



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 Wendy Crosswell,

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

- (a) The identity of the deceased is Wendy Crosswell;
- (b) Ms Crosswell died as a result of complications caused by a dislodged percutaneous endoscopic gastrostomy (PEG) tube;
- (c) The cause of Ms Crosswell's death was peritonitis; and
- (d) Ms Crosswell died on 12 December 2015 at the Royal Hobart Hospital, Hobart, Tasmania.

In making these findings I have had regard to the material obtained as a result of investigation into Ms Crosswell's death carried out pursuant to the provisions of the *Coroners Act 1995*. That information included affidavits dealing with formal identification of the body and life being extinct, a report of Dr Christopher Hamilton Lawrence the Tasmanian State Forensic Pathologist who performed an autopsy on Ms Crosswell's body on 15 December 2015; an affidavit from her older sister Cheryl Harris and medical records.

In addition I was provided with a report from Dr Anthony J Bell MD FRACP FCICM who reviewed the circumstances surrounding Ms Crosswell's death. Reports were also sought, and obtained, from Dr Michael Wilkinson MB Ch B FRANZCR, visiting specialist radiologist at the Royal Hobart Hospital, who reviewed, along with Dr Anning, a registrar in radiology, the results of a fluoroscopic procedure performed by Dr Anning on Ms Crosswell between 3.00pm and 3:15pm on Friday 11 December 2015.

I find, on the basis of the evidence as follows. Ms Crosswell developed pyelonephritis whilst holidaying with her family on a cruise ship in the South Pacific. She was transferred from the ship by helicopter to hospital in Brisbane on 5 October 2015.

Although gravely ill, Ms Crosswell's condition stabilised sufficiently such that she was able to be airlifted from Brisbane to the Royal Hobart Hospital on 20 November 2015.

At the Royal Hobart Hospital Ms Crosswell was assessed and appropriate therapy started. She was having significant difficulty swallowing and as a result a nasogastric (NG) feeding tube was inserted. However, because of continuing difficulties with her continuing to pull the

NG tube out, a decision was made to insert a PEG tube. This procedure was done without apparent complication on 1 December 2015.

In the early hours of 11 December 2015 Ms Crosswell was thought to have pulled at, and dislodged, the PEG tube. Notes recorded at the time indicate she was seen to be agitated and scratching at her skin. Accordingly an x-ray of the tube was ordered and carried out. The results of the x-ray were interpreted wrongly, as the tube being in the correct position.

Dr Bell's opinion, supported by the appearance of the images themselves and the opinion of radiologist Dr Stephen Broadhurst, is that the radiological imagery was wrongly interpreted and the radiological report produced as a consequence of the procedure also wrong. It is noted that Dr Wilkinson and Dr Anning both acknowledged the error that had been made in interpreting the radiological results.

The result of the PEG tube being dislodged and the fact that it was dislodged not being detected was that Ms Crosswell quickly developed peritonitis which rapidly proved fatal.

Dr Bell expressed the opinion that the handling of the situation with respect to the PEG tube was poor. He said that "the suspicion of displacement should have led to... rapid investigation of the tube position". He noted no antibiotic coverage was given and that the radiological examination was not carried out expeditiously and when it was performed was incorrectly reported.

I observe that Dr Bell's written opinion was sent to the appropriate officer at the Royal Hobart Hospital with an invitation for the hospital or the Tasmanian Health Service to make any comment. No reply was received.

I accept Dr Bell's opinion. I am satisfied that the care afforded to Ms Crosswell was not of an acceptable standard. I do note however that Ms Crosswell was very ill indeed with little or no realistic chance of recovering to any functional degree from the pyelonephritis which was the cause of her being in hospital in the first place. It follows that I cannot conclude that the substandard care she received made any change to her probable outcome.

Recommendations and Comments

The circumstances of the death of Ms Crosswell require me to **recommend** pursuant to Section 28 (2) of the *Coroners Act* 1995 that more care must be taken in interpreting and reporting upon the results of radiological examination in circumstances where PEG tubes are suspected of being dislodged or wrongly positioned.

I convey my sincere condolences to the family and loved ones of Wendy Crosswell.

Dated 20 June 2017 at Hobart in the state of Tasmania

Simon Cooper
Coroner