



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 001585

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Therese McCarthy
Deceased:	Oscar Hector Ortiz
Date of birth:	18 October 1952
Date of death:	29 March 2019
Cause of death:	1a: Right sided subdural haemorrhage
Place of death:	10 Storrington Avenue Hoppers Crossing, Victoria
Keywords:	Anticoagulation (apixaban) – Antiplatelet medication (aspirin) – Medication management – Bleeding risk

INTRODUCTION

1. On 29 March 2019, Oscar Hector Ortiz, who was 66 years old, was found by deceased at home by his daughter. At the time of his death, Mr Ortiz lived alone in Hoppers Crossing. For reasons not pertinent to the circumstances of his death, Mr Ortiz's partner, Nubia Acevedo, was not residing with him at that time.
2. Mr Ortiz is also survived by his children, Natalia, Oscar and Eric.

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

Circumstances in which the death occurred

3. On 29 March 2019, Natalia and her partner attended Mr Ortiz's home as she was concerned by his recent lack of contact. They gained entry via the back door using Natalia's spare key. On entering her father's bedroom, Natalia found him deceased and lying in bed on his back and observed a small amount of vomit around his mouth.
4. Emergency services were contacted, and Victoria Police and Ambulance Victoria paramedics arrived a short time later. Responding paramedics were unable to find signs of life and pronounced Mr Ortiz deceased at 10.11pm.
5. Natalia advised police that she last saw her father in January 2019 but spoke with him on 26 March 2019. She further advised that her father resided with his partner, who had been in hospital for the last 8 months and suggested he may not have been keeping up with his medications in her absence.¹

Identity of the deceased

6. On 29 March 2019, Oscar Hector Ortiz, born 18 October 1952, was visually identified by his daughter, Natalia Ortiz-Acevedo.
7. Identity is not in dispute and requires no further investigation.

¹ Victoria Police, Police report of death for the coroner dated 29 March 2019.

Medical cause of death

8. On 2 April 2019 Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy and provided a written report of her findings dated 22 October 2019.
9. Dr Glengarry observed in her report the presence of minor natural disease in the form of mild cardiovascular disease and a small tumour within the thyroid gland (papillary microcarcinoma). Dr Glengarry did not identify any evidence of metastases and did not consider the tumour or cardiovascular disease to have contributed to death.
10. Toxicological analysis of post-mortem samples identified the presence of orphenadrine, a muscle relaxant, and pholcodine, an opioid cough suppressant (antitussive), each of which did not contribute to Mr Ortiz's death. No alcohol, illicit drugs, or other prescribed medications were identified.
11. Dr Glengarry was assisted by the results of a neuropathological examination conducted by Dr Linda Iles, during which it was observed that Mr Ortiz had sustained a right-sided subdural haemorrhage, or bleeding across the surface of the brain. Dr Glengarry commented that the accumulation of blood can cause pressure and swelling in the brain, leading to fatal compromise of brain functions.
12. Dr Glengarry did not identify any evidence of external injury, nor any disease processes sufficient to have triggered a fall or stumble which may have resulted in bleeding. Notwithstanding, Dr Glengarry considered that while no such injuries could be identified, an impact to the head by a broad or soft surface cannot be excluded because they may leave no evidence of injury within the skin or tissues beneath the scalp.
13. The neuropathological examination also identified evidence of subacute and chronic subdural haemorrhage, which indicated that Mr Ortiz had previously suffered multiple episodes of bleeding over time. Dr Glengarry commented that symptoms of a subdural haematoma, such as headache, vomiting, altered level of consciousness, seizures or coma, are not always immediately apparent and their onset may be delayed following a period of lucidity. Dr Glengarry noted that if left untreated, a subdural haemorrhage is sufficient to cause death, or that a chronic subdural haemorrhage may require only minimal trauma to occur.

14. Dr Glengarry provided an opinion that the medical cause of death was '*1(a) Right sided subdural haemorrhage*'.
15. I accept Dr Glengarry's opinion.

