



# 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, Simon Cooper, Coroner, having investigated the death of Graeme Charles Davis

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

- a) The identity of the deceased is Graeme Charles Davis;
- b) Mr Davis died following elective surgery at the Launceston General Hospital;
- c) The cause of Mr Davis' death was sepsis; and
- d) Mr Davis died on 27 January 2018 at the Launceston General Hospital, Launceston, Tasmania.

#### **Introduction**

1. In making the above findings I have had regard to the evidence gained in the investigation into Mr Davis' death. The evidence includes:

- The Police Report of Death for the Coroner;
- An opinion of the pathologist who conducted the autopsy;
- Affidavit of Patricia Davis, wife of Mr Davis;
- Medical reports and records from Tasmanian Health Service;
- A précis of Mr Davis' medical records prepared by forensic nurse, L Newman; and
- Report from Dr A J Bell, Coronial Medical Consultant.

#### **Background**

2. Mr Davis was born in Launceston, Tasmania on 25 January 1962. At the time of his death, he was aged 56 and living with his wife, Patricia, at Dilston, Tasmania. He was a proud and devoted father and grandfather, capable and successful in business and an active contributor to his community.
3. Until October 2017, he was fit and healthy, rarely consulting a doctor. During that month he experienced back pain, for which he consulted a general practitioner. He was referred to Mr Rob Jensen, urologist. In December, he was diagnosed as suffering from bladder squamous cell carcinoma.

4. On 11 January 2018, Mr Davis was admitted to the Launceston General Hospital (LGH) to undergo an operation to remove his bladder, form an ileal conduit and dissect the surrounding lymph nodes.
5. Mr Jensen, assisted by Drs Roth and Matthews, performed the operation. The surgery proceeded without incident, and following it, Mr Davis was admitted to the hospital's high dependency unit.

### **Circumstances of Death**

6. Following surgery until 15 January 2018, Mr Davis' medical records indicate he made steady improvement. But early in the morning of 16 January he suffered nausea, vomiting and abdominal pain. His blood oxygen saturations were low and he was breathless.
7. From then on, Mr Davis' condition worsened. On 20 January, his abdominal wound was draining serous fluid and the medical notes describe it as appearing 'bad'. His white blood cell count was slightly elevated and it was by now apparent he had a serious infection.
8. The following day, 21 January, an urgent CT scan showed right sided basal atelectasis and right sided small pleural effusion. His scrotum was swollen and other soft tissue swelling is noted in his medical records. A 'serous ooze from the lower part of his wound' was noted in the CT request.
9. Mr Davis was taken back to the operating theatre where Mr Jensen repaired the lower abdominal wound. During the operation, Mr Davis was given a single dose of cefazolin (an antibiotic), apparently with a view to preventing further wound infection.
10. Mr Davis' medical notes record he was afebrile and his wound was described as 'acceptable'. But his abdomen was distended, his white blood count elevated and his C reactive protein (CRP) at 205 mg/L strongly suggestive of a bacterial infection.<sup>1</sup> A culture taken from a sample obtained two days earlier grew heavy *Staphylococcus aureus*.
11. During the same day, Mr Davis' temperature reached 39 degrees centigrade, but later, his condition appeared to improve, although his blood pressure remained elevated. No antibiotics were administered, although Mr Davis' medical records note that the issue of antibiotics was to be discussed the 'next day'.

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<sup>1</sup> Normal CRP is less than 5 mg/L and anything greater than 100 mg/L is a clear indication of bacterial infection.

12. Antibiotics were not commenced the next day either, seemingly because the urology team appeared to think Mr Davis' wound was not infected. This view was reached on a day when his CRP had climbed to 284 mg/L, a urine specimen tested positive to *Klebsiella pneumoniae* and his wound continued to ooze.
13. Antibiotics were not commenced the following day either, even though Mr Davis' white blood cell count had risen, albumen level had fallen and his CRP remained elevated.
14. On 25 January 2018, planning for Mr Davis' discharged commenced. However, as the day wore on it became apparent he had a urinary tract infection with fever, increased white blood cell count elevation, high CRP and a positive urine culture. Antibiotics were commenced intravenously. Mr Davis' medical notes indicate he was suffering urosepsis and a plan was developed to continue current management with intravenous antibiotics (although it is unclear whether any were in fact prescribed).
15. At 10.25pm that day a code blue was called because Mr Davis suffered a period of unconsciousness whilst he was on the toilet. Later still, his antibiotic therapy was changed and further blood cultures taken.
16. On 26 January 2018 Mr Davis was reviewed by a urology registrar, Dr Roth (who had assisted in the original operation on 11 January 2018). Dr Roth noted a diagnosis of urosepsis. A CT scan of Mr Davis' abdomen and pelvis was ordered. A substantial fluid collection arising from the pelvis and extending into the lower abdomen was noted. Medical records indicate that nursing staff were informed that the blood culture was positive. Vital signs showed a low blood pressure during the day. During the afternoon of 26 January 2018 Mr Davis' temperature rose, his respiratory rate rose and his oxygen saturations were low. It is apparent by then Mr Davis was gravely ill. It seems from his medical records that the previously ordered antibiotic therapy was administered some four hours late. The records record a note to "look out for blood culture sensitivities". No change was made to his treatment; he continued to deteriorate, suffered a cardiac arrest and died shortly after midnight on 27 January 2018.

### **Investigation**

17. Mr Davis' death was not reported pursuant to the provisions of the *Coroners Act 1995*.

18. The *Coroners Act 1995* provides that a death is reportable if it appears to be one that occurs “after a medical procedure where the death may be causally related to that procedure, and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death”. I note that the obligation to report of death is a personal one. Section 19 of the *Coroners Act 1995* provides “a person who has reasonable grounds to believe that a reportable death...has not been reported must report it as soon as possible to a coroner or a police officer”. The failure to comply with this obligation is an offence.<sup>2</sup>
19. It is apparent from Mr Davis’ medical records that whether his death should be reported was discussed by various medical practitioners at the LGH. In any event, his death was not reported and a Medical Certificate of Death was issued. The cause of death contained in the Medical Certificate of Death was said to be pulmonary embolism.
20. A post-mortem was performed on Mr Davis’ body by hospital pathologist, Dr Fernando. She found fluid collections with inflamed and necrotic tissue within the surgical bed in Mr Davis’ pelvic area. Both kidneys showed marked medullary congestion and his lungs were also congested.
21. Significantly, no evidence of pulmonary embolism was found at post-mortem.
22. Dr Fernando expressed the opinion that “in view of the clinical scenario of sudden unexpected demise most likely cause of death would be acute coronary ischaemia in a person with ongoing infection with multi-organ involvement”.
23. Eventually, in 2019, the Office of the Health Complaints Commissioner, having received a complaint about Mr Davis’ treatment from his widow, referred the matter to me. Initially, I too was not persuaded the matter was one reportable under the *Coroners Act 1995*.
24. When further information was forthcoming last year, I concluded on the basis of that evidence, that the matter was in fact one reportable under the *Coroners Act 1995* and commenced to investigate Mr Davis’ death as a medico-legal matter.
25. As part of that investigation the treatment received by Mr Davis was reviewed by Dr A J Bell MB BS MD FRACP FCICM, the Medical Advisor to the Coronial Division. Dr Bell provided a report.

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<sup>2</sup> See section 19(1).

26. In that report, Dr Bell said:

*“The drug charts show that antibiotic administration was deficient. This failure to administer appropriate antibiotics at appropriate times was an unacceptable level of practice. There was no timely administration of antibiotics.*

*There was a failure to diagnose the site of sepsis. The presence of sepsis with an increasing swelling in the scrotum and perineum, pus leaking from the wound should have led to a diagnosis. Urine containing pus indicates infection. Positive cultures indicate infection. Positive blood culture requires immediate treatment usually in an intensive care unit.*

*The interpretation of the elevated CRP results appears deficient. The results should have initiated a search for a site of bacterial infection.*

*Also the tolerance of a physiologically young human to sepsis leads to the underestimation of severity of the illness. Also the fluctuating course leads to confusion by doctors, such as the comment on 26.01.2018 “feeling better now, afebrile”.*

*The interpretation of the post-mortem examination by the pathologist is incorrect. There is no reason to postulate a cardiac event when sepsis patients frequently deteriorate rapidly and die. This is a clinical experience which pathologists would not be experienced and have treated.*

*The failure to recognise and appreciate the severity of sepsis lead [sic] to a preventable death.”*

27. I accept Dr Bell’s opinion. I do not consider that Mr Davis’ death was due to, as the Medical Certificate of Death indicated, a pulmonary embolism, nor, as the post-mortem report suggested, cardiac related.

### **Conclusion**

28. The cause of Mr Davis’ death was sepsis. That sepsis developed following surgery performed at the Launceston General Hospital on 11 January 2018. It developed and worsened whilst Mr Davis was an inpatient at the Launceston General Hospital.

29. Antibiotics were required to treat Mr Davis’ sepsis. No antibiotics were prescribed until a short time prior to his death, by which time it is apparent it was too late.

30. The fact that Mr Davis was suffering from sepsis should have been obvious to his treating team from at least 20 January 2018, if not before.
31. The treatment received by Mr Davis after his operation was poor. The failure to properly diagnose infection and treat it with antibiotics was regrettable. The delay in the administration of antibiotics, once prescribed, was most unfortunate.
32. In summary, I am of the view that Mr Davis' death was entirely avoidable. He died because of poor medical treatment.
33. These findings were sent, in draft, to the Launceston General Hospital. No issue was taken in relation to any aspect of them.

#### **Comments and Recommendations**

34. The circumstances of Mr Davis' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.
35. I convey my sincere condolences to the family and loved ones of Graeme Charles Davis.

**Dated** 12 April 2021 at Hobart in the State of Tasmania.

**Simon Cooper**  
**Coroner**