



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION



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## Record of Investigation into Death (Without Inquest)

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Rod Chandler, Coroner, having investigated the death of John James Novaski

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

- a) The identity of the deceased is John James Novaski;
- b) Mr Novaski was born in Poland on 1 June 1941 and was aged 76 years;
- c) Mr Novaski died on 10 October 2017 at Turners Beach, Tasmania; and
- d) The cause of Mr Novaski's death was advanced atherosclerotic and hypertensive cardiovascular disease.

### **Background**

On 12 June 2017 Mr Novaski had a heart attack whilst holidaying in Melbourne. He was taken to the Alfred Hospital where a coronary angiograph showed a sub-total occlusion of the left anterior descending coronary artery. It was treated with a stent and he was discharged after four days.

On the evening of 21 June Mr Novaski developed shortness of breath at his Turners Beach home. An ambulance was called and he was taken to the Mersey Community Hospital (MCH) at Latrobe. His condition was stabilised and he was transferred the following morning to the Launceston General Hospital (LGH). At the LGH, Mr Novaski was noted to be pain free but was bradycardic (slow heart rate) at times. A coronary angiogram on 26 June showed a right coronary proximal stenosis of 99%. The artery was dilated and a stent was placed. Two overlapping stents were also placed in an obtuse marginal artery which had a 90% lesion. Two other artery lesions were noted but not stented. The following day Mr Novaski was discharged home.

On 1 August 2017 Mr Novaski was reviewed by Interventional Cardiologist, Dr Rohit Barthwal. It was noted that his heart rhythm was in atrial fibrillation which was treated by increasing his beta-blocker therapy. The plan was made for Mr Novaski to undergo a cardiac rehabilitation programme and for him to undergo a transoesophageal echocardiogram and cardioversion procedure after two months. This took place on 3 October and Mr Novaski's normal heart rhythm was restored.

## **Circumstances Surrounding the Death**

Mrs Novaski reports that on 9 October 2017 her husband “*didn’t feel right.*” She took him to see his general practitioner, Dr Anthony Lyall, at Beaconsfield. He reported that he had been experiencing shortness of breath on exertion since the procedure with Dr Barthwal 6 days previously. Dr Lyall took an ECG which he interpreted as “*bigeminal beat with variable heart block.*” He immediately referred Mr Novaski to the LGH and provided a referral letter including a copy of his ECG.

Mr Novaski presented at the LGH’s Emergency Department (ED) at around 1.00pm. He was triaged as a category 3 patient (i.e. to be seen within 30 minutes). Mr Jay Ang, a fifth year medical student, attended Mr Novaski in the waiting room as all of the more suitable spaces were occupied. He obtained a history and carried out an examination. A chest x-ray was ordered and blood samples taken. Blood results were available at 3.10pm and included an elevated troponin reading of 59. A second troponin reading was sought but at 5.49pm advice was received that the sample was haemolysed and could not be analysed. A further blood sample was not taken. Mr Novaski’s case was then discussed with ED registrar, Dr Trellly Patunavanu, who directed that Mr Novaski be discharged home. In a report received from Dr Patunavanu he provides this explanation: “*In view of the fact that he was clinically well, his CXR (chest x ray), and ECG were OK and, he already had a booking from his Cardiologist for review within a few days, he was discharged without repeating the second troponin.*”

Mrs Novaski says that she and her husband arrived home at about 8.30pm. She reports: “*John was really tired and went to bed straight away.*” The next morning Mrs Novaski left the home to do some grocery shopping. She returned at around 11.15am and found her husband collapsed on the lounge room floor. Ambulance Tasmania was called. Its officers confirmed that Mr Novaski was deceased.

A post-mortem was carried out by forensic pathologist, Dr Donald Ritchey. In his opinion the cause of Mr Novaski’s death was advanced atherosclerotic and hypertensive cardiovascular disease. I accept this opinion.

## **Investigation**

This has been informed by:

1. Police Report of Death.
2. An affidavit provided by Mrs Elizabeth Novaski.
3. A review of Mr Novaski’s hospital records carried out by clinical nurse, Ms L K Newman.
4. A report from Dr Lucy Reed, Director of Emergency Medicine at the LGH.
5. A report from Dr Trellly Patunvanu.
6. A report from Dr Peter Renshaw, Director of Clinical Services at the LGH.
7. A report from Dr A J Bell as medical adviser to the coroner.

In their respective reports Drs Reed and Renshaw acknowledge multiple deficiencies in the hospital care provided to Mr Novaski on 9 October 2017. These include:

- I. The failure to ensure that Mr Novaski was seen by a medical practitioner within the 30 minutes mandated by his triage category. It was in fact around 3 hours before he was seen by a doctor.

- II. The failure to comply with LGH policy requiring a qualified doctor, along with his shadowing student, to see Mr Novaski together and for the doctor to write up and sign the medical notes. In this instance Mr Ang saw Mr Novaski alone and it was he who wrote up the notes but not until after Mr Novaski's discharge. They were not signed by Dr Patunvanu.
- III. Acknowledgement that Mr Novaski's first troponin reading was elevated, that it was not recognised as a high risk marker and that it was not managed in accord with standard pathways. In this case the pathway required a repeat troponin test.
- IV. The failure to consider the contents of Dr Lyall's referral letter along with his ECG and to take them into account in their assessment of Mr Novaski and his proper management.
- V. The failure to ensure that the ECG taken at the LGH was interpreted by a medical practitioner. Instead its interpretation was left to Mr Ang. Dr Renshaw does not consider his analysis to be correct. Rather it's his view that the ECG "*clearly shows a first degree heart block.*"
- VI. Acknowledgement that Mr Novaski was a high risk patient, particularly in the light of his recent cardiac history. He required a referral to cardiology and it was an error for him to be discharged without a cardiology consultation.
- VII. Acknowledgement that the records do not include:
  - a. A recorded rationale for Mr Novaski's discharge.
  - b. An explanation for the failure to refer Mr Novaski to cardiology.

The investigation shows that 9 October 2017 was a particularly busy day for the ED being rated at Level 3, its highest level in terms of bed management and patient flow. For the 24 hour period there were 136 patient presentations with multiple patients being managed in the ED pending their admission to the hospital. Of these patients 12 had been kept in the ED in excess of 24 hours, 3 over 30 hours, 2 over 50 hours and one patient had been awaiting admission over 61 hours. Dr Reed describes the effect of this state of affairs in these terms:

*"I am certain the state of the department may have had an impact on the quality of care. There were numerous patients with extremely long lengths of stay in the department which will always impact our ability to find beds for our acute presentations. When patients are seen in the waiting room or in a chair rather than a bed we are cognitively biased as to our decision making and will tend to view the case with a lower acuity in mind."*

### **Findings, Comments and Recommendations**

Mr Novaski's recent history clearly demonstrated a serious and chronic heart condition making him a high risk patient. When Dr Lyall referred him to the LGH on 9 October 2017 his condition mandated a level of care which reflected the seriousness of his condition. Unfortunately and most concerning, the care provided by the LGH fell well short of the standard required. I have set out above a list of those shortcomings which have been acknowledged by senior medical personnel at the LGH. Most critical in my view was the decision to discharge Mr Novaski without first ensuring that he was reviewed by a cardiologist. In the circumstances this was a serious and 'hard-to-believe' misjudgement.

I am unable to find that Mr Novaski's death would have been prevented if he had been seen by Dr Barthwal or one of his colleagues on 9 October. However, the involvement of a cardiologist at this time in the decision making around Mr Novaski's care and treatment would have given him a far better prospect of survival.

It is not reasonable of me to be critical of the decisions made upon Mr Novaski's care without acknowledging the environment in which those decisions were made. In this respect it is clear that on 9 October 2017 the LGH did not have the capacity to meet patient demand. In the result, multiple patients requiring admission to wards remained in the ED for grossly extended periods because of bed shortage. This meant that ED staff remained involved in these patients' care whilst at the same time being required to attend to the needs of incoming patients. It also meant a lack of available facilities in ED for the proper care and treatment of its patients (this is illustrated by the need to attend to Mr Novaski whilst he was in the waiting room). Inevitably these circumstances must seriously impact upon the quality of patient care, most notably because decisions are too hastily made without adequate time for proper consideration and because those decisions are overly influenced by the hospital's 'bedblock' and a subconscious desire to avoid making the situation worse. It is likely, in my view, that these factors were relevant to the substandard care provided to Mr Novaski.

[Bruinger 2018 TASCD 350](#) was a recent decision of mine involving overcrowding in the ED of the Royal Hobart Hospital where I made these comments:

*"The (overcrowding) as described by Dr Huckerby had the prospect of seriously compromising patient safety. It must also have been particularly difficult and stressful for the medical and ancillary staff. In these circumstances it behoves those persons responsible for the management of the RHH to investigate the situation and to adopt changes which prevents or at least significantly reduces the prospect of its repetition."*

Mr Novaski's case makes these comments similarly applicable to the LGH.

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 Novaski's family and loved ones.

**Dated:** 1 day of March 2019 at Hobart in the State of Tasmania.

**Rod Chandler**  
Coroner