QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of SD**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	08/11/2024
FILE NO(s):	2023/4105
FINDINGS OF:	Ainslie Kirkegaard, Coroner
CATCHWORDS:	CORONERS: health care related death; large regional public hospital; malignant haematology; Hodgkin lymphoma; peripheral T-cell lymphoma (PTCL); onsite second pathology opinion diagnosis processes; lack of onsite subspecialised immunohistochemistry testing (PAX5); notification of critical diagnosis processes; Multidisciplinary Team (MDT) processes; misdiagnosis and incorrect treatment decision; Ryan's Rule procedure

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Background

1. SD is a 61-year-old man who died in palliative care at a small regional hospital on 24 August 2023.

2. His death was reported to the coroner as a health care related death.

SD's medical history

3. SD's medical records show he had a history including mild chronic obstructive pulmonary disease (COPD), squamous cell carcinomas and neuropathic pain.

4. SD developed neuropathic symptoms and chronic itch which was causing him stress in December 2022. He was initially prescribed gabapentin but developed a skin reaction on his back after one week and was changed to pregabalin which helped the paraesthesia. He was seen by a dermatologist who prescribed steroid creams, with no improvement. He had a history of dermatitis and eczema. Allergy testing was positive to dust mites and coconut. He was also taking naturopathic herbal supplements, medicinal cannabis, and antihistamines.

5. SD saw a new general practitioner on 20 April 2023 with persisting cough and some difficulty breathing at night which had started in January 2023. The GP noted SD had been diagnosed with occupational-related COPD in 2021. The GP prescribed a supplement and ordered a series of blood tests, sputum testing and chest x-ray with a plan to arrange lung function tests and perform a skin biopsy after those results became available. SD had a phone consultation with the GP on 24 April 2023 reporting a worsening of his productive cough and breathing issues. He had stopped the pregabalin and commenced prednisolone 1mg. The GP was concerned SD had pneumonia as his blood test results showed elevated inflammatory markers and leukocytosis, so he referred him to the large regional hospital emergency department.

6. SD presented to the emergency department that day and underwent further imaging which revealed a 100mm mediastinal mass, concerning for malignancy. He was admitted for further clinical investigation including biopsy of the mass. A mediastinal biopsy sample collected on 28 April 2023 was reported on 2 May 2023 as "*Malignant, favour syncytial variant Hodgkin Lymphoma, second opinion pending."* The onsite anatomical pathologist reporting the histology felt a second opinion was warranted. Additional immunohistochemistry testing to help inform the diagnosis was being undertaken at a Pathology Queensland laboratory offsite as the hospital onsite Pathology Queensland laboratory did not have this testing capability. The immunohistochemistry result was subsequently reported as "*Pax 5 is negative*", indicating the presenting disease was unlikely to be Hodgkin lymphoma.

7. The hospital's Malignant Haematology Multidisciplinary Team (MDT) meeting discussed SD's case on 4 May 2023. MDTs are weekly meetings held to discuss selected cases, review the clinical presentation, symptoms, clinical investigation, determine the diagnosis, and best treatment options. The meetings are formally chaired and attended by hematologists, nursing and specialty experts from radiology and pathology. The immunohistochemistry result became available approximately two hours before this meeting but was not presented to the meeting. This is because the result had not been published when the anatomical pathologist was preparing for the meeting. The MDT considered the provisional mediastinal mass biopsy histology, determining the most likely diagnosis was Hodgkin lymphoma and recommended SD commence systemic chemotherapy to treat Hodgkin lymphoma. The MDT noted the immunohistochemistry results were pending, as was a second pathology opinion. It transpires neither were followed up and SD was commenced and continued on treatment for Hodgkin lymphoma.

8. A routine staging PET scan performed on 5 May 2023 showed extensive nodal disease and pleural and pericardial effusions. SD commenced chemotherapy on 8 May 2023. He underwent pericardiocentesis on 10 May 2023. Pericardial fluid was sent for cytology. This was referred to an offsite Pathology Queensland laboratory as per routine practice. The offsite anatomical pathologist who reported the cytology requested the previous biopsy slide as he identified a discrepancy between what he was seeing on cytology and what had previously been suggested

on histology. The cytology report summary (report published on 19 May 2023) noted "*Atypical T-cell proliferation in keeping with T cell lymphoproliferative disorder".* SD's treating team were not aware of this new information and continued treating him for Hodgkin lymphoma.

9. SD was discharged home on 13 May 2023 under the Hospital in the Home service to continue receiving intravenous antibiotics for a hospital acquired staph infection. This continued until 23 May 2023.

10. SD raised concerns with the haematology team about his persistent chronic itch when seen at the Cancer Care Centre on 18 May 2023. He was itchy all over with a rash on his back, buttocks, and arms. He was referred for dermatology review.

11. SD received chemotherapy on 22 May 2023 at which time he was reviewed by the infectious diseases team. He was seen in the dermatology team on 25 May 2023. A punch biopsy was taken from his back. He was given some steroid creams and advised to take antihistamines. Histology reported a differential diagnosis including drug eruption or erythema multiforme spectrum as possibilities.

12. SD received his next chemotherapy cycle on 5 June 2023. He underwent echocardiogram on 12 June 2023 which showed a small amount of fluid around the heart. When seen by the haematology team at the Cancer Care Centre on 15 June 2023, he was prescribed a seven-day course of oral antibiotics for the punch biopsy wound on his back.

13. SD had his next cycle of chemotherapy on 19 June 2023 and was given prescriptions for his eyes and a cream for his rash.

14. SD saw the haematology team again on 29 June 2023 by which time he was coughing more. His family expressed concerns about the appearance of the biopsy wound and his eyes, one of which had developed a yellow film. His optometrist had prepared a report which the family provided to the haematology team that day with a request that he be reviewed by an ophthalmologist.

15. SD had his next chemotherapy cycle on 3 July 2023. He had been handling his treatment relatively well, staying active and still able to mow the lawns and attend to jobs around the house.

SD's readmission to hospital in July 2023

16. SD presented to the emergency department on 11 July 2023 as the biopsy wound was now weeping, swollen and sore. He was investigated with blood tests and ultrasound scan and readmitted to hospital for treatment with intravenous antibiotics.

17. A routine mid-cycle PET scan performed on 14 July 2023 showed no response to chemotherapy treatment. His treating team had expected the lymphoma to gone, so they added a new and stronger chemotherapy agent. He remained in hospital for a week before being discharged home.

18. SD was due for a further chemotherapy cycle on 24 July 2023 but was readmitted to hospital on 17 July 2023 with a worsening left thoracic abscess, after presenting with fevers, increasing pain and a new purulent discharge from the biopsy wound. He was treated with antibiotics and steroids and underwent surgical debridement of the wound on 25 July 2023. Histology showed acute suppurative inflammation. He was too unwell to receive his chemotherapy.

19. SD's case was discussed by the Malignant Haematology MDT on 20 July 2023 with a recommendation for alternative treatment and input from a tertiary public hospital regarding potential autologous stem cell transplant. SD participated in a telehealth consultation with a consultant specialist from the tertiary hospital who advised he would require more invasive 'salvage' therapy. SD was administered GemOx an alternative treatment for Hodgkin lymphoma on 3 August 2023.

20. SD's condition deteriorated rapidly from 3 August 2023 becoming too unwell for further chemotherapy. He underwent multiple medical reviews with multiple specialty team input (cardiology, stroke, surgical, respiratory, infectious diseases, and haematology). His wife repeatedly raised concerns with nursing and medical staff about his condition and his failure to improve as expected. On 8 August 2023, SD was coughing, shaking and he spiked a fever. Nursing staff could not find any doctors to review him. His wife raised this with one of the haematologists the following day, 9 August 2023. SD fell in the bathroom and cleaned up the blood himself.

21. His wife activated Ryan's Rule on 10 August 2023 and was expecting independent clinical review, but this did not occur. The family was very concerned about how quickly SD was deteriorating, particularly when compared to another relative with Hodgkin lymphoma who appeared to be responding very well to treatment despite being in poorer health than SD prior to their diagnosis. That afternoon a nurse from the paediatric team attended to SD and advised his observations were 'fine'. His wife told the nurse of her concerns, but the family felt dismissed by the nurse who said she would speak with the Nurse Unit Manager. No further escalation occurred.

22. SD had a further fall on 12 August 2023. He was medically reviewed and sent for brain imaging. He had a seizure during the scan and further seizure activity once back on the ward. CT scan showed left frontal and parafalcine hypodensity with differentials of oedema, lymphoma, infection, or stroke. The treating team told his wife he was thought to have suffered a stroke. He was commenced on Keppra. She asked for a bed alarm in case SD had another seizure.

23. SD's condition continued to deteriorate over the following four days, triggering multiple Medical Emergency Team reviews.

24. Cardiology review on 15 August 2023 noted the diagnosis of T-cell lymphoproliferative disorder.

25. On 17 August 2023, a consultant haematologist requested urgent review of the previous biopsies. Pathology reported the following day, 18 August 2023, confirmed the diagnosis of CD30 positive T-cell lymphoproliferative disorder (PTCL), not Hodgkin lymphoma. There were initial discussions about commencing SD on monoclonal antibody therapy for PTCL but by 21 August 2023 it was considered too late for targeted treatment. SD told his family he "couldn't do it anymore". He could no longer walk or toilet himself independently and his chronic itch was unbearable. He elected to transition to comfort measures and was transferred to the small regional public hospital. SD died in the early hours of 24 August 2023, the day of the couple's daughter's birthday.

Autopsy findings

26. External examination noted features of recent rapid weight loss, a large bruise and haematoma to the right side of the head and multiple crusted sores on the body consistent with excoriated lesions and an open wound to the left back which appeared clean though not healed.

27. Full body CT scan showed extensive mediastinal and upper abdominal lymphadenopathy compatible with a lymphoproliferative disorder/lymphoma and left frontal lobe brain hypodense lesions with regions of cortical hyperdensity. The reporting radiologist identified central nervous system lymphoma and metastatic disease with possible leptomeningeal involvement as the primary considerations.

28. Internal examination revealed extensive tumour deposits. There was a large mediastinal mass measuring 160mm comprising multiple firm cream nodules consistent with a lymphoproliferative lesion/lymphoma. The tumour partially or completely encircled many of the thoracic structures including trachea, superior vena cava, left subclavian artery, origin of the right brachiocephalic artery, right common carotid artery, right subclavian artery, left pulmonary artery, and coronary arteries and also involved the epicardial surface of the heart, pleural surfaces of the lungs, bilateral lung hila, and paraoesophageal and pre-tracheal lymph nodes. There was also involvement of extra-thoracic structures including spleen, liver, bone marrow, paraaortic, mesenteric and liver hilar nodes.

The tumour showed histological features consistent with a lymphoproliferative disorder (lymphoma) in keeping with the ante mortem diagnosis. Neuropathology examination noted central nervous system involvement reported as T-cell lymphoproliferative disorder in keeping with anaplastic large cell lymphoma with multifocal leptomeningeal infiltrates and bilateral frontal haemorrhagic necrosis. There were also large bilateral pleural effusions, large pericardial effusion, a small ascites within the abdomen and mild coronary atherosclerosis. There was no evidence of colitis.

29. The pathologist explained that while there was evidence of head injury, this was not fatal and was considered to be a complication of lymphoma. Central nervous system involvement by lymphoma would affect balance and level of consciousness, and deconditioning would result in weakness, all of which would contribute to increased risk of falls. The pathologist explained ongoing bleeding would have been a complication of thrombocytopaenia secondary to bone marrow insufficiency due to replacement of normal blood cell precursors by lymphoma. Bleeding in the setting of thrombocytopaenia can occur spontaneously or with minimal trauma.

30. The pathologist also identified poor wound healing, fluid accumulation and infection as secondary complications of SD's advanced lymphoma (including the effects of chemotherapy treatment).

31. Post-mortem subtyping of lymphoma is hindered by autolytic changes, but the pathologist considered the findings consistent with the ante-mortem descriptions.

32. Having regard to these findings and the documented clinical history, the pathologist determined the cause of death to be lymphoma (medically managed).

Peripheral T-cell lymphomas (PTCL)

33. PTCL are a group of rare, fast growing non-Hodgkin lymphomas that are diagnostically challenging. It is an aggressive disease requiring prompt treatment. Subtype classification is essential as treatment is based on the subtype. However, correct classification is difficult due to the relatively low prevalence and lack of confidence by most pathologists in diagnosis. Most PTCLs have a 5-year overall survival with chemotherapy of only approximately 30%. In contrast, the prognosis for Hodgkin lymphoma is significantly more favourable with patients in SD's age group having a 5-year overall survival of approximately 90%.

Hospital & Health Service (HHS) clinical review outcomes

34. The relevant HHS commissioned a Root Cause Analysis (RCA) of its health service provision to SD. This is a systemic analysis of what happened and why and is designed to make recommendations to prevent adverse health outcomes from happening again, rather than to apportion blame or determine liability or investigate an individual clinician's professional competence. It is conducted by a review team who had no involvement in the patient's care.

35. The RCA team identified a number of factors contributing to the initial misdiagnosis.

Diagnosis pathway

36. The RCA identified that the planned onsite second pathology opinion for diagnosis did not occur. The lack of an established process for robust tracking of onsite second opinion diagnosis requests contributed to missed opportunities to review the initial diagnosis and treatment.

37. The usual process for a second pathology opinion at the large regional public hospital was for this to be handed over to an onsite anatomical pathologist with lymphoma expertise. The RCA identified this onsite second opinion was not completed likely due to a combination of workload pressures, the pathologist's part-time position, pathologist leave with no backfill and a gap in the process of following up on completion of second opinion requests. Further, the RCA identified variable processes for requesting and follow up of onsite second opinions and tracking of

completion, with no standardised process for managing and tracking onsite referrals between pathologists. Anatomical pathologists were using a variety of methods including whiteboards, paper templates and/or the Pathology Queensland reporting system AUSLAB list.

38. The RCA team recommended Pathology Queensland consider reviewing its processes for onsite second opinion diagnosis and establish a minimum standard for tracking and completion of requests. I am advised that as at September 2024, Pathology Queensland had reviewed the onsite second opinion diagnosis processes to establish a minimum standard for the tracking and completing of requests.

39. The immunohistochemistry Pax 5 result was a critical piece of diagnostic information, but it was not followed up by Pathology Queensland onsite or by the haematology treating team. This led to a treatment decision being made on an incomplete diagnosis.

40. Immunohistochemistry is one of several pathology tests (all cytology other than respiratory samples and some immunohistochemistry including Pax 5) that could not be performed onsite at the large regional public hospital due to lack of local laboratory capacity, and needed to be sent offsite, extending the reporting timeframes. The RCA identified that increasing the hospital onsite pathology laboratory capacity to perform more subspecialised immunohistochemistry staining such as Pax 5 as an improvement that would increase timeliness of reports, assist with the availability of some key diagnostic findings for MDTs and support more timely decision making on diagnose and treatment.

41. The RCA recommended that the hospital's Cancer Care Directorate liaise with the onsite Pathology Queensland laboratory to explore options for increasing the suite of more specialised immunohistochemistry markers such as Pax 5 to be performed onsite at the hospital. As at September 2024, Pathology Queensland had validated and introduced additional immunohistochemistry markers at the hospital laboratory, including PAX-5. This is now up and running on-site and expected to improve turnaround time of results for patients being worked up for classical Hodgkin and B cell lymphomas, and ensure cases remain on-site.

Pathology reports and notification

42. The RCA identified that Pathology Queensland did not notify the treating haematology team of the change in diagnosis to a rare lymphoma subtype with critical implications for patient care.

43. The results of the pericardial fluid cytology were communicated by phone call to the onsite anatomical pathologist but not to the treating haematology team. The cytology results were available for review by the treating team on the Pathology Queensland reporting system AUSCARE and also on the integrated electronic medical record but there is no documentation in the patient record that the treating team ever noted this result. Further, this result was not discussed at the second MDT meeting on 20 July 2023. Factors contributing to this were considered to include reporting of the new PTCL diagnosis in the pericardiocentesis cytology report and not in the standard location (as a supplementary second opinion report in the original histopathology report) and gaps in pathology result review processes. Pathology Queensland advised the RCA team this result was not assessed as meeting the criteria for a critical result and a phone call to the treating team. It was agreed that while it was not a new diagnosis of lymphoma, it was a critical diagnostic result of PTCL in variance to the original preliminary diagnosis with significant implications for SD's ongoing care.

44. The RCA team recommended Pathology Queensland consider reviewing its procedure for notifying a critical diagnosis to ensure that when there is a variance in the diagnostic opinion expressed by the reviewing pathologist with the original diagnosis, with significant implications for patient care, this results in a phone call to the treating team. As at September 2024, Pathology Queensland had reviewed and altered its Notification of Critical Diagnosis Anatomical Pathology Procedure to achieve this outcome. The critical result policy documents have been updated to reflect this, and the report formatting document has also been updated to formalise who is responsible for notifying the critical result and ensuring all supplementary reports are added appropriately. These changes have been notified to all pathologists.

Haematology pathology review and management

45. The RCA identified gaps in the review and endorsement of pathology results including several results were 'unendorsed', some results did not trigger a personal notification to the ordering clinician and gaps in the manual transfer of results notification when there was a change in treating team.

46. The RCA team noted that notification of pathology results to the requesting clinician's digital personal message centre inbox does not always occur, but pathology results are available to treating teams directly from the patient digital record and pathology endorse lists. This was being investigated by the HHS digital health team.

47. The RCA recommended that the haematology unit review its pathology review and management processes with consideration to be given to ways to ensure all pathology reports (including 'result only' reports) are reviewed for all patients. As at September 2024, the hospital's Haematology Unit had developed a list of high risk pathology and imaging results required to be ordered under the name of the Senior Medical Officer (SMO) so the result will be returned to the responsible SMO. I am advised this new requirement had been added to the medical orientation manual and a Safe Care communique distributed to the current medical staff rotation.

Multidisciplinary team meetings

48. The RCA identified the lack of a clear follow up plan by the Malignant Haematology MDT and missed opportunities to represent SD's case which had an incomplete diagnosis.

49. Despite the 'outstanding' immunohistochemistry PAX 5 result and the second pathology opinion, the first MDT meeting on 4 May 2023 considered it a priority to commence SD on chemotherapy treatment as soon as possible given his acuity and presenting so unwell.

50. The RCA team identified second MDT meeting on 20 July 2023 was another critical juncture. This is because Hodgkin lymphoma is highly chemotherapy sensitive so when SD was not responding to treatment, this meeting was a missed opportunity to review his diagnosis. Workload pressures were significant for the onsite anatomical pathologist with a high level of reporting, challenges to recruitment and no backfill for leave, impacting on their ability to prepare for MDTs. The RCA identified gaps in the MDT process including limited review of all available pathology, absence of a clear plan (including representing SD's case to confirm the incomplete diagnosis) and assigning tasks for follow up. Proposed improvement to the MDT process included the availability of complete pathology results, re-presentation of case to ensure case review when patients are not progressing as expected and ensuring appropriate pathology expertise at all meetings.

51. The RCA recommended that the Haematology Unit review its MDT process with consideration to be given to clear roles and responsibility for MDT members/specialties, review of case selection, reducing the number of cases discussed to allow adequate time for case discussion, clear documentation of plans and assigned responsibilities, improved discussion and input, streamlining disease group discussions, mandatory attendance by specialty experts as required and prompts to minimise cognitive bias.

52. As at September 2024, revised Malignant Haematology MDT meeting Terms of Reference were in use. They limit discussion to a maximum of six cases per meeting, with complex cases requiring multidisciplinary discussion presented first. Full diagnostics are required for referral to the MDT. Where full diagnostics are not available but urgent advice is sought for clinical management, the case is to be discussed and noted for representation at the next meeting. At least one Senior Medical Officer 'disease lead' (acute leukaemia, lymphoma, multiple myeloma, chronic lymphocytic leukaemia, myeloproliferative disorders) is required to participate in discussions and offer expert opinion. The quorum for complex case discussions is three haematologists, one radiologist and one pathologist. In the event a radiologist or pathologist is unable to attend, but electronic final reports are available, these can be used for discussion, but the case needs to be represented at an upcoming MDT when the radiologist or pathologist is

present.

Pathology Queensland anatomical pathology workload pressures

53. The RCA identified onsite anatomical pathology workload pressure as a contributing factor across multiple steps in the process of making SD's diagnosis from follow up of the second pathology opinion, follow up of outstanding actions, preparation time for MDT meetings including review and presentation of all relevant pathology results. While the two MDTs at which SD's case was discussed were attended by an anatomical pathologist, the RCA identified this did not always occur due to reasons including pathologist leave. The RCA team was also informed of recent extensive delays in receiving time critical second opinions from offsite Pathology Queensland laboratories which significantly impacts clinical care and can delay commencement of treatment. I note this was recently reported as a new operational risk by the Cancer Care Directorate.

54. The Chief Pathologist advises Pathology Queensland has taken the events leading up to SD's death very seriously, taking the opportunity to improve its processes and resourcing.

55. As at September 2024, the Chief Pathologist advised Pathology Queensland it was tackling the pathologist shortage, having successfully retained its 2023 trainees as pathologists, increased its training positions for 2024, and after a sustained and ongoing advertising campaign, employed a number of additional pathologists and laboratory sites which it advises will significantly ease the pressures and movement of work between sites.

RCA consideration of family concerns

56. The RCA process also considered the family's concerns about SD and their experience over the course of his treatment with the HHS. I am advised the HHS has since taken the following actions in response to various of those concerns:

    (a) The Haematology Unit now has a Monday morning team meeting including staff from all clinical disciplines (medical, nursing, and allied health) who are actively encouraged to raise any concerns that staff or family have raised regarding inpatients and identify patient of concern for review. The outcomes of these meetings are formally documented in the patient record;

    (b) Haematology medical team rotations have changed from weekly to a fortnightly basis meaning teams care for patients over a longer period giving them an opportunity to get to know patients and their families better and establish therapeutic relationships with them;

    (c) The HHS reviewed its Ryan's Rule process to ensure all Ryan's Rule calls that progress to escalation to the Executive Director Medical Services will be assessed for the degree of clinical review required, who will conduct the review and contact of the chosen clinical reviewer to ensure clinical reviews are undertaken when required – I note nursing staff in the Cancer Care ward have received a case presentation to reflect on SD's second admission, his declining condition and what happened when SD's wife activated Ryan's Rule.

    The RCA review team provided feedback on the revised process and related education to ensure the response to a Ryan's Rule activation includes a full clinical review of the patient's health condition and treatment including consideration of a second opinion and does not focus only on immediate/acute deterioration, and to ensure timely feedback to the Directorate Clinical Director and Nursing Service Directors for all Ryan's Rule calls on the next business day.