BACKGROUND

16. Since June 2012, Mr Ortiz had been attending Wyndham Health Care for management of a range of chronic conditions including diabetes arthritis, back pain, and elevated cholesterol and lipids and for investigation of fainting episodes. He did not have a recorded history of seizures or recurring headaches. For the relevant period, his treating general practitioner (**GP**) was Dr Zaid Albrefkany.
17. On 5 December 2017, Mr Ortiz presented to Werribee Mercy Hospital following a fainting episode. He underwent multiple investigations, including blood tests, electrocardiogram (**ECG**), and a computed tomography (**CT**) brain scan. These initial investigations did not reveal any abnormalities, and Mr Ortiz was referred to Werribee Heart to specialists for further investigation. A subsequent echocardiogram and monitoring of heart rhythm and ambulatory blood pressure similarly did not identify any abnormalities.
18. On 20 December 2017, Mr Ortiz's GP arranged magnetic resonance imaging (**MRI**), which revealed "*foci of chronic small vessel ischaemia*" consistent with small vessel disease associated with diabetes or smoking, but no other abnormalities. Dr Albrefkany commenced Mr Ortiz on 100mg aspirin daily in response to these findings.
19. Mr Ortiz was then referred to the cardiology unit at St Vincent's Hospital and in June 2018, a loop recorder was implanted for long-term heart rhythm monitoring. Interrogation of the loop recorder in August 2018 and February 2019 revealed intermittent or 'paroxysmal' episodes of asymptomatic atrial fibrillation, an irregularity of heart rhythm which increases the risk of blood clots and stroke. In light of Mr Ortiz's assessed 'moderate-high' risk of stroke, he was commenced on apixaban, an anticoagulant, 5mg twice daily by St Vincent's Hospital in August 2018. This was later reduced to 2.5mg twice daily on 24 December 2018.
20. On 20 March 2019, Mr Ortiz consulted Dr Albrefkany for a sore throat and was prescribed antibiotics and norgesic, an analgesic containing paracetamol and orphenadrine.
21. During a diabetes check-up on 25 March 2019, Mr Ortiz complained of a tension headache and Dr Albrefkany arranged routine blood tests.

THE CORONIAL INVESTIGATION

22. Mr Ortiz'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.
23. 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.
24. 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.
25. In July 2025, I assumed carriage of the investigation into Mr Ortiz's death from then Coroner John Olle for the purpose of finalising the case and making findings.
26. This finding draws on the totality of the coronial investigation into Mr Ortiz's death, including evidence obtained from Mr Ortiz's treating clinicians at Werribee Mercy Hospital, St Vincent's Hospital, and Wyndham Health Care; assistance sought from the Coroners Prevention Unit (CPU) regarding the medical treatment Mr Ortiz received proximate to his death; an independent expert report commissioned by the Court from cardiologist Associate Professor Neil Strathmore (**A/Professor Strathmore**); and submissions filed on behalf of St Vincent's Hospital, together with expert reports prepared by Professor Richard Harper (**Professor Harper**).
27. Whilst I have reviewed all the material, 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.²

² 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.

28. It is acknowledged that considerable time has passed since the death, and that the protracted nature of coronial investigations may prolong the uncertainty and distress of the family. Whilst regrettable, the passage of time since Mr Ortiz's death should not be taken to suggest inaction on the part of the Court. As is set out in detail below, the investigation into Mr Ortiz's death was comprehensive and ongoing, reflecting the complexity of his care, the need for the Court to obtain and evaluate substantial clinical evidence, and the need to afford procedural fairness to those directly involved in Mr Ortiz's care.

CORONERS PREVENTION UNIT

29. As part of the investigation, assistance was sought from the Coroners Prevention Unit (CPU). The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.
30. The CPU conducted a review of Mr Ortiz's records from Wyndham Health Care, Werribee Heart and St Vincent's Hospital.
31. Having regard to Dr Glengarry's findings, the CPU noted that Mr Ortiz's daily aspirin intake as prescribed to Mr Ortiz in 2017, may have increased his risk of bleeding following any minor trauma. The CPU explained that while the concurrent use of low-dose aspirin and anticoagulant medication carries benefits for those patients in whom this combination of medication is indicated by reducing the rate of adverse vascular events, it is also associated with a clinically significant increase in the rate of bleeding events.
32. Statements were requested from GP Dr Albrefkany and Dr Ian Matthews, a consultant physician and cardiologist with St Vincent's Hospital to clarify any clinical indications for the prescription of medications, including any consideration of the risks associated with concurrent use of aspirin and apixaban.
33. A further statement was obtained by Dr Matthews to elaborate and clarify certain aspects of his first statement.

34. Following receipt of those statements, the court sought an expert report from A/Professor Neil Strathmore, cardiologist. Both St Vincent's Hospital and Dr Matthews were each provided with A/Professor Neil Strathmore's report. In response, St Vincent's Hospital provided two expert reports from Professor Richard Harper, cardiologist.

Statement of Dr Zaid Albrefkany, Wyndham Health Care

35. Dr Albrefkany provided the medical records and a witness statement setting out Mr Ortiz's clinical course following his hospital presentation in December 2017, including the initial investigations conducted by Werribee Heart and referral to St Vincent's Hospital in June 2018.³ Dr Albrefkany advised that in prescribing low-dose aspirin in December 2017, he was conscious of Mr Ortiz's high risk of cardiovascular complications and stroke prevention; his history of diabetes and hyperlipidaemia; and the recent MRI findings of 'foci of small vessel ischaemia'.⁴
36. Dr Albrefkany referred to correspondence from Werribee Heart by Dr Matthews on 17 January 2018 that acknowledged both Werribee Heart and St Vincent's Hospital were apprised of Mr Ortiz's current medications, including 100mg of aspirin daily. In response to a query regarding the clinical indication for apixaban, he ultimately deferred to St Vincent's Hospital clinicians regarding the commencement of any anticoagulant medication and continuation of aspirin therapy.
37. Dr Albrefkany advised that to the best of his recollection, Mr Ortiz had no recorded history of head trauma, headaches or migraines. When Mr Ortiz complained of tension headache during the consultation of 25 March 2019, Dr Albrefkany recalled the presentation on 20 March 2019 when he complained of stress and symptoms of upper respiratory tract infection (URTI).⁵ Dr Albrefkany advised that the diagnosis of 'tension headache' was based upon Mr Ortiz's reported frontal headache; the fact that he was otherwise well; and that had recently experienced emotional stress regarding his partner's ill-health.

³ Statement of Dr Zaid Albrefkany, Wyndham Health Care, dated 15 October 2020.

⁴ Medical records, Wyndham Health Care, Consultation notes recorded by Dr Zaid Albrefkany on 27 December 2017.

⁵ Medical records, Wyndham Health Care, Consultation notes recorded by Dr Zaid Albrefkany on 25 March 2019.

38. Dr Albrefkany arranged a routine blood test, given Mr Ortiz's history of diabetes, the results of which did not indicate any abnormalities and noted that Mr Ortiz attended the pathology lab attached to the Wyndham Health Care, and he did not present with worsening headache or further 'troubling' symptoms.
39. The CPU reviewed the medical material and noted:
- a) there were other valid concerns which may have precipitated a diagnosis of tension headache. In the absence of any reported head trauma or previous complaints, there was no reason for Dr Albrefkany to have suspected bleeding around the brain.
 - b) In relation to Dr Albrefkany's prescription of low-dose aspirin, the CPU noted that while aspirin is widely used for secondary prevention of coronary heart disease, there were no Australian guidelines recommending the use of aspirin for primary prevention.
 - c) current 2012 guidelines from the National Vascular Disease Prevention Alliance,⁶ suggest a "conservative approach" to aspirin therapy in the prevention of cardiovascular disease for patients with diabetes, given that aspirin therapy is associated with a "*statistically nonsignificant 8-12% reduction in risk of major cardiovascular events in people with diabetes*".⁷
 - d) that an anti-platelet drug is recommended for patients with diabetes who have known atherosclerotic cardiovascular disease, as a form of secondary prevention for cardiovascular events.
 - e) in the absence of known vascular disease, the administration of aspirin therapy for primary prevention did not appear indicated, and any benefit of anti-platelet treatment would not outweigh Mr Ortiz's increased risk of bleeding complications associated with concurrent anticoagulant therapy.
 - f) It was not unreasonable for Dr Albrefkany's to defer to treatment advice provided by the specialists at St Vincent's.

⁶ The National Vascular Disease Prevention Alliance (NVDPA) is an alliance of four leading organisations: Diabetes Australia, the National Heart Foundation of Australia, Kidney Health Australia and the National Stroke Foundation.

⁷ NVDPA, '[Guidelines for the management of Absolute cardiovascular disease risk](#)' (2012).

Statement of Dr Ian Matthews, St Vincent's Hospital

40. Dr Matthews provided two statements to the court. His evidence was that in January 2018, he reviewed Mr Ortiz at Werribee Heart for the investigation of multiple blackouts (syncope). Mr Ortiz had presented at Werribee Hospital with multiple syncopal episodes within 24 hours. No cause for the syncope was found, and a routine CT brain scan revealed no evidence of subdural haemorrhages at that stage and a normal 12 lead ECG.⁸
41. Mr Ortiz was subsequently referred to St Vincent's Hospital on 19 June 2018, for insertion of a loop recorder by Dr Matthews and Dr Uwais Mohamed, for investigation of any underlying cause for his syncope.⁹
42. Dr Matthews advised that during the course of investigations for recurrent episodes of syncope, Mr Ortiz was prescribed apixaban for stroke prevention in response to findings of multiple episodes of asymptomatic atrial fibrillation detected by the loop recorder. Dr Matthews added that Mr Ortiz was not prescribed aspirin by St Vincent's Hospital clinicians. While clinicians were aware he was taking aspirin, Dr Matthews noted that it was unclear to them why Mr Ortiz was prescribed aspirin.
43. Dr Matthews advised that Mr Ortiz was counselled as to the bleeding risks associated with taking anticoagulant apixaban, which was lower than the risk of ischaemic stroke if anticoagulant therapy was not commenced. Dr Matthews noted that at the time he prescribed apixaban, there were no obvious contraindications.
44. A supplementary response was sought from St Vincent's Hospital and Dr Matthews, in relation to the prescription of apixaban and expressly the question of any consideration of any contraindications related to concurrent aspirin therapy.
45. In that further statement to the Court, Dr Matthews confirmed that at the time of prescribing apixaban, Mr Ortiz's prescribing cardiologist was aware of his existing aspirin therapy. He stated that this information was contained in a letter from Werribee Heart.¹⁰
46. Dr Matthews detailed the recognised cardio- or cerebro-vascular indications for the prescription of apixaban and aspirin, including the risks associated with concurrent use.

⁸ Statement of Dr Ian Matthews, St Vincent's Hospital, dated 3 October 2020.

⁹ Medical records, Werribee Heart, Correspondence from Dr Ian Matthews to Dr Zaid Albrefkany dated 23 May 2018.

¹⁰ Statement of Dr Ian Matthews, St Vincent's Hospital, dated 16 December 2020.

47. Dr Matthews reiterated that it was not clear to St Vincent's Hospital clinicians why Mr Ortiz was also prescribed aspirin, nor whether he was instructed or advised to cease taking aspirin. Dr Matthews acknowledged that the responsibility of considering and addressing interactions, precautions and contraindications of existing medications lay with the prescribing clinician and also noted that pharmacists also have a role to play in this regard.
48. Dr Matthews further advised that Mr Ortiz's death had not been the subject of a review within the hospital and noted that it was not until November 2019 that St Vincent's Hospital became aware of Mr Ortiz's death, when a request was made by the Coroner for his medical records.
49. The CPU advised that there was a clear indication for Mr Ortiz to have been prescribed apixaban but emphasised that the concurrent use of aspirin and apixaban potentially placed Mr Ortiz at an increased risk of serious bleeding complications. The guidelines published by the National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand (CSANZ) which refers to the management of atrial fibrillation recommends that aspirin not be used for stroke prevention in patients such as Mr Ortiz.¹¹
50. The CPU advised that having reviewed correspondence between Dr Albrekany and clinicians from St Vincent's Hospital, all clinicians involved in Mr Ortiz's care were aware of his concurrent prescription of aspirin and apixaban. As Dr Matthews had acknowledged, the primary responsibility for ensuring there were no contraindications for prescribing a particular medication lay with the prescribing doctor. However, there was no evidence of a deliberate clinical decision by St Vincent's Hospital clinicians for Mr Ortiz to remain on aspirin when he was then prescribed apixaban.
51. The CPU noted the clinical indications for contemporaneous prescriptions of aspirin and apixaban set out by Dr Matthews but noted that none applied to Mr Ortiz at the time.
52. The CPU acknowledged that the prescription of apixaban was appropriate but expressed concern that there was inadequate assessment of Mr Ortiz's concurrent medications, more particularly, any need for him to remain on both apixaban and aspirin, and the possible risks. The CPU emphasised that when used in isolation, both aspirin and apixaban remain associated with a small risk of spontaneous intracranial and other adverse bleeding events.

¹¹ National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, '[Australian Clinical Guidelines for the Diagnosis and Management of Atrial Fibrillation](#)' (2018) *Heart, Lung and Circulation* 27, 1209-1266.

Expert report of cardiologist Associate Professor Neil Strathmore

53. To address concerns regarding the suitability of a combined treatment with apixaban and aspirin, an expert report was commissioned by the Court from cardiologist A/Professor Strathmore.¹²
54. A/Professor Strathmore advised there is strong evidence for aspirin use in secondary prevention following an ischaemic event, but that the evidence for its benefit in primary prevention is limited or conflicting.¹³ He explained that several changes in the Australian Therapeutic Guidelines Cardiovascular (ATGC) occurred between 2012 and 2018 with respect to the use of aspirin in primary prevention and set out the relevant history.
55. In the 2008 (Version 5) guidelines, aspirin was described as beneficial in reducing the risk of major cardiovascular events if the risk of such an event within the next 5 years was greater than 15%. This recommendation of the ATGC was revised in 2012 (Version 6) and no longer recommended routine aspirin use in the primary prevention of cardiovascular disease for patients with diabetes. A 2012 guideline published by the Australian National Heart Foundation in relation to Absolute Cardiovascular Disease Risk similarly did not recommend routine use of aspirin for primary prevention, even in high-risk groups.
56. In 2018 (Version 7 of ATGC), there appeared a minor but relevant revision that:
- ... “Aspirin and other antiplatelet drugs are not routinely recommended for the primary prevention of cardiovascular disease (CVD), including in older people, people with diabetes or people with absolute CVD risk.”*
57. By 2017, aspirin was no longer recommended as best practice for the primary prevention of cardiovascular and cerebrovascular disease, including small vessel cerebral disease. He noted that despite the updated guidelines, aspirin was still widely used for primary prevention.

¹² Correspondence from Coroners Court of Victoria to Associate Professor Neil Strathmore dated 20 October 2023.

¹³ Report of Associate Professor Neil Strathmore dated 6 November 2023.

58. A/Professor Strathmore attributed the shift in recommendations to trial evidence which demonstrated little or no cardiovascular benefit of aspirin when used for primary prevention, but with an increased risk of bleeding events, such as the increased risk of gastrointestinal bleeding risk observed in a 2017 JPAD trial for patients with type 2 diabetes.¹⁴
59. Having regard to Mr Ortiz's risk of small-vessel disease and the MRI findings of December 2017, A/Professor Strathmore cited the 2017 Therapeutic Guidelines Neurology and an October 2017 consensus review by the European Society of Cardiology and noted that there was no evidence to support the role of anti-platelet drugs in treating small vessel ischaemic change. He further noted that the generally accepted approach at that time was to optimise patient blood pressure and lipid therapy and cease smoking, rather than commencing or continuing aspirin therapy.
60. A/Professor Strathmore advised that the NPS MedicineWise guidelines available to Australian Health Practitioners in December 2016 indicated that the risk of bleeding for patients prescribed aspirin alongside an oral anticoagulant is increased by as much as 80%. He noted that the guidelines also referred to the National Heart Foundation's guidelines regarding Acute Coronary Syndrome, which recommended that low-dose aspirin be ceased in the event an anticoagulant is indicated, unless a cardiologist recommends their concurrent use.
61. Using established risk scores, A/Professor Strathmore calculated Mr Ortiz's untreated thromboembolic risk as 2.8% using the CHADS2 score,¹⁵ relying only on history of diabetes, and between 2.2 to 2.9% using the CHA2DS2-VASc score,¹⁶ which considers diabetes and age range in calculating risk of stroke, transient ischaemic attack, or systemic embolism. Using a reasonable estimate of thromboembolic risk of 3% per year, A/Professor Strathmore calculated that commencing apixaban was expected to reduce the risk by approximately two-thirds.

¹⁴ Yoshihiko Saito et al, 'Low-Dose Aspirin for Primary Prevention of Cardiovascular Events in Patients with Type 2 Diabetes Mellitus' (2017) *Circulation* 135, 659-670.

¹⁵ The CHADS2 score considers the following conditions: congestive heart failure (C); hypertension (H); age (A); diabetes mellitus (D); and prior stroke, transient ischaemic attack or thromboembolism (S2).

¹⁶ The CHA2DS2-VASc refines the CHADS2 score to consider: congestive heart failure (C); hypertension (H); age ≥ 75 years (A2); diabetes mellitus (D); prior stroke, transient ischaemic attack or thromboembolism (S2); vascular disease (V); age 65-74 years (A); and sex category (Sc).

