Neutral Citation No. [2004] IEHC 416

THE HIGH COURT

1995 761 P

BETWEEN

UNA GOTTSTEIN

PLAINTIFF

and

HEILA MAGUIRE AND MICHAEL WALSH

DEFENDANTS

Judgment delivered by Mr. Justice Johnson on the 21st day of December, 2004.

1. The plaintiff in this case is the widow of the deceased, Alfred Gottstein. For some months prior to September of 1992 Mr. Gottstein had been suffering from a throat affliction which transpired to be carcinoma of the throat.

2. The plaintiff, who is originally from Germany, lived in Kerry where he kept substantial holdings and carried on business there. He was admitted to hospital in Beaumont under the second named defendant, Professor Walsh, for an operation on his throat to remove the cancerous growth.

3. The effect of this operation was to grossly distort the access to the lungs which was covered by a flap for the purposes of healing after the operation. A tracheostomy was inserted to enable the deceased to breathe. The tracheostomy is a pipe inserted into the trachea which enables the air to flow directly into the throat and lungs without having to go through the mouth and in this particular situation it is particularly to be noted that the airways were blocked because of the operation and the steps taken were to ensure it was going to be successful.

4. The operation appears to have gone well and there is no criticism of Professor Walsh or the staff regarding the execution of the operation.

5. After the operation at the direction of the anaesthetist, Mr. Gottstein was taken to the I.C.U unit of the hospital for initial care.

6. The following evening, that is the evening of 8th September, 1992 at approximately 10.00 pm Mr. Gottstein developed some discomfort in his chest, communicated this to Nurse Armstrong who was his special nurse and beside him and she contacted Dr. Ward who was actually at the next bed and he indicated that morphine should be administered to Mr. Gottstein. This was done. A short time later Mr. Gottstein again drew the attention of the Nurse Harrington to his situation and she approached him for the purposes of ensuring that his airways were clear and she ambu-bagged him. This is a device whereby air is blown through the tracheostomy tube to ensure that there is a free and full airflow.

7. At the time Mr. Gottstein was on C.P.A.P., i.e. air was being pumped through the tracheostomy tube into the patient.

8. Nurse Harrington was specialising on the deceased that night. She had been trained in intensive care in Beaumont School of Nursing. Sister Connolly, her superior, allocated her to Mr. Gottstein.

9. The plaintiff had left the deceased's bedside at 9.45 pm and Nurse Harrington at approximately that time had begun to prepare the drugs which would be administered at 10.00 pm. Mr. Gottstein was at all times in Nurse Harrington's sight. The deceased beckoned Nurse Harrington and indicated he had a pain in his chest. Mr. Gottstein again indicated that he was suffering from pain on inhalation. Nurse Harrington then went to check the airway was clear again. She administered some more oxygen by using the ambu-bag. This meant disconnecting the deceased from the ventilator and using the ambu-bag to give him oxygen. She then attempted to suction the deceased, i.e that is clear the tracheostomy air tubes, which is done by way of a suction catheter. However once she got it 5 or 6 cm into the tracheostomy tube she discovered resistance. This alerted Nurse Harrington immediately to the fact that the deceased had a problem and she called assistance immediately. Nurse Connolly was attending the patient in the next bed and she came to the assistance of Nurse Harrington. It was explained to her what had happened and she then ambu-bagged again and set about introducing a saline solution down the tracheostomy tube to help loosen any secretions that might have been there. Sister Connolly took over. It was clear something had gone wrong because when they took out the inner tube to check it, it was completely clear. Then Sister Connelly set about deflating the cuff on the tracheostomy tube, then attempted to re-suction again. Sister Connolly having failed to relieve the situation with that immediately sent for the anaesthetist and Dr. Ward was paged. This all took some two minutes or so. Dr. Ward was upstairs, some four or five flights away and when he was paged he came as quickly as he could. Quite clearly Mr. Gottstein was now in distress. When Dr. Ward arrived the nurses assisted him but Dr. Ward ambu-bagged again, realised there was a problem and sent for Dr. O'Connor, the senior registrar available at the time. By this time it ought to have been clear that the tracheostomy had become displaced.

10. Dr. Ward ambu-bagged again and when Dr. O'Connor arrived she ambu-bagged again. It was by now clear the tracheostomy had become displaced. Dr. O'Connor then decided to attempt to gain access orally for the patient. This required the giving of certain drugs, these drugs having already been prepared by Dr. Ward and it took two or three minutes for them to take effect and thereafter Dr. O'Connor achieved access on her second attempt orally.

11. It was whilst Dr. O'Connor was attempting to achieve access orally, Dr. Ward had at that point attempted to gain access through the trachea by cutting the stitches around the tracheostomy and attempted with his fingers to get an airway in. However he was unable so to do and by the time an airway was established by Dr. O'Connor, Mr. Gottstein had become brain dead. It was too late.

12. There was no ENT specifically trained doctor in the hospital on that night nor was there any person in the Intensive Care Unit specifically trained for the purposes of replacing a tracheostomy tube and this case now despite the length of time it took in court has boiled down to the fact that no one in the Intensive Care Unit or available was so trained and could deal effectively with the matter as arose, namely the replacement of a displaced tracheostomy.

13. The case against Professor Walsh is that he sent and allowed a patient of his be taken in the condition that he was after the operation to the Intensive Care Unit where he knew there was no one specifically trained to replace a tracheostomy tube.

14. The plaintiff's evidence from Mr. Stafford and Mr. Bradley made it quite clear that in their practices in England they have specific ENT wards to which they send their patients after surgery. They also swore, and I accept it, that there the nurses are specifically trained to replace tracheostomy tubes.

15. There was a great deal of evidence for the defence and I accept it, that in Ireland nurses are specifically not trained to change tracheostomies at all, specifically not the first change after an operation. I accept the evidence that this is the practice in Ireland, that nurses are not so trained and I don't think the plaintiff in reality at the end of the case were laying any specific criticism against the hospital for failing to train the nurses to do the tracheostomy change or the tracheostomy replacement.

16. Therefore it is quite clear Mr. Gottstein had a successful operation, properly carried out, he was taken at the direction of the anaesthetist to the I.C.U unit where no nurse was trained to replace a tracheostomy in the event of it becoming dislodged and where the two doctors involved were specifically anaesthetists by training and who did not hold themselves out as having any expertise or real training in the replacement of tracheostomies.

17. The plaintiff does not criticise the nurses in the Intensive Care Unit for anything they did.

18. Neither is there any criticism of the doctors for what they did, though the attempts to gain access to the airflow could have been done more quickly.

19. In my view there can be no negligence found against the doctors or nurses on the grounds that they made a mistake or did something wrong in their care of the deceased. The criticism by the plaintiff is to the effect that no one in the Intensive Care Unit or available in the hospital was specifically trained to replace the tracheostomy tube if it became dislodged. In this regard the plaintiff does not specify eventually whether it be a nurse or a doctor who should be the trained person, merely that there should have been someone present in the Intensive Care Unit or available in the hospital capable and trained to replace a displaced tracheostomy.

20. There was a divergence of evidence regarding the regularity with which tracheostomies get displaced for one reason or another. The plaintiff's witnesses, Mr. Stafford and Mr. Bradley were adamant whereas it was not common, did happen and it was necessary to have the expertise to deal with the emergency as it arose. This is the gravamen of the case. If a tracheostomy becomes displaced it becomes an emergency because it is a life threatening situation and unless it can be dealt with immediately, the patient will die. I was particularly impressed with the evidence of both Mr. Stafford and Mr. Bradley which appear to be logical and direct. Mr. Stafford stated and I quote:-

> *"People who are directly in contact with these patients must be able to look after them if the tube displaces or becomes obstructed. In that respect they need to have some special training. General nursing training would not prepare a nurse, or a junior doctor for that matter, for managing such a situation because it is pretty scary and you need to act quickly, so we do make a point of only allowing tracheostomy patients to be nursed by nurses who have had special training and the special training involves changing tracheostomy tubes initially under supervision and then on their own in patients who have had new tracheotomies fashioned. It is the only way you can prepare them for such an event".*

21. Mr. Stafford further went on to say:-

> *"I would expect the nurse who was looking after this patient to be able to deal with the eventualities that we anticipate, one of them being the displacement of the tube. I would certainly not put a nurse in the situation of having to look after such a patient if they have no experience in managing this type of patient.*

22. Again Dr. Stafford stated and I quote:-

> *"The fact is that this chap did have a tracheal tube dislodgment which was not dealt with quickly enough to prevent him from sustaining brain damage which led to his death.*

23. A further quotation from Mr. Stafford who dealt with the plaintiffs view of this case very clearly:-

> *"I think it is an unacceptable situation because of the risks involved in nursing patients who have tracheostomy tubes. I think I have made this clear in previous statements but I will make it clearer. Because of the risk of an acute obstruction or displacement of a tracheostomy tube it is incumbent upon a unit to have a situation where a patient's tracheostomy tube can be adequately dealt with within a period of minutes. There is no leeway in this matter and therefore they should make provision for these, albeit uncommon events to be dealt with adequately, particularly in the circumstance where a tracheostomy is done as presumed protective measure for the patient's benefit, this was not a therapeutic procedure, the tracheostomy was done to ensure the safety of the patient's airways".*

24. Mr. Bradley's evidence substantiated and supported Mr. Stafford's, not only in general but in particular also.

25. The plaintiff's evidence regarding this is contradicted by the defence witnesses who basically say in some cases they have never seen the displacement of a tracheostomy at all in their experience or otherwise it is extremely rare. This evidence given by a number of witnesses for the defence is in complete contradiction to the evidence of Mr. Stafford and Mr. Bradley and to the literature which has presented to me.

26. The literature which has been presented to me on the subject indicates quite clearly that it is an emergency which can happen and in a document produced by Mr. McGrath on behalf of the second named plaintiff described as not uncommon.

27. It is also an eventuality which is dealt with specifically in the nursing "protocol" which was produced by the first named defendant to the plaintiff's solicitor and therein it is dealt with specifically.

28. We will deal with the protocol at a later stage in this judgment. Therefore the case for the plaintiff in the final submissions made on behalf of the plaintiff was simplified into:

> (a) the failure of the hospital to have adequately trained personnel to deal with a dislodged tracheostomy in the Intensive Care Unit or available in the hospital and
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> (b) the fact that Professor Walsh allowed his patient to go to this Intensive Care Unit knowing that there was no person fully and adequately trained there.

29. Mr. Fox on behalf of the first named defendant indicated that there was no evidence that such expertise should be available in an I.C.U unit and in fact pointed out that Beaumont was the leading hospital in the country ant that that was the standard and that you couldn't expect to have expertise in every regard in an Intensive Care Unit.

30. The second named defendant basically indicated that it was the anaesthetist who was in charge of the patient at the time and it was he who directed that the deceased should be taken to the ICU unit.

31. The I.C.U unit in Beaumont is run independently apparently of the specialists in various other parts of the hospital, certainly Professor Walsh did not appear to have any input into its manning or organisation which depended completely on, and was run by, anaesthetists.

32. It should be emphasised of course that anaesthetists are trained in the accessing of the airways orally and that is what was done in this case. The question is was it negligent on the part of the first named defendant to take into the Intensive Care Unit a person with a tracheostomy newly inserted without having in the Intensive Care Unit the expertise to deal directly with a dislodged tracheostomy if it occurred. Despite the fact of the satisfaction expressed by many of the defence witnesses with the situation in Beaumont Hospital, the plaintiff relies on the decision of Mr. Justice Walshe in *Jeremiah O'Donovan v. the Cork County Council & Ors*. Irish Reports 1967 at page 173 and in particular at page 193 and I quote:-

> *"There was evidence that it is a practice, and an accepted practice, and as a result there is no evidence to the contrary. Challenge, unsupported by evidence is not sufficient to put this matter in issue. A medical practitioner cannot be held negligent if he follows a general and approved practice in the situation with which he is faced, see Daniels v. Heskin and the cases therein referred to. That proposition is not however without qualification, if there is a common practice which has inherent affects which ought to be obvious to any person giving the matter due consideration, the fact that it has been shown to be widely and generally adopted over a period of time does not make the practice any less negligent. Neglect of duty does not cease by repetition to be neglect of duty".*

33. In this regard I accept the evidence of Mr. Bradley and Mr. Stafford that this is a complication which may and does arise as a result of an insertion of a tracheostomy.

34. I am reinforced in this view by the literature which was produced to me in court dealing with the displacement of tracheostomies. In this regard the article produced by Mr. McGrath for the second named defendant by Michael Freidman and Hahni Ibrahim, in this article it states, and I quote,

> *"Accidental extubation of the tracheostomy tube in the post-operative period is a well recognised and not an uncommon event."*

35. Secondly, in the city hospital, NCH University Hospital OMC, Nottingham Health Care, NHS Nursing Practice Guidelines, it is stated at page 6 under the heading "Early Complications Dealing Specifically With Premature Extubation" and I quote:-

> *"In the first three to five days immediately following tracheostomy insertion premature extubation and/or accidental dicanulation is potentially more fatal because a tract has not yet formed between the edges of the skin and the trachea".*

36. Another article, also by Charles E. Morgan and Susan Dixon, indicated that displacement is not uncommon and is equally not uncommon to be called to the bedside to replace a new tracheostomy tube.

37. In this regard this reinforces the protocol produced by the hospital itself but it is interesting to note that despite the protestations the defence that tracheal dilators are only of historic value, not used any longer, that they are in complete disagreement with the plaintiff's witnesses and indeed with the literature which has been produced including their own protocol. Under those circumstances having regard to the nature of this case and taking into account the fact that the oral access had been rendered a great deal more difficult because of the nature of the surgery, the question remains were the defendants negligent in failing to have the necessary expertise to deal with that emergency.

38. Taking into account the principles laid down in O'Donovan, I am satisfied that the failure to have in the Intensive Care Unit of the hospital a person, nurse or doctor, skilled in the replacement of a tracheostomy tube under the circumstances of the present case in is an inherent defect in what appears to be the practice which ought to be obvious to any person giving the matter due consideration and having given it due consideration, it is obvious to me.

39. I therefore find that the first named defendant is guilty of negligence, having failed to have such a skilled person in the Intensive Care Unit or immediately available in the hospital. I also find on the balance of probabilities and all the evidence in the case that had a person appropriately trained within the I.C.U. or the hospital been present that the deceased would not have died.

40. With regard to the second named defendant it is quite clear that the operation was done in a skilful manner. Professor Walsh is working in an environment where there do not appear to be specialist ENT wards for the purposes of dealing with post-operative treatment and the system is that the anaesthetist direct who should go to the Intensive Care. In this particular instance Professor Walsh does not appear to have had any authority in the staffing or organisation of the Intensive Care Unit. This is something which I find most peculiar insofar as the second named defendant knew, or ought to have been aware of the possibility of the extubation, he knew, or ought to have known that there would be nobody in the Intensive Care Unit with the appropriate skills to deal with this eventuality. Despite what I have been told of the structures within the first named defendants hospital, namely, that the Intensive Care Unit is run as an independent exercise by the anaesthetists. I find that because of his overall responsibility for the patient he must be held to be legally responsible for the failure of the first named defendant to provide the appropriate care in the Intensive Care Unit in the events which arose. And under those circumstances I also find the second named defendant negligent.

41. I accept it was an emergency, but that is what Intensive Care Units are there to deal with, among other things, and indeed one could scarcely have envisaged a situation where a patient who has a nurse actually individually looking after him in such a hospital should not have the necessary training or a doctor properly trained to deal with this problem which was a known occurrence.

42 Two further items I have already alluded to in this judgment which I wish to deal with now. One is the question of the statements by various witnesses for the defence that tracheal dilators are not really used and are only for historical purposes. That is in direct contravention and contradiction of the evidence of Mr. Carney and Mr. Stafford and I am satisfied and accept the evidence of the plaintiff's witnesses in this regard and once again I am backed up by the literature wherein it is stated that the items kept at the bedside include tracheal dilators and indeed, in the document produced by the first named defendant for the Nurses Protocol, they are also mentioned there, but even more specifically.

43. Finally, the Nurses Protocol itself. This document which was produced by the first named defendant, their servant or their agents

to the plaintiff's solicitor setting out what was said to be the nursing protocol in the hospital at the time of the operation it transpired was,

> (a) A document which had been manufactured by the first named defendant from nursing notes because there was not a protocol apparently in existence at the time. It was given to the plaintiff's solicitor on the basis that it was the protocol that was there at the time. After five days of the trial this was disavowed. I am still mystified as to why this should have been done, but having regard to the fact that it has been stated that this was taken from the nursing notes and the notes given to the nurses, it is interesting to note that its specifically deals with the events which took place in this case, and I quote:-
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> > *"A tracheal dilator can be used to keep stoma opening and patent in the event of tracheostomy tube falling out or being removed by patient and inability to insert another tube".*

44. It would appear to me that had that protocol been followed this case may never have been necessary and it is also quite clear that in the minds of the hospital, this eventuality was quite clearly present and certainly was not indicated to be an unusual or strange occurrence.