



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 Robert Neil Handasyde

Find that:

- (a) The identity of the deceased is Robert Neil Handasyde;
- (b) Mr Handasyde was born on 16 January 1929 and was aged 86 years;
- (c) Mr Handasyde died at the North West Regional Hospital (NWRH) in Burnie on 27 June 2015;
- (d) The cause of Mr Handasyde's death was sepsis with septic shock, due to urinary tract infection, pyelonephritis (infection in the kidney) and focal areas of infection in the prostate gland.

Background

Mr Handasyde and his wife Noreen resided in Penguin. He was a retired farmer. His medical history included coronary artery bypass grafting in 1987 and an old right frontal lobe infarct revealed by CT scan in 2009. In about September 2014 he ceased all medications preferring to only take natural health products.

Mr Handasyde first attended general practitioner, Dr Elvis Igbinovia, on 26 March 2015. He reported having had ongoing dizzy spells for about one month. They usually lasted for about five minutes and resolved spontaneously. Mrs Handasyde, who also attended with her husband, expressed her concerns about her husband's urinary incontinence and nocturia. She reported that he had been under the care of an urologist some years previously for "folds in his bladder." An electrocardiogram was interpreted by Dr Igbinovia to show atrial fibrillation. Mr Handasyde was referred to a cardiologist and for a Holter monitor investigation. He was also referred to an incontinence clinic.

On 31 March Mr Handasyde had two further dizzy spells which he reported to Dr Igbinovia. He was prescribed clopidogrel and indapamide. However, on 14 April Mr Handasyde reported feeling better and that he had not had any dizzy spells during the preceding week.

On 24 April the Holter monitor recording was carried out. It was analysed three days later. However, the report upon the monitoring was not forwarded to Dr Igbinovia until 19 May. He considered the report to be “*unremarkable.*”

From 30 April to 3 May Mr Handasyde was a patient of the NWRH having presented at the Emergency Department (ED) with multiple episodes of bright red rectal bleeding. A colonoscopy showed pan-colonic diverticulitis. He continued to receive clopidogrel and indapamide. During his admission he suffered an episode of urinary retention. A bladder scan showed 700ml of urine in the bladder. A urinary catheter was inserted and 450ml of urine was drained. Over 4 hours a total of 1150ml was drained. On 30 April an ECG was performed but was not interpreted.

On 11 May physician, Dr R A Watts, performed an echocardiogram. It seems likely that at this time he was unaware of the results of the Holter monitoring.

Mr and Mrs Handasyde attended Dr Igbinovia on 20 May and 11 June. On each occasion they expressed concern about his persistent use of incontinence pads at night. On the latter occasion Mrs Handasyde reported having measured her husband's urine output for one night and that he had passed 400mls.

On 15 June Mr Handasyde again presented at the ED of NWRH having had a fall at home several days previously. Respite arrangements were then organised and on 16 June 2015 Mr Handasyde was admitted to the Eliza Purton Nursing Home (EPNH) in Ulverstone.

Circumstances Surrounding the Death

At EPNH Mr Handasyde complained from the outset of low back pain and dysuria (difficulty passing urine and pain when doing so). He was seen by Dr Igbinovia on 17 June and started on topical Voltaren. The next day he had a urinalysis which indicated a likely urinary tract infection and Dr Igbinovia was advised the details. Dr Igbinovia then directed that Mr Handasyde be administered oral Trimethoprim 300mg daily.

On 19 June it was recorded that Mr Handasyde had been groaning in pain overnight. He was given paracetamol. During the day his temperature was recorded at 40.4°C, blood pressure of 145/55 mmHg, respiratory rate of 19bpm and heart rate of 78bpm. It was noted that Dr Igbinovia had been expected to attend to review Mr Handasyde but did not do so. At 6.00pm the Trimethoprim was commenced.

Mr Handasyde's condition remained relatively unchanged on 20 June. However, the following day it was noted that the simple analgesia was not managing his pain. He was reviewed by Dr Ian Emmett who prescribed Endone 5mg. It was recorded that later that day he seemed more settled. The administration of Endone continued and by about midday on 23 June Mr Handasyde had become unresponsive and opiate toxicity was suspected by EPNH's nursing staff. Ambulance Tasmania was called and paramedics administered IV naloxone. Mr Handasyde was then transported to NWRH. In the ED was observed until 3.00pm. He remained alert and comfortable. His Endone dose was reduced and he was discharged back to EPNH arriving at about 4.00pm. The following day he was reviewed by

Dr Igbinovia who directed that the Endone be withheld for 24 hours with the EPNH nurse recording that Dr Igbinovia did not believe Mr Handasyde to be in pain and that he was *“delirious and confused.”*

In the morning of 25 June staff at EPNH reported to Dr Igbinovia that Mr Handasyde was again unresponsive. He then spoke to Mrs Handasyde after which he directed that Mr Handasyde be transferred back to NWRH. This occurred via ambulance at about 1.00pm. At the hospital Mr Handasyde's condition was assessed to be terminal. Medical staff discussed his situation with family members and it was agreed to implement comfort care. Mr Handasyde's condition continued to deteriorate and he died at about 8.25am on 27 June 2015.

Post-Mortem Examination

This was carried out by pathologist, Dr Terry Brain. In his opinion the cause of Mr Handasyde's death was sepsis, prostatic and renal severe inflammation.

Investigation

This has included consideration of:

- An affidavit along with a handwritten chronology provided by Mrs Handasyde.
- Medical reports provided by Dr Igbinovia and Dr R A Watts.
- A review of Mr Handasyde's records at NWRH and at EPNH carried out by Research Nurse, Ms L K Newman.
- A report made by Dr A J Bell as medical adviser to the coroner.

In his report Dr Bell has made these observations:

- Mr Handasyde's history made evident on 26 March 2015 clearly suggested that he had a bladder neck obstruction with over-flow incontinence. He required urgent referral to an urologist for assessment. It would not have been inappropriate to have made a contemporaneous referral to an incontinence clinic.
- The symptoms of bladder neck obstruction with over-flow incontinence can be readily and simply relieved by insertion of a urinary catheter or supra-pubic catheter, either of which would have provided immediate relief. A catheter can be left in situ to provide ongoing symptom relief.
- In addition bladder neck obstruction can be treated with urological surgery. This was an option for Mr Handasyde.

- By inserting a catheter and/or undergoing urological surgery Mr Handasyde would have been relieved of having a full bladder and hence would not have been exposed to the risk of serious infection.
- From 21 to 23 June 2015 Mr Handasyde received 20mg of endone within 48 hours per 5mg doses. The usual starting dose for endone is 2.5 to 5mg orally. For patients with renal failure the blood levels after a single dose are doubled. This occurred in Mr Handasyde's case because of his renal failure. It caused his opiate toxicity and coma which required his visit to hospital on 23 June 2015.
- That in his opinion Mr Handasyde had septic shock by 19 June 2015 as evidenced by his temperature of 40.4°C and a blood pressure systolic falling by 40mmHg. He required emergency transfer to hospital and commencement of intravenous antibiotics. The use of an oral antibiotic was incorrect practice.
- When Dr Igbinovia did not attend to review Mr Handasyde on 19 June EPNH should have, on its own initiative, arranged for his hospitalisation. The seriousness of his condition required this to occur.
- That in his opinion the medical staff at NWRH overly focussed upon Mr Handasyde's rectal bleeding when he presented on 30 April 2015. Instead focus should have been on the patient as a whole. This should have led to a full history being obtained which should have alerted the medical staff to Mr Handasyde's urinary obstruction and his immediate need to see an urologist.
- That in his opinion the failure to make a timely diagnosis of Mr Handasyde's urinary obstruction and to implement appropriate treatment led to Mr Handasyde developing an infection of the retained urine leading to pyelonephritis septicaemia and leading in turn to death.
- Had Mr Handasyde's urinary condition been promptly and appropriately treated it is likely that his death would have been avoided.
- That the cause of death as stated by Dr Brain, could be expansively described as sepsis with septic shock, due to urinary tract infection, pyelonephritis (infection in the kidney) and focal areas of infection in the prostate gland.

Findings, Comments and Recommendations

It is apparent, and I so find, accepting the description provided by Dr Bell, that the cause of Mr Handasyde's death was sepsis with septic shock, due to urinary tract infection, pyelonephritis (infection in the kidney) and focal areas of infection in the prostate gland.

I am satisfied, accepting the opinion of Dr Bell, that Mr Handasyde was suffering from a bladder neck obstruction when he first attended Dr Igbinovia on 26 March 2015. Regrettably the diagnosis was not made at that time or on later occasions when Mr Handasyde

consulted his general practitioner or indeed following his admission to NWRH on 30 April 2015. In the result Mr Handasyde's urinary condition went untreated leading to infection and death. This was a tragic outcome which, in all likelihood would have been avoided if Mr Handasyde had received proper medical care.

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.

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

Dated: 8 May 2017 at Hobart in the State of Tasmania.

Rod Chandler
Coroner