62. In calculating the associated risk scores for bleeding, A/Professor Strathmore employed the HAS-BLED¹⁷ score which considered Mr Ortiz's age and aspirin therapy and returned a bleeding risk of 2-4%, or "*moderate risk for major bleeding*", roughly double the risk posed in the absence of aspirin therapy.
63. A/Professor Strathmore described the indication for Mr Ortiz's aspirin prescription as 'weak', having regard to his history of diabetes, hypercholesterolaemia and findings of chronic small vessel ischaemia. A/Professor Strathmore emphasised that combination therapy involving aspirin and oral anticoagulant is generally reserved for specific secondary-prevention scenarios, none of which applied to Mr Ortiz. He noted that there was a clear indication to prescribe Mr Ortiz apixaban for stroke prevention in newly diagnosed atrial fibrillation but indicated that the widely available guidelines supported the conclusion that aspirin therapy should have been ceased in the absence of a clear indication for secondary prevention.
64. Importantly, A/Professor Strathmore was unable to identify from Mr Ortiz's records any documented reconciliation of his concurrent anti-platelet and anticoagulant therapies, nor any consideration or plan to cease aspirin in response to commencing apixaban. A/Professor Strathmore expressed the view that therefore Mr Ortiz's prescribed medications were inconsistent with safe prescribing practices, and his management fell below the standard reasonably expected of a consultant cardiologist, noting that the concurrent use of aspirin and apixaban was not justified, nor were the benefits overtly considered against the relevant risks.

Expert reports of Professor Richard Harper

65. Representatives of St Vincent's Hospital were furnished with a copy of A/Professor Strathmore's report and afforded an opportunity to respond to criticisms in the report.¹⁸ Submissions were later filed with the Court on behalf of St Vincent's Hospital, which were accompanied by two expert reports from cardiologist Professor Harper.
66. In the first of his reports, Professor Harper agreed that apixaban was clinically indicated to reduce Mr Ortiz's risk of ischaemic stroke related to atrial fibrillation and referred to an associated risk reduction by factor of 70%.¹⁹ Professor Harper expressed the view that some cardiologists would have considered it reasonable to continue aspirin and apixaban. He

¹⁷ The HAS-BLED scoring system assesses the following conditions: hypertension (H); abnormal liver or renal function (A), prior history of stroke (S); prior major bleeding or predisposition to bleeding (B); labile INR (L); elderly, aged over 65 years (E); and drug or alcohol use, medication which predisposes patient to bleeding (D).

¹⁸ Correspondence from Coroners Court of Victoria to St Vincent's Hospital dated 5 February 2024.

¹⁹ Report of Professor Richard Harper dated 13 March 2024.

- accepted, however, that most would have ceased Mr Ortiz's aspirin when prescribing apixaban as the medication in combination has little or no additional benefit in reducing the risk of stroke, as compared to only prescribing apixaban alone, and increases the risk of bleeding.
67. Professor Harper considered that in the event Mr Ortiz's treating cardiologist was unaware of a clinical indication for aspirin, it would have been prudent to make enquiries to ensure that it remained appropriate to prescribe aspirin and apixaban in combination.
 68. Professor Harper was asked to weigh Mr Ortiz's risk of major bleeding as against his risk of intracranial bleeding arising from the concurrent use of apixaban and aspirin. He accepted A/Professor Strathmore's use of the CHA2DS2-VASc score in calculating Mr Ortiz's risk of ischaemic stroke but adopted 2.2% at the lower end of the range. Professor Harper disputed the use of the HAS-BLED score as an accurate reflection of Mr Ortiz's bleeding risk, having regard to its data validation from patient trials involving warfarin and reduced applicability for patients taking a direct oral anticoagulant, such as apixaban.
 69. Using figures from a 2021 study or 'ARISTOTLE trial',²⁰ Professor Harper calculated Mr Ortiz's risk of bleeding as 2.56% per year when taking aspirin and apixaban, which he noted to be slightly higher than the risk of stroke. The relevant study also considered the use of aspirin alongside apixaban and other direct oral anticoagulants and observed an increase in overall risk of bleeding by approximately 20%, however the medications in combination were not observed to increase the risk of intracranial bleeding.
 70. In calculating Mr Ortiz's risk of intracranial bleeding taking apixaban alone, Professor Harper relied on the ARISTOTLE data, which estimated a 0.33% per annum reduction in the risk of ischaemic stroke for patients prescribed apixaban, rather than warfarin. To calculate the same risk for concurrent use of apixaban and aspirin, Professor Harper referred to the ARISTOTLE trial Professor Harper concluded that there was no material change in Mr Ortiz's risk of intracranial bleeding due to his concurrent use of apixaban and aspirin.

²⁰ Christopher B Granger et al, for the ARISTOTLE Committees and Investigators, 'Apixaban versus Warfarin in Patients with Atrial Fibrillation' (2011) *New England Journal of Medicine* 365, 981-92.

71. Given the limited availability of relevant studies, Professor Harper was unable to confidently calculate a reduction in Mr Ortiz's bleeding risk arising from the 50% reduction in apixaban dose in December 2018 but in a supplementary report, estimated an approximate risk reduction of between 10 to 15%.²¹

Submissions on behalf of St Vincent's Hospital in response to proposed adverse comments

72. Whilst St Vincent's Hospital acknowledged that best practice recommendations for prescription of aspirin have evolved over time, the hospital referred to the consistent views of A/Professor Strathmore and Professor Harper with respect to the practice of cardiologists in August 2018 to prescribe apixaban and aspirin.²² Further, the role of the prescribing clinician in determining the clinical indication for aspirin was accepted, but St Vincent's Hospital submitted that there was insufficient evidence for the coroner to conclude that alternative prescribing practices or cessation of aspirin would have reduced Mr Ortiz's risk of intracranial bleeding or prevented his death.
73. The hospital drew the Court's attention to Professor Harper's calculation of Mr Ortiz's risk of major bleeding due to concurrent use of apixaban and aspirin and, having regard to the findings of right-sided subdural haemorrhage at autopsy, disputed that the figures reached by A/Professor Strathmore could be extrapolated to apply to Mr Ortiz's specific risk of intracranial bleeding. The hospital referred to Professor Harper's discussion of bleeding within the gastro-intestinal tract as the common bleeding event associated with apixaban, which Professor Harper noted to be regarded as less significant than the risk of stroke.
74. St Vincent's Hospital submitted that there was an already statistically low probability of fatal subdural haemorrhage, irrespective of whether apixaban or aspirin are used together, separately or in the absence of any treatment. Using Professor Harper's estimation of a 10 to 15% risk reduction after Mr Ortiz's apixaban dosage was halved, it was submitted that it was open for the Court to find that Ortiz's risk of intracranial bleeding per year was 0.28% at the time of his death.
75. The hospital challenged the assertion of A/Professor Strathmore that the risks of apixaban outweighed its benefit in circumstances where aspirin was not ceased. It was submitted that the evidence indicated there was no demonstrable change in the risk of intracranial bleeding

²¹ Report of Professor Richard Harper dated 23 May 2024.

²² Submissions on behalf of St Vincent's Hospital dated 29 May 2024.

with the concurrent use of aspirin and apixaban, and that the evidence did not support a finding that ceasing aspirin would have mitigated against, nor significantly altered Mr Ortiz's risk of intracranial bleeding.

Conclusions and findings

76. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* standard which imports a specific standard of satisfaction regarding the factual findings a tribunal must make.²³ Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.
77. I accept that Mr Ortiz's intracranial bleeding was a recognised, albeit relatively uncommon complication of his prescribed anticoagulant medication, and that it was appropriate to commence anticoagulant therapy. I also note the concessions made by Dr Matthews regarding the responsibility for considering and reconciling interactions, precautions and contraindications of existing medication which lie with the prescribing clinicians. The court also notes that Professor Harper, remarked that it would have been prudent for enquiries to have been made to ensure that it remained appropriate to prescribe aspirin and apixaban to Mr Ortiz in combination.
78. Whilst no definitive conclusion as to the precise cause of Mr Ortiz's bleeding can be drawn from the available evidence, it is clear from the chronology that the various haemorrhages occurred following the commencement of apixaban and aspirin. Mr Ortiz had a normal CT brain scan on 4 December 2017 and normal brain MRI on 20 December 2017, and there is nothing in the clinical notes pointing to any relevant clinical symptoms. Moreover, no evidence of external injury to the skin of his head and no bruising beneath the scalp was identified post-mortem although Dr Glengarry qualified this by noting that 'this does not *exclude* an impact to the head as an impact with a broad or soft surface may leave no injury

²³ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...'

to the skin or tissues beneath the scalp.’ Dr Glengarry concluded that it appears this man has had multiple episodes of bleeding over time.

79. However, it is common ground that there may have an increased risk of bleeding associated with the concurrent use of aspirin and apixaban, even if the nature and level of the risk of bleeding is not common ground. Absent any patient notes evincing it, there is no record reflecting a detailed (or even superficial) consideration of the potential iatrogenic impact of aspirin in combination with apixaban. The evidence supports a finding that the treating cardiology physicians were aware Mr Ortiz was taking aspirin when they prescribed apixaban.
80. As stated by A/Professor Strathmore, the prescribing practices were inconsistent with safe prescribing practices and the management of Mr Ortiz fell below the standard reasonably expected of a consultant cardiologist, noting that the risk associated with the concurrent use of aspirin and apixaban for a person with Mr Ortiz’s comorbidities may not have been justified, nor were the benefits overtly recorded against those risks.
81. Absent evidence of such consideration, then it is the process of assessing and prescribing medications which warrants the court’s commentary as this falls properly within the ambit of the coronial role to help prevent deaths, promote public health and the administration of justice.
82. The coroner’s public health mandate calls for attention to be given to the importance of clinicians’ practice when prescribing medications, that the current risks are known, considered, recorded and any decision made in this context reflect such considerations. This important measure also includes but is not limited to an acknowledgment that the patient understands and accepts those risks.
83. The court recommends that St Vincent’s Hospital, together with the Board’s committee with responsibility for quality and clinical safety, review the performance of the hospital to ensure compliance with the Australian Commission on Quality and Safety in Health Care Standards.²⁴
84. The Australian Quality and Safety in Health Care Standards specifically address the level of care a consumer can expect from a health service organisation when prescribing medications and documenting the necessity for such medication. Clear guidance is provided to ensure that

²⁴ [The NSQHS Standards | Australian Commission on Safety and Quality in Health Care](#)

health services apply these standards and implement strategies to improve medication outcomes and associated processes.

85. These standards include factors such as the documentation of patient information, medication reconciliation, and continuity of medication management implemented via the following actions:
- a) Clinicians must obtain and record a Best Possible Medication History which includes all current medications, allergies and adverse reactions, ideally using two information sources (Action 4.05);
 - b) Prescribing clinicians must review any proposed new or additional prescriptions against a patient's Best Possible Medication History and documented treatment plan, reconcile any discrepancies that arise (Action 4.06);
 - c) Health service organisations must have processes in place to perform, prioritise and document medication reviews for a patient, based on the patient's clinical needs, with a view to minimising the risk of medication-related complications and setting out the resulting actions (Action 4.10);
 - d) The patient must be provided with information regarding their current medications and associated risks (Action 4.11); and
 - e) A list of a patient's current medications must be provided to receiving clinicians at transitions of care and patients on discharge and must document the basis for any changes in medication (Action 4.12).
86. This investigation identified that at the time of Mr Ortiz's death, there was a change to clinical guidance in respect to apixaban and aspirin medications in combination. The clinical guidance is now clearer as to the suitability of this combination being prescribed to certain members of the community with other comorbidities. It is recommended that both Royal Australasian College of Physicians (**RACP**) and the Royal Australian College of General Practitioners (**RACGP**) consider capturing this contemporary best practice guidance on the prescription of aspirin and oral anticoagulants (and the risks thereof) to general practitioners and physicians/cardiologists, with a view to promulgating that best practice to the relevant medical professions.

FINDINGS

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

- a) the identity of the deceased was Oscar Hector Ortiz, born 18 October 1952;
- b) the death occurred on 29 March 2019 at 10 Storrington Avenue, Hoppers Crossing, Victoria, from a right sided subdural haemorrhage; and
- c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

- (i) That St Vincent's Hospital, together with the Board's committee with responsibility for quality and clinical safety, review the performance of the hospital to ensure compliance with the Medication Safety Standard, Australian Quality and Safety in Health Care Standards²⁵.
- (ii) That both Royal Australasian College of Physicians and the Royal Australian College of General Practitioners consider capturing the contemporary best practice guidance on the prescription of aspirin and oral anticoagulants (and the risks thereof) to general practitioners and physicians/cardiologists, with a view to promulgating that best practice to the relevant medical professions.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I convey my sincere condolences to Mr Ortiz's family for their loss. I also acknowledge the protracted nature of coronial proceedings and the potential to further compound a family's grief.

²⁵ [Medication Safety Standard | Australian Commission on Safety and Quality in Health Care](#)

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

Oscar Ortiz

Natalia Ortiz-Acevedo

St Vincent's Health, c/- K&L Gates

Royal Australasian College of Physicians

Royal Australian College of General Practitioners

Sergeant Rebecca Perkins, Coronial Investigator

Signature:



Coroner Therese McCarthy

Date: 12 February 2026

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.
