MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Neville Ernest Wade,

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Neville Ernest Wade;

b) Mr Wade died in the circumstances set out further in this finding;

c) The cause of Mr Wade's death was acute myocardial ischaemia due to coronary atherosclerosis; and

d) Mr Wade died on 18 August 2019, at the North West Regional Hospital, Burnie in Tasmania.

Introduction

1. In making the above findings I have had regard to the evidence gained in the investigation into Mr Wade's death. The evidence includes:

- Tasmania Police Report of Death for the Coroner;
- The report of the pathologist who conducted the examination of Mr Wade's body;
- Affidavits confirming life extinct and formal identification;
- Medical records and reports;
- A report from the medical advisor to the Coronial Division; and
- A letter from the Department of Health and Human Services dated 23 December 2020.

Background

2. Mr Wade was born in Sydney, Australia on 18 July 1939. At the time of his death he was aged 80 years, married, had had five children, was a retired bus driver and lived with his daughter in Penguin, Tasmania.

Circumstances of Death

3. On 12 August 2019, Mr Wade was admitted to the North West Regional Hospital (NWRH) for a knee operation. The operation was carried out initially under spinal anaesthetic but converted to general anaesthetic. Post-operatively, Mr Wade was stable.

4. On 15 August 2019, Mr Wade developed abdominal pain and a chest cough. A chest x-ray was ordered. It showed changes to his right lower lung. An abdominal x-ray showed faecal impaction. Standard tests indicated an elevated white cell count, and a significantly elevated troponin level. During the day, Mr Wade's oxygen saturation fell to 82 percent. Oxygen therapy was apparently successful; later the same day his oxygen saturation rose to 92 percent.

5. Later still the same day a medical emergency team (MET) call was made and Mr Wade reviewed. An ECG was performed, but his medical records do not record any comment in relation to that. The ECG however showed an acute anterior myocardial infarction. The fact of that myocardial infarction appears to have been overlooked – certainly there was no change to his treatment following the ECG.

6. In the early hours of the following day, Mr Wade's oxygen saturation dropped to 72 percent. Two further MET calls were made and oxygen therapy administered. The recorded diagnosis in relation to the first MET call was a type I respiratory failure, secondary to sepsis with possibly hospital acquired pneumonia. It is not clear the basis upon which this diagnosis was arrived at.

7. Mr Wade did not improve. Staff at the NWRH sought advice from a cardiology unit at the Launceston General Hospital (LGH). However, Mr Wade's condition continued to deteriorate. He was made comfortable and died on 18 August 2019.

Investigation

8. The fact of his death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified and then taken by mortuary ambulance to the LGH. At the LGH, experienced pathologist, Dr Terry Brain, examined Mr Wade's body and reviewed his medical records. Dr Brain provided a report in which he expressed the opinion that the cause of Mr Wade's death was acute myocardial ischaemia due to coronary atherosclerosis. I accept Dr Brain's opinion.

9. The circumstances of Mr Wade's death were reviewed by Dr Anthony J Bell MB BS MD FRACP FCICM, the medical advisor to the Coronial Division. In a report dated 10 September 2019, Dr Bell expressed the view that the MET calls appear to have been poorly managed and the ECG inadequately read and interpreted. Although a troponin level test was ordered (and processed), the results of that were either not followed up, or if they were, improperly understood.

10. In short, the fact that Mr Wade had suffered a myocardial infarct, whilst quite clear in an ECG taken on 15 August 2019, was "missed" by Mr Wade's treating team at the NWRH.

11. This finding, in draft, was sent to the relevant government agency (the Department of Health and Human Services) responsible for the running of the NWRH. In a reply dated 23 December 2020, the Executive Director of Medical Services indicated that the circumstances surrounding Mr Wade's death had been discussed by a number of senior clinicians at the NWRH. The result of that review acknowledged that the ICU team attending the MET call on 15 August 2019 "did not adequately interpret the ECG and this had been fed back to them".

12. In addition, the same letter outlined a number of improvements that have been put in place at the NWRH, subsequent to Mr Wade's death. Those improvements include the establishment of a new cardiology team available for clinical consultation, echocardiographic and stress testing and regular auditing in relation to the MET call system.

Comments and Recommendations

13. The circumstances of Mr Wade's death are such as to require me to **<u>comment</u>**, pursuant to section 28 of the *Coroners Act* 1995, that it is important that staff at the North West Regional Hospital improve their reading and interpretation of ECG results. I acknowledge the response of the hospital to Mr Wade's death. In light of that response I do not consider it necessary to make any recommendations.

14. I convey my sincere condolences to the family and loved ones of Mr Wade.

Dated: 24 May 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner