MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of EM

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

a) The identity of the deceased is EM, date of birth 29 July 1947.

b) EM was 76 years of age, was widowed and lived in Glenorchy. She has three adult children to her first husband. Her existing medical conditions included vascular dementia and emphysema. On 4 October 2023, EM was admitted to the Royal Hobart Hospital (RHH) with abdominal pain, shortness of breath and confusion. She was investigated comprehensively. She was diagnosed with sepsis of unknown origin and underwent treatment, including with antibiotics. With her symptoms having slowly improved, she was discharged on 16 October 2023, twelve days after her presentation.

In the evening of 30 October 2023, EM was taken by ambulance to the RHH experiencing fever, diarrhoea and reduced consciousness. A diagnosis of sepsis was made based upon her symptoms. EM was treated in the emergency department for an extended period of time, before being transferred to the Trauma and Acute Surgery Unit where she continued to be treated for her sepsis. The source of the sepsis could not be ascertained by the treating medical practitioners. A number of Medical Emergency Team (MET) calls were made to EM for tachycardia and hypotension. These culminated in a MET call on 2 November 2023 during which EM told nursing staff that she was having difficulty breathing before her Glascow Coma Score dropped and she became hypoxic and tachycardic. She required a jaw thrust and oropharyngeal airway to maintain oxygen saturations and was found to be in respiratory failure. In light of her poor

prognosis, and following discussions with her family, further active treatment was not provided. She passed away that day.

c) Following autopsy, the State Forensic Pathologist concluded that EM died of natural causes, being sepsis as a result of myocarditis (infection of the heart) and tricuspid valve endocarditis (infection of the heart valve). The State Forensic Pathologist also reported that EM's hypertension and cardiomegaly were significant contributory conditions. I accept the opinion of the State Forensic Pathologist regarding the cause of death.

d) EM died on 2 November 2023 at the Royal Hobart Hospital, Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;
- Affidavit as to identity;
- Opinions of the State Forensic Pathologist, who conducted the autopsy;
- Correspondence and information from AK, daughter of EM;
- Medical reviews by Dr Anthony Bell, Coronial Medical Consultant;
- O'Briens Bridge Medical Centre records;
- Tasmanian Health Service records;
- Review of discharge by Forensic Nurse, Mr Kevin Egan; and
- Report by Dr Dinendra Gill, Clinical Director Medical and Cancer Service, Department of Health, regarding EM's treatment and discharge.

Comments and Recommendations

The issues arising for comment in this investigation focus upon the source of EM's sepsis not being identified and also inadequacies in her discharge planning and communication. I discuss these below.

EM was discharged on 16 October 2023 without the origin of her sepsis – infective endocarditis – being diagnosed. EM's condition was improving at the time of discharge. She had been treated with antibiotics and the results of comprehensive investigations, including some cardiac investigations, were negative. However, at discharge, she experienced continued pain, including pain across the chest, abdominal pain and lack of mobility. It is not clear whether, in her first admission,

EM's septic condition was due to infective endocarditis. If she had this condition, it was not considered by her treating medical practitioners as a differential diagnosis at any time during the admission.

However, the expert evidence is that EM's condition was very difficult to diagnose. The reason for such difficulty includes the lack of clinical signs or positive blood cultures and the wide variation in fever patterns with little diagnostic utility. In the case of right-sided infective endocarditis of the tricuspid valve, being EM's condition, symptoms may mimic a respiratory tract infection. I also accept that EM's clinical symptoms (chest and abdominal pain) did not appear related to the eventual findings at autopsy. Moreover, 90% of patients contracting infective endocarditis are intravenous drug users, not a category applicable to EM.

Given these factors, and the fact that her condition appeared to be resolving, I do not criticise the failure to undertake further specialised cardiac investigations that may have assisted in confirming or excluding infective endocarditis.

The coronial medical consultant reported that right-sided infective endocarditis has a high mortality rate, especially in the elderly, and EM may have died even if the diagnosis had been correctly made and she had been treated further as an inpatient with the required long-term intravenous antibiotics.

EM's daughter questioned why her mother was discharged without antibiotics. Upon the expert evidence, discharging EM without antibiotics was sound medical practice for a diagnosis of fever of unknown origin. The major reason for this is that if the infection re-occurs the bacteria may be cultured, the origin of the infection found and appropriate antibiotics used to treat it.

EM did not fully recover between her two hospital admissions. She had continued abdominal pain and, according to her daughter, a severe lack of mobility due to her pain. As discussed, it is plausible that, at all material times, her state of sepsis was due to infective endocarditis. However, it is also plausible that her initial presentation was for sepsis of a different origin, and she subsequently developed a new septic process due to infective endocarditis. I cannot make positive findings on this point except to find that her second presentation to hospital was certainly because of sepsis from infective endocarditis. Upon the evidence, even if she had been correctly diagnosed and treated at that time, it is unlikely that she would have survived.

Regardless of whether EM presented on each occasion with a different source of sepsis, a serious issue in this investigation involves a lack of discharge planning and

a failure to provide her general practitioner with a comprehensive discharge summary and plan shortly after her discharge on 16 October 2023.

The hospital discharge summary was not completed at separation or within 48 hours as per hospital protocol. In fact, according to the medical records, the discharge summary was completed on 3 November 2023, being the day after her death.

EM consulted her general practitioner on 19 October 2023, 24 October 2023 and 25 October 2023. She complained of right-sided abdominal pain and palpitations which had been present since her discharge from hospital. The general practitioner specifically recorded in the consultation notes that she had not received a discharge summary from the hospital. However, in the consultation of 25 October 2023, she encouraged EM to present again to the hospital emergency department if her symptoms persisted.

In correspondence for the investigation, the hospital acknowledged that the lack of a discharge summary and communication of a discharge plan to the general practitioner impacted upon patient care as the general practitioner would have been unclear regarding the underlying issue and appropriate management following discharge.

This case is a particularly pronounced example of a patient presenting responsibly to her general practitioner following discharge, with the general practitioner requiring guidance on the nature of her recent inpatient treatment, diagnosis and recommended plan. If EM's general practitioner had received a discharge plan, then he/she may have referred her back to hospital at an earlier time. This may have been an opportunity to treat her at an earlier stage, providing her with a higher chance of survival.

The hospital reported in its correspondence for this investigation that it is continually working to improve compliance with discharge plan timeliness and this case highlights the critical importance of timely communication with general practitioners.

The discharge summary, as it appears in the records, does not set out a clear plan for her ongoing treatment and support. It also does not appear that discharge planning took into account the suitability of her accommodation arrangements, her mobility, the need for home services and details of further general practitioner consultations and other assessments. It is vital that a well-documented and communicated plan for discharge is formulated with appropriate input from the family and patient as well as from medical, nursing and allied health staff.

I **recommend** that the Tasmanian Health Service continues to monitor and, where necessary, educate its health professionals on (a) the timeliness and quality of discharge summaries; and (b) compliance with discharge planning protocols.

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

Dated: 9 December 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner