MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends, and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of HN

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

a) The identity of the deceased is HN;

b) HN died as a result of haemopericardium due to parietal pericardial haemorrhage due to pericardial trauma from pericardiocentesis due to, or because of, pericardial effusion;

c) The cause of HN's death was cardiac tamponade; and

d) HN died, aged 83 years, on 11 September 2022 at the Launceston General Hospital, Launceston, Tasmania.

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

- Tasmanian Health Service – Death Report to Coroner;
- Police Report of Death for the Coroner;
- Affidavit verifying identity;
- Report – Dr Andrew Reid, Forensic Pathologist;
- Report – Dr Anthony J Bell, Medical Advisor to the Coronial Division;
- Medical Records – Tasmanian Health Service; and
- Medical Records – Charles Street Clinic.

Circumstances of death

On 11 September 2022 HN was taken to the Launceston General Hospital (LGH) Emergency Department by ambulance. She arrived there at 2.34 am after developing central chest pain the previous morning.

It is apparent she had suffered haemorrhagic pericarditis at least a day prior to her admission to the LGH.

Investigations were carried out including a CT scan of the pulmonary arteries approximately two hours after admission. That CT scan was not reported to show haemorrhagic pericardial fluid.

HN's symptoms suggested pericardial tamponade and therefore she should have undergone an urgent echocardiogram, particularly in light of her complex history. It is not clear from her medical records whether an echocardiogram was carried out – although her medical records are deficient in several respects. Those deficiencies include an absence of electrocardiograms, echocardiogram reports, procedure and medical notes in relation to particular decisions taken relating to HN's treatment.

In any event, HN underwent an aortic angiogram at 1:13 pm. That procedure indicated that the ascending aorta was dilated (as compared to an echocardiogram carried out six weeks earlier) but there was no evidence of an aortic dissection.

Later the same day at 6.26 pm her medical records indicate she was stable and comfortable. The records note that HN expressed the view that in the event of a cardiac arrest she did not wish for CPR, intubation or mechanical ventilation.

At 7.22 pm a medical emergency team call was made. Her heart rate was 74 bpm, she was struggling to breathe and was agitated. There was evidence of left lower lobe consolidation. Her blood pressure fell and HN had severe metabolic acidosis. She continued to deteriorate and died just after 9.00 pm the same day.

Investigation

The fact of HN's death was reported in accordance with the *Coroners Act* 1995. The body was formally identified and then taken to Hobart by mortuary ambulance. On 13 September 2022, in the mortuary of the Royal Hobart Hospital, the State Forensic Pathologist Dr Andrew Reid performed an autopsy. Dr Reid provided a report in which he expressed the opinion that the cause of HN's death was a cardiac tamponade due to haemopericardium resulting from a traumatic parietal pericardial haemorrhage. I accept Dr Reid's opinion.

Because of the circumstances of HN's death I requested Dr Anthony J Bell MD FRACP FCICM, the Medical Advisor to the Coronial Division, to review HN's care and treatment following her admission to the LGH.

Dr Bell provided a detailed report. He noted in his report that his assessment of HN's treatment was hampered by the absence of critical information in her medical records. The information absent from those records includes:

- Electrocardiograms;
- Echocardiogram reports; and
- Some procedural and medical notes – particularly relating to decision making.

I agree with Dr Bell. The absence of critical information (an absence which remains unexplained by the Launceston General Hospital) makes a consideration of the circumstances surrounding HN's death practically impossible. For example, her medical records *appear* to indicate that pericardial fluid was removed some time after 6:50 pm on Saturday, 10 September 2022. The records *appear* to indicate that the procedure was done by a registrar supervised by an emergency physician with the assistance of an echocardiogram. There is, however, no echocardiogram in the medical records nor is there any material in the records which casts any light on why, contrary to ordinary practice dictating that the procedure be carried out by an experienced cardiologist, the procedure was undertaken by a registrar at all.

In short, the documentation in relation to the treatment HN received at the Launceston General Hospital was substandard and its lack of availability and accuracy, apart from potentially compromising her treatment, has made my investigation extremely difficult.

Comments and Recommendations

The circumstances of HN's death require me to **comment** pursuant to Section 28 of the *Coroners Act* 1995 that accurate, comprehensive and legible medical records must be kept in relation to treatment received by all patients at all times.

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

Dated: 13 June 2023 at Hobart in the State of Tasmania.

Simon Cooper

Coroner