IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2022 003557**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

| | |
|---|---|
| Findings of: | AUDREY JAMIESON, CORONER |
| Deceased: | Barbara Anne Deal |
| Date of birth: | 11 November 1935 |
| Date of death: | 29 June 2022 |
| Cause of death: | 1(a) PULMONARY THROMBOEMBOLISM IN THE SETTING OF DEEP LEG VEIN THROMBOSIS<br>1(b) RECENT L4/5 SPONDYLOLISTHESIS LUMBAR INTERBODY FUSION SURGERY<br>2 ISCHAEMIC HEART DISEASE WITH CORONARY ARTERY BYPASS GRAFT AND VALVULAR HEART DISEASE |
| Place of death: | Melbourne Private Hospital, 1F Royal Parade, Parkville, Victoria, 3052 |
| Keywords: | Pulmonary embolism, deep vein thrombosis, hospitalised patient VTE, natural causes |

## INTRODUCTION

1. On 29 June 2022, Barbara Anne Deal (**Barbara**) was 86 years old when she died at Melbourne Private Hospital, 17 days after spinal surgery. At the time of her death, Barbara lived alone at her Rushworth home.

Medical History

2. Barbara had a medical history of ischaemic heart disease, coronary artery bypass grafts, atrial fibrillation, and stage 2-3 chronic kidney disease. She was medicated using the anticoagulant, apixaban.

3. In 2019, Barbara commenced attending upon neurosurgeon, Dr Caroline Tan (**Dr Tan**). Barbara was experiencing chronic, progressive low back pain which Dr Tan determined was due to degenerative spondylolisthesis of the lumbar 4 and 5 vertebrae (**L4** and **L5**) – a condition in which degenerative changes in the spine causes one vertebra to slip over the one below. Barbara received facet joint blocks[1] and reported they provided *'good pain relief'*. She preferred conservative management to surgical intervention.

4. Between 2019 and 2022, Barbara's back pain worsened and was *'having a significant impact on her'.* She re-visited Dr Tan, who advised the escalating pain was due to spondylolisthesis and explained it could be treated with a spinal fusion – a surgical procedure to permanently join two or more vertebra. In May 2022, Barbara agreed to an L4/L5 fusion.

5. The surgery was scheduled for 4 June 2022. On 1 June 2022, Barbara was admitted to Melbourne Private Hospital for pre-operative 'work up'. However, the operation was cancelled with hours' notice as there was no operating theatre available. Barbara remained hospitalised in the hope a theatre would soon become available. The operation was rescheduled for 12 June 2022. During the intervening eight days, Barbara was not administered her regular anticoagulant – apixaban.

## THE CORONIAL INVESTIGATION

6. Barbara'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.

[1] The injection of an anaesthetic agent and corticosteroid into the spinal column.

7. 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.

8. 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.

9. This finding draws on the totality of the coronial investigation into the death of Barbara Anne Deal. 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]

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

### Circumstances in which the death occurred

10. On 12 June 2022, at approximately 1pm, the operation commenced. Dr Tan performed the surgery using a posterior lumbar fusion technique and described it as *'uneventful'*. A laminectomy – removal of all or part of the vertebrae – and a fusion was performed on the L4/L5 vertebrae.

11. On 13 June 2022, the day following the operation, Barbara was recommenced on an anticoagulant – 20mg of enoxaparin. On 18 June 2022, six days post-operation, there was some *'discharge from the wound drainsite'*. Barbara was otherwise *'stable'* and could walk using a gutter frame.

12. On 20 June 2022, eight days post-operation, Barbara experienced an *'episode of unexplained sudden nausea and vomiting'* lasting 45 minutes.

[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.

13. The episode subsided with an antiemetic. On 22 June 2022, ten days post-operation, Barbara reported increased pain which was not resolved by opioid pain killers.

14. On 23 June 2022, the pain persisted, and Barbara was observably *'drowsy'*. Barbara's son, Robert Deal (**Mr Deal**) contacted Dr Tan to express concerns that his mother was confused. At 2:52pm, Dr Tan reviewed Barbara and noted she was *'delirious and falling asleep in the middle of lunch'*. Dr Tan also noted *'pool of urine'* at Barbara's feet. Dr Tan reviewed her medication chart and noted she was administered oxycodone and buprenorphine and *'suspected adverse effects of medication so [she] immediately ceased the opiates and reduced [Barbara's] dose of gabapentin'.* Dr Tan conferred with Mr Deal and determined to transfer Barbara to Eastern Private Hospital.

15. On 24 June 2022, Barbara was more alert but reported *'feeling "off"'* with nausea, abdominal tenderness and sweating. That night, she was hypotensive and sweating and had been incontinent of faeces. At approximately midnight, a nurse observed Brbara was feverish, *'slurring her words and her oxygen saturation was very low'*. A Medical Emergency Team (**MET**) call was made, and Barbara was transferred to the Intensive Care Unit (**ICU**).

16. On 25 June 2022, clinicians believed Barbara was septic, and considered a pulmonary embolism was *'unlikely'.* On 26 June 2022, clinicians noted *'coarse crackles'* when listening to her right lung.

17. On 27 June 2022, Barbara was reviewed by the infectious diseases team who suggested a diagnosis of bacterial sepsis. However, blood cultures remained negative and lumbar spine magnetic resonance imaging (**MRI**) did not show an infection of the surgical site. Dr Tan expressed, to other clinicians, her *'scepticism about the diagnosis of sepsis'.* According to Dr Tan, the clinicians did not share Dr Tan's concerns and did not consider further investigation was necessary.

18. On 28 June 2022, Barbara returned to the neurosurgery ward. Dr Tan believed *'she was still looking unwell'.*

19. On the morning of 29 June 2022, Barbara was *'confused, very fatigued, lethargic and short of breath'.* There are no recorded nursing observations after 11:45am.

20. At approximately 5:30pm, an infectious diseases clinician recorded Barbara *'appeared unwell and was suffering from new right upper quadrant and epigastric pain'.* During the night, large dark/black stools were documented. Clinicians ordered bloods and a computed tomography

(**CT**) of the abdomen and pelvis. Medical records indicate that the results of the CT were to be discussed with a senior clinician, however, there is no entry whether this occurred.

21. At approximately 7:30pm, Dr Tan arrived on the ward and observed *'[Barbara] screaming in agony'*. Barbara rated her abdominal pain as a 10/10. A MET call was underway, and an ICU nurse drew bloods. Dr Tan reviewed the blood gas results and considered them *'very abnormal'.*

22. While Dr Tan attempted to gain intravenous access, Barbara *'became very agitated'*. She experienced a cardiac arrest, and a Code Blue was called. An ICU clinician commenced cardiopulmonary resuscitation (**CPR**). After approximately 30 minutes of resuscitation efforts, CPR was discontinued, and Barbara was declared deceased.

**Identity of the deceased**

23. On 30 June 2022, Barbara Anne Deal, born 11 November 1935, was visually identified by her son, Robert Deal, who completed a Statement of Identification.

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

**Medical cause of death**

25. Forensic Pathologist Dr Victoria Francis (**Dr Francis**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Barbara Deal on 8 July 2022. Dr Francis considered the Victoria Police Report of Death for the Coroner (**Form 83**), the post-mortem computed tomography (**CT**) scan and the e-Medical Deposition Form completed by Melbourne Private Hospital and provided a written report of her findings dated 8 February 2023.

26. The post-mortem examination revealed a pulmonary thromboembolism (**PE**) in the pulmonary trunk obstructing both major pulmonary arteries and a left leg deep vein thrombosis (**DVT**). Also identified was right pleural effusion with diffuse left pleural adhesions.

27. Dr Francis stated that risk factors for DVT and PE are hypercoagulable states which can be primary or secondary. Primary causes include hereditary alterations to the blood factors responsible for forming and destroying clots. Secondary causes include recent surgery and immobility. In this instance, Dr Francis noted that Barbara had recently undergone surgery and likely had reduced mobility post-operatively.

28. Also identified was cardiomegaly – an enlarged heart – triple-vessel coronary artery bypass grafts with no evidence of acute complication, tricuspid valvular annuloplasty with no evidence of acute complication. Anterior rib and sternal fractures were identified which is associated with CPR efforts. There was no evidence of fresh or altered blood in the length of the gastrointestinal tract and nor did post-mortem microbiology detect bacterial pathogens in the rectal tissue.

29. Dr Francis provided an opinion that the medical cause of death was 1(a) PULMONARY THROMBOEMBOLISM IN THE SETTING OF DEEP LEG VEIN THROMBOSIS, 1 (b) RECENT L4/5 SPONDYLOLISTHESIS LUMBAR INTERBODY FUSION SURGERY and 2 ISCHAEMIC HEART DISEASE WITH CORONARY ARTERY BYPASS GRAFT AND VALVULAR HEART DISEASE.

## FAMILY CONCERNS

30. During my investigation, Mr Deal expressed concerns regarding the medical treatment provided to Barbara by Melbourne Private Hospital following her procedure on 12 June 2022. Mr Deal expressed concerns regarding the standard of documentation across Barbara's hospitalisation, specifically that *'no medication observations were recorded from 11am on the day [Barbara] passed'.*

31. I note that other concerns conveyed by Mr Deal do not fall within the coronial scope. My investigation is confined by legislation to the circumstances proximate and causal to Barbara's death. While I acknowledge the distress these events have brought to Mr Deal and the extended Deal family, it remains that these concerns fall outside of my powers of investigation.

## CORONERS PREVENTION UNIT

32. However, in consideration of the family concerns, I sought the assistance of the Coroners Prevention Unit (**CPU**) to better understand the medical treatment provided to Barbara at Melbourne Private Hospital.[3]

[3] The Coroners Prevention Unit (CPU) 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.

33. The CPU provided me with context on the prevalence of and risk factors associated with the development of a venous thromboembolism (**VTE**) such as a DVT or PE. Hospitalised patients have a recognised increased risk of VTE – approximately 100 times greater than the general community.[4] VTE is fatal in 4-11% of affected patients, with mortality rates dependent on multiple factors including time of diagnosis. In 25% of persons affected, sudden death is the first clinical sign of a PE.

34. The prevention of VTE in acute care hospitals has been recognised nationally and internationally as a priority area for ensuring patient safety.

35. Risk factors for developing VTE within the hospital setting include age – over 40 years and doubling with each subsequent decade – obesity, major surgery, cancer, immobility and previous VTE.

Venous Thromboembolism Risk Assessment

36. Given that surgery and post-operative immobility are risk factors for a VTE, the CPU considered whether VTE risk assessments were performed during Barbara's admission.

37. The relevant Healthscope[5] policy, in place at the time, stated:

> *'A VTE risk screening is completed for all patients by either a Medical Office or Nurse within 8 hours of admission to a healthcare facility, is repeated every 7 days of admission, and whenever there has been a relevant change in the patient's condition'.*

38. In a statement provided by the Director of Nursing at Melbourne Private Hospital, Robyn English (**Ms English**), stated:

> *'It appears that this aspect of the policy was not strictly complied with as an initial VTE risk screen was only completed at 1526 hours on 2 June 2022 (i.e. roughly 28 hours following [Barbara's] admission)'.*

39. Following the initial VTE risk screen, Barbara was recorded as being *'at no or low risk, with a risk factor being her age'.* Ms English qualified that *'it may have been appropriate to assess*

[4] Heit JA, Melton LJ, III, Lohse CM, Petterson TM, Silverstein MD, Mohr DN, et al. Incidence of venous thromboembolism in hospitalized patients' vs community residents. Mayo Clinic Proceedings. 2001.76(11):1102-10.
[5] Healthscope Ltd. operates multiple private healthcare facilities across Australia, including Melbourne Private Hospital.

*[Barbara] at a higher risk score'* though maintained that even if she was referred to a pharmacist to review her medications, her management would not have changed.

40. With respect to repeating the VTE assessment every seven days or upon a relevant change in the patient's condition, Ms English stated:

> *'It appears this aspect of the policy was not strictly complied with, as the records indicate that a further VTE risk assessment was not conducted until 25 June 2022'*

41. And further,

> *'Ideally a VTE risk assessment should have been conducted following [Barbara's operation] on 12 June 2022'.*

42. It was not until Barbara was admitted to the ICU, on 25 June 2022, that Barbara's VTE risk was re-assessed. At this time, she was categorised as being *'at risk or high risk'.*

Venous Thromboembolism Prophylaxis

43. The CPU reviewed the prescription and administration of anticoagulant therapy to Barbara. Importantly, VTE prophylaxis is available in two forms: pharmacological (medications) and mechanical (such as stockings).

44. While awaiting the rescheduling of her operation, between 1 and 12 June 2022, Barbara was not administered VTE pharmacological prophylaxis. Record keeping regarding mechanical prophylaxis during this period is suboptimal. On 1 June 2022, records indicate Barbara was wearing thrombo-embolic deterrent (**TED**) stockings, however, there is no record of such mechanical prophylaxis between 2 and 3 June 2022. On 4 June 2022, Barbara is noted to have TED stockings in situ while she was awaiting her procedure – as at this time the operation had not yet been cancelled. Between 5 and 7 June 2022, there is no record of mechanical prophylaxis.

45. On the inconsistencies in medical records, Ms English stated *'[she] would assume that [Barbara] continued to have TED stockings in situ at this time as there are subsequent entries in the medical records confirming that these prophylaxis measures were in place. [She has] confirmed with the Melbourne Private Hospital's Neurosurgery Unit Nursing Unit Manager that it would not be usual practice to remove a patient's TED stocking*

46. Regarding post-operative VTE prophylaxis, between 12 and 29 July 2022, Dr Tan stated:

*'For the first post-operative day, [Barbara] did not have any pharmacological prophylaxis, and this is in keeping with common surgical practice, to avoid causing a surgical site haemorrhage. She had a VTE prophylaxis in the form of [Thrombo-Embolic Deterrent] stockings and sequential calf compression in the operating room and also on the ward after surgery'.*

47. Regarding the administration of 20mg of enoxaparin from 13 June 2022, Dr Tan stated she felt that 20mg of enoxaparin, in conjunction with TED stockings and calf compression, *'would provide reasonable VTE prophylaxis'.* Dr Tan so decided on the basis of *'some medical literature which indicates that advanced age, low body weight and renal impairment can increase the effect of enoxaparin'.*

48. On 23 June 2022, the enoxaparin was ceased and on 24 June 2022, Barbara's regular apixaban was prescribed. Medical records depict a *'W'* written next to *'apixaban'* indicating that it was withheld. The rationale, and who ordered the medication be withheld, is not clear from the records. Ms English could not provide an explanation: *'It appears that [Barbara's] pharmacological prophylaxis was ceased. . . I am unable to ascertain why this was the case'.* Nor did Dr Tan provide an explanation: *'I do not know why the [apixaban] dose on 24 June [. . . ] was not given as charted'.*

49. On 25-26 June 2022, Barbara was administered 40mg enoxaparin, aspirin, TED stockings and calf compression. On 27-29 June 2022, she was administered apixaban. It is not clear why Barbara's dose of enoxaparin was increased to 40mg, nor why she was subsequently provided apixaban.

50. The Healthscope policy regarding VTE prophylaxis outlines:

*'It is the responsibility of a patient's treating medical officer to manage the pharmacological/chemic and/or mechanical prophylaxis of VTE'.*

51. In her statement and despite being Barbara's overseeing clinician, Dr Tan could not identify a single staff member that was responsible for Barbara's VTE prophylaxis:

*'No single person was formally assigned the responsibility for managing VTE prophylaxis. It is my usual practice to ask a physician or group of physicians to co-manage my surgical patients. I rely on the physicians to ensure that I have not missed any clinical issue or neglected some aspect of good clinical care'.*

52. Ms English's statement similarly reflected that VTE prophylaxis was overseen by multiple clinicians.

53. Ms English also stated Barbara received VTE prophylaxis measures additional to pharmacological management including *'early ambulation through nursing and physiotherapy reviews'* and *'adequate hydration through oral and [intravenous] fluids'.* However, she acknowledged that *'there is no record of [Barbara] being provided with ongoing education, although this is standard practice. . . There is otherwise no documented evidence that written information such as the brochure "Blood Clots – Reducing your Risk" was given to [Barbara]'.*

Comments of the CPU on Barbara's Medical Management

54. Having considered the Healthscope policies in place at the time of Barbara's death, and the conclusions of the various internal review panels and committees, the CPU provided me with their view as to the appropriateness of medical management and importantly, whether Barbara's death could have been prevented.

55. The CPU noted that at the time of her admission, on 1 June 2022, Barbara was assessed at a low risk of a VTE, and she did not receive pharmacological prophylaxis. Importantly, the SCV Guideline – despite that it was implemented after her death – does not discuss VTE assessment and prophylaxis in the context of postponed operations.

56. In light of a lengthy admission, lack of VTE risk assessment and pharmacy review, it is difficult to ascertain if a change to VTE prophylaxis in the pre-operative period would have altered her death. As with any extended period of hospitalisation, Barbara's mobility was necessarily reduced than if she had remained at home. Regarding the decision to keep Barbara in hospital when her operation was postposed, Dr Tan recalled, *'there was no theatre availability until 12 June 2022, but the theatre manager stated that it might be possible to get to theatre time before 12 June 2022'.* Accordingly, it appears the rationale for keeping Barbara hospitalised in the intervening eight days was in case an *'unexpected surgery cancellation'* occurred and the operation could resume earlier than 12 June 2022. The CPU could not determine whether being discharged home in the interim would have altered Barbara's outcome.

57. The CPU considered whether, if the Healthscope VTE policies had been adhered to, the development of a DVT and PE could have been avoided. Specifically, if VTE risk assessments

had been repeated at the prescribed 7-day intervals. The CPU agreed with Dr Tan's statement that *'pulmonary embolism can occur even in patients receiving the highest dose of prophylactic dose of enoxaparin'* and concluded that it could not determine whether more frequent VTE risk assessments would have altered the outcome.

## INTERNAL AND EXTERNAL REVIEWS OF BARBARA'S DEATH

Failure to Refer Barbara's Death to Safer Care Victoria

58. Melbourne Private Hospital did not notify Safer Care Victoria (**SCV**) of Barbara's death given it did not believe it constituted a sentinel event. SCV defines a 'sentinel event' as *'an unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious physical or psychological injury to a patient as a result of system and process deficiencies at the health service entity'.*

59. SCV clarified that since 1 July 2018, private hospitals are required to notify SCV of sentinel events. When a death is identified by the healthcare provider as a sentinel event, a panel is formed consisting of internal and external clinicians who undertake a Root Cause Analysis. The resulting report, which contained the panel's findings and recommendations, is submitted to SCV.

60. The Sentinel Event Program enables SCV to *'maintain oversight of the responsive to, review of an improvements resulting from serious adverse patient safety events in Victorian health services'.*

61. Ms English stated that *'it was considered that the circumstances of [Barbara's] death did not meet the requirements for such a notification at the time'.* She continued that *'at the time, [Barbara's] cause of death was unclear. . . There was no indication at the time that [Barbara's] sudden and unexpected deterioration on 29 June 2022 was a result of any medication systems issue on the part of [Melbourne Private Hospital].*

62. In the absence of a referral to SCV and having learned of Barbara's medical cause of death, Melbourne Private Hospital undertook internal reviews relating to Barbara's death.

Victorian Audit of Surgical Mortality

63. Dr Tan completed a report relating to Barbara's death for the Victorian Audit of Surgical Mortality. In March 2024, Dr Tan informed the Court that she had been informed *'the case*

*had progressed to a second line review but the second line assessor does not have sufficient information to make conclusions'.*

64. I will direct that a copy of this finding be made available to the Victorian Audit of Surgical Mortality with the view that it assists in their second line review of Barbara's death.

Clinical Review Committee

65. Barbara's death was reported to Melbourne Private Hospital's quarterly Clinical Review Committee (**the CRC**). Notably, the CRC does not comprise any independent experts.

66. The CRC considered the administration of VTE prophylaxis with the benefit of hindsight and with reference to the SCV Victorian Guideline for the Prevention of Venous Thromboembolism in Adult Hospitalised Patients (**the Guideline**). The Guideline was not in force at the time of Barbara's death.

67. The Guideline was endorsed in 2023 and contains several recommendations on VTE prophylaxis. Of note, key recommendations to surgeons include:

> *'pharmacological VTE prophylaxis should be administered after skin closure in surgical patients, on the evening of the day of surgery – unless there is an active decision or specific indication to delay administration to the following day'.*

68. Key recommendations for all neurosurgical patients include:

> *'All patients should have mechanical prophylaxis applied until they can ambulate or can receive pharmacological prophylaxis with LMHW [low-molecular-weight heparin]'*
>
> *'IPC [intermittent pneumatic compression] should be applied intra-operatively and continued until mobile'*
>
> *'If IPC is not available or contraindicated, Graduated Compression Stockings (GCS) should be applied. GCS and IPC should not be in place at the same time'* and;
>
> *'LMWH should be started 24-48 hours post-operatively (at Consultant discretion) and continued for period of hospitalisation. Mechanical prophylaxis can be removed once chemoprophylaxis has been commenced'.*

69. On 15 November 2023, the CRC found that *'the decision to administer 20mg enoxaparin post-operatively did not comply with [the] Guideline'* but acknowledged *'the Guideline was not in place at the time of [Barbara's] admission inn June 2022'.*

70. It ultimately concluded *'the nature and frequency of [Barbara's] clinical reviews throughout her admission to be appropriate'.*

Melbourne Private Hospital Morbidity and Mortality Review

71. On 5 December 2022, Barbara's death was considered by the Melbourne Private Hospital Morbidity and Mortality Review. Its findings were consistent with those of the CRC.

Melbourne Private Hospital Medical Advisory Committee

72. The Medical Advisory Committee made similar findings to the CRC and Morbidity and Mortality Review, namely that the administration of the 20mg enoxaparin was not consistent with the Guideline.

73. It stated that *'no issues were identified by the CRC, [Morbidity and Mortality Review] or the [Medical Advisory Committee] in relation to the medical treatment provided to [Barbara] during her admission in June 2022 (based on the relevant policies/guidelines in place at the time)'.*

Critical System Review

74. A Critical Systems Review was completed by the quality manager, the neurosurgical nurse unit manager, neurosurgical educator and Ms English as Director of Nursing.

75. Ms English stated *'the [Critical Systems Review] did not identify any deficiencies in [Barbara's] management that would have prevented her death'.*

76. Nonetheless, recommendations were made for improvement and to *'reinforce [Melbourne Private Hospital's] current practice and procedures',* including to improve the effectiveness of communication style and clarity, and to initiate a MET call when vitals are within normal limits, but escalation is required.

**DISCUSSION**

1. It is concerning that Dr Tan, even with the benefit of hindsight, did not identify herself as the *'patient's treating medical officer'* and therefore as the clinician responsible for Barbara's

care. Indeed, according to Healthscope's policies, Dr Tan was in fact responsible for the oversight of Barbara's VTE prophylaxis.

2. It is evident that there was something of a 'haphazard' approach to Barbara's pharmacological prophylaxis. Medical records indicate that medication was interchanged, withheld or their doses varied without accompanying explanation(s). It is troubling that in the three years since Barbara's death, the reasons for these decisions are yet to be deciphered.

3. Of note, it is concerning that neither Dr Tan nor Ms English could explain why her apixaban was withheld on 24 June 2022, nor were they able to identify who had ordered the medication be withheld. I consider it likely these issues were caused, in part, because Dr Tan did not consider herself principally responsible to oversee Barbara's VTE medication.

4. I acknowledge that many supports, such as education and mechanical prophylaxis, are provided to patients as *'standard practice'*. However, suboptimal record keeping introduces doubt as to whether these were indeed provided to Barbara.

5. Unfortunately, it is not uncommon that medical practitioners and broader healthcare services misunderstand the SCV sentinel event process. For the proper and independent review of such deaths, it is imperative that medical practitioners understand their reporting obligations under SCV's Victorian sentinel event guide.

6. The failure of hospitals to identify sentinel events have been the subject of previous coronial recommendation. One such recommendation was made by State Coroner Judge John Cain that SCV review and focus on the cooperation of health services providing reviews, root cause analyses and reports relating to sentinel events.

7. In its Annual Report of 2023-2024, SCV dedicated itself to *'update the Victorian sentinel event guide to ensure the healthcare sector understands their requirements when notifying and reviewing sentinel events'*. On 26 February 2024, SCV updated its *'Victorian sentinel events guide (version 2)'* which provides assistance to clinicians to understand their responsibilities when a sentinel events occurs.[6]

[6] The SCV guide for clinicians, last updated on 26 February 2024, can be accessed here: https://www.safercare.vic.gov.au/sites/default/files/2024-02/victorian-sentinel-event-guide-2024_0.pdf.

## RECOMMENDATIONS

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

1. In the interests of promoting public health and safety and reducing like deaths, I recommend that **Healthscope** consult *the 'Victorian sentinel event guide (Version 2)'* published by Safer Care Victoria and provide education to its clinicians on their responsibility to identify, report and investigate patient deaths which constitute sentinel events.

## FINDINGS AND CONCLUSION

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

   a. the identity of the deceased was Barbara Anne Deal, born 11 November 1935;

   b. the death occurred on 29 June 2022 at Melbourne Private Hospital 1F Royal Parade, Parkville, Victoria, 3052; and,

   c. I accept and adopt the medical cause of death ascribed by Dr Francis and I find that Barbara Anne Deal died due to a pulmonary thromboembolism which arose from a deep leg vein thrombosis.

2. AND having discussed the suboptimal administration of venous thromboembolism prophylaxis, I find that clinicians did not adhere to its policies and did not adequately consider the impact of the delayed operation on Barbara Anne Deal's treatment.

3. AND I find that by not conducting repeat risk assessments, clinicians missed an opportunity to appropriately re-evaluate Barbara Anne Deal's risk and act accordingly.

4. AND I find that medical records made during Barbara Anne Deal's admission are substandard. It is concerning that even in the time since Barbara Anne Deal's death, and with the assistance of all related materials, Healthscope has been unable to decipher its own records.

5. AND I acknowledge that pulmonary thromboembolism can occur in any patient, including those receiving adequate prophylaxis, and in the absence of comprehensive medical records, I cannot determine whether Barbara Anne Deal's death could have been prevented.

6. AND FURTHER I have reviewed the Safer Care Victoria guideline relating to the prevention of venous thromboembolisms in hospitalised patients and which articulates recommendations

to clinicians and all Victorian health services to promote best practice in risk management. In my view, the Guideline is a stride towards contributing to a reduction in the incidence of preventable deaths in the state of Victoria. I commend Safer Care Victoria for the preventative measures taken to improve the outcome for patients at risk of developing venous thromboembolism-related complications. I am satisfied that the document addresses the concerns identified by my investigation into Barbara Anne Deal's death and obviates the need for further coronial comment or recommendation in this regard.

I convey my sincere condolences to Barbara'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.

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

Robert Deal, Senior Next of Kin

Healthscope

Melbourne Private Hospital, c/- MinterEllison

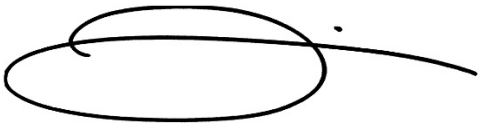
Safer Care Victoria

Dr Caroline Tan

Australian Health Practitioner Regulation Agency

Senior Constable Matthew Trewern, Coroner's Investigator

Signature:




AUDREY JAMIESON

CORONER

Date: 28 March 2025

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.