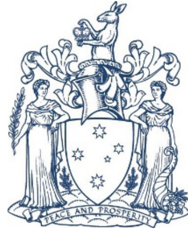

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000240

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	Kevin John Harris
Date of birth:	12 September 1984
Date of death:	11 or 12 January 2023
Cause of death:	1(a) PULMONARY THROMBOEMBOLISM IN THE SETTING OF DEEP VEIN THROMBOSIS 2 LEFT TIBIAL PLATEAU FRACTURE SUSTAINED IN A FALL, WHO CLASS II OBESITY
Place of death:	Unit 4/67 Playne Street, Frankston, Victoria, 3199

INTRODUCTION

1. On 12 January 2023, Kevin John Harris (**Kevin**) was 38 years old when he was located deceased in his home, he sustained a fractured knee sixteen days earlier. At the time of his death, Kevin lived alone in Frankston.

Background

2. Kevin was born to Teresa Harris (**Ms Harris**) and Michael Harris (**Mr Harris**) and was raised in Frankston with his sibling. Ms Harris recalls Kevin enjoyed a *'happy and healthy upbringing'*, that he *'never acted up or would cause [his parents] any trouble'*.

3. In 2004, after completing his schooling, Kevin commenced working at Coles Supermarket (**Coles**) in Frankston. Kevin was still employed by Coles at the time of his death.

Medical History

4. Kevin had an unremarkable medical history. He had diagnoses of obesity and gastro-oesophageal reflux and was prescribed medication for the latter.

THE CORONIAL INVESTIGATION

5. Kevin'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.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Kevin's death. The Coroner's Investigator conducted inquiries on my behalf, including taking

statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Kevin John Harris 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

10. On 27 December 2022, Kevin was working in the Coles' storeroom when he slipped and fell on some loose grapes. Other employees were in the storeroom at the time, but none witnessed the fall itself. Kevin described to his colleagues that *'he slipped, and his knee had gone behind his other knee and that he landed awkwardly'.* According to his colleague, she offered Kevin an ice pack three times, but he declined each offer.

11. While the injury was being logged by staff, Kevin sat and rested his knee. As time progressed, he began stumbling and struggled to walk. Kevin's manager permitted him to leave his shift, and his colleagues attempted to organise a ride home for him, however, Kevin insisted that he was able to walk home.

12. However, Kevin could not walk far and soon after leaving Coles, he contacted Ms Harris and asked to be collected. Ms Harris picked him up and they drove directly to his general medical practitioner (**GP**), Dr Marat Grosman (**Dr Grosman**). During the consultation, Kevin was unable to bear weight on the knee and needed a wheelchair to move around. Dr Grosman noted that Kevin's knee was *'mildly swollen'* and tender, though Kevin retained his full range of movement. Dr Grosman applied the McMurray's test and did not believe there was meniscus damage within the joint.[2]

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[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.

[2] The McMurray's test is used to determine the presence of a meniscal tear within the knee.

13. In Dr Grosman's opinion, Kevin had sustained a *'soft tissue injury to the knee'*. He advised Kevin to rest, apply an ice pack and to take anti-inflammatory medication. Dr Grosman advised Kevin to return for further assessment if his pain escalated.

14. Kevin spent the following few days at his parents' house. Ms Harris retrieved a spare 4-wheel-walker which Kevin used to get around.

15. On 2 January 2023, six days after the initial injury, Kevin's pain was not subsiding and he was still unable to weight bear, and so re-visited Dr Grosman. Dr Grosman noted there was continued minor swelling and referred Kevin for a magnetic resonance imaging (**MRI**) scan.

16. On 9 January 2023, Kevin and Dr Grosman discussed the MRI results, which demonstrated a displaced fracture of the medial tibial condyle, with a large joint effusion. Dr Grosman referred him for physiotherapy. Kevin continued to follow Dr Grosman's advice and took the week off work to rest and elevate his leg.

17. By 11 January 2023, Kevin had returned to his unit. He organised paperwork for a WorkCover claim relating to the injury and had dinner with his parents. Mr and Ms Harris noticed Kevin's knee was increasingly swollen, and he was short of breath. According to Ms Harris, Kevin spent most of the night in a recliner and attempted to walk using crutches per Dr Grosman's recommendation. However, Kevin '*was able to get around better using the 4-wheel walker'*. At approximately 7:30pm, Mr Harris drove Kevin home.

18. On 12 January 2023, at approximately 9:30am, Mr Harris arrived at Kevin's unit to have him sign WorkCover documents. Mr Harris entered the living room and located Kevin lying on the couch, unresponsive.

19. Mr Harris contacted emergency services. Ambulance Victoria paramedics arrived at Kevin's home but were unable to revive him. At 10:01am, paramedics declared Kevin deceased.

20. Victora Police members in attendance noted that Kevin's left leg was raised on the couch, and there was several walking aids located in the living room.

Identity of the deceased

21. On 12 January 2023, Kevin John Harris, born 12 September 1984, was visually identified by his father, Michael Harris, who completed a formal Statement of Identification.

