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 Rodney James Hanslow

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

a) The identity of the deceased is Rodney James Hanslow;

b) Mr Hanslow died as a result of a traumatic brain injury, subarachnoid and subdural haemorrhage sustained in an unwitnessed fall at his home on 3 July 2021, following which a duodenal ulcer developed;

c) The cause of Mr Hanslow's death was progressive cognitive decline/decompensation and gastrointestinal haemorrhage; and

d) Mr Hanslow died on 8 August 2021 at Calvary Hospital Lenah Valley, Tasmania.

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

- Calvary Health Care Tasmania – Death Report to Coroner;
- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Report – Dr Andrew Reid, Forensic Pathologist;
- Report – Dr Anthony J Bell, Medical Advisor to the Coronial Division;
- Précis – Medical Records, Ms L Newman, Clinical Nurse Supervisor; and
- Medical Records – Calvary Hospital.

Background

1. Mr Hanslow was born in Hobart, Tasmania on 15 March 1935. At the time of his death he was aged 86 years and living in his home at Lenah Valley, Tasmania. He was a retired bus driver, firefighter and hospital volunteer. Relevantly, his medical history included Parkinson's disease and short-term memory loss. In addition, he suffered

gastro-oesophageal reflux disease for which he took a proton pump inhibitor (PPI) and had done so since approximately 2007. The fact that he required PPI medication is noted in his medical history sent by facsimile from his GP to Calvary Hospital on 9 July 2021.

Circumstances of death

2. On 3 July 2021 Mr Hanslow sustained an injury to the right side of his head, as a result of an unwitnessed fall at home when he struck his head on a refrigerator. Reportedly, he suffered a short loss of consciousness but no medical attention was sought until 5 July 2021 when he went to his GP who ordered a CT scan of the brain. The CT scan (the results of which were available the following day) showed a subacute right subdural and subarachnoid haemorrhage. That day Mr Hanslow was admitted as an inpatient at Calvary Hospital.

3. The following day (7 July 2021) at approximately 1.20 pm, Mr Hanslow fell when he was attempting to get out of bed and struck his head on the floor. A MET call was made and a head CT scan carried out which did not demonstrate that he had suffered any new injuries as a result of the fall. Later the same evening Mr Hanslow was significantly agitated and a code black called.

4. Over the next two weeks Mr Hanslow remained in hospital for medical treatment in which his predominant issues were confusion/delirium, agitation and impulsivity.

5. During the following two weeks he was reviewed by a cardiologist, a physician and an endocrinologist as well as various allied health services (occupational therapy, physiotherapy and speech pathology). His medical records indicate that a "sitter" was required to be present with him essentially at all times.

6. Mr Hanslow's nursing chart records a dark stool on 21 July 2021. Mr Hanslow was also noted to have abdominal discomfort.

7. On 22 July 2021, the following is recorded in Mr Hanslow's nursing record "*B/O [bowels open] black and large amount*" of melaena. Although nursing staff do not appear to have advised the relevant physician Mr Hanslow's son did. In response Mr Hanslow was given a single oral dose of 40 mg of esomeprazole (a PPI medication).

8. By 23 July 2021 a general physician (Dr Wood-Baker) had become involved in Mr Hanslow's care and appears thereafter to have been the main doctor overseeing his care and treatment. On the same day, Mr Hanslow's nursing notes indicate a stool specimen was obtained but there is apparently no pathology/microbiology report

anywhere in his records. That in itself is not unusual as ordinarily a stick test for blood in the ward would be carried out. However, there does not appear to be any record of that occurring either.

9. On 24 and 25 July 2021, Mr Hanslow's nursing notes indicate that he passed black, tarry stools. He remained agitated, confused and delirious. He underwent a number of CT scans of his brain which showed evolution of the subdural haematoma and resolution of the subarachnoid haemorrhage. Nonetheless his mobility was decreased and he was unable to communicate meaningfully.

10. Black coloured stools are mentioned in his nursing notes on 27 July, 31 July and 1 August 2021. The fact that he continued to pass black coloured tarry stools does not appear to have been passed on to any clinician for some days.

11. On 29 July 2021, Mr Hanslow was reviewed by a geriatrician, Dr Chamberlain, who made extensive notes in his medical records. He was reviewed again by an endocrinologist.

12. A limited MRI scan was carried out on 2 August 2021. The results showed residual bilateral subdural haematomas and findings consistent with moderate frontal lobe ischaemic microangiopathy. On the same day his haemoglobin levels were 97 g/L (down from 134 g/L on 31 July 2021 and 171 g/L on 18 July 2021), although this fact does not appear to have been mentioned in his medical review notes.

13. On 3 August 2021, the pathology laboratory telephoned the ward to advise that Mr Hanslow's haemoglobin level was now 78 g/L. His medical record indicates that Dr Wood-Baker was informed. Dr Chamberlain reviewed Mr Hanslow the same day and noted the drop in haemoglobin level. His notes were "*new anaemia in the setting of elevated urea, no PR blood loss documented… consider addition of PPI [and for nursing staff] to be vigilant regarding bowel actions, watch for potential PR blood loss/melaena*". This is the second mention of PPI in his medical records (apart from the facsimile sent by his GP on 9 July 2021 and the single dose prescribed on 22 July 2021).

14. Efforts were made to treat him with intravenous fluids but unfortunately Mr Hanslow was non-compliant. Around this time his blood pressure was noted to be low but other vital signs were within acceptable parameters.

15. On 4 August 2021 a rectal examination showed blood/melaena and as a consequence Dr Wood-Baker planned a blood transfusion and commenced a PPI. This is the first time that PPI appears in his medication chart whilst at Calvary Hospital during his final

admission. Consent for the blood transfusion was unable to be obtained that day. Mr Hanslow was by now hypotensive.

16. On 5 August 2021 Mr Hanslow passed copious melaena in the morning. He was by now critically unwell. He received a blood transfusion and was transferred to theatre for a gastroscopy. As a result of that procedure a bleeding duodenal ulcer was located. The ulcer was treated and the bleeding stopped.

17. After discussion with Mr Hanslow's family, active treatment was ceased and end-of-life palliative care commenced. Mr Hanslow was made as comfortable as the circumstances allowed and died on 8 August 2021.

What a coroner does

18. Before considering the circumstances of Mr Hanslow's death it is necessary to say something about what a coroner does and does not do. In Tasmania a coroner's power is to be found in the *Coroners Act* 1995. It is that Act which says what a coroner can do. The Act provides that a coroner has jurisdiction to investigate any death that "appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury".

19. I consider that Mr Hanslow's death meets this definition. It follows that I have jurisdiction to investigate it.

20. When investigating death, a coroner is required to answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. Those questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death. The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

21. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation. I should make it very clear that I do not consider anyone has committed any offences in relation to Mr Hanslow's death.

22. It is not part of the coroner's role either to investigate the adequacy or otherwise of communication between hospitals and the family of a deceased person.

23. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred. 'How' has been determined to mean *"by what means and in what circumstances"*, a phrase which involves the application of the ordinary concepts of legal causation. Any coronial investigation necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1) (b) upon the coroner.

24. It is important to recognise that a degree of caution must necessarily attend this aspect of the coroners function. Self-evidently, the analysis involves a consideration of all the circumstances involving the death including decisions that were made at the time that may or may not have impacted upon the ultimate outcome. A coroner enjoys the distinct advantage of knowing exactly what occurred when making that assessment – something medical practitioners involved in the care of a patient who ultimately dies did not.

25. The standard of proof in the coronial jurisdiction is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.

26. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness. A coroner must ensure that any person (and the term *'person'* means legal person, which includes any legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

Investigation

27. The fact of Mr Hanslow's death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified and then taken to the Royal Hobart Hospital where experienced forensic pathologist Dr Andrew Reid examined his body. Dr Reid provided a report in which he expressed the opinion that the cause of Mr Hanslow's death was progressive cognitive decline/decompensation and a

gastrointestinal haemorrhage. He noted that the death occurred against a background of a traumatic brain injury that is to say subarachnoid and subdural haemorrhage sustained in the fall at his home on 3 July 2021. Dr Reid noted the duodenal ulcer had also been discovered on 5 August 2021. Finally, Dr Reid noted a background of Parkinson's disease and recurring falls including a witnessed fall in hospital on 7 July 2021.

28. I accept Dr Reid's opinion as to the cause of Mr Hanslow's death.

29. Given the circumstances of his death, Mr Hanslow's passing was investigated by the Medico-Legal committee of the Coronial Division. That investigation involved obtaining and analysing his medical records from the Calvary Hospital. In addition comprehensive review of his treatment was carried out by Dr Anthony J Bell, the Coronial Division's Medical Advisor. The focus of the investigation was Mr Hanslow's fall in hospital and his medical treatment generally.

The fall in hospital

30. In summary, the fall Mr Hanslow had on 7 July 2021 caused or contributed to his death. I do not consider the failure to complete the FRAT was causative of Mr Hanslow's death. He was assessed correctly after admission as being at high risk of falls.

31. I do note that it appears he was not seen by a physiotherapist until 2.55 pm on 9 July 2021, approximately 50 hours after being admitted. I also note that Mr Hanslow was wearing apparently provided slip resistant socks.

32. However, there is no mention in Mr Hanslow's hospital records regarding what might be described as "normal" fall prevention strategies such as the use of bed rails, floor mats, call bells, what height the bed was from the floor nor whether Mr Hanslow was assigned supervision upon admission. It is possible that some or all of those measures were implemented; but it is impossible to tell from his medical records.

33. Nonetheless, as I have noted above, I do not consider the fall caused or contributed to Mr Hanslow's death.

General Medical Treatment

34. However, the situation is quite different in relation to his medical treatment. In summary, the failure to continue his proton pump inhibitor was a matter of major

significance in relation to his death. So too was the apparent failure on the part of nursing staff to pass on to relevant medical practitioners critical information in relation to Mr Hanslow passing significant volumes of melaena.

35. In summary, on the evidence I consider:

- The failure to continue a Proton Pump Inhibitor (PPI) after 22 July 2021 was an error;
- The apparent failure of medical staff to read nursing notes was an error; and
- The apparent failure on the part of nursing staff to pass information to medical staff about Mr Hanslow's significant volume of melaena was an error.

36. I consider these errors contributed to Mr Hanslow's death.

37. It is well recognised that patients with upper gastrointestinal (GI) bleeding commonly present with either hematemesis or melaena. Melaena is a clear sign of gastrointestinal bleeding. As I have already set out above there are multiple entries in his medical records where nursing staff detected its presence but effectively did nothing about it. Certainly, the information was apparently not passed on by nursing staff.

38. When Dr Davari became aware (from Mr Hanslow's son, not nursing staff) that Mr Hanslow had passed melaena on 22 July 2021, he should have continued with PPI medication. One dose was simply inadequate. This is particularly so given the fact that Mr Hanslow had required PPI for around 14 years. The presence of melaena made that drug, in my view, absolutely essential.

39. I note that upon identifying the ulcer, Mr Hanslow was indeed placed on a PPI medication. However, by then it was too late as the damage caused by the gastrointestinal bleed and the ulcer was too great. Both could have been avoided if his PPI medication, which he required and had used since at least 2007 (a fact about which the hospital was aware) had been given to him or at the very least continued beyond a single dose on 22 July 2021.

40. It seems to me that there was a significant underestimation of the significance of the presence of melaena by staff at Calvary Hospital. I consider in the circumstances that there was a failure to commence and continue appropriate treatment such as at the very least the use of a PPI. It also seems clear from the evidence that there was a delay in the diagnosis of the ulcer. I consider that the haemorrhage could have been

avoided or minimised if the PPI had continued to be administered as there was ample indicators in the form of the increased melaena being found, a recognised marker of GI bleeds.

Conclusion

41. In summary, the significance of the melaena was either underestimated and/or undertreated. There was an apparent lack of communication between nursing and medical staff. The medical staff made serious errors in relation to diagnosis and management of Mr Hanslow leading to a fatal outcome.

42. These findings, in draft, were sent to Calvary Hospital for comment. I did not understand any issue to be taken with my findings of fact or conclusions.

43. Calvary Hospital carried out a Serious Clinical Incident Investigation in the aftermath of Mr Hanslow's death. As part of the response to my draft findings, Calvary provided the report produced following that process. That review identified a number of areas where communication, policy and procedure can and should be improved. I endorse those recommendations.

Comments and Recommendations

44. The circumstances of Mr Hanslow's death do not require me to make any specific comments or recommendations pursuant to section 28 of the *Coroners Act* 1995, although I observe that I have reached the view that the care and the medical treatment provided to Mr Hanslow at Calvary Hospital prior to his death was below an acceptable standard.

45. Finally, I wish to express my sincere and respectful condolences to Mr Hanslow's family on their loss.

Dated: 17 February 2023 at Hobart in the State of Tasmania.

Simon Cooper
Coroner