IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2011 / 2323

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JOHN OLLE, Coroner having investigated the death of ANDREW JOHN GRIFFITH

without holding an inquest:
find that the identity of the deceased was ANDREW JOHN GRIFFITH
born on 21 May 1962
and the death occurred on 24 June 2011
at 129 Disney Street, Crib Point 3919

from:

1(a) ACUTE MYOCARDIAL INFARCTION

1(b) CORONARY ARTERY ATHEROSCLEROSIS WITH THROMBUS

Pursuant to Section 67(2) of the *Coroners Act 2008*, I make these findings with respect to the following circumstances:

1. Mr Andrew John Griffith was aged 49 years at the time of his death. He lived with his family at 129 Disney Street, Crib Point.

2. Mr Griffith was recently feeling unwell. On 22 June 2011, he presented to his long term General Practitioner, Dr Paul Muirden, of Balnarring Village Medical Clinic, complaining of anxiety and retrosternal chest pain which responded to Quickeze/Gaviscon. He was diagnosed with indigestion and prescribed Pariet. Dr Muirden also doubled Mr Griffith's dose of Citapralam antidepressant medication from 20mg to 40mg and performed a blood test, including a full blood examination, liver enzymes, creatinine and blood glucose levels, however no cardiac markers.

3. On 24 June 2011, Mr Griffith's wife, Claire, went shopping at 11.00am and returned at 1.00pm to find Mr Griffiths on the lounge, unconscious and not breathing. An ambulance was called and Mrs Griffith administered CPR. When Ambulance Victoria paramedics arrived CPR continued, however was unsuccessful.

Coroners Prevention Unit ("CPU[1]")

4. Mr Griffith had significant risk factors for heart disease. These risk factors included smoking, hypertension,[2] diabetes, hypercholesterolaemia[3] and a family history of heart disease and cardiac arrest at a young age.

5. On 12 November 2012, Mrs Griffith's wrote to the Coroner's Court to inform that in the days prior to her husbands passing, he was experiencing tingling in his hands and was not sleeping for fear of dying, not eating and having lots of showers to ease his heartburn.

6. At my request, CPU reviewed the medical management of Mr Griffiths, obtaining statements of Dr Muirden, and expert opinions of Dr Morton Rawlin, General Practitioner and Dr Guy Sansom, Emergency Physician.

STATEMENT OF DR PAUL MUIRDEN

7. Mr Griffith was a patient of the Balnarring Village Medical Centre, where Dr Muirden practised, since July 2006. He had a long-term history of anxiety, for which he was medicated and prevented him from working. Dr Muirden reported that Mr Griffith's was experiencing retrosternal discomfort with no breathlessness for some days, which was mild to moderate in intensity. He was not pale, sweaty or nauseated and the pain was unchanged with exercise, yet decreased with Gaviscon.[4] The vital signs of blood pressure, cardiac and chest auscultation were not documented in the medical record. However, Dr Muirden said they were within normal limits and that, as such, he did not make a record in his notes.[5]

8. Dr Muirden indicated that he accepted Mr Griffith's interpretation of his symptoms:

---

1. CPU is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.
2. High blood pressure.
3. High levels of cholesterol in the blood.
4. Report of Dr Muirden, dated 6 July 2012, 1.
5. Ibid.

> On the basis of the relationship between the use of Gavison and Quick-eze and his improvement in symptoms, my findings on examination and the responses to my questioning of Mr Griffiths I made a clinical diagnosis that his pain was caused by Oesophagitis.[6]

9. Dr Muirden considered that Mr Griffith's complaints might have been cardiac in origin. However, he did not perform an electrocardiogram because the clinical presentation, to him at the time, was an oesophageal problem.

10. Dr Muirden reported that Mrs Griffiths informed him on 29 June 2011 that her husband's condition worsened after the final consultation, however he minimised his symptoms to avoid hospital, and had not been accurate about the effect of Quick-Eze and Gavison, and that consequently, 'the situation was complicated by [Mr Griffith's] reluctance to be straightforward' with him.[7]

EXPERT REPORT OF DR MORTON RAWLIN

11. Dr Rawlin reported that the statement provided by Dr Muirden infers that an appropriate discussion occurred between Mr Griffith and Mr Muirden. He opined that due to Mr Griffith's reporting that the pain improved with antacids and was not worsened by exercise 'was a significant negative in deciding about cardiac aetiology'[8] and that Mr Griffiths unfortunately understated his pain, overstated the effect of the antacid and denied exercise exacerbation.[9]

12. Dr Rawlin reported that given this history, a diagnosis of gastro-oesophageal pain was possible. Although, he conceded, examination findings would likely be normal with upper abdominal soreness. He concluded that the investigations performed were reasonable given the diagnosis of ischaemic chest pain was ruled out. The results of the blood test were non-specific and non-diagnostic.

13. In a later report dated 4 January 2013, Dr Rawlin concluded that although the diagnosis may be obvious in retrospect, it is not obvious during the consultation. He accepted that Mr Griffith's downplaying of his symptoms was a major contributing factor to the misdiagnosis, rather than Dr Muirden's failure to follow the standard acute coronary syndrome diagnostic pathway.[10] Dr Rawlin conceded that the clinical management pathway was incorrect, due to

---

6 Report of Dr Muirden, above n 4, 2.
7 Ibid.
8 Report of Dr Morton Rawlin, dated 5 December 2012, 2.
9 Ibid.
10 Report of Dr Rawlin, above n 8, 1.

attribution of the wrong underlying cause of the symptoms, which led to a missed opportunity to perform an electrocardiogram and take blood to measure cardiac enzymes. This exemplifies an unfortunate set of circumstances which reiterates the importance of patients being full and frank with health practitioners so to ensure that the most appropriate medical treatment is administered.

REPORT OF DR GUY SANSOM

14. On 6 May 2013, Dr Sansom provided a report, in relation to the adequacy of Dr Muirden's clinical assessment, investigations performed, the differential diagnostic pathway followed as well as commenting on the opinion and conclusion made by Dr Rawlin in his reports.

15. Dr Sansom concurred with Dr Rawlin that the GP clinical management plan was appropriate to the working provisional diagnosis. In reviewing the 22 June 2011 medical record, Dr Sansom concluded that it was reasonable to diagnose a gastro-oesophageal cause. Although there were no detailed GP notes confirming the symptoms, examination and plan for clinical management, Dr Sansom defended the absence of Dr Muirden's record documentation by explanation of Dr Muirdens' familiarity with the patient.[11]

16. Notably, Dr Sansom opined:

> If a cardiac cause were suspected, testing would very likely have revealed a heart attack had occurred (probably one week earlier). The reluctance of the patient to share all his symptoms with the doctor can make it impossible for a doctor to reach the correct conclusion unless the doctor suspects that this is occurring. His wife believes that this may in part have been due to a fear of hospitals.[12]

17. Dr Sansom recommended that doctors better document their assessment, management and follow-up plans, to assist that doctor, or a different doctor that may see the patient, at a later date. He also reiterated the importance of continuing public health campaigns for patients to seek medical advice at the onset of severe chest pain.[13]

CONCLUSION

18. Expert opinions provided by Dr Rawlin and Dr Sansom, respectively, concur with the statement provided by Dr Muirden, that it was reasonable to diagnose a gastro-oesophageal cause of Mr Griffith's pain. A cardiac cause would have been determined if an

---

11 Report of Dr Sansom dated 6 May 2013, 4.
12 Ibid 4.
13 Report of Dr Sansom, above n 11, 4.

electrocardiogram and blood testing for cardiac enzymes were performed. However, sadly, due to Mr Griffith not being entirely full and frank with Dr Muirden regarding his symptoms and level of pain/discomfort, in conjunction with his understatement regarding the effect of the antacids, the cardiac cause was not identified.

19. I am satisfied that whilst Dr Muirden did not record a detailed clinical plan documenting assessment, management and follow-up in Mr Griffith's medical record, this may well be due to his familiarity with Mr Griffith, who has been a patient at Balnarring Village Medical Clinic since July 2006. As Dr Sansom conceded, supplementary notes, as opposed to extensive notes, is not uncommon and can be the standard practice for a well-known patient. However, this matter does emphasise the significance of documenting a clearly articulated management plan if symptoms are unrelieved by the implemented treatment, and the importance of vital sign documentation in every patients medical record.

20. This matter also highlights the importance of heightening public awareness of heart attack warning signs. There is an ongoing need to publicly campaign for patients to seek medical advice at the onset of severe chest pain, so that symptoms can be quickly and accurately identified and medical treatment administered as soon as possible.

21. I am satisfied that no further investigation is required.

Post Mortem Medical Investigation

22. On 24 June, 2011 Dr Melissa Baker, Forensic Pathologist at The Victorian Institute of Forensic Medicine performed an autopsy. Dr Baker formulated the cause of death as:

    1(a) Acute myocardial infarction; and

    1(b) Coronary artery atherosclerosis with thrombus.

    Dr Baker commented:

    > The deceased's recent presentation to his general practitioner (two days before death) with chest pain is noted. The age of the infarct as determined histologically is approximately one week.[14]

23. I find that Mr Andrew John Griffith died on 24 June 2011 and that the cause of his death was:

    1(a) Acute myocardial infarction; and

---

[14] Report of Dr Melissa Baker, dated 30 August 2011, 10.

1(b) Coronary artery atherosclerosis

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations connected with the death:

I recommend that the Royal Australasian College of General Practitioners:

1. Promote utilisation of the National Heart Foundation educational resources on signs of a heart attack.

2. Emphasise the importance of a clearly articulated management plan if symptoms are unrelieved by the implemented treatment.

3. Emphasise the importance of vital sign documentation in the medical record.

4. Emphasise the dangers of accepting an anxiety disorder as an explanation for clinical symptoms.

I direct that a copy of this finding be provided to the following:

The Family of Mr Andrew Griffith;
Mrs Dianne Field;
The Royal Australasian College of General Practitioners; and
Investigating Member, Victoria Police.

Signature:

JOHN OLLE
CORONER
Date 4 February 2014