting him through an operation where the chances of him dying on the operating table were so high. In truth it seemed to me that the possibility of laparotomy was more theoretical than real. Accordingly having discussed the matter with Mrs Magill on 29 December 1999 the decision was taken to make him as comfortable as possible with palliative treatment until his death on 30 December 1999.

[315] It is not without significance that no expert on the plaintiffs' behalf criticised the care which Professor Spence or Dr McNamee dispensed in the BCH.

[316] In short I found no evidence that the deceased should have been surgically investigated as suggested by Mrs Magill on or around 24/25 December 1999 or that any treatment should have been given other than that administered as set out above. In my view the treatment of this patient in the BCH was in line with the steps that would have been taken by a competent body of medical opinion.

The issue of the allegedly voided stent and the ultra sound/CT scans of 27/28 December 1999

[317] It was the plaintiff's evidence that on 27 December 1999 her husband's pain had been becoming progressively worse. She said that she was restraining him, that he was pulling at the central line and was essentially very disturbed. He was grimacing in pain. On that date she lifted the sheet covering him and saw black blood spreading down the sheet. She told one of the nurses to send for Sister O'Kane. She saw Sister O'Kane with protective gloves on lift something which she was now convinced was a metal stent that the deceased had passed per rectum and, to the best of the plaintiff's recollection, put this into a bottle. At that time Mrs Magill said she said nothing because she was heartbroken.

[318] Some time after this the plaintiff believes that it was probably Dr Fogarty who asked to give consent to an operation to aspirate fluid/bile and indicated that perforation had occurred.

[319] The plaintiff then asserted that Sister O'Kane said "Who's a clever girl. It wasn't until he passed it, that they knew what had happened. Dr George was coming in each morning and looking at Brian and saying something has gone terribly wrong".

[320] She said that some time later her husband came back from the aspiration, shaking. He seemed close to death. At some point Sister O'Kane told her that they had found bile. The plaintiff asked how much and Sister O'Kane told her that they could not get the drain in and that Professor Spence said this was because they had hit the bowel. It was the plaintiff's case that the finding of the stent had triggered the further investigative treatment.

[321] Mrs Magill went on to assert that the stent had been surreptitiously replaced by a procedure on 28 December 1999.She called in aid the suggestion by Dr Rauws that he could see on the x-ray of 25 December 1999 the T configuration in an odd kinked position illustrating her contention that it had moved since the original insertion. He is clearly mistaken about this X ray which manifestly shows no stents and meant to refer to the CT scan of 23 December 1999.

[322] In aid of her supposition Mrs Magill drew attention to:

- the note made by Dr Fogarty and Sister O'Kane to which I have already drawn attention re her allegation this was free bile aspirated and claimed that the reference to the bile duct "injury" was in fact to a perforation.
- Her evidence that Professor Spence had allegedly told Sister O'Kane that they could not get the drain in because they had hit bowel. Mrs Magill asserted that not only had the stent been replaced during the course of this procedure, but that the treatment given to her husband during this procedure "finished him off".

- Her own recollection of the deteriorating condition of her husband after this procedure.
- The note of Dr George at 12.00 noon on 28 December 1999 which recorded inter alia: "Mr Magill has deteriorated rapidly since I saw him 24 hours ago. He is restless, agitated, hypoxic."
- The procedure ,which allegedly was a straightforward aspiration of bile from the abdominal cavity, had taken 2 hours instead of what she suggested should have taken 20 minutes indicating the complex procedure of stent insertion had occurred.
- The note in the record of the procedure made by Dr Sheils that "a stent is noted at the level of the common bile duct and the patient's previous history is noted". Mrs Magill suggested that this lent weight to the suspicion that there was only one stent at the time of this procedure and that a second was inserted.

[323] It was the defendants' case that no metal stent was ever extruded. Before turning to the vital evidence of Sister O'Kane and Dr Shiels who was the radiological registrar present on 28 December 1999 during the scan procedures I have looked to find extraneous evidence touching on the issue their evidence . The following points were made to this end:

- Dr Ellis had never heard of a metal stent moving or of one being excreted. The fact of the matter is that these stents are within a rigid environment and are locked in a permanent condition.
- The CT scan of 23 December 1999 showed the stents clearly still in place in the T-shaped configuration. On this occasion the T-configuration is in good position with no build up of bile in the area.
- Dr McEniff was firm in asserting that the stents were in appropriate position in the CT scan of 23 December 1999 and by the nature of the left hand side being inserted into the right stent to form the T shape it had to be somewhat kinked. This is no evidence of it having moved by the 23 December 1999.
- Dr McEniff shared the view of Dr Ellis that in his experience metal stents do not move. They are self expanding and adhere to the wall of the biliary duct in a tenacious manner. There have been some instances of erosion through the bowel wall but this will take months if not years to happen. For the stent to be extruded per rectum the stents would have to travel through the common bile duct, through the ampulla (sphincter at the end of the common bile duct) , all the way through the large/small bowel and out through the rectum. Dr McEniff considered it was simply not possible. The fact of the matter is that for this metal stent to have been excreted, it would have to have gone several metres through the bowel over the course of several days before being excreted on 27th. Why then would it have

been seen on the CT scan on 23 December 1999 and again on 28 December 1999? However both he and Dr Ellis indicated it would have been possible for a plastic stent to have been extruded.

- Dr McEniff confirmed that the insertion of a stent is a very lengthy and substantial procedure and would have to be carried out by an interventionist radiologist. Neither Dr Shiels nor Dr Foster were interventionist radiologists. Inevitably a note would be made that such a procedure had been carried out.
- There were still two stents found in situ in the CT scan of 28 December 1999.
- There were still two stents in position at the post mortem.

[324] I regard the independent evidence as weighing heavily against the plaintiff's contentions. I now turn to the evidence of the main personalities involved in these allegations.

[325] The plaintiff called Sister O'Kane as a witness. I have already found that her reference to "free bile in the abdominal cavity" which is contained in her nursing notes she had been taken from the information which she had been given from Dr Shiels. Mrs Magill had said that this witness and she got on extremely well and Sister O'Kane had been sympathetic to her.

[326] I had no difficulty in accepting this when I heard Sister O'Kane. This witness was an extremely experienced nurse, having been a sister since 1978, spent 12 years as a kidney transplant theatre sister and then a night duty sister for 8 years on the wards. She was in charge of 5 nurses at the relevant time in 1999. She struck me as a nurse who would have been the pattern of patience and sympathy to someone such as the plaintiff. I do not accept that this nurse removed a metal stent from the patient's bed as suggested by Mrs Magill for several reasons exclusively related to the evidence Sister O'Kane. These are:

- I believed this experienced nurse when she told me that had she in fact removed a stent from the bed of the deceased as a result of him having evacuated it from his bowel, it would have been passed on to appropriate authorities recorded it in her notes and informed a doctor. I formed the clear impression that there had been a good relationship between the plaintiff and this very sympathetic nurse. Why would Sister O'Kane act against her interests?
- Had anything had been put into a bottle by her, it would have been taken up to the laboratory for medical staff to deal with. For this to have happened, not only would Nurse O'Kane's notes have disappeared, and she to have forgotten all about this event, but the notes in the laboratory would also have disappeared. I do not understand why anyone would have done this or why the nursing

records would somehow have been altered to now reveal no mention of it.

- Nurse O'Kane indicated that she had never come across a stent being voided before and I have no doubt that this is something that would have stood out in her memory had it occurred
- I accept the witness's denial that she would never have said "What a clever girl. It wasn't until he passed it that they knew what had happened". I do not understand how Nurse O'Kane could ever have formed this opinion since she was not taking part in any of the surgery or procedures. She did not know Dr Collins and would not have been in the position to comment on any of the previous activity that had occurred on the part of the doctors prior to coming to the BCH.

I am driven to conclude that the plaintiff's observation of what the nurse did was faulty and unreliable. I fear that, as in other instances in this case, the plaintiff's recollection of what was said has been fatally flawed by her conviction as to the mistreatment of her husband.

[327] Dr Shiels, called by the plaintiff, was a crucial witness in regard to this aspect of the case. She is now a consultant radiologist with special interest in cross sectional imagining. Whilst she has a special interest in CT scans, MRI scans and ultra sound scans, she was not an interventional radiologist and therefore did not insert stents or drains. This contrasts with Dr Ellis who is an interventionist radiologist. Her evidence was that Professor Spence had requested that there be an ultra sound scan (USS) of Mr Magill and thereafter a CT scan.

[328] On 28 December 1999 the USC of the abdomen was carried out by Dr Shiels. Her note records, inter alia:

> "Stents noted. Free fluid++ around the spleen and around the pelvis …"

Dr Shiels discussed with Professor Spence by telephone the findings of the USS. He noted the presence of free fluid and he required a CT scan to be carried out. The witness said that depending on the outcome of this a decision would be made either to aspirate or to drain the fluid. That decision would depend upon the CT scan.

[329] She drew attention to the consent for that procedure which was signed by the deceased and which set out the terms of the operation as "diagnostic aspiration of fluid+- insertion of tube". By this she said it clearly was indicated that no decision had been taken which option would be actioned because it would depend upon what the CT revealed.

[330] The witness indicated that there was always an increased risk of infection if a drain was inserted. The decision would depend on the fluid that was aspirated. If there was pus or foul smelling material or if the fluid was localised, then drainage might be inserted. However if there were small amounts of free fluid about the pelvis and abdomen, then it would not be advisable to insert drains in several places because of the increasing risk of infection.

[331] Accordingly the CT scan was carried out. Free fluid was noted around the liver, spleen, right abdomen and in the pelvis. Dr Shiel's note of that CT scan recorded:

> "Fat planes noted around the pancreas are very infected - ? pancreatitis.
>
> 200 mls of bile stained fluid were drained from the right paracotic gutter. A further 50-100 mls of fluid were drained from the left side of the pelvis. Attempted placement of a drain into this collection was not possible.
>
> Sample has been sent for analysis including amylase levels to be checked.
>
> Findings were discussed with Professor Spence.
>
> He is to be reviewed by Professor Spence's evening.
>
> Post procedure scan show some residual fluid around the liver and spleen and in the pelvis."

[332] According to Dr Shiels, thereafter she dictated a note on 28 December 1999 about the CT scan of the abdomen which was subsequently typed up, checked by her and made available on 4 January 2000. Inter alia, this note recorded:

> "Spiral unenhanced imaging was performed through the abdomen and pelvis. IV contrast was not given due to the patient's renal status. A skiff of free fluid was noted around the liver. Further free fluid was noted adjacent to the spleen. Marked infection of fat planes around the pancreas was noted. The pancreas itself appeared a little swollen. A stent is noted at the level of common bile duct and the patient's previous history is noted. Marked infection of fat planes in the remainder of the abdomen and pelvis are also noted

> with further free fluid noted in the right para colic gutter and in the left and right sides of the pelvis. We therefore attempted to drain fluid from the right para colic gutter to assess its content and some bile stained fluid was identified. It was not foul smelling and no pus was identified. The fluid was similar when aspirated from the left and right sides of the pelvis. There is insufficient amount of fluid to insert a little drain. A follow up scan is to be performed tomorrow to reassess the amount of fluid. Immediately after drainage a residual amount of fluid was identified. … Fluid was sent for analysis including amylase levels."

[333] I was very impressed by Dr Shiels who gave her evidence clearly and succinctly in a measured and dignified manner. I accepted her evidence that whilst she was very suspicious that the CT scan provided evidence of pancreatitis-- the swelling of the pancreas, the injection of fat planes, the free fluid in the abdomen and pelvis-- she could not be definitive in the absence of the use of intravenous dye which would have shown up necrosis of the pancreas. She was unable to insert this dye because the dye itself is necrotoxic and could damage the kidneys of the patient. It was clearly contra-indicated for a patient with the condition of Mr Magill. She was criticised for seeming to differ from the conclusions of Dr Rauws in this regard but I considered that her evidence was redolent of a doctor who was careful in her diagnosis and was not prepared to go beyond being strongly suspicious in the absence of definitive proof.

[334] I also believed her when she said that this was bile stained fluid of a moderate amount. Her note is clear in this regard. The plaintiff challenged the reference to "++" as being more consistent with Dr Rauws's conclusion of "lots of free fluid". I was satisfied that Dr Shiels was correct to indicate that this amounted to more than a small amount/moderate amount and reflected the fact that there had been a number of areas of free fluid. Her description was purely in terms of distribution and was not quantitative. I also accept entirely the logic of Dr Shiels' assertion that biliary stents can appear confluent when two portions have been joined together. In this case the evidence of the defendant was that the left and the right stents had been joined during the PTC procedure and therefore I can well imagine two portions abutting each other and appearing confluent as one stent hence her reference to "a stent "in her notes.

[335] The conclusion that this fluid was as Dr Shiels described was corroborated by the fact that when the material was sent for analysis, there was no growth when cultured and the pus element was small. Had it been infected she would have expected a growth of the culture and plenty of pus

cells although she recognised that this was outside her field. In her view the material aspirated was probably not infected.

[336] I have dealt earlier in this judgment with the errors that I considered Dr Fogarty and Sister O'Kane to have been guilty of in describing this fluid as "bile " I found no reason to disbelieve the clear assertion of Dr Sheils that the material was simply bile-stained fluid.

[337] The next issue with this witness arose out of whether or not there had been an attempt to negligently insert a drain. It was the plaintiff's case that the attempt to introduce a tube or drain had hastened the deterioration of the deceased. I was satisfied from the evidence of Dr Shiels that a drain had not been inserted, that no attempt had been made to insert such a drain and that Dr Shiels was correct to say that they had aspirated some fluid using a small green needle.

[338] She gave good logical reasons why a drain had not and would not have been used.

- It would have been recorded in her note that an attempt had been made to use a drain and that some difficulty in the form of bowel obstruction had been encountered. Why would she not have put this in the note?
- She is not an interventionist consultant. She would not have been the person who inserted the drain. Dr Foster, a consultant at that time, was present and he would have done it. Had he done it there clearly would have been a reference by Dr Shiels in her note. There would have been no reason whatsoever for covering up that matter at this stage.
- There was not sufficient fluid at that stage to justify the risk of drainage. There was sufficient sample from each side of the abdomen for testing/assessment of the fluid. It is clear that the decision as to whether there was going to be aspiration or drainage was something that was countenanced before the operation. I believe Dr Shiels when she told me that she had personally performed the aspiration, that there was not an adequate amount of fluid in the area to justify insertion of the drainage and that physically no attempt was made to put the drainage in.
- This was not a short matter but something that may have taken an hour or longer. I have no doubt that this witness would have remembered an attempt to insert the drainage and would have recorded in the careful note that she prepared.

[339] If the bile had been infected she would have expected it to be green soupish type of material i.e. thick green fluid and not the light yellow stained

material that she found. Her reference to the drain not being "possible" was because of the diffuse nature of the skiffs of free fluid.

[340] Insofar as Sister O'Kane had made a note in the nursing records that "no tube inserted due to difficulty", again I believe this is an instance of a nurse misinterpreting the source notes which were made by Dr Shiels. Superficially it may seem to have a resonance with what the plaintiff alleges Sister O'Kane told her Professor Spence indicated, but there is absolutely nothing in the source note to suggest that there was any difficulty of a physical nature in inserting the drain. The drain was not inserted because it was inappropriate that it should even be attempted. Sister O'Kane was adamant that had she been informed subsequent to the ultra sound and CT scans of 28 December 1999 that an unsuccessful attempt had been made to insert a drain which had failed due to "hitting the bowel", she would have written this down. In the event she wrote "Attempted placement of a drain into the collection was not possible". This is what she derived from the notes.

[341] In substance I did not believe that Dr Shiels was perjuring herself or that she had deliberately fabricated her notes at the time of the scans. Why would she have done this? What would have been wrong with indicating that there had been an attempt to introduce drainage but it had been unsuccessful? This can happen from time to time and I can see no reason why the doctors would have conspired to conceal this.

[342] Dr Shiels was recalled by me after she had completed her evidence to deal with a discrete issue which had arisen during the cross examination of Dr Collins for the first time (almost 2 months into this trial) in this namely that that during the course of the procedure on 20 December 1999 a further stent had been inserted into the deceased to replace the stent which had been excreted and was removed by Sister O'Kane.

[343] Having heard Dr Shiels on this matter and having considered the objective evidence of the presence of 2 stents in the various scans etc, I completely reject Mrs Magill's unsubstantiated allegation for the following reasons –

- I found Dr Shiels to be a completely credible witness.
- Dr Shiels is not an interventionist radiologist and indeed has never inserted a stent in her career.
- Dr Foster, a consultant radiologist, is also not an interventionist radiologist and would not perform stent insertion.
- Stent insertion is a difficult and complex area. Dr Shiels assured me that it is carried out in an interventionist suite quite separate from the TT scanner room where this procedure was carried out. In other words if a stent was being inserted it would not even be carried out in the CT scanner room.

- Neither Dr Shiels nor Dr Foster could have carried out this complex procedure of inserting a stent without both of them being fully aware of what was happening. They would both have needed to be party to this shameful cover up. It would be done not only in the presence of Dr Foster and Dr Shiels but also radiographer and possibly even a nurse with Professor Spence in the general area. It is in my view risible to suggest that such a procedure could have been done without all of these clinicians being involved in some conspiracy to conceal it. Why would they do this? If the stent had been excreted, what would be the mystery about a decision to insert a further stent?
- The process that was carried out was diagnostic aspiration to assess if the fluid was infected. Dr Shiels as a registrar had performed dozens of such aspirations and is aware of many since she has become a consultant albeit she has not carried them out herself. They have never led to death. The fact of the matter is this is a minor procedure and it is highly unlikely to have made any contribution to the deterioration in an already very ill man.
- All the independent objective evidence to which I have earlier referred cries out against a stent being extruded and thereafter surreptitiously replaced.

[344] Accordingly I reject as without foundation the suggestion that a further stent had been inserted during this procedure. The allegation made by Mrs Magill illustrated her lack of insight into the nature of some of the allegations that she was making. Her problem was that Professor Crane had found two stents at the post mortem and if she was to convince anyone that a stent had been excreted, she was driven to making this wholly fanciful allegation. She was unable in this instance, as in other examples during this case, to stand back and recognise the total implausibility at any stage of points such as this. It illustrated how her judgment had been distorted in the course of this unhappy set of events. The late introduction of this concept several weeks after the trial had commenced illustrated Mrs Magill's seemingly endless capacity to generate new instances of *mauvaise foi* against the doctors who treated her husband together with a troubling tendency on the part of Mrs Magill to produce completely new allegations even 10 years after her original concerns had apparently surfaced.

The Plaintiff

[345] I had the opportunity to observe this plaintiff closely over the course of this 45 day trial. She gave evidence in chief and was cross-examined. In addition she cross-examined all of the witnesses called by the defendants. I have no doubt that she is a very intelligent woman who is, and will remain, convinced that the care of her husband in these hospitals and by these doctors was substandard and led to his death. Mrs Magill has suffered the most devastating of traumas, helplessly observing a much loved husband

deteriorating and dying before her very eyes over a period of less than 3 weeks in hospital .She has become consumed by a smouldering sense of injustice over the years since his death which I am afraid is quite unjustified on the facts . I have come to the melancholic conclusion that she has allowed this misplaced sense of injustice to overwhelm her judgment and create a false and dangerously selective recollection of events which over time she may even have come to believe in some instances actually happened notwithstanding the inherent unlikelihood of so much that she asserted. Her inventory of complaint was seared through with thoroughly improbable allegations of fabrication, dissimulation and mendacity. I regret to say that from time to time even the most implausible of propositions and allegations commended themselves to her where she felt they served her purposes heedless of the stress that she has undoubtedly occasioned to those who felt the weight of her accusations.

[346] If her case was right, virtually every doctor with whom she came into contact acted negligently over the three hospitals involved. Initially she had made a claim against the General Practitioner founded on an alleged misdiagnosis but although she had withdrawn this claim after advice from her medical experts 2 or 3 weeks before trial she still expressed the view before me that the GP may have been negligent.

[347] In the course of her evidence—which increasingly added fresh charges to those pleaded in her statements of claim as the case proceeded -- she variously made allegations of mendacity, fabrication of notes and medical negligence against Professor Spence, Dr Crothers(radiologist), Dr Collins (Gastroenterologist), Dr Gibbons his specialist registrar, Dr Lee the JHO on duty at the RVH, Dr Ellis (interventionist radiologist), Professor Spence, Mr Diamond, Dr Fitzsimons the admitting doctor at the RVH, Dr McNamee (Renal Consultant), Dr Fogarty senior registrar in nephrology in BCH, Dr Shiels (Radiologist), Dr Foster (consultant radiologist acting with Dr Shiels), Dr Lindsay JHO, Dr Cunningham SHO, Dr George (Anaesthetist), Dr Carson (the Medical Director), Dr Murray, Professor Crane the state pathologist and Dr Sloane a histopathologist in the RVH. Nursing staff in all three hospitals also came under her unflinching criticism including allegations of mendacity, inefficiency, defective and fabricated note-taking, and failing to respond to the needs of her husband. Moreover she did not shrink from accusing some of the expert witnesses called on behalf of the defendants of deliberate bias and bad faith in their evidence. In essence I have had to decide whether the plaintiff is inaccurate in her recollection or whether all of these witnesses are incompetent and most have been deliberately lying to this court.

[348] As the evidence unfolded I became increasingly convinced that it was the plaintiff who lacked credibility and not these defendants and their servants and agents. She has I fear –perhaps even unconsciously— in many instances, bewilderingly transposed her sad and traumatic recollections of

the condition of her husband in the final days of his life back to an earlier period of his treatment despite the mountain of evidence to the contrary.

Professor Spence

[349] Other than the medical issues with which I have already dealt, the plaintiff's main case against Professor Spence can be outlined as follows:

- Failing to properly manage the diagnosis, treatment and care of the deceased and in particular failing to arrange multidisciplinary meetings amongst the experts treating him.
- Failing to address or properly interpret the scans of 9 December 1999 and 13 December 1999 and to advise proceeding directly to a PTC thereafter.
- Failing to examine the ERCP films or to ensure that Mr Diamond did.
- Failing to address the risks of ERCP or the potential post ERCP problems by addressing the medical and nursing notes appropriately.
- Erroneously deciding with Mr Diamond that the deceased suffered a type 4 Bismuth tumour and refusing to resect same.
- Failing to consider transferring the deceased to a centre of excellence elsewhere in the UK.
- Breach of contract by virtue of failing to examine the ERCP films, concluding the tumour was a type 4, failing to reassess his diagnosis and coming to overhasty conclusions.
- In the BCH being party to a general decision to prematurely give up on treatment to save the life of the deceased and failing to intervene surgically.

The Plaintiff's evidence against Professor Spence included that set out in the following paragraphs.

