



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 Aaron Douglas Frith

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

- a) The identity of the deceased is Aaron Douglas Frith;
- b) Mr Frith died as a result of right deep vein thrombosis following a repair of his ruptured right Achilles tendon;
- c) The cause of Mr Frith's death was a pulmonary embolism; and
- d) Mr Frith died on 20 September 2018 at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Frith's death. The evidence includes an opinion of the forensic pathologist who conducted the autopsy; the results of toxicological analysis of samples taken at autopsy; an opinion from the medical advisor to the coroner's office; a detailed affidavit by Mr Frith's mother Ms Jacqueline Edwards; relevant police and witness affidavits; and medical records and reports.

Mr Frith was born in Launceston on 24 July 1982, the son of Ms Jacqueline Edwards and Mr Murray Frith. He had an older sister. His mother reported that he sustained liver and head injuries when he was hit by a car aged 2, but appears to have made a good recovery from that incident.

He moved with his mother and sister to Margate in Southern Tasmania in 1988 after the divorce of his parents. He received his education in southern Tasmania. During his life he worked in a variety of jobs, was married and the father to two daughters Charlotte and Brooke.

Aged 36 at the time of his death Mr Frith had a recorded medical history of obesity and hypertension. A review of his medical records indicates that he did not consistently take the medication prescribed for his hypertension.

On 28 August 2018 he was running down the hill with his daughter Brooke at a scout event when he “felt something go” in his right calf. Later the same day his mother took him to the Calvary Hospital where he had a back slab applied, was supplied with crutches and referred for an ultrasound scan.

Mr Frith had the ultrasound on 30 August 2018. It showed he had suffered a full thickness tear of his Achilles tendon.

On 31 August 2018 Mr Frith’s GP referred him to the Emergency Department (ED) of the Royal Hobart Hospital. At the ED Mr Frith was placed in an equinus slab to immobilise his leg and commenced on an oral anticoagulant as deep vein thrombosis (DVT) and venous thromboembolism prevention. An appointment was made for Mr Frith at the hospital’s orthopaedic clinic.

Following his visit to the orthopaedic clinic surgery was performed on Mr Frith’s Achilles tendon on 15 September 2018. A plaster slab was applied after that surgery and aspirin was commenced as venous thromboembolism prevention. He was discharged home.

Three days later, on 18 September 2018, Mr Frith collapsed at home. He was assisted by his close friend Ms Emily Kate Smith. He refused Ms Smith’s suggestion that he be taken to the ED. Ms Smith subsequently told investigators that Mr Frith was lethargic and exhausted for the remainder of the day.

The next day, at 5.30pm, Mr Frith passed out whilst going to the toilet. Ms Smith was again present. She called an ambulance. The ambulance arrived at 6.20pm. Observations taken by paramedics showed a respiratory rate of 44 bpm, oxygen saturation 95% on ambient air, heart rate 120 bpm and blood pressure 124/84 mmHg. Mr Frith was transported to the Royal Hobart Hospital where a clinical diagnosis of a saddle pulmonary embolism was confirmed when a CT scan of the pulmonary arteries was carried out. He was transferred to the Intensive Care Unit of the Hospital.

After initially being stable, Mr Frith experienced a sudden deterioration at 2.38am on 20 September 2018 and died. Because Mr Frith’s death was sudden and unexpected, it was reported pursuant to the Coroners Act 1995. His body was formally identified and then transferred to the hospital’s mortuary. At the mortuary, an autopsy was carried out by forensic pathologist Dr Christopher Hamilton Lawrence. Dr Lawrence expressed the opinion that Mr Frith died as a consequence of a pulmonary embolism due to right deep vein thrombosis following the repair of his ruptured right Achilles tendon. I accept Dr Lawrence’s opinion. Samples taken at autopsy were subsequently analysed toxicologically at the laboratory of Forensic Science Service Tasmania. Nothing other than caffeine was detected as being present in those samples.

The circumstances of Mr Frith's death and the treatment he received in the lead up to it were investigated. I received a comprehensive report from Dr Anthony J Bell MB BS MD FRACP FCICM, medical advisor to the Coronial Division. Apart from looking at the particular circumstances of Mr Frith's medical management and death, Dr Bell's report focused in particular upon the circumstances in which prophylaxis is required to prevent pulmonary embolism.

Of Mr Frith's medical management, Dr Bell said that Achilles tendon rupture appears to be a reason to administer drug based prophylactic anticoagulation at least while the patient's leg is immobilised.

The question raised by Mr Frith's case is whether he should have been prescribed prophylactic anticoagulation to prevent his developing either a DVT and/or PE. Dr Bell's analysis of the literature in relation to this question suggests there is a continued debate about the benefit of such anticoagulation. He made the point however, that individualisation of prophylaxis should be a standard practice. In Mr Frith's case, given he was borderline morbidly obese (a well recognised risk factor in the circumstances) I am satisfied that an individualised approach called for the prescription of prophylactic anticoagulation.

Comments and Recommendations

The circumstances of Mr Frith's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act 1995*. I do however **comment** that the situation in relation to prophylactic anticoagulation with ruptured Achilles tendon treatment calls for an individualised approach.

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

Dated 30 September 2019 at Hobart in the State of Tasmania.

Simon Cooper
Coroner