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 Catherine Diana Barnett

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

a) The identity of the deceased is Catherine Diana Barnett;
b) Ms Barnett died in hospital as a result of a right coronary artery thrombosis;
c) The cause of Ms Barnett's death was an acute myocardial infarct; and
d) Ms Barnett died on 13 March 2021 at Calvary Hospital, Lenah Valley in Tasmania.

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

- Police Report of Death for the Coroner;
- Calvary Health Care Tasmania – Death Report to Coroner
- Affidavits establishing identity and life extinct;
- Report – Dr Christopher Lawrence, Forensic Pathologist
- Report – Dr Anthony J Bell, Medical Advisor Coroner's Office;
- Medical records précis prepared by Ms Libby Newman, Forensic Nurse
- Medical Records – Augusta Medical Centre;
- Medical Records – Calvary Health Care Tasmania; and
- Letter, Calvary Lenah Valley Hospital 15 November 2021.

Introduction

Ms Barnett was aged 55 at the time of her death. She was in a long-term relationship and a mother of four children. Aside from being a smoker, Ms Barnett had no medical history of note.

Circumstances of death

At about 5.30 pm on Sunday, 7 March 2021, Ms Barnett went to the Emergency Department of Calvary Hospital in Lenah Valley. Her medical records kept by the Hospital indicate that she

described a 24 hour history of feeling unwell with particular aches and pains in the arms and chest with associated sweating. Noted in the history were episodes of vomiting.

Ms Barnett was examined and her vital signs recorded in her records. Her temperature was a maximum of 37.6°C, BP 135/80 mmHg and heart rate 80 bpm. The notes record her chest as being clear and heart sounds normal. Her abdomen and calves were not tender.

Blood tests were performed at about 7.00 pm. The results of that testing showed an elevated white cell count and slightly elevated monocytes. However Ms Barnett' C reactive protein was normal.

An abdominal CT scan was carried out which indicated possible acute cholecystitis.

Notably, no ECG was ordered or carried out.

Ms Barnett was kept in the ED overnight, treated with IV fluids and discharged the following morning. She rested at home for the next three days before returning to work on Thursday and Friday.

The following morning, Saturday, 13 March 2021, Ms Barnett was taken back to the Emergency Department at Calvary Hospital by her partner. She was lethargic, weak, sweating and pale. Staff assisted her to a cubicle where her blood pressure was found to be very low and she was tachycardic. Medical staff transferred her to the resuscitation area where IV fluids were commenced and a MET call made shortly afterwards. Resuscitation efforts were commenced and continued prior to Ms Barnett being transferred urgently to the hospital's Critical Care Unit. Shortly after her arrival in the Critical Care Unit, Ms Barnett suffered a cardiac arrest. Attempts at resuscitation included intubation and ventilation but were unsuccessful. Ms Barnett died at about 10.20 am.

Investigation

The fact of Ms Barnett's death was reported in accordance with the requirements of the *Coroners Act* 1995, although I note unlike hospitals run by the Tasmanian Health Service, Calvary Hospital does not utilise a Hospital Report of Death to the Coroner. I consider that there would be considerable merit in the hospital adopting such an approach.

In any event I return to Mrs Barnett's death. Following formal identification her body was taken to the mortuary at the Royal Hobart Hospital for autopsy. The Forensic Pathologist who carried out the autopsy, Dr Christopher Lawrence, provided a report in which he expressed the opinion that the cause of Ms Barnett's death was an acute myocardial infarction due to right coronary artery thrombosis. I accept Dr Lawrence's opinion.

The circumstances of Ms Barnett's death were reviewed by the Coronial Division Medico-Legal panel. As part of that investigation, her medical records were obtained and carefully reviewed. In addition, Ms Barnett's course of treatment was analysed by the Medical Advisor to the Coronial Division, Dr Anthony J Bell MB BS MD FRACPM FCICM. Dr Bell provided a report in which he said that:

> *"Chest pain, arm pain, sweating, lethargy and vomiting in a heavy smoker indicate a need to perform a more detailed medical history directed an [sic] ischaemic heart disease. An electrocardiogram was essential as was a troponin level (or two measurements). This should have led to the correct diagnosis and appropriate treatment."*

I accept Dr Bell's opinion. Ms Barnett presented to the emergency department of a hospital and reported symptoms consistent with a myocardial infarction. At the very least, an ECG should have been performed and her troponin levels tested. Had either, or both, been carried out, it is reasonable to conclude that the existence of her ischaemic heart disease would have been identified.

Instead, Ms Barnett was discharged home with an acute, undiagnosed and ultimately fatal condition.

These findings were sent, in draft, to Calvary Hospital for comment. A reply was received from the hospital, to which I have had specific regard. However, nothing in the letter from the hospital persuades me it is appropriate in any way to change the conclusions I have reached.

Comments and Recommendations

The circumstances of Ms Barnett'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 Ms Barnett.

Dated: 13 December 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner