MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Kelly John Dillon

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

a) The identity of the deceased is Kelly John Dillon (Mr Dillon);

b) Mr Dillon died in the circumstances set out below;

c) Mr Dillon's cause of death was pulmonary thromboembolus; and

d) Mr Dillon died between 17 and 18 February 2022 at Riverside, Tasmania.

Introduction

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mr Dillon's death which includes:

- the Police Report of Death for the Coroner;
- affidavits as to identity;
- affidavit of Dr Donald Ritchey, forensic pathologist which sets out his post mortem findings and opinion as to Mr Dillon's cause of death;
- Mr Dillon's medical records obtained from the Exeter Medical Centre;
- Incident report form obtained from Mr Dillon's employer and attached photos; and
- Report of Dr Anthony Bell MD FRACP FCICM Medical Advisor to the Coronial Division of the Magistrates Court.

In addition my office received an email from Tania Buchanan (Ms Buchanan) dated 11 March 2022, and a letter from Ogilvie Jennings lawyers dated 27 April 2022 which says that firm acts for Mr Dillon's son, Aryn, on instructions from Ms Buchanan. I also received an email from Page Seager lawyers dated 6 April 2022 which says that firm acts for the workers compensation

insurer of Mr Dillon's employer who is identified in that email as NOSS Tasmania Inc. trading as Northern Occupational Support Service (NOSS).

Ordinarily when a person dies by natural causes the senior next of kin is forwarded a letter by the coroner which sets out those causes. Because of the concerns raised by Ms Buchanan in her email I arranged for Dr Bell to review this case.

The Coronial Jurisdiction

Before looking at the circumstances surrounding Mr Dillon's death it is appropriate in this case to say something about the role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any *'reportable death'*.[1] A *'reportable death'* includes, amongst other things, a death where the death occurred in Tasmania and it was unexpected.[2] Mr Dillon's death meets that definition.

When investigating any death, a coroner performs a very different role to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and make the findings, if possible, which are set out in s28 of the *Coroners Act* 1995 (the Act). Those findings include who the deceased was, how he or she died, what was the cause of the person's death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions.

A coroner does not have the power to charge anyone with crimes or offences arising out of the death the subject of an investigation. Nor does a coroner have power to determine issues associated with inheritance or other matters arising from the administration of a deceased's estate or whether a dependant of a deceased person has a claim under the *Workers Rehabilitation and Compensation Act* 1988.

As noted above, one matter the Act requires is a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

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[1] See s21 of the *Coroners* Act 1995.
[2] See s3 of the *Coroners Act* 1995.

A coroner may comment on any matter connected with the death into which he or she is enquiring. The power to make comment *"arises as a consequence of the [coroner's] obligation to make findings ... It is not free ranging. It must be comment "on any matter connected with the death" ... It arises as a consequence of the exercise of the coroner's prime function, that is, to make "findings".*[3]

The standard of proof applicable to a coronial investigation is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings may reflect adversely upon an individual, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.[4]

Background

Kerry John Dillon was born on 8 January 1964 and resided alone in Riverside, a suburb of Launceston in northern Tasmania. At the date of his death he was employed by NOSS as a disability support worker. From information supplied by both Ms Buchanan, in her email, and Ogilvie Jennings, in that firm's letter, Ms Buchanan says she was Mr Dillon's former partner and the mother of his child Aryn Dillon.

Circumstances of Death

In the early afternoon on Friday 18 February 2022 Mr Dallas Marshall, who had known Mr Dillon from number of years, located Mr Dillon in the hallway of his home. He was slumped against a sliding door to the toilet. Mr Marshall commenced CPR after calling emergency services at 13:12 hours and continued until paramedics from Ambulance Tasmania arrived. It was determined by the paramedics Mr Dillon was deceased. At 13:55 hours police attended Mr Dillon's address and met with the paramedics and Mr Marshall. Police contacted the practice of Mr Dillon's general practitioner who revealed Mr Dillon had attended an appointment the previous day but that his death was unexpected.

Police were of the view, given Mr Dillon's location in his residence, that he was on the route one would take if walking from his bedroom to the toilet. This opinion was based on the fact

[3] See *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[4] (1938) 60 CLR 336.

Mr Dillon was pointing towards the direction of the toilet which indicated he may have come from his bedroom. After an inspection of the premises police determined Mr Dillon's property appeared undisturbed and therefore it was concluded there were no suspicious circumstances surrounding his death.

In her email, Ms Buchanan says the following:

"I would like to inform you of some information that I believe may be pertinent to the coronial investigation into the death of Kelly John Dillon. In the days preceding his death, Kelly was involved in an incident at his workplace (NOSS) where Kelly received heavy trauma and deep bruising to his arm. Following this incident Kelly was given a week off sick leave whereupon he sought medical attention from his doctor, Dr Lee at Exeter Medical Centre for a sore arm and a cough with shortness of breath, which developed after the incident at his work."

Ms Buchanan says she believes the incident at work may have contributed to Mr Dillon's death.

Investigation

The employer of Mr Dillon has provided an incident report which has been *"approved/closed off by"* Siena Norman on 16 February 2022, that is prior to Mr Dillon's death. Ms Norman is described in the report as Community Services Manager. The report records Mr Dillon reported on 15 February 2022 at 14:35 hours a client was *"swearing at peers and staff. Threw a chair at me."* Prior to throwing the chair it is reported the client was playing bingo with his peers when he became elevated and started swearing and yelling at both staff and his peers. He pushed a table over and loudly swore and yelled at staff and clients. Mr Dillon says he *"started diverting clients and support workers out the side door of the hall to minimise the amount of people walking past [the client]. I sat 3 metres away from [the client] to keep distance between clients and [the client]. The client picked up a chair and threw it at my left leg"*. Mr Dillon says his left lower leg was bruised. He reported the incident to Sally-Anne Burling at 14:40 hours that day.

The next section of the report is completed by Mr Dillon's supervisor, Rachael Preston. She says she called Mr Dillon to see how he was and reports *"[h]e is okay and will forward through photo of bruising."* From information set out further in the report it appears this conversation occurred on 15 February 2022 and in addition to Mr Dillon saying he was okay he also indicated he *"did not require EAP or DR"*.

I have also been provided with photographs of bruising; the first sent to the employer on 15 February 2022 at 14:01 hours, the second sent to the employer on 16 February 2022 at 13:15 hours and the third sent to the employer on 17 February 2022 at 11:29 hours. Those photographs show moderate bruising to the lateral side of the left leg just below the knee. With the last photograph are the following text messages between the employer and Mr Dillon:

"How are you feeling today

are you off work

I feel terrible am going to doctors at 3 can hardly get out of bed

That's not good

Look after yourself

Thanks Jane, I appreciate you... " (The remainder of this message has not been reproduced).

The records of the general practitioner disclose that Mr Dillon saw Dr Chris Lee on 17 February 2022. At 15:11 hours and 31 seconds the following is recorded in the records:

"Visit type:
Surgery Consultation
Intense malaise this past 2 days
Aching epigastrium
Very SOB
No malaena
No reflux Sx
Mod Etoh x 4 beers 5 days per week

Examination:
General:
BP (Sitting):120/70
Pulse (Sitting): 84 Regular
Looks very pale

Reason for contact:
Malaise"

The entry further records that both pathology and diagnostic imaging was requested and a medical certificate was provided to Mr Dillon. That medical certificate is dated 17 February

2022 and certifies Mr Dillon unfit for work from the 17 until 22 February 2022 inclusive because *"he is suffering from a medical condition"*.

The very experienced forensic pathologist, Dr Donald Ritchey, performed a post-mortem examination on Mr Dillon on 22 February 2022. After conducting both an external and internal examination and after considering the results of microscopic, toxicological and microbiological testing he sets out his opinion in his affidavit in the following terms:

"The cause of death of this 58-year-old man, Kelly John DILLON, was pulmonary thromboemboli complicating deep venous thrombosis. Significant contributing factors were advanced atherosclerotic coronary vascular disease and centriacinar emphysema with active respiratory bronchiolitis.

The autopsy revealed an enlarged heart (cardiomegaly) with marked thickening of the wall of the left main chamber of the heart (concentric left ventricular hypertrophy) in a pattern indicating long-standing disease. There was stenotic atherosclerosis of the coronary arteries supplying blood to the heart muscle. The immediate cause of death was an impacted thrombus (blood clot) within the pulmonary artery that supplies blood to the lungs from the heart.

Pulmonary thromboemboli begin as blood clots, usually within the deep vessels of the legs. When these break free the clots travel through the venous vascular system and right side of the heart to become impacted in the blood vessel supplying blood from the heart to the lungs. The sudden blockage of blood flow causes shortness of breath and death by a mechanism of cardiac arrhythmia. Trauma of the legs is a common precursor of deep vein blood clots."

I accept Dr Ritchey's opinion.

Dr Bell, in his report, examines the relationship between the cause of death and the injury suffered by Mr Dillon at work. His report also examines the care provided by Dr Lee. Dr Bell notes Mr Dillon's medical history of significance which includes being a smoker for 20 years, he had suffered from anxiety in 2015 and he had a mild alcohol misuse syndrome. He had also previously been prescribed a Ventolin inhaler and a number of other medications in the past. Dr Bell notes the history in relation to the incident at work and what is recorded by Dr Lee, in his note of 17 February 2022. In addition Dr Bell has taken into account the opinion of Dr Ritchey.

Dr Bell says the most common example of venous thrombosis, which people present to a medical practitioner with, is deep vein thrombosis of the lower extremity and pulmonary

embolism. The causes of venous thrombosis can be divided into 2 groups the first of which is a hereditary cause and the second is an acquired cause. He says Mr Dillon did not have a hereditary cause. He refers to a large population-based study which investigated venous thromboembolism risk following a minor injury that is one which did not require surgery, a plaster cast, hospitalisation or extended bed rest at home for at least 4 days. The study found a minor injury occurring in the preceding 3 to 4 weeks was associated with a 3 to 5 fold increase in the risk of deep vein thrombosis. Although this number sounds large Dr Bell says the actual increase in males aged 55 to 59 years is 100 per 100,000 people (0.1%) to 300 to 500 per 100,000 people (0.3 to 0.5%).

The injury which Mr Dillon sustained therefore increased the risk of deep vein thrombosis. Dr Bell notes the injury was minor and does not appear to have been mentioned to Dr Lee. Accordingly Dr Lee was faced with a patient who complained of the symptoms set out in the doctor's note which I have reproduced on page 5. The note does not disclose whether Dr Lee measured Mr Dillon's respiratory rate although dyspnoea (shortness of breath) is noted. Dr Bell says an adult patient with acute dyspnoea presents difficult challenges in diagnosis and management. He says:

"Epidemiologically , the most common diagnoses among older adult patients presenting to an emergency department with a complaint of acute shortness of breath and manifesting signs of respiratory distress (respiratory rate greater than 25 bpm, oxygen saturation less than 93%) are decompensated heart failure (CCF), and pneumonia, chronic obstructive pulmonary disease (COPD), pulmonary embolism (PE) and asthma. The diagnosis of PE should be considered in any patient with acute dyspnoea. Presentation varies widely, but dyspnoea and tachpnoea are the most common signs. A large minority of patients have no known risk factor at the time of diagnosis. The diagnoses mostly excluded in this case are COPD and asthma, no wheeze is observed and normal heart rate CCF and pneumonia."

Dr Bell says this information is derived from emergency department data and not GP related studies. He says Dr Lee as a general practitioner would, accordingly, be less versed in the information presented. The second issue is the other symptoms Mr Dillon complained about which led Dr Lee to consider a cause for the malaise and therefore his investigation was focused on malaise and pallor. The shortness of breath could have been related to the pallor as this is present in cases of significant anaemia.

Dr Bell concludes by saying on the evidence available Dr Lee would not be expected to diagnose PE. The diagnosis of PE presents diagnostic difficulties. In addition Dr Bell says that although the trauma at work increased the risk of venous thromboembolism it cannot be proven that the trauma Mr Dillon sustained at work caused this condition and therefore his death.

Dr Bell is a very experienced emergency doctor who has also previously been the chief medical officer at the Royal Hobart Hospital. He is well qualified to provide the opinions he has provided in this case and I accept them. I am not satisfied to the requisite standard that the injury Mr Dillon sustained at work caused the venous thromboembolism which led to his death.

Comments and Recommendations

Death caused by "*pulmonary thromboemboli complicating deep venous thrombosis*"[5] together with the other significant contributing factors mentioned by Dr Ritchey is a death which has resulted from natural causes. In these circumstances I have decided that an inquest is not required and that my function as coroner has now concluded.

I convey my sincere condolences to the family and loved ones of Mr Dillon.

Dated: 19 May 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner

[5] See page 6.