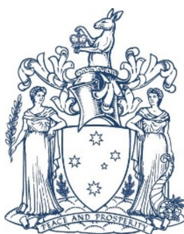

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 1237

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Amended pursuant to Section 76 of the Coroners Act 2008
on 6 April 2021[1]

Findings of:	**DARREN J BRACKEN, CORONER**
Deceased:	**PAMELA ROBSON PATTISON**
Date of birth:	25 AUGUST 1944
Date of death:	25 FEBRUARY 2020
Cause of death:	1(a) HAEMOPERICARDIUM 1(b) DISSECTION OF THE ASCENDING AORTA
Place of death:	1/25A SOUTH ROAD, MOE, VICTORIA 3825

[1] This document is an amended version of the Finding without Inquest dated 29 March 2021. Corrections to paragraphs 3 and 32(b) have been made pursuant to Section 76 of the *Coroners Act 2008* (Vic).

INTRODUCTION

1. Pamela Robson Pattison was 75 years of age when she died between 24-25 February 2020 from haemopericardium in the setting of dissection of the ascending aorta. The exact date of Mrs Pattison's death is not known and cannot be ascertained. At the time of her death Ms Pattison, who was recently widowed, lived alone at 1/25A South Road Moe Victoria.

2. Mrs Pattison, a retired teacher, was originally from England. She had two children who both predeceased her. Her only family member in Australia was her granddaughter, Teegan, who had recently moved to Queensland. Mrs Pattison is survived by her sister, Joan Rees, who lives in Scotland.

3. In a statement to the court, Mrs Pattison's friend of 25 years, Kathleen Rabl provided background information. Mrs Rabl explained that Mrs Pattison's husband died of prostate cancer in September 2019. Prior to his death, Mr and Mrs Pattison sold their farm in Balook[2] and Mrs Pattison purchased and moved into a unit at 1/25A South Road, Moe.

4. Mrs Pattison's medical history included Type 2 diabetes, hypertension and chronic kidney disease. At the time of her death, she was recovering from shingles and had recently given up smoking cigarettes.

5. Mrs Rabl described her friend as being very active in various community and social activities such as a craft group, the Yarram Historical Society, Friends of the Tarra Bulga National Park, and the Rhythm of the Rain Forest Committee.

6. Mrs Pattison had planned to travel to UK on 29 March 2020 to take her husband's ashes to his country of birth. Mrs Rabl said Mrs Pattison was looking forward to the trip.

[2] The suburb in which Mr and Mrs Pattison's farm was located was incorrectly designated as Nilma North.

THE CORONIAL INVESTIGATION

7. Mrs Pattison's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Whilst I have reviewed all the material before me, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities. [3]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

11. On 18 March 2020, Ruth Bennett, a friend of Ms Pattison identified the deceased as Pamela Robson Pattison.

12. Identity is not in dispute and requires no further investigation.

Medical cause of death

13. On 5 March 2020, Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination and provided a written report of his findings dated 6 March 2020.

[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

14. The CT scan revealed a dilated calcified ascending aorta with apparent dissection and haemopericardium, calcified arteries and aortic valve.

15. Toxicological analysis of post-mortem samples was not performed

16. Dr Bedford provided an opinion that the medical cause of death was '*1(a) Haemopericardium (1b) Dissection of the ascending aorta".*[4]

Circumstances in which the death occurred

17. On 20 February 2020, Mrs Pattison attended a consultation with GP Dr Paul Brougham at Breed Street Clinic, Traralgon. Dr Brougham provided a statement to the court in which he noted that Mrs Pattison presented with a number of issues including an episode of central chest pain radiating to her jaw, which had occurred the previous night. There was still some discomfort at the time of the consultation, but no sweating and the pain was not related to exertion. Dr Brougham arranged for an ECG and considered this unchanged from an ECG in 2019.

18. Mrs Pattison spent the weekend of 22-23 February 2020 in Melbourne for the occasion of friends' 50th wedding anniversary, staying with another friend, Sheila Whiteman. Following Mrs Pattison's death, Mrs Rabl spoke to Ms Whiteman who told her that, during the weekend, Mrs Pattison "*had a turn*" from which she recovered after a rest. Ms Whiteman urged Mrs Pattison to see her doctor.

19. At approximately 2.00pm on 24 February 2020, Mrs Pattison stopped off at Mrs Rabl's home in Nilma North on her way back from Melbourne. Mrs Rabl said that, although Mrs Pattison had given up smoking, during her visits Mrs Pattison would smoke a couple of cigarettes with Mrs Rabl's husband, Matt Rabl and:

> "*That day, she had two cigarettes with Matt, one when she arrived and one when she left, and a cup of tea. It was a warmish day and she had some water too. After the first cigarette she said she was feeling tired and was saw* [sic] *across the chest area. She motioned to me across the top of her chest area between her shoulder and breasts".*

20. Mrs Rabl encouraged Mrs Pattison to make an appointment with her doctor to get it checked out. Mrs Pattison then lay on Mrs Rabl's couch and slept for an hour to an hour and a half. On waking she told Mrs Rabl she felt a bit better. When Mrs Pattison left Mrs Rabl's home, she promised to ring her later that night and at approximately 5.05pm she called Mrs Rabl to say

[4] A serious condition in which the inner layer of the aorta tears. Blood enters the tear causing the inner and middle layers of the aorta to separate, and potentially rupture.

she had arrived home safely, that she was tired and going to bed. Mrs Rabl reiterated her advice that Mrs Pattison should attend her GP. Mrs Pattison apparently called her GP's rooms to make an appointment for the following day.

21. On 25 February 2020, a concerned friend and neighbour noticed that Mrs Pattison's car was in the garage and the house secured but that Mrs Pattison was not answering the door or her phone. Police were called and asked to perform a welfare check, during which Mrs Pattison was located, deceased, lying on her back in the bathroom doorway. There were no suspicious circumstances.

22. Diagnosis of aortic dissection is often missed with fatal consequences. In 2013, Coroner Paresa Spanos held an inquest into the death of Constandia Petzierides[5]. Mrs Petzierides died as the result of a haemothorax secondary to a dissecting thoracic aorta, the diagnosis of which had been missed by the emergency clinicians who saw her in the 24 hours prior to her death.

23. As part of her investigation, Coroner Spanos obtained a report from emergency physician Dr David Eddey in which he relevantly states:

> "*In order to diagnose aortic dissection four things need to occur. Firstly the clinician needs to be aware of the condition, however rare, as a cause for chest pain or one of the atypical presentations of aortic dissection. Secondly, the clinician needs to take a history and perform a clinical examination in such a way as to get the appropriate information from the patient (i.e they need to ask the right question and examine the patient for specific signs). Thirdly they need to interpret the information from the point of view of risk of aortic dissection and lastly they need to perform appropriate investigations to diagnose or exclude the condition.*
>
> *Because of the diverse manifestations of acute aortic dissection and the high chance of a fatal outcome if left untreated, clinicians must have a high index of suspicion for aortic dissection. Rapid recognition and treatment may improve survival and maximise recovery of peripheral malperfusion deficits such as stroke. Misdiagnosis as ACS may lead to inappropriate treatment – antiplatelet therapy and thrombolysis that may be lethal and coronary angiography. Delayed diagnosis may also delay antihypertensive therapy allowing propagation of the dissection and worsening prognosis.*

[5]Available on the Coroner's Court of Victoria website under case file No. 157110

The variable clinical manifestations of aortic dissection present a challenging differential diagnostic problem. Patients with aortic dissection may be diagnosed as having many other conditions, including myocardial infarction, pericarditis, pulmonary embolism, pneumothorax, pleurisy, ureteric colic, acute cholecystitis, biliary colic, musculoskeletal back pain, stroke, syncope, paraplegia, peripheral vascular disease and arterial embolism. Acute myocardial infarction is a common initial incorrect diagnosis, particularly in a patient with severe chest pain and an abnormal ECG".

24. Although Dr Eddey's opinion was directed to emergency physicians, it is equally apposite to general practitioners, to whom many such patients may present.

25. Following Coroner Spanos' findings into the death of Mrs Petzierides, the court formulated a series of questions to be directed to treating clinicians in circumstances where a patient has died as the result of an undiagnosed aortic dissection. I directed that a statement be obtained from Dr Brougham and that he be asked to respond to specific pertinent questions.

26. In his response, Dr Brougham told me that his differential diagnosis was primarily an acute myocardial infarction given Mrs Pattison's history of diabetes, hypertension and smoking. He told me that he was satisfied that her ECG was unchanged from that performed in 2019. He stated that:

"*The episode of pain had occurred the previous evening and I was seeing her early in the afternoon of the following day so beyond the time frame for any thrombolysis if there was an acute myocardial infarction. I did not organise any other investigations apart from a CT scan of her left wrist because she was complaining about pain still* [on 20 January 2020 Mrs Pattison presented to another GP at the Breed Street Clinic following a fall onto her outstretched left hand]

27. Dr Brougham continued:

"*I am not aware of any previous episodes of chest pain. I was managing her risk factors in terms of cardiac health in that her HbA1C was well controlled, blood pressure was normally under 130/80 and I had encouraged her to cease smoking which she had done so. This was all on the background of her husband's death in October 2019".*

28. It appears that Dr Brougham did not consider aortic dissection as a differential diagnosis or interpret the information he obtained from the point of view of aortic dissection. It is not possible to say that, had Dr Brougham considered and investigated the possibility of aortic

dissection, that the outcome would have been different. However, the circumstances of Mrs Pattisons death reveal a lost opportunity and I therefore make the recommendations below directed to the Royal Australian College of General Practitioners regarding education about and awareness of diagnosis of aortic dissection in general practice. I attach to my finding a copy of Coroner Spanos' findings into the death of Constandia Petzierides (to which Dr Eddey's report is attached) together with Coroner Jamieson's findings into the death of Sununtha Suttha [6](delivered in October 2018).

29. I otherwise find that there are no suspicious circumstances and that no further investigation into Mrs Pattison's death is required.

RECOMMENDATIONS

30. Pursuant to section 72(2) of the Act, I recommend:

    That the Royal Australian College of General Practitioners consider highlighting to its Trainees, Fellows and Members the importance of considering the diagnosis of aortic dissection for patients presenting in general practice with chest pain and the nuanced presentations of aortic dissection, particularly in circumstances where ischaemic heart disease has been excluded.

31. Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

FINDINGS AND CONCLUSION

32. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was Pamela Robson Pattison, born on 25 August 1944;

    (b) the death occurred on 25 February 2020 at 1/25A South Street, Moe,[7] Victoria; and

    (c) the death occurred in the circumstances described above in paragraphs 17 - 28.

[6] Available on the Coroner's Court of Victoria website Case ID COR 2017 0935

[7] The place at which the death occurred was incorrectly designated as 771 Bloomfield Road, Nilma North.

I direct that a copy of this finding be provided to the following:

Mrs Joan Rees, Senior Next of Kin;

Dr Matthew Miles, CEO, The Royal Australian College of General Practitioners; and

Constable Jacklyn A'Herne, Victoria Police, Coroner's Investigator

Signature:

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DARREN J BRACKEN

CORONER

Date: 7 April 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.