IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 5051

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	Bernice Snell
Date of birth:	29 April 1948
Date of death:	28 August 2022
Cause of death:	1(a) Cardiac Arrest 1(b) Pulmonary embolism 1(c) Deep venous thrombosis
Place of death:	Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria, 3844

INTRODUCTION

1. On 28 August 2022, Bernice Snell (**Mrs Snell**) was 74 years old when she passed away at the Latrobe Regional Hospital. At the time of her death, Mrs Snell lived at Mirboo North. She was a much-loved mother, grandmother, life-advisor and sister to her family and friends.

2. As a cherished member of the Mirboo North Community Mrs Snell was an integral part of basketball and was the secretary at the Basketball association for twenty years.

3. Mrs Snell had a medical history which included Hypertension, Hypercholesterolaemia, Type 2 Diabetes, and hyperthyroidism.

4. On 4 December 2021, Mrs Snell was admitted to the Latrobe Regional Hospital (**LRH**) and was treated for a bleeding gastric ulcer. The treatment included a gastroscopy, a blood transfusion and prescribed medication to treat H Pylori, the bacteria responsible for the bleeding ulcer.

5. At an unknown time, shortly before Mrs Snell's death, she was prescribed a short course of treatment for H Pylori that was completed on 27 August 2022.

THE CORONIAL INVESTIGATION

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. On 2 September 2022, an investigation was commenced by the Coroners Court following a request from Mrs Snell's family.

9. This finding draws on the totality of the coronial investigation into the death of Mrs Snell 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. At approximately 10.00am on Saturday 27 August 2022, Mrs Snell presented to the Emergency Department (**ED**) at LRH with her daughter Lauren. Her left leg was swollen, and she had been experiencing pain in her left calf and groin for the prior two days.

11. Her observations were taken, her temperature was 36.5C, pulse 90 beats per minute and respiration rate was 16 respirations per minute. The observations were unremarkable.

12. At 2.23pm, Mrs Snell was seen by the ED Doctor who suspected that Mrs Snell had a Deep vein thrombosis (**DVT**) and she underwent a D Dimer test.

13. At 5.06pm the D Dimer test result was published, revealing a level 14.9 (elevated). Mrs Snell was admitted to the Short Stay Unit (**SSU**) and a DVT ultrasound was scheduled for the morning of 28 August 2022.

14. Mrs Snell's observations were taken at 9.30pm and were unremarkable.

15. Shortly before 1.00am on 28 August 2022, Mrs Snell requested pain relief as her legs were sore. She was given pain relief and advised the nurse that she required to use the toilet.

16. Mrs Snell stood up, she was unsteady and used a four-wheel walking frame to walk to the toilet.

17. At approximately 1.05 am, Mrs Snell pressed the call bell and the nurse found her on the floor, she was conscious and complained that she felt nauseous and dizzy.

18. At approximately 1.06 am, a medical emergency team call was made and a code blue call.

[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.

19. In response to the calls, an ED registrar, ED consultant, intensive care unit (**ICU**) registrar, ICU consultant, medical registrar, five ED nurses, one ICU nurse and the hospital coordinator attended on Mrs Snell.

20. The medical team commenced cardiopulmonary resuscitation and provided resuscitation drugs.

21. At 1.50 am, Mrs Snell was declared deceased.

Identity of the deceased

22. On 28 September 2022, Bernice Snell, born 29 April 1948, was identified by Dr Jae Lee (**Dr Lee**) from Latrobe Regional Hospital who treated Mrs Snell prior to her death.

23. Identity is not disputed and requires no further investigation.

Medical cause of death

24. Dr Lee completed a Medical Cause of Death form on 28 August 2022.

25. Dr Lee provided an opinion that the medical cause of death was 1 (a) *Cardiac arrest* 1 (b) *Pulmonary embolism* 1 (c) *Deep venous thrombosis.*

26. I accept Dr Lee's opinion.

FAMILY CONCERNS

27. On 2 September 2022 and 13 October 2022, Mrs Snell's son, Matthew wrote to the Court on behalf of the Snell family expressing a number of concerns with regards to his mother's medical management at LRH. These concerns broadly included:

    a) The delay in assessing Mrs Snell when she presented to the ED.

    b) No Anti-coagulation medication was administered.

    c) The death was not reported to the Coroner.

28. In receipt of the family's concerns, the court undertook an investigation. A Statement from Dr Tony Chan, Co- Director of the ED, LRH and correspondence from Dr Chong Zhou, Forensic Pathologist of the Victorian Institute of Forensic Medicine was sought and received.

The delay in assessing Mrs Snell when she presented to the ED

29. When she first presented to the ED at LRH Mrs Snell was triaged as a category 4 patient. The target time for a category 4 patient to be seen by a doctor is one hour.[2] There was a period of four hours and twenty-four minutes between the time that Mrs Snell presented to the ED and when she was seen by a doctor.

30. Dr Chan in his statement dated 9 November 2022 is unable to point to a specific reason for the delay other than staff shortages of junior and senior doctors, access block[3] and groups of people attending ED at once for treatment.

31. At the time that Mrs Snell presented to the ED, between the hours of 8am and midday, twenty-four patients attended the ED. Between midday and midnight, a further fifty-eight patients arrived. Dr Chan made the following comments on staffing:

> [*During the morning shift, there was one consultant, one registrar and seven junior doctors. The ED was short one consultant. During the evening shift, there was one consultant, no registrars and eight junior doctors. The ED was short of one consultant again. During the night shift, there was one consultant on call, one registrar and four junior doctors. The acuities of the patients were high on this day and the resuscitation cubicles in the ED were full throughout the entire day*.]

32. Dr Chan advised that LRH has been actively recruiting staff and in the short term in an effort to attract staff, LRH has increased the hourly rate for locum doctors and in the long term are recruiting from overseas.

No Anti-coagulation medication was administered

33. When Mrs Snell presented to the ED, she had completed that day a treatment for H Pylori, the bacteria that was responsible for her bleeding ulcer in December 2021. In addition, the treating Doctor was advised that there was a family history of DVT.

[2] Statement of Dr Chan dated 9 November 2022

[3] This occurs where patients who have been assessed in the emergency department and require admission to a hospital bed are delayed from leaving the emergency department for more than eight hours due to a lack of inpatient bed capacity.

34. Mrs Snell's age was a pre-disposing risk factor for a DVT. This combined with the D Dimer test result showing an elevated level caused the treating doctor to suspect that she had a DVT and a scan was scheduled for the morning of 29 August 2022.

35. The Senior Consultant considered ordering the administration of anticoagulant, clexane for the suspected DVT, however he formed the opinion that it was not the correct treatment due to Mrs Snell's '*recent gastric ulcer, bleed requiring transfusion and recurrent H Pylori*'[4].

36. In addition, Mrs Snell had several risk factors that placed in her a high-risk category in the risk of bleeding. The factors were:

    a) Being over 65 years of age.
    b) Previous bleeding.
    c) Anaemia.

37. Dr Chan stated that in addition to Mrs Snell being in the high-risk category for a risk of bleeding, there was a likelihood that she had an active gastric ulcer. In forming this opinion Dr Chan considered that Mrs Snell had recurrent H Pylori, and had just completed another course of eradication treatment. If Mrs Snell had an active gastric ulcer and was given the anti-coagulate medication, her condition would be complicated by a gastric bleed.

38. The definitive test for a DVT is a DVT ultrasound. In addition to the D Dimer test, a pre-test probability (**PTP**) test is used to assess the likelihood of a DVT. In Mrs Snell's case the D Dimer test was high, Dr Chan advised that this result can also indicate an alternative diagnosis such as[5]:

> [*widespread malignancy, overwhelming sepsis, a dissecting aortic aneurysm, trauma and other causes. It may also be due to the presence of a large clot in an active gastric ulcer*]

39. The PTP test was conducted by the treating doctor, Mrs Snell had the presence of oedema and calf swelling. She was scored as having a moderate probability of having a DVT.

[4] Statement of Dr Chan dated 9 November 2022
[5] Statement of Dr Chan dated 9 November 2022

40. Dr Chan conceded that it would have been useful for Mrs Snell to have had the DVT ultrasound at an earlier point in time. Mrs Snell presented to the ED on a Saturday when ultrasounds are only available for urgent cases. Her moderate PTP score meant that it was appropriate for the DVT scan to be scheduled for the following day.

The death was not reported to the Coroner

41. Following Mrs Snell's death, LRH contacted the Coronial Admissions and Enquiries Office (**CA&E**) to enquire about whether Mrs Snell's death was reportable. Staff at CA&E discussed the case with Dr Zhou who advised that on the information available to her, the death was by natural causes and was not unexpected, due to Mrs Snell's co-morbidities.

42. On 5 September 2022, Mrs Snell's son, Matthew Snell telephoned CA&E enquiring about an investigation by the Coroner into his mother's death. Mr Snell was concerned about whether any action or inaction by the hospital caused his mother's death and was therefore preventable.

43. Following Mr Snell's inquiries to the Court, the case was further reviewed by Dr Matthew Lynch, a Senior Forensic Pathologist at VIFM, who discussed the case with me at a preliminary meeting on 13 September 2023. Dr Lynch told me that the family were concerned about whether a delayed diagnosis contributed to Mrs Snell's death.

44. Following the meeting with Dr Lynch, I reviewed the available records and the concerns of the family and formed a view that the case was reportable because the records indicated there may have been a delay in diagnosing the DVT which caused or contributed to the death. Hence, I commenced the investigation and sought relevant material from the hospital.

45. In correspondence to the Court dated 19 December 2022, Dr Zhou advised that when she determined that Mrs Snell's death was not a reportable death, she was not aware that the family had raised concerns of care. Dr Zhou stated that was advised that there was no indication that her death was due to anything other than natural causes.[6]

46. The medical information that was provided to Dr Zhou included the following:

[6] Dr Chong, email dated 19.12.2022

[*The deceased had multiple cardiovascular risk factors (i.e. hypertension, hypercholesterolaemia, type 2 diabetes. There was no history of falls, trauma, or procedures*.]

47. Dr Zhou advised that had she been aware of the family's concerns of care, she would have recommended that Mrs Snell's death be reported to the Coroner.

48. I accept Dr Zhou's rationale for Mrs Snell's death not being reported to the Coroner on 28 August 2022 and make no further comment.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Bernice Snell, born 29 April 1948;

    b) the death occurred on 28 August 2022 at Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria, 3844, from 1 (a) *Cardiac arrest* 1 (b) *Pulmonary embolism* 1 (c) *Deep venous thrombosis*; and

    c) the death occurred in the circumstances described above.

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

I order that this finding be published on the internet in accordance with section 73(1) *Coroners Act 2008* and the rules.

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

Matthew Snell, Senior Next of Kin

Signature:

Coroner Katherine Lorenz
Date : 25 October 2023

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.