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

Medical cause of death

23. Forensic Pathologist Dr Gregory Young (**Dr Young**) of the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on the body of Kevin Harris on 16 January 2023. Dr Young considered the Victoria Police Report of Death for the Coroner (**Form 83**), medical records and post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 28 February 2023.

24. The post-mortem examination revealed venous thromboembolism including pulmonary thromboemboli in the pulmonary trunk and throughout both lungs, and a deep vein thrombosis in the lower left leg. Pulmonary thromboemboli are dislodged blood clots that pass into the lung's circulation, resulting in the blockage of blood vessels. In most circumstances, the clots first form in the deep veins in the leg, known as a deep vein thrombosis.

25. Also identified was ischaemic heart disease including cardiac hypertrophy with left ventricular hypertrophy, severe atherosclerosis of the left interior descending coronary artery and myocardial fibrosis.

26. Other natural disease was identified including hepatic steatosis – 'fatty liver' – cholelithiasis – 'gallstones' – and World Health Organisation (**WHO**) Class II obesity (a BMI of 37.6 kg/m^2).[3] There was no evidence of long-term complications of COVID-19.

27. Also identified at post-mortem examination was a left tibial plateau fracture.

28. Dr Young stated that Kevin' leg injury, alongside obesity and immobilisation, were major risk factors in the development of a deep vein thrombosis and pulmonary thromboembolism

29. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any common drugs or poisons.

30. Dr Young provided an opinion that the medical cause of death was 1 (a) PULMONARY THROMBOEMBOLISM IN THE SETTING OF DEEP VEIN THROMBOSIS.

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[3] The World Health Organisation (**WHO**) provides stratifies Body Mass Index (**BMI**) into categories of obesity. These categories range from underweight to Class I Obesity (with a BMI of 30.0–34.9 kg/m^2), Class II Obesity (with a BMI of 35.0–39.9 kg/m^2) and Class III obesity (with a BMI greater than 40 kg/m^2). Class II obesity is considered 'moderate risk' obesity.

CORONERS PREVENTION UNIT

31. In the interests of a comprehensive investigation, I sought the assistance of the Coroners Prevention Unit (**CPU**) to determine whether the development of the fatal pulmonary thromboembolism could have been earlier detected.[4]

32. Deep vein thromboses (**DVT**), which can dislodge and travel to the lungs forming a pulmonary thromboembolism (**PE**), can arise due to multiple factors. Of those, immobility is a recognised risk factor for the development of DVTs. When an individual is immobile, the blood flow in the veins slows, increasing the risk of clot formation.

33. Symptoms of a DVT include throbbing in the affected leg, usually in the calf or thigh, swelling in the leg, warm and red or darkened skin around the painful area. Symptoms of a PE include sudden shortness of breath and chest pain.

34. In his statement to the Court, Dr Grosman spoke regarding his initial consult with Kevin on 27 December 2022. During the examination, Kevin's knee was *'mildly swollen, and was tender over the joint line (lateral more than medial)'*.

35. On 2 January 2023, when Kevin re-attended the clinic, Dr Grosman he examined the knee and observed ongoing *'minor swelling'* and ordered the MRI scan. On 9 January 2023, Kevin returned to discuss the MRI results and had noted *'difficulty mobilising due to pain in his knee'*. However, there is no evidence that Dr Grosman conducted an examination of the leg.

36. Regarding Kevin's risk of developing a DVT and/or PE, Dr Grosman stated that *'at no time did [Kevin] present with shortness of breath'* and that though he presented with *'swelling of the left lower leg, this was not his main complaint. There was some swelling of the left knee, which was thought to be a result of his injury'*. It is not clear whether Dr Grosman considered whether the swelling could have been caused by a DVT.

37. Dr Grosman continued:

> *'[Kevin] did not present with symptoms that suggested a VTE [venous thromboembolism]. Although there was swelling this was reasonably attributable to*

[4] 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.

the injury…At no point did [Kevin] present with shortness of breath, which would indicate a VTE'.

38. The CPU considered this proposition put forward by Dr Grosman and considered it is not entirely correct. 'Venous thromboembolism' (**VTE**) is a term which encompasses both DVTs and PEs. The CPU clarified that a VTE can present without shortness of breath when there is a DVT present – a clot confined to the lower limb which may cause swelling but does not cause shortness of breath.

39. With respect to VTE risk factors, Dr Grosman stated:

> *'My personal protocol to assess for VTE is to investigate any presentation that may suggest VTE such as unexplained pain or swelling in the lower leg, unexplained chest pain or shortness of breath. There is no clinical protocol for assessment and management of VTE.*
>
> *[Kevin] did not have any underlying risk factors for VTE, apart from possible obesity'.*

40. The CPU did not agree that Kevin did not have any risk factors for VTE. The CPU cited an article published in the Australian Family Physician – a peer-reviewed journal published by the Royal Australian College of General Practitioners (**RACGP**) – entitled *'Deep Vein Thrombosis: Risks and Diagnosis'*. The article highlights a fracture of the lower limb as a *'strong clinical risk factor'*, and immobilisation including bed rest for more than three days, and obesity are *'weak clinical risk factors'*.

General practitioner management of patients with isolated lower limb injury and non-weightbearing immobilisation

41. At the time of writing, there is a paucity of guidelines for GPs when assessing or managing patients with an isolated lower limb injury and who are at risk of developing a VTE. The CPU considered it is appropriate for uncomplicated DVTs to be diagnosed and managed within the general practice setting. However, it could not locate published nor endorsed clinical guidelines on the RACGP's website regarding VTE, DVT or PE assessment and/or management by GPs.[5]

[5] I note that in 2009, the RACGP, in its journal 'Australian Family Physician' published an article entitled, *'Venous thromboembolism Management in general practice'* which identified that GPs are being *'increasingly called upon'* for VTE prophylaxis, diagnosis and treatment.

42. Relevant guidelines largely refer to 'hospitalised' patients. Since Kevin's death, one such guideline was published by Safer Care Victoria, entitled, 'Victorian Guideline for the Prevention of Venous Thromboembolism in Adult Hospitalised Patients' (**the Guideline**). It relates predominantly to the management of VTEs in *'adult hospitalised patients admitted to Victorian health services'* rather than the management of patients in general practice.[6]

43. The CPU applied the Guideline to Kevin's circumstance given that he had an isolated lower limb injury and was non-weightbearing and he did not have previous major risk factors for VTE – his risk factor of obesity placed him in the 'moderate risk' group. For a patient such as Kevin, the Guideline recommended to *'consider VTE prophylaxis on an individual basis (consider treating this group as High Risk)'.*

44. Even if the Guideline was applicable to Kevin at the time of his death, the CPU considered there was no certainty that Kevin would have been provided by VTE prophylaxis – such as an anticoagulant.

45. In the absence of clear guidelines on GP practice, the CPU considered that Dr Grosman's management of Kevin's left knee was reasonable. While other GPs may have opted for an early orthopaedic review, the CPU opined the management of his injury was 'conservative', and that avoiding to weight bear – and therefore a degree of immobility - is central to this approach. The CPU considered it was unlikely that an orthopaedic surgeon would have prescribed prophylactic anticoagulation as Kevin was able to mobilise on crutches and a four-wheeled frame.

46. From medical records and Dr Grosman's observations, the CPU did not consider there was an opportunity for Dr Grosman to consider the diagnosis of a VTE. I note that Kevin's shortness of breath was first observed by his family on the evening of 11 January 2023.

47. The CPU concluded that the management by Dr Grosman was reasonable, and that Kevin did not appear to have symptoms or signs of a DVT or PE during his last consult on 9 January 2023.

48. There is no evidence from the Harris family that Kevin was experiencing shortness of breath, or increased swelling of the lower leg prior to the evening of 11 January 2023. The CPU

[6] Safer Care Victoria, *'Victorian Guideline for the Prevention of Venous Thromboembolism in Adult Hospitalised Patients: Guideline 2023'* accessible at: https://www.safercare.vic.gov.au/sites/default/files/2023-10/Guideline%20for%20the%20Prevention%20of%20Venous%20Thromboembolism.pdf.

therefore considered, there was no reason for Dr Grosman to have been concerned about the presence of a VTE at the times he consulted with Kevin.

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 with the aim of preventing like deaths, I recommend that the **Royal Australian College of General Practitioners** consider the creation and publication of a clinical guideline for the diagnosis, prophylaxis and treatment of venous thromboembolism for patients in the general practice setting.

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 Kevin John Harris, born 12 September 1984;

   b. the death occurred on 12 January 2023 at Unit 4/67 Playne Street, Frankston, Victoria, 3199; and,

   c. I accept and adopt the medical cause of death as ascribed by Dr Gregory Yong and find that Kevin John Harris died due to pulmonary thromboembolism in the setting of deep vein thrombosis.

2. AND I find that Kevin John Harris' fatal venous thromboembolism arose as result of multiple risk factors including the fracture sustained in the fall at his workplace on 27 December 2022, his subsequent reduced mobility and pre-existing obesity.

3. AND I have considered the opinion provided by the Coroners Prevention Unit and find that the medical treatment provided to Kevin John Harris by his general practitioner was reasonable and appropriate based on the signs and symptoms at the time of his consultations.

I convey my sincere condolences to Kevin'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:

Michael and Teresa Harris, Senior Next of Kin, c/- Gordon Legal

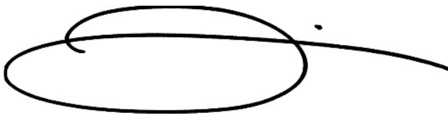
Dr Marat Grosman, c/- Medical One Frankston

Royal Australian College of General Practitioners

WorkSafe Victoria

Senior Constable Robert Rennie, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 18 December 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.