In the UIC

[350] On the 15 December 1999 Professor Spence saw the plaintiff and her husband in UIC. He said, "News is good. This is a rare condition. Only one other case that I am aware of in Northern Ireland and this person works in the media and is doing well. It is more prevalent in the African population." When the plaintiff pointed out the proximity of the bile duct and the liver he told her that he would chair the management of his health needs, that he would be looking after him and the next time he" went fishing" he was "to bring him a fish".

[351] Later that day after she had spoken to Mr Diamond and was told that her husband's condition was inoperable, the plaintiff related to Professor Spence what Mr Diamond had said. Professor Spence said, "Don't listen to

him. I am the expert. There is an African connection. This is slow growing and people can live this. I'll be looking after you."

[352] Because they were getting mixed messages the deceased informed her he wanted a second opinion and so the plaintiff telephoned Addenbrooke Hospital. She felt that it had been accepted that her husband "was finished" and no one was looking at the decision process.

In the BCH

[353] From 25 December 1999 onwards the plaintiff asserted her husband's condition was deteriorating. His abdomen was swollen and hard and his breathing obstructed. On 26 December 1999 she observed red blood emanating from his penis and he was in terrible pain. His body was arching to control the pain and he was biting his lip and shouting out. According to the plaintiff Sister O'Kane and some younger nurses were very affected and disturbed by his condition. Sister O'Kane said to her, "I want you to know that Dr McNamee has been informed of this". The plaintiff claimed she knew dialysis was having no effect because Sister O'Kane was good enough to tell the plaintiff the readings. Mrs Magill felt that they were simply going through the motions of renal dialysis and the problem had not been treated.

[354] The plaintiff recorded that Sister O'Kane said "I am going to ring Professor Spence. It's more than my job is worth. Professor Spence will say it is Dr McNamee's responsibility."(*This was allegedly because Dr McNamee had indicated that the problem was something to do with the ERCP or the stents and that was Professor Spence's area and no that of Dr McNamee).* The nurse then informed the plaintiff that Professor Spence was coming but that he was "not too pleased".

[355] Professor Spence arrived about 11.00pm on 26 December 1999. He said to the plaintiff "It is Christmas now, I've my own family to consider". The plaintiff said that he informed her that his own son was being examined for a brain tumour and he has bowel problems since birth. She asked him if it would be possible for investigation since her husband's abdomen was swollen, there was fluid and the plaintiff felt it important to investigate where the fluid was coming from. It was the plaintiff's evidence that Professor Spence was not pleased about coming in and wanted nothing more to do with it.

[356] The plaintiff contended that she next spoke to Professor Spence at about 11.00pm on 28 December 1999 when Sister O'Kane related to the plaintiff that Professor Spence wished to speak to her. The plaintiff told him that they had found bile but Professor Spence was reluctant to admit this He said "I am still willing to operate. I don't want blamed if he dies on the table." The plaintiff informed him that he was dying anyway whereupon

Professor Spence told her that Dr George was standing by, he was an excellent anaesthetist and that he would be in at 8.00am.

[357] Moving to the evidence of this defendant, I found Professor Spence to be a candid and reflective witness. I formed a clear impression that this was not only an extremely experienced and erudite surgeon, with a most impressive curriculum vitae but also a sensitive professional not given to overhasty, flippant or uninformed opinions. Again and again the UIC nursing staff paid unsolicited, and in my experience in medical negligence cases over many years, almost unprecedented tribute to his caring and dedicated attitude to the welfare of his patients. I was left in no doubt that there was a genuine professional bond between this surgeon and the nursing staff which inured to a process of close communication between them about the condition of each patient, including this deceased, each time he attended the wards. I was satisfied as time went on that his own seemingly unquenchable enthusiasm for lavishing praise on his staff and colleagues reflected on his part a genuine affection for and appreciation of them rather than an attempt to dissemble.

[358] Professor Spence has been a consultant surgeon in the BCH as a general surgeon with a special interest in head and neck surgery and breast cancer. He continues to practice as a general surgeon on call for emergencies and regularly sees acute gall bladder and pancreatitis problems. He has published extensively, mainly on general surgery and oncology and was the author/co-author of a number of textbooks primarily on cancer. In the past he has trained in Capetown with Professor Terblanche who was a leading expert in pancreatic surgery. During the 1970s he had trained in Belfast with Professor Johnston who was primarily interested in tumours of the liver and liver problems. Returning to Belfast on 1986 he had for the first 8 or 9 years carried out a number of operations involving the liver and the pancreas. I was satisfied therefore that he was a highly experienced and distinguished surgeon who was well versed in the risks of such procedures as ERCP and who would have been alive to any signs or symptoms of illness arising there from. He would have been aware of the possibilities of other centres of excellence in the UK and the criteria necessary for transfer.

[359] Having listened to this witness carefully during the course of his evidence, I reject immediately a number of the completely unsubstantiated allegations that the plaintiff made against him. These include suggestions that he had manufactured, imagined or carelessly inserted a reference to loss of weight on the part of the deceased when he first met him on 9 December 1999. Apart from the fact that two quite independent sources namely the admitting nurse at the Ulster Independent Clinic and Dr George the admitting consultant at the UIC made precisely the same note as a result of speaking to the plaintiff, I am satisfied that a careful consultant such as Professor Spence would have fully appreciated the significance of lost weight

and would not have made such a note lightly. The plaintiff's bold assertion that she had been present during the whole interview with her husband and that unquestionably no such reference was made, served to undermine my confidence in her ability to accurately recollect conversations or events over this period and to fuel my concerns about her readiness to make unsubstantiated allegations of malpractice against the defendants. In this context I also observe that I consider it highly implausible that Dr George would have in some manner manufactured or imagined the contents of the admission note which he made on the deceased's admission to BCH on 24 December 1999. The fact that Dr Fitzsimmons, the SHO who spoke to the deceased on 17 December 1999 on his admission to RVH made no similar note of this does not deflect me in my conviction that this reference was made to three other people. As Professor Spence said, experience shows that patients do not always rehearse precisely the same details particularly if they are asked the history on a number of occasions. Thus I am satisfied the plaintiff had a two week history of jaundice, itch, diarrohea and weight loss.

[360] I also reject the scarcely veiled suggestion made by the plaintiff to Professor Spence that he was some how involved in an unsavoury decision to wrongfully introduce Dr Sloan on 10 February 2000 into the post mortem process. I am satisfied that Professor Spence had no knowledge of Dr Sloan's involvement until very recently and I reject entirely the plaintiff's attack upon his integrity in this regard. What possible motive could he possibly have had for doing this? Every expert in the case agrees the plaintiff had a tumour. Why would Professor Spence need to resort to subterfuge to establish something that every expert already knew?

[361] I believe that Professor Spence made a sequenced plan in advance once he had seen the deceased on 9 December 1999 in UIC. He assembled a team of experts in various disciplines to treat the patient. First, an ultrasound was to be carried out. If this did not provide an answer to the jaundice, then a CAT scan would follow it. If that provided no answer, then an ERCP would be arranged. I have no doubt he acted with characteristic thoroughness when he sought to invoke the specialist assistance of Dr Crothers, the radiologist, Dr Collins, the endoscopist, Mr Diamond, the hepatobiliary surgeon, Dr Ellis the interventionist radiologist and if necessary an oncologist. Professor Spence does not have any expertise in radiology and thus he would defer to Dr Crothers, Dr Collins and Dr Ellis. His previous experience as a general surgeon and in particular the specialist work he had done during the year he worked in South Africa with Professor Terblanche in a specialist unit together with the hepato-biliary surgery he had performed in the early 1990s would all have allowed him to make informed opinions on such matters as the presence of a klatskin tumour (as in fact he did) but that, very properly, ultimately he was deferring to the expertise of the surgeon who would be taking the final decision about resection. I have no doubt that Professor Spence, was telling me the truth when he said that whilst discussing these matters, he was

prepared to defer to the expert in these fields and to change any diagnosis in response to their advice. This was an entirely proper thing to do and in my view the only appropriate method to orchestrate the management of the patient and approach treatment.

[362] Mrs Magill in cross examination pressed Professor Spence to go into the minutiae of these areas e.g. discussions of the ERCP and the decision to resect. It was clear to me that Professor Spence did display areas of great knowledge in these matters but that he was careful always to insist that he would defer to the experts in each field as in the event he did.

[363] Whilst there was no concept of multi disciplinary discussions in 1999 – whereas in later years there clearly was – I accept entirely that there was discussion between Professor Spence and these other experts before decisions were finally taken.

[364] Mrs Magill laid particular stress on Professor Spence's alleged failure to view the ERCP films himself or ask for the direct opinion of Dr Ellis who had discussed the significance of the ERCP with Dr Collins. This in the event was a highly significant conversation because in the course of it Dr Ellis informed Dr Collins that on the left side he had calculated the extent of the tumour to be 1 cm. The calculation meant that Mr Diamond was to conclude that there was insufficient tumour free area along the duct wall up to the segmental area to allow for resectability. Neither Professor Spence nor Mr Diamond spoke directly to Dr Ellis. Obviously had there been multi-disciplinary meetings in 1999 as there now are, Professor Spence and Mr Diamond would have heard this from the horse's mouth. I consider, however, that it is necessary to keep one's feet on the ground and look at the reality of medical practice within busy hospitals at this time.

[365] Dr Ellis gave evidence that he has been asked for opinions - perhaps 5-10 times per day, perhaps hundreds of times per year –by various physicians about the content of x-rays/ERCP/PTCs etc. He is a busy radiologist who is obviously recognised as an expert interventionist radiologist. In those circumstances I an persuaded that it was perfectly proper for Professor Spence and Mr Diamond to rely on Dr Collins relating the conversation he has had with Dr Ellis on these key areas to the relevant surgeon. I do not find it incompetent or negligent for highly trained consultants to rely on each other to give the relevant assessment in their specialist fields and for one specialist to communicate this to another. In this context I believe there is merit to the point made by Dr Ellis that the advent of multi-disciplinary meetings that now occur has coincided with increase in staff. Since 1999 there are now three interventionist radiologists and more than one hepato-biliary surgeon all of which allows one of these experts to be released to attend meetings. That would have been much more difficult with the lower numbers of specialists in 1999.

[366] I am satisfied that the role of Professor Spence in this case was to look after the deceased in a global or general sense. He assembled a number of specialist experts appropriate to the tasks in hand and was importing suitable experts during the process of the treatment of Mr Magill until he left the UIC.

[367] Having watched him give evidence and having formed the impression I have earlier adumbrated, I have no hesitation in rejecting the allegations that he criticised Mr Diamond or asserted his expertise over him when discussing the matter with Mrs Magill in UIC. Why would he do this when it was common case that Mr Diamond was the only hepato-biliary surgeon in the hospital? To diminish his expertise would be preposterous.

[368] Similarly to suggest that Professor Spence at any stage sought to wash his hands of treating this patient would be the very antithesis of all the steps he had taken to orchestrate speedy and comprehensive treatment of this patient. Apart from being wholly uncharacteristic of the witness as he appeared before me, it would have been illogical. There was a wealth of evidence that in the BCH a number of procedures were invoked to treat the deceased including drug treatment, renal dialysis, aspiration, ultrasound and CT scanning and serious consideration was given to surgery. A number of consultants from different disciplines were addressing his plight including Professor Spence, Dr McNamee and Dr George.

[369] I have already found that there was no basis for any contention that the metal stent placed in the PTC procedures was either wrongly positioned, extruded or replaced in the BCH. Hence the allegation that Professor Spence should have requested Dr Foster to consider the X ray of 25 December 1999 does not arise.

[370] It was the evidence of Dr McNamee which I have accepted and of Professor Spence – well corroborated by the records - that the deceased was initially improving in the early period in BCH and hence the question of an operation does not arise. He was on haemodialysis, antibiotics and clinically his abdominal symptoms were showing some sign of improvement. Additionally I accept the evidence of Professor Spence that at this time in any event this man was not fit for surgery and by 27 December 1999 the outcome was becoming inevitable. Difficult though it obviously is for any despairing relative to accept ,the fact remains that Professor Spence was correct to assert that consideration has to be given to the futility of putting a patient through an operation where he may well die on the operation table or shortly afterwards.

[371] I have already dealt with the reasons why surgery was not performed on 25 December 1999 by Professor Spence re the pancreatitis that Mrs Magill insists was then evident. I can understand the difficulty in comprehending

the evidence given by Professor Spence and others including Dr Rauws in this case that in any event there is no proven treatment for pancreatitis other than supportive care in the absence of an abscess. Supportive care was being given i.e. fluid, antibiotic cover and renal treatment. Dr Shiels and Dr Foster had found no evidence of such an abscess in the aspiration procedure as late as 28 December 1999. I have already indicated earlier in this judgment that I am satisfied that this procedure was not aimed at surreptitiously replacing a voided stent and insofar as the plaintiff accused Professor Spence obliquely or otherwise in any subterfuge arising there from I acquit him entirely.

[372] I believe that even at the eleventh hour, Professor Spence properly discussed with Dr George the possibility of an operation to clear out the bile-stained fluid as a last ditch stand. At that stage Mr Magill was in multi organ failure, ongoing sepsis, renal failure and increasing poor coagulation. Again Professor Spence raised the chilling spectre of putting him through an operation where the chances of him dying on the operating table were so high. In truth it seemed to me that the possibility of laparotomy was more theoretical than real. Accordingly, having discussed the matter with Mrs Magill on 29 December 1999 the decision was taken to make him as comfortable as possible with palliative treatment until his death on 30 December 1999.

[373] It is not without significance that no expert on the plaintiffs' behalf criticised the care which Professor Spence dispensed in the BCH.

[374] I find no basis for the case made against Professor Spence either in tort or contract and I dismiss the case against him.

Dr Collins

[375] Other than the medical issues with which I have already dealt, the plaintiff's case against Dr Collins in tort and contract included the following allegations:

- Wrongfully directing the decision making process;
- Offering misleading advice on the classification of the tumour;
- Over-hastily agreeing with Mr Diamond that it was a non resectable type 4 klatskin tumour and failing to advise further investigations before so classifying the tumour;
- Failing to ensure Mr Diamond saw the ERCP films;
- Failing to carry out the ERCP competently;
- Misleading those involved in treatment by confusing the left and right ducts;
- Purveying information to the plaintiff and to this court which was false and misleading, and treating her in a dismissive and unprofessional manner;

- Whilst in the RVH leaving the care of the patient in the hands of a SHO who was not sufficiently experienced and was inadequately supervised namely Dr Lee; and
- Assault and false imprisonment.

[376]] The plaintiff's evidence against Dr Collins included the allegations set out in the following paragraphs.

Whilst in the UIC

[377] At 6.00 pm on 14 December 1999, after the ERCP had been completed and the deceased had returned to the UIC, Dr Collins had come to see him. He seemed to stumble into the room and sat on the bed. Mrs Magill made no deduction from this alleged stumble and accordingly I have not pursued this further He did not identify himself or greet either the deceased or the plaintiff. The plaintiff asserted he said "I pushed and pushed and I couldn't get through. There is something there. Cholangiocarcinoma or carcinoma was mentioned. The plaintiff asserted that her husband was not well at this time and struggled to sit up.

[378] Dr Collins asked the plaintiff to step outside. He appeared very angry and he said "Do you realise what I have just told you. Do you realise the significance? I have told him his number is up (*or words to that effect*) and he is smiling at me".

[379] The plaintiff claimed that she asked Dr Collins:

- If a biopsy or a brushing had been taken (she had previous experience of this in 1978) but Dr Collins said he could not get one.
- If he had seen anything to which he replied he had not.
- If there were any pictures as she wanted a second opinion and Dr Collins told her that no pictures had been taken.
- If there was any hope of surgery and he replied "You have picked the wrong place. There is a man in the Mater but you wouldn't want to go there". He also said that Professor Spence was "useless". He added "There is nothing here. This place is no good. With all his problems no one would want him." Dr Collins also had said "He might be lucky. He might get a year."

[380] The plaintiff contended that she was concerned about Dr Collins' attitude to human life and she was very frightened.

Whilst in the RVH

[381] On 17 December 1999 about 5pm Dr Collins was on the ward in the RVH. He said, "Evening folks". The plaintiff informed Dr Collins of her

deep concern about her husband and asked if there had been a perforation and infection. He said, "What are you telling me this for? It has nothing to do with me." This was notwithstanding that, above the deceased's bed, Dr Collins was noted as the consultant.

[382] The plaintiff claimed that the deceased was becoming progressively more ill and there was very little drainage of bile. She denies the truth of the Dr Collins' note of 17 December 1999 at 8.00 pm that records him attending and noting "Patient recovering well. Abdomen not distended".

[383] The plaintiff next encountered Dr Collins on 20 December 1999 in a ward in the RVH at around 4.00pm with his senior registrar, Dr Gibbons. Mrs Magill asserted Dr Collins looked angry. As the plaintiff passed him he said, in the presence of Dr Gibbons, "Take your husband home Mrs Magill. This is the NHS." The plaintiff then continued to bring some ice to Mr Magill. Dr Gibbons came and said, "Your husband is to be discharged tomorrow. Bring his clothes."

[384] On 23 December 1999 when the plaintiff arrived at the RVH about 11.30 am Dr Caroline Lee and Dr Gibbons were in the ward. The plaintiff asked what had happened to her husband. Dr Lee, the SHO, said, "He is a lucky man. He is getting a CT scan this afternoon." The plaintiff said, "My husband is dying. I warned you about this". Dr Gibbons laughed. The plaintiff said to him, "Do not model yourself on Dr Collins. He is a bad model. I have been asking for investigations and nothing has been done".

[385] The plaintiff proceeded to the bed where nurses were around her husband. Dr Collins came through the ward in a rush. He said, "Can I speak to you?" He took her into a room with Dr Gibbons. Dr Collins was very agitated. The plaintiff cannot remember the exact words he uttered but it was to the effect that the plaintiff had questioned his professional competence. She replied that she was not questioning his competence and told him to show some maturity. Collins rushed out of the room and said, "I am having nothing to do with this. Nothing to do with you."

[386] The plaintiff returned to her husband. Dr Collins then approached and put his arm around her stating, "Can we forget what I have said. I lost my son in this hospital some years ago." The plaintiff told him she was sorry whereupon Dr Collins said, "It hurt me when you called me insensitive." The plaintiff shook hands with him and said, "You are dealing with a decent person. I am concerned about my husband. Is there a chance of an IC bed for him?"

[387] Dr Murray, an ICU consultant and a Dr McCarroll (whom the plaintiff subsequently accepted was Dr McCloskey) an ICU registrar then came to her whilst in the presence of Dr Collins. The plaintiff relayed her concerns to Dr

Murray who looked at the ground. Dr Collins was very agitated and said, "What do you want treatment for? Isn't he going to die anyway?"

[388] During his period in the RVH especially when his condition began to deteriorate, Mrs Magill suggested that the care of her husband was largely left in the hands of an SHO, Dr Lee, who was in her view too inexperienced to look after her husband and lacked appropriate supervision.

[389] I shall defer comment on the allegations of 24 December 1999 until addressing the allegations of assault etc in a separate section of the judgment.

[390] I have already dealt with most of the allegations against Dr Collins earlier in this judgment e.g. the involvement of Dr Collins in the decision making process, the classification of the tumour and his role in this, the necessity for Mr Diamond to have seen the ERCP films, the competence invested in the ERCP procedure and I shall shortly address Dr Lee's competence when dealing with the role of the medical and nursing staff in the RVH .

[391] Dr Collins has been a consultant physician / gastroenterologist at RVH since 1990 with a very distinguished curriculum vitae which included holding the post of Secretary at the Royal College of Physicians of Edinburgh between 2004 and 2009 and the publication of approximately 82 articles most of them in the field of gastroenterology. He is the author of a leading text book on gastrointestinal emergencies which has been widely sold throughout the world and he has been an examiner for the Royal College of Physicians for about 15 years.

[392] In the past Dr Collins trained at the medical college of Wisconsin under a leading world authority on patients with recurrent pancreatitis and ERCP namely Professor Joseph Geenan. During that period he also saw a great number of patients with cholangiocarcinoma i.e. carcinoma of the bile duct. In Northern Ireland he has seen about five cases per annum of this rare condition.

[393] Dr Collins give evidence that he had commenced carrying out ERCP in 1986 when a senior registrar. Thereafter he had serious involvement in the procedures in the USA in 1987 and since then has been regularly carrying them out over the last 20 years, having performed many hundreds of ERCPs at the time of this procedure in 1999. I was satisfied that Dr Collins was an extremely experienced endoscopist who was well versed in carrying out the procedure of ERCP.

[394] I found Dr Collins to be a pensive and sensitive witness who was not given to overstating his arguments and was measured in his assessments. He struck me as a deeply reflective physician who has been profoundly

wounded by the attacks on his integrity and professional expertise mounted and maintained by Mrs Magill over the last 10 years. Whilst I was cautious before accepting accolades to him from those who still work with Dr Collins, it did not surprise me that Dr Lindsay the JHO on duty at RVH on 23 December 1999 in her evidence characterised Mr Collins as an approachable consultant who was gentle, "nice", and "not scary". She depicted him as a quiet professional, caring for staff and patients who in her opinion was never aggressive in his demeanour or given to outbursts of rage or anger. She had gleaned this impression from accompanying him on ward rounds and claimed to know him reasonably well. Dr Lee, a SHO at the relevant time, struck a similar note when describing her experience with him as behaving in "a calm gentlemanly manner" in the face of a verbal assault from Mrs Magill on 24 December 1999.

[395] One of the primary difficulties I found with Mrs Magill's evidence in this and other areas was her abject refusal to apply logic or reason to the plausibility or likely accuracy of her recollection on a number of issues. Some instances may appear minor but the cumulative effect has influenced my overall belief in her credibility. Certain illustrations in relation to Dr Collins will suffice.

[396] I consider it inherently unlikely that a senior consultant such as Dr Collins would have entered the room where the deceased was when he had come to the UIC to perform the post procedure medical check for the ERCP and made no attempt to identify himself or ascertain who the plaintiff was. If the plaintiff is right, Dr Collins had no idea who she was. For example she might have been a well-meaning neighbour who had visited; a member of Mr Magill's erstwhile staff at the bank or some other inconsequential acquaintance who should not have been privy to personal details about the plaintiff. Why would Dr Collins not identify himself or inquire as to who she was before launching not an analysis of his terminal condition? The idea that a senior consultant would have so acted is preposterous. .Mrs Magill vigorously dismissed the notion that with the passage of time she could simply have forgotten these inconsequential introductory remarks. I suspect that this is an example of Mrs Magill allowing her reason and her recollection to be overwhelmed by her dislike for Dr Collins to the extent that every action that she recalls is now subconsciously tainted by her with some unacceptable piece of behaviour to be attributed to Dr Collins.

[397] I was satisfied that Dr Collins has had a close personal and working relationship with Professor Spence for over 30 years. Professor Spence has regularly referred patients to him in the National Health and in the private sector and then he in turn has looked after family relations of Professor Spence. It was clear to me from both the evidence of Professor Spence and of Dr Collins, that they hold each other in high esteem. Hence I found it wholly implausible that Dr Collins would have told the plaintiff that he considered

Professor Spence to be "useless" as she alleged to have occurred on 14 December 2009. Similarly I find entirely illogical the suggestion that Professor Spence would have wantonly criticised the UIC ("the wrong place") or the Mater Hospital when he worked himself in the UIC for a number of years, was still retaining visitation there, and had no obvious cause to criticise the Mater Hospital. Why would he have spoken in such an indiscreet and unprofessional manner to someone who was a total stranger?

[398] The plaintiff refused to accept that antibiotics were given to the deceased prior to the ERCP notwithstanding a clear contemporaneous nursing record that antibiotics were given to the deceased prior to the ERCP on the basis that her husband said no one came near him prior to the procedure. She failed to see the inherent unlikelihood of a nurse, who had specifically not given the antibiotics if the plaintiff is correct, contemporaneously deciding to fabricate a record that they had been given rather than simply making no entry at all. Once again I think this is another instance where the plaintiff has refused to bring reason to bear on the inherent unlikelihood of the point she was making.

[399] It was common case that when Dr Collins inserted the plastic stents on 14 December 1999 during the ERCP procedure this was on the right side and that he was unable to place any stent on the left side. The endoscopy report of 14 December 1999, prepared by Dr Collins, referred to insertion of a 5 French gauge stent in the left duct. This was clearly a mistake which he corrected in his letter of 15 December 1999 to Professor Spence, where he unequivocally referred to the stents in the right hand side. However a letter from Mr Diamond to Professor Spence of 15 December 1999 repeated the same mistake about the stenting side. Sadly the discharge note of 3 March 2000 made the same mistake again, referring to the left duct. The inaccuracy was repeated for the fourth time in the course of Dr Collins' statement to the coroner substantially later.

[400] Mrs Magill has asserted that this confusion served to disguise what Dr Collins had accomplished or rather failed to accomplish in terms of drainage at ERCP and was deliberately calculated to mislead the reader into believing an investigation into the left side had been carried out when in fact it had not.

[401] Dr Collins explanation was that in writing the discharge note and Coronial statement he had referred to his original RVH note and repeated the error.

[402] Dr O'Connor, having read the records in this case, was satisfied that the mistake by Dr Collins in his typewritten note of the ERCP was a purely typographical error which, whilst it should not happen, does occur from time to time because of the pressure under which consultants work. He was satisfied that it had had no material impact whatsoever on the treatment that

the patient subsequently received. Dr Collins gained nothing by perpetuating this mistake and certainly no one on the plaintiff's behalf - save for the plaintiff herself - suggested that any benefit accrued to him by making this mistake. There was not a scintilla of evidence that it had any impact at all on the patient's treatment.

[403] Obviously greater care should have been taken with the RVH note but I had no doubt that it was a human error made by an extremely busy physician who carried out hundreds of such procedures in the course of a year and had allowed a momentary slip to occur. Throughout the trial the plaintiff insisted on accusing him of deliberately inserting the reference to the left duct in order to mislead a number of different people. It was indicative of her approach to the whole matter that the plaintiff could not be deflected from finding a base motive in what was manifestly a human error.

[404] My conviction that Dr Collins was a careful physician was underlined by the detailed attention he had clearly given to his notes in general notwithstanding the typographical error to which I have earlier referred. When he first saw the deceased on 10 December 1999, his notes recorded a full and comprehensive battery of tests to be carried out including blood count, coagulation screen, assessment of the blood group lest a transfusion would be necessary, examination for hepatitis even though he felt this extremely unlikely etc. At each turn of events, the comprehensive note was made.

[405] On 14 December 1999 he recorded the presence of the stricture and further the needs of the patient including PTC, internal/external drain, needle biopsy of the hilum and consideration of surgical exploration. The typewritten note of the same date is comprehensive and the fact that it contained one typographical error in referring to the left instead of the right stent does not persuade me that this is anything other than the merest of the oversights.

[406] What conceivable reason could he possibly have for being very angry on the occasion when he spoke to the plaintiff outside the door on 14 December 1999 in the aftermath of the ERCP? If the plaintiff was right he was telling the patient he had an incurable tumour .Why would he be angry? This is yet another example of the plaintiff entirely misinterpreting the approach of Dr Collins either consciously or subconsciously in a manner adverse to him. On the contrary, inviting her out of the room seems to me much more consistent with Dr Collins sensitively declining to spell out to the deceased that he might be suffering a potentially terminal illness. The independent facts smack more of a caring responsible attitude than an implausible and irrational angry outburst. If my assessment of Dr Collins is correct I consider it extremely unlikely that he would have used an unprofessional and insensitive phrase such as "his number is up".

[407] Why would he deny that photographs had been taken at the ERCP? Denial would be easily confounded at some later stage since a number of other experts knew about the ERCP films. How would denial benefit Dr Collins especially if Mrs Magill was bent on a second opinion? The suggestion that he did this to prevent access by whoever would give a second opinion is fanciful because such an expert, if he was a gastroenterologist, would inevitably know that films would have been conventionally taken and a cover up would be fruitless.

[408] I also consider it very unlikely that Dr Collins at that stage would have said that it was anything more than a possibility that the plaintiff could be suffering a tumour since he could not possibly have known at that stage that it was definitively a tumour. Invoking logic as my criterion, I can see no reason why Dr Collins would have made up his mind about the resectability of the deceased's tumour by 14 December 1999 i.e. after the ERCP since a gastroenterologist would never have the last or definitive word on such a decision. He could have ended up looking very foolish by venturing an opinion which might not be shared by the surgeon. The fact of the matter is that he is neither a radiologist nor a surgeon and issues such as the bisthmus scale or the resectability of a tumour would be quite outside his field. He would of course have been generally aware of a low resectability rate of such tumours but other than being engaged generally in a discussion about them I do not believe he could possibly have formed a definitive opinion or have ventured such views at this early stage.

[409] Mrs Magill cross-examined Dr Collins in the context of Mr Diamond's letter of 15 December 1999 to Professor Spence in which Mr Diamond set out his conclusion that the deceased had a type 4 klatskin tumour. His written addendum records "I have since chatted to John (*this is clearly Dr Collins*) and we are happy there is a type 4 tumour - thus stenting is the best option." The inference here is that both Mr Diamond and Dr Collins had concluded as early as 14/15 December that this was an inoperable type 4 tumour. I am satisfied that this was a loose use of language by Mr Diamond because not only would Dr Collins have been unlikely to have voiced a definitive opinion on the issue given his field of expertise, but I could not imagine Mr Diamond accepting an uninformed opinion which would influence his conclusion from a gastroenterologist on this issue. Mr Diamond would have well recognised that Dr Collins would have been making a singularly uninformed opinion. I fully accept Dr Collins' assertion that he did not tell Mr Diamond that the segments in the left duct were involved. How could he have done otherwise? The ERCP clearly does not show any segmental involvement. He did tell him that he felt it involved the right and left ducts because once again, I am satisfied that there is evidence even to my unpractised eye that there was such involvement albeit of a minimal level on the left side. He also relayed to him the measurement of left duct intrusion calculated by Dr Ellis. Hence I

cannot accept that Dr Collins attempted to influence Mr Diamond or, even if he did, that Mr Diamond would have accepted any influence from Dr Collins on the ultimate decision of resectability. I found it not without significance that Dr Ellis said that he would be "amazed" if Dr Collins "made a call on operability" because he is not a surgeon.

[410] The thrust of Mrs Magill's case in this regard was that there was an all too casual approach by the team of Professor Spence, Dr Collins, Dr Ellis and Mr Diamond to this issue. It is highly unfortunate that the correspondence passing between Mr Diamond and Professor Spence may have lent some weight to this assertion. I am satisfied however having heard the witnesses that whatever the looseness of the language in the correspondence - and after all these were not legal documents where words were to be weighed with a jeweller's scales - in the event only Mr Diamond would have been sufficiently qualified to take the final decision .

[411] The fact of the matter is that Dr Collins' post procedure letter of 15 December 1999 to Professor Spence makes it absolutely clear that he held an open mind on the issue. The final paragraph of that letter reads:

> "I have discussed the situation with Dr Ellis and we both feel that this man needs a PTC an internal/external drain followed by consideration for either surgery or palliation with a metal wall stent placed radiologically or by a rendezvous procedure."

[412] Had Dr Collins at that stage concluded, either with or without Mr Diamond's assertion, that surgery was not an option, why would he have entertained the possibility of surgery in his letter to Professor Spence? Why would he tell Mrs Magill one thing and tell exactly the opposite to Professor Spence? Why would he agree with Mr Diamond that the tumour was irresectable and not communicate this to Professor Spence? Why would he have "given up" on Mr Magill before he had even spoken to Dr Ellis or had the reports from the PTC? Why would he have told Mr Diamond on 15 December 1999 when he spoke to him that there was segmental involvement when manifestly the ERCP did not reveal this? Common sense provides an impediment to Mrs Magill's assertions.

[413] It is clear that the other consultants in the case relevant to this issue shared the same approach of detached deference to the final decision of the surgeon on this matter of resectability. Professor Spence's report after death to the GP Dr Logue recorded:

> "The ERCP showed that he had a Klatskin tumour which appeared to be irresectable in that it was involving both the initial bifurcation of the hepatic

> ducts and subsequent second order ducts. I felt the lesion was irresectable and as you know I obtained a second opinion from Mr Tom Diamond, Surgeon at the Mater Hospital. Mr Diamond also felt, like myself, that this was irresectable. After discussion with Mr Diamond and Dr Collins we felt the best type of palliation would be to perform a stenting procedure to his right and left hepatic ducts".

The whole thrust of this letter is that in the last analysis the decision about the inoperability was taken by Mr Diamond the Consultant who provided the second opinion. Dr Collins is cast in the role of a consultant who discussed only the best type of palliation.

[414] I find a similar inflexibility of approach in the plaintiff's assertion that no examination by Dr Collins took place on the evening of 17 December 1999 at 8pm notwithstanding his clear note to the contrary. What possible reason could there be for Dr Collins making up a note of an examination – which would have lasted no more than a few minutes – if he was nowhere near the patient on that night? The note must have been made on 17 December because it is followed by a note thereafter made on 18th by another doctor. Even suggestions by counsel to her that she might have been away from her husband at the toilet or to have a meal did not serve to deflect her from her conviction that there was no possibility of Dr Collins having examined her husband, however briefly, at 8pm on 17 December 1999 or at any time that evening. Her unflinching refusal to think well of Dr Collins defies logic and serves once more to undermine my confidence in the plaintiff's recollections. The truth is that she has probably simply overlooked this examination after a period of ten years but such is her conviction that Dr Collins has fabricated his role that she refuses to countenance a possible mistake on her part even when logic cries out for her to do so.

[415] Equally, her assertion that Dr Collins said to her on the evening of 17 December "What are you telling me this for. It has nothing to do with me" is not credible of belief. He was the consultant in charge of the patient and it would have been ludicrous for him to have told the plaintiff that her concerns about her husband had nothing to do with him. Having watched Mrs Magill carefully during this case, I have no doubt that if the consultant in charge had made such a denial, she would have made a complaint about it. In any event such a dismissive attitude would have been entirely contrary not only to the impression Dr Collins made on me but it would have been the antithesis of the unstinting efforts I believe Dr Collins made to arrest the interest of other experts in the renal, high dependency and UIC units for the treatment of this patient.

[416] I also found very implausible Mrs Magill's account of the conversation she alleges she had with Dr Collins about 4 pm on 20 December 1999 when he told her, in passing, "Take you husband home Mrs Magill. This is the NHS." I accept the evidence from the medical practitioners that it would be highly unusual for a patient who had been stented to leave on the same day and of course he was not discharged. Why would Dr Collins have suggested the opposite?

[417] On the contrary, the evidence of Dr Gibbons, Dr Lee the SHO and Dr Collins was that the plaintiff at that stage wished her husband to be returned to the UIC. Dr Gibbons entered up a note, clearly made on 20 December 1999 because it is in chronological sequence with medical notes made earlier on 20 December and before a note of 21 December by different doctors, to the effect "Plan – ……. Aim to transfer to UIC tomorrow." Why would Dr Gibbons have recorded this at that time if as the plaintiff said Dr Gibbons had told her that her husband was to be discharged tomorrow and she was to bring in his clothes. Once again why would a doctor at this stage have told her one thing and simultaneously recorded the exact opposite in a note? What would be the logic in so doing? Not only would discharge on that day be entirely contrary to the accepted practice but it would be an act of abject wickedness for Dr Gibbons to have completely manufactured a note which bore no relation to any conversations he had had with the plaintiff? It strikes me as inconceivable and is another instance of where the plaintiff's recollection has been radically distorted by her conviction that her husband was mistreated and Dr Collins is to blame.

[418] Corroboration was given to the desire on the plaintiff's part to return to the UIC by virtue of the evidence of Dr Lee. She had returned after a week off work on study leave on 20 December and met the deceased for the first time. The note of Dr Gibbons of 20 December 1999 indicating that the plan was to transfer the patient to UIC next day carried a resonance with her. Dr Collins had also told her he was going to the UIC and she recalled discussing the transfer with the plaintiff and both were happy with the intended arrangement . Her note of 21 December 1999 records:

> "Plan. Check liver function tests. If no deterioration,
> send back to UIC later today."

[419] It struck me that Dr Lee had absolutely no reason to manufacture this evidence, never having met the deceased before, and the significance of him wishing to return to the UIC in the context of the earlier conversations with Dr Gibbon and Dr Collins would have been lost on her. Why would she record a reference to UIC if, as the plaintiff asserts, it never even arose? Was she in some conspiracy with Dr Gibbons to mislead the plaintiff? Dr Lees' account tied in with her common sense assertion that in the 24 hours after the procedure, it is important that any complications be assessed and it is

therefore better that the patient be at hand in the RVH than in the clinic. If no complication would arise then he could be transferred. Comparing the two differing accounts of this issue, I find the plaintiff's version more implausible.

[420] The events of 23 December 1999, setting the background for the hotly contested events of 24 December 1999, require some detailed analysis.

[421] It was the evidence of Dr Collins that he was off work due to illness on 22 December 1999 and returned on 23 December 1999 about 11.30am to clear up some administrative work. Given that he had an infection he doubted the advisability of visiting the wards. However he received a telephone call from the senior registrar, Dr Gibbons, that Mr Magill had become unwell and that he had had some interaction with Mrs Magill whereupon he came to the ward to see the patient and spoke to junior staff, Dr Gibbons and Dr Lee. He himself then made a note of his examination of the patient at 1.00 pm. I accept entirely the authenticity of this note. I cannot envisage for one moment Dr Collins making up a series of fictitious entries about the various readings that he recorded on that note.

[422] Dr Collins said that before he had examined the plaintiff he had a conversation with Dr Gibbons in the ward. Dr Gibbons looked in a distressed condition and upset on the verge of tears .This description conformed with the description of Dr Gibbons later given in evidence by Dr Lee . Mrs Magill had spoken to him. I am satisfied that this evidence of Dr Collins and Dr Lee was truthful and that it fully corroborates the note that Dr Gibbons made of 23 December 1999 at 12.30 pm recording the exchange he had had with Mrs Magill.

> "I attempted to discuss Mr Magill's condition with his wife .She was not willing to discuss his condition and claimed that I was a poor example of humanity and not fit to look after her husband. She has demanded Pro. Spence be contacted and her husband transferred to UIC immediately. I did not have an opportunity to discuss our management plan concerning iv fluids, iv Tazocin and CT abdomen this afternoon."

[423] Mrs Magill insisted this is yet another note that has been fabricated and no such conversation took place. Having heard Dr Gibbons give evidence, I have not the slightest doubt that this earnest and conscientious witness would never have acted in this manner. What possible reason would there be for this doctor to fabricate a note – which is in chronological sequence with other notes contemporaneously made - adverse to Mrs Magill about a conversation that had never taken place?

[424] At this stage Mrs Magill was close to her husband's bed and was in a highly agitated state of emotion according to Dr Collins. It was his evidence that he took Mrs Magill into the nursing office with Dr Gibbons and a nurse to discuss her husband's condition. He asserted that the meeting was one sided with Mrs Magill handing out much verbal criticism and abuse and that he had difficulty getting a word in. He recalled three things that stood out in her accusations - that he was inhumane, a poor role model for Dr Gibbons and immature. Dr Collins said that although he had worked in many parts of the USA, England and in the RVH, he had rarely come across an instance where a patient's relative had attacked a member of staff in this manner. Since he was making no progress with her he claims he stood up and left the room, the exchange having lasted about 10 minutes.

[425] Dr Collins then indicated that he made arrangements for intensive care doctors to examine the plaintiff and shortly thereafter Dr Murray and Dr McCluskey attended with him. They assessed the situation and made a care plan which included antibiotics to be given intravenously and a central venous catheter.

[426] Dr Collins said that he spoke again to Mrs Magill after the arrival of the doctors from the intensive care and she had calmed down considerably. He tried to reassure her that things were being carried out by himself, Dr Murray and Dr McCluskey. It was his evidence that as part of the empathetic process, he told her that he knew how she was feeling because his son some years before had collapsed in a similar manner. He expressly denied saying, in the presence of Dr Murray and Dr McCluskey, "What do you want treatment for. Isn't he dying anyway"?

[427] The events of 23rd were unquestionably extremely distressing for the plaintiff. It is common case that the deceased was deteriorating on this date and it is likely that the plaintiff, doubtless weary and grief-stricken after a night by his bedside, had been profoundly affected by his condition. I have no doubt that this has adversely affected her recollection. She clearly had a number of confrontations with medical staff and nurses all of which I am satisfied were borne out of her intense sense of despair at the state of her husband. Sadly I believe that she has been so gripped by the grief that her recollection is deeply flawed and patently unreliable.

[428] I have no doubt that there was an unhappy exchange between Dr Collins and Mrs Magill, and that Dr Collins mentioned his experience with his son in order to recreate an empathy between him and Mrs Magill. I believe this was indicative of his understanding of the stress which Mrs Magill was under and the efforts this physician was making to restore her confidence in the medical team. I reject the suggestion that he has fabricated the note of 23 December 1999 at 1300 hours when he records, inter alia:

> "Discuss situation with Mrs Magill. She demands an ICU bed. She has called me and Dr Gibbon "inhuman" and "immature" . . . The patient's wife has been difficult to reassure. I have contacted Dr Brian McCloskey, ISU, who has kindly said that he will come down and assess the overall situation with regard to . . . support".

[429] Moreover it seems wholly implausible that Dr Collins would have been so insensitive and inexplicably foolish to have said in front of two witnesses namely Dr Murray and Dr McCloskey "What do you want treatment for. Isn't he going to die anyway"? Why would he have summoned the interventionists from the ICU if he did not want them to deal with the patient or if he felt it would be to no avail in any event? Far from being a physician dismissive of her concerns, I have formed the impression that Dr Collins was taking all conceivable steps at this stage to enlist help for her husband. What logical reason could there possibly be for such an outburst in such circumstances? I believed Dr Murray when he told me that he would not have tolerated such behaviour and at least would have spoken privately to Dr Collins thereafter about his behaviour. I have no doubt that had this been said in front of Dr Murray he would have remembered it being said. I have concluded that there is no substance in any of these claims against Dr Collins and I dismiss the claims in tort and contract against him.

Dr Collins and allegation of assault and false imprisonment of 24 December 1999

[430] In order to create the setting for this matter it is necessary to survey the sequence of the events leading up to the disputed encounter. It was by all accounts a very difficult and traumatic day for Mrs Magill in view of the state of her husband but also a very frenetic day of activity on behalf of Mr Magill by the medical staff; activity which I suspect Mrs Magill neither understands nor appreciates.

[431] On 24 December 1999 2 renal registrars, Dr Cunningham and Dr McCarroll, attended separately on the deceased. The three page note entry of Dr McCarroll and the two page entry of Dr Cunningham are testimony to the detailed examination and treatment which these doctors both bestowed on Mr Magill. Clearly his kidneys were deteriorating in function and he was unwell. Dr Lee records speaking to Dr Burton at the RVH who in turn spoke to Dr Lowry on the issue of transfer to the intensive care unit. She also spoke to Dr Collins. I accept that the problem here, which Mrs Magill may not have been prepared to countenance, was that the intensive care unit beds were in very short supply and generally were given to problem respiratory patients which would not of course have included the deceased. Dr Lee was carrying out these enquiries at a time when Dr Gibbons and Dr Collins were both in

the area overseeing what she was doing. Dr Collins was also dealing with the issue of reference to the intensive care units. I fear that Mrs Magill's frustration at what she considered was a lack of progress fuelled the confrontation that was to occur.

[432] It was the plaintiff's evidence that about 9.00/9.30 am on 24 December Dr Collins informed her that the deceased was being transferred to a renal bed because of renal failure. Subsequently, Dr Lee informed her that the offer of the renal bed had been withdrawn and that he was not being moved to a renal bed. The plaintiff claimed that she told Dr Lee that if her husband did not get renal dialysis he would die whereupon Dr Lee advised her to write down a telephone number so she could telephone Professor Spence. The doctor then advised the plaintiff to speak to Dr Collins and led her into the female ward to meet Dr Collins.

[433] Dr Lee's account was very different. It was her evidence that she explained carefully to the plaintiff that the deceased had been assessed by the ICU team as well as by a nephrologist and it was not necessary to perform dialysis but if the need did arise he would be transferred to ICU for this purpose. It was Dr Lee's account that the plaintiff became emotional and unwilling to accept advice or explanation about this matter. Mrs Magill continually talked over her, not listening to what was being said and forming her own conclusions and interpretation of the situation. In cross examination the plaintiff denied recollection of any such conversation. There was before me a detailed note of that conversation which had been made by Dr Lee before 1.00 pm on that date. Dr Lee's note included the following extracts:

> "Wife very agitated, unreasonable and not listening to explanation. Making her own conclusions and assumptions despite thorough and clear explanation of above situation (*this referred to the ICU position).*"

[434] I pause to observe that over the course of this lengthy trial I witnessed several instances where this plaintiff behaved precisely in that fashion, ignoring factual impediments to her theories, making conclusions and assumptions which seemed to defy logical explanation. It has to be borne in mind that a wide variety of witnesses in addition to Dr Lee at different times claimed to have had similar experiences with Mrs Magill e.g. Dr Collins, Dr Gibbons and Nurse Manson. The note of Dr Gibbons of 23 December 1999 where he records:

> "I attempted to discuss Mr Magill's condition with his wife. She was not willing to discuss his condition and claimed that I was "a poor example of humanity" and "not fit to work with her husband""

carried a similar resonance to the note depicted on 24th by Dr Lee.

