



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Alexander Frank Patterson

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

- a) The identity of the deceased is Alexander Frank Patterson, date of birth 26 March 1958.
- b) Mr Patterson was 65 years of age, single and lived in East Devonport with his father. He suffered type 2 diabetes and was a regular smoker. He worked as a volunteer with St Vincent de Paul Society in Devonport. On the morning of 22 May 2023, Mr Patterson felt unwell and vomited blood. After arriving at work, he remained very unwell and his colleagues called for an ambulance. He was transported immediately to the Mersey Community Hospital in a hypoglycaemic state. After medical assessment, he was diagnosed with an infection with atypical pneumonia causing confusion and hypoglycaemia. This diagnosis was incorrect and Mr Patterson, in fact, was bleeding from a duodenal ulcer with a large artery in its base. About 6 hours after his presentation to hospital, Mr Patterson's condition deteriorated quickly and he became pale and unresponsive. Despite resuscitative measures, he passed away at 8.49pm that evening.
- c) Mr Patterson died as a result of a bleeding duodenal ulcer.
- d) Mr Patterson died on 22 May 2023 at Latrobe, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mr Alexander Frank Patterson's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;

- Tasmanian Health Service Death Report to Coroner;
- Tasmanian Health Service records;
- East Devonport Medical Centre records;
- Tasmanian Health Service Root Cause Analysis report; and
- Review of medical issues by Dr Anthony Bell, coronial medical consultant.

Comments and Recommendations

An issue arose in this case regarding the failure of treating doctors to make a correct diagnosis of Mr Patterson's condition at the Mersey Community Hospital. In this case, I have had the benefit of a report by Dr Anthony Bell, coronial medical consultant, and a Tasmanian Health Service Root Cause Analysis report ("RCA report") prepared by a suitably qualified expert panel.

Based upon the opinions expressed in these reports, I find that Mr Patterson's gastrointestinal bleeding (from his duodenal ulcer) should have been diagnosed at his hospital presentation.

Significantly, the presence of isolated elevated urea in the context of postural hypotension meant that a gastrointestinal bleed should have been considered as the primary diagnosis. In his report, Dr Bell also emphasised the other factors supporting this diagnosis – hematemesis occurring that morning and black stool found upon rectal examination. Dr Bell also commented that the evidence did not indicate that Mr Patterson was suffering infection or pneumonia.

If Mr Patterson had been diagnosed correctly with gastrointestinal bleeding, appropriate emergency treatment would have followed. This should have included urgent transfer for endoscopy or other surgical options to control the bleeding. Assuming a correct diagnosis and rapid escalation of care, Mr Patterson would have had a chance of survival. As the diagnosis was missed, his death was, unfortunately, a certainty.

The RCA report dealt comprehensively with the various reasons why the diagnosis of Mr Patterson's condition deviated unacceptably from the correct diagnosis. The panel specifically considered that, in this case, there had been "premature diagnostic closure" and failure in communication of key information between clinicians which led to the treating team making a diagnosis of pneumonia. The panel specifically noted the ineffective communication between clinicians of the elevated urea, a significant diagnostic sign.

The RCA panel made four recommendations, the two primary recommendations being as follows:

- That the Emergency Department at the Mersey Community Hospital consider the introduction of a validated scoring scale and flowchart/pathway for the management of a suspected upper gastrointestinal haemorrhage; and
- That the Tasmanian Health Service conduct audits of medical documentation to ensure it meets the requirements of the relevant NSQHS standard.

I **recommend** that the Tasmanian Health Service take timely steps to implement the recommendations specified in the RCA report if it has not already done so.

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

Dated: 27 June 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart

Coroner