IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002241

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Leveasque Peterson
Deceased:	Lilian Isabella Lister
Date of birth:	27 February 1934
Date of death:	30 April 2021
Cause of death:	1(a) HAEMORRHAGE SECONDARY TO AN ULCERATED VARICOSE VEIN
Place of death:	10 / 1 Dobell Drive, Chelsea, Victoria, 3196
Keywords:	Ulcerated varicose vein, haemorrhage, venous insufficiency

INTRODUCTION

1. On 30 April 2021, Lilian Isabella Lister was 87 years old when she was located deceased at her home in Chelsea. She is survived by her adult children, Debra Lister, Gregg Lister, and Karina Randall.

2. Lillian's medical history included moderate peripheral arterial disease. She attended a Vascular Surgeon for this condition. Lillian was also a patient of the Aspendale Gardens Medical Centre and under the care of a General Practitioner **(GP**).

3. Lillian's vascular surgeon first saw Lillian on 18 June 2014 for arterial concerns. He performed a superficial femoral artery and popliteal artery stenting on her left leg for an occlusion through the area. A follow up Arterial Duplex scan in October 2014 demonstrated satisfactory flow through the femoral popliteal segment with areas of moderate in-stent stenosis.

4. According to her vascular surgeon, on 16 May 2020, Lillian underwent a Deep Vein Thrombosis **(DVT**) Study after presenting to the Frankston Hospital with a 5-day history of increased swelling over her right foot and distal calf. At this time, DVT was not identified.

5. Lillian's surgeon stated that on 19 October 2020, an Arterial Duplex scan confirmed satisfactory patency of the left popliteal bypass graft. He reviewed Lillian on 29 October 2020 and wrote to her GP, indicating that her '*left femoropopliteal bypass graft continues to work well and is free of any narrowing*.' He further noted that Lillian's other concern was swelling of her right leg. He also noted that she had significant varicose veins on that right leg and requested a Venous Duplex scan.

6. On 26 November 2020, Lillian attended her vascular surgeon for a review. He noted that the Venous Duplex scan demonstrated deep venous insufficiency throughout the femoral, popliteal, and peroneal veins and in addition, demonstrated reflux throughout the Great Saphenous vein. He noted that she was not having trouble with claudication and made plans to review the situation in 12 months' time.

THE CORONIAL INVESTIGATION

7. Lilian'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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Lilian's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence

11. This finding draws on the totality of the coronial investigation into the death of Lilian Isabella Lister including evidence contained in the coronial brief. 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.[1]

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

Circumstances in which the death occurred

12. At 6:15am on 30 April 2021, Ms Debra Lister attended her mother's residence. She did not enter the premises at this time but left some catalogues for her mother by the front door. She also left a note advising that Mr Gregg Lister would attend at 1.15pm to take Lillian grocery shopping.

13. At 1:15pm, Mr Lister arrived at the residence and observed that the catalogues were still by the front door. He attempted to raise his mother, but there was no response within the house. Mr Lister contacted Ms Debra Lister and attended her nearby residence to obtain a spare key.

[1] 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. At approximately 1.30pm, Mr Lister returned to his mother's home and gained access to the property. Upon entering the living room, he observed a trail of blood on the floor, leading to the kitchen. He subsequently located his mother on the kitchen floor. It was apparent that she was deceased. Emergency services were contacted.

15. Police and paramedics arrived shortly thereafter and observed that Lillian was in an upright position, with her legs in front of her. There was dried blood in the vicinity however paramedics were unable to immediately identify the source of the bleeding.

16. Police also observed a trail of blood from the lounge to the kitchen. Lillian's socks were located in the lounge room and were also stained with blood. Police did not identify any signs of injury or defensive wounds on Lillian.

17. Lillian's children advised that they had last seen her on 24 April 2021 when they attended brunch together in Chelsea. Lillian was returned home at 1.30pm that day. Mr Lister stated that he attempted to contact his mother at approximately 6pm on 29 April 2021 with no answer. He noted that on occasion, Lillian was known to inadvertently place her phone on flight mode.

Identity of the deceased

18. On 30 April 2021, Lilian Isabella Lister, born 27 February 1934, was visually identified by her son, Gregg Lister.

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

Medical cause of death

20. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an external examination on 3 May 2021 and provided a written report of her findings dated 21 May 2021.

21. The post-mortem CT scan revealed cholelithiasis. The external examination revealed a venous ulcer over the medial right ankle. There were associated varicose veins which were confirmed to be the source of bleeding.

22. Dr Archer noted that bleeding is a potential complication of varicose veins, and haemorrhage can be torrential and potentially life threatening. Very close veins or venous ulcers can bleed due to minor trauma and bleeding can be exacerbated by standing or activity. Acute anaemia

due to blood loss can also interact with pre-existing natural disease to hasten death, such as Lillian's cardiac condition (paroxysmal atrial fibrillation), ischemic heart disease, and congestive heart failure.

23. Dr Archer provided an opinion that the medical cause of death was *1 (a) Haemorrhage secondary to an ulcerated varicose vein.* Dr Archer opined that the death was due to natural causes.

24. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Lilian Isabella Lister, born 27 February 1934;

    b) the death occurred on 30 April 2021 at 10 / 1 Dobell Drive, Chelsea, Victoria, 3196, from natural causes, namely, haemorrhage secondary to an ulcerated varicose vein; and

    c) the death occurred in the circumstances described above.

26. Venous bleeding is often painless and there can be significant bleeding before it is even noticed. Immediate treatment for a lower limb venous bleed is to rest, elevate the limb and put direct pressure over the point of bleeding. Adequate compression is usually enough, to contain the situation.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

27. Varicose veins are defined as dilated veins larger than 4mm which are characterised by decreased venous compliance and contractility. In varicose veins, the venous valves can become strained and overworked, leading to pooling of blood in the legs. This is exacerbated by factors such as age, smoking, diet, and level of exercise. Varicose veins typically affect an older population and haemorrhage can be a common complication of varicose veins. This can occur spontaneously, or by trauma to the affected leg.

28. Whilst haemorrhage is common, recent medical literature suggests that fatality from ruptured varicose veins sit at 0.01% of all deaths (8 out of 10686 deaths in a 10-year period)[2]. A total of 66 cases of death from fatal haemorrhage due to varicose vein ruptures have been described in reports, indicating its rarity.[3] Despite the rarity of these events I consider the prevention steps to be so basic and simple to implement that they warrant targeted communication to the community.

Public knowledge of the treatment of varicose veins:

29. In considering the Victorian Department of Health's "Better Health" website for advice on varicose veins,[4] I note that the advice discusses factors such as the causes, symptoms, and prevention of varicose veins. It also discusses complications of varicose vein surgery and self-care at home following this surgery, such as going for walks and wearing compression stockings. However, it does not provide advice on what a person should do if they experience a bleed/haemorrhage of a varicose vein or even list bleeding as a potential complication.

30. In contrast, the National Health Services (**NHS**) website in the United Kingdom provides the following advice to the public regarding bleeding of varicose veins:

> '*You should lie down, raise your leg, and apply direct pressure to your wound. Seek immediate medical advice if this does not stop the bleeding.'*[5]

RECOMMENDATION

31. I recommend this simple first aid advice should be broadly communicated to the general public via public health channels, including the Better Health website.

I convey my sincere condolences to Lilian's family for their loss.

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.

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[2] Serenela Serinelli, Luigi Bonaccorso and Lorenzo Gitto, '*Fatal Bleeding caused by a ruptured varicose vein*,' Medico-Legal Journal 2020 Vol 88(1) accessed at https://journals.sagepub.com/doi/pdf/10.1177/0968533219885621

[3] Fragkouli et al, '*Unusual death due to a bleeding from a varicose vein: a case report*, BMC Research Notes 2012, accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3499307/

[4] Varicose veins and spider veins, Better Health Channel, Victorian Department of Health, accessed at https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/varicose-veins-and-spider-veins#treatment-of-varicose-veins-and-spider-veins

[5] Varicose Veins-Complications, UK National Health Service, accessed at https://www.nhs.uk/conditions/varicose-veins/complications/

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

Gregg Lister, Senior Next of Kin

Paris Hayes, Coroner's Investigator

The Victorian Department of Health

Signature:

Coroner Leveasque Peterson

Date : 11 July 2024

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.