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 Paul Louis Brown

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

a) The identity of the deceased is Paul Louis Brown, date of birth 7 October 1959;

b) Mr Brown was 64 years of age and lived in Burnie. He had a complex medical history including diabetes, mental illness with suicide attempts, chronic alcohol misuse, traumatic brain injury in 2021, hypertension and hypercholesterolaemia. On 2 February 2024 Mr Brown was admitted to the intensive care unit of the North West Regional Hospital with diabetic ketoacidosis and acute kidney injury. Whilst in the intensive care unit he developed increased troponin levels. Discussion occurred between his treating doctors and the Launceston General Hospital ("LGH") cardiology service and there was an initial diagnosis of non-ST elevation myocardial infarction ("NSTEMI"- partial coronary artery blockage). Mr Brown was assessed as not for urgent transfer or therapeutic heparin, an anticoagulant, at that time;

Following further ECG changes and a further troponin rise, Mr Brown's case was again discussed with the LGH cardiology service. Based upon these discussions, it was decided that Mr Brown should be administered dual antiplatelet therapy and heparin infusion due to STEMI (complete blockage of coronary artery). He was assessed as still not for transfer to the LGH or urgent angiogram, rather for medical management in the context of his existing conditions;

However, the following evening, Mr Brown developed chest pain. The treatment plan was then revised, again in consultation with LGH cardiology service, to include thrombolysis[1] (if not contraindicated) and for transfer to the LGH. Prior to

[1] Particular drugs used to dissolve dangerous blood clots, including in the case of heart attacks.

administering thrombolysis, a CT scan of Mr Brown's brain was conducted to determine the safety of thrombolysis. The CT scan showed bi-frontal leucoencephalomalacia and left temporal leucoencephalomalacia (relating to old brain trauma) but there was no evidence of haemorrhage. The ICU team therefore administered the thrombolytic Tenecteplase to Mr Brown before transferring him to the LGH intensive care unit;

Mr Brown arrived at the LGH at about 12.30am on 4 February 2024. In the intensive care unit, his GCS fell to 10/15. An urgent CT scan of his brain showed a major left-sided subdural haematoma with midline shift. This brain bleed was considered inoperable and unsurvivable by the neurosurgical team. Mr Brown continued to deteriorate and was appropriately transitioned to palliative care. He passed away at 8.08pm on 4 February 2024;

c) The cause of death was subdural haematoma with mass effect following thrombolysis for an acute myocardial infarct. Diabetic ketoacidosis, chronic kidney disease and alcohol misuse contributed to the cause of death;

d) Mr Brown died on 4 February 2024 at Launceston, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Mr Paul Louis Brown's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Department of Health Final RCA Report;
- Medical review by Dr Anthony Bell, Coronial Medical Consultant; and
- Correspondence from Dr Viney Joshi, Executive Director of Medical Services THS Hospitals North.

Comments and Recommendations

Mr Brown's subdural haematoma causing his death was caused by the administration of thrombolysis and was a known risk of thrombolysis. I have had regard to the Tasmanian Health Service RCA report, in which the RCA panel concluded as follows:

> *"The sense of urgency to thrombolyse the patient prior to AT arrival combined with a lack of training in the use of the "Thrombolysis for STEMI Clinical Pathway" led to the pathway not being followed in its entirety which meant the contraindications were overlooked. This led to the patient inappropriately receiving thrombolysis which caused a catastrophic brain bleed from which he did not survive."*

The RCA panel stated that Mr Brown's previous traumatic brain injury with intracranial haemorrhage was an absolute contraindication and thrombolysis should not have occurred. The panel stated that the registrar in question was aware that Mr Brown had a previous traumatic brain injury in 2022 but did not appreciate that therefore thrombolysis should not have gone ahead. It also appears from the RCA report that the LGH cardiology team, when providing advice to the North West Regional Hospital clinicians, were not advised that Mr Brown had a past history of intracranial haemorrhage. The RCA panel recommended various measures of these put in place, including education and early transfer to LGH, in response to this case.

In this investigation, I sought an independent review by the Coronial Medical Consultant, Dr Anthony Bell. Dr Bell did not consider that the thrombolysis of Mr Brown was inappropriate in light of the age of the previous traumatic brain injury (well over the three-month period as an absolute contraindication) and the CT scan findings. He stated that the ICU registrar adopted sound practice in ordering an urgent CT scan prior to thrombolysis. I also note that the experienced forensic pathologist, Dr Donald Ritchey, who conducted a review of the medical records formed the view that Mr Brown's previous traumatic brain injury was not likely to be contributory to his death.

I have also received correspondence from Dr Viney Joshi, executive Director of Medical Services THS Hospitals North. Dr Joshi was in agreement with Dr Bell's comments that Mr Brown did not have an intracranial haemorrhage in the last three months and, given his acute medical episode, appropriate treatment was given.

In light of the urgency of the situation and the potential efficacy of thrombolysis, I am satisfied (notwithstanding the RCA report) that Mr Brown was treated appropriately. Unfortunately, he succumbed to a known risk of the treatment. I comment that it may be appropriate for the

Thrombolysis for STEMI Clinical Pathway to be reviewed to ensure that it aligns with the literature.

The circumstances of Mr Brown's death are not such as to require me to make recommendations pursuant to section 28 of the *Coroners Act* 1995.

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

Dated: 17 December 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner