



Western

Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 37/16

*I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of **John HOUGHTON** with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 11 & 12 October 2016 find the identity of the deceased was **John HOUGHTON** and that death occurred on 11 July 2014 at Fremantle Hospital as the result of Metastatic Bladder Cancer in the following circumstances:-*

Counsel Appearing:

Mr T Bishop assisted the Deputy State Coroner

Mr T Palmer (and with him Ms M Smith instructed by Avant Law) appeared on behalf of Dr Daryl Stephens

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INTRODUCTION

John Houghton (the deceased) had been seen by Dr Daryl Stephens, a urologist, on 8 & 30 May 2014 as the result of his Medical General Practitioner's (GP) concern with the deceased's urinary tract infection (UTI) and an ultrasound on 29 April 2014 which showed a bladder wall irregularity.

The deceased was scheduled for a hip replacement procedure on 23 June 2014 which then occurred. Following the deceased's hip replacement he presented to the Peel Health Campus (PHC) Emergency Department (ED) with pain in his right flank, urinary frequency, tiredness and weight loss. A CT scan indicated an invasive bladder cancer which required tertiary level care and the deceased was transferred to Fremantle Hospital (FH) on 5 July 2014, where he died on 11 July 2014, just 17 days after the right hip replacement procedure.

No post mortem examination was undertaken and the urologist at FH, with care of the deceased, recorded his death as due to metastatic bladder cancer.

The deceased was 72 years of age.

Concerns were raised at FH the deceased should not have undergone a hip replacement procedure without investigation of the bladder wall irregularity for cancer. The matter was then reported to the coroner.

This was a discretionary inquest pursuant to section 22 (2) of the *Coroners Act 1996* (WA) and was held in the same week as another inquest into the death of a patient, also under the care of Dr Stephens in 2014. The evidence was heard contiguously to examine Dr Stephens' treatment, management and care of his patients.

Dr Daryl Stephens is a consultant urologist who became a Fellow of the Royal Australian College of Surgeons Urology in 1981 and has worked as a proceduralist since then, both in Australia and overseas.¹ He is currently practicing in Mackay, Queensland, and is an adjunct professor at James Cook University. His career has been that of a generalist, of both primary and secondary referrals, in emergency urology and prostate cancer. The majority of his work has been clinical with only more recently an academic role.

Dr Stephens has worked in both the public and private systems, both in Australia and the UK. He practiced in Perth for 16 years, increasingly in the private sector, prior to moving to Queensland where he consults, increasingly in the public sector.²

¹ t 12.10.16, p39

² t 12.10.16, p140

BACKGROUND

The Deceased

The deceased was born in England on 30 August 1941 and moved to South Australia in 1970. He was married and he and his wife had four children. The deceased's wife died three years before him.

The deceased was initially in the Army, before becoming a banker. He moved to Western Australia in 1989.

The deceased's GP was Dr Huan Nguyen of Mandurah Medical Centre and he first saw the deceased on 3 October 2005 for a check-up. At that time Dr Nguyen considered the deceased to be in good health and not requiring any regular medication. By the time of his death the deceased's medical history included a right hip fracture, gallstones not requiring surgery, transurethral resection of the prostate, phimosis circumcision and a degenerative right hip. He had been a smoker for most of his life.

In November 2010 the deceased presented to his GP with a history of lower back pain for two months, referred to his left flank. He was diagnosed as having pyelonephritis and commenced on antibiotics. He had a large bladder residual on ultrasound with bladder wall trabeculations. He was referred to a urologist and a transurethral resection of his prostate was undertaken. Biopsy indicated the prostate

tissue was benign. In October 2011 the deceased developed phimosis and on this occasion Dr Nguyen referred him to Dr Daryl Stephens for a circumcision.

The deceased was treated in the PHC for a UTI in February 2014 and consulted his GP upon discharge due to his concern with a 6 month history of right hip pain.

X-rays ordered by Dr Nguyen revealed severe degenerative changes in the right hip joint with a possibility of a vascular necrosis. Dr Nguyen referred the deceased to Mr Michael Anderson, an orthopaedic surgeon, and prescribed Panadol Osteo, pending specialist review.

In April 2014 the deceased complained to Dr Nguyen he had ongoing flank pain since the UTI in February 2014. Dr Nguyen arranged a urine test and ultrasound of the renal tract which revealed the deceased again had a UTI and bladder wall irregularity, which Dr Nguyen believed raised the possibility of a neoplastic mass. The ultrasound report referred to the need for a cystoscopy to examine the reason for the bladder wall thickening.

Dr Nguyen provided the deceased with a prescription for antibiotics and advised him to postpone any pending hip operation until reviewed by Dr Stephens as to his ultrasound report. Dr Nguyen was concerned that, despite the deceased having no history of bladder cancer, he had

been a chronic smoker and Dr Nguyen wished for the ultrasound to be reviewed prior to any decisions made about the hip replacement.³

The referral to Dr Stephens from Dr Nguyen was by way of letter, dated 1 May 2014, requesting an opinion from Dr Stephens as to management of the deceased, due to having had yet another UTI, and the ultrasound showing the bladder wall irregularities with trabeculation and diverticula present, mild soft tissue thickening along the wall of the diverticulum to the left bladder base, with a significant post void residual. Dr Nguyen enclosed a copy of the ultrasound with his referral.⁴ The ultrasound report twice made reference to the need for cystoscopic evaluation, once in the main body of the report with respect to the bladder and again in the comment section. This was to exclude the possibility of a neoplastic mass lesion and confirm instead a mucosal fold.

Dr Stephens saw the deceased on 8 May 2014 and reviewed the ultrasound report. Dr Stephens said in evidence he would not have relied on the report, but would have asked for a copy of the films to be forwarded so he could view the ultrasound for himself. He also performed his own, limited, ultrasound on his first review.⁵

³ Ex 3, tab 4

⁴ Ex 3, tab 10

⁵ t 12.10.16, p176-177

In his response to Dr Nguyen, dated 8 May 2014, Dr Stephens commented he could feel no masses and that the deceased's bladder was not palpable. On rectal examination Dr Stephens noted a hefty left side of the prostate gland remanent, which was observable as a 25-30g remnant prostate with resection at the posterior bladder neck. Dr Stephens advised he suspected the deceased would need to have another prostate bore in the future, but that he understood the present concern to be sterile urine for the up and coming hip operation. To facilitate this Dr Stephens commenced the deceased on Macrochantin to ensure sterile urine before the hip operation.

In evidence Dr Stephens agreed that following his review of the deceased's ultrasound film he did not believe the bladder wall irregularity was any more than an irregularity normally seen in a patient suffering with recurrent UTIs. He did not believe the irregularity on the bladder wall to be any indication the deceased was suffering from a tumour in his bladder.⁶

Dr Stephens agreed he believed it necessary to exclude the possibility of a bladder cancer, but did not consider that diagnosis to be likely. However, he had referred the deceased for a flexible cystoscope following the appointment of 8 May 2014.⁷

⁶ t 12.10.16, p182, 185

⁷ t 12.10.16, p179-180

Dr Stephens' appointment book for 8 May 2014 indicated he saw the deceased at 3:15pm, and following that review asked his secretary to arrange for the deceased to have a flexible cystoscopy at PHC whenever the lists made one available.⁸ In evidence Dr Stephens stated he did not have control of the lists at PHC and was subject to the listings as arranged by that hospital.⁹ There is no mention of the need for a flexible cystoscopy in his letter to Dr Nguyen, however, the cystoscopy was suggested in the ultrasound report sent to him by Dr Nguyen.

Dr Stephens was unable to determine when the cystoscopy would become available, so was preparing the deceased's suitability for the hip replacement by ensuring an infection free urinary tract.

A letter from Dr Stephens to PHC dated 28 May 2014 referred to the deceased's need for a transurethral resection of prostate (TURP) due to having a remanent prostrate, but indicated the main problem was the deceased's need to have sterile urine for his up and coming procedure. Dr Stephens stated he had commenced the deceased on Macrochantin on 28 May 2014 and pointed out to urology at PHC the deceased needed a flexible cystoscopy prior to his procedure. Presumably both references to a procedure mean hip operation because that was the procedure the deceased was awaiting.

⁸ Ex 3, tab 10

⁹ t 12.10.16, p182

On 30 May 2014 Dr Stephens saw the deceased again and, on enquiry, discovered the deceased's hip operation had been listed for 23 June 2014. Dr Stephens had not yet received a date for the deceased's flexible cystoscopy and it was unlikely he would receive a date prior to the date for the hip replacement. Dr Stephens did not believe there was a likelihood the deceased had bladder cancer and believed it important, with the hip replacement imminent, that procedure go ahead in view of the fact the deceased had sterile urine and had been waiting with some anxiety for the hip replacement.¹⁰

Dr Stephens did not consider it necessary the deceased have the flexible cystoscopy prior to the hip replacement which was less than three weeks away.¹¹

Following Dr Stephens' review of the deceased on 30 May 2014 he wrote to Dr Nguyen and indicated he was happy the Macrochantin treatment had worked as the deceased appeared to have no obvious UTIs at the time. He insisted the deceased stay on prophylaxis antibiotics until after the hip operation. Dr Stephens commented on an episode of urethral bleeding after the ultrasound, and referred to the need for the flexible cystoscopy and another TURP, following the hip replacement.¹²

¹⁰ t 11.10.16, p131

¹¹ t 12.10.16, p188

¹² Ex 3, tab 10

From Dr Stephens' personal notes with respect to the deceased it is possible to infer Dr Stephens had originally requested the deceased have a flexible cystoscopy and be placed on the wait list at PHC where Dr Stephens was not in control of the lists. It had been his intention the cystoscopy would occur prior to the hip operation, but on understanding how close the hip operation was, and realising that was not going to be a possibility, he considered it unlikely the deceased had bladder cancer and thought it preferable the deceased continue with his hip operation which had already been put off once before.

Hip Operation

The deceased's hip operation was performed by Orthopaedic Surgeon Michael Anderson, and Mr Anderson indicated in evidence that the deceased was experiencing significant pain due to his hip degeneration.¹³ Mr Anderson referred to the deceased's pain as *"typical arthritic right sided hip symptoms with a level of symptoms that had become unacceptable to him"*.¹⁴

The deceased had no health cover and therefore needed to be placed on a public waiting list for surgery. Mr Anderson indicated in evidence that he had retired from practice in tertiary hospitals as a result of his concerns the public

¹³ † 11.10.16, p129

¹⁴ Ex 3, tab 9

waiting lists were up to four years for hip surgery, and in the case of the deceased this would have been unacceptable.¹⁵ The waiting list at PHC was much shorter and Mr Anderson now generally worked at the small hospitals, where he believed he could get his patients more rapid attention away from the tertiary centres.

Mr Anderson pointed out that prior to any replacement surgery to the hip it was necessary for a urine analysis and that the deceased's urine analysis of 21 May 2014 indicated a significant infection. This needed to be dealt with prior to any surgery.

Mr Anderson indicated he was also in receipt of correspondence with Dr Stephens, a urologist, of both 30 April and 8 May 2014 referring to UTIs and the prescription of antibiotics. Mr Anderson indicated the follow-up letter from Dr Stephens indicated the deceased no longer had a UTI and, in the absence of any other apparent urological problem, Mr Anderson proceeded with the right hip replacement through the PHC on 23 June 2014. The procedure was uneventful with no orthopaedic complications.¹⁶

Mr Anderson did not see any apparent suspicion of bladder cancer in his records for the deceased preoperatively and, in his view, the fact of a localised cancer or metastases did not

¹⁵ † 11.10.16, p134

¹⁶ Ex 3, tab 9

necessarily preclude the hip replacement surgery. The deceased's symptoms from his hip were sufficient to warrant surgery to ensure a better quality of life and improved mobility.

Mr Anderson pointed out that he had dealt with a number of patients in his career who had a poor prognosis, with established malignancy prior to hip replacement, and he had still performed surgery to ensure those patients had as good a quality of life as could be hoped for, which had continued for some months after the hip replacement procedure.

In evidence Mr Anderson indicated that even if he had known of the malignancy, it would have been a matter for discussion with the deceased as to the continuation of the hip surgery and the improved quality of life. It was his opinion the deceased would have chosen to proceed with hip surgery despite the elevated risk of surgery, due to the deceased's extreme pain.¹⁷

POST HIP REPLACEMENT

On 3 July 2014 the deceased presented to the ED at PHC with a sharp pain in his right flank and increased urination. Dr Sturdy, Chief Executive Officer of PHC, reported the deceased had a recent history of total hip replacement at PHC 10 days earlier and appeared to be making a good

¹⁷ † 11.10.16, p132

recovery from that operation.¹⁸ Mr Anderson indicated the deceased was immediately mobile following the hip operation which he had not been before.¹⁹

Dr Sturdy noted hospital records indicated the deceased had pre-existing tiredness and weight loss. He was investigated at PHC and it was noted he had disseminated bladder cancer with extravesical invasion, left hydronephrosis, probable pulmonary and bony metastases, with hypercalcaemia. He was treated at PHC with intravenous hydration and bisphosphonate therapy, but these produced minimal improvement in his symptoms. As a result he was transferred to Fremantle Hospital on 5 July 2014 for further management.²⁰

Fremantle Hospital (FH)

The deceased was admitted to FH urology team on 5 July 2014 following transfer from PHC with the newly diagnosed metastatic bladder cancer.

A CT scan undertaken at PHC showed bilateral hydronephrosis, extravesical invasion, metastatic nodal and bone disease. The deceased had been complaining of generalised aches and pains in his muscles and bones, right

¹⁸ Ex 3, tab 5

¹⁹ t 11.10.16, p133

²⁰ Ex 3, tab 5

lower quadrant/flank abdominal pain and increasing lethargy.²¹

The FH notes indicated his calcium levels were high, with a CT scan showing chronic obstructive pulmonary disease (COPD) and some lower zone nodules, presumed to be metastatic in nature. He was provided with bisphosphonate therapy for correction of hypercalcaemia with a good result.

On 6 July 2014 the deceased developed a temperature and tachypnoea and a chest ray showed extensive bilateral pulmonary infiltrates which were worse on the left, consistent with a lower respiratory tract infection. He was commenced on intravenous antibiotics.

The deceased continued to experience ongoing shortness of breath, increased respiratory rate and low oxygen saturations and an ultrasound Doppler on 9 July 2014 confirmed a left common femoral vein non-occlusive thrombosis. This had occurred despite anticoagulant prophylaxis following his hip replacement. The deceased was a known smoker and a previous CT scan had shown COPD.

The physicians thought his respiratory symptoms were hypoxic respiratory failure, probably due to a combination of pulmonary embolus and pneumonia, on a background of

²¹ Ex 3, tab 6

advanced COPD. Despite the institution of treatment it was apparent the deceased's prognosis was poor and his ongoing care became palliative.

All active medical treatment was ceased and he was declared deceased on 11 July 2014.²²

The deceased did not undergo a post mortem examination and the death certificate from FH indicated he had died of metastatic bladder cancer. Bladder cancer, or treatment for cancer in general, elevates the possibility of death by way of pulmonary embolism, as does orthopaedic surgery,²³ although the deceased was mobile following his hip surgery. The progression of the deceased's cancer was extremely aggressive, but even so it was probably present prior to the hip surgery in June 2014.²⁴

REVIEW BY PROFESSOR DICKON HAYNE

Professor Dickon Hayne, head of Urology at Fiona Stanley Hospital, was provided with documentation with respect to the death of the deceased and asked for his opinion on Dr Stephens' management of the deceased, in view of the ultrasound of 29 April 2014, and the deceased's death on 11 July 2014.

²² Ex 3, tab 6

²³ Ex 3, tab 8

²⁴ Ex 3, tab 14

Professor Hayne was of the opinion the deceased's GP had appropriately referred the deceased to a urologist with the ultrasound suggesting the possibility of a bladder tumour which could be elucidated by use of a flexible cystoscopy, as referred to in the ultrasound report.

The deceased was appropriately seen by Dr Stephens on 8 May 2014, however, Professor Hayne believed the response to the report should have been to list the deceased for an urgent flexible cystoscopy, as well as commencing appropriate antibiotics to treat any current infection.

In evidence Professor Hayne was critical of the failure to arrange a flexible cystoscopy to elucidate the possibility of bladder cancer prior to the deceased's hip replacement procedure. Professor Hayne indicated hip replacement surgery could adversely affect the deceased's effective early treatment for aggressive bladder cancer. Professor Hayne also believed the repeat UTIs were a concern for a male patient, and indicative of the probability of cancer.²⁵

Professor Hayne believed that in the circumstances the deceased should have been provided with antibiotics and then had the cystoscopy as soon as possible, under antibiotic cover, to diagnose a bladder tumour. Bladder

²⁵ † 11.10.16, p74

tumours metastasise very quickly and the empirical evidence indicates that early diagnosis is essential.²⁶

Professor Hayne would also have performed a CT urogram, and possibly taken tissue for biopsy to determine whether the cancer had metastasised,²⁷ all of which would then dictate the most effective management.

In evidence Professor Hayne indicated he had been a consultant urologist at FH at the time the deceased died.²⁸ He had control of the urology lists, both at FH when he was there, and at Fiona Stanley Hospital, and it was his view he would have been in a position to arrange a flexible cystoscopy for a public patient within two weeks of reviewing the ultrasound report.²⁹

Professor Hayne indicated Dr Stephens' plan to have a flexible cystoscopy soon was appropriate, but was concerned it was to be performed after the hip replacement.³⁰ Professor Hayne believed Dr Stephens was unduly focused on the deceased's prostrate, as opposed to the possible bladder tumour as suggested by the ultrasound and the haematuria following the consult on 30 May 2014. Professor Hayne stated a cystoscopy was the gold standard

²⁶ † 11.10.16, p75

²⁷ † 11.10.16, p79

²⁸ † 11.10.16, p66

²⁹ † 11.10.16, p81

³⁰ † 11.10.16, p71

investigation most mandated in the circumstances of the deceased.³¹

Professor Hayne believed that had the bladder tumour been diagnosed and the hip surgery postponed as a result of a flexible cystoscopy, then the bladder cancer would have been investigated and treated prior to July 2014. The deceased's bladder cancer was clearly very aggressive to have progressed from a bladder wall thickening in late April 2014 to serious metastases by the time of his death in July. Professor Hayne believed it was likely, although not necessarily, metastatic when first seen by Dr Stephens on 8 May 2014.³²

Professor Hayne believed early treatment would have improved the deceased's survival rate and the elective hip surgery, in the context of undiagnosed metastatic cancer, should have been avoided. Professor Hayne stated deep vein thrombosis and subsequent venous thromboembolism is a relatively common complication of both orthopaedic surgery and pelvic cancer such as bladder cancer. The deceased's likely succumbing to pulmonary embolism was not unexpected in view of both the surgery and the pelvic cancer.³³

³¹ † 11.10.16, p73, 75

³² † 11.10.16, p78-79

³³ † 11.10.16, p82

Professor Hayne was of the view that both the failure to investigate and treat for bladder cancer, and performing major elective hip surgery, could have reduced the deceased's survival time from his metastatic cancer.³⁴

REVIEW BY PROFESSOR BROOKS

A report was also provided to the court on behalf of Dr Stephens from A/Professor Andrew J Brooks who also has a very impressive C.V.³⁵ He is an urological surgeon and in his view the ultrasound report of 29 April 2014 was “*vague*”. Professor Brooks stated established bladder cancer is fairly obvious on ultrasound and that it was not apparent from the report that the deceased had bladder cancer at that stage. He believed Dr Stephens was entitled to form the view that changes mentioned in the report were subtle and not particularly indicative of bladder cancer.

It is not evident either Professor Hayne or Professor Brooks understood Dr Stephens had viewed the ultrasound film for himself and did not believe the changes were consistent with cancer, but rather those normally seen with recurrent urinary tract infections.

Dr Brooks stated the deceased's ultrasound reported a “*mucosal abnormality that in retrospect was likely to have*

³⁴ † 11.10.16, p84

³⁵ Ex 3, tab 14

been transitional cell carcinoma".³⁶ He pointed out that in the space of nine weeks that disease progressed to cause bilateral uretic obstruction which was an extremely rapid course of events, and while it was likely the deceased had metastatic disease at the time of the ultrasound on 29 April 2014, he did not believe that diagnosis at that time would have had a significant effect on his survival time.

Professor Brooks was of the opinion the public waiting lists are such that it was "*reasonable to delay the flexible cystoscopy until after the hip replacement*".³⁷ He indicated there was nothing in the deceased's clinical history which would suggest a high probability of bladder cancer and nothing to suggest it was as highly aggressive as it turned out to be.

Professor Brooks certainly agreed that a flexible cystoscopy and urine cytology were appropriate forms of investigation for the deceased, but that ensuring the deceased had sterile urine prior to a hip replacement with a plan to perform the flexible cystoscopy following the procedure, was not unreasonable in view of the lack of evidence the deceased had such an aggressive bladder cancer.

In contradistinction to Professor Hayne, Professor Brooks did not think earlier diagnosis and treatment of the bladder cancer would have made a significant difference to the

³⁶ Ex 3, tab 14

³⁷ Ex 3, tab 14

deceased's survival time. Professor Hayne believed early treatment of the bladder cancer may have prolonged the deceased's life, although he could not comment on the quality of that life with serious hip pain.

Mr Anderson was quite clear he believed the deceased would have chosen to alleviate his hip pain, rather than delay the procedure again.

CAUSE AND MANNER OF DEATH

There was no post mortem examination and the death certificate indicated death was due to metastatic bladder cancer, although Professor Hayne considered the mechanism of death likely to have been complications of the combined effect of the bladder cancer and hip surgery, in the form of pulmonary embolism. Both the bladder cancer and the need for hip replacement due to arthritis resulted from naturally occurring conditions.

I find death occurred by way of Natural Causes.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 72 year old man who was suffering recurrent UTIs which were causing him significant discomfort in conjunction with severe arthritis which required a hip replacement.

His GP appropriately arranged for an ultrasound to examine the basis for the recurrent UTIs, abnormal in a male and possibly indicative of bladder cancer.

That ultrasound indicated a thickening of the bladder wall, which Dr Stephens interpreted as a probably normal finding where there were recurrent urinary tract infections, on his review of the ultrasound film.

It is common ground, in hindsight, the irregularity seen was likely to be metastatic bladder cancer, and although usually very observable on ultrasound, should have warranted urgent flexible cystoscopy to determine, in real time, the appearance of the bladder wall.

Professor Hayne described the view generally seen via cystoscopy and indicated it was very easy to identify bladder cancer that way. He believed he would have been able to obtain a flexible cystoscopy procedure for the deceased in two weeks.

This was not the experience of Dr Stephens or Mr Anderson, with listing procedures in lists over which they did not have control.

Dr Stephens indicated he had requested the deceased be placed on a list for flexible cystoscopy following his appointment on 8 May 2014. The appointment entry does

imply Dr Stephens considered the deceased should be placed on the flexible cystoscopy list and it was a matter his secretary would have organised.

By 28 May 2014 a date for cystoscopy had not been received and Dr Stephens again requested the deceased have the flexible cystoscopy prior to his upcoming “*procedure*”.

On 30 May 2014 Dr Stephens understood the deceased’s hip replacement was listed for 23 June 2014 and it was unlikely he would receive the cystoscopy prior to that date. It had already been over three weeks since his original request the deceased be placed on the list for cystoscopy.

Dr Stephens ensured the deceased had sterile urine and was maintained on prophylaxis to ensure that remained the case for the hip replacement. Both Dr Stephens and Mr Anderson were of the view the deceased would have preferred continuation of the hip replacement procedure due to the extreme pain he was experiencing from his hip.

I accept the optimal course of management for the deceased would have been a flexible cystoscopy within two weeks from 8 May 2014, when Dr Stephens first requested the deceased be placed on the PHC list. Had that occurred then treatment could have proceeded with the deceased being informed as to his management options with respect to the

hip replacement on 23 June 2014 and any diagnosis which may have flowed from the cystoscopy.

However, that did not occur, and despite Dr Stephens' follow-up letter of 28 May 2014 to PHC, the deceased had still not been listed for cystoscopy, by the time of his hip operation. It is common ground it would be preferable, if there was a certainty as to bladder cancer, that any major operation was undertaken with knowledge and informed consent by the patient of the underlying malignancy.

Dr Stephens said his review of the ultrasound film did not convince him it was likely the deceased had bladder cancer, although it was a matter he wished to elucidate prior to any further investigations for the deceased's remnant prostate. Having achieved a sterile urine for the deceased's hip replacement procedure he considered the hip replacement should proceed as a matter of priority for the deceased's quality of life.

The deceased had his hip replacement on 23 June 2014 and, according to Mr Anderson, experienced immediate relief from pain.

On 3 July 2014 the deceased attended at PHC due to ongoing pain in his flank and on further investigation it was discovered he had metastatic bladder cancer.

The deceased was transferred to FH where he was managed for his bladder cancer, but unfortunately died on 11 July 2014.

There is no doubt it would have been preferable the deceased be in a position to make his own decision about the competing interests of his management and treatment for bladder cancer and hip replacement. However, without some certainty as to the likelihood his prognosis would have been improved by the ability to make an informed decision, I am not prepared to comment further on the deceased's optimal bladder cancer management. His family have already lost the deceased and without some positive assurance that could have been avoided, uncertainty does not assist them in coming to terms with that loss, and does not assist the community with clear guidelines to avoid such complications in the future, where there may be significant delays in listing diagnostic procedures in the public system.

E F Vicker
Deputy State Coroner
31 March 2017