



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION



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## Record of Investigation into Death (Without Inquest)

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Rod Chandler, Coroner, having investigated the death of David Paul Unwin

### **Find, pursuant to Section 28 of the Coroners Act 1995, that:**

- a) The identity of the deceased is David Paul Unwin;
- b) Mr Unwin was born in the United Kingdom on 28 August 1961 and was aged 55 years;
- c) Mr Unwin died at George Town at an unknown time in the period 9 January to 11 January 2017; and
- d) The cause of Mr Unwin's death was probable sepsis in the setting of immunosuppression, a skin wound and chronic diarrhoea following a previous kidney transplant (requiring immunosuppressant drugs to prevent transplant rejection) due to polycystic kidney disease.

### **Background**

Mr Unwin emigrated with his family to Australia in 1973, initially living in Western Australia. He married but had been separated from his wife Angela for many years. They had two daughters, Angela and Gwen. Mr Unwin moved to Tasmania from Queensland in about 2015. He had just completed his training as a nurse. He took up residence at George Town and was employed by Able Australia as a carer.

Mr Unwin's medical history is dominated by polycystic renal disease diagnosed in 1996 and which eventually necessitated dialysis. In August 2009 he received a cadaveric renal transplant after which he developed a chronic antibody mediated rejection of his new organ.

### **Circumstances Surrounding the Death**

The evidence reveals this chronology of events:

1. On 11 April 2016 Mr Unwin reported to Dr Amanda Clifford of the George Town Medical Centre (GTMC) that he was "*feeling rundown and is having a lot of diarrhoea.*" Faecal occult blood testing was arranged and after three positive results

were received a referral was made to the Launceston General Hospital (LGH) for a colonoscopy. This was on 3 May 2016.

2. On 16 September 2016 Mr Unwin reported to Dr Clifford: *"Few weeks of feeling unwell."* He had recently had root canal therapy without antibiotic cover. Blood tests were ordered. They showed a creatinine level of 263 micromoles/L. The level of creatinine in the blood is a reliable indicator of renal function. Mr Unwin's usual level was 180 micromoles/L thus a reading of 263 micromoles/L suggested that his kidney function had deteriorated significantly. It was arranged for Mr Unwin to be seen by renal physician, Dr Mathew Mathew at the LGH Renal Clinic.
3. Mr Unwin saw Dr Mathew on 21 September. His creatinine had slightly reduced to 243 micromoles/L. Dr Mathew considered that his deteriorated renal function was attributable to an infection related to the recent dental treatment and that the appropriate antibiotic therapy was in place. An appointment was made for Mr Unwin to next see Dr Mathew on 11 January 2017.
4. On 11 December 2016 Mr Unwin attended Dr Adam Renwick who noted: *"Left upper leg abscess, under gluteal fold. Past 4 days, getting worse."* He was given ceftriaxone, an antibiotic. At the same consultation it was also noted: *"Diarrhoea ongoing since earlier in year. Weight loss ~16 kg in 8 weeks-unexplained."* Mr Unwin was still on the LGH waiting list for his colonoscopy.
5. From 12 December 2016 to 3 January 2017 Mr Unwin made regular visits to Dr Ikechi Gbenimacho for treatment of his upper leg abscess. Blood testing on 15 December showed a creatinine level of 342 micromoles/L with anaemia. At a consultation on the same day Mr Unwin complained of nausea and vomiting.
6. On 19 December Dr Gbenimacho recorded: *"Dr Mathew is of the opinion that worsened renal function is most likely due to the gluteal cellulitis; will improve with resolution."*
7. Dr Mathew acknowledges the phone conversation with Dr Gbenimacho but says that he assumed it was a case of *"simple cellulitis."* He says that he *"was not told about the abscess, the ongoing diarrhoea nor the weight loss."* He further says that it was his expectation that Dr Gbenimacho would have been in touch with him again in 24 to 48 hours if Mr Unwin's condition had not improved and as he had not heard from him he assumed *"that everything got back to normal."*
8. Dr Gbenimacho saw Mr Unwin again on 22 and 28 December and considered that his abscess was healing satisfactorily.
9. He next saw him on 3 January 2017 and again it was noted that the abscess was continuing to heal.
10. On 6 January Mr Unwin again attended Dr Gbenimacho's practice for his wound to be re-dressed by a registered nurse. She reports the area of the abscess *"looking clean."*
11. Also on 6 January Mr Unwin had a blood sample collected by Launceston Pathology for testing. The test had been ordered by Dr Mathew preparatory to his upcoming appointment with Mr Unwin at the LGH Renal Clinic on 11 January.
12. The results of Mr Unwin's blood tests were available in the afternoon of 6 January. Launceston Pathology has in place protocols to identify test results which are critical, meaning that they *"may indicate a life threatening medical condition and require immediate notification to the referring doctor."* The results from Mr Unwin's tests qualified as 'critical results' and accordingly Launceston Pathology took steps to give

notice of them. Their records show that on 6 January at 5.21pm Dr Mathew was phoned and advised of the results. Copies of the results were then faxed to his rooms and to the LGH clinic. The results were also transmitted to Dr Clifford's practice at George Town. Among the results was the reading for Mr Unwin's creatinine level of 381 micromoles/L indicating a continuing rise. A copy of the written results was also delivered to Dr Mathew's rooms on 9 January.

13. Dr Mathews has no memory of receiving the phone advice from Launceston Pathology. However, he does not dispute that it occurred. He postulates that he made the decision that it was appropriate to wait to see Mr Unwin at the pre-arranged appointment on 11 January and that it was unnecessary to take more urgent action. He says this decision was made in the context that he assumed Mr Unwin had recovered from his cellulitis and that he remained unaware of those other afflictions from which Mr Unwin had been suffering.
14. It is accepted that the GTMC received a copy of the blood tests results on 6 January but Dr Gbenimacho was not working that day and did not sight them. He did not sight them on the following Monday either when he returned to work as he was unaware that they had been ordered and they were not addressed to him in any event. It seems that the Centre had a general review of downloaded pathology results on Tuesday 10 January and it was then that Mr Unwin's results were noted for the first time.

Mr Peter Unwin resides at East Devonport and saw his brother David "fairly regularly" after he moved to Tasmania. He says: *"I last saw David on Monday just gone, 9 January 2017. I had a hospital appointment in Launceston and David came with me. He wasn't looking well that day. He had lost a lot of weight, had the shakes and was hyperventilating. I spoke to him about calling an ambulance and advised it very strongly but he said he had an appointment with the Doctor the next day so didn't need or want the ambulance. I am a registered nurse, although not practising, and I really think he should have seen someone that day but he wouldn't. I dropped David off at his house about 5.30pm on Monday but didn't actually come inside. I watched him go to the front door then headed home to Devonport. David had not said anything about what he planned to do that evening."* Mr Peter Unwin further says that on this Monday his brother David told him that he believed his transplanted kidney was failing, that his creatinine levels were "out of whack" and that he expected he would have to resume dialysis.

During the next couple of days Mr Peter Unwin daily phoned his brother to check on him. However, his calls were not answered nor did his brother return his calls. Mr Peter Unwin's next hospital appointment was on Friday 13 January and he decided to call at his brother's George Town home en route to that appointment. He arrived at the address at around 9.45am. He knocked on the door with no response. He was then able to look through a window and could see his brother seated in the lounge room. However, again, there was no response when he knocked on the window. He was able to enter the residence via the front door and immediately attended his brother. It was clear that he was deceased. The Tasmania Ambulance Service was called and promptly attended.

## Post-Mortem Report

This was carried out by pathologist, Dr Rosanne Devadas. In her opinion the cause of Mr Unwin's death was probable sepsis in the setting of immunosuppression, a skin wound and chronic diarrhoea following a previous kidney transplant (requiring immunosuppressant drugs to prevent transplant rejection) due to polycystic kidney disease.

## Investigation

This has been informed by:

- a) The Police Report of Death;
- b) An affidavit provided by Mr Peter Unwin;
- c) A review of Mr Unwin's general practitioner and hospital records carried out by clinical nurse, Ms L K Newman;
- d) Reports from Dr Mathew;
- e) A report from Dr Gbenimacho;
- f) A report from Launceston Pathology; and
- g) A report provided by Dr A J Bell as medical adviser to the coroner. For this case it is relevant to observe that Dr Bell is a fellow of the Royal Australian College of Physicians, that he completed training in nephrology in Canada, the United States and Australia and that he practiced nephrology for 18 years, both in the public and private domains.

In his report Dr Bell includes these observations:

- i. Kidney transplantation is the treatment of choice for end-stage renal disease. A successful kidney transplant improves the quality of life and reduces the mortality risk for most patients when compared with maintenance dialysis. However, patients require close follow-up after transplantation since they are on complex immunosuppressive regimes that render them at risk for infection, malignancy, and cardiovascular disease. In addition, these patients often have multiple comorbidities due to, or as a cause of, their underlying end-stage renal disease. Ordinarily a specialist follow-up review each three months would be reasonable.
- ii. The onset of persistent diarrhoea in an immunosuppressed state requires relatively urgent investigation. The presence of three positive occult blood results in the stool is a further indicator for prompt investigation. This includes looking for infection, opportunistic infections and malignancy. In Mr Unwin's case he required urgent referral by his general practitioner or by Dr Mathew to a gastroenterologist.
- iii. The complex of symptoms presenting in December 2016 including nausea, vomiting, fever, weight loss and associated gluteal abscess were suggestive of renal function deterioration. They necessitated hospital admission and investigation including an urgent colonoscopy. The gluteal abscess required urgent ulcer ultrasound investigation and surgical review. The significant elevation of creatinine required review by a nephrologist.
- iv. That, in his opinion, the decrease in Mr Unwin's renal function presenting in December 2016 was significant but there was a prospect of his previous level of kidney function being restored if his other illnesses were cured.

- v. That, in his opinion, Dr Mathew underestimated the degree of Mr Unwin's illness at the time of his phone conversation with Dr Gbenimacho on 19 December 2016. The advice given to Dr Gbenimacho at that time was kidney-centred and lacked the holistic approach required by immunosuppressed patients.

### Findings, Comments and Recommendations

I accept the opinion of Dr Devadas upon the cause of Mr Unwin's death.

The evidence does not permit me to make a precise finding upon the time and date of Mr Unwin's death. He was last seen alive by his brother at around 5.30pm on Monday 9 January. He did not attend his appointment with Dr Mathew set for 10.00am on 11 January and calls made by his brother to that time were unanswered and not returned. The evidence leads me to conclude that Mr Unwin died at an unknown time in the period after 5.30pm on 9 January and before 10.00am on 11 January 2017.

It is self-evident that transplant recipients require their ongoing health to be closely and regularly monitored and for any deterioration in their state of health to be promptly investigated and treated. This is particularly so for a patient such as Mr Unwin who had a known history of renal dysfunction and organ rejection. Unfortunately, the evidence shows, and I so find, that Mr Unwin did not receive the level of medical care which his condition required. I point to these matters:

1. The failure to ensure that the colonoscopy, considered necessary following positive faecal occult blood testing, ongoing diarrhoea and weight loss, was carried out. It is noted that Mr Unwin was referred for this procedure on 3 May 2016 but it had not taken place by the time of his death some 8 months later.
2. Dr Mathew says that he normally reviews long-term renal transplant patients on a three monthly basis, a practice which I note accords with the opinion of Dr Bell and which I accept to be appropriate. However, the record in this case shows that Dr Mathew saw Mr Unwin on one occasion only in the 9 months preceding his death.
3. In mid-December 2016 Mr Unwin presented with an upper leg abscess and complained of nausea, vomiting, continuing weight loss and diarrhoea. His creatinine level was 342 micromoles/L. I accept Dr Bell's opinion that this state of affairs mandated Mr Unwin's hospitalisation and a comprehensive investigation of his condition.
4. The failure to ensure that Mr Unwin was hospitalised on 6 January 2017 when his creatinine level was 381 micromoles/L or double his usual level.

Events on 6 January require particular comment. I accept that Dr Gbenimacho had not ordered the blood tests taken on that day and hence was not looking out for the results. I accept too that they were not addressed to him. Nevertheless, Mr Unwin was a patient of the GTMC and the failure to sight the results until the fourth day after their delivery (although including a weekend) does suggest a shortcoming in the Centre's procedures around the sighting of blood test results, particularly those which the pathologist has categorised as 'critical.' It leads me to **recommend** that GTMC and other general practices in the State carry out a review of their practices and procedures around the sighting of pathology results with a view to ensuring that those results which require an urgent response do not 'fall through the cracks' and are seen and responded to at the earliest opportunity.

The evidence provided by Launceston Pathology does satisfy me that Dr Mathew was advised of Mr Unwin's blood test results in the late afternoon of 6 January. I am satisfied too that Dr Mathew made the decision at this time that the blood test results did not warrant an urgent response and instead that it was appropriate for the situation to be reviewed when he saw Mr Unwin at his appointment which had been set for 11 January. This decision was, with the benefit of hindsight, regrettable. I am satisfied that Mr Unwin's condition at this time required his immediate hospitalisation and the failure to ensure that this occurred denied him the best chance of survival.

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. The circumstances of the death do not require me to make any further comment or to make any recommendations.

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

**Dated:** 5 November 2018 at Hobart in the State of Tasmania.

**Rod Chandler**  
**Coroner**