



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Noeline Dawn Howard

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

- a) The identity of the deceased is Noeline Dawn Howard;
- b) Mrs Howard died in the circumstances set out further in this finding;
- c) The cause of Mrs Howard's death was pulmonary embolism due to carcinomatosis;
and
- d) Mrs Howard died on 30 June 2017 at the Hobart Private Hospital, Tasmania.

Introduction

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

- An affidavit of Mr Leonard Howard, Mrs Howard's widower;
- A précis of Mrs Howard's medical records prepared by a forensic nurse;
- A report from a specialist respiratory physician;
- Mrs Howard's medical records from Rosny Doctors;
- Report of Death – Hobart Private Hospital; and
- Hobart Private Hospital Medical Records.

What a Coroner Does

- I. Before looking at the circumstances surrounding Mrs Howard's death, something should be said about the role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any "reportable death".¹ A "reportable death" includes a death where the death occurred in Tasmania and which occurs during a medical procedure, or after a medical procedure where the death may be causally related to that procedure, and a

¹ See section 21 of the *Coroners Act 1995*.

medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.² Mrs Howard's death meets that definition.

2. When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Coroners Act 1995* ('the Act') asks. Those questions 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.
3. A coroner does not have the power to charge anyone with crimes or offences arising out of the death the subject of investigation. Nor does a coroner have power to determine issues associated with inheritance or other matters arising from the administering of deceased estates.
4. As noted above, one matter that the Act requires is that 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.
5. 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
6. 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

² See section 3 of the *Coroners Act 1995*.

³ See *Harmsworth v The State Coroner* [1989] VR 989 at 996.

⁴ (1938) 60 CLR 336.

Background

7. Aged 76 years at the time of her death, married to Leonard in 1960, and mother of three adult children, Mrs Howard died on 30 June 2017. During her working life she ran the family home, raised the children and later worked as a cleaner and for Australia Post.⁵ Her death was not initially reported pursuant to the provisions of the Act and thus no autopsy or other standard post-mortem investigations could be conducted.
8. In fact, Mrs Howard's death was not reported until 23 August 2017 and then only as result of a review carried out by the Department of Health and Human Services.
9. The Act places an obligation on any person who has reasonable grounds to believe a death has not been reported to a coroner to report that death "as soon as possible to a coroner or a police officer".⁶ A failure to do so is an offence.

Circumstances of Death

10. Mrs Howard was taken by Ambulance from her home to the Hobart Private Hospital (HPH) on 24 June 2017, due to shortness of breath.⁷ Her medical records indicate that she had an extensive past medical history and suffered from a number of co-morbidities including type II diabetes, obesity and heart difficulties.
11. Her husband reported that in the last three months of her life, Mrs Howard had difficulty with breathing and seemed to have a constant cold. He offered to take her to hospital on a number of occasions but he said she would "flatly refuse". In the immediate lead up to her hospitalisation, Mrs Howard was under the treatment of her general practitioner mainly in relation to management of a leg ulcer. The ulcer had been treated conservatively. I am satisfied that it had nothing to do with her death.
12. Mrs Howard was initially seen in the Emergency Department (ED) of the HPH during the afternoon of 24 June 2017. At the time of her admission, her vital signs were a respiratory rate of 26 breaths per minute, oxygen saturations of 95% breathing room air, and 97% breathing supplemental oxygen at 2 L/min by nasal prongs. Her initial assessment triaged her at category 3. She was subsequently reviewed by a medical officer. Of note, bilateral basal crackles were heard on examination.

⁵ See affidavit of Leonard Charles Thomas Howard sworn 28 January 2018.

⁶ See section 19.

⁷ Précis of medical records prepared by forensic nurse L Newman, page 1.

13. Routine blood tests and a chest x-ray were carried out. The blood tests showed an increase in her white cell count and an elevated C-Reactive Protein (CRP) to 96.4. The chest x-ray was also abnormal. Although her medical records of the HPH do not document a diagnosis,⁸ she appears to have been treated with intravenous fluids, nebulised bronchodilators and antibiotics. No pharmacological prophylaxis against venous thromboembolism was prescribed initially.
14. In a report to me reviewing Mrs Howard's treatment at the HPH, Dr Richard Wood-Baker, a very experienced specialist in respiratory medicine, expressed the opinion that the chest x-ray abnormalities combined with the blood results were consistent with a diagnosis of community-acquired pneumonia possibly exacerbating an underlying COPD.⁹ Although not apparent from the HPH records, this appears to have been the diagnosis arrived at.
15. Mrs Howard's clinical condition, initially stable in the 24 hours following her admission, began to deteriorate. She had an episode of hypoglycaemia which was managed. I am satisfied on the evidence that her diabetes remained stable thereafter and did not contribute to her death.
16. On 26 June 2017, Mrs Howard's observations indicate she was symptomatically more breathless. Her respiratory rate was stable at 21 – 23 breaths per minute and her oxygen saturation, along with supplemental oxygen was, relatively speaking, stable.
17. A further blood test was carried out later in the same day. She was treated with a GTN patch for what was apparently considered to be a worsening pulmonary oedema.
18. Mrs Howard's clinical condition continued to deteriorate as the day wore on and a CT pulmonary angiogram (CTPA) was requested. The CTPA could not be performed because Mrs Howard was unable to lie flat. This was to prove potentially significant. I note that it does not appear that any alternative investigation such as an ECG was requested. I say this because there is no reference to such a course documented in Mrs Howard's medical records. I note that, at the very least, it would have enabled confirmation of the diagnosis of pulmonary oedema to be confirmed or not.
19. The following day, 27 June 2017, prophylactic anticoagulation was commenced.

⁸ HPH medical records.

⁹ Report Dr Richard Wood-Baker, 5 July 2018.

20. For a time, her condition remained stable. However, on 30 June 2017, a day after having been returned to the medical ward, a Medical Emergency Team call was made following an acute deterioration in Mrs Howard's condition. She was able to be resuscitated. An ECG and a CTPA were carried out; the latter showing multiple pulmonary emboli and pulmonary nodules.
21. Despite additional anticoagulation and further attempts to resuscitate Mrs Howard, she progressively became worse and died later the same day.
22. I have already mentioned that no-one involved in Mrs Howard's death reported the fact of her death in accordance with the *Coroners Act 1995*.

Discussion

23. It is apparent from Mrs Howard's medical records that she was diagnosed, first with community acquired pneumonia and then second, with pulmonary oedema. Unfortunately, both diagnoses were incorrect and there was, on any reasonable view, a delay in reaching the correct diagnosis of multiple pulmonary emboli and carcinomatosis (i.e. widespread cancer).
24. Dr Wood-Baker in his report expressed the opinion that "the outcome in this case has been contributed to by a delay in diagnosis, and anticoagulation treatment. The literature suggests that the short-term outcome may have been improved by an early, accurate diagnosis and treatment. Whether earlier prescription of venous thromboembolism prophylaxis during the admission would have been beneficial is unclear."
25. I accept Dr Wood-Baker's opinion. It is apparent, on the evidence, that there was a failure to correctly diagnose Mrs Howard's condition and as a consequence to treat it. What is less clear is whether earlier correct diagnosis would have changed the outcome for Mrs Howard.
26. This finding was sent, in draft, to the Hobart Private Hospital for comment. The Hospital's solicitors responded, disputing my jurisdiction to deal with the matter, as I understand that submission. The submission was based on a fundamentally flawed premise – that the term 'medical procedure' is not defined in the *Coroners Act 1995*. In fact it is. Section 3 provides:

“medical procedure means a procedure performed on a person by, or under the general supervision of, a medical practitioner and includes –

- (a) imaging; and*
- (b) an examination whether internal or external; and*
- (c) a surgical procedure”.*

27. In their submission, the Hospital’s solicitors set out the list of medical procedures that Mrs Howard underwent. They included: blood tests, a chest x-ray, the administration of IV fluids and various agents to stabilise hypoglycaemia and so on. Any suggestion that Mrs Howard did not undergo a medical procedure in terms of the *Coroners Act 1995* is a nonsense.
28. For death to be reportable, it need only be one that ‘*may*’ be casually related to the medical procedure and not reasonably expected. I do not understand the HPH to assert that Mrs Howard’s unfortunate death does not meet this test.
29. Finally, I have regard to the balance of the submissions received from the solicitors for the HPH in reaching these conclusions.

Comments and Recommendations

30. The circumstances of Mrs Howard’s death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.
31. I convey my sincere condolences to the family and loved ones of Mrs Howard.

Dated 11 August 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner