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 Wendy Margaret Henriksen.

Find That:

a) The identity of the deceased is Wendy Margaret Henriksen.

b) Mrs Henriksen was born in Devonport on 11 February 1942 and was aged 72 years.

c) Mrs Henriksen died at the Launceston General Hospital ('LGH') in Launceston on 10 July 2014.

d) The cause of Mrs Henriksen's death was probable sepsis complicating chemotherapy for non-Hodgkin's lymphoma.

Background:

Mrs Henriksen was married to Barry Gregory Henriksen. They had three children. They resided at 14/414 Westbury Road at Prospect.

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Mrs Henriksen's medical history included non-Hodgkin's lymphoma diagnosed in May 2014. On 18 June 2014 she began a course of chemotherapy for treatment of this illness.

Circumstances Surrounding the Death:

In the early hours of 10 July 2014 Mrs Henriksen woke with severe abdominal pain and nausea. It did not abate and at about 4.30am her husband called for an ambulance. Ambulance officers attended and administered pain relief before conveying Mrs Henriksen to the LGH. She was received in the Emergency Department (ED) at about 5.40am. Mrs Henriksen reported that the day previously she had undergone chemotherapy. She said that she had vomited twice at home before the ambulance arrived and that she had opened her bowels at about 3.00am. She complained of pain *"throughout"* her abdomen. Her vital signs were taken. She was lucid. The chest was clear. The blood lactate was elevated at 6.1 mmol/L. The abdomen had diffuse tenderness with guarding. An ultrasound showed no free fluid in the abdomal cavity. A diagnosis of peritonitis or bowel perforation was considered. She was referred for review by the surgical team and analgesia was commenced.

At about 8.00am Mrs Henriksen was seen by a member of the surgical team and was then admitted to the surgical ward. There was a further review of Mrs Henriksen by the surgical team at about 9am. The team included surgeon, Mr Brian Kirkby and a surgical registrar. At this time Mrs Henriksen's blood pressure had fallen to 107/60mmHG, her heart rate had increased to 110bpm and her oxygen saturation had fallen. Her abdomen was noted to be tender with no signs of peritonitis. A diagnosis of perforated diverticulum was considered. The plan was for Mrs Henriksen to have a CT scan of her abdomen and for her then to be reviewed. Meantime the antibiotic Tazocin was commenced.

Hourly clinical observations were made of Mrs Henriksen. At 1.00pm her temperature was recorded at 36˚C, her pulse was 120bpm, her respiratory rate was 20, blood pressure 86/57 and her oxygen saturation was 93%. The notes show that at 1:30pm she was reviewed by the surgical registrar. His impression at this time was that Mrs Henriksen may have been suffering from peritonitis and/or septic shock. He recommended that she be reviewed by a consultant.

It is recorded that surgical consultant, Dr Nishanthi Gurusinghe attended Mrs Henriksen at 2:07pm. She noted that the CT scan taken earlier showed moderate colonic distension and ascites. She further noted that Mrs Henriksen had been persistently tachycardic since about 6.00am and that she was complaining of worsening abdominal pain. She observed, on examination, a distended abdomen which was not peritonitic. There was no percussion tenderness. In her view there was not any perforation but she was concerned about the effects of Mrs Henriksen's chemotherapy masking the clinical signs and she requested a left lateral decubitus film. This showed no evidence of perforation. Mrs Henriksen's oncology team was consulted and they confirmed that her bowel had not been involved with the lymphoma.

During that afternoon nursing staff continued to regularly record Mrs Henriksen's clinical observations. They showed a gradual decline in her condition. At 5:45pm a nurse had difficulty taking the observations. At that time her blood pressure was recorded at 82/50 and her heart rate was 110 bpm. She recorded that Mrs Henriksen was groaning in pain, was pale in colour and peripherally cold. About an hour later she was reviewed by Mr Kirkby. At this time her temperature was 37.1˚C, her oxygen saturation less than 80% on 3 litres of oxygen via nasal prongs and her blood pressure was recorded 70/45. A decision was made to transfer Mrs Henriksen to the Intensive Care Unit (ICU) and this was done at 7:10pm. It seems that during the transfer Mrs Henriksen's intravenous access was dislodged and lost and it took about 2 minutes to gain peripheral access.

It was noted that on her arrival in the ICU Mrs Henriksen was unconscious. An attempt was made to insert a femoral central line. At this point Mrs Henriksen vomited. A nearby suction device did not function and a portable appliance had to be acquired. Mrs Henriksen then had a cardiac arrest and CPR was initiated. It was maintained until 7:55pm but Mrs Henriksen could not be revived.

Post Mortem Examination:

This was undertaken by Forensic Pathologist, Dr Donald Ritchey. In his opinion the cause of Mrs Henriksen's death was probable sepsis complicating chemotherapy for non-Hodgkin's lymphoma.

Dr Ritchey's report includes this comment:

"The autopsy revealed a well-developed, well-nourished elderly Caucasian woman with alopecia (baldness) consistent with the history of systemic chemotherapy for non-Hodgkin's lymphoma. An anatomical cause of death was not identified at autopsy. The clinical history of abdominal pain and hypotensive cardiac arrest in addition to admission laboratory data indicating markedly

elevated white blood cell count with neutrophilia (predominance of neutrophils) strongly suggests bacterial sepsis as a cause of death. A definite source of sepsis was not identified at autopsy. Individuals treated with chemotherapy for malignant conditions are immunosuppressed and therefore at greatly increased risk of bacterial sepsis. There was no evidence of residual or recurrent lymphoma identified at autopsy."

Investigation:

This has included the following:

a. Consideration of an affidavit with annexures provided by Mrs Andrea Shadboldt, a daughter of Mrs Henriksen.

b. A review of Mrs Henriksen's records at the LGH carried out by research nurse, Ms Libby Newman.

c. Consideration of reports provided by:

Surgical Consultant, Dr Nishanthi Gurusinghe;

Radiologist, Dr Gavin Mackie;

Consultant surgeon, Mr Brian Kirkby;

Registrar, Dr Clement; and

Professor J Froelich.

d. Consideration of correspondence received from Dr Peter Renshaw, Director of Clinical Services at the LGH.

e. Provision of a report compiled by Dr A J Bell as medical adviser to the Coroner.

f. Meetings attended by myself, Dr Bell, Ms Newman, Dr Ritchey and State Forensic Pathologist, Dr Christopher Lawrence to monitor the investigation.

In his report Dr Bell has expressed these opinions:

- At the time of her arrival in the ED Mrs Henriksen was not shocked, did not have diabetic ketoacidosis, renal or liver failure. In this setting her elevated lactate was an indication of a severe medical emergency requiring urgent investigation, supportive care and treatment. The ED, and later the surgical team, failed to appreciate the severity and

progressive nature of Mrs Henriksen's illness and to respond appropriately.

- The oncology team was informed of Mrs Henriksen's admission to the ED but their input was not sought until around 2.00pm. This was poor practice given the critical nature of her illness and the absence of a definitive diagnosis. The surgical team should have consulted the oncology team by the time of its review at 9.00am and later with the results of the CT scan.

- That by 1.00pm on 10 July 2014 the signs indicated that Mrs Henriksen was in septic shock. She was hypotensive, tachycardic and had mild tachypnoea and worsening oxygen saturations. At this point she required immediate admission to ICU for supportive management.

- At her surgical consultation at 2.07pm Dr Gurusinghe found no evidence of bowel perforation. It appears that no other cause for Mrs Henriksen's septic shock was considered. Her care was then returned to Mr Kirkby. It was at about this time that the decision was taken not to proceed with an emergency diagnostic laparotomy. This procedure offered the best chance of diagnosing the cause for Mrs Henriksen's presentation.

- It is not a light undertaking to commit to surgery for a patient one day post-chemotherapy.

- There is a likelihood, particularly given the results of the CT scan, that a laparotomy would have revealed Mrs Henriksen to have an inflamed colon requiring resection. Thereafter, Mrs Henriksen required management in the ICU including the administration of high dose antibiotics.

- Mrs Henriksen was critically ill and even with appropriate therapy her prospects of survival were no greater than 50%.

Findings, Comments and Recommendations:

I accept the opinion of Dr Ritchey upon the cause of death.

It is apparent that Mrs Henriksen's presentation at the LGH made for a difficult diagnosis. A tool to assist in such diagnosis would ordinarily include a diagnostic laparotomy. However, I accept that Mrs Henriksen's chemotherapy treatment undergone on the day prior to her hospital admission heightened the risk of surgery and indeed the risk of any other procedure which the laparotomy revealed to be necessary. In this circumstance I make no criticism of the decision taken not to proceed to a laparotomy, particularly when there was not

any clear evidence of an underlying cause for Mrs Henriksen's presentation which may have been capable of surgical repair.

However, once the decision was taken not to proceed to laparotomy, it was incumbent upon Mrs Henriksen carers to avail her of a level of care which maximised her prospects of survival. This required her admission to the ICU and the initiation of maximal supportive therapy. This should have occurred at around 1.00pm on 10 July 2014 when it was evident that she was in septic shock and certainly well before 7.10pm when the decision to transfer was made. The delay in making this transfer represented, in my view, suboptimal care.

I am unable to find that Mrs Henriksen's death would have been avoided had she received appropriate and prompt therapy in the ICU. She was, after all, seriously ill. Nevertheless, I am satisfied that a transfer to the ICU in the early afternoon of 10 July 2014 would have better increased her survival prospects.

I have decided not to hold a public inquest into this death because my investigation has sufficiently disclosed the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how her death occurred and the particulars needed to register her 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 investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations.

I extend my sincere condolences to Mrs Henriksen's family and loved ones.

Dated the 18 day of July 2016 at Hobart in the State of Tasmania

Rod Chandler

CORONER