# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

**RECORD OF INVESTIGATION INTO DEATH (WITHOUT INQUEST)**

*Coroners Act 1995*
*Coroners Rules 2006*
*Rule 11*

I, Rod Chandler, Coroner, having investigated the death of Barry Lindsay TETLEY

**FIND THAT**

(a) The identity of the deceased is Barry Lindsay Tetley;

(b) Mr Tetley died on 1 April 2013 at the Royal Hobart Hospital ('the Royal') in Hobart;

(c) Mr Tetley was born at Leeds in England on 24 April 1940 and was aged 72 years;

(d) Mr Tetley was a divorcee and a retired school teacher; and

(e) Mr Tetley died of sepsis of undetermined source. Possibilities include pneumonia or a spinal epidural abscess.

**CIRCUMSTANCES SURROUNDING THE DEATH**

Mr Tetley resided alone at Boomer Bay. His son and former wife are both resident in Western Australia. He enjoyed good health and was physically active.

In mid-March 2013 Mr Tetley was manually moving a heavy barbeque when he experienced left-sided lower back pain. He initially consulted an osteopath and was then referred to his general practitioner. On 27 March he had an x-ray of his lumbosacral spine but was unaware of the results on 31 March. On that day he called for an ambulance to attend him at his home because of back pain. The ambulance officers recorded that Mr Tetley's appetite was low which he attributed to his back pain. He was using crutches to walk. He was conveyed to the Royal.

In the Royal's Emergency Department ('ED') nursing staff recorded Mr Tetley's temperature at 37.7 degrees centigrade, his blood pressure was 133/74, a heart rate of 64, and oxygen of 98% on room air. It was noted by the attending intern that Mr Tetley described sharp and stabbing pain localised to the left L4 sacroiliac joint area with some radiation into his left buttock. It was also noted that Mr Tetley was unable to weight bear without the use of crutches and his activities of daily living were being severely impeded. Mr Tetley also described trouble swallowing and needing fluid to assist with washing down solid foods. He was experiencing pain in the night and occasionally felt "*hot and cold.*" The intern recorded Mr Tetley's temperature at 37.9

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degrees centigrade. Blood tests were ordered as was a lumbar spine x-ray. The x-ray did not reveal any bony abnormalities. The full blood count showed a high white blood cell count with a neutrophilia. Biochemistry revealed a low sodium level (134 mmol/L), a low albumin level (27g/L), an elevated alkaline phosphatase (ALP) (160 iu/l), and the C reactive protein ('CRP') was elevated at 77.9mg/l.

Mr Tetley was treated with analgesics. It is recorded that the intern discussed the case with an unidentified but presumably more senior doctor and a plan was formulated to admit Mr Tetley to the Short Stay Unit ('SSU') overnight and to decrease his analgesia to a level which would allow him to mobilise without being partially sedated and a falls risk. He was transferred to the SSU in the mid afternoon. At 10.00pm his blood pressure was stated to be *"slightly low."*

At 6.30am on 1 April Mr Tetley's blood pressure was recorded at 98/59mmHG. He was reviewed by the Emergency Department Registrar and it was noted that Mr Tetley was feeling much better and his pain was controlled. Any clinical review of Mr Tetley undertaken at this time was not recorded. He was discharged that morning at about 10.15am and left the hospital with a friend, Mr Dragan Minic. They went to Mr Minic's home at West Hobart.

Shortly after his discharge Mr Tetley developed chest pain and shortness of breath. At 11.05am an ambulance was called. Paramedics found Mr Tetley sitting on a flight of stairs and being supported by friends. He was described as appearing pale and in respiratory distress. He was placed in the ambulance. At this point his blood pressure was unrecordable and his heart rate was 120. His oxygen saturation rate was 78% and his respiratory rate was 24. He was given oxygen. His heart rate began to slow, his conscious state decreased and he was in cardiac arrest. He was intubated by the paramedics, ventilated and CPR commenced. He was then urgently transported to the Royal's ED.

Resuscitation efforts were maintained in the ED and Mr Tetley appeared to stabilise. However, he remained critically unwell and was transferred to the Intensive Care Unit. Late that evening his condition deteriorated further and he had another cardiac arrest. He could not be resuscitated despite active efforts. He died at 11.20pm.

**INVESTIGATION**

Forensic Pathologist, Dr Donald Ritchie, undertook a post-mortem examination. Dr Ritchie described the cause of death in these terms:

> *"The cause of death of this 72 year old man, Barry Lindsay Tetley, was probable sepsis complicating community acquired pneumonia (streptococcus digalactiae). A significant complicating factor was perimortem aspiration pneumonia. Mr Tetley was seen at the Royal Hobart Hospital where he had complaints of back pain. He was evaluated overnight and released. Later in the day he developed acute chest pain and collapsed. He was admitted to the Royal Hobart Hospital Intensive Care Unit where aggressive efforts to save his life were unsuccessful. Cultures of blood obtained during readmission grew streptococcus digalactiae, a B-haemolytic streptococcus with infectious profile similar to Streptococcus pyogenes.*
> *The autopsy revealed a well developed, well nourished elderly Caucasion with markedly heavy, congested lungs with palpable consolidation that microscopically had marked acute pneumonia and apparent aspiration pneumonia superimposed. There was no evidence of significant heart disease. Back pain is a well recognised if atypical presenting symptom of community acquired pneumonia."*

The investigation has also included a review of Mr Tetley's hospital records undertaken by Research Nurse, Ms Libby Newman and an assessment of Mr Tetley's management and treatment at the Royal carried out by Dr A J Bell as the Coroner's medical adviser. Dr Bell has reported that in his opinion:

- Mr Tetley's clinical history and the results of his examination undertaken at the Royal should have raised concerns that his back pain was not the 'standard mechanical back pain.' He points to the pain being focal, severe and present at rest. Too, there were symptoms of hot and cold feelings, loss of appetite, decreased oral intake and a degree of dysphasia. Also there was localised tenderness at the site of the pain suggestive of infection or cancer.

- On his initial presentation at the ED Mr Tetley clearly had a fever. His blood count was suggestive of infection as the CRP was elevated and the serum albumin and serum sodium levels were both diminished. The elevated ALP suggested a bone infection.

- Mr Tetley's course in the ED was inconsistently monitored. Although nursing staff had noted him to be hypotensive during the night of his admission this fact appears to have been ignored or overlooked by the doctor who discharged him the following morning. Too, there is not any record of that doctor examining Mr Tetley or taking his vital signs prior to his discharge.

- It is apparent that at the time of his ED discharge Mr Tetley was suffering from sepsis with hypotension. The area of back pain identified by Mr Tetley was the likely site of the sepsis. His pneumonia was secondary to it. The diagnosis of sepsis with secondary pneumonia was missed by the Royal's medical staff.

- Mr Tetley should not have been discharged from the ED on the morning of 1 April. Instead he required a full septic screen, blood cultures, chest x-ray and MRI imaging of the spine at the site of his pain. Following the blood cultures a course of intravenous antibiotic therapy should have been commenced.

- If properly treated Mr Tetley had a 95% chance of surviving his sepsis. Because there were no focal neurological signs it was unlikely that he would have suffered any neurological damage such as paraplegia.

- Medical practitioners need to be alert to the multiple presentations of sepsis. A patient's vital signs are a critical component in its diagnosis. There can be marked variations in those signs, especially in the sepsis' early stages.

- All patients should have their case reviewed before discharge from a medical facility. This should include a re-examination of the observation charts, the blood results and the radiology examinations. Vital signs should also be taken and recorded. A brief case summary should then be entered into the medical record.

I accept those opinions as expressed by Dr Bell.

Both Drs Bell and Ritchey are agreed that the primary cause of Mr Tetley's death was sepsis. However, Dr Bell has raised the possibility that the source of that sepsis was a spinal epidural abscess rather than pneumonia. Whilst Dr Ritchey did not observe an abscess at autopsy he has since advised me that this may be an alternate explanation for the subsequent sepsis. This leads me to formally find sepsis to be the cause of Mr Tetley's death with its source being

undetermined. However, I also record that a possible source of the sepsis was either pneumonia or a spinal epidural abscess

**FINDINGS, COMMENTS & RECOMMENDATIONS**

It is self-evident and I so find that Mr Tetley was discharged from the ED on the day of his death when he was suffering from sepsis with pneumonia as a secondary condition. For those reasons identified by Dr Bell, the medical staff should have appreciated that he was suffering from sepsis and should not have discharged him. By doing so Mr Tetley was denied the best chance of surviving his illness.

This is another in a series of recent coronial cases investigated by me where a person has died because of a failure to make a timely diagnosis of sepsis. This leads me to again remind the medical fraternity that sepsis is a life-threatening condition which is often difficult to diagnose because it can present in multiple circumstances and because of a tendency for its signs to fluctuate. It's diagnosis requires close vigilance of the patient's vital signs and an understanding that particular changes or fluctuations in those signs may be explained by sepsis.

This is also another instance where a patient has been discharged by a medical facility without a proper review of his status including the taking of his vital signs and also without including a notation of that review in the records. I repeat my **recommendation** made in previous cases (eg. Frances Proposch-Quarrell, died 6 July 2004 and Joanne Jean York, died 31 January 2010) to the effect that an hospital should not discharge a patient without first undertaking a review of their medical status which review should include the taking and recording of their vital signs.

I have decided not to hold a public inquest into this death because my investigations have sufficiently disclosed the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigations conducted by me. The circumstances of the death do not require me to make any further comment or any recommenndations.

I conclude this matter by conveying my sincere condolences to Mr Tetley's family.

**DATED:** 19 September 2014 at Hobart in the State of Tasmania

**Rod Chandler**
**CORONER**