MAGISTRATES COURT
TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of OQ.

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

a) The identity of the deceased is OQ, date of birth 4 April 1982.

b) OQ was 41 years of age and lived with her partner in Collinsvale. She was employed by Nexus as a disability support worker and she has one child, RT (born in 2000), to a previous partner. OQ did not have a history of significant medical conditions. In 2014 she underwent an MRI scan of the brain for persistent vertigo and headaches. This did not reveal any abnormality. Her regular general practitioner's records note that in 2015 she suffered migraine but that this was an "inactive" condition. It does, however, appear that OQ suffered with migraines or headaches over a lengthy period.

In the late morning of 15 July 2023, OQ was taken by ambulance to the Royal Hobart Hospital (RHH) emergency department. She told attending paramedics that, for two days, she had experienced headaches, neck tightness, photosensitivity, intermittent vertigo, nausea and vomiting. She also reported having a syncopal episode (loss of consciousness) with urinary incontinence while watching television the previous evening. Upon arrival at hospital, she did not wait for medical review and left.

Early the following morning, 16 July 2023, she presented to the emergency department of the Hobart Private Hospital (HPH) stating that she had a sudden onset of headache the previous evening. She reported that the onset of her headache was slower than that of her friend who had an aneurysm. She did not

take up the offer of a CT scan of the brain and suggested that a particular medication had resolved the headache on a previous occasion. She was provided with pain relief for migraine, which had good effect, and she returned home that evening.

The next morning, 17 July 2023, OQ attended her general practitioner with a return of the headache. A provisional diagnosis of migraine was made by the general practitioner and she was treated with sumatriptan. At this consultation, her general practitioner discussed with her the need to present to the hospital emergency department if the headache persisted into the following day.

However, at 11.00pm that same evening, OQ attended the RHH emergency department with ongoing headache associated with nausea and vomiting but no other clinical signs or symptoms. She was treated in the Emergency Medical Unit with chlorpromazine infusion with good effect and was discharged the following morning.

On the morning of 19 July 2023, OQ again presented to the RHH emergency department with similar symptoms of headache and nausea, which she said had been present for the last four days. However, she also described the onset of bilateral leg weakness. A CT scan of her head was undertaken and showed a subarachnoid haemorrhage and multiple saccular aneurysms. A coiling procedure to thrombose two aneurysms took place and a plan was made to surgically clip a further aneurysm at a later date.

However, on 20 July 2023, OQ suffered a drop in her level of a consciousness. A further CT scan showed severe vasospasm (constriction of the arteries associated with the aneurysms), and she was taken for interventional radiology treatment for that condition. However, after the procedure, OQ's intracranial pressure became significantly elevated. Imaging confirmed widespread brain damage in the form of acute bilateral anterior cerebral artery infarcts. She was assessed as being unable to survive and she was transitioned to palliative care after discussions with her family. She passed away in hospital that day.

c) OQ died of frontal lobe ischaemic infarcts (strokes) caused by cerebral artery vasospasm complicating subarachnoid haemorrhage (due to ruptured saccular aneurysm).

d) OQ died on 20 July 2023 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavit confirming identification;
- Opinion of the forensic pathologist regarding cause of death;
- General practitioner records for OQ;
- Hospital and ambulance records;
- Medical review by Dr Anthony Bell MD FRACP FCICM, Coronial Medical Consultant; and
- Correspondence to the Coroner from Professor Kate Burbury, Executive Director of Medical Services and Research, Tasmanian Health Service - South.

Comments and Recommendations

I requested that this case be reviewed by the Coronial Medical Consultant, Dr Anthony Bell.

Dr Bell provided a detailed report analysing the medical care and treatment provided to OQ in her five medical presentations before her death. Dr Bell formed the following opinions:

- There were no issues surrounding ambulance or RHH treatment or care of OQ on 15 July 2023, particularly as she did not wait for a medical review upon arrival at hospital.
- There was no significant issue relating to OQ's treatment or care at HPH on 16 July 2023, particularly as OQ declined the offer of a CT scan of the brain. Dr Bell particularly noted that the HPH would not have had access to important information regarding OQ's symptoms (including syncopal episode) from Ambulance Tasmania records of the previous day. However, Dr Bell suggested that a CT scan should have been "ordered" rather than "offered" in light of the severity of the headache. However, he noted that OQ may still have refused it.
- No criticism should attach to the treatment by the general practitioner on 17 July 2023, particularly as she provided advice that OQ should attend the hospital emergency department the following day if her headache persisted. Further, the general practitioner did not have available the ambulance report or hospital records.
- There was too rapid an acceptance by treating practitioners at the RHH on 18 July 2023 that OQ was suffering from migraine. The life-threatening and not uncommon diagnosis of subarachnoid haemorrhage was not sufficiently considered. Further, it is apparent that there was no consideration of the

ambulance notes from 15 July 2023 despite this being available and recording symptoms which should have given rise to investigation for subarachnoid haemorrhage and prompted a CT scan of the brain. A CT scan would have revealed the subarachnoid haemorrhage.

- The diagnosis of OQ's subarachnoid haemorrhage was partly delayed and complicated by her own decisions to decline treatment on two occasions in the days before her death as well as the fact that she presented to different treatment providers (two separate hospitals and her general practitioner). It also appears that she underplayed her symptoms when communicating them to clinicians.
- It is possible that earlier diagnosis and treatment of subarachnoid haemorrhage would have increased her chance of survival.

I accept the analysis by Dr Bell. I cannot positively determine whether OQ would have survived if she had been investigated for and diagnosed with a subarachnoid haemorrhage at an earlier time in the course of her medical presentations before her death. However, her condition may have been stabilised by securing the aneurysm through surgical or endovascular clipping, stenting or coiling the ruptured blood vessels. Further, the diagnosis and treatment of her vasospasm (a serious complication of subarachnoid haemorrhage) at an earlier time may have also reduced her risk of death.

A Tasmanian Health Service Root Cause Analysis (RCA) was conducted following OQ's death. Like Dr Bell, the RCA panel identified that there were missed opportunities for an earlier diagnosis and treatment of her subarachnoid haemorrhage at the RHH.

Additionally, the RCA panel determined that OQ's blood pressure was not managed optimally post-operatively in various respects, mainly caused by communication and documentation issues. Thus, there were opportunities to have reduced her risk of cerebral ischaemia in the setting of vasospasm. My investigation has not focused upon this aspect of OQ's treatment. However, the RCA panel made recommendations for systems improvements and I would expect that the RHH has implemented or will implement those recommendations to address the issues.

Dr Kate Burbury, Executive Director of Medical Services and Research, Tasmanian Health Service - South, provided correspondence indicating that as a result of the RCA recommendations, the RHH will undertake an audit in the emergency department to determine:

(a) Current rates of timely diagnosis of subarachnoid haemorrhage;

(b) Whether current emergency department practice is in line with expected standards for subarachnoid haemorrhage diagnosis;

(c) Whether any opportunities exist to improve practice in the emergency department; and

(d) Whether quality improvement work should be undertaken to address audit results as required.

I expect that, following the audit, the RHH will undertake any quality improvement measures assessed as being necessary. I therefore do not make formal recommendations.

OQ's death highlights the importance of medical practitioners actively investigating the possibility of life-threatening intracranial conditions in patients presenting with relevant symptoms.

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

Dated: 29 April 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner