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 a death of Jim Orton-Tracey

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

a) The identity of the deceased is Jim Orton-Tracey;
b) Mr Orton-Tracey died in the circumstances described below;
c) The cause of death was massive pulmonary embolism; and
d) Mr Orton-Tracey died on 23 March 2018 at Holwell in Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Orton-Tracey's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; an opinion of the coronial medical consultant; a police report of death; affidavits of identification and life extinct; and medical records and reports.

Jim Orton-Tracey was born in England on 17 September 1954. He was aged 63 years and was in good health with no known medical conditions. He was separated and was employed as a truck driver.

On Thursday 8 March 2018 Mr Orton-Tracey was travelling to work when his utility vehicle broke down. While pushing the vehicle off the road he felt a sudden pain in the back of his left calf. He attended his general practitioner and was referred to physiotherapy.

The following day, 9 March, Mr Orton-Tracey presented at the Emergency Department of the Launceston General Hospital (LGH) with ongoing pain in his calf. It was determined by ultrasound that he had ruptured his Achilles tendon. Mr Orton-Tracey was fitted with an equinus back slab below his knee and discharged with aspirin.

On Wednesday 21 March Mr Orton-Tracey was reviewed at the orthopaedic clinic at the LGH. The consultant surgeon, Mr Roger Butorac, recommended surgical repair at this time. Mr Orton-Tracey did not wish to have surgery. Mr Butorac then recommended an above knee cast for 4 weeks; Mr Orton-Tracey also refused this treatment. Therefore, a 'moon' boot with a heel raise was fitted with a review to take place in 4 weeks.

The following day, being 22 March, Mr Orton-Tracey complained of feeling unwell, including chest pain and back pain.

On Friday 23 March he continued to feel unwell, including pain down his arm. At around midday he called out to his son, Mr Tynan Tracey, for assistance. Mr Tracey found that his father was incoherent, appeared to be fainting and was unable to speak. He immediately called an ambulance and began CPR. On arrival, paramedics attempted resuscitation for approximately 30 minutes but without success. Mr Orton-Tracey was pronounced deceased at 1.55pm.

An autopsy was performed by pathologist, Dr Terry Brain. In Dr Brain's opinion the cause of Mr Orton-Tracey's death was massive pulmonary embolism due to an immobilised left leg due to a torn Achilles tendon. I accept Dr Brain's opinion as to cause of death.

Mr Orton-Tracey's case was reviewed by Dr AJ Bell, coronial medical consultant. Dr Bell stated that the only medical issue raised by this case is whether Mr Orton-Tracey should have been given prophylactic anticoagulation to prevent deep vein thrombosis and pulmonary embolism.

Dr Bell, in reviewing the literature, noted that there was no cogent evidence in the studies that anticoagulation reduced the risk of these conditions in respect of lower leg injuries and immobilisation. He concluded that the decision not to prescribe anticoagulants to Mr Orton-Tracey was reasonable. He was also of the belief that Mr Orton-Tracey received good quality medical care in the management of his condition. I accept his opinion.

Comments and Recommendations

The circumstances of Mr Jim Orton-Tracey's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the Coroners Act 1995.

I convey my sincere condolences to the family and loved ones of Mr Orton-Tracey.

Dated: 26 July 2018 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner