



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 Peter Leslie Fellows

Find that:

- a) The identity of the deceased is Peter Leslie Fellows;
- b) Mr Fellows was born in Launceston on 29 January 1981 and was aged 33 years;
- c) Mr Fellows died on 21 August 2014 at the Launceston General Hospital (LGH) in Launceston; and
- d) The cause of Mr Fellow's death was decompensated congestive cardiac failure complicating acute myocardial infarct caused by advanced atherosclerotic coronary vascular disease. A significant contributing factor was obesity.

Background

Mr Fellows was the youngest of four children of Leslie and Barbara Fellows. He resided with his mother at 3 Quinn Avenue in Georgetown, his father having died on 22 May 2014. He was single and an Invalid Pensioner.

Mr Fellows had a lengthy and complex medical history. Since infancy he had suffered from asthma and eczema which had required hospitalisation on multiple occasions. He took oral steroids to manage these conditions and was steroid dependent. His health was complicated by corneal keratoconus and early cataracts which severely limited his vision. He was morbidly obese, weighing 101.8 kg at the time of his death.

Circumstances Surrounding the Death

In the late afternoon of 19 August 2014, Mr Fellows presented at the Anne Street Medical Services practice with a history of light-headedness and having felt unwell for the previous week, along with vague left-sided chest pains and nausea. There was no history of palpitations or shortness of breath, nor was he complaining of chest pain. He was seen by Registrar, Dr Miriam Woodgate. Upon her examination his blood pressure

was 95/60 and pulse 90bpm. He was afebrile, his heart sounds were dual with no extra sounds, he had no internal/chest wall tenderness, his chest sounded clear, and his abdomen was soft and non-tender. In Dr Woodgate's opinion Mr Fellows was suffering from a viral illness. She recommended suitable symptomatic treatment. Later that afternoon Mr Fellows returned to the surgery with his mother. She reported that her son was unwell and 'not himself.' Mr Fellows was again reviewed by Dr Woodgate. His blood pressure was still 95/60 but his pulse had increased to 103 bpm. On this occasion Dr Woodgate ordered an ECG. It showed changes consistent with severe ischaemia of the myocardium. Mr Fellows was then diagnosed with cardiac ischaemia and an ambulance was called to transport him to the LGH. It arrived at the Emergency Department (ED) at 7.09pm.

Mr Fellows was reviewed by a senior ED registrar. The history recorded was two to three days of shortness of breath and pre-syncope on exertion. There was associated pressure-type chest pain which was relieved by rest, and the heart rate was 112 bpm with blood pressure of 160/126 mmHg. An ECG was reported as showing marked lateral ST segment depression. The blood troponin level was significantly elevated. A diagnosis of acute coronary syndrome was made and Mr Fellows was referred to the cardiology team.

Mr Fellows was promptly seen by cardiology registrar, Dr Ramanathan Parameswaran. By this time his blood pressure had fallen to 105/70 and his heart rate was 108bpm. Dr Parameswaran recorded the problem as "*new onset heart failure*" and initiated treatment for congestive cardiac failure with fluid restriction, frusemide, and an angiotensin converting enzyme inhibitor.

At 10.50pm, the nursing notes indicate that Mr Fellows was "*pain free*" and comfortable. His heart rate was 100bpm and his blood pressure was "*hard to detect*." At 11.15pm, his blood pressure was recorded at 91/75 and the bed was tilted. He remained hypotensive with his blood pressure noted at 92/60 about three hours later.

In the morning of 20 August, Mr Fellows was seen by consultant cardiologist, Dr George Koshy, on his ward round. His blood pressure at that time was noted at 93/63 with a heart rate of 106bpm. The troponin was noted to be rising. The jugular venous pressure was elevated and there was a wide split of the second heart sound with no gallop rhythm heard. A diagnosis of congestive cardiac failure was made and a beta blocker was added to Mr Fellows' drug regime. The treatment plan was for a "*.....coronary angiogram later on?tomorrow (when better)*."

During the course of 20 August, Mr Fellows' blood pressure was reported to be very difficult to obtain. Frequently, the systolic readings were sub-100mmHg. At 8.30pm his blood pressure was recorded at 85mmHg systolic. There was a medical review and the foot end of Mr Fellows' bed was raised. Mr Fellows appeared settled and denied pain. However, his pulse and blood pressure continued to be very difficult to obtain.

At about 5.55am on 21 August Mr Fellows became unresponsive. Shortly afterwards he had a cardio pulmonary arrest. A Code Blue was called and CPR initiated. However, Mr Fellows could not be revived and he was declared deceased at 6.26am. For the duration of his admission Mr Fellows had remained in the ED.

Post-Mortem Examination

This was carried out by forensic pathologist, Dr Donald Ritchey. In his opinion the cause of Mr Fellows' death was decompensated congestive cardiac failure complicating acute myocardial infarct caused by advanced atherosclerotic coronary vascular disease. A significant contributing factor was obesity.

Investigation

This has been informed by:

- A review of Mr Fellows' records at the LGH carried out by research nurse, Ms L K Newman.
- Reports provided by Dr Tim Mooney of Anne Street Medical Services, along with Mr Fellows' Progress Notes from that practice.
- An affidavit provided by Mr Fellows' mother.
- The Patient Care Report from Ambulance Tasmania.
- A report from Associate Professor B Herman, Director of Cardiology at LGH.
- A report from Dr Parameswaran.
- A report from Dr Koshy.
- Correspondence from HWL Ebsworth, lawyers acting on behalf of Dr Koshy.

The focus of this investigation has been upon the adequacy of Mr Fellows' cardiac care during the 1 ½ days prior to his death when he was a patient in the ED of the LGH. To this end, specific reports upon this issue were sought from Dr A J Bell, the medical adviser to the coroner, and from Cardiologist, Professor Michael Jelinek, former Director of Cardiology at St Vincent's Hospital in Victoria. Their jointly held opinions can be summarised as follows:

1. That Mr Fellows had coronary artery disease with cardiac failure and a dilated, poorly contracting heart. His illness was severe, unusual and rare, particularly for a person of his relatively young age.

2. That after his admission to the LGH Mr Fellows developed cardiogenic shock, and his treatment should have focused upon this condition rather than chronic congestive heart failure.
3. The plan for a coronary angiogram to exclude coronary artery narrowing was appropriate.
4. That Mr Fellows was too ill to undergo the coronary angiogram as he would have been unable to lie flat for the length of time required by the procedure. In some instances it is feasible to carry out this procedure under general anaesthetic by intubating the patient and utilising a ventilator. In Dr Bell's opinion this option would have been taken by him if Mr Fellows had been his patient. However, he accepts that the alternative option chosen by Dr Koshy, i.e. to postpone the angiogram pending an improvement in Mr Fellows' overall condition, was a reasonable and understandable course to take.
5. That Dr Koshy's decision to prescribe a beta-blocker for Mr Fellows in the morning of 20 August was an error. Mr Fellows was too ill to be prescribed this medication at this time.
6. Mr Fellows' condition deteriorated during the course of 20 August and the decision to prescribe the beta-blocker should have been reviewed and cancelled prior to its administration at 10.00pm on 20 August.
7. That Mr Fellows' falling blood pressure over the course of 20 August required active intervention to try and improve heart function. Use of a medication such as dobutamine would have been appropriate. If Mr Fellows' ischaemia worsened then the fitting of an aortic balloon pump may have been beneficial.
8. That Mr Fellows' condition would have been better monitored in a Critical Care Unit or an Intensive Care Unit equipped with a flow guided pulmonary artery catheter and invasively monitored arterial blood pressure, rather than in the ED.
9. Had Mr Fellows had a coronary angiogram, followed by coronary artery bypass surgery, he may have been able to survive. However, he was severely ill and his prospect of survival, even with full care, was more unlikely than likely.

Findings, Comments and Recommendations

I accept the opinion of Dr Ritchey upon the cause of Mr Fellows' death.

It is apparent that Mr Fellows was seriously ill when he presented at the ED on 19 August 2014. Also, it is clear, accepting the combined opinion of Dr Bell and Professor Jelinek, that during his admission Mr Fellows suffered cardiogenic shock requiring specific treatment for that condition. I am satisfied, again accepting the opinion evidence of Dr Bell and Professor Jelinek, that such treatment should not have included

the administration of a beta blocker, as it was likely to have caused a deterioration in his condition.

As I have said, Mr Fellows was seriously ill and there was a very real likelihood of his death, even if he had received the full battery of available treatments. In this context it cannot be said that his death would have been avoided if he had not been administered beta-blocker medication.

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 Fellows' family and loved ones.

Dated: 15 May 2017 at Hobart in the State of Tasmania.

Rod Chandler
Coroner