



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Leigh Mackey, Coroner, having investigated the death of Helen Lynette Phillips

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

- a) The identity of the deceased is Helen Lynette Phillips.
- b) On 12 December 2022 Mrs Phillips was at home alone when she fell from a three step ladder. She experienced a period of loss of consciousness and fractured her 5th and 7th ribs. She was taken to the Mersey Community Hospital (MCH) by her neighbour. Her chest was scanned and the rib fractures identified. Mrs Phillips was kept at MCH overnight for pain relief and observation and discharged home the following day. A scan of her brain was not undertaken at MCH.

On 20 December 2022 Mrs Phillips was at home when she had a heart attack (STEMI)¹. She was attended to by Ambulance Tasmania (AT). Mrs Phillips was transported to the Launceston General Hospital (LGH) for thrombolysis² following consultation between the attending paramedic and the AT retrieval doctor, Dr Choi, as per AT protocol.

Active bleeding, major trauma/surgery within the previous six weeks and prior intracranial haemorrhage (ICH) are contraindications for thrombolysis.³ The AT and LGH teams were unaware of the history of head strike and the potential of Mrs Phillips to have suffered an ICH in the fall. They were aware that she had fractured her ribs.

¹ A STEMI is ST segment elevation myocardial infarction (heart attack).

² Thrombolysis is a treatment protocol in which drugs are introduced to break down clots to achieve rapid reperfusion of the heart.

³ The clot dissolving capability of thrombolysis can cause the breakdown of clotting in other areas of the body beyond the heart including the brain causing haemorrhage.

Following thrombolysis Mrs Phillips developed symptoms of a headache, facial drooping, confusion, and her movements became uncoordinated. A CT scan demonstrated subdural haemorrhage (SDH)⁴ which resulted in Mrs Phillips transfer to the Intensive Care Unit. A repeat CT scan demonstrated increased volume of the SDH and new brainstem and intraventricular haemorrhages. In consultation with Mrs Phillips' family the decision was made for cessation of active treatment and transition to comfort care.

- c) Mrs Phillips' cause of death was intracranial (subdural, intraventricular and brainstem) haemorrhage.
- d) Mrs Phillips died on 21 December 2022 at Launceston, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavit as to identity;
- Opinions of the forensic pathologist;
- Medical records;
- AT records and recordings;
- Affidavit of Richard John Phillips;
- Report of Dr Anthony Bell; and
- Letter from the Department of Health, Professor Dinesh Arya.

Background

When she died Mrs Phillips was 77 years old (date of birth 27 August 1945). In her youth she had trained and graduated as a registered nurse and travelled to and worked in several countries around the world. Upon returning to Australia she joined the Australian Air Force as a nursing officer and moved to Malaysia in 1976. It was there she met and married her husband, Richard. Upon her return to Australia in 1978 she and Richard worked in different areas of Australia before settling in Devonport Tasmania in 2009. Mrs Phillips and Richard had two daughters, Angela and Amanda and, by the time of her death were grandparents to six grandchildren.

Mrs Phillips is described as having led an active and healthy lifestyle throughout her life. On 20 January 2021, she suffered a STEMI at home. AT attended and she was taken to the

⁴ A type of ICH where the bleeding is between the brain and the skull.

Mersey Community Hospital (MCH) where she underwent successful thrombolysis. On 20 January 2021 she was transferred to the Launceston General Hospital (LGH) and a left heart catheterisation and angioplasty to the mid right coronary artery and implant of a stent were performed, also successfully.

Mrs Phillips suffered a prolapse and as a result underwent surgical repair with no complications on 9 November 2022.

On 12 December 2022 Mrs Phillips was home alone, Richard was away. She was decorating their home for the upcoming arrival of her two daughters and their families for Christmas. Mrs Phillips was using a step ladder when she fell from the ladder onto the floor. She was taken by neighbours to the MCH and was seen in the emergency department. She described standing on the third step of a ladder, her last recollection was reaching up to a cupboard and then waking laying on her back on the carpet floor. She had palpable pain at her left lateral ribs worse on inspiration. The duration of unconsciousness was not known and she denied recent dizziness/chest pain/nausea/shortness of breath/diaphoresis. She was described in the notes of the emergency department as having nil evidence of head strike, no headache or evidence of a head injury and a Glasgow Coma Scale (GCS) score of 15. A CT scan of the chest and upper abdomen was performed and revealed acute mildly displaced fracture of the left 5th and 7th lateral ribs. A scan of the brain was not performed. Mrs Phillips was admitted overnight for observation and discharged home on 13 December 2022.

Whilst on examination there was no evidence of a head strike and Mrs Phillips' symptoms all related to her fractured ribs the potential for head injury was evident. I have been assisted by the report of Dr Anthony Bell, Medical Advisor for the Coronial Division, who has observed that in the circumstances of a fall involving an elderly person and where there was sufficient force to cause two ribs to fracture, it is a "difficult call"⁵ to exclude an ICH by the absence of symptoms. Symptoms of an ICH may take some time to become overt.

Following her discharge from MCH Mrs Phillips was attended to again by AT the following day due to ongoing pain. Her neurological examination was normal. She refused transport to hospital.

On 20 December 2022 Mrs Phillips was at home. Also at home were Richard and their two daughters, their partners and the grandchildren. Mrs Phillips started to experience severe chest pain and vomiting. AT were called and arrived at the home promptly.

⁵ Report of Dr A J Bell dated 10 October 2023 p3.

A paramedic on site liaised with Dr Choi by telephone. I have been provided with and listened to the recordings of the calls made between the onsite paramedic, Dr Choi and the cardiology registrar of the LGH. Those recordings reflect that the paramedic relayed to Dr Choi a current history of central crushing chest pain and a past history of right sided infarct 18 months previously, investigation by her General Practitioner of recurrent falls, the fracture of two ribs on the left one week previously and she had a recent prolapse of the bladder repaired in November 2022. Dr Choi confirmed Mrs Phillips was experiencing a high lateral STEMI based on ECG results and advised she needed thrombolysis. He sought information as to the existence of any contraindications. The November 2022 prolapse surgery and the 12 December 2022 fracture of the ribs were raised and discussed. Dr Choi was then advised by the on-scene paramedic that “...other than that we are all clear for the rest of the checklist. They are her only significant medical problems”.

In the circumstances of a STEMI AT have in place a written protocol to be followed (STEMI Care). STEMI Care states that focus should be on achieving reperfusion of the heart muscle through either thrombolysis or PPCI, that access to that treatment is time sensitive as with time the “clot matures” rendering thrombolysis less effective, the AT retrieval consultant must be contacted in all cases and a checklist should be completed for patients.

The checklist is incorporated in the AT’s Reperfusion Checklist and Thrombolysis Informed Consent document (the Checklist) and lists the contraindications to thrombolysis as:

- Active bleeding or bleeding disorder;
- Severe, uncontrolled hypertension (BP >180/110 mmHg);
- History of major trauma or surgery within the previous 6 weeks;
- Gastrointestinal or genitourinary bleeding within the previous 2-4 weeks;
- Stroke/TIA within the previous 12 months;
- Prior intracranial haemorrhage at any time;
- Suspected Aortic Dissection; and
- Known malignant intracranial neoplasm.⁶

To highlight the significance of the contraindications they are identified, in bold, as “absolute contraindications to thrombolysis” in the Checklist. Similar protocols have been issued by The Tasmanian Health Service for the management of a patient with a STEMI.⁷ Those protocols also identify and highlight contraindications for thrombolytic therapy. Absolute

⁶ AT Reperfusion Checklist and Thrombolysis Informed Consent protocol.

⁷ ST Elevation Myocardial Infarction (STEMI) Reperfusion Management and Code STEMI pre-Notification protocols.

contraindications are listed in the protocols in the same terms as the Checklist. Relative contraindications are also listed in the THS protocols as:

- Current anticoagulants (including warfarin and novel anticoagulant agents);
- Traumatic or prolonged CPR (greater than 10 minutes);
- History of chronic, severe, poorly controlled hypertension;
- Advanced liver disease;
- Advanced metastatic cancer;
- Non-compressible vascular punctures; and
- Pregnancy or within one week postpartum.

The contraindications to thrombolysis identified and discussed on the telephone between Dr Choi and the onsite paramedic, as identified earlier in these findings, were the current fracture of Mrs Phillips' ribs and her recent, albeit minor surgery. Given that the surgery had occurred longer than one month previously thrombolysis was approved.

The AT Checklist directs that the patient must read or have read to them information which includes that thrombolysis can cause serious side effects including life-threatening stroke (about 1% of patients) and other, not life threatening, significant bleeding (about 4%) and provide their informed consent to the therapy.

To the knowledge of the treating AT and LGH teams "absolute" contraindications for thrombolysis were not present. The November 2022 prolapse surgery was considered minor. The potential for there to have been a prior ICH was unknown to them. Whilst the AT retrieval doctor and paramedic were aware of the fractured ribs and the mechanism for them being a fall they did not have a history from Mrs Phillips of a head strike or the potential for an ICH. It is not known if Mrs Phillips was specifically asked if she had struck her head or had a prior ICH but if she had, given her the history she gave when she attended at the MCH following the fall, it is unlikely she would have given a history of head strike to AT and in the absence of a head CT scan would have not been advised of or become aware of having suffered an ICH.

The failure to have taken a head CT scan at the MCH and identify if Mrs Phillips had suffered an ICH was a lost opportunity to identify the existence of an "absolute" contraindication to the use of thrombolysis two weeks later. It is likely, given the subsequent events following the delivery of the thrombolysis, that had Mrs Phillips been given a CT scan of her brain on 12 December 2022 at the MCH it would have revealed that she had suffered a small ICH. Mrs Phillips would have as a result knowledge of having suffered an ICH which she could

have provided as history to the AT and LGH on 20 December 2022. Further the record of the CT scan, demonstrating the ICH, would have been accessible by Dr Choi and the cardiac team at LGH alerting them to the existence of an absolute contraindication to the therapy.

Given Mrs Phillips' medical course, following her discharge from the MCH on 13 December 2022 until the 20 December 2022 STEMI the ICH had likely clotted. The introduction of the clot dissolving properties of the thrombolysis protocol likely caused that clotting, in addition to the intended clot in the artery to the heart, to dissolve. Whilst the treatment was an effective response to the STEMI resulting in rapid reperfusion of her heart it had the unintended consequence of causing an ICH resulting in Mrs Phillips' death.

Comments and Recommendations

The AT and LGH teams involved in the care of Mrs Phillips following her STEMI and subsequent intracranial haemorrhages provided Mrs Phillips with appropriate care based on the history known to them.

Had the MCH undertaken a CT scan of the brain when Mrs Phillips attended the emergency department after her fall on 12 December 2022 to determine if there was an intracranial bleed and if such a bleed had been identified, thrombolysis would not have been offered given that a history of intracranial bleed, is an absolute contraindication to such therapy and its existence would have been known at least by her and her family and may have been discoverable by the LGH team from her medical record.

Dr Choi and the AT paramedic were alert to the need to consider carefully the potential for contraindications to thrombolysis and did so on the basis of the history then known to them. Had a past intracranial bleed been identified, noting previous ICH is an absolute contraindication for thrombolysis, it is unlikely that they would have proceeded with that therapy.

At the time of presenting to the emergency department of MCH Mrs Phillips was 77 years old, provided a history of a fall from height and consequent loss of consciousness for an unknown period and was found to have suffered a fracture of two ribs indicating there was not insignificant force to her impact with the floor. Symptoms of an ICH can be silent. Risk of an ICH in an elderly brain can be high. In the circumstances of Mrs Phillips presentation to the MCH on 12 December 2022 Mrs Phillips should have been offered and undergone a CT scan of the brain. MCH ought to have in place written procedures requiring CT scanning of the brain in circumstances such as those in which Mrs Phillips presented; a fall of some force

and a loss of consciousness, regardless of the absence of overt signs and symptoms of head injury.

A copy of these findings in draft were provided to the Department of Health for their comment. I have considered the Department's response which took the form of a letter from Professor Dinesh Arya, Deputy Secretary, Clinical Quality, Regulation and Accreditation and Chief Medical Officer, dated 16 January 2025. Dr Arya notes that at the time of Mrs Phillips attendance at the MCH on 12 December 2022 she did not present with signs nor symptoms suggesting the suffering of a head injury including scalp hematoma, neurological deficits, altered level of alertness over a significant period of observation, abnormal behaviour, including agitation or other significant behavioural changes or vomiting indicating increased intracranial pressure. Whilst I accept that the decision not to scan the brain was taken in light of this presentation as I found earlier in these findings Mrs Phillips was an elderly person, had fallen from a height with sufficient force to fracture ribs and with a brief period of loss of consciousness. The absence of the signs and symptoms of a head injury identified by Dr Arya, whilst an indication, do not necessarily and completely exclude the suffering of an ICH. Dr Arya notes that if a CT scan had been undertaken at the MCH it may not have conclusively demonstrated an ICH but would have assisted in achieving greater clinical certainty. Accordingly he advises that necessary protocols are now in place to ensure that a person with a clinical presentation similar to Mrs Phillips (with a history of a fall at her age and a history of loss of consciousness) consideration will be given to a CT scan of the brain.⁸

Dr Arya further notes, and I accept that it is not possible to be definitive about whether Mrs Phillips did suffer an ICH following the 12 December 2022 fall and if a CT scan taken at the time would have detected it. The alternative explanation exists that she was in the very small percentage of cases, approximately 1%, that develop ICH as a consequence of thrombolytic therapy. Nevertheless had Mrs Phillips been given a CT scan at the MCH on 12 December 2022 the opportunity to have a clearer clinical picture available at the time of deciding whether to provide thrombolytic therapy, including a recent fall involving loss of consciousness, was lost.

The circumstances of Mrs Helen Phillips' death are not such as to require me to make any further comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.

⁸ Letter Department of Health 16 January 2025.

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

Dated: 17 March 2025 at Hobart, in the State of Tasmania.

Leigh Mackey
Coroner