Report of the Inquiry Board appointed in terms of the Inquiries Act (Chapter 270 of the Laws of Malta) concerning the death of Mr Stephen Mangion at the Emergency Department of Mater Dei Hospital on 27th August 2024.

Judge Emeritus Dr Joseph David Camilleri
Chairperson

Dr Herbert Felice
Member

Ms Sylvia Spiteri
Member

Dr Kristina Cassar
Secretary

Report of the Inquiry Board appointed in terms of the Inquiries Act (Chapter 270 of the Laws of Malta) concerning the death of Mr Stephen Mangion at the Emergency Department of Mater Dei Hospital on 27th August 2024.

1. On 27th August 2024, Mr Stephen Mangion, who was 55 years old, collapsed and died at 23:00 hours at the Emergency Department of Mater Dei Hospital. On the following days, this event was reported and commented upon in a rather sensational manner on social media. There was talk about how Mr Mangion first went to the Floriana Health Centre, complaining of severe chest pain, how he was instructed to go to the Emergency Department of Mater Dei Hospital, how an ambulance was not available to take him there, how he collapsed and suffered an untimely death while waiting for a long time to be seen by triage at the emergency waiting area and how this was possibly a case of manslaughter.

2. As is usual in similar circumstances, a Magisterial inquiry was immediately appointed.

3. On 29th August 2024, the Honourable Minister for Health and Active Ageing, Dr Jo Etienne Abela MD MPhil MRCS FRCSEd FEBS MP, appointed the undersigned, Judge Emeritus Dr Joseph David Camilleri BA LLD, to set up an Inquiry, in terms of the Inquiries Act (Chapter 273 of the Laws of Malta) to establish the circumstances surrounding the demise of Mr Stephen Mangion [redacted], who presented at Floriana Health Centre and subsequently at the Emergency Department of Mater Dei Hospital on 27th August 2024.

4. This independent Ministerial Inquiry was assigned the following terms of reference:

   The inquiry shall determine whether any wrongful action or omission by any person from any department /section within the remit of the Ministry for Health and Active Ageing facilitated the death of Mr Stephen Mangion

or failed to prevent it. In particular the following points should be addressed:

a) *The names and grades of the caring professionals who attended Mr Mangion at Floriana Health Centre;*

b) *Mr Mangion's complaints, general condition, vital parameters, examination, investigations and provisional diagnosis at Floriana health Centre;*

c) *Any treatment administered or advised;*

d) *Onward referral and transfer arrangements suggested from primary to secondary care (Mater Dei Hospital);*

e) *Whether Mr Mangion's onward referral was discussed with the secondary care team;*

f) *The actual mode and nature of transfer (if different from suggested) from Floriana Health Centre to Mater Dei Hospital;*

g) *The names and grades of the caring professionals who attended Mr Mangion at the Emergency Department in Mater Dei Hospital;*

h) *Mr Mangion's complaints, general condition, vital parameters, examination, investigations and provisional diagnosis at the Emergency Department in Mater Dei Hospital;*

i) *Any treatment administered or advised;*

j) Whether there was any undue delay in time to triage and time to first senior medical contact;

k) The locations within Mater Dei Hospital where triage, observation, assessment and treatment were delivered;

l) To determine whether any person knew or ought to have known, or caused an immediate risk to Mr Mangion's life;

m) To determine whether any person failed to take measures within the scope of his/her powers which, judged reasonably, s/he might have been expected to take in order to avoid that risk;

n) To determine whether the management structures at Floriana Health Centre and Mater Dei Hospital have fulfilled and are fulfilling their obligation to take preventive operational measures to protect patients;

o) To determine whether nursing and medical case notes are properly and regularly documented and whether in the case under reference this procedure was strictly adhered to and observed;

p) To determine whether standard operational procedures are in place and whether members of staff are aware of what procedures to follow in similar circumstances;

q) To determine whether in the carrying out of their duties and for the case under reference, members of staff failed to act in a manner that reflects the values promoted in the Code of Ethics in Schedule 1 of the Public Administration Act (Cap 595 of the Laws of Malta) which serves amongst others, as an ethical benchmark;

r) *To present any formal or any informal recommendations for due consideration by the Minister.*

5. The appointment letter of the Honourable Minister for Health and Active Ageing additionally directed that:

   The inquiry shall be conducted in such a way as not to impede or compromise any criminal investigation.

   The outcome of the inquiry is to be concluded and presented to me by not later than 30 September 2024. The contents of this report will be made public, insofar as disclosure of any parts does not breach Data Protection Regulation and/or prejudice ongoing or future criminal or disciplinary investigation.

   You shall have access to all information held at Floriana Health Centre and Mater Dei Hospital and the Secretary shall be appointed to assist you as necessary.

   The Inquiry Board shall be made of:

   Judge Emeritus Dr J.D. Camilleri (Chairperson)

   Dr Herbert Felice (Member)

   Ms Sylvia Spiteri (Member)

   Dr Kristina Cassar (Secretary)

6. Before proceeding to carry out their assignment, the Chairperson and Members of the Inquiry Board took and subscribed the oath of office mentioned in Article 5 of the said Inquiries Act.

7. Subsequently, the Inquiry Board held five (5) sittings, where the testimony of twenty-two witnesses[1] was registered, and several documents[2] as well as CCTV footage of cameras situated at the Floriana Health Centre and the

[1] See the document *List of Witnesses heard* marked "Document R1"
[2] See the document *List of Documents* marked "Document R2"

Emergency Department at Mater Dei Hospital were exhibited and duly examined.[3]

8. The Board held an on-site inspection at the Emergency Department of Mater Dei Hospital on 6th September 2024, where [redacted] exhibited a copy of the plan of the Emergency Department and gave the Board all information requested.

9. The Inquiry Board held further meetings (5) to examine well all the evidence collected as well as all the circumstances of the case and is now in a position to report as follows in the following six (6) sections, namely:

   A. A summary of the most salient facts derived from witnesses' testimonies.

   B. What CCTV footage of cameras situated at the Floriana Health Centre reveals.

   C. What CCTV footage of cameras situated at the Emergency Department at Mater Dei Hospital reveals.

   D. An examination of the Inquiry terms of reference in the light of the three above mentioned sections.

   E. A list of recommendations for due consideration by the Honourable Minister for Health and Active Ageing, and finally,

   F. Conclusion

[3] Although not strictly necessary for the terms of reference of the Inquiry, the Board offered [redacted] (ex-wife of the deceased) two opportunities to give evidence (6th September 2024 and 23rd September 2024) and she failed to attend.

Section A. A summary of the most salient facts derived from witnesses' testimonies.

1. [redacted] Senior Health Care Worker, stated that on 27th August 2024 she was on duty at Client Support Services, Siġġiewi. She could not remember anything about Mr Mangion's call, as there was nothing particularly noteworthy about it.

   However, the Board established that at 18:46, a telephone call from Mr Stephen Mangion seeking medical advice from the Telemedicine service was registered. This call was passed on to[redacted].

2. [redacted] Senior General Practitioner at the Siġġiewi Telemedicine centre. All calls to any health centre are diverted to this centre. The system started during COVID to decrease the number of patients attending the health clinics or hospital unnecessarily. Patients can talk to a doctor, they can be guided, advised, and can even send a picture of a rash for example. The system has worked well and is still in place.

   On 27th August 2024, Mr Stephen Mangion phoned at about 18:46. He complained of central chest pain, described as burning not compressive. The pain started at 5 a.m. It did not radiate to the shoulders. It was not accompanied by sweating. Mr Mangion described the pain in the morning as burning. He took Omeprazole and felt better. He thought that it could be stomach acid. Now it was no longer burning and was worse with movement.

   He was advised to attend Floriana Health Centre. Mr Mangion refused. Mr Mangion's friend,[redacted] took the phone. He asked[redacted] if another Omeprazole would help. [redacted] told him that this would not help and advised a pain killer e.g. Solpadine – *"panadol with a small dose of codeine"*. Again, advised to attend a polyclinic. The call then ended.

3. [redacted] Clerk at Floriana Health Centre.[redacted] was the first person to meet Mr Mangion, who was accompanied by another man. Mr Mangion complained of chest pain and [redacted] registered him on the Electronic Patient Records (EPR) as suffering from chest pain. The time was 19:09

hours on 27th August 2024. [redacted] immediately called the treatment room and asked for nurse [redacted]. [redacted] added that Mr Mangion was seen straight away, and he did not wait in any queue.

4. [redacted] Senior Staff Nurse, Floriana Health Centre. On 27th August 2024 at about 19:15 hours, the receptionist at Floriana Health Centre informed him that the patient, Mr Mangion, was complaining of shortness of breath. Mr Mangion was accompanied by a friend, a nurse named [redacted], whom he knew. [redacted] took Mr Mangion for treatment in cubicle number 1 of the treatment room. He asked him to lie down on the couch, but Mr Mangion told him that he was fine if he just sits down. [redacted] insisted that he gets on the couch and once there, [redacted] started to take the patient's parameters. He took his blood oxygen saturation, blood pressure, temperature and blood glucose and he found that all parameters were within normal limits, except for his blood pressure which was high. At this stage, [redacted] entered cubicle 1 and [redacted] gave him all the parameters' readings. [redacted] instructed him to take the patient's ECG and nurse [redacted] brought the monitor and attached the five (5) ECG leads to the patient.

   [redacted] who stated that he has almost thirty years' experience as a nurse, added that Mr Mangion looked normal to him. Although he was all the time complaining of burning pain in his stomach, he had a very good sense of humour. The patient stayed at Floriana Health Centre for about 15 minutes. [redacted] referred him to the Emergency Department (ED) of Mater Dei Hospital (MDH).

   [redacted] said that in the ECG room of Floriana Health Centre, there is an ECG monitor with 12 leads that can be used at the doctor's discretion.

5. [redacted] Senior Staff Nurse, Floriana Health Centre. [redacted] stated that she was attending to another patient in the central cubicle at the Floriana Health Centre treatment room, when she saw Mr Mangion entering from the side door, accompanied by another person. He presented himself as a normal person and did not show any signs that he was in pain. He entered walking and left walking. [redacted] stated that she brought the monitor from the central cubicle and attached the five ECG

leads to Mr Mangion's person in cubicle 1. She stood there near the patient for only a few seconds. She did not remember at what time this 5-lead ECG was taken.

[redacted] stated that at Floriana Health Centre there is an ECG monitor with 12 leads, which is kept in a locked room. The monitor can be used at the doctor's discretion.

6. [redacted], General Practitioner Trainee, Primary HealthCare (accompanied by [redacted]).

[redacted] is in his first year of GP training. He had done one year as a BST General Medicine but now switched to GP training. He is presently in gynaecology rotation for two months and works once weekly in health centres, either Floriana, Gzira, or Qormi, between 17:00 - 20:00.

On 27th August, he was working at Floriana Health Centre. He worked for two hours in the GP room, then at about 19:00 he continued working in the treatment room seeing urgent cases. He was consulted by a younger Foundation doctor regarding a patient, then at about 19:10, he saw Mr Stephen Mangion who was in a cubicle.

History & examination

Mr Mangion was accompanied by a male. A history was taken, whereby Mr Mangion described a mild compressing chest pain. The pain started at 4:00 a.m. Mr Mangion had phoned a doctor, possibly the telemedicine doctor, who advised to repeat Omeprazole. This did not help, the pain persisted.

Mr Mangion stated that he was passing through a stressful period, going through a separation. He gave a history of smoking 20 cigarettes daily, of hypertension and of high cholesterol. He said that he had stopped his treatment out of his own will. He had no known allergies.

On examination, he had normal heart sounds, normal breath sounds, his abdomen was soft and there was no lower limb swelling or pain. No sweating.

The chest pain was not severe, he was comfortable, not distressed and talking to his friend.

Mr Mangion was attached to a monitor, which monitored his heart rate and oxygen saturation. He was not tachycardic and oxygen levels were normal. He was afebrile. Blood pressure was high at 217/117. The assisting nurse attached him to a 3-lead ECG which was normal. Repeat blood pressure was 214/120. Oxygen was 97% on air.

Mr Mangion was advised to go to hospital and the patient agreed.

Ambulance

[redacted] phoned 112, who enquired whether Mr Mangion had signs of heart failure, which he did not.

[redacted] was told that an ambulance was not immediately available and that one would be sent as soon as available. He was not informed how long this would take.

Transfer to ED

[redacted] told Mr Mangion that ambulance was not available and that it could take a while. Mr Mangion and his friend decided to go to the ED on their own. His friend was going to drive. [redacted] agreed to this since although Mr Mangion was stable, he was still an urgent case and felt that he should be seen in hospital as quickly as possible. Distance to MDH was not too far.

There was nothing more that could be done in the health centre.

Ticket of Referral

The ticket of referral (TOR) was then filled by [redacted] at about 19:32 (ref to Doc TOR1 and TOR2) and attached to the 3-lead ECG strip. The TOR was labelled as chest pain with high blood pressure - high risk patient.

[redacted] would have liked to have a 12-lead ECG to perform a full ECG. This was not available.

Discussion of patients between health centre and ED

The standard practice is that on weekdays, Monday to Friday between 8:00 - 16:00, before referring a patient to ED the health centre doctor phones ED to discuss the case with the lead physician at the ED. There are printed instructions stating this on an A4 paper stuck to the notice board. This service is available up to 16:00. Mr Mangion was seen at 19:10.

[redacted] stated that work at the health centres has increased with waiting times sometimes reaching three (3) hours. On that day, it was not too bad.

EPR documentation

In order not to waste time, [redacted] planned to fill the EPR record (digital documentation) at a later time. He therefore took a photo of the TOR (ref to Doc TOR1 and TOR2) with his phone and sent the patient to the ED.

[redacted] continued with his work. When eventually the following morning he went to open the visit of Mr Mangion on EPR, it could not be accessed so the note could not be uploaded. The passing away of Mr Mangion blocks his file on the ERP system.

EPR notes cannot be accessed by the ED. ED only require a TOR from the health centres.

This did not in any way effect the clinical management of Mr Mangion either at the health centre or at the ED.

7. [redacted] Senior Staff Nurse, Emergency Department MDH. [redacted] has been working at the ED of MDH for the last eight years. On the night of 27th August 2024 he was working at the Control Room, processing 112 calls. At about 8 p.m., he received a phone call from a doctor from Floriana Health Centre, informing him that an ambulance was needed to transfer Mr Stephen Mangion, a 55 year old patient who had been suffering from chest pain for a number of hours, to the Emergency Department of Mater Dei Hospital. He explained that ambulances are classified into 3 categories according to urgency priority: Blue being the least urgent, manned by two Emergency Ambulance Responders (EARs);

orange, manned by two EARs and a nurse; and red, also manned by two EARs and a nurse. Red, however, takes precedence over orange and blue, because it concerns cases of a more grievous nature.

In order to classify under which category Mr Mangion's case fell, [redacted] asked the doctor making the call which were the factors that were most worrying. The doctor answered that Mr Mangion had a very high blood pressure – more than 200, together with chest pain. With these symptoms, [redacted] immediately thought of heart failure. However, he was informed that Mr Mangion was not suffering from fluid in the lung or severe shortness of breath and that he was not taking the medication assigned to treat his medical condition. [redacted] stated: *Kont diġà naf li għalkemm bħala telefonata kienet ta' code orange imma ma kellix nurses available biex joħorġu immedjatament għalih u fil-fatt over the phone mill-ewwel għedtilha, "Isma' s-sinjur żommuh taħt għajnejkom għax bħalissa m'għandix nurses lil min nibgħat straight away. Just kif ikolli r-riżorsi available nibgħatuhilkom mill-ewwel."*

[redacted] further stated that: *L-ambulanza kienu available. Jiġifieri ambulanza per se bħala vettura kien hemm available. Li ma kienx hemm available huwa n-nurse.*

He stated that on that night *kellna 4 nurses li huma allokati li joħorġu l-ambulanzi. Issa dawn l-4 nurses kienu kollha fuq xogħol differenti, jiġifieri jkunu qed jaraw pazjenti oħra. Allura peress li ma kienx hemm xi ħadd min joħroġ, min jirrispondi għalih għalina tiġi qisha pendenti dik l-ambulanza. Jiġifieri l-ambulanza per se kien hemm available. Just ma kienx hemm nurse li tmur mal-ambulanza on site.*

[redacted] stated that 10 minutes later, his colleague [redacted], received a call from the Floriana Health Centre to cancel the call for the ambulance as they were using their own transport.

In [redacted]'s view, the Standard Operating Procedures (SOPs) regarding the dispatching criteria of ambulances need updating to reflect current needs and resources: *Fis-sens tan-natura tat-telefonata ħafna minnhom qishom jgħidulek weħidhom x'għandha tkun ir-response. Jiġifieri jekk xi ħadd fuq it-telefon iċempel u jgħidlek, "Xi ħadd mhux qed jieħu nifs u mitluf minn sensih." Bla ma trid tgħid, "Isma' din hija waħda mill-ewwel li rrid noħroġ." Jiġifieri qishom ċertu kategoriji joħorġu weħidhom speċjalment imbagħad tkun esperjenzat fl-emerġenza. Imma xorta nemmen li għandu jkun hemm backing up minn SOPs li huma aktar riċenti.*

[redacted] commented on the lack of human resources at the ED and the difficulty to retain these human resources due to the intensity and the stressful nature of the work: *Rari li kien id-dipartiment li kellu jmexxihom. Jiġifieri ħafna drabi tkun għażla personali jew jaraw postijiet oħra b'kundizzjonijiet aħjar ta'*

xogħol li ħafna drabi dik tkun għax tridu tifhmu li dipartiment f'emerġenza huwa tolling ħafna u jekk ma jkollokx ċertu mħabba lejn ix-xogħol naħseb li diffiċli tistikja u tibqa' fih. So jew jaraw xogħlijiet oħra li huwa aktar attraenti jew imorru fil-privat. Hemm min jirriżenja. Ikollna affarijiet varji. Unfortunately imma mbagħad għal dak li actually jibqa' taffetwa fuq ir-riżorsi li jkun hemm available. Jiġifieri irrelevant minn dan il-każ naħseb li kulħadd jixtieq li jkun hemm 6, 7 nurses available biex joħorġu ambulanzi. Imma jekk qed tillimita għal 4 biss u dawk l-4 qegħdin fuq xogħol tipprova tuża moħħok u l-esperjenza tiegħek kif tagħti anke l-aħjar servizz bir-riżorsi limitati li jkollok. Dik hija r-realtà unfortunately.

8. [redacted] Nurse, Emergency Department MDH. [redacted] has been working almost for the last eight years at the ED of MDH. On the night of 27th August 2024 she was working at the Control Room, processing 112 calls. At a time that she could not recall, she received a telephone call from a doctor from Floriana Health Centre, informing her that the ambulance requested earlier to transfer Mr Stephen Mangion to the ED was not needed anymore. She therefore recorded that the ambulance was *"Cancelled or aborted by caller." U għamilt nota taħt, "Will use own transport."*

Asked by the Board whether she wished to make any suggestions as to how the working conditions of emergency nurses could be improved, the witness did comment on the hard conditions under which emergency nurses work:

Naħseb l-akbar issue tkun id-demand, il-public demand mal-ammont ta' nurses li jkollna to dispatch mal-ammont ta' nurses available for dispatch u l-ammont ta' ambulanzi available. Dak l-akbar problema hemm ġew. [...] L-ammont ta' xogħol dejjem jiżdied. Tiġi exhausted minn kollox basically kemm emotionally u kemm mentally. It is too much. Fil-verità l-life span ta' emergency nurse huwa 3 to 5 years. [...] It is too much. Li taħdem hemm ġew too much. Satisfying ħafna imma naħseb bl-understaffing, l-ammont ta' patients presenting to the department. [...] Plus ovvjament imbagħad some people start a family u some get promoted. Hemm variations differenti ta' why some people leave. Recently kellna ħafna promotions to nursing officers li fair enough mhux se tħalli lil xi ħadd jibqa' fejn hu. [...] Kellna ħafna nies eċċellenti li telqu, saru nursing officers u riċenti. Imbagħad kellna nurse irrifjutat il-promotion biex tibqa' magħna wkoll tant kemm jogħġobha x-xogħol. [...] we do not just need to increase staff għax on a good day, eżempju ġieli public holiday we are a lot of nurses. Imma jekk nibqgħu bi 3 areas u se jkollok 5 nurses in 1 area, se noqgħodu 5 nurses naħbtu f'xulxin. So increase the number of areas, increase the number of nurses. [...] I would rather have longer shifts and longer offs to be fair if it makes sense. It is my personal preference.

9. [redacted], friend of the deceased. [redacted] stated that he has always been a very close friend of Mr Stephen Mangion and his brother [redacted]. He had also been to school with [redacted]. [redacted] is a nurse by profession and at the moment working on reduced hours.

On 27th August 2024 at 8:00 a.m., Mr Stephen Mangion had sent him a message telling him that he was not well. He stated that he went over to Mr Mangion's home and since Mr Mangion told him that he had a burning sensation in his stomach and the medication for his stomach had finished, he offered to go and buy it for him.

He realised that Mr Mangion was not well and encouraged him to go see a doctor *U rajtu qisu mhux sewwa. Għedltu, "Steve ejja nmorru għand it-tabib." Qalli, "Le, le, le. Mur għand ommok. Tinkwitanix."*

Mr Mangion was terrified of doctors, as pointed out by the witness: *Uuuu. Gwerra biex tieħdu. [...] Gwerra kbira. Aħjar ma nafx fejn tieħdu milli tieħdu għand tabib. Insommu u mort nara lil ommi u bdejt nibgħatlu u ġieli jgħidli tajjeb, u ġieli jgħidli agħar u ġieli hekk. Ma tafx kif.*

[redacted] stated that he left Mr Mangion to go and visit his mother at St Vincent de Paul. He kept sending him messages asking how he was. The pain was not constant, sometimes he was feeling better, sometimes worse, and sometimes so and so.

[redacted] realised that Mr Mangion was not his usual self because the TV was off and this was unusual *Hu ma kienx tajjeb għax television ma xegħlux. Dak is-soltu ma tmurx id-dar u ssiblu t-television mitfi. Jiġifieri t-television kien mitfi. Ma kellux moħħ.*

Mr Mangion had told him that he wanted to sleep: *qalli, "Issa norqod nipprova". Għax bil-lejl ma raqadx [...] Għandi jkun tah xi battikata f'12:00am. Ma nafx x'qalli. Ma tajtx kasu* and that he had been in pain since 4:00 a.m. in the morning.

[redacted] stated that he visited Mr Mangion again at about 18:00 and it was then that it was decided that they call Floriana doctor and according to what was stated Mr Mangion spoke to the doctor over the phone who told him... *x'qed tħoss. Qallu forsi għandek muscle pain u hekk it-tabib. Qallu "Ħu 2 panadols." Imbagħad għedtlu, "Ilbes Steve għax mhux qiegħed tajjeb." Qalli, "Le." Għedtlu, "Ilbes ħalli nmorru. Ħa nmur il-karozza. Ilħaq ilbes. Stennini isfel.*

[redacted] continued his statement that he drove Mr Mangion to Floriana Health Centre where they were seen to immediately by two doctors and two nurses, as he stated: *Il-Furjana dħalna mill-ewwel. Daħluna u ġie t-tabib, ġew 2 tobba u 2 nurses u għamlulu l-monitor u hekk. Qallu, "Għandek pressjoni għolja." It-tabib għax smajtu għax jien kont ħdejn il-pultieri, ma tafx kif inhuma hemm. Qallu, "Se jkolli nibgħatek l-isptar għax għandek il-pressjoni 200." Smajtu jiġifieri.*

According to [redacted], he saw from the look on Mr Mangion's face that he was not willing to go to hospital and [redacted] thought that he would end up going home instead. When the doctor informed them that there might be a waiting time of about half an hour, [redacted] offered to take him himself to the ED at MDH as this would be quicker, and after the doctor gave it some thought he agreed that they should go with their own transport. *Għedtlu, "Isma' jekk trid inwaslu. Bħalma ġibtu hawn nieħdu hemm." Qisu waqaf ftti it-tabib, qalli "Mela ħudu int." U morna malajr. Wasalna malajr. Dħalna, irreġistra u hekk u forsi għamilna 20 minuta. Għajtulu għat-traige.*

[redacted] continued to state that in triage they were quickly seen and they were then escorted through the back door of the triage room and an ECG was done. He remained with Mr Mangion and they were asked to sit down on the chairs in front of reception, not the outside one but on the inside. A second ECG was taken five minutes later.

[redacted] stated that during his time with Mr Mangion, the patient was uncomfortable and to him he looked unwell, a little pale and sometimes sweaty. A photo of both [redacted] and Mr Mangion which was shown to the Board (ref to Doc DC1) did not show Mr Mangion to be pale or sweaty but according to [redacted] he was slightly so. [redacted] also said that Mr Mangion was uncomfortable and had pain in his chest, abdomen, and back: *"mbagħad kif uncomfortable ħafna. Kien jitgħawweġ u jqum u joqgħod u dawn it-teatrini ma tafx kif. Hu beda juġgħu hawn qal u żaqqu u dahru. Kullimkien beda juġgħah."*

[redacted] stayed with Mr Mangion until [redacted], the deceased's brother, came to relieve him some time between 21:30 and 22:00.

[redacted] continued to state that, after he left, he called [redacted] again at about 22:45, when he was informed by a very agitated [redacted] that Mr Stephen Mangion had collapsed and was very bad. He went back to hospital but by the time he arrived, his friend had passed away.

10. [redacted], brother of the deceased. According to [redacted], the previous Saturday they had been out together shopping and on Sunday they met and had a meal together. [redacted] stated that on Monday they had not met but they phoned each other. The witness stated that: *Normali. Normali. Għalija ħija qatt ma bata b'qalbu. Jiddispjaċini li ... miż-żewġ naħat kulħadd jgħaġġel, kulħadd jivvinta u jitfa'. Jien kont miegħu, miet f'idejja u daqskemm nafu jien naħseb ma jafu ħadd għax ħuti aħna kollha close qegħdin 5. Imma jien u hu l-iżjed għax hu l-Belt, jien nidħol il-Belt kull jum, għandi post il-Belt ukoll.*

[redacted] stated that his brother had family problems, having passed through separation, and that he thinks Stephen's wife also got an annulment of marriage or divorce, but it had been over two years. [redacted] also stated that, notwithstanding the separation, Stephen and his wife had remained friends, but the separation had affected Stephen a lot. [redacted] was his confidant in these matters: *ħija kien jitkellem, kien jiftaħ qalbu u jgħidli, "Ħassejtha." Xtaq jirranġa imma dik hija ħaġa personali tagħhom imma dik hi l-verità.*

[redacted] continued to state that up to three weeks before, [redacted] had slept at his house since they had kept a good friendly relationship because of their children and [redacted] supported him. Their son is 20 years old and the daughter is going to be 17 years old. The son lives with his father when he is not staying at his girlfriend's. The daughter works in Malta in a pharmacy and sleeps at her father's but during the weekend she goes to her mother in Gozo since her mother is Gozitan. [redacted] also still has friendly relations with Stephen's ex-wife, occasionally going out for a coffee.

[redacted] stated that on the tragedy night of the 27th at about 20:00, he received a call from Stephen telling him that he was at MDH. He stated that Stephen told him *"Għandi uġiegħ kbir f'sidri. Ma niflaħx iżjed. Minn sidri għal dahri."*

[redacted] had offered to go to MDH but Stephen informed him that there was no need and that their friend [redacted] was with him. [redacted] continued to state that he was not at ease with this and he decided to go and relieve [redacted] who had been there a long time. At about 21:00 - 21:15, he arrived at MDH.

[redacted] continued to state that: *Issa jien ir-rabja li għandi li dawn is-sagħtejn li għamilt miegħu, għalkemm kien ilu xi siegħa oħra qabel jekk mhux iżjed, uġiegħ kbir f'sidru għal dahru, darba, tnejn, tlieta mar mad-desk għax aħna konna area 1, it-triage*

barra bagħtitu ġewwa. Pressjoni fuq 200. Qaltlu li għandu pressjoni għolja anke meta mar il-Furjana, u qam, "Ma niflaħx iżjed. Ma niflaħx iżjed." Sejjer hekk dan u ma nafx min, għax in-nurses jinbidlu, deħlin u ħerġin wara l-bank. Waħda minnhom għandi idea tagħha, ma rrid nagħmel ħsara lil ħadd tifħimnix ħażin, qaltlu, "Stenna wara min imissek." Veru kien ġenn sħiħ. Ma nistgħux ninnegawha din. Imbagħad għedtlu, "Ejja Stephen oqgħod ħdejja. Ikkalma." F'xi ħin qalli, "Ħa nmur nagħmel pipì." Mar jagħmel pipì, reġa' ġie u reġa' mar u t-tieni darba xi nurse tagħtu żewġ, li għalija daħqa stajt tajthomlu jien id-dar, panadols, paracetamols, għad għandi t-tazza tal-plastic żammejtha. L-aħħar ħaġa li mess b'idejh. Imbagħad saqsini x'ħin hu u kienu l-10:20. Bqajt niftakarha. Għedtlu, "L-10:20." U reġa' qam, reġa' mar mad-desk, "Għamluli xi ħaġa. Ma niflaħx iżjed." Reġa' ġie ħdejja bil-qiegħda.

[redacted] continued to state that just a few minutes later, his brother collapsed and he helped him onto the floor. Stephen turned blue/black in the face and doctors and nurses were immediately assisting him and intubating him. [redacted] heard someone say that there was no pulse and no breathing. After that, there was a lot of commotion. Stephen was taken away and [redacted] called all the family including his partner, his siblings, and Stephen's son. [redacted] came to speak to him but it was too late. [redacted] knew his brother had been dead when he was on the floor.

In his statement, [redacted] also stated that Stephen had often told him that he missed taking his medications, but he had never been in hospital with heart problems, unlike himself who had a pacemaker. [redacted] also stated that there is a history of cardiac disease from his mother's side with young age mortality (aunt and uncle). They were all tall over 6ft 2 as was his brother and himself.

[redacted] also confirmed that Stephen did not drive himself to MDH but it was their friend [redacted] who had accompanied him unlike what had been said in the media.

11. [redacted] Triage Nurse, Emergency Department MDH. [redacted] has been occupying this role for the last six years. She has received continuous triage training to be able to use the Emergency Severity Index (ESI) system effectively. She was the triage nurse when Mr Mangion presented to the ED in the evening of 27th August 2024. She took note of the medical information contained in the ticket of referral from Floriana Health Centre and on the basis of that information, together with the information received from Mr Mangion himself and his general

appearance, she concluded that he merited an ESI-2 category. ESI-1 patients are those needing **immediate** attention. Mr Mangion was not classified as an ESI-1 patient because from all the information presented to her, he did not need such immediate attention. Although he informed her that he had chest pain since the morning and she noted that he had a high blood pressure, Mr Mangion was fully alert, he was able to speak and had no shortness of breath, and he entered the room walking.

The witness could not recall the exact time when Mr Mangion arrived at triage, but she referred to the triage note (Doc PF2), from which it was concluded that the patient registered at the ED reception at 8:00 p.m. and that triage was completed by 8:16 p.m. She had enough information to classify Mr Mangion as an ESI-2 patient in less than three minutes. She had registered the triage complaint and the patient's parameters, which she took, on the triage note.

On finishing triage, the witness followed the usual procedure regarding cases of ESI-2 patients complaining of chest pain, namely she took the patient to the ECG room where the ECG technician took Mr Mangion's ECG.

12 [redacted] ECG technician, Emergency Department and Catheterisation lab MDH. [redacted] stated that on 27th August she was working night duty at the ED and at about 20:15, the triage nurse brought the patient Mr Stephen Mangion for an ECG. He was accompanied by his friend. [redacted] stated that the triage nurse informed her that he was an ESI-2 case with compressive chest pain radiating to back, referred from the health centre because he was in pain and had a systolic blood pressure of over 200.

[redacted] stated that, while taking his ECG, she asked the patient if he took any medication for his blood pressure and he told her something *along the lines of "Meta noħodhom." Jiġifieri ma kienx qed joħodhom b'mod regolari kif suppost.*

[redacted] also stated that Mr Mangion told her that he had a family history of heart disease relating to his mother and aunt but she did not remember exactly. Mr Mangion told her that he was diabetic and a smoker. [redacted] stated that, upon taking his ECG, it showed that he had

a right bundle branch block (RBBB). [redacted] was shown Doc KB31082401 & 2.

Mela dan l-ewwel wieħed li ħadtlu li huwa 12 lead ECG. Jiġifieri kif ħadtlu 12 lead ECG, jien kif inħares lejh huwa right bundle branch block jiġifieri għandu wide complex u qisha jgħidulha RSR pattern. Jiġifieri qisha M shaped minn leads V1 sa V3 u jkollok AVR ukoll. Meta tħares lejn ECG hekk, ma jgħidlekx, "Isma' dan huwa attakk tal-qalb." Imma it can hide an MI, jiġifieri myocardial ischemia. Allura it was worrying me għax given li kien għadu symptomatic, kien għadu miġugħ u beda jurini li kien discomfort għax għedt, "Mill-ECG m'hemmx affarijiet li tgħid straight forward attakk ta' qalb." Qalli, "Imma istra miġugħ. Għadni miġugħ." Mort nurih il-lead doctor. Kien ukoll iffirmali hawnhekk u qalli, "Qed iħassibni ftit dan l-ECG." Għax jien meta wrejtu l-ECG għedtlu li kellu systolic over 200, diabetic, tajtu naqru overview tal-patient, family history u anke l-patient wiċċu kellu qisu flushed face. Kien ruxxan, qisu fir-roża u kien miġugħ ovvjament. Għax qalli, "Dawn il-leads t'hawnhekk." [...]

I was pointing it out li dan għandu systolic ta' 200 u bdejt ngħidlu. Raha wkoll jiġifieri. Qalli, "Dawn il-leads qed iħasbuni ftit għax għandu naqra high take off." High take off given li hemm dan l-RBBB u it can hide the potential of possibly ma' cardiac ischemia qalli, "Let's take a right to posterior." Li huwa l-18 lead li mbagħad għedt lil Stephen, għedtlu "Ejja miegħi sal-ECG room." U ħadtu l-18 lead li juri r-right side u l-posterior side tal-qalb. Minnu erġajt mort nurih il-lead doctor u qisna kkonkludejna li as in m'hemmx myocardial ischemia f'dan l-ECG imma at the back of my mind la qara RBBB bdiet tħassibni xi ftit għax it can evolve, it can change into a heart attack imma jien dak il-ħin għedtlu, "Ok. Mela 12 lead u 18 lead għamilnihom." U t-tnejn li huma rahom. Jien dak il-ħin saqsejtu erġajt bqajt ninsisti, "Imma l-patient għadu miġugħ." Erġajt irrepetejtlu l-istess ħaġa, systolic over 200, ma kienx qed jieħu l-mediċini kif suppost. Diabetic, smoker. Jidher li, kien qalli li jpejjep ukoll, family history u għedtlu, "Ma nafx jekk forsi tridx issaqsih xi mistoqsijiet." Għax jien mort nagħtih l-ECGs kien area 1 bil-qiegħda u Stephen għedtlu biex ipoġġi faċċata tad-desk area 1 fejn ikun hemm it-tobba mad-desk. Jien għedtlu hekk għax is-soltu taf int tara pressjoni għolja, hekk it is concerning. Jien inkwetajt xi ftit. Tipo għedtlu, "Ma nafx jekk tridx issaqsih xi domandi jew forsi while he is waiting nieħdu xi troponin levels." I was suggesting maybe what we can do while he is waiting. [...] Lil-lead doctor ta' dak il-ħin. Tagħni l-karti. Qalli, "Thank you." As in no need. Jien għedtlu "Ok." Twejt il-karti, twejt dawn l-ECGs iffirmati mat-triage tajthom imbagħad lil-lead nurse biex imbagħad il-lead nurse lill-patient jagħtuh tim. Jekk jagħtu tim A għal area 1 jew tim B għal area 3.

[redacted] stated that the patient remained waiting in Area 1 according to ED protocols in place. Reference was made to Doc PF4.

[redacted] presented Doc NC1 stating that for chest pain patients who are walk-ins, the ECG is done in the ECG room. *Ħaġa oħra li rrid ngħid hu li l-ECGs, dawn baqgħu qatt ma ġew ibbukati. [...] Għax aħna konna bdejna l-online system fejn*

l-ECGs jiġu bbukati. Issa f'dan il-każ jekk nixmu. [...] Li meta t-tabib jibda jarahom itellgħu online request fuq iSoft, fuq sistema li nużaw aħna.

Doc NC2 was presented and it explains that when a doctor does not book the ECG online within one hour, the ECG technician will upload the ECG onto dashboard and mark it as 'X'. This will not have the doctor's name and it still does not solve the problem that the doctor has not booked the ECG. They have a system that it is the responsibility of the doctor who will be seeing the patient who should book it. Sometimes even when the doctors have the ECG in hand they still do not book the ECG, so only the hard copy remains. The ECG technician at times will go to the area, locate the doctor who will be seeing the patient, and ask him to book it so that the technician can merge it and upload it online. They will do it and the importance of this is that it shows *"Authorised by." Jew "Seen by Dr." so and so* which is documented online. [redacted] followed the protocol and took the ECG because Mr Mangion was an ESI-2.

[redacted] continued to state that the second 18-lead ECG which was taken shows the beat of the heart from different views. [redacted] stated that if a 12-lead ECG was taken at the health centre this would have been a better choice.

[redacted] stated that the next time she saw the patient was when he was on the floor and later she followed him into the resus room just in case an ECG was needed but this was not requested and she left the room again.

[redacted] stated that, as an ECG technician, she had seen cases when similar ECGs resulted in a heart attack. It was not a straightforward ECG, it still concerned her particularly in view of his high blood pressure. When asked if, in hindsight knowing the cause of his death, one could have suspected it from the ECG taken, [redacted] did not think so.

During that night, she remembered that there were other patients who had ECG changes which could have turned into cardiac ischaemia. [redacted] stated that her role is that of an ECG technician and the lead nurse will later follow up each patient in the priority they are to be seen.

[redacted] stated that ideally the ECG should be booked at the triage area. There is the 'fast-track' at times but she was not sure about this as she sees mostly nurses in triage. The ECG for ESI-2 cases is done without

primary booking as that is the protocol they follow. This should later be booked online.

13. [redacted] Charge nurse, Emergency Department MDH. One of the main responsibilities of [redacted] is to apportion emergency nurses to particular jobs.

[redacted] stated that on the night in question, Mr Mangion was sitting on one of the chairs in the clinical area of Area 1 reserved for high-risk patients who can walk and who were classified by triage as ESI-2. These persons would have already been triaged and would be waiting there until they are allotted a cubicle and can be seen by the doctor. The witness specified that this area is inside the clinical area and is not to be confused with the outside waiting area near the ED reception. These ESI-2 patients are kept in Area 1 to be under close observation.

Mr Mangion waited for roughly two hours. The witness stated that Mr Mangion: *Bħala clinical appearance deher komdu, mhux under distress. In fatti dak huwa wieħed mir-roles tiegħi meta jkun hemm patients li huma distressed allavolja l-konsulent ukoll bħali jkollu aċċess għal ESI2, jekk jien naqbad xi ħaġa li tinkwetani mill-esperjenza tiegħi ovvjament se ninfurma lit-tobba, as in naħdmu flimkien. [...] Fl-opinjoni tiegħi ma kienx jidher li hu distressed. Kien hemm perjodu fejn anke kien qiegħed bil-wieqaf jimxi, jitkellem mar-relative tiegħu. Kellna l-ECG li kien jidher li ma kienx hemm affarijiet, skont it-tabib, strambi, jiġifieri ta' inkwiet kbir [...] Tant kemm hu hekk li r-relative tiegħu saqsini fi x'ħin se narawh. [...] Li nagħmel hu nmur fir-rack, fil-pile fejn hemm l-ESI2, jiġifieri l-każijiet l-istess ta' urġenza u ngħidlu kemm fadal pazjenti qablu bejn wieħed u ieħor. Ovvjament ngħidilhom ukoll li jista' jagħti l-każ li jekk jidħol xi ħadd aktar urġenti, agħar, ikollna ovvjament aktar delays.*

[redacted] stated that there are some eight (8) chairs in the clinical waiting area and there are 10 cubicles on each side. On the night in question, all these were fully occupied. The witness stated that: *Li hu żgur jekk mhux sejjer żball dakinhar fiż-żmien ta' siegħa u ftit daħlu 14 new cases li fil-maġġoranza kienu kollha ESI2s.*

He was asked by the Board whether the workload was normal at the ED on that particular night. The witness remarked: *Skont xiex nifhmu bih normali. Unfortunately in-norma saret aħna ma nlaħqux max-xogħol. [...] It was extremely busy li nista' ngħid I was struggling biex inqassam ir-riżorsi għax kienu limitati. Jien biex nagħti eżempju aħna suppost inkunu 30 nurse. In-norma saret li ġieli nkunu 15, 16. Qed*

ngħidu li ħafna min-nurses issa huma juniors ukoll li għadna qed nittrenjawhom. Jiġifieri their set of skills huma limitati. Allura jaqa' ħafna xogħol fuq is-senior nurses.

The Board asked [redacted] whether he saw Mr Mangion's collapse in the clinical area and the witness replied thus:

Jien kont l-ewwel wieħed li messejtu, [...] Bażikament kien qiegħed bil-wieqfa, ir-relative qisu beda jgħajjat għall-għajnuna, [...] indur u nara lis-sur Mangion qed jagħtih ħass ħażin u qisu qed iżomm mas-siġġijiiet. Jien middejtu mal-art bdejt nassessjah, kien għadu qed jieħu n-nifs biss però kien jidher li n-nifs huwa batut ħafna. Ovvjament ġew kollegi tiegħi jgħinuni fejn għamiltlu nasopharyngeal airway għax kellu problema bl-airway, beda jonħor imma ovvjament mhux b'mod normali, kien għad kellu carotid pulse biss però billi nifs batut talbt għall-oxygen li ġabuli mill-ewwel kollegi tiegħi u ... nivventilah. Imbagħad qbadnih, daħħalnih, tfajnih fuq stretcher, daħħalnih ġor-resus fejn sakemm hu u dieħel fir-resus kien għad kellu pulse u mbagħad komplew il-kollegi tiegħi għax jien ovvjament ikolli bżonn nieħu ħsieb il-floor. Ma kontx inkun nista' nillarga u nibqa' ma' pazjent wieħed. Il-ħin kollu ndur u nara li kollox, l-operations qegħdin sewwa. Milli jidher imbagħad ftit wara bdew il-compressions jiġifieri bdew CPR.

The Board asked the witness whether at any time before Mr Mangion collapsed, he noticed that he was short of breath. [redacted] replied:

Le. Issa jien ukoll il-ħin kollu tiela' u nieżel hemm inkun u ndur u interact ma' dawk il-pazjenti li jkun hemm. Jiġifieri mhix xi ħaġa li nagħmel darba kull siegħa imma tkun qed issir xi ħaġa kontinwa. Jiġifieri kieku għall-argument kien se jkun għarqan jew jidher distressed kont se ninduna mill-ewwel.

14 [redacted] <u>Staff Nurse, Emergency Department MDH</u>. [redacted] has been occupying this role for five (5) and a half years. On the night of 27th August, she was allocated to Area 3 which is one of the clinical areas where ESI-2 cases are seen.

[redacted] stated that at about 22:20, Mr Mangion came asking her how many patients were before him. She checked in their rack and told him that he had two others before him. [redacted] continued to state that Mr Mangion touched his stomach area and told her that *"Reġa' ġej l-uġiegħ."* When [redacted] asked him when was the last time he took Panadols, he informed her that it was about 1 p.m. She asked him if he wished to have Panadols and since at the time it was 10:20 p.m., she offered him Panadols again. She stated that she went to Area 2 treatment room and he followed

her there. She gave him two Panadols and he walked back to Area 1 seating area.

The witness stated that *Lili dik id-darba biss avviċinani. Fl-area li konna fiha aħna, jiġifieri minn fejn konna se naraw lilu sa fejn naf jien jien dik id-darba biss rajtu.*

The Board asked the witness if any monitoring was done while the patient was sitting down waiting. [redacted] replied that *Li jiġri x'ħin jidħol mit-triage il-pazjent, pazjent li jkollu wġiegħ f'sidru jew uġiegħ fuq l-istonku jew hekk hija proċedura li aħna nieħdu ECG. Jiġifieri l-ECG kien sarlu. Mela saqsini kemm fadal qablu ċċekjajt jekk kellux ECG just in case immisjajnih jew xi ħaġa, però kellu ECG u dan l-ECG kien iffirmat minn tabib ukoll. Jiġifieri xi ħadd rah. Issa wara hekk dawn il-pazjenti li nikklassifikawhom bħala high risk imma għadu ma bediex jarahom tabib ikunu bil-qiegħda warajna bażikament. So ikunu taħt għajnejna. Ma jkunux monitored fis-sens ta' ma jkunux attached ma' monitor.*

When the Board further inquired if there are instances when an initiative is taken by nurses/ doctors whereby something other than an ECG is done, [redacted] replied that *Mela jiddependi kien jippreżenta l-pazjent. Jekk il-pazjent ikun li aħna ngħidu ħażin, fis-sens, li f'għajnejna jkun qed jidher ħażin, f'dak il-każ ġieli nqabżuhom pazjenti li ma jkunux qed jidhru ħżiena. Pereżempju dak il-lejl in question kellna 2 pazjenti hekk li jkollhom pereżempju pressjoni baxxa ħafna, ikunu pallidi, f'dak il-każ naqbdu u ndaħluhom ġo kamra u tipo nibdew nagħtuhom it-treatment.*

When the Board asked how Mr Mangion presented, [redacted] stated that *X'ħin daħal ikellem lili daħal jimxi, ma kienx jidher pallidu, ma kienx jidher qed jaqta' nifsu. Aħna ngħidu diaphoretic, ma kienx imxarrab bl-għaraq. Kien tipo pjuttost normali. Qisni qed inkellem lilek tipo.*

The witness concluded that she had started her shift at 19:00. [redacted] did not know if Mr Mangion had approached or spoken to any other person before her since the area he was sitting in is not visible from Area 3, which is where she was stationed. No one else, including his brother or his friend, had approached her.

15. [redacted], Staff Nurse, Emergency Department MDH. [redacted] has been occupying this role for three (3) years. [redacted] stated that on 27th August she was on night duty. She did not know the exact time but she stated that Mr Mangion approached her and asked how much longer did he have to wait to be seen by the doctor. She assessed the triage waiting pile and informed him of how many patients were still to be seen before him. It may have been two persons, but she was not sure of this

when asked by the Board. When asked about her impression of Mr Mangion, she stated: *Huwa qalli li kien daqsxejn skomdu. Saqsejtu ħax affarijiet taluġiegħ. Imma mbagħad kompliet nurse oħra miegħu.*

When the Board asked the witness to describe what *skomdu* means and the expression of his face and if he was touching any part of his body, she replied that he was *skomdu* but did not remember anything else. Asked again what she meant by the word *skomdu*, she replied that *skomdu* means *Li mhux komdu kif inhu.*

Asked if she means *Għandu xi ħaġa qed iddejqu,* she answered *Hekk hu.* When asked by the Board *Lilek tinkwetak ħafna, tinkwetak ftit meta xi ħadd jiġi jgħidlek, "Qed iħossni skomdu."?* she replied that *Ikun hemm ħafna nies li jkunu skomdi l-emerġenza biex ngħidlek il-verità.*

16. [redacted], Consultant at the Emergency Department MDH (accompanied by advocate [redacted].

[redacted] has been a consultant at the ED for the past 13 years and has worked in the ED for a total of 24 years. General duties include administrative, educational, training, and clinical. On the day, he was the overall lead consultant from 20:00 until midnight.

[redacted] explained the duties of the Clinical Area Lead Consultant: Overseeing all patients; making first medical encounter, not necessarily taking over the patient, but familiarising yourself with the clinical problem, you talk to and examine the patient, write a short clinical note and formalise an initial clinical plan; *You are the final say*; performing 2-hourly ward rounds to clear cubicles; consulted by junior doctors.

[redacted] also explained the duties of the Overall Lead Consultant: Mostly administrative; phone consultations with doctors from other hospitals, from Primary HealthCare, and private doctors; organising investigations such as CT scans or preparing treatment for referred patients; reviewing ECGs done in ED and those tele-transmitted from ambulances.

The event

There was no phone call about Mr Stephen Mangion after 20:00.

Before 20:00, [redacted] was working as a Clinical Area Lead Consultant not receiving phone calls.

The first encounter with Mr Mangion was when [redacted] reviewed his ECG at about 20:20 (ECG taken about a minute earlier). The ECG did not show clear signs of an acute myocardial infarction (AMI). *Because there was a suspicion of a 'high take-off' in one of the leads*, a second ECG with posterior and right-sided leads was requested and this was seen at about 20:28. Again, there were no signs of ST elevation, no ECG changes suggesting AMI. The first ECG was signed by [redacted], a copy of it was uploaded on the Patient Dashboard, the second ECG was not uploaded. A note was written and signed on the ECG.

Mr Mangion was assigned to Area 3, waiting close to the central circular doctors' desk about 3 metres away.

The next clinical encounter was in the resuscitation room after the patient collapsed, at about 22:30. [redacted] was clinical lead physician in charge of the CPR. [redacted] entered the room to assess whether there was adequate staff to perform the resuscitation. He stayed there to help. At about 22:35, he performed an ultrasound, which is his speciality area, and noted a 2cm (about – not accurately measured) fluid layer around the heart. A diagnosis of tamponade was made, and the cardiologist, [redacted] was called. They prepared to aspirate the pericardial fluid (pericardiocentesis). The procedure was not successful. [redacted] stated that this is a difficult procedure even in the best of circumstances with a cooperative patient, let alone in a patient who is receiving chest compressions. The witness stated that:

The impression when they told me the history to be honest with you was of dissection at the outset.

An abdominal aortic flap was suspected on ultrasound, a dissection that extended backwards. This was confirmed to [redacted] during the Magisterial Inquiry when he was informed of the autopsy findings. During resuscitation, [redacted] went to speak with the relatives who asked for him since one of them was an acquaintance of his. At that point, [redacted] told them that they suspected an aortic dissection. The relatives told him that the pain radiated to the back at 4 a.m., Mr Mangion remained in pain and conscious. This relative was not present at the ED prior to the collapse.

During resuscitation, the ECG pattern did not evolve in a typical AMI pattern, going to VT/VF, but *it was asystolic from go.*

Furthermore, this was not a slowly forming pericardial effusion which gives a progressive fall in blood pressure and eventually leads to cardiac arrest, here Mr Mangion just suddenly went into cardiac arrest.

All this fit the diagnosis of a large aortic dissection extending from the abdomen backwards past the arch and suddenly causing a cardiac tamponade. The witness explained that, in this context, any pericardial fluid that is drained would immediately reaccumulate each time the heart pumps.

At this point [redacted] was overall in charge of the CPR, [redacted] was helping with performing the ultrasound, and [redacted] was trying to drain the pericardial effusion.

ESI system

[redacted] explained that the ESI triage system used locally does not give a time scale when a patient has to be seen.

It is a system commonly used internationally, particularly in the USA (at least five systems are in use worldwide). Different systems cannot be compared, some give a time frame but are very laborious and take a lot of time to assess patients. Our system is not in any way inferior to others.

The witness stated that the choice of triage system used falls under the nursing umbrella. This was their choice. It is fast and efficient.

Mr Mangion was correctly labelled as an ESI-2 category. This category can have a wide spectrum of clinical acuity. The system allows for upgrading (but not downgrading) a patient's acuity. In fact, on the night, two ESI-2 patients who arrived after Mr Mangion were attended to earlier because they deteriorated and were deemed to be more clinically unstable.

Between 20:20, when the ECG was taken, and 22:30, when he collapsed, Mr Mangion was sitting in the clinical area 2-3 metres away from the central circular doctors' desk waiting to be seen, as is normally done. If a patient is labelled as ESI-2, he is admitted to a clinical area.

Remarks by [redacted]:

Dissection of the Aorta & Tamponade

In an ideal situation, a patient is attended to the moment he presents.

Had Mr Mangion been admitted directly into a cubicle, it is not clear whether a correct diagnosis would have been reached earlier. Dissection of the aorta can be a very difficult and tricky diagnosis, and the triage note stated 'chest pain on lying down', this suggested pericarditis or pneumonia.

Had the diagnosis been made earlier, it is also not clear if it would have made a difference to the outcome since Mr Mangion presented very late, 16 hours after the start of the pain at 4 a.m.

Had the diagnosis been suspected earlier within the two-hour time frame at ED, a CT Angio would have been organised and read, he would then be assessed by the cardiothoracic surgeons and taken to theatre. This is also a lengthy process.

In Malta, an aortic dissection *from top to bottom, dissection past the arch* is not operated upon locally. There is no possibility for a repair in Malta for this condition. Patients are operated in Belgium in Maastricht. It is one of the few conditions we cannot deal with locally.

Note-taking

Doctors' notes are all digital on iCM/ iSoft as was done in this case (ref to Doc KB2). These notes may not be present in the patients' file but are always available on iCM. The time frame is automatically recorded. In this case, documentation was done after the CPR was over.

Nurses still take written notes.

Work load

ED is always very busy. The number of patients can fluctuate. Additionally, the ED is very undermanned.

On that particular day, two hours prior to the arrival of Mr Mangion, 40 patients of all categories registered at ED i.e. > 3 patients every 10 minutes or 1 patient every 3 minutes. There were 22 ESI-2 registrations, 1 every 5-7 minutes. Between 20:00 - 20:16, there were 8 registrations. This situation is difficult to keep up with (ref to Doc KB3). [redacted] explained that we are not achieving our targets according to the patients' charter of 2016 and the College of Emergency Medicine Physicians recommendations which state that 50% of patients have to be seen within 2 hours; we are achieving 20%.

Patient numbers are always increasing, about 2.2% increase per year. In the case of ESI-2 patients alone, this increment is 4.4%. The patients presenting are becoming more complex, require more time, and are more likely to be admitted.

Staff numbers

Staffing levels have nearly shrunk since 1-2 years with a near 'exodus of trainees', possibly a post COVID effect. 70 trainees joined, of which 36 left. Adequate training posts are available.

Causes for doctors leaving the ED include:

1. The work load
2. The shift system - not very family-friendly
3. Pay is not more than that of others.

Some suggestions:

1. Introducing 'family-friendly' measures
2. Flexi roster where you work on preferred hours or days. Allowing time for travel and lengthy holidays
3. Doctors planning a family, in particular, need this shift flexibility
4. Creative efforts for recruitment and retention.

[redacted] explained that presentations were made to the Minister in this regard, resulting in the setting up of plans to expand the service according to a timeline. The physical size of the department will also expand.

Off-loading the ED

Once a patient is worked up and ready for admission, he may have to wait in the ED corridor or in a cubicle if unstable. This further clogs the ED and causes crowding.

Systems of off-loading patients in the ED are only partly in place. There is a transfer ward which however does not take all patients, e.g. surgical patients requiring admission must first be reassessed by surgical assistants and wait for blood/ radiology results, this could take over 2 hours; also very sick and unstable patients have to be transferred directly to the ward from the ED on to an available bed on the wards. This system needs to be improved.

17. [redacted] Resident Specialist, Emergency Department MDH. (accompanied by [redacted]

[redacted] has occupied this role since 2021. On 27th August 2024, [redacted] had a night shift duty between 20:00 - 04:00.

[redacted] stated that the previous day had been particularly heavy in terms of patients presenting to the ED. This always creates a backlog of patients still waiting to be seen from earlier shifts. This situation may take 2-3 days to normalise. In fact, this was the case on that day. Furthermore, few doctors were on duty:

[redacted] was assigned as Lead Physician (Senior Decision Maker) of Area 3, assisted by:

One Higher Specialist Trainee (HST) 1 – Young doctor in training (1st year out of 4 years) – not allowed to take clinical decisions on their own.

One Medical Officer – Doctor with a state warrant but who has not yet started speciality training.

Three Foundation Year (FY) doctors – Qualified doctors who are still without a state warrant (usually given after working for two years in the National Health Service). FY doctors are not allowed to take clinical decisions on their own.

Patients assigned to Area 3 are all very sick patients, ESI-2 and some ESI-1. At the start of the shift, Area 3 was packed with all 6 cubicles full and patients in the corridor, including patients on stretchers awaiting transfer to wards.

[redacted] explained that one patient [redacted] awaiting ward transfer suddenly deteriorated with severe shortness of breath. He needed immediate attention and in fact ended up in ITU. There were other unstable patients. [redacted] started a round of all the patients, reviewing their files and organising their investigations and treatment.

These other patients included:

[redacted] – Sepsis causing severe hypotension and confusion

[redacted] – Sepsis causing hypotension; hypoxia and high temperature

[redacted] – Sepsis and hypotension

All these patients require intense care within one hour.

[redacted] – Cocaine toxicity with hallucinations, was aggressive and attempting self-harm. He had to be restrained by his father, the medical and security staff. There was quite a commotion in the area.

[redacted] – Relapse of schizophrenia with paranoia and afraid of everyone.

The witness explained that, at some time after 22:00, he was about to perform some tests (venous blood gases) on blood samples from the mentioned patients on machines close to where Mr Mangion was sitting (close to the clinical station between Area 3 and Area 2), when he heard a sudden commotion/ agitation. [redacted] saw a male person holding his chest and leaning onto a man sitting next to him who then laid him on the floor. [redacted] put the blood samples aside and rushed to the collapsed

person (Mr Mangion). At the time, he did not know who the collapsed person was.

[redacted] turned him over and Mr Mangion was gasping. [redacted], lead nurse on duty, came over and inserted a nasopharyngeal airway, a crash pack was brought over, and he started to bag the patient. At the time, there was a carotid pulse. More help came over and Mr Mangion was transferred onto a stretcher and transported to the resuscitation room (probably resuscitation room 2).

The patient did not collapse in the waiting area, he collapsed next to the chairs in the corridor leading from Area 3 to Area 1.

On entering the resuscitation room, the patient was pulseless. Defibrillation pads showed asystole. Full CPR was initiated. Venous access was established and an intraosseous needle was also inserted. Chest compressions were started, Adrenaline was given, and fluid infusions were set up. Eight (8) cycles of Adrenaline were given according to ALS guidelines. The patient was successfully intubated by an ED consultant, [redacted]. No muscle relaxing drugs were required as the patient did not have a gag reflex, he was flaccid.

Reversible causes were explored, bloods were taken for electrolyte levels, blood pH, and hypoxia. He was also assessed for hypothermia, pneumothorax, needle marks, and obvious signs of deep vein thrombosis. An assistant got his past medical history from the notes and a relative. An echocardiogram during the CPR showed a pericardial effusion. [redacted], cardiologist on-call, was called to attempt a pericardiocentesis. This procedure was not successful (during a CPR, this procedure becomes more difficult due to the movement caused by the chest compressions).

After 35 minutes of CPR, at 23:00, the patient remained in asystole and was declared dead.

Eventually, the cause of death was revealed unofficially through hearsay – extensive aortic dissection causing tamponade.

[redacted] only got to know of the patient's history (long standing severe hypertension, noncompliance to treatment, and the multiple risk factors, including smoking, diabetes, and high cholesterol) after the collapse. He was not aware that his present symptoms had started at 4 a.m.

An aortic dissection is difficult to treat even if diagnosed early, and it always carries a high mortality rate. At the time of presentation to the ED, the extent of damage was such that probably it was already too late for anything to be done. He was a *ticking time bomb.*

[redacted] was the only senior doctor in Area 3. He was seeing patients one after another according to their clinical severity, in fact two patients who arrived after Mr Mangion became hypotensive, they jumped the queue and were directly assigned a cubicle and actively treated. During the two hours and 12 minutes that Mr Mangion was waiting after his triage, [redacted] was very busy attending to very sick patients. Furthermore, during the CPR on Mr Mangion, there was notification of a motorcycle accident involving one fatality and a second patient requiring assistance. In such situations one has to organise a team to treat this incoming patient.

Recommendations

[redacted] explained that understaffing at the ED is now the norm, with one senior doctor covering a whole clinical area. During the whole eight (8) hours of duty, there is never any time for a break, sometimes even for toilet purposes. One very serious case is immediately followed by another. There is never a cooling off period. [redacted] recommended more incentives to attract ED doctors, e.g. work conditions, shift times, the shift system itself, monetary compensation. Often ED doctors have to travel to Gozo to cover the ED there.

Presently the ED is working with half the recommended facilities. Increasing these facilities would require a proportional increase in ED staff.

Dedicated computer programmes which eliminate lengthy documentations of patient records could also help efficiency.

Patients who are ready for transfer or discharged from the ED should not be made to wait in the ED. These transfers involve lengthy bureaucratic processes e.g. SAMOC patients kept in isolation occupying cubicles, or surgical patients awaiting review by relatively junior doctors before being transferred to a surgical ward. This is useless duplication of work. A holding bay would help solve this problem.

[redacted] mentioned the present streaming of priority 3 patients who are being seen directly by a consultant and a clinical decision taken quickly. This system is working well but is only available during the day, it should be extended over the whole 24 hours.

18. [redacted], Resident Specialist in Cardiology, MDH. [redacted] was on duty on 27th August 2024.

CPR call

At about 22:30, [redacted] received a CPR call regarding a cardiac arrest at the ED. He went to the resuscitation room. He had already been informed of echo findings regarding a large pericardial effusion. [redacted] repeated the ultrasound and confirmed these findings; he also reviewed the ECGs and the history. Aortic dissection was strongly suspected with a presentation of prolonged chest pain and fluid around the heart.

This scenario is associated with a very high mortality, particularly when a patient arrives late and when there is a large fluid collection around the heart. 10 minutes of CPR had already passed and there was no response, the ECG showed a flat line.

Pericardiocentesis

During the CPR, draining of the pericardial effusion was attempted but was unsuccessful.

The procedure can itself be difficult especially so when performed in an emergency situation with chest compressions going on. During a CPR, chest compressions can only be stopped for a few seconds at a time since there is no heartbeat. In the best of circumstances, in a calm environment and on a stable cooperative patient, this procedure can take 30 minutes.

Doc KB2 was read and explained. The ECG did not show any signs of either an acute heart attack or of a pericardial effusion. In the presence of a large pericardial effusion, the QRS voltages (the size of the electrical signals) on the ECG are usually small, in this case they were of normal height.

Molecular autopsy for genetic studies

[redacted] was informed that there was a family history of Sudden Cardiac Death (SCD). Source of this information was not clear; possibly from other doctors, or possibly from the patient's family.

There is a family history of Brugada Syndrome which can cause SCD but which is totally unrelated to Mr Mangion's pathology (dissection of the aorta).

Because of this family history, [redacted] recommended that a molecular autopsy for genetic studies be requested, studies which are not done on a regular basis. Splenic samples are usually taken. Spleen gives a higher pick-up rate than blood. This genetic information could be of clinical relevance to the deceased's direct relatives.

Locally, there is no legal obligation to take these samples unless they are directly related to the patient's cause of death, it is at the discretion of the pathologist. In a Magisterial Inquiry, it is the court that pays for the autopsy and funds are limited.

Access to autopsy findings

Very often the autopsy findings are not revealed to the direct relatives at all unless they make a formal request through the law courts. In this case, the media revealed that he died of aortic dissection. Whoever cares for his relatives would need to screen them for this condition.

In court-led autopsies, the pathologist performing the procedure is bound by secrecy, he cannot inform anyone, in this case specialists of inheritable genetic conditions, of their findings.

This information regarding the family history of SCD was not provided in the testimony of [redacted], the brother of the deceased.

Recommendations

The pathologists performing all autopsies should have the authority that, when indicated, they either request genetic studies or they communicate with relevant experts. Protocols in this regard have been presented to the

Chief Justice and there should be a meeting with the Attorney General. Introducing these changes is a lengthy process. It took the UK 20 years. There they have Coroner who decides what to do.

Studies have shown that, in situations of sudden cardiac deaths, sending the heart to specialised centres can result in 66% discrepancy in the final diagnosis. This could be very relevant to the direct relatives.

19. [redacted] & [redacted], Specialists in Pathology, MDH.

The cause of death was aortic dissection. The dissection was large, extending from the root, to the ascending, arch, thoracic and abdominal aorta down to the level of the renal arteries. The exit point was the pericardium. There were extensive large plaques. The entry point could not be identified, it could have been a small slit in any of these plaques. The dissection may have extended in any direction, up or down, depending on where it started.

The heart showed severe chronic disease. It was severely concentrically hypertrophied, it weighed 800 grammes, twice the normal weight, compatible with untreated severe hypertension. There was also diffuse severe coronary artery disease: LAD 80%; large D1 70%; LCx 30% & RCA 80% stenosed. The myocardium was also scarred in a scattered pattern (not regional), suggestive of multiple small infarctions, also typical of hypertension. These were confirmed by microscopy.

There was over 200 ml of blood and clot in the pericardial sac.

There was also evidence of severe hypertension in the kidneys with scarring and microscopic evidence of hypertensive kidney disease.

The use of illicit drugs was excluded using a dipstick. There is an association of aortic dissection with cocaine and heroin abuse. The dipstick was negative.

All the risk factors for aortic dissection were present.

Asked whether genetic testing was being considered, [redacted] felt that there was enough evidence as to what the underlying pathology was. Genetic testing was not required.

[redacted] had access to the patient's history from what is available on iSoft. The patient's family history was not available.

Regarding the possibility of Marfan's syndrome because of several family members being very tall, the patient, who was also tall had no other Marfanoid features, and there was ample pathology to explain the cause of the dissection. If he also happened to have Marfan's then this would be an added risk factor not a cause for the dissection.

When asked about the recommendations of the cardiologist that a molecular genetic autopsy be done, [redacted] felt that it is the pathologist who should decide if this is required. In this case, there was enough evidence to explain what the underlying pathological process was.

The presentation of the patient was quite typical for an extensive dissection with pain in multiple areas – low back, abdomen, back and chest. He sometimes complained of burning epigastric pain. Symptoms lasted over several hours. When the pericardium was involved, the patient suddenly collapsed. The pericardial fluid/ blood pressed upon the heart preventing it from pumping. That is cardiac tamponade.

The evolving dissection classically presents with severe pain depending on the part of the aorta involved, however this patient was never in severe unbearable pain. Pain threshold varies, also he was a diabetic which could mask the pain.

Aortic dissection can be operated at high risk. Considering the extent of this dissection, the background pathologies, including the myocardial hypertrophy, the coronary artery disease and the renal disease, his risks would have been extremely high and possibly he would not have been fit for surgery.

Had an echocardiogram been done early on admission to the ED, it would probably have been normal. The pericardial effusion was sudden and caused the collapse.

In a patient presenting with his symptoms, one would first think of ischaemic heart disease and not of aortic dissection, common things being common. Initial investigations would include an ECG, blood tests for troponin, and a chest x-ray.

Autopsy report conclusion

The witnesses reported the conclusions derived following post-mortem examination:

The cause of death in this case is certified as being due to a cardiac tamponade secondary to an extensive aortic dissection involving the ascending, arch and descending aorta. A background of atherosclerotic ischemic heart disease, the myocardial hypertrophy of hypertensive type is present which is also contributory to death.

20. [redacted], Deputy Clinical Chairperson of Primary HealthCare.

[redacted] stated that he has been working in Primary HealthCare since 1996 and that he has been occupying the position of Deputy Clinical Chairperson since December of last year. He indicated the healthcare professionals that fall under his jurisdiction. He explained how the nine (9) Primary HealthCare centres are organised in three (3) areas and how a Principal General Practitioner (PGP) is in charge of each health centre. In the morning, there will be a PGP in each health centre. In the afternoon, evening, and part of the night, there will be two (2) PGPs covering the nine (9) health centres. During the night in question, these two PGPs were [redacted] and [redacted]. At Floriana Health Centre on that night, there were two (2) GP trainees year 2, one (1) GP trainee year 1 and one (1) Foundation Doctor. The doctor who examined Mr Mangion was a GP trainee year 1.

Asked by the Board whether a GP trainee year 1 is entitled to take medical decisions, the witness replied that these are doctors with an MD Degree. They have followed the foundation course and obtained the full Council warrant. If they were in private practice they can take medical decisions. Asked whether this situation applies also in the structure of the Primary HealthCare, [redacted] answered that: *Dawn ovvjament jafu. Huma jkollhom bħala parti mit-training għandhom GP trainer assenjat ma' kull wieħed minnhom. Jiġifieri GP trainer follows their training one to one over the whole course of the 3 years. Huma dejjem jafu li they consult with their GP trainer jekk insterta li qiegħed xogħol. IL-GP trainers jgħidulhom "Anke jekk ma nkunx qiegħed xogħol ċempilli." Jafu li jistgħu jikkonsultaw ma' ... [tobba} li jkunu l-health centre l-oħrajn u jafu li hemm il-Principal GPs. Jiġifieri jien meta kont fis-sitwazzjoni tagħhom ma kenitx l-ewwel darba li ċempilt Principal GP biex nikkonferma xi ħaġa jew nistaqsi xi ħaġa.*

Regarding Mr Mangion, [redacted] stated that he was not present at the Floriana Health Centre. However, from what [redacted] (the GP trainee who saw the patient) told him and from observing the relevant CCTV footage, he could see that Mr Mangion did not wait in the waiting area of the health centre but was registered and was immediately taken to the treatment room. [redacted] later informed him that: *Jiġifieri per standard procedure, f'każ hekk qabbad l-affarijiet li kellu jqabbadlu bħala monitoring u ħadlu l-history kif hemm miktub hemmhekk, dehrlu li kellu bżonn imur l-emerġenza u ċempel il-112. I cannot see any other way of doing it.*

The witness remarked that documentation at health centres is done via the EPR. He stated that he could not find any record of Mr Mangion on the EPR system. However, [redacted] handed to him a copy of the ticket of referral (ref to Doc TOR1 and TOR2) which he wrote on 27th August 2024. [redacted] told him that, so as not to delay the patient, he decided to take a photo of the referral ticket with the intention that when he would be less busy, he would type all the contents of the referral ticket onto the EPR system. When he tried to do this, his attempt was unsuccessful as in the meantime Mr Mangion unfortunately passed away and the system did not allow him to do so.

Besides presenting Doc TOR1 and TOR2, the witness exhibited the attached Doc GA1 and GA2 which are self-explanatory. Continuing his testimony, [redacted] referred to the fast-tracked referral system which is in operation only from Monday to Friday from 8 a.m. to 4 p.m.:

Issa din għandna proċedura aħna Monday to Friday 8:00 till 4:00 qabel niffeferu pazjent ankejekk ikun akut, jiġifieri jekk ikun akut marid ħafna l-ewwel inċemplu l-112. Imma after that phone għandna a direct line mal-casualty RS jew HST fejn inċemplulu, niddiskutu l-każ u naqblu jekk għandu jiġi bżonn referred l-emeġenza jew le. F'dak il-każ li jkun hemm qbil li jiġi referred l-emerġenza l-pazjent jingħata a different ticket of referral, ċjoè l-istess ticket of referral imma tkun ipprintjata fuq kulur karta oħra li hija pink. Biex fir-reception tal-emerġenza jagħrfu li dan diġà tkellem ma' tabib tal-emeġenza u jiġi fast tracked ukoll. Jiġifieri jiġi m'għajjat lit-tabib ma' min tkellem biex jieħu ħsieb. The whole point kienet li min bħal speċi jkun diġà rah a medical person diġà beda l-proċess li beda jarah xi ħadd u ma nitilfuhx. Għax otherwise joqgħod jistenna, jerġa' jibda jarah in-nurse u dawn l-affarijiet. [...] Issa ovvjament il-proċedura mhix in place after 4 o'clock. So after 4 o'clock it-tabib jagħmel ticket of referral. Issa jekk jidhirlu li l-pazjent għandu bżonn ambulanza kif kien f'dan il-każ iċempel 112 u dak huwa l-kuntatt li sar.[...] So it-tabib li għamel minn kif infurmani mexa mal-proċedura kif kienet available għalih dak il-ħin. Jiġifieri ċempel il-112.

The Board asked the witness whether this service could be extended 24/7 and [redacted] replied:

We are all for it being extended to 24/7. Ovvjament milli nista' nifhem din bdiet, jekk tippermettuli nagħti l-history tagħha din bdiet bħala pilot project sa fejn niftakar jien is-sena li għaddiet u milli nista' nifhem kienet to enhance the collaboration u biex nikkonfermaw bejn Primary health care u l-Emergency Department u biex nikkonfermaw li r-referrals li qed jibagħtu t-tobba tagħna actually referrals li għandhom bżonn imorru l-emerġenza. Meta sar dan il-proġett pilota li sar ġo Paola Health Centre instab li l-clinical judgement bejn tabib tal-health centre u tabib tal-emerġenza they ... together in 99% of the cases u għal bidu kien hemm reżistenza tista' tgħid minn kulħadd għax ħadd, you are into ... another step. Imma serviet ħafna to cement the collaboration between the 2 departments. Wara dak ittieħdet din id-deċiżjoni li dan il-proġett pilota jiġi estiż għall-health centres kollha imma bqajna bl-istess ħinijiet Monday to Friday 8:00 till 4:00. My understanding tas-sitwazzjoni hija li l-emerġenza għandna relazzjoni estremament tajba mal-clinical chair u mad-deputy clinical chair. Hemmhekk nikkollaboraw tajjeb ħafna, ħafna, ħafna u qed nippruvaw insibu metodi kif nikkollaboraw aktar imma milli nista' nifhem at this point in time m'għandux l-HR capability li jkun jista' joffrilna din it-24/7 availability.

21 [redacted], Clinical Chairperson of Emergency Department, MDH. [redacted] is responsible for the clinical side of the ED and directly in charge of the ED doctors. He is also responsible for the ED service; however, nurses and Emergency Ambulance Responders have their own management structures. All ED specialists are themselves responsible for their clinical decisions.

Demise of [redacted]

With every death occurring at the ED, even if expected, the Clinical Chair and the Legal office are informed via email showing the patient's details and whether an autopsy is required, if police are involved, or if the death certificate is going to be issued by the GP. Any unexpected death triggers involvement of the police, as in this case. [redacted] stated that, in the morning following the incident, [redacted] phoned him to inform him about the case. He eventually informed the Medical Director responsible for legal affairs, [redacted]

According to the documented MDH digital data, Mr Stephen Mangion registered at the ED at 20:00 (ref to Doc PF1) and at 20:16 triage was done. The patient was given an ESI of 2.

Nurse duties & availability

Triage nurses are internally trained and have to follow and pass an online course. Triage takes less than 10 mins. 2-3 nurses are performing triage at any one time. On the day, between 20:00 and 21:00, 21 patients registered. These potentially required a total of 210 minutes of triage time.

The number of nurses available is much less than the minimum required. The witness stated:

Biss l-ammont ta' nurses li għandha fid-dipartiment huwa ħafna inqas mill-minimu. Jekk inqasmu n-nurses kollha, il-bieraħ biex joħorġu għall-ambulanzi, għal 800,000 persuna 3 nurses. Kif jista' jkun meta aħna qed inmissu 204 ambulanzi kull jum?

Making reference to Doc PF2, the witness explained that 'presenting complaint' is filled in by the receptionist, who is a non-clinical person and writes what the patient says. This needs to be standardised and is being worked upon.

'Triage complaint' (ref to PF2) is filled in by the triage nurse. A code identified the triage nurse as [redacted].

According to an ECG KPI (ref to Doc PF4), all chest pains are referred for an ECG immediately, which in this case was done at 20:18 and some minutes later a second ECG was taken (right and posterior leads). These are reviewed by the lead consultant to exclude ischaemic causes. The patient is then seen according to the workload.

Making reference to Doc PF1, the witness explained that triage started at around 20:13, triage was completed at 20:16, and there was an additional input at 23:35 when [redacted] scanned the patient's details post-CPR. The witness stressed that the time stamp only indicates when the data is filled.

[redacted] explained that waiting ESI-2 patients wait their turn to be seen; however, if a patient deteriorates e.g. becomes hypotensive, he jumps the queue and is directly seen to.

Elaborating on the cubicle availability, the witness stated that the total number of cubicles is 32, including 3 Resuscitation rooms and 18 cubicles assigned for ESI-2 cases.

Workload

Making reference to Doc PF3, [redacted] provided the number of resuscitation and ESI-2 cases that evening:

19:00 - 20:00 – 2 resuscitation patients and 4 ESI-2 patients

20:00 - 21:00 – 1 resuscitation patient and 14 ESI-2 patients

At 20:00, there were 13 ESI-2 patients still waiting to be seen (ref to Doc PF3).

On the day, the number of patients attending the ED peaked between 20:00 - 21:00, with 21 patients in one hour, of which 14 were ESI-2. Usually, the peak is in the morning hours (ref to Doc PF5). The previous day was also extremely busy with a record of 348 patient registrations causing a backlog of patients.

Resources, work conditions, problems

Junior doctors work a shift system which results in a lower pay package. Consultants work according to job plans and voluntarily work extra afternoon sessions.

The witness explained how resources have to be shared with Gozo ED. One (1) Basic Specialist Trainee (BST) is sent to Gozo on a daily basis and five (5) consultants work 50% of their time in Gozo. Furthermore, sick leave has to be covered.

The doctors are very stretched and overworked and are easily burnt out. Fewer doctors want to specialise in emergency medicine. Doctors are resigning from the department. Social media is not helping.

Suggestions

[redacted] explained that they are currently trying to improve the pay package and improve work-life balance (on shift system, doctors get one weekend off for every eight weekends working).

On the day

There was an Overall Lead consultant who has an administrative role. In Area 3, [redacted], Resident Specialist, was seeing six (6) very sick patients when Mr Mangion collapsed. He was helped by an RMO, not trained in A&E, and 2 FY doctors.

Waiting area

The witness referred to Doc PF7, which is a memo dated October 2022. All ESI-2 patients wait in the clinical area in front of the central desk in front of nurses and not in the waiting area as stated on social media.

Waiting time

Patients cannot know what the waiting time will be because patient arrival and clinical conditions are very dynamic and constantly changing. The waiting time is changing all the time.

The number of patients attending the ED is not only increasing, but the clinical problems are becoming more complex. This results in more time spent with each patient (ref to Doc PF8).

Section B. What CCTV footage of cameras situated at the Floriana Health Centre reveals.

Floriana Health Centre	27th August 2024
Main Door No 5	
19:08:56	Stephen Mangion (SM) seen entering Floriana Health Centre walking from the road accompanied by his friend [redacted].
Main Reception	
19:09:49	SM registering at reception speaking to receptionist and rubbing his chest.
19:10:43	Nurse – [redacted] seen escorting SM & [redacted] into the treatment room from side door near reception.
19:44:16	SM & [redacted] seen leaving the treatment room from same door.
19:45:15	SM seen leaving the health centre while speaking on his mobile. DC left at the same time.

Section C. What CCTV footage of cameras situated at the Emergency Department at Mater Dei Hospital reveals.

Mater Dei Hospital, Emergency Department (ED)	27th August 2024
Screening	Main Door Reception area
19:58:15	SM & [redacted] seen entering the main door leading to the reception of the ED.
Window 4 in	Reception
20:01:47	SM seen registering at reception.
Window 4 out	Reception (time shown is one hour ahead)

21:01:41	SM seen registering at reception.
21:02:37	SM seen touching his back and rubbing his stomach.
21:02:56	SM seen walking away from reception desk.
Waiting Area	
20:05:11	SM & [redacted] seen sitting down at the main reception area. SM seen talking on the mobile while sitting relaxed with his legs crossed.
20:12:38	SM called into Triage room A.
Area 1	Inside near cubicle areas
20:16:25	SM seen entering Area 1 accompanied by triage nurse [redacted] & [redacted]. They are escorted to the ECG room.
Area 1 desk Minutes on this CCTV camera were not clearly seen since one digit was obscured by a black monitor screen in the background.	Showing desk in front of seating chair area for ESI-2 patients. These were the chairs SM & [redacted] sat on while waiting to be seen in a cubicle.
20:1--: 52	SM seen entering the ECG room.
20:2--:21	[redacted] seen waiting outside ECG room.
20:2--:42	[redacted] (ECG technician) seen showing the ECG to [redacted] (lead doctor) and discussing with him.
20:2--:02	[redacted] is seen calling SM again to the ECG room for a repeat ECG.
20:3--:11	[redacted] shows ECG to [redacted] SM goes to sit on the chairs in front of the desk.
21:2--:56	SM seen standing up talking on mobile.
21:3--:28	[redacted] seen walking away towards right side corridor talking on mobile.
21:3--52	[redacted], SM's brother, arrives accompanied by DC.

21:3—24	SM seen talking to [redacted] and rubbing the right back side of his brother.
21:3—26	SM stands up to walk a few steps and [redacted] is seen talking on his mobile.
21:40:27	SM stands up to speak to a passing Police Officer who seemed to be a friend of his.
21:4--:43	[redacted] leaving
21:4--:58	SM seen standing up, touching his chest and stretching his arms backwards and immediately sitting down again.
21:49:32	SM seen standing up walking up and down in front of desk for a few seconds and sitting down again.
22:00:08	Police Officer walking out again stops to speak to SM. The Police Officer goes to speak to a male staff at the desk and walks away to the right corridor.
22:02:07	Police Officer returns, says a few words to SM and leaves again.
22:02:48	SM stands up for a few seconds and sits down again.
22:04:45	SM seen standing up, holding his back and walking towards Area 3 (right corridor), turns back and walks till end of desk on left.
22:04:54	SM walks again towards the right and back again to sit down.
22:07	SM walks towards right corridor.
Area 2	
22:07	SM entering toilet and leaving soon after.
Area 1 desk	
22:09	SM returns
22:13:20	SM stands up, rubs back and chest. Seems to be in pain. Approaches the desk to speak to a non-ED doctor on site.
22:13:25	SM goes to nurse at desk. She is seen indicating towards Area 3.
Area 2	

22:15:50	SM walking towards Area 3.
Area 3	
22:16	SM speaks to nurse at desk of Area 3. He is seen rubbing his chest and back. Nurse seen checking papers at desk.
22:17	SM seen talking to another nurse and rubbing his chest and back. Nurse walks away and SM follows her.
Area 2	
22:17:30	SM followed nurse to the room in front of the toilet in Area 2. Nurse came out and gave him pills.
Area 1 desk	
22:18	SM seen taking tablets and sitting down one chair away from his brother.
22:20	Man sitting between SM and [redacted] is called into a cubicle, leaving the chair empty.
22:22	[redacted] is seen moving quickly towards his brother and staff rushing towards them. SM is seen lying on the floor and nurses and doctors and nursing aids seem to be performing CPR.
Ambulance Bay	
22:26:58	SM seen being wheeled into Resus room 1 on a stretcher while staff are performing CPR.
22:27	[redacted] seen entering Resus room followed soon after by other staff and ECG technician.

Section D. An examination of the Inquiry terms of reference in the light of the three above mentioned sections.

(a) The names and grades of the caring professionals who attended Mr Mangion at Floriana Health Centre

The Board noted that, before attending at Floriana Health Centre (FHC), Mr Mangion phoned the Call Centre at the Client Support Services, Siġġiewi to seek medical advice, as shown below.

Time	Location	Name	Grade
18.46	Client Support Services Siġġiewi	[redacted]	Senior Health Care Worker
18.47	Telemedicine Consultation – Siġġiewi	[redacted]	Senior General Practitioner
19.09	FHC – Reception	[redacted]	G4S Clerk
19.11	FHC – Treatment Room	[redacted]	General Practitioner Trainee
19.11	FHC – Treatment Room	[redacted]	Senior Staff Nurse
19.11	FHC – Treatment Room	[redacted]	Senior Staff Nurse

(b) Mr Mangion's complaints, general condition, vital parameters, examination, investigations and provisional diagnosis at Floriana Health Centre.

Call Centre Siġġiewi (Ref to Doc GA1):

18:47: Telephone consultation done by [redacted]

Caller complained of burning central chest pain since the morning. Had Omeprazole with some improvement. However, the pain was then

reported to be worse with movements and not burning in nature. No other features reported.

Floriana Health Centre:

19:09: Registration at FHC – [redacted] registered the patient on EPR. Mr Mangion was escorted immediately to the treatment room by [redacted], senior staff nurse who was on night duty at FHC treatment room.

According to the testimony by [redacted], he was informed by the receptionist that Mr Mangion was complaining of shortness of breath (SOB). This was the reason he was immediately seen in the treatment room. He was accompanied by [redacted], a very close friend of Mr Mangion and a nurse by profession. They were led into a cubicle. According to [redacted]'s testimony, the patient did not seem distressed or out of breath. At first Mr Mangion did not want to lie down on the coach when asked to but he was convinced to do so. The nurse did not see any distress in the patient. A pulse oximeter was attached to his finger so that the saturation of oxygen in the blood could be determined. The result was 97% on room air (RA) (ref to Doc TOR2). This was considered normal. [redacted] recorded that the patient had informed him that he was diabetic, although this was not documented on the ticket of referral written by [redacted] (General Practitioner trainee who was on duty at the time in the treatment room and who saw the patient).

19:11: Seen by [redacted] (Ref to Doc TOR1 and TOR2):

[redacted] reported that the patient was a 55-year-old male, known case of hypertension, dyslipidaemia, and a smoker. On Valsartan 160mg daily, Simvastatin 20mg nocte, and Omeprazole 20mg daily; however, the patient was uncompliant to treatment.

Mr Mangion complained of compressive chest pain that started that morning, associated with nausea but no vomiting, no headache, no dizziness, no acute visual disturbance, and no shortness of breath. The patient took two (2) Omeprazole 20mg and his pain persisted.

On examination: Blood pressure 217/118, repeated blood pressure 214/120, pulse 62bpm, temperature 37.2 degrees Celsius, oxygen saturation 97% on room air.

Cardiovascular system: S1 + S2 + 0. Chest: clear. Abdomen: soft not tender, no guarding/ rigidity. Lower limbs: no abnormality detected.

A 3-lead ECG was done and the strip was attached to the ticket of referral and given to Mr Mangion to take to the ED at Mater Dei Hospital.

The impression was of chest pain in a high-risk patient with a systolic blood pressure over 200mmHg.

(c) Any treatment administered or advised.

Call Centre Siġġiewi (Ref to Doc GA1):

[redacted] recommended that the patient goes to the health centre. The patient refused referral to health centre. [redacted] advised the patient to take Solpadeine.

Floriana Health Centre:

No active treatment was administered but he was monitored in the treatment room.

[redacted] requested that the patient be put on monitor. Since the monitor available was being used on another patient in the same room, this was transferred for use on Mr Mangion by [redacted] senior staff nurse who was attending to the other patient. She also assisted [redacted] in fixing the leads onto Mr Mangion's chest. According to the testimony of [redacted], the patient was never in distress and he was also joking with them while the leads were being applied.

According to the testimony of [redacted], [redacted] did not request a 12-lead ECG. Although this machine is available on premises in the ECG room under lock and key and is available on request by a doctor, from [redacted]

[redacted]s testimony it seemed that he was not aware that he could have requested the use of this machine at this time of day.

Mr Mangion was subsequently referred by [redacted] to the ED at Mater Dei Hospital.

(d) Onward referral and transfer arrangements suggested from primary to secondary care (Mater Dei Hospital).

[redacted] called 112 at 19:39:22 requesting an ambulance. The call was transferred to the ED ambulance control room and was received by [redacted], Senior Staff Nurse. According to protocol, a patient with chest pain, no shortness of breath and high blood pressure is classified as Category Orange – ambulance with nurse in attendance. [redacted] informed the doctor at FHC that an ambulance was available but no nurse was immediately available and advised to keep the patient monitored at FHC under his supervision until an ambulance could be dispatched. The call was registered on CAD at 19:39:41 and documented as: no nurses available for immediate dispatch. In his testimony, [redacted] explained that the nurses allocated to assist on ambulance calls were occupied tending to patients at that time.

[redacted], Mr Mangion's friend and a nurse by profession, offered to drive the patient himself to the ED since Mr Mangion seemed reluctant to go to hospital. After giving it some thought, [redacted] did not object. At 19:45:13, [redacted] called 112 to cancel the ambulance request. The call was transferred to the ED control room and was received by [redacted] Staff Nurse. The request to cancel the ambulance was registered on CAD at 19:45:32 and documented as: Reason: 9. Aborted or Cancelled by caller. Note: Will use own transport.

According to [redacted] within 20 minutes Mr Mangion had already arrived at MDH and had been triaged. This was supported by CCTV footage and CPAS evidence confirming that they left FHC at 19:47 and were registered at the ED reception at 20:00 by [redacted] (clerk/receptionist at ED).

(e) Whether Mr Mangion's onward referral was discussed with the secondary care team.

According to the testimony of [redacted], Deputy Clinical Chairperson of Primary HealthCare, the "Fast Track Service" (when the patient's onward referral from Primary HealthCare is discussed with the secondary care team) is only in function from Monday to Friday from 8:00 a.m. until 4:00 p.m., where a direct telephone line is available to contact the Emergency Resident Specialist (RS) or Higher Specialist Trainee (HST). At other times, there will be no assigned decision-making doctor to take calls from the Primary HealthCare centres. Since Mr Mangion's onward referral was made after 16:00, his case was not discussed with the secondary care team.

(f) The actual mode and nature of transfer (if different from suggested) from Floriana Health Centre to Mater Dei Hospital.

As explained above, [redacted] offered to drive Mr Mangion to MDH.

(g) The names and grades of the caring professionals who attended Mr Mangion at the Emergency Department in Mater Dei Hospital.

Time	Location	Name	Grade/Relation
19:39:22	ED ambulance control room	[redacted]	Senior Staff Nurse
19:45:32	ED ambulance control room	[redacted]	Staff Nurse
20:00	ED reception	[redacted]	Clerk/Receptionist
20:16 end of triage	Triage room A	[redacted]	Triage Staff Nurse

20:17	Clinical Area 1 – ECG room	[redacted]	ECG Technician
20:20	Clinical Area 1	[redacted]	Consultant ED & Lead Doctor
20:25	Clinical Area 1 – ECG room	[redacted]	ECG Technician
20:30	Clinical Area 1	[redacted]	Consultant ED & Lead Doctor
22:15	Area 3	[redacted]	Area 3 Nurse
22:15	Area 3	[redacted]	Area 3 Nurse
22:30	Clinical Area 1	[redacted]	Charge Nurse
22:30	Clinical Area 1 & Resus room 1	[redacted]	RS ED
Circa 22:30	Resus room 1	[redacted]	Consultant ED & Lead Doctor
Circa 22:30	Resus room 1	[redacted]	ECG Technician
Circa 22:40	Resus room 1	[redacted]	Cardiologist

(h) Mr Mangion's complaints, general condition, vital parameters, examination, investigations and provisional diagnosis at the Emergency Department in Mater Dei Hospital.

At the ED reception, Mr Mangion was registered as presenting with 'compressive chest pain' (ref to Doc PF1).

The triage nurse documented (ref to Doc PF2) that the patient complained of chest pain since the morning, worse on lying down. He denied nausea and vomiting.

On examination at triage: Blood pressure 227/107, pulse 75bpm, respiratory rate 17, oxygen saturation 98% on air.

According to triage nurse [redacted] Mr Mangion was alert and communicative and he was classified as an ESI-2 (patients who are high risk but do not need immediate attention due to life threatening

conditions). Given that Mr Mangion presented with chest pain and was categorised as ESI-2, an ECG was requested as per MDH ED protocol (ref to Doc PF4).

The ECG was reviewed by [redacted], who noted a possible high take-off. An extended ECG with right-sided and posterior leads was requested. No ECG signs of acute myocardial infarction were present.

(i) Any treatment administered or advised.

22.20: Paracetamol x2 tablets (as per CCTV footage and triage sheet documentation – ref to Doc PF2)

(j) Whether there was any undue delay in time to triage and time to first senior medical contact.

20:16: Triage was terminated in Triage room A after Mr Mangion had been registered at the ED reception at 20:00. Immediately after, he was escorted in the company of his friend [redacted] to Clinical Area 1. The ECG technician called him in to the ECG room located in Clinical Area 1 and an ECG was recorded at 20:19.

20:20: The ECG technician showed the printed ECG to [redacted] (ref to Doc PF4) who was at the desk in Area 1 which is about 2 meters away/ in front of the seating area in Clinical Area 1 where Mr Mangion and his friend were asked to sit.

20:22: [redacted] requested the ECG technician to record another ECG with the right and posterior leads. Mr Mangion was asked to go back to the ECG room for this. ECG was signed by [redacted].

20:30: [redacted] reviewed the second ECG and signed it. There were no signs of any ST elevations.

In view of the above, the Board concluded that there was no delay between registration and triage and for an ECG to be taken following the triage. There was also no delay in the review of the ECGs by the lead consultant. However, since no cubicles were available, he could not be provided with immediate clinical care and was made to wait for about two hours in the clinical area where he eventually collapsed. Resuscitation was prompt and professionally done.

(k) The locations within Mater Dei Hospital where triage, observation, assessment and treatment were delivered.

- Triage was done in Triage room A – Mr Mangion was called in from the main waiting area near the ED reception and entered from Door A into the examination cubicle in Triage room A. From this room, he exited via a door leading to Area 1, where the Clinical Area 1 seating is located in front of the central desk in this area.
- The ECG room is also located in Area 1. Mr Mangion walked to this room twice to have two ECG recordings done.
- Mr Mangion and his friend [redacted] were asked to sit on the chairs available in Clinical Area 1 where patients who are classified as ESI-2 are asked to wait until a cubicle is available for the doctor to see them.
- When Mr Mangion arrested, he was taken to Resus room 1.

(l) To determine whether any person knew or ought to have known, or caused an immediate risk to Mr Mangion's life.

The history provided by Mr Mangion was extremely fragmented from the onset; he first complained of epigastric pain at home, later he complained of pain related to movement to the GP at the Telemedicine centre, then

he complained of chest pain to the GP trainee at the Floriana Health Centre and at the ED, but these complaints were never all presented together to any one particular healthcare professional. Furthermore, Mr Mangion was very afraid of doctors and was reluctant to seek medical attention, even at Floriana Health Centre. According to CCTV footage and the photo provided to the Board by [redacted] (ref to Doc DC1), he was not extremely distressed, he was not pale or sweaty, he was walking around, talking, and using his mobile phone. It was only in the last 15 minutes before his collapse that he complained that his pain was recurring and requested analgesia. All ECGs were not indicative of any acute cardiac condition. This scenario made it very difficult to establish a correct diagnosis. This evidence was provided by all the different doctors/ nurses who attended him.

The Board concluded that no person knew or ought to have known, or caused an immediate risk to Mr Mangion's life. On the contrary, each healthcare provider did his best under the circumstances.

(m) To determine whether any person failed to take measures within the scope of his/her powers which, judged reasonably, s/he might have been expected to take in order to avoid that risk.

The Board concluded that no person failed to take measures within the scope of his/her powers which, judged reasonably, s/he might have been expected to take in order to avoid that risk. However, it seemed to the Board that, with the present system and available facilities, during exceptionally busy periods ESI-2 patients may have to wait for a long time for a cubicle, during which time they may end up not being adequately clinically reassessed.

(n) To determine whether the management structures at Floriana Health Centre and Mater Dei Hospital have fulfilled and are fulfilling their obligation to take preventive operational measures to protect patients.

Primary HealthCare

The Board notes that:

- The telemedicine service was very efficient. The doctor was easily available, gave appropriate advice, and communicated in a professional manner.
- At Floriana Health Centre, the patient was seen to immediately given his presenting complaint.
- The patient was correctly assessed and managed by the staff.

However, the Board would like to point out that:

- On the day, only doctors in training were seeing patients at Floriana Health Centre at the time when the patient presented.
- These doctors had no easy access to take advice from Specialists in Family Medicine.
- The fast-track system was not operational at the time of presentation of Mr Mangion to the health centre (around 7 p.m.).
- The Board was informed that, at this time, 12-lead ECG machines are kept under lock and key and are only made available if requested by the doctor. It is not clear that [redacted] was aware of this.

Mater Dei Hospital

The Board notes that:

- The ambulance control room service functioned well, giving appropriate advice.
- At ED, the patient was registered immediately.
- The patient was rapidly and correctly triaged. He was appropriately categorised as ESI-2.
- An ECG was carried out immediately, as per protocol.

- The ECG technician immediately showed the ECG to the overall lead doctor, as per protocol, who requested an extended ECG tracing. This was immediately done.
- The patient was not left in the main waiting area and was immediately transferred to the Clinical Area of Area 1 to be kept under supervision.
- Allocation of staff was done adequately notwithstanding the workload in relation to the available staff.
- Resuscitation was timely and correctly carried out according to Advanced Life Support (ALS) guidelines. Support staff was available and acted accordingly.

<u>However, the Board would like to point out that</u>:

- The ambulance service was extremely busy and would have been more efficient if qualified nurses were more easily available.
- These ambulance nurses are taken from the overall pool of nursing staff in the ED.
- Human resources were not sufficient to keep up with the exceptional workload on the day. Only one (1) senior decision maker was available in Area 3, where the patient was allocated. At the time, he had to deal with six (6) critically ill patients, all requiring constant medical attention.
- Towards the end of the two hours waiting in the clinical area, the patient was seen restless and in pain. He consulted with the nurses regarding his waiting time. He was given analgesia. This also called for clinical reassessment.
- The number of cubicles was not sufficient to keep up efficiently with the patient load on the day.
- The ED is overloaded with cases on a daily basis, resulting in long waiting times for patients and in excess stress on the healthcare professionals.
- The work environment is not attracting and retaining healthcare professionals, both doctors and nurses. This has to be addressed from

all aspects, such as work schedule, pay structures, and family-friendly measures.

Additionally, the Board noted that different systems of digital documentation are in place and access to these systems is not uniform across the whole health system. For example, the documentation system used in the primary health service (EPR) is not accessible by the ED doctors.

(o) To determine whether nursing and medical case notes are properly and regularly documented and whether in the case under reference this procedure was strictly adhered to and observed.

The Board noted that:

- Primary HealthCare and MDH do not use the same documentation systems.
- EPR documentation cannot be accessed by MDH healthcare providers.
- No EPR documentation was found pertaining to Mr Mangion's visit at Floriana Health Centre. [redacted] stated that he intended to do this at a later time in order not to delay the care provided to the other patients present at the health centre at the time.
- Communication between Primary HealthCare and MDH is paper-based via a ticket of referral (ref to Doc TOR1 and TOR2), which was available in this case.
- Within the ED, both digital and paper-based documentation is in place.
- None of the ECGs carried out on Mr Mangion were booked and only one was uploaded onto the patient's dashboard.

It must be stressed that all the above did not affect in any way the quality of care that Mr Mangion received.

The Board also noted that all available documentation was of good quality.

(p) To determine whether standard operational procedures are in place and whether members of staff are aware of what procedures to follow in similar circumstances.

The Board noted that some SOPs are not always being timely updated and do not always reflect the present reality regarding workload, personnel, work environment, and current practices.

The Board noted that all healthcare professionals involved were aware of the correct pathways or procedures to follow.

(q) To determine whether in the carrying out of their duties and for the case under reference, members of staff failed to act in a manner that reflects the values promoted in the code of Ethics in Schedule 1 of the Public Administration Act (Cap 595 of the Laws of Malta) which serves amongst others, as an ethical benchmark.

The Board is of the opinion that members of staff acted in a manner that reflects the values promoted in the code of Ethics in Schedule 1 of the Public Administration Act (Cap 595 of the Laws of Malta) which serves amongst others, as an ethical benchmark.

(r) To present any formal or any informal recommendations for due consideration by the Minister.

Kindly refer to Section E.

Section E. A list of recommendations for due consideration by the Honourable Minister for Health and Active Ageing.

1. The Board noted the lack of continuity in documentation between Primary HealthCare and Mater Dei Hospital, and between professions within the same institution and department. The Board also noted an inconsistency in the mode of documentation in terms of hand-written versus electronic documentation. The Board recommends having a standard documentation system for doctors, nurses, and other healthcare professionals across all healthcare settings.

2. The Board noted a shortcoming regarding communication between Primary HealthCare and Mater Dei Hospital after 4 p.m. during weekdays and during the weekend when the fast-track system is not operational. Although at present all doctors can discuss referrals to the ED at any time with the lead decision-maker at the ED, the Board recommends officially extending the fast-track system to cover a 24-hour period, seven (7) days a week.

3. [redacted] was aware that this was a high-risk patient: *"imp chest pain in high risk patient. Systolic > 200"*. It would be good practice for junior trainees (like [redacted] who is a GP trainee 1, which is equivalent to a BST1 who is a non-decision maker at MDH) to be encouraged to discuss high-risk patients with their seniors, especially when an ambulance is not immediately available to transfer the patient to the ED as happened in this particular case. [redacted] said that there were two (2) Principal General Practitioners ([redacted] and [redacted]) on-call that evening for all health centres.

4. To the Board, it appeared that there is no protocol/ memo within Primary HealthCare to guide doctors in situations where the required ambulance is not immediately available. The Board recommends that there should be a protocol/ memo in place in this regard. If the patient/ guardian refuses to follow the clinical advice, the patient and/ or the guardian where applicable should assume responsibility and this should be documented by signing a relevant document.

5. The Board noted that all Primary HealthCare centres have an ECG machine whereby 12-lead ECGs can be carried out by appointment. Presently, when

no ECG service is available, this machine is kept under lock and key in the ECG room and it is somewhat of a lengthy process to avail of it. The Board recommends the **timely** availability of a 12-lead ECG within all Primary HealthCare centres at all times and that all healthcare providers should be made aware of this.

6. The Board recommends the availability of point of care (POC) blood tests (e.g. troponin, D-dimer) within Primary HealthCare to further help stratify acuity.

7. The Board recommends that, for high-risk patients identified at the triage stage, a decision-maker makes first medical contact at this point with a view to initiate investigations while the patient is waiting to be seen. Currently only an ECG is being taken when indicated (e.g. for ESI-2 chest pain patients).

8. During waiting time, the patient would have benefitted from reassessment of his circulatory state, with monitoring of parameters and clinical signs. Pain relief and blood-pressure lowering treatment could have been considered. The fact that no cubicle was available should not have excluded the patient from receiving such basic clinical observations and possible initiation of treatment.

9. The Board recommends that during very busy hours, a qualified person should be specifically allocated to go round the Clinical Area 1 seating area and reassess whether the patients' needs have changed. This information would then be relayed to the lead nurse/ lead doctor.

10. With reference to the memos presented as documents PF4 and PF7, the Board recommends adding certain parameters to the ESI assessment, for example, chest pain patients who are expected to wait for a long time get repeated ECGs and repeated assessment of haemodynamic/ circulatory status, such as blood pressure, heart rate, and oxygen saturation. If a prolonged wait is expected, blood tests for cardiac enzymes should be taken on arrival. This is in line with international cardiology guidelines and is probably what happens in the ED from Monday to Friday between 8 a.m. and 4 p.m. when the fast-track system would be operational.

11. Document PF4 is a memo which explains the procedure for ECG recording in patients who are classified as ESI-2 and present with chest pain, palpitations, or new-onset arrythmias. This memo is dated 2nd August

2022. The Board recommends that the fifth point, which reads "*In case of normal ECG the disposition decision is taken between lead nurse and lead doctor according to work load and available cubicles*", should be revised. Patients should be managed according to their clinical risk as set by international guidelines and not based on ED bed and staff availability. This is clearly set out in the ESI handbook (ref to Doc KB1) on pages v and 7. This particularly applies to chest pain, even with a normal ECG.

12. The Board noted that not all ECGs carried out on Mr Mangion were uploaded onto the patient's dashboard. The Board emphasises the importance of booking and uploading all investigation results, including ECGs requested at triage stage. This will ensure that no investigation results are misplaced/ lost.

13. With the present ambulance and ED workload, one should consider increasing the nursing compliment and setting up a dedicated ambulance nurses section (possibly using a rotation system) to avoid depleting the ED pool from nursing personnel. This would help to keep the waiting time for orange-coded ambulances (nurse-accompanied ambulances) to a minimum.

14. The Board noted that the long waiting time between triage and medical contact was primarily due to the unavailability of a cubicle and limited human resources. The Board fully supports the Ministerial proposal for the expansion of the ED services as noted in the MDH Action Plan.

15. The Board recommends prioritising the attraction and retention of ED personnel through various means, such as improving the work environment, family-friendly measures, etc.

16. Currently, once patients have been worked up at the ED (A&E ready), they have to wait until a bed is made available in the wards, thus clogging and crowding the ED. The Board recommends having a designated area or ward where such patients can be transferred to allow timely assessment of new patients. These areas should not be administered by the ED personnel.

17. The Board noted that some SOPs are not always being updated and do not always reflect the present reality regarding workload, personnel, work environment, and current practices. The Board recommends that the

relevant departments should regularly review and update all SOPs in place.

18. From CCTV footage pertaining to the ED at Mater Dei Hospital (Area 1 desk), the Board noted that the footage provided did not **fully** capture the seating area within the Clinical Area 1 where the patient was seated and being observed. The Board recommends that this clinical area for patients assigned ESI-2 should be **fully** captured, even for record purposes.

19. The Board noted that molecular autopsy for genetics was recommended by the cardiologist attempting pericardiocentesis in view of a documented family history of sudden cardiac death (SCD). Unfortunately, this advice was not taken up by the pathologists performing the autopsy since this history was not adequately emphasised to them and because it was not directly related to the cause of death. Such information would be of clinical significance to the direct patient's relatives and possibly prevent further sudden cardiac deaths.

20. Currently, Magisterial autopsy findings can be made available to the family after application to the Attorney General, which can be a cumbersome process to the family. The conclusions of all autopsy findings should be made easily available to the immediate family, barring legal concerns.

Section F. Conclusion

After examining all evidence, including the autopsy findings, the Board is of the strong opinion that no single individual was responsible for the demise of Mr Stephen Mangion. Because of the complex and extensive nature of the underlying pathology, namely the extensive aortic dissection, nothing could have been done to avoid the demise of Mr Mangion. The dissection was probably already established when Mr Mangion felt the abdominal pain at 4 a.m. and had definitely extended to the aortic root by the time he presented to the health centre at around 7:10 p.m. complaining of chest pain. Controlling his blood pressure at such a late stage when the dissection was already so extensive would, in great probability, not have helped him at all and the final outcome unavoidable.

In most modern medical services, no facilities or expertise are available to surgically intervene on **extensive** aortic dissections in the acute phase. No such facilities exist in Malta.

The Board unfortunately notes that Mr Mangion did not take good care of himself. He was a smoker and was non-compliant to treatment for hypertension and hypercholesterolaemia, factors which probably aggravated his condition.

Long waiting times at the ED would be detrimental to any patient, especially those with chest pain secondary to ischaemic heart disease. However, in the case of Mr Mangion, it did not make any difference to his demise since the process of aortic dissection was probably occurring since 4 a.m. and the pericardial involvement happened suddenly at the moment of collapse. With this in mind, the Board feels that the service needs to improve and respectfully puts forward the above recommendations.

Document R1: List of Witnesses heard

Name	ID	Role
[redacted]	[redacted]	Senior Health Care Worker, Primary HealthCare
		Senior General Practitioner, Primary HealthCare
		Clerk, Primary HealthCare
		Senior Staff Nurse, Primary HealthCare
		Senior Staff Nurse, Primary HealthCare
		General Practitioner Trainee, Primary HealthCare
		Senior Staff Nurse, Emergency Department Mater Dei Hospital
		Nurse, Emergency Department Mater Dei Hospital
		Friend of the deceased
		Brother of the deceased
		Nurse, Emergency Department Mater Dei Hospital
		ECG technician, Mater Dei Hospital
		Charge nurse, Emergency Department Mater Dei Hospital
		Nurse, Emergency Department Mater Dei Hospital
		Nurse, Emergency Department Mater Dei Hospital
		Consultant & Lead Doctor, Emergency Department Mater Dei Hospital
		Resident Specialist, Emergency Department Mater Dei Hospital
		Resident Specialist in Cardiology, Mater Dei Hospital
		Specialist in Pathology, Mater Dei Hospital
		Specialist in Pathology, Mater Dei Hospital
		Deputy Clinical Chairperson, Primary HealthCare
		Clinical Chairperson, Emergency Department Mater Dei Hospital

Document R2: List of Documents

Reference	Document
	Oaths taken by the Chairperson and Members of the Board (x3)
	Confirmation of transfer of CCTV footage from Primary HealthCare to the Inquiry Board
	Confirmation of transfer of CCTV footage from Mater Dei Hospital to the Inquiry Board
DC1	Photo (selfie) of Mr Mangion (left) and [redacted] (right) taken on 27/08/2024 in Area 1 of the Emergency Department of Mater Dei Hospital
NC1	Procedures to follow for ECG requests in the Emergency Department
NC2	Email circulated by the Clinical Chairperson of the Emergency Department with instructions on the online ECG request procedure
NC3	Email circulated by the Principal ECG Technician making reference to the online ECG request procedure at the Emergency Department
KB31082401	Copy of the original ECG done on Mr Mangion on 27/08/2024 at 20:19:59
KB31082402	Copy of the original ECG done on Mr Mangion on 27/08/2024 at 20:28:27
KB1	Emergency Severity Index (ESI) Handbook Fifth Edition
KB2	Documentation on iSoft by [redacted] and [redacted]
KB3	Timeline of case and Emergency Department statistics for 27/08/2024
KB4	Copy of presentation delivered by the Association of Emergency Physicians of Malta (AEPM) to the Health Ministry on the current situation within the Emergency Department in comparison with international targets
JM1	Sketch of the layout of the Emergency Department - Areas 1, 2, and 3
DP/TBB	Sketch of the aorta and the heart with tamponade
TOR1	Ticket of Referral to the Emergency Department done by [redacted] - front page
TOR2	Ticket of Referral to the Emergency Department done by [redacted] - back page
GA1	EPR note done by [redacted] reflecting the telephone consultation held with Mr Stephen Mangion
GA2	Timeline and list of caring professionals from Primary HealthCare who were involved in the case
GA3	Email communication with the Deputy Clinical Chairperson of Primary HealthCare on the availability of ECG within health centres
PF1	CPAS record of registration of the deceased at the Emergency Department of MDH on 27/08/2024
PF2	Emergency Department triage sheet of the deceased (A&E No. 49661561)
PF3	The ED department statistics for 27/08/2024
PF4	Memo on 'Triage to ECG time' KPI
PF5	Statistics on number of patients (ESI 1-5) presenting to the Emergency Department per hour

PF6	Number of registered ESI 1/2 patients and number of decision-making doctors assigned for ESI 1/2s between 16:00 - 00:00hrs on 27/08/2024
PF7	Memo on 'ESI 2 and vulnerable patients'
PF8	Email thread on the proposal and justifications for the improvement of medical recruitment and retention in the Emergency Department
PF9	ECG done on Mr Mangion on 27-Aug-2024 at 20:19:59 as seen on Patient Dashboard
PF10	Plan of the Emergency Department of Mater Dei Hospital
	Transcripts of witnesses' testimonies (in the same order as per Doc R1)