IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004037

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Vicki Karon Grigg
Date of birth:	14 February 1958
Date of death:	13 July 2025
Cause of death:	1a : Pulmonary thrombo-embolism 1b : Deep venous thrombosis Contributing condition 2 : WHO Class III obesity
Place of death:	36 Marys Lane Violet Town Victoria 3669

INTRODUCTION

1. On 13 July 2025, Vicki Karon Grigg was 67 years old when she died at home shortly after being discharged from hospital. At the time, she lived alone in Violet Town where she was employed as a postal delivery worker.

2. Vicki's medical history included asthma, high cholesterol and WHO Class III obesity.[1]

THE CORONIAL INVESTIGATION

3. Vicki'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.

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 death of Vicki Karon Grigg. 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] Vicki had a Body Mass Index (BMI) of 51.6 kg/m^2. The World Health Organisation (**WHO**) provides stratifies BMI scores 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).

[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

Background circumstances

7. On 4 July 2025, Vicki visited her general medical practitioner (**GP**) and reported an asthma attack, coughing up sputum with a fever and wheezing for a few days. On assessment, the GP noted she had significant shortness of breath and lowered oxygen saturation.

8. The GP provided Vicki with bronchodilators[3] and referred her to the Goulburn Valley Health Emergency Department (**ED**). Vicki arrived at the ED that evening and tested positive for Influenza A.

9. Vicki was admitted under the Respiratory Team and commenced on treatment comprising oxygen therapy, bronchodilators, inhaled and oral steroids, antibiotics and antivirals. She was commenced on an anticoagulant, 40mg enoxaparin once daily.

10. A chest x-ray showed changes in the right lower zone and a computed tomography (**CT**) scan also showed changes in keeping with asthma and mild bronchiectasis.[4] Vicki appeared to be improving and from 6 July 2025, was ambulating with a walking aid. She was however, at all times noted to be short of breath on exertion with mildly lowered oxygen saturation. Vicki was regularly reviewed by the Respiratory Unit consultant ward round and registrar and was provided with oxygen therapy via a nasal cannula (also known as *'nasal prongs'*) to improve her oxygen levels.

11. On 10 July 2025, clinicians performed their final medical review, and Vicki was discharged that afternoon. Her oxygen saturation on room air was around 93-95% however she still reported shortness of breath on exertion. She was discharged with a steroid and bronchodilator inhaler, and a plan for out-patient respiratory function testing and review with the respiratory clinic between six and eight weeks following discharge. Her enoxaparin was ceased at the time of her discharge.

[3] Salbutamol (known by its brand name *'Ventolin'*) is an example of a bronchodilator.

[4] A chronic structural abnormality of the bronchi (larger airways) in which longstanding airway inflammation—often secondary to severe or poorly controlled asthma—leads to irreversible dilation and thickening of the bronchial walls. This results in impaired mucociliary clearance, recurrent infection, and persistent airway obstruction that coexists with the patient's underlying asthmatic disease.

12. Vicki was instructed to see her GP in one week for review and appeared to have been provided with written discharge advice including: *'please seek medical attention if your shortness of breath is ongoing after exercise, or if you are severely short of breath'.*

13. On the morning of 13 July 2025, Vicki called emergency services in respiratory distress. A GoodSAM[5] responder attended her residence and commenced cardiopulmonary resuscitation (**CPR**). Ambulance Victoria paramedics arrived and found no cardiac rhythm. Vicki was declared deceased at 11:08 am.

Identity of the deceased

14. On 21 July 2025, Vicki Karon Grigg, born 14 February 1958, was visually identified by her son, Daniel Grigg.

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

Medical cause of death

16. Forensic Pathologist Dr Hans de Boer of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 17 July 2025 and provided a written report of his findings dated 22 July 2025.

17. The post-mortem examination revealed bilateral proximal pulmonary thromboembolism, cardiac hypertrophy,[6] mild emphysema and chronic bronchitis, severe steatosis hepatis (known as *'fatty liver'*) with cirrhosis.

18. Dr de Boer stated that cardiac hypertrophy (an enlarged heart), lung changes possibly suggestive of chronic obstructive pulmonary disease, and marked fatty changs of the liver with fibrosis were not directly related to the cause of death.

19. Dr de Boer provided an opinion that the medical cause of death was 1(a) *Pulmonary thrombo-embolism* secondary to 1(b) *deep venous thrombosis* with a contributing condition of 2 *WHO Class III obesity.* Dr de Boer provided an opinion that the death was due to natural causes.

20. I accept Dr de Boer's opinion as to cause of death.

[5] A smartphone-based emergency response system used in Australia that alerts nearby registered first responders to suspected cardiac arrests reported to Triple Zero (000), enabling early CPR and defibrillation before ambulance arrival. It integrates with state ambulance services and maps nearby automated external defibrillators (AED) to improve survival from out-of-hospital cardiac arrest.

[6] The heart weighed 504 grams.

SAFER CARE VICTORIA GUIDELINE FOR THE PREVENTION OF VENOUS THROMBOEMBOLISM

21. By way of context, *'venous thromboembolism'* (**VTE**) is a broad term that refers to both deep vein thrombosis (**DVT**) and pulmonary thromboembolism (**PE**). Risk factors for VTE include a previous VTE, active cancer, age over 60 years, prolonged severe immobility, pregnancy or post-partum less than six weeks, marked obesity, oestrogen-containing hormone replacement therapy or oral contraceptives, thrombophilia, general anaesthesia and medical comorbidities such as heart failure, ischaemic stroke, and inflammatory diseases.

22. A PE can form when a DVT travels from the lower body, such as in the calves, to the vessels in the lungs.

23. In 2023, Safer Care Victoria (**SCV**) released its guideline titled, *'Victorian Guideline for the Prevention of Venous Thromboembolism in Adult Hospitalised Patients'* (**SCV Guideline**).[7] It does not specifically recommend that patients with obesity be prescribed a higher than standard dose of anticoagulant.

24. It does, however, indicate that clinicians should *'consider adjusted dose LWMH* [low molecular weight heparin][8] *in patients with a BMI >40'*. It makes a corresponding recommendation to reduce the dose of anticoagulant for patients with a low BMI.

25. At Part 7.3.5 of the SCV Guideline, titled *'Thromboprophylaxis in Patients with Obesity'*, the following recommendations are made:

    a) The decision to use total/actual, ideal, adjusted, lean body weight, or BMI in the risk assessment and venous thromboembolism prevention plan should be clearly documented in the patient's medical record,

    b) Consultation with the health service's haematology team is *'strongly recommended'* for dosing advice; and,

    c) An increased dose of anticoagulant *'may be considered reasonable'* and the document outlines regimes of enoxaparin 60mg daily or 40mg 12 hourly.

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

[8] Low molecular weight heparin refers to anticoagulant drugs that are derived from standard (unfractionated) heparin but processed to produce smaller molecules with more predictable effects. Enoxaparin is a low molecular weight heparin.

26. The SCV Guideline does also state that *'Some studies, and some health services in Victoria, support giving a standard dose of LMWH, basing their recommendations on a lack of contrary evidence and that the VTE prophylaxis dosing should be based on lean body mass, not total body weight or BMI'.*

STATEMENT OF GOULBURN VALLEY HEALTH

27. Dr Nader Fayazi (**Dr Fayazi**), Respiratory Physician of Goulburn Valley Health (**GV Health**) provided a statement dated 8 January 2025. Dr Fayazi based his statement on GV Health medical records except *'where [he] had personal involvement'* – it is unclear where that is.

28. Dr Fayazi pointed to the Goulburn Valley Health Clinical Practice Guideline titled *'Prevention of Venous Thromboembolism (VTE)'* (**GV Health Guideline**). The GV Health Guideline requires that all adult patients are to be *'assessed for their risk of VTE within 24 hours of admission'*.

29. When asked whether Vicki received a VTE risk assessment at the time of her admission, Dr Fayazi did not refer to a singular entry to her medical record to indicate that she had. He did not outline what VTE risk factors staff had identified.

30. Dr Fayazi stated that Vicki was anticoagulated using 40mg enoxaparin daily commencing 5 July 2025. He stated that medical records *'do not record whether or not consideration was given to a higher dose of Enoxaparin being prescribed'*.

31. According to Dr Fayazi, at the time of Vicki's discharge *'there was no perceived risk of blood clots because she was able to mobilise in preparation for her discharge'*.

32. Dr Fayazi stated that he recommended to GV Health that it *'review the [VTE] Guideline to address the inclusion of a recommendation regarding enoxaparin dosage for patients with elevated BMI in the assessment tool contained in Appendix 3 of the [VTE] Guideline'*.

CORONERS PREVENTION UNIT

33. Given that Vicki had been discharged from hospital three days prior to her death, I sought the assistance of the Coroners Prevention Unit (**CPU**)[9] to better understand the appropriateness of her clinical management, specifically clinician's management of her VTE risk assessment.

[9] 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

34. The CPU considered materials including Vicki's medical records, the statement of Dr Fayazi, the GV Health Guideline and the SCV Guideline.

The GV Health Guideline

35. At the outset, the CPU identified that the GV Health Guideline does not contain a checklist or other similar tool which clinicians can use to assess a patient's VTE risk. While its appendices contain flowcharts and similar diagrams to assist in clinical decision-making, they do not appear to be documents intended to be attached to the patient's medical record.

36. Having considered the GV Health Guideline and Dr Fayazi's comment that it does not a require the use of a higher dose of enoxaparin for patients with a significantly elevated BMI, the CPU identified that a footnote/comment of the VTE Guideline which reads, *'consider consulting haematology for patients of weight greater than 130kg'*. This is consistent with the SCV Guideline which *'strongly'* recommends haematology input for VTE prophylaxis in obese patients.

VTE risk assessment(s)

37. The CPU identified there was no indication that clinicians conducted a VTE risk assessment at the time of Vicki's admission.

38. With regard to her discharge and whether Vicki's enoxaparin ought to be extended after she returned home, the CPU pointed to Dr Fayazi's description of Vicki's clinical state at the time of her discharge: *'she displayed minimal shortness of breath on exertion'*. The CPU identified the correspondence medical record entry, made at 10:30pm on 9 July 2025 (the day before discharge) which read, *'minimal, just walking around the room, SOBOE'* where '*SOBOE*; means *'shortness of breath on exertion'*.

39. The CPU did not agree with Dr Fayazi that entry meant Vicki experienced minimal shortness of breath on exertion. Rather, it contended the proper interpretation was that Vicki experienced shortness of breath on minimal exertion. Computer-based nursing notes recorded that Vicki was persistently *'SOBOE++'* when mobilising with a mobility aid between 6 and 10 July 2025. The CPU contended that *'++'* would not be considered *'minimal'*.

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.

40. While GV Health concluded that Vicki was at *'no risk'* of VTE upon discharge, the CPU stated her increased weight, documented shortness of breath, and possibly, her corticosteroid (prednisolone) use did indeed put her at risk.

41. The CPU pointed to the GV Health Guideline which requires that *'Patients who have been identified as being at risk of VTE during their admission should be reassessed at the point of discharge. Consideration should be made regarding the need for extended prophylaxis'.* However, the CPU stated that there was no indication from the medical records that clinicians considered whether to extend Vicki's anticoagulant. The CPU acknowledged that Vicki was mobilising in the ward however in the context of her illness, shortness of breath on exertion, increased weight and social situation (living alone), it concluded that a more critical appraisal of the likelihood of her being normally mobile upon her return to home may have been beneficial.

42. With respect to corticosteroid use and VTE risk, the CPU stated that neither the GV Health Guideline nor the SCV Guideline on VTE risk management explicitly mention this risk. It continued that there is evidence established in academic research that corticosteroids, such as the prednisolone that Vicki was taking while in hospital and following her discharge, are associated with an increased risk of VTE and that consideration of this fact in clinicians' overall VTE risk management at the time of discharge may have been beneficial.

Assessment of the CPU

43. The CPU concluded that the overall medical and nursing assessment and management of Vicki was appropriate and generally well documented.

44. On the basis of the analysis conducted, the CPU commented that Vicki's dose of enoxaparin (40mg daily) may have been inadequate due to her weight. Whilst there is no indication from the medical records that consideration was given to adjusting the enoxaparin dose on account of Vicki's weight, the CPU qualified there is no clear Victorian guidance which indicates this was mandated.

SUBMISSIONS OF GOULBURN VALLEY HEALTH

45. In advance of finalising the investigation into Vicki's death, the Court provided GV Health with notice of the conclusions which I was intending to make and the opinions of the CPU.

46. In response, GV Health provided a statement by Dr Arup Bhattacharya (**Dr Bhattacharya**) dated 13 February 2026. It also provided submissions dated 16 February and 5 June 2026 (collectively, **submissions**).[10]

47. Across its submissions, GV Health submitted:

a) That the opinions expressed by the CPU should not be treated as admissible evidence and the only evidence before me is the statements of Dr Fayazi and Dr Bhattacharya and GV Health medical records,

b) A finding that Vicki's VTE risk was not assessed at the time of admission is contrary to the evidence of Dr Fayazi and Dr Bhattacharya,

c) Comments that VTE prophylaxis dosing or duration may have been inadequate are speculative and should not be relied on as there is insufficient evidence to support the same,

d) Comments by the CPU that prednisolone use may have increased Vicki's VTE risk should be considered with limited weight as they are based on academic research only and not reflected in clinical guidelines available to GV Health,

e) A finding that GV Health did not assess Vicki's VTE risk at the time of discharge is contrary to the evidence of Dr Fayazi and Dr Bhattacharya,

f) Vicki received multidisciplinary review and treatment over her five-day admission, and a holistic review of the records supports Dr Fayazi and Dr Bhattacharya's opinions that it was reasonable to assess Vicki as not being at high risk of VTE at the time of discharge; and,

g) There was no existing guideline or clinical practice that recommended extending VTE prophylaxis post-discharge for non-surgery patients with Vicki's health profile and that GV Health complied with the SCV Guideline regarding consideration of post-discharge VTE prophylaxis.

[10] Containing annexures of the GV Health Haematology Referral Guidelines and Prevention of Venous Thromboembolism (VTE) in Adult Patients.

Admissibility of CPU Opinion

48. At the outset, GV Health submitted that the CPU's opinions *'ought not be relied on by the Coroner in making findings, unless they are views that would be reasonably open to the Coroner based on the materials alone and in the absence of expert clinical opinion'*.

49. GV Health acknowledged the Court is not bound by the rules of evidence (as established by the *Evidence Act 2008* (Vic)). GV Health was provided with a de-identified copy of the memorandum produced by the CPU. The memorandum was authored by a member of the CPU's Health and Medical Investigation Team who is a Senior Emergency Physician with over 30 years' experience and has co-authored several research papers. The author is a Fellow of the Australasian College of Emergency Medicine (**ACEM**) and has held several offices at the ACEM including as Director, Victorian Faculty Chair, Member of the Court of Examiners and Chair of the Primary Examination Committee. In this finding, a reference to *'the CPU'* is a reference to the opinion provided by that clinician.

50. GV Health is correct that this Court is not bound by the rules of evidence.[11] However, coroners may, as I have, take guidance from the rules of evidence when assessing the probative value of material adduced during a coronial investigation.[12] The contemplation of expert evidence necessarily invokes the operation of the Court's *Code of Conduct for Expert Witnesses*,[13] which governs expert witnesses including their duty of impartiality and independence, and the weighing of evidence in the event that there is conflicting expert opinion evidence.

51. I consider the author of the CPU report is suitably qualified to comment on the medical management of Vicki's condition by GV Health.

52. For completeness, Dr Bhattacharya is a specialist physician in geriatric medicine – recalling that Vicki was 67[14] - and is the Divisional Clinical Director of Medicine at GV Health. Dr Bhattacharya is a Fellow of the Royal Colleges of London, Edinburgh, Glasgow and the Royal Australasian College of Physicians. His special interests are neurodegenerative disorders

[11] *The Act* section 62.
[12] *See* judgment of Evatt J in *R v War Pensions Entitlement Appeal Tribunal; Ex parte Bott* (1933) 50 CLR 228, 256. See also Re Pochi v Minister for Immigration and Ethnic Affairs (1979) 26 ALR 247, 256; judgment of French CJ in *Kostas v HIA Insurance Services Pty Ltd* [2010] HCA 32.
[13] *Information for Expert Witnesses,* available via the Court's website at: https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/information%2Bfor%2Bexpert%2Bwitnesses.pdf.
[14] There is no prescribe age at which a person becomes 'eligible' for geriatric medical care. Different health services have different guidelines which also depend on non-age related factors including comorbidities. Most Victorian health services provide geriatric medicine to individuals 65 years and older.

including Parkinson's disease, stroke and disorders of cognition, and he has been a Principal Investigator in a Stroke Thrombolysis Trial.

53. As noted, Dr Fayazi is a Respiratory Physician.

54. In so far as Dr Bhattacharya and Dr Fayazi's evidence was relied on by GV Health in making its submissions and to the extent that there is a conflict between the evidence submitted by Dr Fayazi and Dr Bhattacharya and the evidence submitted by the CPU, I have considered the relative expertise of those clinicians.

55. In so considering, I have contemplated the statutory and common law rules of opinion evidence notwithstanding that this Court is not bound by those same benchmarks. I am satisfied that the CPU clinician is suitably qualified and possesses *'specialised knowledge'*[15] to provide an expert opinion in the current matter and I consider the CPU evidence is admissible. I am satisfied that the opinion provided to me was within the scope of expertise, and by reference to the evidence, explained the pathway of reasoning that was relied upon in arriving at the relevant conclusions.

VTE risk assessment at the time of Vicki's admission

56. GV Health contested the CPU's conclusion that there was '*no indication that clinicians conducted a VTE risk assessment'.* Dr Bhattacharya contended that the very fact Vicki was prescribed VTE prophylaxis was proof that a VTE risk assessment had been conducted. He stated: '*The decision to prescribe VTE prophylaxis on this occasion is clear evidence that Ms Grigg's risk of VTE was considered. The registrar's examination of Ms Grigg's lower limbs and documentation that no calf tenderness was elicited is further evidence that the registrar was considering the risk of VTE as part of the initial assessment, as the primary purpose of assessing calf tenderness is looking for signs of deep vein thrombosis (DVT).'*

57. Dr Bhattacharya acknowledged that the box for *'VTE risk assessed'* had not been ticked on Vicki's medical records however maintained that *'completing the order for prophylaxis in that section in confirmation that VTE risk was assessed'*. GV Health submitted it was not reasonably open for me to find that GV Health failed to conduct a VTE risk assessment at the time of Vicki's admission.

[15] To adopt the wording of section 79 *Evidence Act 2008.*

58. The CPU considered this submission and Dr Bhattacharya's statement and reiterated that there was no evidence that a VTE risk assessment was undertaken and explained that the act alone of prescribing a VTE prophylactic does not constitute a proper VTE risk assessment. It continued that had a comprehensive VTE risk assessment been performed, that Vicki's increased risk of VTE (due to obesity among other factors) would have been documented, in keeping with accepted standards of medical record keeping.

59. Regarding the calf examination, the CPU explained that this forms part of the examination of a patient complaining of shortness of breath. Calf tenderness may represent evidence of an existing DVT and therefore a source for a PE which is a potential cause for shortness of breath.

60. According to the CPU, GV Health's calf examination could not have formed part of a standard VTE risk assessment as its primary purpose was to identify the presence of a DVT not Vicki's risk of developing one.[16]

Prophylaxis dose

61. GV Health took issue with the CPU's comment that the 40mg of enoxaparin prescribed to Vicki *'may have been inadequate due to her weight'* and submitted there was insufficient evidence to make a corresponding finding given the comment's meaning and significance was *'unclear'*.

62. GV Health pointed to the SCV Guideline and its recommendation that: *'Although obesity is a recognised risk factor for VTE, the appropriate dose of LMWH* [low molecular weight heparin] *is unclear'*.[17]

63. Dr Bhattacharya pointed to GV Health's own VTE prophylaxis guideline (**GV Health Guideline**) which contained the following direction:

> *For patients at high risk of VTE who weigh >130kg a higher dose of LMWH should be considered. A dose of 60mg daily or 40mg twice daily dose of enoxaparin may be needed.*
>
> *Patients who weigh <130kg should receive a standard dose of enoxaparin.*

[16] The CPU acknowledged that a calf examination may form part of a VTE risk assessment where it is performed for the purpose of identifying varicose veins with phlebitis, however, the CPU noted that this was not raised in the GV Health submissions which submitted that the purpose of examining Vicki's calves was to check for signs of DVT (not risk).

[17] SCV Guideline, section 7.3.5, p 49 accessible at: https://www.safercare.vic.gov.au/sites/default/files/2023-10/Guideline%20for%20the%20Prevention%20of%20Venous%20Thromboembolism.pdf.

64. It was Dr Bhattacharya's clinical view that the dose of 40mg enoxaparin once daily was *'in line with clinical practice at the time'*. He noted that the GV Health Guideline only recommends *'consideration'* of a higher dose for patients over 130kg and stated that at the time of Vicki's admission, it was not GV Health's practice *'to routinely increase the dosage of VTE prophylaxis as a result of a patient's obesity in the absence of other risk factors like a history of VTE disease'*.

65. Dr Bhattacharya explained that Vicki's shortness of breath was explained by a diagnosis of Influenza A resulting in an exacerbation of her pre-existing COPD. Dr Bhattacharya explained, in his view, that *'in light of the confirmed diagnosis and clear explanation for Ms Grigg's symptoms, there were no additional factors in my view that suggested an increased risk of pulmonary embolism which warranted a higher dosage of prophylaxis'*.

66. GV Health acknowledged in its submissions that it had changed the GV Health Guideline relating to patients with obesity and indicated it *'agrees that a dosage of 60mg enoxaparin would <u>also</u> have been reasonable'* (emphasis mine). It maintained its objection, however, to the comment that a dose of 40mg enoxaparin *'may have been inadequate'*.

67. The CPU responded to the GV Health's submissions and disagreed that its comment that 40mg enoxaparin *'may have been inadequate due to her weight'* constituted an expert opinion, but that it was a comment reflecting the SCV Guideline.

68. The CPU agreed that the SCV Guideline does not prescribe a singular *'appropriate'* dose for patients with obesity but rather invites and advises haematology consultation and other consideration such as the use of *'total/actual, ideal, adjusted, lean body weight or body mass index (BMI) in the risk assessment'*. It pointed to interstate equivalents of the SCV Guideline including by the NSW Clinical Excellence Commission VTE Risk Assessment Tool which states that in patients with a BMI above 35kg/m^2 to *'seek specialist advice regarding these patient groups. Evidence in extremes of body weight is limited and careful clinical consideration is required'*, and similarly the Queensland Health Guideline which states that *'patients with body mass index (BMI) of 30 kg/m^2 or greater have an increased risk of VTE and may not follow a predictable dose-response relationship. <u>LMWH at standard prophylactic dose is unlikely to be sufficient in patients with a BMI of 40 kg/m2 or greater</u>'* (emphasis mine). I note that Vicki had a BMI of 51.6 kg/m^2.

69. Having referenced the interstate guidance, the CPU maintained that whether 40mg enoxaparin *'may have been inadequate due to [Vicki]'s weight'* was not an expert opinion but was a crystallisation of the key recommendation of the SCV Guideline.

70. The CPU disagreed with Dr Bhattacharya's contention that after Vicki tested positive for Influenza A, that there were *'no additional factors'* which suggested an increased risk of PE. The CPU pointed to Vicki's obesity, age (over 60), active or chronic lung disease and period of relative immobility during admission as widely accepted additional risk factors for VTE.

Consultation with GV Health Haematology Service

71. GV Health made submissions regarding CPU's comments which were contained in an earlier draft of this finding. The CPU was initially of the understanding that GV Health had only a visiting haematology service provided by St Vincent's, as much was published on GV Health's website at the time of the CPU's initial opinion.

72. GV Health and Dr Bhattacharya clarified that GV Health has an on-site haematologist who can provide advice during business hours and that the St Vincent's haematology service provides out-of-business-hours support. Dr Bhattacharya stated that *'in his experience*', contact with the haematology service is *'readily available and occurs frequently'*.

73. Dr Bhattacharya stated it was *'understandable'* in the absence of clinical complexity or diagnostic uncertainty, that clinicians did not consult the haematology service regarding Vicki's dose of VTE prophylaxis.

74. The CPU noted GV Health and Dr Bhattacharya's clarification on the availability of haematology advice and therefore questioned why, if it was readily available, it was not undertaken? The CPU maintained that haematology advice ought to have been obtained. It stated that even though the underlying illness causing shortness of breath was identified and diagnosed, it did not diminish Vicki's VTE risk and therefore the requirement for a proper VTE risk assessment and the adjustment of the of dose of enoxaparin given her significant obesity remained.

75. The CPU observed that haematology input would have been relatively easy to obtain and reiterated that the SCV Guideline specifically recommends obtaining haematology advice. The CPU disagreed that Vicki was not a clinically complex patient and that her obesity necessarily introduced complexity and some uncertainty regarding the appropriate dose of enoxaparin.

Vicki's VTE risk at the time of discharge

76. GV Health disputed CPU's opinion that Vicki's increased weight, documented shortness of breath, and possibly, her corticosteroid (prednisolone) use put her at risk of VTE. GV Health referred to Dr Fayazi's statement at the time of discharge *'there was no perceived risk of blood clots because she was able to mobilise in preparation for her discharge'* and that she displayed *'minimal shortness of breath on exertion'*.

77. As identified above, the CPU had a different interpretation of the medical record entry to Dr Fayazi and in fact considered the entry meant Vicki had shortness of breath on minimal exertion.[18] In response to the CPU's interpretation, GV Health pointed to Dr Bhattacharya's statement. Dr Bhattacharya stated that Vicki had chronic shortness of breath and pointed to Ambulance Victoria records of 4 July 2025 that she had *'decreased exercise tolerance normally'*.

78. GV Health also referred to Dr Bhattacharya's statement as evidence to support its position that Vicki *'was assessed by the physiotherapy team to have returned to her pre-morbid level of function prior to discharge*'. Dr Bhattacharya stated that Vicki was *'referred for physiotherapy assessment, which occurred on 9 July 2025 prior to discharge. It is documented that Ms Grigg was discharged from the physiotherapy service because she had reached her pre-morbid level of functioning in relation to mobility'.*

79. Dr Bhattacharya stated that *'prednisolone does not materially increase the risk of VTE'* and that prednisolone use is not referred to in the SCV Guideline nor the GV Health Guideline.

80. GV Health submitted that *'the evidence of Dr Fayazi and Dr Bhattacharya that Ms Grigg was not at risk of VTE upon discharge should be accepted*'. It submitted, as a corollary, that their evidence *'supports a finding that there was no clinical indication for continuing to prescribe VTE prophylaxis following discharge'*. Dr Bhattacharya stated that *'in my view, the decision to cease VTE prophylaxis at discharge was appropriate and straightforward and I would not expect the treating team to document the clinical rationale for ceasing VTE prophylaxis in the records'*.

81. The CPU maintained that its interpretation of the medical entry ought to be read that Vicki had shortness of breath on minimal exertion.

[18] The medical entry read, *'minimal, just walking around room, SOBOE'.*

82. The CPU turned to consider the physiotherapy assessment to which GV Health referred and noted that there was no clinical record to indicate that the physiotherapy team undertook a physical assessment of Vicki. It pointed to two entries made by the physiotherapy team in Vicki's medical record:

83. The first occurred on 7 July 2025 in response to a clinician's referral to the physiotherapy service. It read:

> *'Referral received – PT to Ax mobility, no reason given as to why needs PT input. Referral declined.*

84. The following day, on 7 July 2025, Vicki was re-referred to the service with the reason for referral was:

> *'?below baseline mobility for physio review please?'*

85. The second entry by the physiotherapy team was made on 9 July 2025 and read:

> *'re-referral received – PT to Ax mobility. Pt using 2WF* [2-wheeled frame] *for SOBOE but reported able to amb indep* [ambulance independently]*, nil aid on ward. Patient at PMLOF* [pre-morbid level of functioning]*. PT referral declined.'*

86. It was the CPU's opinion that given both referrals for assessment were declined, no physiotherapy assessment had occurred as GV Health and Dr Bhattacharya stated.

87. The CPU stated that Vicki's medical records indicated with respect to her mobility that:

a) She was independent in activities of daily living on admission and was bilaterally independent (did not require a walking aid for either side),

b) Between 6 and 10 July 2025, nursing notes indicated she was independent using a 2-wheeled walker and had *'SOBOE++'* where *'+'* indicates emphasis,

c) On 9 July 2025, Vicki had *'SOBOE++'* and needed supplementary oxygen when ambulating; and,

d) On 10 July 2025, a night duty nursing note queried whether Vicki was to be discharged with *'home O_2'* referring to a tank of oxygen.

88. Having referred to these entries, the CPU disagreed with GV Health's submission that Vicki had returned to her pre-morbid level of functioning. It substantiated this position as follows:

a) Prior to her admission, Vicki could undertake her daily living tasks independently and she worked as a postal delivery worker which indicates that her pre-morbid level of functioning was that she did not require any mobility aid(s),

b) She relied on a 2-wheeled walker to mobilise and was short of breath ('++') in the ward from 6 to 19 July 2025,

c) She required supplemental oxygen when walking on the day prior to discharge

d) On the morning of discharge a nurse questioned the need for home oxygen; and

e) The physiotherapy team's entry to her medial record on 9 July 2025 that she had returned to her pre-morbid level of functioning was incorrect as she was using a 2-wheeled walker at this time when prior to admission, she did not normally use a walking aid.

89. The CPU contended that the physiotherapy entry to the medical record of 9 July 2025 was likely based on medical records or from verbal information provided between teams. It was unlikely, according to the CPU, that the physiotherapy service had conducted a physical review of Vicki.

90. With regard to the possible connection between prednisolone and VTE risk, the CPU explained that medical research and literature supports an independent association between glucocorticoid[19] use and increased VTE risk across multiple diseases and populations.

91. The CPU pointed to a study which examined the issue in patients with asthma and concluded with *'evidence of an association between glucocorticoid use and VTE, particularly in new users of systemic glucocorticoids. Carefully weighing risk and benefit prior to initiating glucocorticoids in patients with asthma and monitoring for adverse events may be prudent'*.[20]

[19] Prednisolone is a glucocorticoid, a form of corticosteroid.

[20] Clin Epidemiol 2022 Jan 20:14:83-93 *Glucocorticoids and Risk of Venous Thromboembolism in Asthma Patients Aged 20–59 Years in the United Kingdom's CPRD 1995–2015* accessible at https://pmc.ncbi.nlm.nih.gov/articles/PMC8786344/; Eur Respir J. 2013 Sep, 42(3): 655-61 *Risk of deep vein thrombosis and pulmonary embolism in asthma* accessible at https://pubmed.ncbi.nlm.nih.gov/23258790/; Br J Haematol 2021 Mar 21;193(6):1194–1202 *Glucocorticoid use and risk of first and recurrent venous thromboembolism: self-controlled case-series and cohort study* accessible at: https://pmc.ncbi.nlm.nih.gov/articles/PMC8251551/; Thromb Res 2016 Apr:140: 46-50 *Oral and inhaled corticosteroid use and risk of recurrent pulmonary embolism* accessible at https://pubmed.ncbi.nlm.nih.gov/26897283/; JAMA Intern Med. 2013 May 13;173(9):743-52 *Use of*

92. GV Health acknowledged that research date suggested an association between corticosteroids and an increased risk of VTE however noted there was no application of that research to clinical guidelines. It stated that *'the SCV Guideline does not contain any reference to corticosteroids or any recommendation that its use should be factored into VTE risk assessment and treatment plans'*. It submitted that in the absence of such reference, there was insufficient data to support a finding that Vicki's consumption of corticosteroids should be considered when assessing her VTE risk and management.

93. In response to GV Health's submission that cessation of Vicki's VTE prophylaxis means that a VTE risk assessment was necessarily conducted, the CPU stated that simply ceasing a hospital prescribed medication at discharge does not materially constitute active consideration of the need for ongoing prophylaxis. The CPU pointed to the GV Health Guideline which stated that *'patients who have been identified as being at risk of VTE during their admission should be reassessed at the point of discharge. Consideration should be made regarding the need for extended prophylaxis'*.

94. The CPU also pointed to the SCV Guideline which contains a *'Key Recommendation'* to reassess VTE risk and the need for ongoing VTE prophylaxis upon discharge from hospital. There was no written evidence that this assessment was undertaken when Vicki was discharged.

Multidisciplinary nature of Vicki's hospital admission

95. GV Health submitted that the CPU considered each element of Vicki's admission in isolation and *'focussed on what is or is not documented in the record of each interaction'*. It submitted that Vicki received *'multidisciplinary review and assessment over the course of her admission'* and that each clinician who received her had the *'benefit of her complete clinical records, which were contributed to by a multidisciplinary team that included nursing, medical and allied health staff'*.

96. GV Health stated that the clinician who assessed Vicki at the time of her discharge had access to the following information:

glucocorticoids and risk of venous thromboembolism: a nationwide population-based case-control study accessible at: https://pubmed.ncbi.nlm.nih.gov/23546607/; Chest Volume 143, Issue 5, May 2013, Pages 1337-1342 *Use of Oral Glucocorticoids and the Risk of Pulmonary Embolism: A Population-Based Case-Control Study* accessible at https://www.sciencedirect.com/science/article/abs/pii/S0012369213603323#preview-section-abstract.

a) The initial assessment conducted at admission including that she had no history of VTE and no lower limb examination findings indicative of DVT,

b) Five days of medical and nursing observations, which indicated that her condition improved and she was mobilising and in a stable condition;

c) The assessment of the physiotherapy team that her mobility had returned to pre-admission baseline;

d) The CT chest scan with contrast performed on 9 July 2025, which revealed no evidence of large, proximal thrombi or any other signs suggestive of PE (although GV Health acknowledges that this was not a dedicated CT pulmonary angiogram).

97. GV Health submitted that the CPU's assessment did not appreciate this information and that the discharge summary was not to be considered in isolation. Rather, that Vicki's discharge involved a *'holistic consideration of the comprehensive histories, examinations, investigations and treatment provided throughout a patient's admission'*.

98. GV Health reiterated the evidence of Dr Fayazi that when considering the information available to GV Health clinicians at the time of Vicki's discharge, being that there was no reason to assess her as at high risk of VTE post-discharge.

DISCUSSION

VTE risk assessment at the time of Vicki's admission

99. I do not accept GV Health's submission that the fact that Vicki was prescribed a VTE prophylaxis is proof that clinicians performed a VTE risk assessment. These two actions can be performed each in isolation, one does not necessarily follow from the other. There is no contemporaneous medical record entry that demonstrates clinicians considered Vicki's VTE risk factors, obesity among them. I cannot rule out that Vicki was prescribed a *'standard dose'* of VTE prophylaxis as a matter of routine practice without regard being had to her particular risk level.

100. I do not accept that the calf examination performed is proof that GV Health considered Vicki's VTE risk or that it comprised part thereof. As described by GV Health, the primary purpose of the calf examination was to *'assess for signs of deep vein thrombosis'* (emphasis mine) present at the time of the examination, rather than constituting an assessment (or part of one) of Vicki's risk of developing a VTE.

Prophylaxis dose

101. Turning to Dr Bhattacharya's evidence, he stated it was not GV Health's practice *'to routinely increase the dosage of VTE prophylaxis as a result of a patient's obesity in the absence of other risk factors like a history of VTE disease'* and that the administration of 40mg enoxaparin was *'in line with clinical practice at the time'*. I do not accept, as Dr Bhattacharya put it, that Vicki had *'no additional factors'* other than her obesity. VTE risk factors listed at 3.2.1 of the SCV Guideline applicable to Vicki (other than obesity) include her age (over 60 years) and what was her current state of immobility.[21] She also had *'active or chronic lung disease'* in the form of COPD which increased her risk of VTE despite having tested positive for Influenza A.

102. That is to say, Vicki was not a patient that fit within GV Health's *'routine practice'* and she ought to have been recognised and treated accordingly. There is no evidence that clinicians considered a higher dose of VTE prophylaxis as the GV Health Guideline recommended.

103. I note that neither the SCV Guideline nor the GV Health Guideline prescribe a standard or acceptable dose of VTE prophylaxis for patients with obesity. However, I do not accept GV Health's submission that it is not open for me to find that 40mg of enoxaparin may not have been adequate. The crystallisation of the SCV Guideline is that a standard dose may be inadequate for patients with obesity and that clinicians should actively turn their mind to the patient's risk factors when determining a suitable dose. The absence of a singular dose for patients with obesity reflects, in my view, the dynamic nature of VTE prophylaxis with the consequence that an appropriate dose must be calculated on a case-by-case basis.

104. The available evidence indicates to me that GV Health did not appreciate the totality of Vicki's VTE risk profile and that she sat at the intersection of multiple risk factors. In those circumstances it is open to me to consider that the *'standard dose'* clinicians prescribed may have been inadequate in light of that risk.

Consultation with the GV Health Haematology Service

[21] With respect to her immobility, heading 3.2.1 of the SCV Guideline indicates that *'Significantly reduced mobility relative to normal state'* is a VTE risk factor.

105. I accept that referral to and/or liaison with a haematology service is not explicitly required by either the GV Health Guideline or the SCV Guideline. Nonetheless, the SCV strongly recommends the same and I consider that it would have been best practice to do so.

106. I do not accept that Vicki's presentation was absent of clinical complexity which obviated the need for haematology contact. By reference to GV Health's own guideline, by virtue of her elevated weight alone (> 130 kg) a greater dose of VTE prophylaxis may have been needed and should have been considered. That is, her obesity alone introduced clinical complexity and contemplation of the suitable dose would have been assisted by collaboration with the haematology service. In my view, it was particularly important that the haematology service was consulted given that Vicki had additional VTE risk factors.

107. Dr Bhattacharya made clear that GV Health clinicians often do and can easily contact the health service's haematology service. I echo the CPU's position that it is troubling that such contact did not occur.

Vicki's VTE risk at the time of discharge

Vicki's level of mobility at the time of her discharge

108. I do not accept that Vicki was at her premorbid level of functioning at the time of her discharge. Prior to her admission, she was able to ambulate independently, and she worked as a postal worker – an occupation which likely necessitated a level of exertion/walking/mobilising. At the time of her discharge, she was short of breath and unable to walk without an aid. I accept that Vicki's diagnosis of Influenza A likely exacerbated her COPD with the caveat that chronic lung disease is nonetheless a VTE risk factor which could not be ignored in light of that diagnosis.

109. Turning to the extent of Vicki's shortness of breath, the disparate interpretations of GV Health and CPU of her medical record made on 9 July 2025 (the day prior to discharge) have been difficult to reconcile. I note in this regard, that GV Health has not provided a statement from the author of that record.

110. That medical record reads:

> *'Pt A+O. E+D well. 92% sats on exertion (minimal, just walking around room, SOBOE) Sats 93→95 RA when rested. Due to SOBOE+ ↓sats on exertion, to have Vicki stay until tomorrow* [. . .]*'*

111. In the days prior to the medical record in question, Vicki had *'SOBOE++'* and she required supplementary oxygen when ambulating during the night shift following the entry.

112. Having read the medical record and considered it in the context of Vicki's admission more broadly and her trajectory in the preceding days, I am of the view that she was experiencing shortness of breath on minimal exertion, and that level of exertion was walking around the room. This was plainly not her pre-morbid level of functioning.

113. I do not accept GV Health's evidence that the physiotherapy team made an assessment that Vicki's mobility had returned to her pre-admission baseline. In my view, to purport that Vicki was assessed by and subsequently discharged from the physiotherapy service is an overstatement at best, of the available evidence. Medical records demonstrate that Vicki was twice referred to the physiotherapy service and that referral was declined both times. I take that to mean the physiotherapy team did not physically assess Vicki, nor was she accepted into their service.

114. It is likely that the *'assessment'* to which GV Health referred was a records-based review of Vicki's progress. However, having noted that Vicki's VTE risk level (or corresponding risk assessment) was not documented in her medical records, I do not consider that it gave an accurate picture of her clinical course.

Prednisolone and VTE risk

115. I acknowledge that prednisolone use is not a risk factor mentioned in the GV Health Guideline nor the SCV Guideline.[22]

116. I point to the Medical Board's code of conduct, *'Good medical practice: a code of conduct for doctors in Australia'*[23] (**Code of Conduct**) which makes a number of recommendations to practitioners including that they provide treatment options based on the best available information,[24] make responsible and effective use of the resources available[25] and keep their knowledge and skills up to date.[26] It is a corollary of these recommendations, in my view, that

[22] Nor are corticosteroids or glucocorticoids (as groups to which prednisolone belongs) mentioned.
[23] Medical Board, Australian Health Practitioner Regulation Agency, *Good medical practice: a code of conduct for doctors in Australia* (**Code of Conduct**) accessible at https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.
[24] Medical Board, Code of Conduct standard 3.2.6.
[25] Medical Board, Code of Conduct standard 3.2.12.
[26] Medical Board, Code of Conduct standard 9.2.1.

clinicians keep up to date with medical research and literature even where that data may not be included in formalised guidelines.

117. On the basis that a possible connection between prednisolone use and VTEs has not been formally recognised in the SCV Guideline, I do not expect GV Health clinicians to have factored the same into their contemplation of Vicki's VTE risk at the time of discharge. However I have referred to the Medical Board of Australia's code of conduct above for GV Health's information only and to emphasise the need for clinicians to keep themselves informed of medical developments.

Was Vicki's VTE risk assessed at the time of discharge and ought she have received ongoing VTE prophylaxis?

118. There is no evidence that clinicians turned their mind to Vicki's risk of VTE at the time of discharge nor whether she should be continued on VTE prophylaxis after her return home.

119. The GV Health Guideline states that *'patients who have been identified as being at risk of VTE during their admission should be reassessed at the point of discharge. Consideration should be made regarding the need for extended prophylaxis'.* The SCV Guideline contains a broader recommendation for clinicians to re-assess a patient's VTE risk at the time of discharge and assess whether ongoing VTE prophylaxis is indicated.

120. Based on my understanding of the relevant Guidelines, Vicki's VTE risk ought to have been re-assessed on 10 July 2025 when she was discharged. This did not occur. It is my understanding, based on the evidence and submissions before me, that such an assessment did not occur because clinicians did not identify Vicki as *'being at risk of VTE'* during her admission, to adopt the wording of the GV Health Guideline. In that sense, the deviation from the GV Health Guideline is inextricably linked to GV Health's earlier lack of appreciation of Vicki's risk factors.

121. I do not accept that the mere fact Vicki's VTE prophylaxis was ceased at the time of her discharge is proof that clinicians re-assessed her VTE risk and concluded that she was not at a risk level to warrant extending the medication. There are no contemporaneous medical records to indicate that clinicians entertained such considerations.

122. Contrary to Dr Bhattacharya's position, I expect that clinicians ought to have documented their justification for ceasing Vicki's VTE prophylaxis in her medical record, had they turned their minds to that contemplation. She demonstrated multiple risk factors (obesity, age >60

years, chronic lung disease and immobility) which first, warranted a re-assessment of her risk and second, a thorough consideration of ongoing VTE prophylaxis. The decision to cease prophylaxis in an at-risk patient ought to have been clearly documented in keeping with expected standards.

123. Referring again to the Code of Conduct for medical practitioners, the Medical Board states that *'maintaining clear and accurate medical records is essential for the continuing good care of patients'*.[27] Good medical practice in this regards includes *'keeping accurate, up to date and legible records that report relevant details of clinical history, clinical findings, investigations, diagnosis, information given to patients, medication, referral and other management in a form that can be understood by other health practitioners'*[28] and ensuring that the records are sufficient to facilitate continuity of patient care.[29] The decision to cease prophylaxis in an at-risk patient is, in my view a *'relevant detail'* of Vicki's clinical history. Had Vicki's VTE risk level been re-assessed or the decision to extend VTE prophylaxis been considered, this ought to have been recorded.

Multidisciplinary nature of Vicki's hospital admission

124. It is not lost on me that GV Health submitted that Vicki received care from a multidisciplinary team of clinicians who had the *'benefit of her complete clinical records'*, despite having also acknowledged that clinicians had not filled in necessary components of said clinical records (for example, the *'VTE risk assessed'* checkbox).

125. I do not accept that a holistic review of Vicki's admission (including histories, examinations, investigations and treatment) indicated she was not at high risk of VTE at the time of discharge. She had several ongoing VTE risk factors that have been canvassed in this Finding.

126. GV Health submitted that the discharging clinician had access to the following information:

    a. First, Vicki did not have a history of VTE, and a calf examination did not reveal findings indicative of a DVT. I accept this.

    b. Second, five days of medical and nursing observations indicating her condition was improving, she was mobilising and in a stable condition. I do not accept that this is the overall impression from medical and nursing observations. Entries to Vicki's

[27] Medical Board, Code of Conduct section 10.5 Medical Records.
[28] Medical Board, Code of Conduct standard 10.5.1.
[29] Medical Board, Code of Conduct standard 10.5.4.

medical records in the days preceding her discharge indicate she was significantly short of breath (*'++'*), only able to walk with an aid and required supplementary oxygen. Irrespective of the diagnosis of Influenza A, Vicki was not mobilising nor functioning at her pre-morbid level – that is, independently.

c. Third, that the physiotherapy team had assessed Vicki to have returned to her pre-admission baseline. As discussed above, I do not accept that such an assessment had occurred. While an on-paper review of Vicki's condition may have occurred, such a review was necessarily undermined by a paucity of contemporaneous record keeping already discussed.

d. Fourth, a CT scan had been performed the day before which was clear. I note, as GV Health acknowledged, that this was not a dedicated CT pulmonary angiogram which is the gold standard for identifying a PE.

127. I do not accept that Vicki was not at risk of VTE when she was discharged.

128. It was open to clinicians to have extended Vicki's VTE prophylaxis after her discharge.

ACTIONS TAKEN BY GOLDBURN VALLEY HEALTH SINCE VICKI'S DEATH

129. In Dr Bhattacharya's statement, he addressed changes which GV Health have made in relation to VTE prophylaxis in patients with obesity.

130. GV Health updated its guideline which now recommends that clinicians *'prescribe 60mg enoxaparin subcutaneous daily for patients with a body weight greater than 130kg and no contraindications such as impaired renal function'*. The GV Health Guideline also includes the SCV Guideline as a reference.

131. GV Health also considered whether to include a VTE risk assessment checklist into its template medication chart, which would require clinicians to record a patient's VTE risk category, contraindications for prophylaxis, pharmacological option and alternatives as opposed to a *'checkbox'* only.

132. Following a consultation process with senior and junior clinicians, including Dr Bhattacharya, GV Health decided that the checklist was *'too cluttered and difficult to follow'*. It was decided not to incorporate the checklist into medication charts and instead that the current form and its *'check boxes confirming whether VTE risk has been assessed and whether prophylaxis is not required or contraindicated'* would remain.

133. Dr Bhattacharya stated that *'GV Health was satisfied that including a prefilled option for VTE prophylaxis and a checkbox for a VTE risk assessment would achieve the primary goal of reminding clinicians to perform a VTE risk assessment and consider VTE prophylaxis, and that otherwise clinicians were able to identify when VTE risk management was complex and required further specialist input.'*

134. I commend GV Health for exploring this option. However, it is apparent that the intention of the checkbox to *'remind'* clinicians to perform a VTE risk assessment, identify when a patient's needs were complex and seek specialist (haematology) input did not work in this circumstance despite Vicki demonstrating several risk factors.

135. I note that during by the conclusion of my investigation, it was my intention to recommend that GV Health update its guideline to provide greater clarity regarding the dose of VTE prophylaxis for patients with obesity. GV Health has already made such an amendment and has obviated the need for further coronial recommendation.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Vicki Karon Grigg, born 14 February 1958;

    b) the death occurred on 13 July 2025 at 36 Marys Lane Violet Town Victoria 3669, from 1(a) *Pulmonary thrombo-embolism* secondary to 1(b) *Deep venous thrombosis* with a contributing condition of 2 *WHO Class III obesity*; and,

    c) the death occurred in the circumstances described above.

137. There is no evidence that Goulburn Valley Health considered Vicki's particular VTE risk during her hospitalisation including at the time of admission or discharge. In light of Vicki's VTE risk factors it is possible that the standard dose of VTE prophylaxis that she was given was inadequate.

138. A paucity of medical records has compromised my investigation to the extent that there is a lack of documentation of clinical decision-making affecting Vicki's treatment pathway. There is no evidence that Goulburn Valley Health clinicians turned their minds to whether a higher dose of VTE prophylaxis was indicated due to Vicki's risk matrix. There were no efforts to consult with the health service's haematology service to determine the same, despite recommendation to do so in the relevant Goulburn Valley Health and Safer Care Victoria guidelines.

139. At the time of discharge, Vicki demonstrated several risk factors for VTE however, there is no indication these were acknowledged or considered by clinicians. There is no evidence that clinicians considered extending her VTE prophylaxis beyond discharge as is recommended by the Safer Care Victoria guideline.

140. Having so found, it is important to note that VTEs can occur even in patients that receive adequate prophylaxis. For that reason, I am unable to definitively conclude that had Vicki received a higher dose of VTE prophylaxis that her death could have been prevented. I nonetheless find there were several missed opportunities to have better monitored Vicki's risk and to have insulated against the same.

RECOMMENDATIONS

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

i) I recommend that **Goulburn Valley Health** develop an evidence-based tool(s) or checklist(s) for VTE risk assessment with the view that this be completed upon admission and at the time of discharge (when indicated) and revisit the previously rejected proposition that such a risk assessment be attached to a patient's medical records.

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

Pursuant to section 73(1B) 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:

Mr Daniel Grigg, Senior Next of Kin

Goulburn Valley Health

Safer Care Victoria

Sergeant Eva Christou, Reporting member, Victoria Police

Signature:

Coroner Leveasque Peterson

Date: 23 July 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.