    The HHS Ryan's Rule procedure has since been updated with the following changes:

    - all Ryan's Rule activations via 13HEALTH now pass directly to the Executive Director Medical Services (or delegate) in-hours (on-call after hours) for consideration of the best

and most senior clinician appropriate to undertake a full clinical review of the patient's health condition and treatment they are receiving including consideration of a second opinion;

- an immediate bedside assessor is also activated to assess for acute/imminent deterioration;

- the Executive Director Medical Service (or delegate) is responsible for ensure the treating Senior Medical Officer and/or service Clinical or Medical Director is advised of the Ryan's Rule activation; and

- notification of the Ryan's Rule activation is sent directly from 13HEALTH to the appropriate Nursing Service Director via the Executive Director Nursing and Midwifery executive support officer.

(d) A requirement for all inpatient falls to have a timely local review to implement any additional targeted fall prevention strategies where required and ensure the patient's family is notified of the fall. Nursing staff have also discussed the importance of including specific falls related information in their clinical bedside handovers.

(e) Improvement to inpatient telehealth including using the telehealth cart and bedside support during telehealth meetings for all Cancer Care inpatient appointments.

57. SD's family have received open disclosure about the RCA findings, recommendations and implementation. The HHS developed a clinician learning tool video "Patient Experience – SD's Story" which the family has given permission to be shared across the HHS to help promote meaningful partnerships, trust, respect, compassion and listening to patients and their families/care.

Findings required by s.45

Identity of the deceased – *[deidentified for publication]*

How he died –

I find that SD died from lymphoma (CD30 positive T-cell lymphoproliferative disorder) for which he did not receive appropriate chemotherapy. He was incorrectly diagnosed with and treated for Hodgkin lymphoma. This occurred because the Malignant Haematology Multidisciplinary Team meeting at which his case was initially presented on 4 May 2023 made a diagnosis and treatment recommendation without a critical piece of diagnostic information, namely the immunohistochemistry Pax 5 negative result which indicated the presenting disease was not in fact Hodgkin lymphoma. The error was compounded because the cytology finding of atypical T-cell proliferation in keeping with T cell lymphoproliferative disorder was not flagged to or reviewed by the treating haematology team when it was reported on 19 May 2023, or considered by the Malignant Haematology Multidisciplinary Team meeting when it considered SD's case a second time on 20 July 2023. By the time the correct diagnosis was made, it was too late for SD to receive the appropriate chemotherapy.

Systemic issues both locally within the hospital onsite Pathology Queensland laboratory and Pathology Queensland more broadly operated to create multiple missed opportunities to properly inform the treating haematology team's clinical decision making and management of SD's malignancy. Pathology Queensland has since taken appropriate steps at both the local and whole of service level to standardise processes for managing and tracking onsite referrals between pathologists at the onsite laboratory at the large regional public hospital; increase that laboratory's capacity to perform more subspecialised immunohistochemistry such as Pax 5 and improve timeliness of reporting; and change its procedure for notifying a critical diagnosis to ensure that when there is a variance in the diagnostic opinion expressed by the reviewing pathologist with the original diagnosis, with significant implications for patient care, this results in a phone call to the treating team.

The Hospital and Health Service has since taken appropriate steps to ensure that all high risk pathology and imaging results are reported to the responsible haematology Senior Medical Officer, and to improve the rigour of its Malignant Haematology Multidisciplinary Team meetings.

SD's malignancy is a rare and aggressive disease requiring correct and prompt treatment to maximise his chance of survival. The incorrect diagnosis and treatment of Hodgkin lymphoma deprived him of access to treatment which would have maximised his chance to live longer than he did.

His experience and that of his family endeavouring to advocate for him have informed important changes to the Ryan's Rule process across the Hospital and Health Service.

Place of death – Small regional public hospital in Queensland

Date of death – 24/08/2023

Cause of death – 1(a) Lymphoma (medically managed)

I close the investigations.

Ainslie Kirkegaard
Coroner
CORONERS COURT OF QUEENSLAND
08/11/2024