[435] Dr Lee's note went on to record:

> "I explained nothing further could be done at present: that neither she nor I were renal physicians, if they felt that dialysis was not indicated at present, then we have to take their word for it. Explained Dr Collins was contacting renal unit . . . she seemed hysterical and said that we had failed and had not been doing our best for her husband and that we were giving up on him. I stressed we were doing everything – she disagreed on this and she wanted to contact Professor Spence on his mobile".

[436] I find it impossible to believe that Dr Lee has made this note up as suggested by Mrs Magill. I was convinced that Dr Lee was telling me the truth about this conversation and the note corroborated her account. What possible purpose would have been served by contemporaneously fabricating such a note at that time when the confrontation etc with Dr Collins had not even taken place? If she was wishing to assist Dr Collins why would she not pretend to have been present at the alleged assault? It must be observed that this is one of several instances when allegations of note fabrication have been made against disparate witnesses by Mrs Magill. I became increasingly convinced that when the plaintiff was confronted by evidence that challenged her assertions she took refuge in allegations of fabrication in the absence of any other reason she could envisage.

[437] That note however reflects the gathering momentum of Mrs Magill's agitation and hysteria during the course of the morning of 24 December 1999. I believe that her state of mind at that time influenced her behaviour towards Dr Collins and her recollection of what had occurred. I do not believe that Dr Lee informed her that the offer of renal bed had been withdrawn because an offer of a renal bed had never been made according to the notes. She was the JHO under the supervision of Dr Collins and I accept it would have been entirely inappropriate for her to have ventured such a suggestion. She accepts that she may have said that the plaintiff could contact Professor Spence and exhorted her to speak to Dr Collins. However Dr Lee was firm in her recall that Dr Collins had told her that Dr McNamee was happy with the present management, that there was no need for haemodialysis and that he was to be kept informed.

[438] According to the plaintiff Dr Collins was present speaking to Dr Gibbons and another party in the corridor of ward 9 at this time. The plaintiff approached him, informed him that she was concerned about the renal dialysis and that her husband was going to die if he did not get it.

[439] In contrast it was the evidence of Dr Lee that she had been speaking to Dr Collins in the ward when Mrs Magill angrily interjected in a loud voce and commenced to verbally attack Dr Collins telling him he should be ashamed of himself. People in the ward - patients and staff- were looking on. Dr Lee said that she recalled being personally very upset by the accusations that were being made and she would remember this incident for a very long time. It was her evidence that whereas Mrs Magill was shouting and hysterical, Dr Collins conducted himself in a "calm gentlemanly manner".

[440] I watched the demeanour of this witness carefully during this part of her evidence and it was clear to me that this incident had made a very great impact upon her. I had no doubt that she was telling me the truth about it. I am bound to say that, as I have indicated earlier, the aggressive tones adopted by the plaintiff at times e.g. during the cross examination of her by Mr Elliott when she sought to traverse what was put to her and during the cross examination by her of Professor Spence and Dr Collins carried for me a resonance of the case now being made by Dr Lee and Dr Collins in this regard. Certainly had she spoken in the public area in the hospital in the same manner that she adopted at times in this court, I can well understand an attempt being made to usher her away from the public corridor and into a side ward.

[441] The plaintiff then claimed that Dr Collins invited her into a side room, closed the door, stood with his back to the plaintiff for several minutes, turned to face her with his face contorted, advanced towards her, put up his hand (she was not sure if it was fist or his open hand) and went to strike her. The plaintiff opined that he was deranged at that point. She claimed she put up her hand, told him to "stop this nonsense, behave yourself" and as a result he did not strike her.

[442] It was the plaintiff's case that Dr Collins then said, "You are a histrionic woman. You are right, your husband is going to die but I have my Christmas shopping to do". He had his outdoor jacket on. The plaintiff thought that he was leaving the hospital at that stage. She then asked him to let her leave the room but could not get past him because he was near the door. She claimed she said, "Let me out" but he did not move and did not say anything. She claimed that the room was quite small and that she could not walk around him. Thereafter he opened the door.

[443] Dr Collins in evidence before me denied that he had raised his hand to her or prevented her movement at any time. He accepted he may have raised a finger for emphasis during the angry verbal exchange in the room but he did not threaten or try to strike her and she in turn had pointed her finger at him. The plaintiff was not aware that she had done this. Her only recollection was of putting up her hand.

[444] The plaintiff then claimed that she requested Dr Collins to take her to see Dr Ian Carson the medical director of the RVH. Dr Collins was going to walk away and the plaintiff said to him, "If you walk away, I'll lift the telephone and speak to Nigel Gould – health correspondent of the Belfast Telegraph and tell him what you have done".

[445] Mrs Magill contended that she and Dr Collins proceeded to see Dr Carson immediately in his office where she informed Dr Carson that Dr Collins had taken her into a room and raised his hand to strike her.

[446] At some point in Dr Carson's room, the plaintiff alleged Dr Collins seemed upset and she said to him, "Tell the truth". Her recollection was that he did say in the presence of Dr Carson that he had attempted to strike her and Dr Carson had responded telling Dr Collins that he was to give Mrs Magill a written apology and Dr Collins said he would do that.

[447] The plaintiff then alleged that she proceeded to tell Dr Carson about the condition of her husband, that she felt he was neglected, that she wanted an investigation and that if he did not get a renal dialysis he would die. Dr Carson informed her that he was going to arrange immediately for her husband to obtain a renal dialysis.

[448] It was the plaintiff's case that at this meeting Dr Collins was interjecting in an unusual manner, shouting out and interrupting. She conceded that she was also interrupting when he was talking. At one point she said to Dr Carson, "What is wrong with that man?" and Dr Carson said, in the presence of Dr Collins, "He has personal problems". The plaintiff alleged that she said of Dr Collins that he looked clinically depressed and Dr Carson said, "Yes, he has personal problems".

[449] Mrs Magill informed the court that Dr Collins said that her husband was dying and that he couldn't survive the journey if he was going to get treatment in the BCH.

[450] At the end of this meeting the plaintiff alleged Dr Carson took her back to the ward without Dr Collins. Dr Carson said to her, "Bernie, I want you to do nothing about this". Mrs Magill said that she had been to school with Dr Carson's sister and she had told him that if he contacted her she would tell him that she was a decent person.

[451] When they arrived at the bedside of her husband, Dr Carson felt her husband's hands and came out of the cubicle saying, "He's a lovely man. The signs are good. He is kind and his hands are warm. I have a top liver man and I am going to get him. Do nothing about this".

[452] Very shortly afterwards, the deceased was moved to the high dependency unit at the BCH by ambulance.

[453] The evidence of Dr Collins on the events of 24 December 1999 was in marked contrast to that of the plaintiff. It was his evidence that he saw Mr Magill about 9.30 am and made a note of his findings. The blood pressure and the urinary output were low indicating renal failure and continuing sepsis. His plan was to invoke the assistance of the renal unit in the BCH and secure an intensive care unit physician, Dr McCarroll. He spoke to both the intensive care unit doctors and to the renal physicians. About 1.00 pm he was informed that those units had decided that dialysis was not necessary whereupon he telephoned Dr McNamee the Consultant Nephrologist who indicated that the supportive treatment currently being given was sufficient. When Dr Collins returned to the ward to inform Dr Lee, she looked pale and agitated. At that stage Mrs Magill approached them quickly and asked him if he was ashamed of himself for not getting a renal or intensive care unit bed for her husband, that he did not care about her husband, that he was walking away from him and was telling her husband he was going to die.

[454] Dr Collins' evidence was that this took place in ward 9 at a quiet time for patients when they were having a rest and the ward was in darkness. The plaintiff was speaking loudly over Dr Lee and himself in a very angry, loud and agitated manner. Dr Collins determined that they should move out of the ward and at that stage Dr Lee "retreated."

[455] Accordingly Dr Collins asserted that he ushered Mrs Magill into a small room at the side in ward 9. His evidence was that he entered and stood with his back to the wall and Mrs Magill stood to his right. There was a single bed in the room which was between them. It was his assertion that the door was open and was not secured or locked in any way. He denied standing at any time with his back to her, or that he impeded her path in any way. Mrs Magill was standing with her back to the door where the exit was.

[456] Of the exchange between the two parties, Dr Collins asserted that Mrs Magill continued to allege that he was a disgrace, that he had done nothing for her husband, that he was walking away and telling her husband he was going to die. Dr Collins described it as a re-run of the incident of the morning before.

[457] Dr Collins asserted that initially he did not respond but when she paused he did interject to indicate that he was trying everything for her husband including ICU, renal care and advice from those sources. Mrs Magill continued to verbally abuse him. It was clear that he would have to transfer the care of Mr Magill to another consultant in light of these exchanges and that their professional relationship had broken down.

[458] Dr Collins described feeling devastated at what was occurring and proceeded to exit the room immediately into the corridor. Mrs Magill followed him and said, "If you leave here, I shall go to the press, have you suspended and have your name in the public domain". He found her verbally very threatening.

[459] Dr Collins' response, according to him ,was that in light of the serious allegations he suggested they go and see Dr Carson, the medical director and they then proceeded to walk 200 yards to Dr Carson's office in the King Edward building. He denied making any threatening gesture towards her.

[460] Dr Collins accepted that in the presence of Dr Carson he apologised if he had upset Mrs Magill in any way from her point of view by raising his voice. He had no recollection of Dr Carson saying he required a written apology. He denied saying that the patient could not survive the journey if he was going for treatment in the BCH.

[461] In order to ascertain where the truth lay in these two conflicting accounts of what happened within the room I have initially sought, where it is available, any extraneous or independent evidence which might shine some light on the facts.

[462] I turn first to Dr Carson. As I watched him in the witness box I was convinced that he was a manifestly honest and compassionate witness who gave his evidence with the air of a consummate medical professional. He struck me as man of high integrity, perfectly prepared to embrace criticism for those for whom he carried responsibility such as in this instance Dr Collins. He conceded that Dr Collins may have fallen short of the high standard of behaviour expected of consultants when he had raised his voice angrily to Mrs Magill and had perhaps unwisely chosen to confer alone with Mrs Magill in a side room when he could easily have asked a junior doctor e.g. Dr Lee or a nurse to witness the exchange. These concessions about a senior member of his staff unhesitatingly made and unreservedly asserted, impressed me greatly in assessing his veracity. Moreover Dr Carson bore the allegations of mendacity and incompetence mounted against him by Mrs Magill with commendable dignity. I detected in his evidence an underlying sympathy for and sensitivity to Mrs Magill for having lost her husband in traumatic circumstances. I am certain that this sympathy would have been reflected in his dealings with Mrs Magill on the date in question.

[463] I believed him when he told me that when both Dr Collins and Mrs Magill entered his office in the King Edward Building, both appeared quite distressed. Mrs Magill was very distressed principally about her husband's deteriorating condition, her assertion that no one seemed to care about him and his need for intensive care unit and her concerns that his treatment and care was not what she expected. She contended that as a consequence of Dr

Collins's management of her husband, his condition had deteriorated and was in this current state.

[464] I also believe his assertion that Dr Collins repeatedly refuted her allegations that he had threatened to strike her. As mentioned above, Dr Carson candidly admitted that Dr Collins recognised that he had spoken in a manner laced with inappropriate anger in circumstances where both voices had been raised. I accept that Dr Collins apologised for doing so in the presence of Mr Carson and Mrs Magill accepted this apology in his presence. I was convinced that if Dr Collins had admitted in Dr Carson's presence that he had threatened to strike Mrs Magill, Dr Carson would have revealed this to me.

[465] I also consider it significant that whereas Dr Carson recalled the allegation of assault, he had no recollection of any allegation by Mrs Magill of being restrained from leaving or of false imprisonment. I am certain that had such an allegation been made Dr Carson would have remembered it.

[466] I also accept that after about 20 minutes the temperature of the exchanges reduced and a more measured discussion took place. It seemed to me that Dr Carson was properly assessing the situation when he told me that he felt that he had four responsibilities. First, to obtain resolution of the argument between the two parties. Secondly, because of the allegations made concerning Mr Magill's care, he had to assure himself that the patient was receiving proper care. Thirdly, if personal and professional relationships could not be restored between the two of them, another clinician would have to be involved. Fourthly, to inform Mrs Magill that if she had a complaint there was a complaints procedure which she could invoke. In the event Mrs Magill elected not to invoke the complaints procedure because she alleged the recipient of her complaint informed her in terms that nothing could be done whilst legal proceedings were outstanding.

[467] I accept Dr Carson's denial that he suggested Dr Collins should give a written apology. Why do so in circumstances where a verbal one had already been given and accepted? I have no doubt that had that been the case, for his own protection as well as that of Dr Collins, Dr Carson would have made a note to this effect. What I believe did happen was that Dr Collins apologised for raising his voice but there was no question of an apology for raising his hand.

[468] I also do not believe that in the presence of Dr Collins, Dr Carson informed the plaintiff that the consultant had personal problems. Not only would this be professionally humiliating in front of Dr Carson but would be quite unnecessary. It is of course much more likely that, as Dr Carson suggested, he made passing reference to it as a means of persuading Mrs Magill of the sensitivity of Dr Collins when they were walking towards the

ward in the absence of Dr Collins as he described. I have not the slightest doubt that Dr Carson's account of this matter is preferable to that of the plaintiff. Her assertion to the contrary is but another example of where common sense is the primary enemy of her version.

[469] I accept Dr Carson's denial that Dr Collins sought to impede the transfer to BCH of the patient by asserting that he was unfit to travel. On the contrary one would have thought that Dr Collins would have been, as Dr Carson suggested, in full agreement with the transfer in light of the explosive confrontations with him and his staff over the previous days and his attempts to involve the assistance of Dr McNamee. I also consider it inconceivable that Dr Carson would have given an unequivocal indication that the deceased was to be transferred to the BCH. How could he have guaranteed this on Christmas Eve when he had no responsibility for the BCH? For all he knew no bed would be available.

[470] I am satisfied by the evidence of Dr Carson that he did draw to the attention of the plaintiff the complaints procedure. I consider it inconceivable that as the Medical Director of this Trust, in the face of a clear allegation of misconduct by a consultant against a patient's relative, Dr Carson would not have drawn her attention to the complaints procedure. I can think of no reason why he would have failed to do so when the very purpose of the whole meeting was for him to be told about her complaint.

[471] If my assessment of this witness as a man of integrity is correct I can find no room for the plaintiff's contention that he had told her to do nothing at the end of the conversation i.e. that he had attempted to dissuade her from taking any further step in this matter. It seems to me that this witness had taken every step possible to form a constructive relationship with the plaintiff in the short time that he had met her. Not only did he elicit the apology that Dr Collins gave for raising his voice to her, but he accompanied her to Ward 9/10 to visit Mr Magill in the cubicle. This was a doctor at last in whom I consider this woman was prepared to repose her trust. I am satisfied that he told Mr Magill that his wife had brought her concerns about his care to him, that he had come to ascertain the cause of these concerns and that he felt a transfer was in everyone's interests, a proposal to which Mr and Mrs Magill agreed. He was as good as his word and made the necessary arrangements for the transfer having apprised himself of the fitness of the patient to make the journey. He did this by speaking to Professor Spence who was in agreement with the proposal. This was, of course, an entirely proper procedure to take given that the BCH is the regional centre for renal services in Northern Ireland and if active management of his renal condition was necessary, as clearly was the case, it could be dealt with in BCH. This action does not bear the stamp of someone who wished to brush her concerns under the carpet but rather evinces an attempt to address her concerns forthwith. I

reject the suggestion that he lent himself to a tawdry effort to prevent her complaining further.

[472] I therefore commence my assessment of the conflicting accounts between Dr Collins and Mrs Magill by concluding that her version of events in relation to Dr Carson is markedly flawed and riven with implausible assertions.

[473] It is also to be recalled that the plaintiff's evidence is that later on that day Professor Roy Spence had telephoned her and in the course of that he had said, "I want you to know that we are the cream and I got you the cream". She understood this to refer to her allegations that her husband had been neglected. I do not understand why at that stage she would not have immediately informed him that one of the "cream" had assaulted and falsely imprisoned her. Her explanation for this was that she considered that it was irrelevant and that she was focusing on her husband's care and treatment. I found that difficult to understand in the context of the allegation that Professor Spence had been heaping praise on the team that he had assembled. Her silence on the issue suggests that her real complaint was her belief that something more needed to be done for her husband's health.

[474] A further independent source for me to turn to is the significant fact that this matter of assault and false imprisonment was not initially raised by the plaintiff in the course of the letters of claim sent by solicitors Madden and Finucane on 10 May 2000 and 12 May 2000 on her behalf. I have no doubt that an experienced firm of solicitors would have recognised the importance of these instructions and would normally have raised it at the earliest moment if the plaintiff had been stressing the issue.

[475] In this context it is also of significance that on the 24 December 2002 three writs were issued against the defendants but no claim was made for assault or false imprisonment. This did not surface as an allegation until the Statement of Claim of 13 October 2003.

[476] I must also bear in mind that, as I will set out later in this judgment, Mrs Magill has made numerous very serious allegations of professional impropriety against other doctors and nurses in this case which I have found to be flawed and unreliable and her credibility has been undermined.

[477] Finally I now consider the impression made on this court by Dr Collins on this issue. Having watched Dr Collins give evidence before me over a number of days and observed him closely when he was questioned about this matter, I do not believe that his personality or character would lend itself to an assault or false imprisonment of any patient or patient's relatives much less of a middle aged female of small stature. Nor does it fit in with the depiction of his personality and character given by Dr Lindsay or Dr Lee

[478] In any event, even on Mrs Magill's own account, I cannot see any logical reason why Dr Collins would have attempted to strike her. If she is right, she had not raised her voice in the ward and in the room had merely said to him that she felt her husband would die if he did not get renal dialysis. Why would this lead to an assault or an attempt to imprison her in her room? What possible purpose would this have served by him keeping her in the room? There is no logical reason why this would have happened. That in itself suggests that her account is not a probable one.

[479] Of course I recognise that people can act out of character particularly when they are stressed or provoked. I am satisfied that there were unhappy exchanges between Mrs Magill and Dr Collins. The shrill aggressive tone at times adopted by Mrs Magill in this trial when she was giving her evidence, particularly in cross examination, and which I believe she exhibited in the public ward prior to the meeting in the side ward, may well have taxed his patience to the point where he raised his voice when speaking to her in the course of a rancorous exchange on both sides. I believe that the plaintiff was scolding Mr Collins in a raised voice and that he in turn became embroiled in a noisy argument. That the engagement by a consultant in a verbal exchange of this nature, whatever the provocation, should not have occurred was soon recognised by Dr Collins and prompted a swift apology in the presence of Dr Carson. Characteristically Dr Carson captured the mood of what had occurred and in my view properly concluded that this apology was sufficient for his purposes and left it up to Mrs Magill to make a complaint if she wished. I am satisfied that the circumstances as relayed to him left it well within his ambit of professional discretion to decide to take the matter no further.

[480] I do not believe that there was anything vaguely in the nature of an assault or attempted assault or false imprisonment. This is yet another example where Mrs Magill's distress has led her to grievously misinterpret and exaggerate actions of medical staff and which has served to cause her to relay to this court a wholly misleading account of the salient events of this meeting.

[481 In all the circumstances therefore I am not satisfied that the plaintiff has established any assault or false imprisonment on the part of Dr Collins and I dismiss this part of the claim.

Mr Diamond

[482] Other than the medical issues which I have already dealt with, the plaintiff's case against Mr Diamond included the following allegations of tort and breach of contract:

- Failing to examine the ERCP films and failing to communicate with Dr Ellis re his interpretation of the ERCP.
- Failing to direct his mind to the scans performed by Dr Crothers or the ERCP findings and failing to communicate personally with Dr Crothers.
- Concluding in an over hasty manner that the tumour was a type 4 Bismuth scale tumour and not resectable on the basis of an incomplete ERCP.
- Failing to recognise and failing to communicate with Dr Ellis that the PTC did not reveal segmental involvement of the left ductal system.
- "Cobbling" together a case for non resection on the basis of the need for a resection margin of tumour free area.
- Failing to effect a change in diagnosis.

[483] The plaintiff's evidence about Mr Diamond included the following. In the UIC on 15 December 1999, some time in the afternoon, Mr Diamond introduced himself to the plaintiff and her husband as Tony Diamond and informed the deceased that he had three months to live adding that he was in the Mater that morning and had "popped out one" (bile duct tumour) but that the deceased was in the wrong place. The plaintiff was concerned about the direct manner the information was communicated and his lack of concern about the person at the end of his life. After his departure, the plaintiff confirmed with the sister on duty that Mr Diamond had asked if the ERCP X-rays had arrived but none were there.

[484] I have already set out Mr Diamond's history and experience earlier in this judgment. I therefore regarded him as a highly qualified and knowledgeable hepato-biliary surgeon with wide experience inside and outside Northern Ireland. He told me in evidence that he had been introduced into this case at the request of Professor Spence who had described the obstructive jaundice which Mr Magill was suffering and the presence of dilated bile ducts evident both before and after the ERCP. His specific task at the behest of Professor Spence was to give a surgical opinion on the operability of the obstructive lesions seen on the ERCP. Consequently, he first saw Mr Magill on 15 December 1999. I find no reason to disbelieve his assertion that before seeing the patient he had discussed with Professor Spence the USS and CT scan of Dr Crothers, had looked at Mr Magill's UIC notes (which included Dr Crothers' scans), and the notes (both handwritten and typed) made by Dr Collins of the ERCP.

[485] Mr Diamond struck me as a quiet dedicated surgeon who took both his professional and ethnical duties extremely seriously. Whilst he was clearly profoundly offended by the allegations of malpractice, mendacity and unethical behaviour made against him by Mrs Magill, he bore the allegations with stoical reserve. Having observed Mr Diamond carefully over the 1½

days that he was in the witness box, I believe that the approach and the use of language attributed to him by Mrs Magill on the 15 December 1999 would have been foreign to him and wholly uncharacteristic of this surgeon. On a number of times during the course of his evidence he convincingly emphasised that the question of delivering a prognosis to a patient requires a studied approach because different people need to be communicated in different ways. He contended he would usually give a spectrum of time for life expectancy if pressed for a prognosis (e.g. 3-12 months) and this carried a logical force with me. I consider it highly unlikely that within an extremely short time of having met Mr and Mrs Magill this surgeon would have proceeded to announce baldly that he felt the deceased had three months to live. Similarly, I believe it is inherently unlikely that he would have used the phrase "pop out" in relation to a bile duct tumour. In the first place, as he described, it would not capture the nature of the formidable operation that would be involved in removing bile duct tumours. Bile duct tumours invariably go into other surrounding tissues and the operation can take two or more hours to dissect. Hence, use of the phrase "pop out" would be inapposite. I do not believe this phrase was used. I also believed Mr Diamond when he indicated that in any event he had not been operating on bile duct tumours that day as it was a Wednesday. He had commitments in the afternoon and accordingly he would not engage on such difficult operations which could stretch into the afternoon. I believe that he approached this patient in a characteristically quiet professional manner and that the plaintiff's recollection of the conversation is seriously flawed.

[486] I have already dealt in this judgment with the conflict that has arisen as to the criteria for a type 4 Bismuth scale involvement. It will thus be clear that I have determined that Mr Diamond's approach meets the approval of a competent body of expert medical opinion. I am satisfied that Mr Diamond was telling me the truth when he indicated that he interpreted Dr Collins' note of 14 December 1999, referring to "a high hilar CPD/CHD stricture taking out the RHD and LHD", as indicating that the main trunk of the bile ducts and the confluence were filled with tumour and this in his expert opinion —which conforms with a body of other respected medical opinion – constituted a type 4 tumour on the Bismuth scale.

[487] Equally, I am certain that a surgeon as careful as I have assessed Mr Diamond to be would not have closed the door on the possibility of it being a 3A Bismuth classification until all the necessary information was before him and, hence, in his letter to Professor Spence dated 15 December 1999 (but which in the event he said was not sent for a further 2 or 3 days), he said:

> "The involvement of both the right and the left hepatic ducts renders it a type 4 Klatskin tumour and surgical excision isn't feasible when this is the case. I think the best approach for Brian would be to also try

> and get his right lobe drained and Peter Ellis could probably achieve this percutaneously. I have said to him that I would make sure that I see his ERCP films just to be certain that this is the correct final decision and that there is isn't enough duct remaining above the stricture to consider a palliative surgical bypass for him which would be a better option than having stents in situ."

I cannot understand why he would have written this to Professor Spence in these terms if he had no intention of entertaining any possible move from his feeling that this was a type 4 non-resectable tumour. I am certain that he remained open minded about reclassifying this tumour if there was any evidence to justify it. Far from rushing to judgment in this matter I am satisfied that this surgeon displayed the practised caution of a caring and careful surgeon.

[488] I am also satisfied that, whilst it clearly had been his intention to see the ERCP films himself, he found the need to see such films to be redundant once he had personally spoken to Dr Collins who in turn had related to him the view expressed by Dr Ellis. Why would Mr Diamond, a consultant surgeon, not accept the view of an experienced gastroenterologist and an experienced consultant interventionist radiologist on what was the appropriate interpretation of the ERCP and the PTC? It is absolutely clear that the ERCP procedure produces real time imaging and having that described to him by the person who had carried out the procedure, namely Dr Collins, was infinitely preferable to his own reliance on three spot films from an ERCP in circumstances where he was not a radiologist. Moreover, why would he not prefer the opinion of Dr Ellis on this ERCP who described a 1cm tumour rather than relying again on his own unpractised eye as a non-radiologist to second-guess him?

[489] Doubtless the footnote to his letter to Professor Spencer of 15 December 1999 could have been more felicitously phrased when he wrote, "I have since chatted to John and we are happy there is a type 4 tumour and thus stenting is the best option". Mr Diamond as the surgeon would have made the classification and he fully accepted that, despite the content of his note, Dr Collins would not be party to that final surgical decision. I am satisfied that he was telling me the truth when he indicated that Dr Collins told him that the tumour had been high, very tight, difficult to stent on the right side and that some contrast had been witnessed on the left side. I also accept that Dr Collins further told him that Dr Ellis was satisfied there was significant involvement on the right segmental area and on the left duct the tumour had advanced about 1 cm. It was this description which persuaded Mr Diamond that this could not be classified as a type 3A tumour.

[490] Consequently I accept that Dr Diamond came to the perfectly reasonable conclusion that, as a surgeon, there was insufficient tumour free margin to operate and insufficient distance left to effect anastomosis. The fact that the left segments may not have been involved, did not address the need for sufficient length of the duct being tumour free in order to provide sufficient room for resection. He was acutely aware of what it was feasible to do based on his experience. His decision-making process had to go beyond the radiological images that were presented to him. The allegation by Mrs Magill that the idea of a necessary tumour free area was somehow cobbled together to cover up a "failed ERCP" was risible given the wealth of academic and expert opinion put before me endorsing such a concept and stood out as an example of the lengths to which Mrs Magill was prepared to go to buttress her case.

[491] His assessment based on what he was told by Dr Collins, was subsequently confirmed by his own assessment of the PTC which in his opinion did show the stricture going within 2-3 millimetres of the segment on the left side. In short, it was impossible for him to obtain the 5 millimetre margin and the 3 millimetre area necessary for anastomosis.

[492] The evidence of Mr Diamond also conforms with that of Professor Spence when the former indicated that he had spoken to the latter on the evening of 16 December 1999 to appraise him of his final assessment/opinion in light of his conversation with Dr Collins. He concluded that the tumour was not resectable. I therefore concluded that the decision to classify this tumour as a type 4 on the Bismuth classification was that of Mr Diamond.

[493] I believe that in this context there is some weight to be given to the submission from counsel on his behalf, Mr Park, that it is not without significance that no surgeon was called by the plaintiff to challenge Mr Diamond's approach in this matter .

[494] Finally it was Mrs Magill's case that on 10 February 2000 Mr Diamond responded to a telephone message she had left for him six weeks previously. It was Mrs Magill's case that this was a significant call occurring shortly after the post mortem report from Professor Crane had become available. She alleged that the first thing Mr Diamond said was "What have you been told about the post mortem." Mrs Magill unashamedly put to Mr Diamond that he had known what was in the post mortem as a result of either speaking directly to Professor Crane prior to his phone call to Mrs Magill or having discussed it with some of his colleagues. She asserted that the telephone call was to find out if Professor Crane had told Mrs Magill that he had not found any cancer and that this was a bald attempt to improperly influence Mrs Magill.

[495] I observed Mr Diamond closely during this exchange and I have no doubt that the astonishment which he evinced at the audacity of this allegation was genuine. I completely reject Mrs Magill's allegations against him in this context for two reasons. First, because once again I would have found such unethical behaviour wholly uncharacteristic of the view which I have formed of this witness, namely, that he is extremely professional and unflinchingly ethical. Again and again during the course of his evidence he asserted his ethical approach to patients over the years asserting the right of patients to make complaints and the importance of the process for so doing. I believe him when he said that he would never attempt to influence the patient who had a genuine grievance.

[496] Secondly, I believe Professor Crane who denied any contact with Mr Diamond on this subject. I accept the evidence of Mr Diamond that he had only spoken to Professor Crane twice in his life, once 15 years before when he was asked to give a talk and secondly 7 years ago subsequent to an operation on a young man who had died. I do not believe he spoke to him about Mrs Magill.

[497] I consider that he may well have attempted to console or reassure Mrs Magill during this conversation telling her that her husband would have died in any event or that counselling would be a good idea. In the course of the conversation he may have consolingly addressed her as Bernie. Mr Diamond had heard that the patient had died but I do not believe he would have known at that time whether or not a post mortem had been carried out. I consider that Mrs Magill's recollection of the passage of time between the call that she had left with the secretary of Mr Diamond and the date when the call was returned is exaggerated. Mr Diamond indicated that his system was to return calls very promptly and whilst I accept that there may well have been some delay beyond the norm in this instance, I consider the suggestion of six weeks is probably an exaggeration.

[498] His good intentions have been entirely misinterpreted by Mrs Magill. This is another illustration of how Mrs Magill's judgment about individuals and her interpretation of conversations has been distorted by her conviction that an injustice has been worked on her late husband and herself and where all too readily she was prepared to attack the integrity and professional standing of witnesses in this case without pause for reflection as to how plausible her allegations were, what substantive or supporting evidence existed and just how wounding such allegations can be personally.

[499] I have concluded that there is no basis for the claims against Mr Diamond and I dismiss the case against him.

Dr Ellis

[500] Other than the medical issues which I have already dealt with, the plaintiff's case against Dr Ellis included the following:

- Failing to communicate with Professor Spence and Mr Diamond that there was no segmental involvement of the left ductal system and thus misleading them in failing to do so.
- Failing to challenge the conclusion of Mr Diamond re the classification of the tumour and agreeing to palliative procedures.
- Incompetently carrying out the PTC.
- Failing to trigger an alternative diagnosis upon discovering there was no segmental involvement in the left ductal system and failing to communicate with Professor Spence and Mr Diamond in this regard.
- Being insufficiently experienced to carry out the procedure of placing stents and unaware of the risks attendant on it

[501] The plaintiff's evidence against Dr Ellis included the following. She described two short meetings on 17 December 1999 prior to the first PTC in the RVH. First when Dr Ellis had come to the bed and said, "You know what is happening ", and, secondly, after the procedure was finished the plaintiff asked Dr Ellis how it had gone and he replied, "I touched the vagus nerve and his blood pressure dropped. I got the right side in but not the left. I shall try again on Monday". There was no real issue that Dr Ellis had spoken these words but there was dispute as to the totality of his participation with the patient on these occasions.

[502] Mrs Magill next saw Dr Ellis after the second PTC on 20 December 1999 outside the theatre where he simply said, "I have removed the drain and put in the left stent".

[503] It was the evidence of Dr Ellis that on Friday 17 December 1999, subsequent to the deceased's admission to the RVH, he had a long discussion with Mr Magill concerning the procedure, the anatomy involved, the likely outcome and possible complications such as sepsis and bleeding. Subsequently that afternoon he had the opportunity to discuss the procedure with the plaintiff and again outlined the potential outcomes and complications. On Monday 20 December 1999, before the second procedure, he spoke again with Mr Magill, explained the complications of the procedure and obtained his consent. Post procedure, he carried out a patient visit between 6pm and 7pm to ensure the drain was in good position. The deceased's blood pressure and pulse rate were good and he was looking comfortable. Once more Dr Ellis claimed he had a lengthy discussion with Mr and Mrs Magill concerning the second procedure and what he had observed re the obstruction. Dr Ellis said that he visited the patient again

briefly on 21 December 1999 and found everything in order (e.g. his blood pressure and pulse).

[504] It seems to me inherently unlikely that, apart altogether from Dr Ellis' assertion, conventionally a doctor such as Dr Ellis would not meet the patient and describe to him the nature of the procedure and the common case complications that might have arisen. Moreover it would seem obvious that any such consultant would wish to form his own opinion of the patient's fitness for the PTC given the serious nature of the procedure and would personally check his position post procedure. I believe he did do this and satisfied himself that Mr Magill was manifesting no evidence of bleeding (coagulation), pancreatitis, abdominal pain, or infection. His only complaint was of an itch. Mrs Magill refuses to accept that this happened claiming her husband told her he had not seen Dr Ellis the morning of the initial procedure. She also denies that Dr Ellis told her about the presence of the tumour with the grave prognosis. Absent some evidence of consultant indolence or rank disinterest, I can discern no logical reason whatsoever why Dr Ellis would not have spoken to the patient before and after these procedures. My overall impression of Dr Ellis was that he was both committed and conscientious and I would be extremely surprised if the attitude he portrayed in the witness box did not translate into close attention to his patients. I prefer his evidence to that of the plaintiff in this regard.

[505] I have already dealt earlier in this judgment with the discussions between Dr Collins and Dr Ellis surrounding the ERCP, Dr Ellis' denial of involvement in the decision not to resect, his role to provide palliative treatment, the confines of his expertise, the carrying out of the PTC procedure and his experience.

[506] Dr Ellis' curriculum vitae is strewn with marks of academic excellence and high achievement. Unsurprisingly, I found him an intelligent witness who, in his evidence, combined painstaking detail and authoritative references with the patience of someone who recognised the complexity of the issues under discussion and the difficulties that lay people such as Mrs Magill inevitably endure when confronted with them. He had manifestly prepared thoroughly for his examination and cross examination. At times it was obvious that he had anticipated questions that would be put to him which in turn triggered carefully prepared answers. Whilst, therefore, his evidence occasionally lacked spontaneity, as it unfolded I became convinced that this approach was indicative of a witness who had invested a similar degree of thought and preparation into his evidence as he had obviously devoted to the many academic qualifications that he has achieved. I found him, therefore, an impressive and well prepared witness who rarely betrayed impatience or irritation in the face of strong professional attack by the medical experts called on behalf of the plaintiff. In short, not only was I content that he was a stirringly honest witness, but he was one who carried

with him the weight of a responsible body of professional and academic opinion experienced in his field.

[507] I therefore find there is no basis for the claims made against Dr Ellis and accordingly I dismiss the case against him.

Did the standard of medical care, other than that previously discussed, and of nursing care in the Ulster Independent Clinic fall below the competence and skill to be expected from persons holding the relevant positions?

[508] On 10 December 1999 the deceased entered the UIC and remained until 17 December 1999. Mrs Magill's complaints about the nursing care did not really commence until after the ERCP on 14 December 1999. Her evidence with reference to the nursing staff on this period was as follows.

[509] On 14 December 1999, after the ERCP at RVH at about 3:30pm Mrs Magill drove to the UIC and there she saw an ambulance drawing up to the front door and her husband being stretchered out. She was alarmed as she had thought that he could have gone home after the ERCP. He appeared to be wet, clammy, very deeply jaundiced and seriously ill. He was taken up to his room by the ambulance staff without intervention by or presence of nursing staff.

[510] The plaintiff asserted that, although the observation notes in the UIC assert that observation was carried upon his return to the UIC for several hours, she was there between 4.00pm and 8.00pm and no observation was carried out save that at 5.00pm a nurse had put her head in and asked if he wanted a meal. At 6.00pm Dr Collins had arrived and I have dealt elsewhere with the exchange at this time with Dr Collins.

[511] Some time after 8.00 pm, her husband, who had been in a little bathroom attached to the room, called her and showed her large tarry stools that he had passed. Later that evening she had asked Nurse Ray to look at the tarry stools. This nurse put her head round the door and said not to worry as it was the after effects of the ERCP.

[512] On the 15 December 1999, shortly after 11.00am, the plaintiff spoke to the Sister in the hospital and asked to see Professor Spence on his own. This was arranged and she saw Professor Spence. I have dealt elsewhere with the exchange with Professor Spence.

[513] On this day the plaintiff said that her husband complained of abdominal pain as the morning progressed and she noted he—

- refused both lunch and his evening meal;

- was leaning forward and supporting his abdomen because of pain. The pain seemed spasmodic;
- was given medication several times that day;
- passed large tarry stools. There was an obnoxious smell. The plaintiff believed that this was as a result of the ERCP in view of what she had been told;
- was bleeding – not as much as on 14 December 1999 – bright red blood when passing stools.
- complained of feeling sick. She did not recall him vomiting but he did retch over the period 15/16 December 1999;
- appeared to her to be shivering at times. He couldn't get comfortable in bed and at times stood at the window holding on because of pain. He was told by the Sister to practice deep breathing exercises;
- asked for blood tests as he was worried about infection. Accordingly therefore over 14/15 December 1999 he was prescribed medicine for abdominal pain/nausea/itch and jaundice.

[514] In the course of cross examination of the nurses called on behalf of the UIC, the plaintiff crystallised her case against this defendant by making the following points of negligence against the staff:-

- omitting to record these symptoms or to observe them in time or at all, underplaying the symptoms and failing to recognise that these symptoms were indicative of bleeding, perforation of the bile duct, pancreatitis, sepsis or other infection as a result of the ERCP (here in after referred to as "the suggested conditions"). In particular, failing to recognise the significance of symptoms of nausea, crampy pains, loss of appetite, and a temperature spike of 38.2 on the evening of 15 December 1999;
- failing to call for blood cultures as a result of a temperature spike on 15 December 1999;
- making inadequate notes on several occasions and in some instances fabricating notes;
- acting outside their skill level in the absence of a resident medical officer and in the course of prescribing drugs to patients.

[515] In addition the plaintiff alleged against the medical staff:

- providing insufficient information to the nursing staff in the wake of the ERCP procedure;
- Failing to manage the nurses in that there was no one to take an overview of the deceased's condition.

[516] I have already dealt with the competence of the medical staff in my earlier assessments in this judgment (e.g. Dr Crothers, Professor Spence, Dr Collins, etc.). I was satisfied there was no evidence to justify any suggestion

that these consultants failed to consult with, inform or manage the nursing staff. It is clear from the nursing and medical notes that in the UIC there was regular communication between nurses and consultants. The names of Professor Spence and Dr Collins frequently punctuate the notes during the period that Mr Magill was in the UIC. I have no doubt that their presence operated as an appropriate supervision of the dispensation of any drugs and a failsafe method of ensuring the consultants were kept up to date with patient symptoms and developments.

[517] I heard evidence from the matron and chief executive of the UIC and seven other members of the nursing staff who had been on duty during the period that the deceased was in the UIC. I have no hesitation in saying that each of these witnesses gave their evidence in a professional and informed way. Whilst in some instances the note-making left room for studied improvement, I formed the clear impression that they were all thoroughly experienced and efficient nurses in whom I could repose confidence and trust not only in the honesty of their evidence before me but also in the professionalism of the care that they gave to Mr Magill.

[518] I also heard, in the context of the UIC staff, from an expert nursing witness namely Ms Edy, who, inter alia, is a senior lecturer in nursing and a nursing adviser to the Northern Ireland Ombudsman. The weight of her evidence was somewhat diminished because I considered that she was too prone to express strong views on areas of expertise outside her field and too reluctant to make concessions in circumstances where I felt they were merited. Nonetheless, her experience did impact on my deliberations in areas where that frailty did not manifest itself.

[519] I was satisfied from the evidence of the matron and Chief Executive, Diane Graham, that following a staff meeting in September 1994, at which medical practitioners as well as the then matron were present , a protocol was drawn up whereby lists of medication were identified to be used and administered by nursing staff. This complied with the standards for administration of medicines issued by the body now known as the Nursing and Midwifery Council. I was satisfied that it provided sufficient authorisation to the nurses to administer the drugs that were therein set out. The prescriptions mentioned in this case including paracetamol, suppository dulcolax, antacid isolane, sleeping tablet temazepan and the antihistamine drug periton to deal with the itching caused by jaundice, all of which were prescribed by nurses at one time or another to the deceased while in the UIC, were all drugs properly dispensed by nursing staff under the protocol.

[520] Ms Edy asserted that the use of protocols in 1999 was standard practice throughout the 1980s and 1990s in both NHS and private sectors identifying nurses as index practitioners able to dispense the drugs contained therein. To do so did not in my view bring nurses outside their basic skills. It was

particularly useful for night cover when there were not as many doctors available as during the day and nurses could dispense these drugs to relieve pain without calling out a doctor. Nurses would sign for these drugs in the narrative notes and the protocol will act as the prescription. No evidence was called before me to refute this assertion and in the absence of such evidence I was prepared to accept that it was appropriate standard practice to adopt this protocol in the UIC at this time.

[521] A good example of this was in the context of the assertion by the plaintiff that on 15 December 1999, the day after the ERCP, Nurse Carlisle incompetently dealt with the deceased. Her entry in the nursing notes recorded:-

> "C/O crampy, windy abdominal pains this am - ?? constipated.
> Paracetamol + 2 + Dulcolax + Supp Pr
> C 7.30 am".

[522] It was Mrs Magill's case that this one of the early symptoms of sepsis in the aftermath of the ERCP. I considered Nurse Carlisle to be conscientious in her approach and concise in her explanation of the steps she had taken. In short she said that not only would she have consulted with the Sister on duty before dispensing this medication, but at that time the patient's temperature, pulse and blood pressure all were within normal limits. She had closely observed the patient and I have no doubt that this nurse would have observed any symptoms of severe pain, change of pallor or signs of distress as described by Mrs Magill. This experienced nurse, who had been a State Enrolled Nurse since 1979, and had been in the UIC since 1982, made a reasonable decision in concert with another senior nurse in light of what the patient had told her i.e. that he felt that he might be constipated. The overall picture of observation was consistent with her decision. The previous notes for 12/13 December had recorded that his bowels had moved five times overnight but of course that did not prevent him suffering what he thought was constipation by 15 December.

[523] As Ms Graham pointed out, this patient had prepared for this procedure by fasting, had taken drugs to sedate him during the procedure and had air introduced into the gastrointestinal trace during the ERCP procedure. A competent nurse would therefore have expected some digestive upset and windy abdominal pain. The suppositories would assist with the expulsion of air as well as addressing constipation.

[524] I am satisfied that at this stage there were no signs or symptoms which a nurse would have associated with the suggested conditions. Such signs would include a consistent rise in temperature, falling blood pressure, high pulse, rigors, high white cell count, severe constant abdominal pain or

immobility with the patient reluctant to get out of bed or move around (hereinafter called "the alarming signs/symptoms"). The symptoms that Mrs Magill was to complain of namely nausea, not eating, crampy pain and subsequent high temperature spike on one occasion were all occurring at different times. The nausea and fresh blood in the faeces had already been occurring according to the notes prior to the ERCP on 13 December 1999. Nurses have much experience of bowel function and I am satisfied that the steps taken by Nurse Carlisle at this stage were those of a competent nurse.

[525] I was satisfied that all of these nurses had experience with patients who returned in the aftermath of an ERCP procedure and as Nurse Hughes pointed out they had experience of this in any event in their nurse training. Although this is an area where I felt Ms Edy attempted to go into a surgical analysis of the symptoms of ERCP which were beyond her expertise, nonetheless there was some weight in her suggestion that relying on her own experience crampy pain is a frequent feature of post ERCP and is a well known side effect.

[526] It is common case that at about 10.00 pm on the evening of 15 December 1999 there was one incidence of a raised temperature, namely 38.2 degrees, treated with temazepan and paracetamol. Whilst I am satisfied the evidence was that a temperature spike can indicate infection, there were no other accompanying indicators of the suggested conditions and none of the alarming symptoms to which I have earlier referred. In particular Nurse McLaughlin had noted, by the 15 morning at 10.00 am he had bathed independently, had mobilised to the bathroom and around the room. This was part of the encouragement to patients to exercise and get up and about after such a procedure. This nurse was an extremely careful note taker making quite the most extensive notes of any of the nurses in the case and I have no doubt that her note was accurate. I pause to observe that I found not a scintilla of evidence to justify the scarcely veiled allegation of Mrs Magill that these entries were fabricated or made up. I have no doubt in my mind that these nurses of the UIC who gave evidence of these notes were being truthful and candid. The temperature spike on this occasion was an isolated occurrence which, as subsequent readings showed, quickly reduced with appropriate medication and was not repeated.

[527] The observation chart revealed that his temperature, blood pressure and pulse were regularly taken on many occasions from his admission on 10 December 1999. On 15 December 1999 at 6.00 am, 10.00 am, 2.00 pm and 6.00 pm it was normal and after the temporary spike on 15 December at 10.00 pm, it was normal on 16 December 1999 at 6.00 am, 10.00 am, 2.00 pm, 6.00 pm, 10.00 pm, etc.

[528] Nurse Kerr was the nurse on duty at the time when the spike occurred and properly she reported it to the night Sister. Despite evidence from Ms

Edy to the contrary, I consider the temperature spike should have been recorded in the nursing notes as well as the temperature chart, albeit the treatment given was indicated in those notes. Nurse Kerr had been aware of the previous crampy abdominal pain. I am convinced that this experienced nurse – she has been a Staff Nurse in the Clinic since 1979 – would have reported any complaint made to her of persistent or extensive abdominal pain and would have consulted with the night Sister and the relevant consultant on call had this been the case.

[529] It also has to be recalled that this patient was being seen by the practised eye of Professor Spence, Dr Collins and Mr Diamond during his time here. In particular Professor Spence saw him the following day, 16 December 1999 at 4.30 pm and I have no doubt that had there been any evidence of the suggested conditions or the alarming signs/symptoms, this experienced surgeon would have observed them. I also observe at this point that on admission to the RVH, as I shall shortly relate when dealing with the RVH, Dr Fitzsimons examined the deceased and made a detailed note of the patient's answers. His findings, although disputed by the plaintiff, were inconsistent with the case made by the plaintiff of the patient's condition in the period prior to his admission to the RVH when the plaintiff alleged he had been suffering as earlier alleged.

[530] Mrs Magill, cross examining Sister Johnson, insisted that a blood culture ought to have been taken when the temperature spike occurred. I found this witness to be a confident and competent nurse well in control of the facts about which she was being questioned. She made the point that if there was more than one elevation of temperature or if there were other of the alarming signs or symptoms she would have consulted with Professor Spence, a man whom she had known for 20 years, to whom she regularly spoke and who was very approachable. A blood culture would not be conventionally taken where there was an isolated rise in temperature and in any event where it was not at least 38.5 degrees. I had no doubt that this Sister, much less the other experienced nurses, was able to form an overview to the plaintiff's symptoms and would have recorded any complaint of continuing severe abdominal pain.

[531] I have already dealt with the clinical aspects of the plaintiff's assertion that the deceased was passing dark tarry stools from 14 December onwards. Virtually all of these nurses were closely questioned on this topic and I have no doubt that their consistent response to the effect that melaena is a condition well known to them with a particularly pungent smell was truthful. I am certain they would have recognised the dangers of such a condition and would not either individually or collectively have ignored it to the extent of not recording it and/or taking no steps to address it. It seemed to me to be preposterous to suggest that virtually all of these nurses from the UIC would for some unknown reason have ignored such symptoms.

[532] The first nurse who it was alleged should have been aware of this was Nurse Ray, a nurse who is qualified since 1968 and therefore comes to the court armed with a wealth of nursing experience. Nurse Ray was able to relate to me the precise procedure that she would have adopted had she been told about black tarry stools. This would have involved putting a catcher into the toilet bowl to collect the stools, together with a record being made of the frequency of passing, time of passing and colour. It would also trigger increased frequency of observation because of the danger of internal bleeding. She would have informed Professor Spence. Nurse Ray had experience of melaena and was conversant with the particularly pungent smell. Having watched her carefully I had not the slightest doubt that this nurse would have adopted her normal procedure and have acted conscientiously had she been told of such a condition. Absent abject wickedness which was not suggested against her, why would she have acted otherwise and ignored a condition which she well knew was potentially very serious? I believe that she was telling the truth when her note at 8.00 pm on 14 December 1999 recorded:

> "Both patient and wife anxious about future treatment. Telephone call to Professor Spence re above – unable to visit this pm will contact Dr Collins and discuss case. Then visit patient tomorrow. Patient and wife reassured and made aware of above".

[533] This note would be inconsistent with the case made by the plaintiff that her concern emanated from the presence of black tarry stools. It tied in precisely with the timing of Mrs Magill's meeting with Dr Collins when he had indicated to her that her husband was suffering from a terminal condition. I am satisfied that this was the context of the note and conversation with Nurse Ray. It is not without significance that the plaintiff did not raise the issue with Professor Spence or Dr Collins.

[534] The evidence of Nurse Ray on this question of melaena echoed that of Sister Johnson who gave precisely the same description of the symptoms and importance of the condition. I believed her when she said that she would recognise the condition instantly. In the past she has found the condition associated with the patient being very weak, cold, clammy and almost faint. None of these symptoms was present with this patient. His bowel motions would have been questioned on a daily basis - nursing notes record he complained of constipation and his bowel not moving - and inevitably if he had mentioned dark tarry stools to any nurse it would have been recorded.

[535] As well as those to whom I have already referred, the failure would have extended to Nurse Wyndrum, qualified as a nurse since 1975 and a

Sister since the mid 1980s, who would undoubtedly have understood the significance of any complaint of melaena and Nurse McLaughlin, the extremely careful note taker to whom I have already adverted. What possible motivation could there have been for these nurses recording e.g. the movements of his bowels but omitting references to melaena?

[536] Nurse Wyndrum was the nurse on duty when Mrs Magill asserted that her husband was in such pain that he was holding on to the window frame and was instructed to take deep breathing exercises. I have no doubt that this conscientious Sister would have recorded this in the notes had it been the case and would have taken steps to have these matters investigated.

[537] In so far as the individual nurses are concerned, I leave to the last one of the particularly serious allegations of bad faith and fabrication made by the plaintiff against Nurse Hughes. This witness had qualified as a nurse in 1990 in the Isle of Man, had worked in the Intensive Care Unit in the Royal Victoria Hospital between 1996 and 1999 and had been a Staff Nurse in the UIC in 1999. She is an acting Sister since 2006.

[538] Upon the deceased's return to the UIC on 14 December 1999 at about 4.00 pm after he had undergone the ERCP at the RVH, she had noted:

> "Return to room at 4.00 pm, comfortable. Obs. Satisfactory. Patient has had an ERCP and stent insertion and sphincterotomy. Fast until seen by Dr Collins. 6.00 pm s/b Dr Collins allowed to eat and drink".

[539] It was her evidence that she had continued to observe the patient in terms of temperature, pulse and blood pressure at 4.30 pm, 5.00 pm, 6.00 pm and 7.00 pm. She had made entries for the temperature at 4.30 pm (normal at 36 degrees) but not for 5.00 pm, 6.00 pm and 7.00 pm. Entries had been made by her for pulse and blood pressure (all normal) during these observations. The blood pressure had been recorded as 110/70 on all four occasions.

[540] Mrs Magill asserted that she had been with her husband between 4.00 pm and 8.00 pm and that no observation whatsoever had occurred i.e. that Nurse Hughes had completely fabricated these entries.

[541] I watched this witness give evidence very carefully. She was very nervous and clearly under stress but was far from portraying the demeanour of a witness who was attempting to mislead me and perjure herself. Having the opportunity to watch her, it did not come as a surprise to me to learn during the course of her cross examination that she had achieved first class honours in the course of her health studies qualifications because she struck me as a very conscientious, intelligent and caring nurse. I reject entirely the

allegations against her for the following reasons. Firstly, because her demeanour was that of a truthful person, secondly, it would be an absurd risk for her to have taken to have deliberately left out reference to the temperatures if she was fabricating the entire note. It is this that draws attention to the entries. If she had been fabricating the blood pressure and pulse, why would she not have fabricated entries for the temperature? On the contrary, her reason as to why she had not made any entry for the temperatures on three occasions seemed to me perfectly plausible namely that the patient had been asleep (as admitted by Mrs Magill) and she did not want disturb him. It was easy to take blood pressure and pulse from a sleeping patient because of the presence of a cuff but much more difficult to take a temperature. I noted that she was not the only nurse who advocated such a step with patients because Nurse Carlisle said that if a patient was asleep she also would not disturb him by taking his temperature either orally or under his arm provided the other readings were normal and there was nothing to alert her attention by way of concern. Ms Edy made the point that a priority for such a patient after an ERCP was probably rest and that had she been nursing this patient she would have acted in a similar way. I therefore reject Mrs Magill's allegation against this nurse as completely unfounded.

[542] Mrs Magill suggested that her husband had been taken from the ambulance up to the room by the ambulance men without any intervention of the nurses. I found this highly implausible. How would the ambulance men have known what room he was to go to without the intervention of a nurse? How could Mrs Magill be certain which room her husband was to go to without the intervention of a nurse? The ambulance men would have had to have passed the reception in any event. I therefore shared the disbelief of Ms Graham, the matron, that such a procedure would have occurred. I had no doubt that Nurse Hughes did escort the patient from the lift into the room and it was this observation that informed her note that he was comfortable.

[543] Finally, I was satisfied that adequate information had been available to the nursing staff from the medical staff as to the condition of the plaintiff upon his arrival from the RVH on 14 December 1999 e.g. from the face sheet on the nursing note, the endoscopy report of Dr Collins of 14 December 1999 and the notes made by nurses on sequential occasions. I am also satisfied that there was a high degree of overview and supervision of the nurses in this case. They all seemed to me to be highly experienced nurses, well au fait with the relevant procedures.

[544] In short I found no evidence whatsoever to suggest that the standard of care given to the deceased by the nursing or medical staff in the UIC was anything other than the appropriate standard of competence and skill to be expected from nurses holding these posts. I dismiss the claims against the UIC.

Did the standard of medical care, other than that already discussed, and of the nursing care at the RVH fall below the level of competence and skill to be expected from those holding the relevant positions?

[545] The deceased was transferred to the Royal Victoria Hospital (RVH) on 17 December 1999 and remained there until 24 December 1999.

The events between the 17 December and the 22 December 1999

[546] I shall commence by dealing with the evidence of Mrs Magill concerning this period save that I have already dealt with her evidence of the exchanges with Dr Ellis and Dr Collins shortly after his arrival at the RVH and I shall not revisit that aspect

[547] The plaintiff asserted that by 17 December 1999 the deceased was becoming progressively more ill after the first PTC and she observed there was very little drainage of bile. Nurse McQuillan had recorded, "Minimal drainage" whilst other nursing notes claimed, "Stents working well". The plaintiff denies the truth of the note of 17 December 1999 at 8.00 pm that records Dr Collins attending and noting, "Patient recovering well. Abdomen not distended".

[548] On Saturday 18 December 1999 the deceased's condition was deteriorating and he did not take any lunch/evening meal.

[549] On 19 December 1999 the plaintiff brought in some salad from Forestside but he did not eat it.

[550] On 20 December 1999 the deceased underwent the second PTC to have the drain removed and the left stent inserted. I have already adverted to the plaintiff's allegations that at around 4.00 pm Dr Collins and the senior registrar, Dr Gibbon had dictated that her husband was to be discharged leading her to contact Nurse Lily in the UIC for assistance.

[551] On 21 December 1999 the plaintiff alleged that she took the deceased's clothes to the hospital but was informed by Nurse McQuillan, "Your husband couldn't go home. Mr Collins has gone missing".

[552] The deceased had been asking Dr Caroline Lee about the frequent black tarry stools and the plaintiff had been leaving specimens of these stools for tests. Dr Lee said they would be examined and the deceased would be tested and blood examinations carried out. Later blood tests were taken and Dr Lee said, "There is a slight infection but everything is under control". It was the plaintiff's contention that this occurred because of her intervention with Nurse Lilly.

[553] There is no doubt that there was a temperature spike on 21 December 1999 of 38.5 degrees. This is recorded in the nursing notes for that time and date and it also appears on the observation chart. According to the defendants this triggered the taking of a blood culture which was sent to the laboratory. The results of that were received from the laboratory the following day i.e. 22 December 1999 at 5pm recording as follows,

> "Bacteriology – gram – negative rods – coliforms
> No sensitivities.
> Change to augmentin 625 mgs"

[554] On 22 December 1999 the plaintiff brought in some cleaning materials to clean the bath. A nurse agreed that the plaintiff could bath the deceased. His body had purple blotches and was jaundiced. She wheeled him to the bed and stayed there until 9.00 pm. Some time after 9.00 pm a nursing auxiliary said, "You have been written up for an antibiotic but we have got none".

[555] I turn now to my conclusions on the allegations made by the plaintiff for this period. Dr Andrew Fitzsimmons, the junior house officer who saw the deceased on admission to the RVH on 17 December 2004, was potentially an important witness in this regard. Whilst he had no recollection of the deceased and was relying entirely on his note, I state at the outset that I found him a frank witness who made no attempt to tailor his evidence to suit any of the parties in this case despite the suggestions to the contrary by the plaintiff.

[556] Dr Fitzsimons evidence amounted to this:

- His admission note recorded, inter alia, that since the end of October the patient had noticed increasing dark urine, pale stools, jaundice and an itch.
- On direct questioning Mr Magill indicated to Dr Fitzsimmons that his appetite was fine and he had had some diarrhoea over the past 4 weeks but he had no bleeding per rectum.
- He would have systematically examined and palpated the patient's abdomen in 9 separate places with no complaint, wincing or indication of pain from the patient. If he was suffering from inflammation of the pancreas at that time, Dr Fitzsimmons felt that he would have manifested some pain. The absence of any such symptom further suggests to me that this patient was not suffering from pancreatitis at this time on 17 December 1999.
- During the gastro intestinal tract questions, Dr Fitzsimons would have specifically asked the patient if he was suffering any nausea, vomiting or blood discharge and made inquiry about the colour of the diarrhoea in order to ascertain if he was passing blood.

[557] Whilst that there was a possibility the patient was discussing the matter pre-ERCP I nonetheless find it extraordinary that if he had been passing dark tarry tools, suffering pancreatatic pain in his abdomen, nausea and retching, that this would not have emerged at some stage during the questioning of Dr Fitzsimmons. I therefore found this witness' evidence inconsistent with the case made by the plaintiff of the patient's condition in the period prior to his admission to the RVH when the plaintiff alleged he had been suffering, inter alia, all these matters.

[558] The evidence of Dr Fitzsimmons conformed with that of Nurse McQuillan who was a senior staff nurse in Ward 10 at this time. He was responsible for signing the entries to the care plan on 17 December 1999 for the deceased, a document which in my opinion is illustrative of the careful management that was proposed for the deceased at this time. He also filled in a nursing information sheet which recorded that on admission his blood pressure was normal at 141/76, his pulse was normal at 56 as was his temperature at 36.2. His appetite was described as "good".

[559] This evidence in turn conformed with the assertion of Dr Ellis that on 17 December 1999 he had met and spoken to Mr Magill and found him well other than he was complaining bitterly of an itch. It all bears striking contrast with the picture depicted by Mrs Magill of the condition of her husband on 17 December 1999.

[560] Yet another piece of evidence corroborating the assertions of these witnesses and contradicting the plaintiff is to be found in the four hourly entries in the observation chart post PTC 17 December 1999 which I accept as being genuine and accurate despite Mrs Magill again questioning the veracity of them. These observations indicated normal temperature, blood pressure and pulse rate.

[561] The plaintiff steadfastly refused to accept the veracity of the medical notes which challenged her assertion of the paucity of drainage post PTC. Between 9 pm on 17 December 1999 and 18 December 1999 Nurse Crossey's note records "Left external drain draining freely. Output – 100 mls." A record at 2.30 pm on 18 December 1999 by Nurse McQuillan does record "Drain site satisfactory, minimal drainage". I accept the evidence of Nurse McQuillan that in his experience it is not at all unusual for there to be small amounts of bile at times in the aftermath of the PTC. A nursing note of 19 December 1999 records between 9pm-8am "External drain on free drainage. Output – 200 mls." At 20.13 on the same date Nurse McQuillan, records "Drain beginning to collect bile. Patient drinking well".

[562] Ms Christine Kidd, a highly qualified nursing expert with a wealth of nursing experience whose C.V. included being a member of the Nursing Inspectorate for the North West Hospitals between 1994 and 2001 and who

has set up her own care consultancy since 2001, agreed that having read the notes with her practised eye there was no evidence of blockage at this time.

[563] A final piece of independent evidence in this context was the fluid chart which revealed intake and output of fluid which married in with the notes to which I have recorded.

[564] The plaintiff seemed heedless of the suggestion that the concept of a conspiracy of various nurses, none of whom knew the patient before his arrival at the RVH, to contemporaneously alter and manufacture such notes and records was highly improbable absent some evidence of collective arrant wickedness. Accordingly I found an array of evidence to challenge Mrs Magill's assertion that there was very little drainage in the aftermath of the PTC of 17 December 1999.

[565] Nurse McIntyre, a D Grade student nurse, on 18 December 1999 gave evidence that she had seen the deceased on 18 December 1999 in the evening and had recorded, "No complaint apart from itch over abdomen. Requested piriton for itch at night." This was at a time when the plaintiff has alleged his condition was deteriorating. What possible motivation could there have been for a student to contemporaneously make such an entry if the plaintiff was complaining of pain in the abdomen etc and was deteriorating? Her entry on the following morning 19 December 1999 records that he was drinking plenty and the drains remained on free drainage. Once again no reference is made to any other alarming sign or symptom. Was I to believe that even student nurses had decided to fabricate records?

[566] Nurse Belshaw, a very experienced nurse who qualified in 1981, having spent 10 years as a nurse in Australia was a senior staff nurse on duty with the deceased on 20 December 1999. At this time observations were allegedly being taken twice per day. She found normal temperature of 36, normal blood pressure 145 and normal pulse rate at 70 throughout this date.

[567] This witness drew attention to the fluid balance chart maintained by the hospital which revealed that on 19 and 20 December 1999 the deceased had passed urine in the toilet. This meant, according to Nurse Belshaw, that the patient had been fit enough to get out of bed and travel along the corridor to the toilet on these two dates. This conforms with the entry by Nurse McQuillan at 7.30 pm on 21 December 1999, "Comfortable morning. Self caring attended to own hygiene." These normal readings and his mobility did not smack of a patient who was in the seriously ill deteriorating condition as alleged by Mrs Magill.

[568] The fluid balance chart also recorded that his bowels had opened on 19 and 22 December 1999. These bowel movements, according to Nurse Belshaw, would have been recorded as a result of direct questioning of the

deceased. Here was a perfect opportunity for reference to be made to dark tarry stools. I have not the slightest doubt that reference to dark tarry stools during this period would have triggered concern at least in some of the nurses who were attending to him and that it would have been recorded. The absence of the slightest reference to such stools during this period satisfies me that such a complaint was not being made.

[569] Similarly, I do not accept that these nurses would have been unaware of the allegation of black tarry stools or, if they were, that they have deliberately desisted from entering this on the records. All of the nurses, without exception, indicated that melaena would in any event involve a particularly pungent smell which they would recognise. The significance of black tarry stools would indicate blood loss to all of these nurses and I have little doubt that they would not deliberately ignore this either by failing to record it or to draw it to the attention of appropriate medical staff. What possible motivation could there be for so doing?

[570] Up to the evening of 21 December 1999, therefore, I accept the evidence of the nursing staff that there was no reason whatsoever to suspect that this man was suffering from infection of any kind. The suggestion that these nurses were deliberately excluding from the notes and records clear evidence to the contrary seems to me highly unlikely.

[571] There is no doubt that there was a temperature spike on 21 December 1999 of 38.5 degrees. This is clearly recorded in the nursing notes for that time and date and it also appears on the observation chart. Properly, in my view, this triggered the taking of a blood culture which was sent to the laboratory. I find entirely unacceptable the plaintiff's assertion that it had anything to do with an intervention by Nurse Lily from the UIC. The results were received from the laboratory the following day i.e. 22 December 1999 in a lab note at 5pm recording as follows:

> "Bacteriology – gram – negative rods – coliforms
> No sensitivities.
> Change to augmentin 625 mgs"

[572] In the meantime, however, the medical note of 21 December 1999 – 7.40 pm records, "Antibiotics, patient now feeling a lot better. Slightly sore earlier" and at 10.00 pm nursing staff records that he was apyrexic and was comfortable and pain free. Hence temperature was normal within 2½ hours of him having been given antibiotics for the earlier temperature rise. This was followed the next morning i.e. 22 December 1999 by nursing notes recording:

> "22/12/99 – 8.00 am to 8.00 pm Relatively comfortable morning. Some C/O of wind. Gaviscon given as prescribed. Temperature 37 at 5.00 pm. . .

paracetamol given as prescribed which resolved pyrexia. Antibiotics commenced"

[573] The drug prescription and administration records also had some relevance. This showed the antibiotic ciproxin prescribed as being commenced on 22 December but, following the advice in the lab note, augmentin is noted as being dispensed on 22 December 1999 by Nurse Crossey. This serves to illustrate to me that this man was receiving at this stage swift and appropriate treatment by nursing and medical staff.

[574] I observe that this nursing evidence is consistent with that of Dr Caroline Lee SHO. During December 1999 she was a senior house officer working in Wards 9 and 10. She gave evidence that she remembered Mr Magill well, describing him as a very polite respectful gentleman. On 20 December 1999 she carried out an examination of him after the PTC and found him generally well. I came to the conclusion the notes this doctor made were detailed and characteristically careful. In particular on 20 December 1999, she recorded his urea level as normal. It is common case that this is a good guide as to whether or not the deceased was dehydrated. If he was bleeding from his intestine it would be raised as would his haemoglobin (hgb) level, according to Dr Lee. I believe this to be correct. The hgb level was normal as was his white cell count which would not be the case if he was fighting infection. The creatine level (which deals with his renal function) was similarly normal. It was her evidence that her interpretation of the notes of this man of 18/19 December 1999 were not materially different from those that she recorded on 20 December 1999 save that there was some improvement in his itch.

[575] On 21 December 1999 she said she saw him at about 9.00 am, finding improved appetite , no raised temperature, and his blood pressure was normal. It was her evidence that if there was any sign of infection, that would have been reflected in a raised temperature and altered blood pressure level whereas these were normal. A significant entry at this date was to "dark large motions passing wind only today". Her evidence on this was that she clearly had information from the patient that he had a bowel motion the previous day but that he had no bowel motion on that day. Had the description fitted melaena she would have taken immediate action.

[576] I have already dealt with the issue of black tarry stools and at this stage I simply record that Dr Lee indicated she had no recollection of such a matter being raised by Mrs Magill. It was highly significant in my view however that she found the hgb/urea levels normal suggesting that there was no internal bleeding. Dr Lee said that even if Mrs Magill had brought to her attention black tarry stools in the context of a normal hgb and urea she would not have considered this an example of melaena.

[577] I am satisfied that the oral evidence before me and the objective note taking of the nursing staff and Dr Lee are reconcilable and consistent with the case being made that this man was not suffering any material infection until the temperature spike of 21 December 1999 which in itself returned to normal within a short time thus arresting any immediate undue concern pending receipt of the lab report.

[578] Dr Lee's evidence and comprehensive medical note of 22 December 1999 again conforms with the nursing notes for that time observing that the deceased was complaining of crampy right sided abdominal pain which was eased with gaviscon and passing wind. His appetite was unproblematic and his urine dark which is consistent with biliary obstruction according to Dr Lee. Dr Lee concluded that the symptoms were related to his bowels.

[579] She asserted that the reference in her note to, "no guarding and rebound" are highly significant. Guarding occurs where the doctor presses on the abdomen and voluntarily or involuntarily the patient tries to prevent that occurring. Similarly rebound occurs where the abdomen is pressed and released and the abdomen is more painful when released. These symptoms would be present if there was acute abdominal or bowel obstruction but neither was present in this instance. His symptoms, including sluggish bowel signs, pointed towards constipation since he was now apyrexic by 22 December 1999 indicating that the antibiotics had proved satisfactory, and his blood pressure and pulse were normal.

[580] Hence, the plan which she comprehensively set out in her note of early 22 December 1999 in light of those symptoms suggested an abdominal X-ray to confirm if there was constipation, a chest X-ray to be taken to rule out the possibility of the existence of free air causing abdominal problems, if a further temperature rise occurred blood cultures were to be taken, a laxative was prescribed and he was to continue with antibiotics. The chart for regular prescription showed that on this date the antibiotic was changed to ciproxin to be given twice per day at 8.00 am and 10.00 pm. In the event, the arrival of the analysis of the blood cultures at 5.00 pm indicated the presence of the gram negative rods which led to a change of the antibiotic to augmentin on the basis of the recommendation from the bacteriologist.

[581] Interestingly, Mrs Magill's assertion that some time after 9.00 pm on 22 December 1999 a nurse told her that her husband had been written up for an antibiotic but there was none available, is in my view disproven by virtue of the entry in the "drugs not administered chart" which refers on 22 December 1999 to cholestyramine not being in stock. I accept the evidence of Dr Lee that this is not an antibiotic but in fact was for the deceased's itch and is one more illustration of the inaccuracy to which Mrs Magill was prone during the course of this case due to the passage of time albeit she steadfastly asserted that she could remember events as if they had occurred only yesterday.

[582] Once the report was received from the bacteriologist at 5.00 pm on 22 December 1999, treatment was changed to meet this including the prescription of augmentin which he received at 10.00 pm. That, at least in the meantime, these antibiotics were bringing the septicaemia under control is in my view a reasonable deduction for Dr Lee to have drawn at that time. I make no apology for going into the minute detail that I have for this chain of events on 21 and 22 December 1999 because in my view it illustrates both the close attention and care that was given to this man during these times and the reasonableness of the assessments by Dr Lee in light of the symptoms that were presented to her at the time without the benefit of hindsight notwithstanding the trenchant criticism of her by Mrs Magill that she was far too inexperienced to be treating her husband.

[583] Having heard the evidence of Dr Gibbons, Dr McNamee, Dr Fogarty and Dr Collins, all of whom lent their imprimatur to her response to the unfolding events, I am satisfied that these decisions by Dr Lee were appropriate, that she was sufficiently experienced /knowledgeable to make them and that she was adequately supervised and overseen by senior doctors namely Dr Gibbons and Dr Collins.

[584] I find no credible evidence to sustain Mrs Magill's allegations over this period.

The events of the 23 and the 24 December 1999

[585] I now turn to the events of 23 and 24 December 1999 in the RVH which were a matter of much controversy in this case. I shall commence by dealing with the evidence of Mrs Magill and the case that she made concerning this period. The plaintiff relied partly on the evidence she gave of a conversation with her late husband which she said occurred on the evening of the 23 December 1999 when she had gone to visit him, the evidence of a fellow patient in the RVH at this time called Mr Trimble, a statement made by Dr Ellis to the Coroner and her own observation of her husband when she attended the ward on the morning of 23 12 1999 at about 11am.

[586] Around 9.40 pm on the evening of 23 December 1999, the plaintiff said the deceased related in a lucid way what had happened to him in the early hours of 23 December namely:

- about 3.00 am he had wakened from sleep with unimaginable pain in his abdomen and loss of control of the lower limbs which were jerking uncontrollably. He had called repeatedly for help until 6.00 am.
- A nursing auxiliary came and rubbed his feet but she cautioned him that he would waken other patients. The patient in bed beside him

summoned help again and nursing auxiliary returned and told him to be quiet about 6.00 am.

- that he had got out of bed to telephone his wife and collapsed in the ward about 9.00 am.

[587] Mr Trimble gave evidence that he was admitted to one of the 30 beds in Ward 10 beside Mr Magill at the RVH on 17 December 1999. He recalled the early hours of 23 December 1999 and gave evidence that:

- he was woken about 1.30 am by the deceased crying in pain "Oh my God this is never going to stop".
- Mr Magill told him that his legs and stomach were sore and that he wanted a nurse. Mr Trimble approached the nurses station where there were three nurses sitting on three armchairs, told them that Mr Magill needed a nurse and an auxiliary nurse followed him to the bed. He claimed that this nurse said to Mr Magill, "Shhh Mr Magill you will waken the patients" and returned to her station.
- He went back to bed but Mr Magill seemed to be worse and was rubbing his legs saying, "Oh my God it's not going to stop". Mr Trimble found that the deceased was cold, sweating , shivering and wanted a doctor. He declined a suggestion from Mr Trimble to telephone his wife saying that he would not do so at that time of the morning.
- he reported again to the nurses' station that Mr Magill wanted a doctor. The nursing auxiliary came back and this time rubbed the deceased's legs and put a blanket over him because he was shaking. Mr Trimble felt that Mr Magill's condition was deteriorating being cold/sweaty and shaking all the time. He saw no doctor attending to the deceased whilst he was awake save for a nursing auxiliary. Thereafter he went back to sleep until the next morning.
- Mrs Magill had contacted him again about January 2000 to ask him what had happened.

[588] It is noteworthy that Mr Trimble did work as an auxiliary nurse in Wood Lodge in Castlewellan since the early 1990s and I felt he gave his evidence in a dispassionate and sincere manner. He readily conceded that his own treatment had been good, he had never heard Mr Magill complain to nurses prior to 23 December, he had no reason to believe that Mr Magill had woken anyone else that morning and that the auxiliary nurse had spoken to the deceased in "a caring enough voice" albeit she did not do anything on the first occasion. A gap of 20/30 minutes passed between the first and second visits of the auxiliary nurse.

[589] Mrs Magill adverted to the statement made to the Coroner by Dr Ellis in or about April 2000 when, referring to the 23 December 1999, he recounted -

> "On Thursday morning, 23 December 1999, I was contacted by Dr John Collins and was informed that the patient had developed clinical signs of septicaemia in the early hours of the morning. He had appropriately been commenced on IV fluids and Dr Collins had requested that Dr Jim Murray and Dr Brian McCloskey from the regional intensive care unit would see the patient".

Mrs Magill heavily relied on the use of the phrase "signs of septicaemia in the early hours of the morning" to corroborate her assertion that the signs had clearly been missed in the early hours of the morning and not treated appropriately.

[590] Two other nurses, called on behalf of the plaintiff, gave evidence relevant to these events even though neither of them had any independent recollection whatsoever of the patient, Mr Magill. I accepted that the passage of time was responsible for this.

[591] Nurse McFall thought that the probabilities were she had been one of the nurses on duty in Ward 10 in the early hours of 23 12 99. This witness had been in service for 27 years, she is now a service manager with the RVH regularly dealing with complaints by patients/relatives and staff and she was adamant that neither she nor her colleague would have missed someone who was showing the symptoms of septicaemia in the early hours of the morning. Her evidence was, as follows:

- This was one of the busiest wards in the hospital with about 19 beds. Nurses did sit in chairs outside the nursing station during the nightshift which enabled them to see down the ward. If a patient was in discomfort, there was a bedside buzzer system, heard in the nurses' station.
- The nurses are frequently out and about the ward itself. Senior managers regularly visit unannounced during the night. There would have been two staff nurses and a nursing auxiliary. Nurse Crossey would have been the nurse responsible for Mr Magill.
- The prescription records of "once only drugs" named an antibiotic drug zinacef on 17 December and a further antibiotic on 21 December. She did not see any evidence that antibiotics were given 17/18/19 December 1999. Zydol, recorded as being dispensed to the deceased on 23 December 1999, is an analgesic drug not as strong as morphine but is given for moderate to severe pain.
- She did not regard it as being out of the ordinary that there was no entry in the nursing note for that night to the effect that the deceased had asked to see a doctor other than to record that a JHO had

attended. The JHO may have reviewed the deceased and, at his discretion, made a note.

- Any signs of septicaemia – namely raised temperature, raised pulse, low blood pressure etc would have been observed by Nurse Crossey and help would have been sought from the JHO. If she had still been unhappy she would thereafter have contacted the SHO and Dr Collins.
- Auxiliary nurses are extremely experienced and would discuss any problem with the nursing sisters.

[592] Nurse Crossey, employed in December 1999 in Ward 10 RVH as a staff nurse, has served 19 years as a nurse and is now a ward manager in the Lurgan Hospital. She was the author of the nursing note relevant to the period 9.00 pm-8.00 am, 23 December 1999 about 7.30 am towards the end of her shift. It recorded:

> 23/12/99 – 9.00 pm to 8.00 am "No acute problems.
> Slept well. Temp at 7.00 am – 36 c.
> Zydol 100 mg given at 10.00 pm with little effect. JHO asked to see. Nil ordered. Zydol 100 mg given at 6.00 am.".

[593] Her evidence was as follows:

- Significantly, the patient's temperature of 36 recorded at 7.00 am was normal. If a patient was suffering septicaemia she should expect that to be 38. Whatever the position was at 1.00/2.00 am there was no septicaemia at 7.00 am. although the reference to "Zydol" indicated that he must have been in some pain at 10.00 pm and again at 6a.m. and indeed a junior doctor was asked to see him in this case. The pain relief had obviously not worked. Hence the note, "Little effect". The reference to "nil ordered" clearly meant the JHO had not directed anything.
- It would be quite normal for an auxiliary to reassure a patient/rub his legs/give him a blanket if shivering, etc although that should have been documented. However, she said the nursing auxiliaries were very experienced, would report back if someone was in great pain or not able to control the matter and a doctor would be called.
- Dealing with the note "slept well", the witness said if a significant on-going event had occurred it would have made its way into the note.

[594] I believe that this patient was suffering pain during the course of the hours of that nightshift. Why else would he have been given pain killers on two occasions namely at 10.00 pm (apparently with little effect) and again at 6.00 am. A junior house officer was called to see him. All of this conforms with the evidence of Mr Trimble who in my view was a decent, honest man albeit of course his memory on precise detail may be a little vulnerable given

the passage of time. Nonetheless I accept his account of this man complaining of pain during the night, requesting a doctor, having his legs rubbed etc is basically all correct.

[595] I consider the notes made by Nurse Crossey on that occasion to have been inadequate. No account is given of the reason why the pain killers were given, the site of the pain or the reasons why the JHO was called. These events simply are not reflected in a note recording, "No acute problems. Slept well". It did not surprise me that Ms Kidd the expert nursing witness called on behalf of the RVH, and a witness whom I found to be very impressive, did not hesitate to state that if the patient was up during the night for treatment it was inappropriate for the note to have recorded "slept well". Anything abnormal must be recorded. I came to the conclusion that this was a note hastily prepared along with other notes at the end of a busy shift which did not adequately reflect this man's condition during the course of that shift probably because she believed the matter had resolved. Nurses must make an adequate note of the salient issues that arise during a shift so that those coming on thereafter, both nurses and doctors, have an adequate record of what has occurred irrespective of how busy they may have been.

[596] That conclusion, however, does not determine this man was suffering from septicaemia at that time. The temperature recorded at 7.00 am of 36 degrees, which I have no reason to doubt is accurate, is a strong contraindication. It seems to be fairly common case on the part of both Mr Trimble and the nurses that he did sleep for some hours after the nurse and the JHO had seen him. The practised eye of an auxiliary nurse and a junior house officer had been placed on this man and I am satisfied that the very obvious signs of septicaemia during those early morning hours would not have been missed. The deceased had been receiving zydol the previous day and complaining of crampy pains and constipation. It looks as if the JHO simply continued that treatment of zydol and it did result seemingly in the deceased going back to sleep in so far as Mr Trimble was not again disturbed that night. At 8.00 am the medication record notes that the deceased was given his normal medication orally. Breakfast would be served between 8/8.15 am and I have no doubt that the deceased would have been observed at that stage. An adverse condition would undoubtedly have been picked up. The next entry in the records of relevance was that of 9.30 am on the observation chart which revealed a temperature of 37.4 degrees which although at the upper end of normal, was still normal. I, therefore, accept the view of Dr Collins that these signs / symptoms do not suggest a patient suffering form sepsis, septic shock, septicaemia or as Professor Price described it the "GUT wrenching constant pain" of pancreatitis at that time. In brief I have determined that the inadequate state of the nursing notes for the early hours of 23 December 1999 betrays not a deliberate decision on the part of nurses to conceal the fact that he had septic shock but rather an all too casual approach to note taking.

[597] I do not believe that it is productive to impose too strict an interpretation of Dr Ellis' phrase, "in the early hours of the morning". I have listened carefully to his evidence in this matter and I am satisfied that this was simply a loose reference to the obvious development of septicaemia which manifested itself in the deeply concerning drop in blood pressure which is recorded in the notes much later that morning. I have accepted that Dr Collins was off work due to illness at this time and so would not have been informed in the early hours of the morning in any event? It obviously was not the JHO who suggested septicaemia because he had indicated that nothing more was to be done. It was not the nurses because they have given evidence to me that they did not observe any signs of septicaemia. All of this convinces me that this statement by Dr Ellis is no more than an erroneous reference to time which appeared inconsequential at the time of making his statement to the Coroner.

[598] I am not satisfied on the balance of probabilities that the steps subsequently taken at 11.00 am or thereabouts on the morning of 23 December 1999 were necessary in the early hours of the morning or would have changed in any material way the course of the deceased's treatment or death. I am not clear what the cause of Mr Magill's problem was in the early hours of the morning. It conceivably might have been the severe constipation suggested, for example, by Dr Ellis in light of the evidence of gross faecal loading in the abdominal X-ray of 22 December 1999 and Mr Magill's assertion to Dr Ellis on 22 December 1999 that he had not passed any motions that day. Dr Ellis described how constipation can cause excruciating pain and spasm in the bowel. Whatever the cause I am satisfied that it lacked the indiciae of septicaemia/pancreatitis given the readings prior to and at 9.30am to which I have already adverted.

The events of 23 December 1999 from 7am onwards

[599] A separate set of allegations arises out of events in the later part of the morning. I shall commence by dealing with the evidence of Mrs Magill and the case that she made concerning this period after she had arrived in the ward with her brother around 11 am:

- Her husband was on top of the bed, his eyes were rolling in his head and his tongue was protruding with saliva around his mouth. The plaintiff could not rouse him. She thought he had had a stroke.
- She raised the alarm shortly after 11.00 am at a stage when there was no intravenous drip and no medical attention had been given to him. Mrs Magill believed he was in septic shock, was already in acute renal failure and had gone into multi-organ failure. Intravenous fluids ought to have been given much earlier than 11.30am.

- During the course of the day a nurse conveyed to her that the plaintiff had septicaemia, that "they" were keeping it from her and that her husband had got out of bed about 9.00 on 23 December and he collapsed. Nurses were told to put him back in bed. There was no nursing note of this alleged occurrence further fuelling the plaintiff's suspicions that inadequate attention was being given to her husband's plight.

[600] I have already dealt with the plaintiff's evidence and the exchanges that passed between the plaintiff and Dr Gibbons, Dr Lee, Dr Collins, Dr Murray and Dr McCloskey on the 23 December 1999 in the section of this judgment addressing the allegations against Dr Collins. I have found serious cause to question the credibility of the plaintiff in the course of those deliberations.

[601] It is clear that Dr Collins did invoke the assistance of Dr Murray the consultant from the ICU in the RVH. Dr Murray had decided that there was no need for intensive care. It was Mrs Magill's case that Dr Murray had not treated her husband appropriately, had made no proper diagnosis on the occasion when he examined him and had closed his eyes to possibilities of organ failure other than in the renal area and to his condition of sepsis. In essence she claimed that the fact that the deceased was a 66 year old man with diagnosed CC was the reason he was not admitted to intensive care.

[602] About 4.30/5.00 pm the deceased was taken to theatre where an intravenous central line was erected. The plaintiff sat with him throughout the night knowing that he was critically ill. About 9.40 pm he started to speak in a lucid way about the events of that morning. When a nurse entered he declared his wish to be investigated and to be opened up since he had terrible pain. It was the allegation of the plaintiff that this nurse shook her finger at the deceased and said, "I'm not coming to listen to crap like that from you. I am just off the phone from Dr Collins." The plaintiff requested her name but she refused to proffer it.

[603] Some time later the plaintiff alleges that she spoke to Dr Lindsay, the junior house officer, about the conduct of this nurse but was informed by Dr Lindsay that she had nothing to do with the nurses. When the plaintiff raised the concerns about his treatment and the need for investigation, Dr Lindsay allegedly accused her of being aggressive. The plaintiff requested another doctor on call and accordingly a SHO, Dr Cunningham, arrived. On being told by the plaintiff that if no investigation of these symptoms was carried out her husband would die, this SHO said, "If your husband dies tonight in the Royal Victoria Hospital, he will not be the only one to die in this hospital. I have five wards to look after. So be it."

[604] The plaintiff returned to the cubicle where her husband lay. Later that night about 3.30am she saw the nurse who had been rude to her sitting asleep on a chair with her feet on it at the top of the ward. No one else seemed to be around.

[605] I shall now deal with the defendants' evidence on these matters sequentially together with my conclusions.

[606] The evidence of both Nurse Belshaw, a staff nurse on duty on 23 December 1999 from 7.45 am who had been qualified since 1981, having spent 10 years as a nurse in Australia between 1981 and 1991, and Nurse Hanson, a junior Staff Nurse who had been qualified since 1995 and who had been on duty with Nurse Belshaw between 7.45 am and 9.00 am was material.

[607] I have already adverted to the normal temperature entry of 36.4 degrees at 7.00 am made by Nurse Crossey and at 8.00 am the medication record that the deceased was given his normal medication orally. Breakfast would be served between 8/8.15 am and I have no doubt that the deceased would have been observed at that stage.

[608] There is no record in the nursing notes of the deceased having collapsed at 9.00 am. I have no doubt that in an open plan ward such an event could not be missed or overlooked and would be observed and recorded if the incident was as described by Mr Magill. Dr Lee emphasised that on the ward during the course of the morning there would have been herself, the junior house officer Dr Fitzsimmons, nursing staff, auxiliary staff, physios and students. How could such an occurrence have been missed? I accept that there is also a form known as IR1 which is specifically to record incidents such as when a patient collapses for obvious litigation reasons. Nurse Belshaw is an extremely experienced nurse and I found nothing in the manner in which she gave her evidence which led me to believe that she would have been responsible for such a double omission.

[609] The next entry in the records of relevance was that of 9.30 am on the observation chart which revealed a temperature of 37.4 degrees which although at the upper end of normal, was still normal. Dr Lee saw the patient again that morning and recorded at that stage that his blood pressure was 95/65. Once again I am certain that Dr Lee, a very comprehensive note maker, whom I found to be an impressive and conscientious witness, would have observed if the deceased had been exhibiting the signs described by the plaintiff when she arrived at 11/11.30 am. Such a note taker in my view would inevitably have made specific reference to someone in this state. I believe that Dr Lee was correct when she said that she had seen the deceased earlier in the morning before the plaintiff had arrived and that he was not in the condition described by the plaintiff at that time. Her presence together with that of the junior house officer Dr Fitzsimmons, nursing staff, auxiliary

staff, physios and students would inevitably have led to his condition being noticed and addressed.

[610] Characteristically, Dr Lee had actioned a plan which included a CT scan later on that day. Before the plaintiff arrived Dr Lee, aware of the worrying bacteriologist report, had examined the plaintiff and found that that he was tender in the right upper part of his abdomen with some distension. The plan was to resuscitate with fluids and Dr Ellis was to image the biliary system in the afternoon. The note and plan of Dr Lee recorded on 23 December 1999 included the following:-

> "9.00 am today BP equals 95/65".
>
> "Supplementary IV fluids re BP – allow oral intake –
> IV ABS . . . bloods".

[611] This is yet a further instance where Mrs Magill accused a practitioner of fabricating the records. I do not accept that Dr. Lee would have fabricated this clear and detailed note with reference to the various steps that were being taken. The note is clearly in chronological sequence with other notes both before and after and smacks of appropriate care and application in dealing with the patient.

[612] It is clear however that the condition of the deceased at about 9.00 am/9.30 am, when Dr Lee saw him, merited steps being taken including the setting up of a saline drip and administration of dextrose because his blood pressure was reduced and there was a low input of liquid recorded. His blood pressure had been 120/60 at 4.30 pm the previous day and when taken again at 9.30 on the morning of 23 December 1999 was 90/65. Dr. Lee conceded that the records would seem to indicate that the steps that she had directed at 9.30 am or thereabouts were not taken until 11.00 am.

[613] The relevant records are as follows –

- The daily fluid chart records that at 10.00 am 150 mls of water was given to the deceased. Nurse Belshaw's evidence was that this amounts to a drink of water but it does indicate that he was able to swallow adequately. This conforms to a nursing by Nurse Manson that he was "early mobile early am".
- The nursing note between 8.00 am and 12.00 midday by Nurse Manson records that venflon was inserted in the right arm although it was not clear precisely when this was inserted. This would have been necessary in order to insert the IV drip. According to the nurses, whose evidence on this matter I accept principally because it was borne out by the expert Ms Kidd, this must have been inserted by Dr. Fitzsimmons the JHO as it would have been beyond the competence

of nurses. Accordingly there might have been some delay between Dr Lee giving the instruction for the drip to be set up, nurses finding the JHO and he inserting the venflon and having the drip set up.

- The drug chart which records an intravenous antibiotic claforan at 10.10 am on 23 December 1999. This would have been given through an intravenous cannula by a doctor who would have had the opportunity it see the deceased at close quarters. The records also note "two lines present in the right arm and left arm" but the time is not documented.
- Mrs Magill emphasised the curious fact that the note of the claforan records it being given at 10.10 am but prescribed at 11.00 am. I see no reason why this would have been anything more than an administrative mistake in entering the record. Why a nurse would record it being given at 10.10 am and prescribed at 11.00 am? I accept the explanation given by the nursing staff that the likelihood is that a note of the prescription was made at 11.00 am after it had already been administered at 10.10 am.
- The intravenous fluid chart reveals that gelofuscine - given to deal with blood pressure that is not going up quickly enough – was not given until 11.00 am and the saline drip is not recorded until 11.30 am. By 11 am the nursing record is to the effect that his bp had dropped to 75/48. Dr. Lee conceded that this should have been effected earlier in the morning when she had given the instruction to do so at about 9.30am. Nurse Belshaw, who was the nurse in charge at that stage, felt that instruction may not have been given as early 9.30 by Dr. Lee, but even if it was there might be some delay until the drip was set up until perhaps 10.00/10.10 am.
- A nursing note by Nurse Manson at 11am recording the patient was drowsy

[614] It is my belief that Dr. Lee probably did give the instructions for a saline drip and dextrose (subsequently changed on the instruction of Dr. Gibbons to augmentin) close to 9.30 am in accordance with the note she made at the time. Whilst there may have been some understandable delay until the venflon was inserted by a junior doctor to allow the drip to be set up, I believe there may well have been inappropriate delay for whatever reason on this busy ward between approximately 10.00 am and 11.00/11.30 am before these steps were taken.

[615] The question arises as to whether or not the plaintiff has proved that this delay of 1/1½ hours made a material contribution to the already deteriorating condition of the deceased and to his subsequent demise. I am not satisfied on the balance of probabilities that it did for the following reasons. Dr McNamee, a consultant nephrologist at the Belfast City Hospital since 1989 in the Renal Unit gave evidence on this matter. It was his evidence that the blood pressure at 9.30 am of 95/65 was relatively low but by

definition the deceased was not in septic shock at that stage. Classically if he was in septic shock, the blood pressure would be less than 60 systolic. He frequently sees patients in the wards with blood pressure of 70/75 who look unwell, are pale, shocked and have a fast pulse. Dr McNamee dated the time of the deceased falling into septic shock at the time of the reading at 11.30 am when the bp was 72/50 and the patient was definitely hypotensive at that stage. Dr McNamee recorded that in his view the blood pressure had fallen very abruptly and that this was typical of the condition of septic shock. He thought it inconceivable that a condition such as this would be missed by Dr Lee or any of the nurses earlier than this. The signs of septic shock would have been all too obvious i.e. he would have been grey in appearance, hypotensive and unable to sit up. This evidence conformed to that of Dr Collins who also indicated that he would not consider a bp of 95/65 as critical although lower than expected.

[616] Dr McNamee made the point that the administration of the claforan intravenously at 10.10 am - given for pure sepsis and not for the development of septic shock - must have been through access to the vein and this was an appropriate response to the situation as at 9.30 am when the blood pressure was first lowered. He would not have countenanced septic shock at that time. This consultant is frequently called to insert vascular access in patients with septic shock and it is extremely difficult to do so. That it was inserted here without comment is another indication that the patient was not suffering septic shock at 10.10 am when the claforan was administered.

[617] The crucial factor drawn to the court's attention by Dr McNamee, which was not subject to challenge in the case, was that the development of gram negative ecoli or infection – which was detected in the blood culture by the bacteriologist on 22 December 1999 – is a forerunner of any patient who develops septic shock, but many patients will have similar blood cultures and will not develop septic shock. I fear Mrs Magill, until this evidence, had conflated the laboratory finding with the condition of septic shock. Again and again Dr McNamee emphasised the critical symptoms of septic shock which any doctor or nurse would note. In this state for example he did not think that oral fluid could be taken (and it is noted that fluids were given to the deceased orally at 10.00 am by Nurse Belshaw).

[618] This condition of septic shock according to Dr. McNamee can occur on a ward in his experience within seconds or minutes. He recalls speaking to a patient at 11.30 who seemed well but at 11.40 had become desperately ill. Ms. Kidd the nursing expert recalled in her nursing history precisely the same dramatic experience in Altnagelvin hospital. The treatment for someone with septic shock is IV fluids, antibiotic therapy, oxygen and inotrobe. He was absolutely satisfied that Dr. Lee's note of 9.00/9.30 did not disclose septic shock, albeit the patient was unwell. He praised Dr Lee's note as being very full and more than adequate for the purposes. It was not his view that there

was an emergency until 11.30 when this man became critically ill. At that stage the appropriate steps were taken namely that he was given a saline drip and gelofusine.

[619] In Dr. McNamee's opinion the two hour delay in certain of the treatment between 9.30amto 11.30am would not have had any effect in this case and certainly was not critical in this man's deteriorating condition.

[620] Dr Gibbons, the specialist registrar in gastroenterology to Dr. Collins in December 1999 and now a consultant gastroenterologist at Craigavon Area Hospital - who was yet another witness accused of lying and fabricating notes by Mrs Magill - also shared the view that whilst it would have been preferable for Dr. Lee's instruction to have been carried out at about 10.00 am to set up the saline and dextrose solution, the delay had made absolutely no difference to the outcome. In his opinion Mr. Magill's was a very complex biliary situation with a high risk of developing infection in the biliary tree. Any medical intervention was going to be of a temporary remedial nature given the underlying problem. Any delay made no contribution to the eventual outcome and demise.

[621] As a footnote to this matter it is worth recording that Ms. Kidd, the nursing expert called by the defendants, dealing with the delay in acting on Dr Lee's instruction at 9.30am, calculated that the delay of 1 ½ hours would only have deprived the patient of little more than a cupful of fluid given that the prescription was for 500 mls of gelofusine over 6 hours, which would have had negligible impact .

[622] In all the circumstances, therefore, whilst I was satisfied that there was a failure to carry out Dr. Lee's instructions as expeditiously as she would have wished, that delay has not been proven to have contributed materially or at all to the deceased's deteriorating condition.

[623] Both Nurse Belshaw and Nurse Manson denied that they had been involved in telling the plaintiff that the deceased had septicaemia and that the matter was being hidden from them. I watched these nurses and I believed that they were telling me the truth when giving evidence. It seems to me inherently implausible that a nurse would supply a diagnosis of something as complicated as septicaemia - particularly when it was not their role to give a diagnosis. In any event why would a diagnosis of this kind be withheld from the plaintiff? It was probably fairly obvious to the nursing staff that this man was suffering from septicaemia from at least 11.30 onwards but it is the job of the medical staff to have given this diagnosis. I consider it very unlikely that this allegation made by the plaintiff is correct and is, I suspect, another instance where the passage of time has lent itself to another distortion of memory which serves the purposes of her case.

[624] I turn now to the specific allegations made against Nurse Manson. It was Nurse Manson's evidence that some time between 11.00 am and 12 midday the plaintiff had approached her in a very aggressive manner shouting at her in a raised voice. Nurse Manson felt that at this stage that she must have been close to the cubicle where the deceased was located. The plaintiff accused her of being at fault for her husband's condition. Nurse Manson asserted that it was necessary to invite the plaintiff to speak to her in private to remove her from the ward setting and defuse her aggressive approach because other patients were being disturbed. She was in cubicle 3 at that stage where there was no roof curtain and it is easy to hear people speaking so loudly. Nurse Manson, at this stage a young nurse about 25 years of age, commented that she was very upset at the time because of the personal attack upon her.

[625] This witness claimed that she then made a full note of what had happened as well as making an entry in the IR register which records incidents which have occurred on the ward. Her note recorded as follows:

> "Patient's wife expressed dissatisfaction to myself (S/N Manson) regarding the care of her husband and my care of her husband. She became verbally aggressive in the cubicle to myself. I asked her to come and speak to me in the office in private. She said 'I was too young to speak to her in such a manner.' She expressed disgust that her husband had called for the doctor at 6.00 am and had been prescribed painkillers. She was not satisfied that she/he was qualified to do so. This should have been done by a senior registrar. She was also dissatisfied that her husband had been fasting for glucose blood levels until (?) 11.00 am. I explained that I was unaware of this as I had not been the staff nurse looking after him this am and had never done so before. She expressed that it was 'my' fault that her husband nearly died due to dehydration which in her mind had led to him becoming septic and very ill. She explained that his care had in her opinion been mostly negligent. I expressed to her that I would document her opinions in my notes. She was happy for me to do this. She also expressed that she thought 'I (S/N Manson) was the worst case and advocate that she had met' and that she 'would be noting my flippance'. Understandably upset I expressed my regret to her that I was not of more help. As previously explained I had not been involved much in his care prior to lunchtime today. She expressed that

> she was going to compile an official complaint. I offered her assistance if going about same. She refused to let me help. Explained to her that all I could do was to get the consultant to speak to her tomorrow. She left it at that."

[626] The plaintiff denied any such conversation had taken place and variously described the witness Nurse Manson as telling lies, fabricating the conversation/note and concocting the whole story during the course of her cross-examination. This young nurse bore such allegations with great dignity and fortitude. Watching her in the witness box I had not the slightest doubt that she was telling me the truth. It was another instance where Mrs Magill, understandably weary and under great stress, has given vent to her feelings of frustration at the deteriorating condition of her husband by verbally attacking hospital staff unfairly. Mrs Magill, perhaps because of the passage of time, has become completely confused about the sequence of events or alternatively forgotten that such a conversation took place in the midst of quite a number of rancorous exchanges that occurred during this unhappy period. What is more troubling is that it was another instance where Mrs. Magill did not hesitate to accuse a witness of mendacity and concoction heedless of the enormous stress that such unwarranted allegations made upon a person such as Nurse Manson. I take this opportunity to reject the suggestion by the plaintiff that it was Nurse Manson who had said "I'm not coming in here to take crap like that" because I have found Mrs. Magill's account of her encounter with Nurse Manson so unreliable that I can lend no credence to this further allegation.

[627] I fear a similar lack of perspective and proportionality governed her attack upon Dr. Murray, the consultant in anaesthetics and intensive care unit in the Royal Victoria Hospital, who had been asked to see the deceased by Dr. Collins on 23 December 1999. Again and again Mrs. Magill criticised this witness for not embarking on a wholesale appraisal of the deceased's condition. She refused to accept that Dr. Murray was there to deliver a treatment option with regard only to the failure of renal function. It was not his role to commence immediately to second guess all the previous consultants, under whose care the deceased had been, in areas of discipline well outside his own. How could he have done this? The sheer implausibility of the task that Mrs. Magill set Dr. Murray never seemed to occur to her.

[628] It was quite clear to me that Dr. Murray had been called in on 23 December 1999 by Dr. Collins to assess whether Mr. Magill was receiving what he needed in light of his deteriorating renal function. I am satisfied Dr. Murray did precisely that. His note of 23 December 1999 is concise and comprehensive. To improve treatment he set in motion a central venous catheter procedure – in itself a risky enough procedure – and administered to the patient 4 medications, namely dubitamine to increase his blood pressure,

medication to provide extra IV fluids, manitol (which was a diuretic to increase the urinary output) and an antibiotic to deal with the gram negative organism. Having done that, Dr. Murray assessed that Mr. Magill was receiving what he needed at his level and saw no evidence of any other organ failure despite Mrs. Magill's assertions to the contrary.

[629] Beds in the intensive care unit are clearly at a premium – there were 12 at that time only and patients there were being artificially ventilated. If Mr. Magill had required such treatment then it would have been given to him. However, I am satisfied that Dr. Murray made a perfectly competent and rational decision that he did not require intensive care treatment at that stage in light of the central venous catheter and the medications being administered. I fear Mrs. Magill failed to appreciate that Dr. Murray did not have the skills of a pathologist, gastroenterologist, radiologist or surgeon. His skills are confined to the area earlier described and it was never his role to go beyond this narrow remit and action a wholesale review outside his field. I have not the slightest doubt that neither the age of this man nor his perilous condition played any part in the decision not to admit him to intensive care despite the fervent belief of Mrs. Magill that this was the case. I therefore reject her allegations against Dr. Murray.

[630] Dr Lindsay gave evidence before me. At the time of these events in December 1999, she had been a junior house officer in the RVH since November 1999. She has now been a general practitioner for seven years. Unsurprisingly given the passage of time she had no recollection of either the plaintiff or the deceased.

[631] I was satisfied that this doctor had been working on a 24 hour shift overnight 23/24 December 1999, that she would never have been on duty for two 24 hour shifts back to back and consequently was not on duty during the 22/23 i.e. during the early hours of 23 December 1999 when the plaintiff alleges her husband had displayed great pain.

[632] The records revealed that the deceased had been given zydol, a painkiller, as follows. One tablet on 17 December, three on 18, one on 19, two on 20, two on 21, one on 22 and one on 23 at 6.00 am suggesting that he did have pain during these periods. It would be administered by nurses, according to the witness, and prescribed by a doctor. Once it was prescribed by a doctor, the nurses would not have to consult staff about authorisation to give these tablets.

[633] She had no recollection of the conversation that the plaintiff allegedly had with her about the nurse who had been rude. Having watched this witness give evidence in a very forthright and assertive manner, I formed the impression that she was a conscientious and concerned doctor who would not have been dismissive of the plaintiff or of her complaints. Whilst she or

her SHO, Dr. Cunningham, may well have indicated that they were not responsible for nursing standards generally, I was in no doubt that she would have been unafraid to challenge a nurse about this alleged behaviour or to have taken the matter further.

[634] There is a note from Dr. Cunningham of that date setting out that she "spoke to Mr. Magill's wife – she expressed concern about the standard of care her husband had been receiving on Ward 10. She said she was not pleased and people would be answerable. I explained that myself and the junior house officer (Dr. Lindsay) were only here to address her husband's medical problems and not the standard of nursing care or his private health scheme. She agreed to let us continue our duties." I believe this captures the nature of the exchange that actually occurred and it is noteworthy that no specific charge of rudeness is recorded.

[635] I conclude that this is another instance where the passage of time has infected Mrs Magill's powers of accurate recollection of what has happened and where the plaintiff had become so concerned about the state of her husband that she characterised virtually all of the medical staff as potentially unsympathetic. In this context I similarly find it inconceivable that there would be any stage during the night when there would be no nurses in the ward (or asleep when on duty) given the evidence of Ms. Kidd that unannounced inspections regularly occur during the night.

[636] I consider that the events of 23 December 1999 were extremely distressing for the plaintiff. It is common case that the deceased was deteriorating on this date. I consider that the plaintiff has been - understandably - immeasurably affected by the condition of her husband on this date. I have no doubt that it has adversely affected her recollection. She clearly had a number of confrontations with medical staff and nurses all of which, I am satisfied, were borne out of her sense of despair at the state of her husband. Sadly, I believe that she has been so gripped by the grief stricken recollection of the events that her recollection is deeply flawed.

[637] I am satisfied that appropriate steps were taken from that date onwards in the RVH. On 23 December Dr. Collins contacted a specialist nephrologist, Mr. McNamee, in the Mater Hospital to have him assessed. There is a note of Dr. Murray's examination at 1pm and I find nothing to suggest it was other than competent. A central venous line was set up although he determined that dialysis for the renal impairment was not yet necessary. I consider it appropriate therefore for Dr Collins to have taken guidance from this nephrologist. A CT scan and a chest X-ray were both carried out.

[638] Dr. Lee continued to care for the deceased on 23 December 1999 and again she has produced comprehensive notes. In my opinion she took all the

appropriate steps that were necessary including blood tests, urea and creatine tests – both of which were elevated – requested kidney function tests, took random samples of urine, introduced inotropes which were drugs to improve his blood pressure and heart rate. Thereafter appears the note from Dr. Murray, who examined the deceased at 1.00 pm. Dr. Lee was back on the ward at 6.00 pm producing a full record and note of the steps she took. His blood pressure was still low, he was drowsy but comfortable and able to converse very well. She started him on dobutamine and manitol to improve his blood pressure. Thereafter she contacted Dr. Cunningham, the SHO on call, and asked her to see Mr. Magill. Dr. Cunningham's note records him being on dobutamine infusion to try again and improve the bp.

[639] Accordingly I find no basis for the plaintiff's claims during this period now under scrutiny.

The events of 24 December 1999

[640] I have already dealt in some detail with the passage of events on 24 December 1999 in RVH when dealing with the allegations against Dr. Collins and I shall not revisit those issues in this section

[641] On 24 December 1999 two renal registrars, Dr. Cunningham and Dr. McCarroll, attended on the deceased. The three page entry of Dr. McCarroll and the two page entry of Dr Cunningham are testimony to the detailed examination and treatment which these doctors both bestowed on Mr. Magill. Clearly, his kidneys were deteriorating in function and he was unwell. Dr. Lee records speaking to Dr. Burton at the RVH who in turn spoke to Dr. Lowry on the issue of transfer to the intensive care unit. She also spoke to Dr. Collins. I accept that the problem, which Mrs. Magill may not have been prepared to countenance, was that the intensive care unit beds were in very short supply and generally were given to problem respiratory, patients which would not have included the deceased. Dr. Lee was carrying out these enquiries at a time when Dr. Gibbons and Dr. Collins were both in the area overseeing what she was doing. Dr. Collins was also dealing with the issue of reference to the intensive care units.

[642] Mrs. Magill was becoming extremely agitated and upset with this course of events. I am satisfied that Dr. Lee had spoken to Mrs. Magill each day she was on duty, had dealt with her as a family member who was intensely involved and seeking explanations as to what was being done. Renal impairment was clearly now occurring by 24 December 1999. Dr. Lee in my opinion correctly dismissed the suggestion in cross examination that she should have been aware of gathering pancreatitis because the amylase reading was normal during the entire time that the deceased was in the RVH. It was not until his advent in the BCH that the amylase reading became abnormal. The CT scan of 23 December 1999 recorded that the pancreas

appeared normal. There was, however, faecal loading of the colon which leant weight to Dr. Lee's conclusion that this man was constipated. It is interesting to note that that is also the opinion of Dr. Ellis when he gave evidence on the topic.

[643] I reiterate that I reject the allegation of Mrs. Magill that Dr. Lee was overwhelmed and insufficiently experienced to carry out these tasks. I consider that her treatment was appropriate and she was adequately supervised by Dr. Gibbons and Dr. Collins at that time.

[644] On 24 December 1999 Dr. Collins consulted Dr. Murray in the Regional Intensive Care Unit but was told that admission was not required. On this date Dr. Collins also phoned Dr. McNamee for further advice regarding dialysis. Professor Spence also subsequently saw/examined[?] Mr. McNamee asking that the patient be transferred to the Belfast City Hospital to the High Dependency Unit. As I have already indicated, I consider that the decision to have transferred the patient to the BCH was appropriate in all the circumstances.

[645] It was the evidence of Professor Price that it was quite clear from 22nd onwards, once the blood culture had shown the gram negative rods, that things were not going well. His temperature was increasing and his blood pressure was worrying low at 95/65. Sepsis was a not unusual complication of biliary drainage and this is what she felt had happened. She considered it was good practice to have concentrated on the attempts to reduce his bp and to have invoked the help of the ICU expert, Dr. Murray.

[646] It was clear therefore that by 24 December 1999 he had severe septicaemia as evidenced by the drop in the blood pressure i.e. the blood was not getting to the kidneys, the kidneys were closing down and there was very little urine being produced. Whilst the bilirubin readings were improving, this is a completely separate matter and septicaemia was driving the problem. In other words, the cancer and biliary damage were all issues to the side. Septicaemia was affecting the whole body with renal compromise and blood pressure falling. The Renal Unit was introduced and again this was timely and good procedure, according to Professor Rice.

[647] I have elsewhere discussed the circumstances of Mr. Magill's departure from the RVH on 24 December 1999 and his transfer to the BCH.

[648] I therefore find no evidence of incompetence or negligence on the part of the RVH medical or nursing staff during any of the deceased's period here and I dismiss the case against this defendant.

Did the standard of medical care, other than that already discussed, and of nursing care at BCH fall below the level of care and skill to be expected from persons holding the relevant positions?

[649] The plaintiff made it clear during this trial that she made no case against the nursing staff in the BCH other than the matters I shall raise below in regard to Sister O'Kane. Indeed, in the course of her evidence the plaintiff asserted that the atmosphere in the BCH was very good. She did, however, criticise the medical staff in a number of respects. I have already dealt in the course of this judgment with most of these allegations and I shall now summarise the position. Mrs Magill's main thrust against the BCH was:

- Dr. George, Dr. McNamee, Professor Spence and their junior staff failed to grasp a window of opportunity to operate on her husband following his admission to BCH on 24 December 1999.
- A metal stent had been voided from the deceased per rectum on 27 December 1999, retrieved by Sister O'Kane and bottled.
- Dr. Foster and Dr. Shiels had inserted a metal stent in an aspiration procedure on 28 December 1999 in order to conceal this. Dr. Shiels failed to report on 28 December 1999 that the deceased was suffering from pancreatitis, the aspiration procedure, including an attempted insertion of a drain, had materially contributed to the patient's demise as evidenced by disclosures made by Sister O'Kane .
- There was a failure to address the wrongly inserted stent by failing to invite Dr Foster (radiologist) to address the X-ray of 25 December 1999 with this in mind.
- Alternatively, to have surgically investigated the abdomen by way of a surgical washout and a recognition of the presence of pancreatitis.
- Medical staff had given up on the deceased in the BCH and failed to carry out adequate investigation.
- Failing to carry out an operation on 26/27 December 1999
- Admissions were made to her by Dr. Fogarty and Dr. George about perforations to the bile duct and about Dr. Collins' conduct by Dr. Fogarty

[650] I have already dealt with all of these allegations earlier in this judgment and I have found no basis for any of them. I have concluded that there is no evidence capable of sustaining the plaintiff's case against the BCH and I dismiss the case against it.

[651] I conclude by observing that having reviewed my findings I am satisfied that the deceased's treatment at the hands of the defendants or any of them did not in any instance affect the course of his illness or his prospects of survival and accordingly no consideration of the application of the principles in Gregg v Scott is necessary.

Postscript

[652] A large number of experts in different fields have brought their experience to bear on a complex series of interrelated issues in this case. I have concluded that the plaintiff has failed to establish that the medical and nursing staff in any of these hospitals failed to act in accordance with the practice accepted at the relevant time by a responsible body of medical opinion in the medical and nursing field. However, in the crucible of a courtroom, it is often easy to forget the impact on the defendants and in some cases their families where they have had the shadow of professional negligence hanging over their heads for many years and where, in some instances, they have been subjected to the unwelcome glare of public scrutiny in the face of extremely serious allegations of malpractice, fabrication and mendacity. Without exception, I have found that the medical and nursing staff in all of these hospitals who gave evidence before me have faced these allegations with fortitude and dignity. I have concluded that these allegations are unfounded and in no instance have I determined that the conduct of any of them contributed to the eventual sad demise of this man. Accordingly, I see no basis for adverse effect on the careers of any of them as a result of this case.

[653] Finally, I recognise that the plaintiff will be very disappointed at the outcome of this matter. I have no doubt that she was convinced of the justice of her case and the strength of the witnesses she called. As I have recognised in the course of this judgment Mrs. Magill has suffered the most devastating of traumas, helplessly observing a much loved husband deteriorate and die before her eyes over a period of less than 3 weeks in hospital. Whilst I do not anticipate that she will become easily reconciled to my findings, nonetheless I trust that in the future she will apply her undoubted skills and intelligence, which I observed in this court, to other causes and bring some closure to a very unhappy period in her life.