



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 Brian John Kelly

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

- a) The identity of the deceased is Brian John Kelly;
- b) Mr Kelly died as a result of an accidental drug overdose during palliative care for end stage mesothelioma;
- c) The cause of Mr Kelly's death was hydromorphone toxicity; and
- d) Mr Kelly died on 4 January 2020 at the North West Regional Hospital, Burnie, Tasmania.

Introduction

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

- The Police Report of Death for the Coroner;
- Affidavit of Mrs Diane Kelly, sworn 10 August 2020;
- Medical reports and records from the Tasmanian Health Service; and
- Final RCA Report from Tasmanian Health Service.

Background

Mr Kelly was born in Wynyard on 14 June 1948. At the time of his death he was aged 71 years and living with his wife at Ulverstone.

Mr Kelly was diagnosed with prostate cancer in early 2000. In 2012, he was diagnosed with bowel cancer. This resulted in a portion of his bowel being surgically removed. In February 2019, he was diagnosed with mesothelioma in the pleura of the lung. The condition was too extensive to operate.

Circumstances of Death

In the lead up to his death, Mr Kelly was receiving palliative care at home. Because his condition had worsened and his wife was struggling to cope, in the afternoon of 3 January 2020, he was taken to the Emergency Department (ED) at the North West Regional Hospital (NWRH) for treatment.

He died at the Hospital the following day, 4 January 2020. A Medical Certificate of Death was issued by a medical practitioner on 7 January 2020. That certificate records the cause of Mr Kelly's death as metastatic mesothelioma.

A regular review of the certificate by the Executive Director of Medical Services of the NWRH identified an issue with the certificate and the Coroners Office was notified of the matter on 13 January 2020.

The Coronial investigation revealed, in short, that rather than being given 2 milligrams of hydromorphone in the NWRH ED (as he was prescribed), Mr Kelly was given 20 milligrams of that drug.

While I am quite satisfied that the administration of 10 times the appropriate amount of hydromorphone was not deliberate, it bespeaks a shocking lack of attention to basic principles.

The care Mr Kelly received at the NWRH fell well short of an acceptable standard.

Comments and Recommendations

The circumstances of Mr Kelly's death require me to **comment**, once again, that the obligation to report deaths in accordance with the *Coroners Act 1995* is a personal one cast upon medical practitioners. On no reasonable view of the circumstances was it appropriate to issue a medical certificate of death. Mr Kelly's death should have been reported to the coroner at the time it occurred.

As I have already said, I accept that the overdose which caused Mr Kelly's death was accidental. There is no evidence to the contrary. Nonetheless, it was an accident with immediate fatal consequences for a patient of the Hospital. I **comment** that immediate steps need to be taken by the Hospital to ensure an accident of this type cannot happen again. The recommendations contained in the Tasmanian Health Service RCA Final Report should, if carried out, go a significant way to addressing this issue.

I convey my sincere condolences to the family and loved ones of Mr Kelly.

Dated 26 November 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner