



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 David Patrick

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

- a) The identity of the deceased is Robert David Patrick;
- b) Mr Patrick was born on 10 March 1951 and was aged 65 years;
- c) Mr Patrick died on 16 October 2016 at Strahan, Tasmania; and
- d) The cause of Mr Patrick's death was a ruptured abdominal aortic aneurysm.

Background

Mr Patrick resided at Scamander and was a self-employed musician.

On 9 June 2016 Mr Patrick presented to his general practitioner with a cough and haemoptysis (coughing up blood). Lung cancer was suspected and he was referred to respiratory physician, Dr James Markos. He carried out a bronchoscopy on 17 June which showed a small cell carcinoma of the lung. Mr Patrick was then referred to radiation oncologist, Dr Stan Gauden and radiation therapy was commenced on 11 July. This treatment was completed by 12 August with minimal side effects. Mr Patrick was also treated with chemotherapy and had undergone four cycles by 15 September. The chemotherapy was scheduled to resume on 17 October. In the course of his treatments Mr Patrick had a PET/CT scan on 6 July. It showed a large aortic aneurysm. Follow-up scanning on 12 September reported: *"Aneurysmal abdominal aorta is noted involving both the suprarenal and infrarenal portions. The larger infrarenal component measures 73 mm in AP diameter similar to that seen on prior assessment."*

Circumstances Surrounding the Death

On Saturday 15 October 2016, Mr Patrick travelled to Strahan intending to play a gig that night at the Bushman's Inn. He was accompanied by friends Mr Jack Metham and Mr Carl McConnell. They set up the equipment and then did a sound check. Mr Patrick complained of back pain. Initially he lay down on a couch to try to relieve the pain but it did not improve. He then went to his room upstairs and lay down but the pain did not abate. An ambulance was called and it transported Mr Patrick to the West Coast District Hospital (WCDH), arriving at 9.34pm. On route, Mr Patrick was administered 10 mg of morphine for pain control. The

ambulance officer's notes include this entry: *"Pt. states that he has been lifting heavy band equipment today. Now pain in the lower back rated at 8/10. Pt. has a previous lower back injury."*

At the WCDH Mr Patrick was seen by registered nurse, Ms Marijke Schurer. She says that Mr Patrick told her that he had injured his back when lifting heavy musical band equipment. He said his back pain had not been relieved by the morphine given by the ambulance officers. As to his past history Nurse Schurer noted: *"lung cancer June '16, back problem 20 yr. ago, dilated aorta for investigation."* It was noted that Mr Patrick could take himself to the toilet independently and that he could pull up both legs without pain. His clinical observations were recorded. The blood pressure reading was 195/110.

At this time Dr Melanie Van Twest was a general medical practitioner employed at the Queenstown General Practice with on-call responsibilities at the WCDH. At around 10.00pm she was phoned by Nurse Schurer and advised of Mr Patrick's presentation. She was informed of Mr Patrick's recent history. They agreed that it was not necessary for Dr Van Twest to attend at the Hospital. Based on the account provided by Nurse Schurer, Dr Van Twest diagnosed Mr Patrick with back pain related to over-exertion and muscle strain. She authorised a dose of ketorolac, a non-narcotic analgesic which was administered at 10.15pm. About 1 ½ hours later friends of Mr Patrick's arrived from Strahan and he was discharged into their care. According to Nurse Schurer, Mr Patrick stated that he had minimal pain at this time, although she described him as being as *"very tired."*

That night Mr Metham checked on Mr Patrick in his room on two occasions. On the first occasion he says that Mr Patrick was *"in a hell of a lot of pain"* and he gave him some Panadol. He next visited him at around 1.15am and found him asleep.

At 8.23am on 16 October 2016, Mr McConnell phoned Mr Patrick. There was no answer. He went to his room about 30 minutes later and found him deceased in the toilet.

Post-Mortem Report

This was carried out by State Forensic Pathologist, Dr Christopher Lawrence. In his opinion the cause of Mr Patrick's death was a ruptured abdominal aortic aneurysm. I accept this opinion.

Investigation

This has been informed by:

1. A Police Report of Death.
2. A statement provided by Dr Van Twest.
3. An affidavit provided by Dr Van Twest.
4. A report from Registered Nurse Schurer.
5. An Ambulance Tasmania Patient Care Report.
6. An affidavit provided by Mr Metham.
7. An affidavit provided by Mr McConnell.

8. A report from Dr James Markos.
9. Consideration of Mr Patrick's general practitioner records.
10. A précis of Mr Patrick's hospital records completed by research nurse, Ms L K Newman.
11. A report provided by Dr A J Bell as medical advisor to the coroner.

In his report, Dr Bell advises of these matters:

- Small cell cancer can rapidly lead to death, particularly if untreated. In Mr Patrick's case the decision to treat his cancer and delay treatment of the aortic aneurysm was reasonable.
- In retrospect, it is most likely that Mr Patrick's back pain was not due to 'over-exertion and muscle strain' as diagnosed by Dr Van Twest but rather was attributable to his aortic aneurysm either dilating or leaking blood.
- This case presented a difficult diagnosis and Nurse Schurer could not have been expected to understand the significance of back pain for a patient with aortic dilation.
- There was an apparent flaw in the communication between Nurse Schurer and Dr Van Twest. If the latter had been aware of Mr Patrick's elevated blood pressure and aortic aneurysm it would have been reasonable for her to have attended at the WCDH and carried out her own assessment. Hopefully that would have led to her identifying the correct cause of Mr Patrick's pain.
- That when Mr Patrick attended at the WCDH in the evening of 15 October he required immediate transfer to the RHH for surgical treatment of his aortic aneurysm. Contemporaneously, he required medication to manage his elevated blood pressure to reduce the risk of a fatal rupture.

Findings, Comments and Recommendations

In retrospect, it is apparent, accepting the opinion of Dr Bell, that the significant back pain complained of by Mr Patrick was attributable to the rupture or enlargement of his aortic aneurysm. Unfortunately, this diagnosis was not made when Mr Patrick presented at the WCDH. The evidence also makes it clear that Mr Patrick died in the morning of 16 October sometime after 1.15am and before around 8.20am. These facts raise the question whether Mr Patrick's death could have been prevented if he had been correctly diagnosed at the WCDH at the earliest opportunity and his condition managed with medication and a transfer to the RHH.

The evidence suggests that the earliest time the cause for Mr Patrick's back pain could have been correctly diagnosed was around 10.30pm on 15 October 2017. This was a Saturday. Mr Patrick then required transport to the RHH which is the only facility in Tasmania resourced to carry out the required surgery. In all likelihood transport by air would have been the fastest means of conveyance. It is problematic whether an airstrip at Queenstown could have been utilised and it may be that his extraction by air first required his transport by road to the airfield at Strahan. From whichever facility he could have been flown, a plane first needed to be sourced from either Launceston or Hobart. Overall, this would have been a difficult logistical exercise and I consider it most unlikely that Mr Patrick could have been

transported to the RHH and for the surgery to then be undertaken all prior to the fatal rupturing. This leads me to conclude that even if a correct diagnosis of Mr Patrick's condition had been made at the WCDH it is most unlikely that remedial treatment could have been carried out in time to avoid his death.

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, and 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 Patrick's family and loved ones.

Dated: 21 September 2018 at Hobart in the State of Tasmania.

Rod Chandler
Coroner