



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 Jan Axel Pettersson

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

- a) The identity of the deceased is Jan Axel Pettersson;
- b) Mr Pettersson died as a result of an infection of the lungs, brain and meninges;
- c) The cause of Mr Pettersson's death was disseminated fungal (*Cryptococcus*) infection of the lungs, brain and meninges; and
- d) Mr Pettersson died on 10 November 2017 at the Mersey Community Hospital, Latrobe, Tasmania.

Introduction

1. Mr Pettersson, 71 years of age at the time of his death was, until shortly before his death, healthy, active and apparently well. In late June 2017, during a trip to Sweden, he fell from a bicycle. Reportedly, he was unable to explain why he had the fall. After that time, he began to experience dizzy spells.
2. On 5 October 2017, he went to the Mersey Community Hospital (MCH) with fever, some confusion and an unsteady gait. A chest x-ray was taken after his admission. The x-ray showed a mass in his right lung. Medical records indicate that it was considered this was likely malignant lung cancer. However, blood tests indicated inflammatory markers were unremarkable. Mr Pettersson was admitted to a ward.
3. Further investigation, including cultures of blood and urine and a chest x-ray, were undertaken. The results of the chest x-ray suggested the lung mass appeared to have increased in size in 4 days. Mr Pettersson was referred to see a cardiothoracic surgeon at St Vincent's Private Hospital in Melbourne.
4. His condition did not improve. In fact, on 10 October 2017, a Medical Emergency Team (MET) call was made due to his altered level of consciousness. Fevers continued, as did headaches. On 17 October 2017 Mr Pettersson was transferred to the Royal Hobart Hospital where a PET scan was carried out. The results of the scan showed the

pulmonary lesion but no other areas of suspicious uptake. Two days later, on 19 October 2017, an echocardiogram was performed upon Mr Pettersson in Launceston. The results of that investigation showed a dilated left atrium, a mildly hypertrophied ventricle and mild mitral regurgitation (in other words heart abnormalities).

5. Eventually, despite fevers continuing and Mr Pettersson becoming incontinent of urine at times, he was discharged home on 24 October 2017. Just four days later he returned to the MCH after blacking out a number of times at home. A CT scan and CT angiogram of Mr Pettersson's head and brain did not show any particular areas of concern. Mr Pettersson complained of a decrease in his vision as well as his hearing. He continued to suffer from headaches, was lethargic and unsteady on his feet. Plans were made after an MRI scan to transfer him to Melbourne for surgery. In the event, that transfer did not eventuate.
6. He remained at the MCH hypertensive and afebrile. On 3 November 2017, a MET call was made due to him being unresponsive. He recovered spontaneously but his hypertension continued. He was noted to be confused and continued to complain of headaches.
7. On 9 November 2017 a code blue (i.e. cardiac arrest) was called because Mr Pettersson had no pulse and was unresponsive. CPR was performed and his cardiac output returned. A further CT scan of his brain did not show any acute changes. He was transferred to the MCH's Close Observation Unit. His hypertension continued. At around midday the following day he went into respiratory arrest and was transferred to the Hospital's Emergency Department for ongoing resuscitation. The resuscitation was unsuccessful and he died at 1.40pm.
8. The fact of his death was reported in accordance with the requirements of the *Coroners Act 1995*. An autopsy was performed and the preliminary view of the forensic pathologist, (and accepted by the Coroner who was then investigating Mr Pettersson's death) was that he had died from natural causes, namely ischaemic heart disease. However, further investigation (including routine histological testing) indicated that the preliminary conclusion was not supported by the evidence. Further, that testing showed that, at the time of his death, Mr Pettersson had an unexpected fungal infection which affected his lungs and brain. This finding at autopsy suggested that the diagnosis of lung cancer may well have been an error. Accordingly, an investigation in relation to Mr Pettersson's death followed with a focus upon the diagnosis and treatment of his lung condition.

Investigation

9. After being formally identified, Mr Pettersson's body was transported by mortuary ambulance to the Royal Hobart Hospital. As has already been mentioned, an autopsy was carried out. Part of the autopsy involved taking of samples for histological and toxicological analysis. It was only after that process had been completed that the real cause of Mr Pettersson's death - a fatal infection of his lungs, brain and meninges, became apparent.
10. In addition, the Tasmanian Health Service conducted a Root Cause Analysis (RCA). The outcome of that analysis has helped inform these findings. The RCA expressly accepted that no malignancy could be found and acknowledged that Mr Pettersson had been misdiagnosed. Furthermore, and appropriately, the RCA final report acknowledged that there were missed opportunities to explore other diagnoses and initiate appropriate investigations and management of Mr Pettersson.

Conclusion

11. The management of Mr Pettersson at the Mersey Community Hospital was poor. No appropriate management plan for his lung lesion was developed. There was clear evidence of intracranial involvement in his condition but that evidence was not investigated fully or early enough by either MRI scan and / or lumbar puncture to assess cerebrospinal fluid. The infection which caused Mr Pettersson's death was able to have been treated - had it been diagnosed. His death was unnecessary and avoidable.
12. I convey my sincere condolences to the family and loved ones of Mr Pettersson.

Dated 7 April 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner