IN THE CORONERS COURT
OF VICTORIA
AT SHEPPARTON

Court Reference: COR 2009 004738

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of ROBERT J SPENCER

Delivered On:	18 April 2013
Delivered At:	Shepparton Coroners Court
Hearing Dates:	26th and 27th September 2012
Findings of:	Stella Maria Stuthridge, Coroner
Representation:	Mr S. Martin for family Mr J. Goetz for Dr Slot
Coroner's Assistant	S/C P. Lawler

I, Stella Maria Stuthridge, Coroner, having investigated the death of ROBERT JOHN SPENCER
AND having held an inquest in relation to this death on 26th and 27th September 2012
at Shepparton Coroners Court
find that the identity of the deceased was ROBERT JOHN SPENCER
born on 10 December 1965
and the death occurred On 3 October 2009
at 1A Arundel Street, Benalla Victoria 3672
from:

1a MENINGITIS

in the following circumstances:

The Coroners Act (Vic) 2008 describes my functions as a Coroner. The primary purpose of the coronial investigation of a reportable death, is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

My secondary role, if appropriate, is to comment or make recommendations on any other matter connected with the death including public health or safety or the administration of justice. The power of a coronial investigation is not free ranging.[1]

As a Coroner, I am not permitted to include in a finding any statement that a person is, or may be, guilty of an offence. Similarly, it is not my role to make any specific findings on whether there has been any negligence giving rise to the death, which I am investigating.

A Coroner is not bound by the normal rules of evidence.[2] Where findings of fact are made the test is whether there is sufficient evidence to be satisfied on the balance of probabilities. When a Coroner is considering comment or criticisms in respect of a matter these should not be made on the basis of inexact proofs and indirect references.[3]

[1] Harnsworth v The State Coroner [1989] VR 989 at 996
[2] S. 62 Coroners Act (Vic) 2008
[3] Briginshaw v Briginshaw (1939) 60 CLR 336 at 362; Domaszewicz v State Coroner (2004) 11 VR 237 at [81] per Ashley J.

Circumstances

Mr Robert John Spencer was 43 years old when he passed away due to acute Bacterial Meningitis. In the week leading up to his death, Mr Spencer had twice visited Dr Slot. He had also attended two regional hospitals, Benalla and Wangaratta. The central issue in this Inquest is whether Dr Slot should have made a diagnosis of Meningitis.

Mr Robert Spencer worked at the Benalla abattoirs owned by C A Sinclair Pty Ltd. On Friday the 25th September 2009, Mr Spencer was unwell at work. Mr Spencer had lower back pain, a fever and tingling (paraesthesia). Mr Spencer went home and appears to have remained there during Saturday and Sunday.

On Sunday the 27th September 2009 at 9.50 pm, Mr Spencer called an ambulance and was conveyed to Benalla Hospital. The Ambulance paramedic, Mr Simpson made observations of Mr Spencer. He noted the onset of lower back pain 36 hours ago, no history of injury, immobile since, difficulty walking short distances, lower back pain radiating to right buttock and no haematuria (blood in urine) or dysuria (pain on urination).The paramedic's examination was normal save for a temperature of 38.3 degrees. Mr Spencer reported to the paramedic pain of 6/10.

At admission to Benalla Hospital Emergency Department, Registered Nurse, Ms Caramia recorded the following observations: lower back pain 36 hours, febrile illness (fever) since Friday, went home to bed and woke with back pain, took Nurofen and Panadeine fort with little effect. His pulse was 88 and regular, oxygen saturation 98% on room air, respiration 18. Mr Spencer's temperature was recorded at 37.8 degrees.

Nurse Caramia telephoned the on call doctor, Dr O'Brien and discussed these observations with him. Dr O'Brien prescribed Endone and Mr Spencer was sent home with a recommendation to see his usual Doctor the next day. Mr Spencer did not see a Doctor on this occasion.

On Monday the 28th September 2009 Mr Spencer attended the Benalla Church Street Clinic at about 5pm and saw Dr Slot. Dr Slot examined Mr Spencer and found no fever, localised back tenderness and normal blood pressure. Dr Slot noted Mr Spencer appeared otherwise well, he diagnosed a lumbar strain and prescribed Codalgin Forte for the pain and Temaze to assist with sleep. Dr Slot also requested blood tests.

On Tuesday the 29th September 2009, Mr Spencer had the blood taken for analysis at Dorevitch Pathology. The test results were received by Dr Slot on the 30 September 2009. The results showed Mr Spencer had an elevated C-reactive protein (CRP) level.[4] Mr Spencer had an appointment the following day with Dr Slot.

Meanwhile, Mr Spencer appeared increasingly unwell to his friends, Mr Ferguson and Ms Purcell. Mr Spencer was having difficulties moving and appeared in extreme pain. On Wednesday the 30th September 2009, Mr Ferguson and Ms Purcell drove Mr Spencer to Wangaratta Hospital. At 7.10pm Mr Spencer was seen by Registered Nurse, Ms Gregory. She noted a history of 5-7 days back pain with initial shivers and shakes. She also noted he had taken an ambulance to Benalla Hospital last Sunday and was taking oral analgesia prescribed by a local doctor, who he had seen Monday. She noted Mr Spencer had difficulty ambulating and could not recall any trauma to his back. The Nurse took Mr Spencer's observation including a temperature of 36.8 degrees (normal), pulse 78 and respirations 18, blood pressure of 128 over 67 with 100% oxygen saturation on room air. Mr Spencer described his pain to her as 25/10. The Wangaratta Hospital Emergency Department was very busy on this evening. Staff advised there would be a delay in Mr Spencer seeing a doctor. At 9 pm Mr Spencer was given some Endone and Voltaren. At 9.20pm, Mr Spencer left the hospital and returned home. He had not seen a Doctor.

On Thursday the 1st October 2009, Mr Spencer saw Dr Slot again. At this consultation, Dr Slot undertook a second physical examination and discussed the blood test results with Mr Spencer. Dr Slot noted Mr Spencer was not better, he still had lower back pain with reduced mobility. No temperature, shivers or paraesthesia was present. Dr Slot noted minor redness in Mr Spencer's throat. Dr Slot was concerned that the elevated CRP may have been as a result of Mr Spencer having Q fever. He was aware Mr Spencer worked in a local abattoir and this illness is often associated with abattoir workers.

Dr Slot requested further blood tests, an X-ray and wrote a prescription for an antibiotic, Doxylin, to treat possible Q Fever, and Endone, Codalgin and Voltaren, for pain relief.

On Friday the 2nd October 2009, Mr Spencer had an appointment for his X-ray. He had booked a taxi for around 1.30pm. At approximately 1 pm, Mr Spencer spoke with his neighbour. Mr Spencer did not get into the taxi and was not seen alive again.

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[4] This is a marker of an inflammatory process occurring in the patient.

On Saturday the 3rd October 2009, Mr Ferguson and Ms Purcell found Mr Spencer deceased in his lounge room.

Timely Diagnosis

The central issue of concern in this Inquest is whether Mr Spencer's Meningitis could, or should, have been diagnosed by Dr Slot. In particular on the 1st October 2009, when he saw Mr Spencer for the second time and had available to him the blood results showing an elevated CRP.

I have received reports and heard evidence from Associate Professor John Raftos and Professor Mark Cook. Dr Slot also gave evidence at the inquest.

Meningitis

Each of the doctors that gave evidence agreed Mr Spencer's presentation did not match the classical presentation of Meningitis.

Associate Professor Raftos described the illness in the following terms:

> 'Acute bacterial meningitis is a bacterial infection of the cerebrospinal fluid and the lining of the brain. The most common causative organism of bacterial meningitis in immunocompetent patients are streptococcus pneumoniae, neisseria meningitides, haemophilus influenzae, and staphylococcus. The mortality of appropriately treated bacterial meningitis in adults is between 10% and 25%. Historical data indicate that the mortality of bacterial meningitis untreated is close to 100%.
>
> The clinical features of acute bacterial meningitis include fever, headache, neck stiffness, and photophobia.'[5]

Professor Cook noted in his report that Mr Spencer's presentation was very unusual as there appeared to be back pain in isolation, no headache and an initial fever that had resolved.[6] In evidence, Professor Cook commented that usually the neurological features are the most prominent symptom of Meningitis and there were apparently no neurological features complained of, or observed in, Mr Spencer.[7] This unusual presentation made it more difficult to diagnosis Meningitis.

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[5] Pg 6, Report
[6] Pg 4,7-8, Report
[7] TR 99-100

Standard of Care

Associate Professor Raftos gave evidence about the standard of care he believed applied in Mr Spencer's case. He stated once a doctor has the inflammations markers [raised CRP levels] and ongoing back pain, the doctor is required to consider the possibility of infection, and either confirm or exclude illnesses that could cause significant disability, like an acute bacterial infection.[8] In his report, Associate Professor Raftos argued that the correct response was an 'urgent consultation with a specialist neurologist and admission to hospital with treatment with empirical intravenous antibiotics and further investigation.'[9]

In evidence, Associate Professor Raftos conceded that during the presentation at Dr Slot's rooms and Wangaratta Hospital there was no evidence Mr Spencer had a fever.[10] He also conceded in evidence that Dr Slot was faced with 'probably ten valid differential diagnosis.'[11]

Professor Cook disagreed with Associate Professor Raftos assessment and opinion of the treatment of Mr Spencer. Professor Cook noted Mr Spencers presentation was quiet unusual. There were no neurological features, which is usually the most prominent feature of Meningitis.[12] Professor Cook felt that Dr Slot's medical management of Mr Spencer was perfectly appropriate.[13] Professor Cook noted that the evidence that Mr Spencer was rendered almost immobile by his back pain was not available to Dr Slot.[14] That information would have presented a very different clinical picture.

In relation to the appropriate treatment after the raised CRP levels were received, Professor Cook said,

> '...he was referred to his local doctor who performed an appropriate series of investigations and undertook further tests to try and establish the cause of what were abnormal blood results.'[15]

[8] TR 83-84
[9] Pg 10, Report
[10] TR 86
[11] TR 84
[12] TR 99-100
[13] TR 102
[14] TR 104-106
[15] TR 109

Professor Cook noted that Associate Professor Raftos' suggestion was that Mr Spencer should have been hospitalised and treated with intravenous antibiotics once the raised CRP results were received. This did not seem plausible to Professor Cook as there was no clear illness or diagnosis identified at the time.[16] Professor Cook also commented that the X-ray and/or MRI investigations would not assist in diagnosing Meningitis. Further he noted there is often a delay in obtaining an MRI in rural Victoria.[17] Professor Cook expressed the opinion that Dr Slot's treatment of Mr Spencer was reasonable in all the circumstances. Associate Professor Raftos conceded in evidence, that he did not think anyone could have diagnosed Meningitis at the time Dr Slot saw Mr Spencer and had the elevated CRP results.[18]

Mr Alan Neil, chemical Pathologist gave evidence that the raised CRP level was a common result. He stated such results do not indicate a specific illness, such as Meningitis. He confirmed such results require follow up and testing.

Conclusion

I am satisfied Dr Slot ordered the appropriate diagnostic tests at both consultations with Mr Spencer. The diagnosis of possible spinal injury and/or Q fever was reasonable in all the circumstances. At no time during Mr Spencer's presentation to Dr Slot was there sufficient clinical symptoms to warrant an urgent admission to hospital and the administration of intravenous anti-biotic.

I am satisfied Mr Spencer's presentation was very unusual. It is important that this be drawn to the attention of other General Practitioners in the community. To that end I propose to publish the finding on the Coroners Court website. I also propose to forward the finding to The Royal Australian College of General Practitioners and others.

[16] TR 102
[17] TR 112-113
[18] TR 91-92

Notation

The toxicology analysis undertaken of Mr Spencer revealed doxyamine (an anti-histamine) present in Mr Spencer's blood. This drug is a common drug available over the counter and is present in many medicines. This did not contribute to Mr Spencers death. The toxicology results also revealed Mr Spencer had not taken the antibiotic docycyline prescribed by Dr Slot on the 1st October 2009. This did not contribute to Mr Spencer's death.

Signature:

Stella Maria Stuthridge
Coroner
Date: 18 April 2013