MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Tracey Lee Donohue

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Tracey Lee Donohue;

b) Mrs Donohue was born Tracey Lee White on 24 September 1974. At the time of her death, she was aged 44 years and lived with her family at Cooee. She was married to Troy Donohue and there are three children to the marriage - Shae, Ashton and Logan. Mrs Donohue worked as a support worker with Possability. Mrs Donohue was a long-term smoker. She had a history of suffering migraines, tendonitis, soft tissue and muscular injury, left trochanteric bursitis, chronic pain. It is also likely that she had prescription analgesia dependence. She had not been diagnosed with heart-related issues until several weeks before her death.

On 24 January 2019 Mrs Donohue developed central chest pain and was taken by ambulance to the North West Regional Hospital's (NWRH) emergency department (ED) and was treated en route for presumed acute myocardial ischemia (obstructed coronary artery). Treatment and investigations took place in the ED with advice sought from the Launceston General Hospital's cardiology team. A troponin rise was noted on her blood tests but no other particular signs of myocardial ischemia. She was transferred urgently to the LGH where she was admitted under Dr Bhuwan Singh, cardiologist. She was taken from the ED of the LGH following a bedside echocardiogram and other investigations to the cardiac catheterisation laboratory for angiography. A 30% narrowing was noted in her left anterior descending coronary artery but was not deemed to be flow-obstructing. All other arteries and heart functions tested during the procedure were satisfactory. The cardiologist performing the angiography was Dr Thomas David. A CT angiogram was also performed to assess the aorta, with no abnormalities found. Mrs Donohue had been experiencing

chest pain throughout these procedures but this later resolved. Mrs Donohue was transferred to a ward and was stable overnight. The following day she was reviewed by the cardiology team where she was deemed suitable for discharge with cardiologist follow-up in one month. A letter to Mrs Donohue's general practitioner from Dr David recommended dual antiplatelet therapy (that is, both aspirin and clopidogrel) although it is unclear if Dr David saw Mrs Donohue outside of the cardiac catheterisation lab. However, Dr Singh prescribed a medication regime of aspirin and esomeprazole (a protein pump inhibitor), but not clopidogrel. In his report for the investigation, Dr Singh provided reasons why he did not consider that clopidogrel would benefit Mrs Donohue and, in fact, might cause harm. These included issues with her existing gastric dyspepsia and use of prescribed opioids.

On 25 February 2019 Mrs Donohue was reviewed by Dr Singh in his private rooms with a stress echocardiogram. This test was negative for provocable myocardial ischemia. At this time Dr Singh was reassured by the findings of the tests he performed. At that consultation, Mrs Donohue described experiencing particular symptoms, including sharp, periodic, left arm pain and epigastric discomfort. He assessed the symptoms as being longstanding symptoms associated with her chronic pain from her other conditions and considered that she may be suffering a viral infection causing neuritis (nerve inflammation). He did not consider that the symptoms were cardiac in nature. Subsequently, Mrs Donohue continued to take her prescribed aspirin.

On 16 March 2019 Mrs Donohue was at home when she developed shortness of breath and chest pain. Ambulance paramedics attended and, during resuscitation, she rapidly deteriorated to cardiac arrest. Despite the resuscitative efforts by the paramedics and then at the NWRH ED she was unable to be revived and, sadly, died at 8.37pm.

c) Mrs Donohue died of natural causes, being ischemic heart disease. The autopsy revealed that she died due to a complete blockage of her left anterior descending coronary artery. This blockage comprised a 60-70% narrowing of the artery and the remainder blocked by thrombus. It was apparent that her heart disease had worsened rapidly in the 8 weeks before her death.

d) Mrs Donohue died on 16 March 2019 at her home in Cooee, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mrs Donohue's death. The evidence includes:

- The Police Report of Death for the Coroner;
- An opinion of the forensic pathologist who conducted the autopsy;
- The results of toxicological analysis of blood samples taken at autopsy;
- Affidavits confirming identification and life extinct;
- Affidavit of Troy Donohue, husband of Mrs Donohue;
- Affidavit of Ashton Donohue, daughter of Mrs Donohue;
- Records from the Tasmania Health Service;
- General practitioner's records from Records from Tasmanian Family Medical practice;
- Report from Dr Bhuwan Singh, Mrs Donohue's treating cardiologist; and
- Medical review by coronial medical consultant, Dr A J Bell.

Comments and Recommendations

An issue of significance arose in this investigation involving the need to examine whether Mrs Donohue's death could have been reasonably prevented with a treatment regime involving prescribing her another antiplatelet agent and/or a statin to prevent rupture of plaque in the artery. Unfortunately, it was a very difficult task to locate the treating specialist, Dr Singh, who had moved interstate. This unfortunately extended the period of investigation. Dr Singh was ultimately located and he provided a detailed report concerning the reasons for his treatment.

Dr Singh's treatment of Mrs Donohue and the contents of his report were reviewed by the coronial medical consultant, Dr A J Bell. Dr Bell formed the view that Mrs Donohue's diagnosis and treatment was complex due to her long history of pain syndromes. He said that Dr Singh gave cogent reasons for his treatment decisions and, in particular, for why her symptoms may have had a different origin and why a second antiplatelet agent was not given after Mrs Donohue's discharge from hospital on 25 January 2019. I note that Dr Singh stated in his report that he prescribed a statin to Mrs Donohue but the evidence indicates that she was only given a

statin whilst in hospital and not subsequently. It appears that Dr Singh, who is unwell himself, did not have his notes when writing the report and was mistaken in this regard.

I do not criticise Dr Singh's treatment and prescribing decisions. It is clear that he did not consider that Mrs Donohue suffered a cardiac issue that required medication to prevent rupture of plaque. In retrospect, Mrs Donohue's symptoms *were* cardiac in nature and her chances of survival would have been improved if she had been taking another antiplatelet agent, such as clopidigrel as well as a statin. It is also unfortunate that her condition progressed as rapidly as it did, causing her death.

The circumstances of Mrs Donohue's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Tracey Lee Donohue.

Dated: 20 December 2021 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner