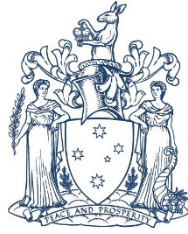

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003186

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	White-Wolf Patricia McLellan
Date of birth:	28 July 1980
Date of death:	9 June 2025
Cause of death:	1a: Pulmonary thromboembolism complicating a fractured left ankle (not operated), sustained in a fall
Place of death:	Northern Hospital Epping 185 Cooper Street Epping Victoria 3076

Aboriginal and Torres Strait Islander readers are respectfully advised that this content contains the name of a deceased Aboriginal and Torres Strait Islander person. Readers are warned that there are words and descriptions that may be culturally distressing.

INTRODUCTION

1. On 9 June 2025, White-Wolf Patricia McLellan was 44 years old when she passed away[1] in hospital. At the time of her passing, White-Wolf lived with her parents in Epping.

2. White-Wolf's father Douglas was a proud Koori man, though she did not openly identify as Aboriginal due to fears around discrimination.

THE CORONIAL INVESTIGATION

3. White-Wolf's passing 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.

4. 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.

5. 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.

6. This finding draws on the totality of the coronial investigation into the passing of White-Wolf Patricia McLellan. 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]

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[1] The term 'passing' is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle. Although White-Wolf did not openly identify as Aboriginal, I have determined to use the word 'passing' instead of 'death' throughout my Finding, save for where required by the words of relevant statutes.

[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.

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

Circumstances in which the death occurred

7. On the morning of 14 May 2025, White-Wolf presented to the Northern Hospital Emergency Department (**ED**) following a fall down the stairs. She was unable to weight bear on her left side.

8. An x-ray of White-Wolf's left ankle and foot showed a Weber B fracture of the distal fibula (ankle) with talar shift.

9. White-Wolf had a CAM (Controlled Ankle Movement) boot fitted and was given crutches to mobilise. A physiotherapy review identified that she was able to move independently with the use of crutches.

10. White-Wolf was discharged home at 10:51am. She was referred to the outpatient Orthopaedic Clinic and Fracture Clinic and was advised to follow up with her general practitioner (**GP**) in the next week. She was encouraged to weight bear as tolerated.

11. On 20 May 2025, White-Wolf was reviewed at the outpatient Fracture Clinic. An x-ray was taken at 11:21am showing an oblique fracture through the distal fibula. No progressive widening through the mortise was observed to suggest instability. Soft tissue thickening was noted.

12. White-Wolf's case was discussed with and reviewed by the Orthopaedic Consultant, and it was determined that she would likely need operative management. A left below-knee cast was applied.

13. Over the following days, White-Wolf had limited mobility and was largely bedbound.

14. White-Wolf experienced severe leg pain on 31 May 2025. The following morning, 1 June 2025, she was exhausted after walking to the toilet.

15. At 12pm, White-Wolf's family found her unconscious, making gurgling noises, and called for an ambulance. Paramedics found her to be bradycardic and then asystolic. She experienced a PEA arrest at 12:10pm. A return of spontaneous circulation was achieved, though she again arrested.

16. White-Wolf arrived at the Northern Hospital ED at 12:59pm after experiencing 20-30 minutes of downtime. She was administered IV Tenecteplase as her presentation was thought to most likely be pulmonary embolism (**PE**).

17. A whole body CT scan showed *acute PE within the distal left main pulmonary artery and extending into the left upper and left lower lobar and segmental pulmonary arteries which are nearly completely occlusive.*

18. White-Wolf was transferred to the ICU under the haematology team. Sadly, despite maximal interventions, she had no meaningful neurological recovery.

19. White-Wolf passed away on 10 June 2025. Her family generously consented to the donation of her organs.

Identity of the deceased

20. On 10 June 2025, White-Wolf Patricia McLellan, born 28 July 1980, was visually identified by her father, Douglas Jackson, who completed a Statement of Identification.

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

Medical cause of death

22. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of White-Wolf McLellan on 12 June 2025. Dr Young considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and e-Medical Deposition Form from Northern Health and provided a written report of his findings dated 13 June 2025.

23. The external examination showed signs of medical intervention and organ and tissue donation. No unexpected signs of trauma were seen.

24. The post mortem CT scan showed a fractured left distal fibula (ankle) and organ donation.

25. Dr Young explained that pulmonary thromboemboli are dislodged blood clots that pass into the lung's blood circulation, resulting in blockage of the blood vessels in the lungs. Most cases are due to blood clots arising in the deep veins of the legs (deep vein thrombosis). Major risk factors include recent surgery, malignancy, smoking, immobility (due to prolonged travel, trauma, burns, pregnancy, obesity), some medications and inherited clotting disturbances. Dr

Young said that White-Wolf's immobility following the ankle fracture and surgery would have significantly predisposed toward the development of deep vein thrombosis and pulmonary thromboembolism.

26. Dr Young provided an opinion that the medical cause of death was 1(a) PULMONARY THROMBOEMBOLISM COMPLICATING A FRACTURED LEFT ANKLE (NOT OPERATED), SUSTAINED IN A FALL.

REVIEW OF CARE

27. Having considered the circumstance of White-Wolf's passing, I referred the matter to the Health and Medical Investigation Team within the Coroners Prevention Unit (**CPU**)[3] for review. I requested the HMIT advise me as to whether the fracture management at Northern Health, including consideration of White-Wolf's risk of deep vein thrombosis (**DVT**)/PE was reasonable and appropriate in the circumstances.

28. In conducting their review, the HMIT considered White-Wolf's medical record. Additionally, the HMIT requested a statement from Northern Health as to whether any reviews had been conducted following her passing and if so, the outcome of those reviews. A statement was provided by Dr Juliette Gentle, Head of Orthopaedic Surgery at Northern Health.

29. Dr Gentle advised that Northern Health had initially reviewed White-Wolf's passing through hospital processes, at a Haematology Complex Clot Conference and an Orthopaedic Team Meeting. Following receipt of the HMIT's request for a statement, a multidisciplinary Structured Clinical Incident Review Template (**SCIRT**) review was undertaken. The SCIRT review involved the departments of emergency medicine, orthopaedics and haematology and included an external clinical expert (haematologist) on the panel.

30. The SCIRT review identified that no VTE risk assessment was documented at either White-Wolf's initial presentation to the Northern Hospital, or at her follow-up appointment at the Fracture Clinic, despite the change from a CAM boot to rigid immobilisation with a below the knee cast.

[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.

31. Northern Health's *Haematology - Thrombosis & Haemostasis Protocols* recommends that patients with isolated injury requiring lower limb immobilisation require VTE Risk Assessment. However, had a risk assessment been conducted, White-Wolf would have fallen into the 'less than 2 VTE risk factor's category, which suggests 'consider VTE prophylaxis on an individual patient basis'. It is unlikely that she would have qualified for VTE prophylaxis.

32. An incidental finding of the SCIRT review was that it is unclear what level of education White-Wolf received regarding the warning signs of VTE, and whether these were thoroughly explained to her in the context of her lower limb immobilisation or provided to her as written information.

33. The following corrective actions were identified for implementation within 60 days:

    a) *Review and update the current haematology protocol to improve clarity of guidance on the management of isolated lower limb injuries requiring VTE prophylaxis, including appropriate anticoagulant agents.*

    b) *Review and update current ED protocol on fracture management to include VTE risk screen, and increase awareness of staff*

    c) *Increase awareness of clinicians in Ortho clinic to consider VTE risk screen for patients with isolated lower limb immobilisation, especially with change in levels of immobilisation*

    d) *Improved written patient resources for VTE and clear information about warning signs for escalation.*

34. Northern Health has created a Management of Ambulatory Adult Patients with Isolated Lower Limb Immobilisation workflow, which has been conditionally endorsed. A copy of the workflow was provided to the Court.

35. The HMIT asked Northern Health to comment on the utility of the Thrombosis Risk Prediction Following Cast Immobilization (TRiP(cast)) score for assessing VTE risk in patients with lower limb trauma that require immobilisation.

36. The TRiP(cast) score is a 14-point clinical tool (that was externally validated in 2024) that determined the 3-month risk of developing VTE in adult patients with lower limb trauma that require immobilization but not hospital admission.

- A score < 7 means there is a 0.7% chance of developing VTE, and so prophylaxis is not recommended.

- A score > 7 is > 1.3% of VTE and so anticoagulation should be considered[4]

37. Dr Gentle said that the applicability of the TRiP(cast) score was considered as a component of the SCIRT review. White-Wolf would have received a score of 4 at her initial presentation to the ED, and 6 at her presentation to the Fracture Clinic. She would not have me the threshold for prophylactic intervention, though the review noted that risk assessment can be nuanced and no risk model can detect every single event accurately.

38. The CPU noted that White-Wolf's TRiP(cast) score would have been calculated as 8 once she became bedbound, but this occurred after medical assessment and was not known to the Northern Health.

39. The CPU advised that given the retrospective application of the TRiP(cast) did not predict that a PE was likely, it cannot be said that White-Wolf's passing was either predictable or preventable.

COMMENTS

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

1. PE is unfortunately not an uncommon cause of death amongst those reported to this Court. It is difficult to predict, prophylaxis may not be effective, and it can be difficult to diagnose. While national standards[5] and state guidelines[6] exist for the prevention of VTE, these apply to admitted patients. There are no guidelines pertaining to the outpatient setting.

2. The HMIT explained the importance of TRiP(cast) – it is the only validated clinical risk tool that address the issue of VTE prophylaxis in non-hospitalised patients, and it is a recent development, post-dating national standards and state guidelines that do not address the issue.

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[4] Douillet D, Penaloza A et alTargeted prophylactic anticoagulation based on the TRiP(cast) score in patients with lower limb immobilisation: a multicentre, stepped wedge, randomised implementation trial. Lancet. 2024 Mar 16;403(10431):1051-1060.

[5] Australian Commission on Safety and Quality in Healthcare, *Venous Thromboembolism Prevention Clinical Care Standard,* < https://www.safetyandquality.gov.au/standards/clinical-care-standards/venous-thromboembolism-prevention-clinical-care-standard>.

[6] Safer Care Victoria, *Victorian Guideline for the Prevention of Venous Thromboembolism in Adult Hospitalised Patients,* < https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/venous-thromboembolism/victorian-guideline>.

3. I commend Northern Health for realising the need for a structured process to assess and manage VTE risk in the outpatient setting and for creating a dedicated workflow. The HMIT noted that Northern Health's workflow is quite similar to TRiP(cast), but with a lower threshold to treat.

4. I consider there is an opportunity to share the learnings from White-Wolf's passing with other health services and will make recommendations that the state and national standards/guidelines are updated accordingly.

RECOMMENDATIONS

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

(i) In the interests of preventing like deaths and promoting public health and safety, I recommend that Safer Care Victoria consider incorporating recommendations for VTE prophylaxis in patients with lower limb trauma requiring immobilisation but not admission in the next iteration of the *Victorian Guideline for the Prevention of Venous Thromboembolism in Adult Hospitalised Patients.*

(ii) In the interests of preventing like deaths and promoting public health and safety, I recommend that the Australian Commission on Safety and Quality in Healthcare consider incorporating recommendations for VTE prophylaxis in patients with lower limb trauma requiring immobilisation but not admission in the next iteration of the *Venous Thromboembolism Prevention Clinical Care Standard.*

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 White-Wolf Patricia McLellan, born 28 July 1980;

   b) the death occurred on 9 June 2025 at the Northern Hospital, 185 Cooper Street, Epping, Victoria 3076

   c) I accept and adopt the medical cause of death ascribed by Dr Gregory Young and I find that White-Wolf Patricia McLellan died from pulmonary thromboembolism complicating a fractured left ankle;

2. AND, while Northern Health have acknowledged that there was an opportunity lost to assess White-Wolf Patricia McLellan for risk of venous-thromboembolism, it is unlikely that a risk assessment would have altered her treatment course. Accordingly, I find that her death was unpredictable and therefore unpreventable.

I convey my sincere condolences to White-Wolf'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:

Belinda McLellan and Douglas Jackson, Senior Next of Kin

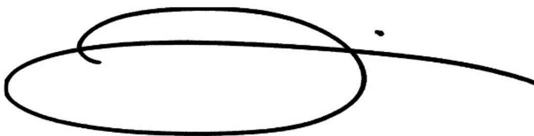
Northern Health

Safer Care Victoria

Australian Commission on Safety and Quality in Healthcare

Sergeant Paul Caridi, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 17 April 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.