



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 Sidney Bedford

Find That:

- (a) The identity of the deceased is Sidney Bedford;
- (b) Mr Bedford was born in London in the United Kingdom on 27 February 1932 and was aged 83 years;
- (c) Mr Bedford died at the St Lukes Campus of Calvary Health Care ('Calvary') in Launceston on 6 November 2015; and
- (d) The cause of Mr Bedford's death was an acute subdural haemorrhage following a fall.

Background

Mr Bedford was a retired builder. Since 2000 he had resided with his wife Joan at St Helens. They had one child, Lee, born on 9 December 1959. Mr Bedford's medical history included coronary artery surgery and aortic valve replacement carried out in Adelaide in 1999, hypertension and lumbar spinal fusion. His medications included warfarin.

Circumstances Surrounding the Death

At about 5:30 am on Friday 30 October 2015 Mr Bedford got up to let his dog out of the house. He then went outside with the dog. This was his normal practice. About 10 minutes later Mrs Bedford heard her husband calling out to her. She was in bed. Her husband was outside and was standing at the bedroom window. His face was "*smothered in blood.*" It seems that he had fallen onto his face on the blue metal driveway whilst wheeling out the rubbish bin. Mrs Bedford immediately telephoned the ambulance. She then went outside and sat with her husband whilst they waited for the ambulance to arrive. Although Mr Bedford was conscious his wife said; "*he did not seem quite himself.*" The ambulance arrived and conveyed Mr Bedford to the St Helens District Hospital. ('SHDH')

At the SHDH Mr Bedford was assessed, his facial wound treated and he was given antibiotics. Arrangements were then made for him to be transported to the Launceston General Hospital. ('LGH')

Mr Bedford arrived at the LGH at 11:09 am. His vital signs were noted to be stable and he was alert and responding appropriately. Lacerations on his forehead and right hand were cleaned and dressed. He had a CT scan of brain which was reported as normal by radiologist, Dr Govind Mishra. He was later reviewed by the plastic surgery registrar and a decision was made for surgical repair of his facial wounds. However, it was agreed that this should be delayed until the blood thinning effect of the warfarin had been sufficiently reversed. He was admitted to the medical ward.

In the morning of 31 October Mr Bedford's vital signs remained stable. He ate a small lunch. He made no complaints of discomfort. However, at 4.20 pm it was observed that he had become confused. Thirty minutes later he lost consciousness and a Code Blue was called. A further CT scan of the brain was promptly arranged. Dr Mishra was again the radiologist. This time he reported the scan showing a large right sided subdural haematoma. Treatment options were then discussed with medical staff of the Neurosurgery Unit at the Royal Hobart Hospital ('RHH') and were canvassed with the family. The decision was taken to put in place palliative care.

On 2 November Mr Bedford was transferred to the Melwood Unit at Calvary where palliation was continued until his death on 6 November 2015.

Post-Mortem Examination

This was carried out by pathologist Dr Ruchira Fernando and was confined to an external examination, a review of the CT scans of the brain and their reports and examination of Mr Bedford's hospital records. In Dr Fernando's opinion the cause of Mr Bedford's death was an acute subdural haemorrhage following a fall. I accept this opinion.

Investigation

This was overseen by Tasmania Police and a report was provided to the coroner. Subsequently Mr Bedford's records at the LGH, including the radiology, were reviewed by Dr AJ Bell as medical adviser to the coroner. A report was sought and provided by Dr Mishra.

In his report Dr Mishra acknowledges that he incorrectly reported upon the CT scan of the brain taken on 30 October in that he failed to identify a 3-4 mm wide acute extra-axial haematoma in the right temporo-frontal region of the brain. He says that he is unable to provide a reason for this mistake save that; *"The haematoma is very small and on normal brain windowing it is difficult to discern, however, by adjusting the windowing when viewing, it is much easier to see by contrasting with surrounding*

tissues.” He goes on; “I would like to express my regret for having missing (sic) this finding on the original CT and would like to extend my sympathy to Mr Bedford’s family for their loss.”

Dr Bell subsequently provided his own report upon Mr Bedford’s care and management at the LGH. It includes:

- An opinion that the care provided by the LGH was timely and of a good standard save that it was “*disrupted*” by the initial incorrect CT scan report.
- Confirmation that Dr Mishra’s report upon the CT scan of 30 October 2015 was incorrect in that it did not identify the presence of an acute right sided haematoma.
- An opinion that Mr Bedford’s subdural haematoma required his transfer to the RHH and admission to its Neurosurgery Unit for close observation, intracranial pressure monitoring and repeat brain imaging.
- An opinion that if Mr Bedford’s subdural haematoma had been diagnosed at the first opportunity and appropriate management initiated there was a reasonable chance of his full neurological recovery.

Findings, Comments and Recommendations

It is apparent that Dr Mishra failed to recognise the right sided subdural haematoma when he first scanned Mr Bedford’s brain, a mistake which he acknowledges. This failure, coupled with the absence of any clinical signs of brain trauma resulted in a delayed diagnosis. I am satisfied, accepting the opinion of Dr Bell, that had a diagnosis of a subdural haematoma been promptly made and appropriate treatment immediately commenced that there was a reasonable chance of Mr Bedford surviving his injuries and having an extended life. It is of course most regrettable that this did not occur.

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 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 investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations.

I convey my sincere condolences to Mr Bedford's family and loved ones.

Dated: 14 day of July 2016 at Hobart in the State of Tasmania.

Rod Chandler
Coroner