IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 004611

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of: Mohamed HAMZA

Delivered On:	21 August 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street SOUTHBANK Vic 3006
Hearing Dates:	16, 17 and 18 March 2015
Findings of:	Coroner Rosemary Carlin
Representation:	Mr Patrick Over for Mrs Odet Hamza Ms Anna L Robertson for Dr Catherina Audish
Police Coronial Support Unit	Sergeant Sharon Wade, Coroner's Assistant

I, ROSEMARY CARLIN, Coroner,
having investigated the death of MOHAMED HAMZA
and having held an inquest in relation to this death at MELBOURNE
on 16, 17 and 18 March 2015
find that the identity of the deceased was MOHAMED HAMZA
born on 5 April 1971
and that the death occurred on 7 December 2011
at 14 Salween Crescent, Roxburgh Park, Victoria 3064
from:
1(a) CORONARY ARTERY ATHEROSCLEROSIS

In the following circumstances:

INTRODUCTION

1. Shortly after 7 p.m. on 7 December 2011, Mohamed Hamza suffered a major heart attack and died in his backyard. He was 40 years old. Earlier that day he attended his general medical practitioner complaining of chest pain and was told it was likely musculoskeletal.

2. An inquest was held to examine the adequacy of the medical management of Mr Hamza.

BACKGROUND[1]

3. Mr Hamza was born on 5 April 1971. At the time of his death he lived in Roxburgh Park, Victoria with his wife, Odet, their son, aged seven, and their twins, who were almost two.

4. Mr Hamza had been a patient of Somerton Road Medical Centre (**SRMC**) since 2006. After 11 September 2009, he always saw the same doctor, Dr Catherina Audish. Dr Audish was a medical practitioner with many years of experience in Iraq, New Zealand and Australia. She had worked in various hospital departments and as a general practitioner. She had medical degrees from Iraq, the United States and Australia. She began working as a general practitioner at SRMC in February 2009.

5. Mr Hamza's medical history included hypercholesterolaemia, but was otherwise unremarkable. He did not smoke and drank alcohol rarely. It appeared he was generally in good health.

[1] This section is a summary of uncontentious facts.

6. In August 2008, Mr Hamza had an episode of renal colic and at this time his cholesterol level was found to be markedly elevated (6.7mmol/L), with elevated LDL (4.8mmol/L) and triglyceride (1.8mmol/L) and a marginally satisfactory HDL (1.1mmol/L). His liver, renal and thyroid functions were normal. At this time, he was prescribed Lipitor 20mg daily.

7. In September 2009, Mr Hamza's cholesterol level was 7.7mmol/L, with both the LDL and HDL components higher than they were previously. His triglyceride was 1.7 mmol/L. The next month Dr Audish increased his dose of Lipitor to 40mg daily.[2] In July 2010 his total cholesterol and LDL were reduced to 5.8mmol/L and 3.5mmol/L respectively.[3] However, his triglyceride had increased and was elevated (2.9mmol/L) and his HDL had decreased and was slightly low (0.99mmol/L).

8. In September 2010, Mr Hamza informed Dr Audish that he did not take his Lipitor regularly, with the consequence that she was unable to alter his dose.

9. In the days before his death, Mr Hamza complained to his wife of intermittent mild chest pain. On 7 December 2011, Mr Hamza went outside to do some gardening. After a few minutes, he returned indoors and lay on the floor with his hand on his chest for about 5 minutes. He told his wife he was experiencing sharp chest pains that felt like stabbing and he was struggling to breathe normally.

10. Mrs Hamza telephoned SRMC and was advised to bring Mr Hamza to the clinic as soon as possible so that the duty nurse could review him. Mrs Hamza immediately drove Mr Hamza and their two youngest children to the clinic.

11. On arrival, the Hamzas reported to reception and then waited outside the treatment room, which was to the side of the reception area.

12. At 2.29 p.m., one of the practice nurses, Gulcin Erduran, saw Mr Hamza in the treatment room. Mrs Hamza was told there was not enough space for them all to be in the room and she waited at the door with the children who were in a double pram.

13. Mr Hamza told Ms Erduran he had three to four days of intermittent chest pain, but today the pain was central, stabbing in nature and radiated to his neck and arm.[4] During her

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[2] The SRMC clinical file, Exhibit E, appears to indicate this was reduced to 20 mg daily on 11 March 2010.

[3] Dr Angas Hamer noted in his statement dated 11 April 2014 that these changes were possibly due to intermittent use of medication and dietary changes.

[4] Transcript page 127. Ms Erduran's clinical notes did not mention arm.

consultation with Mr Hamza, Ms Erduran observed that he was alert, fully conscious and responded to verbal commands. She recorded his vital signs, being blood pressure (129/80), pulse (92 regular), respiration (18)[5] and temperature (36.3 degrees celcius).

14. Ms Erduran performed an electrocardiogram (**ECG**). This involved the attachment of 10 leads to Mr Hamza's body and required him to remove his shirt and lie down on the bed. During the ECG, Ms Erduran noticed a bruise on the left side of Mr Hamza's chest. It was yellowish and appeared old. Mr Hamza told her the bruise was an old bruise sustained while he was playing with his son and it had nothing to do with his pain. After the test, Ms Erduran took the ECG to Dr Audish who was consulting with another patient in the next-door room. Mr Hamza remained lying on the couch waiting to see Dr Audish.

15. Dr Audish observed that the ECG was normal. She then saw Mr Hamza in the treatment room before asking Mr and Mrs Hamza to come into her consulting room. She opened her computer file for Mr Hamza at 2.56 p.m. and closed it 10 minutes 47 seconds later. Dr Audish was told that Mr Hamza had not been taking his Lipitor 'for a while'.[6] She advised the Hamzas that Mr Hamza was likely suffering muscular pain and that he should take Nurofen or Panadol. She ordered various tests not relating to his heart, including blood cholesterol levels. She also referred him to the cardiology department of the Northern Hospital for a non-urgent stress test.

16. At approximately 3 p.m., the Hamzas left Somerton Medical Centre reassured that Mr Hamza's pain was not serious. They collected their son from school and returned home. At approximately 6.45 p.m., Mrs Hamza left the house to go to the local shops. Mr Hamza sat in the backyard with his children.

17. At 7.13 p.m., Mr Hamza's son called 000 after finding his father collapsed in the backyard. Ambulance paramedics attended at 7.27 p.m. and observed Mr Hamza to be unconscious, pulseless and non-breathing. Resuscitation was not attempted as Mr Hamza was already deceased.[7]

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[5] The respiration was not recorded in her clinical notes.

[6] Statement of Dr Audish dated 6 March 2012.

[7] Statement of Stuart North dated 4 September 2013, page 1.

POST MORTEM EXAMINATION

18. An autopsy of Mr Hamza's body was undertaken by Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine. The examination revealed a thrombus occluding an atherosclerotic coronary artery with no associated infarction. According to Dr Burke the occlusion would likely have caused acute myocardial ischaemia leading to a sudden cardiac arrhythmia (heart attack) and sudden death. Dr Burke determined the cause of death to be coronary artery atherosclerosis.

19. During his examination, Dr Burke noted a greenish bruise on Mr Hamza's left lateral chest, 8cm to the left of the mid line and measuring 4cm x 3cm.

CORONIAL INVESTIGATION

General purpose of a coronial investigation

20. Section 67 of the *Coroners Act* 2008 (the Act) requires a coroner investigating a reportable death[8] to find, if possible:

    a. the identity of the deceased;

    b. the cause of death; and

    c. the circumstances in which the death occurred.[9]

21. *Cause* of death in this context is accepted to mean the medical cause or mechanism of death. The *circumstances* in which death occurred is confined to background or surrounding circumstances which are sufficiently proximate or causally related to the death.

22. Under the Act, coroners have another important function and that is, where possible, to contribute to the reduction in number of preventable deaths and the promotion of public health and safety by way of making comment or recommendations about any matter connected to the death they are investigating.

23. When a coroner examines the circumstances in which a person died, this is not to lay blame or attribute legal or moral responsibility to any individual or institution. Rather, it is to determine causal factors and identify any systemic failures with a view to preventing, if

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[8] Reportable death is defined in Section 4 of the Act. Most commonly it refers to unexpected, unnatural or violent deaths, or deaths resulting from accident or injury.

[9] Section 67 of the Act provides that a coroner need not make findings as to circumstances if an inquest was not held, the deceased was not in state care and there is no public interest in doing so.

possible, deaths from occurring in similar circumstances in the future. Coroners do not make determinations of guilt or negligence; they are the province of other jurisdictions. Indeed, the Act specifically prohibits coroners from making a finding or comment that a person has, or may have, committed an offence. A coroner should set out relevant facts, leaving others to draw their own conclusions from the facts.

24. Although it will sometimes be necessary to examine whether particular conduct falls short of acceptable or normal standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor or a mere background circumstance. That is, an act or omission will not usually be regarded as contributing to death unless it involves a departure from reasonable standards of behaviour or a recognised duty. Otherwise, many perfectly innocuous preceding acts or omissions would be causative, even though on a common sense basis they have not contributed to death.

25. When the conduct of a professional person is under scrutiny, it is to be judged according to the prevailing standards of their particular profession or specialty. Further, it is important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person acted appropriately.

26. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities with the *Briginshaw* qualification.[10] A finding that a person has caused or contributed to death should only be made after taking into account the possible damaging effect of such a finding upon the character and reputation of that person and only if the evidence provides a comfortable level of satisfaction as to the finding.

27. The *Briginshaw* qualification is of particular significance in this case as the professional conduct of a medical practitioner falls to be examined. Given the serious consequences for such a professional person of an adverse finding or comment by a coroner, such comment or finding should not be made without clear and cogent evidence.[11]

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[10] *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336, especially at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...."

[11] *Anderson v Blashki* [1993] 2 VR 89 at 95 and *Secretary to the Department of Health and Community Services v Gurvich* at 74.

HISTORY OF THIS INVESTIGATION

28. Mr Hamza's death was reported to the Coroner on 7 December 2011. His death was unexpected and as such, clearly reportable under the Act.

29. By letter dated 12 January 2012, Mrs Hamza raised a number of concerns with the Coroners Court in relation to the medical care of her husband on the date of his death. A previous Coroner commenced an investigation and Sergeant Sharon Wade from the Police Coronial Support Unit assisted in preparing a coronial brief of evidence. The coronial brief included statements from Dr Audish, Ms Erduran and Ms Tabacco as well as an independent expert report from Associate Professor Morton Rawlin as to Dr Audish's medical management. Solicitors for Mrs Hamza and Dr Audish filed further expert medical reports on the same issue.

30. I took over the investigation in January 2014. Inter alia, I obtained a further report from Associate Professor Rawlin. Solicitors for Mrs Hamza and Dr Audish also filed additional expert medical reports. I conducted a mention hearing on 17 November 2014 and an inquest on 16, 17 and 18 March 2015. Submissions were filed by interested parties on 19 June 2015.

SOURCES OF EVIDENCE

31. This finding is based on the totality of the material the product of the coronial investigation of Mr Hamza's death. This includes the coronial brief (version 5), the oral evidence of all witnesses who testified at inquest, any documents tendered at inquest and the final submissions of Counsel who appeared. It is unnecessary to summarise all of this material. It will remain on the Court file.[12] I will refer only to so much of it as is relevant or necessary for narrative clarity.

FINDINGS AS TO UNCONTENTIOUS MATTERS

32. There were no issues in relation to Mr Hamza's identity, the date and place of his death, nor the medical cause of his death.

33. I formally find that Mohamed Hamza, born on 5 April 1971, aged 40, died at 14 Salween Crescent, Roxburgh Park, Victoria, on 7 December 2011 from coronary artery atherosclerosis.

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[12] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

34. As is often the case the primary focus of the coronial investigation and inquest into Mr Hamza's death was the circumstances in which he died, specifically the adequacy of his medical management on 7 December 2011. Particular issues were whether Mrs Hamza should have been advised to call an ambulance when she called SRMC and whether Dr Audish's assessment and treatment was appropriate.

35. At inquest evidence was given by Mrs Hamza, Ms Tabacco, Ms Erduran, Dr Audish and a panel of five medical experts retained by the Court and parties. The panel comprised three General Practitioners: Associate Professor Morton Rawlin, Dr Diane Chambers and Dr James Lynch; a Cardiologist, Dr Angus Hamer; and an Emergency Physician, Associate Professor Graeme Thomson. These medical experts gave their evidence concurrently, a procedure commonly referred to as a *'hot tub'*.

Telephone call to SRMC

36. According to Mrs Hamza when she telephoned SRMC on 7 December 2011, she spoke to 'Connie'. She knew this because Connie identified herself and further she knew Connie very well because the whole Hamza family were patients of the clinic.[13] She told Connie exactly what had happened (Mr Hamza on the floor with severe pain to his chest) and Connie told her to bring Mr Hamza to the clinic.

37. Connie Tabacco was SRMC's practice manager. At the time of the Inquest she had been the practice manager for 5 years and before then she was a receptionist at SRMC for 4 years. She had no medical training. She described SRMC as an extremely busy practice with 5 receptionists employed on any day. Her office was next to the reception desk. Although she was a practice manager, not a receptionist, she did sometimes take calls if the clinic was very busy.

38. Ms Tabacco recalled seeing the Hamza family at the clinic on 7 December 2011, but did not recall speaking to Mrs Hamza on the telephone. She did not deny that she had done so, but stated that if Mrs Hamza had relayed to her that Mr Hamza was lying on the floor clutching his chest she would have advised her to call an ambulance immediately.

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[13] Her actual evidence was that Connie knew her very well, but it amounts to the same thing.

39. Mrs Hamza first nominated 'Connie' as the person who answered her call in her letter to the Court of 12 January 2012. By contrast, Ms Tabacco's statement was made 21 months after the event (on 21 September 2013) and did not mention a telephone call from Mrs Hamza. Her evidence was that she had not read Mrs Hamza's statements and at the time she made her statement she did not know it was alleged that she had answered the call from Mrs Hamza. She could not recall when she first learned of this assertion, however, it appeared it may have been in the witness box, more than three years later. In the circumstances and taking into account Mrs Hamza's certainty and Ms Tabacco's uncertainty, I accept that it was Ms Tabacco to whom Mrs Hamza spoke.

40. As to what was said, however, it is less clear. One would expect that if Mrs Hamza had described the situation as she stated, Ms Tabacco would have advised Mrs Hamza to call an ambulance or done so herself.

41. Given the events, it is highly improbable that Mrs Hamza would not have told Ms Tabacco that Mr Hamza had chest pain. If she said nothing else, I am satisfied that Mrs Hamza at least said that. Appropriate triage, according to the expert panel, would have been for Ms Tabacco to put the call through to a nurse or doctor. Alternatively, if Ms Tabacco had followed the triage sheet now used at the clinic, she would have advised Mrs Hamza to call 000 rather than attend the clinic. Clearly, she did neither.

Staff training at SRMC

42. According to the evidence of the expert medical panel, most General Practice clinics would train their staff at staff meetings, as it is part of the accreditation process. This training would cover appropriate telephone triage. Clinics should also have written flow charts to guide their staff. In the event a telephone call is received from a patient complaining of chest pain the panel agreed that if it was clearly an emergency an ambulance should be called, but otherwise the call should be transferred to a doctor or nurse to assess the patient.

43. Ms Tabacco, although practice manager, was somewhat vague on the details of training given to SRMC staff. She agreed that although the clinic Practice Manual was a training manual given to staff, it was unedifying as to how staff should deal with calls from patients complaining of chest pain. She said that if there was an urgent medical matter a staff member would not refer to the Practice Manual, rather they would ask a person nearby or contact the nurse. Further, she said *'our doctors always - are constantly speaking to the girls'* about how

to handle medical emergencies[14] and *'we have regular staff meetings and these situations are discussed'*[15].

44. Ms Tabacco also said that the clinic had a triage sheet for receptionists with instructions to call 000 in the event someone reports chest pain, but she was not 100% certain whether this was the case in 2011.[16]

45. It emerged during the Inquest that Dr Audish was only an employee of SRMC, which was owned by two other doctors. She claimed not to know what training or instructions were given to SRMC receptionists, nor of the triage sheet. She had not read the Practice Manual and doubted she had ever seen it.[17]

46. As the owners of the SRMC were not present at the Inquest, I have no evidence as to what, if any, training they gave their staff as to how to deal with potential medical emergencies on the telephone.

Whether Mr Hamza had pain at Somerton Road Medical Centre

47. According to Mrs Hamza, after the initial episode when he was on the ground Mr Hamza continued to have chest pain and shortness of breath. Although the pain was constant, the intensity varied and it was no longer stabbing. She described him holding his chest whilst waiting to be seen at the clinic. About 5 or 10 minutes after checking in, Mrs Hamza approached the reception desk again and asked how long it would be before her husband saw the nurse or doctor because he was still having pain in his chest and difficulty breathing.

48. Ms Tabacco's evidence was that she saw Mrs Hamza at the reception desk. Mrs Hamza advised that her husband had refused to attend hospital despite his pain. Ms Tabacco noted that while Mr Hamza waited for a consultation, she observed that *'he seemed quite calm and was seated with his family, he was laughing with his kids for the brief wait, but under no*

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[14] Transcript page 78.

[15] Transcript page 86.

[16] Transcript p 56.19 and p 85.28 ff. She emailed a copy of the Triage sheet to the court after her evidence had finished. It is apparent on its face that this particular triage sheet could not have been in operation at the time of Mr Hamza's death as it bears the words 'Modified by Tasmania Medicare Local May 2012'. The document is even more stringent than the National Heart Foundation guidelines and indicates that in the event a patient calls reporting chest pain or shortness of breath the appropriate response is to "call 000".

[17] At the mention hearing on 17 November 2014, I raised as issues the appropriate procedure when a patient calls a medical practice complaining of chest pain and whether Mrs Hamza should have been advised to call an ambulance when she called SRMC. Dr Audish was represented at the mention hearing; however, her status as an employee at SRMC only became apparent during the Inquest.

circumstances was that patient demonstrating any signs of being in pain or discomfort'.[18] Mrs Hamza did not recall seeing Connie at the clinic, but denied being asked if they had attended hospital and denied the accuracy of Ms Tabacco's observations.

49. I prefer the evidence of Mrs Hamza on this point. Given the reason for his attendance at the clinic (without an appointment) and the unchallenged evidence of Mrs Hamza that she re-approached reception after 5 or 10 minutes to hasten the process, I find it unlikely that Mr Hamza was laughing and playing with his children whilst waiting to be seen. Further, there is no clear reason as to why he would have refused to attend hospital. I do not accept that his lack of vigilance in taking Lipitor translates into a reluctance to go to hospital.

50. Both Ms Erduran and Dr Audish describe Mr Hamza as being pain free at the time of their assessment. This is not reflected in their clinical notes.

51. The treatment room had two beds. Mr Hamza was placed in the far bed. This was a distance of 4 metres from the door.[19] The curtain was drawn around him to preserve his privacy. It is not clear whether there was a patient in the first bed.[20]

52. Ms Erduran said she invariably asks patients upon whom she is performing an ECG whether they have pain. She asks this both in relation to the application of the leads and in relation to their presenting pain. As to the latter, she says 'do you have the pain now?'. Mr Hamza said 'no' to both questions.

53. Dr Audish stated that the first she knew of Mr Hamza's presence in the clinic was when she saw the Hamza family sitting outside the treatment room. Mr Hamza looked comfortable and they exchanged smiles. She presumed they were there for vaccinations or similar. She learned that Mr Hamza was there to see her for chest pain when Ms Erduran brought the ECG report to her whilst she was attending another patient.[21]

54. Dr Audish described Mr Hamza as appearing comfortable and well when she saw him in the treatment room. He was not sweating. He told her that his pain had *'resolved'* shortly after he

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[18] Statement of Connie Tabacco dated 21 September 2013.

[19] Exhibit U, being an email from Ms Tabacco to the Court subsequent to giving evidence and confirmed by Dr Audish in evidence as a measurement that *'seemed accurate'*.

[20] Dr Audish said she thought there was and Ms Erduran could not recall.

[21] By contrast, in her statement dated 19 March 2012, Ms Erduran states that upon Mr Hamza detailing his history of pain, she notified Dr Audish who directed her to perform the ECG. The discrepancy is not significant except to demonstrate fallibility of memory.

arrived at the clinic. She could not remember his exact words.[22] She did not think Mrs Hamza would have been able to hear their conversation from the door.

55. When asked, Mrs Hamza could not recall if her husband was pale or sweaty, only that he was flustered from his breathing difficulties. She claimed she could hear conversations with her husband from the door of the treatment room. She denied being distracted by her twins, who were buckled into the pram and said her main focus was on her husband. Whilst disputing that Dr Audish had spoken to her husband in the treatment room at all, Mrs Hamza also conceded the possibility by saying *'I don't believe [she did]'* and *'I don't recall her talking to him at all, no'* and *'It could be possible but I don't think so'*.[23] In any event, she denied that Mr Hamza ever said that his pain had resolved. In evidence, she maintained that she heard him telling Ms Erduran that he had pain in his jaw and radiating up to his neck and down his left arm *'there and then'*.[24]

56. Mrs Hamza's oral evidence contrasts with her two statements. In her statement of 28 June 2013, she said:

> *Mohamed came out of the nurses room and told me he had spoken to the nurse about the stabbing pain in his chest, where the pain was located (in the upper left hand side of his chest) and that the pain was radiating up to his neck on the left-hand side, his left arm and the bottom of his jaw. He also said he had explained that he had shortness of breath.*
>
> *Mohamed was then taken by the nurse to have an ECG test done. He then returned to wait in the waiting room with me for the doctor.*

57. In her statement of 17 January 2014, Mrs Hamza stated:

> *I recall that after the ECG was performed, whilst waiting to see the doctor, Mohammad was lying down in the treatment room where the ECG had been performed. He was in there for about 15 minutes after the ECG was finished, lying on the treatment bed. I was sitting outside the room with the twins' pram but could see him and speak to him. I asked the nurse how he was, she said everything was normal. Mohamed stayed on the bed until Dr Audish came to take him into her consultation room. Generally, if feeling well, he would sit up in a chair in the waiting room with me.*
>
> *At no time during our attendance do I recall Mohamed saying that the pain in his chest had resolved.*

58. In neither statement did Mrs Hamza say she heard what her husband told the nurse. Moreover, the wording of each suggests that she did not hear the conversation. If she had,

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[22] Transcript page 367.

[23] Transcript pages 29 – 30.

[24] Transcript page 31.

there would have been no need for Mr Hamza to tell her what he had told Ms Erduran or for her to ask Ms Erduran about her assessment. It is also noteworthy that Mrs Hamza does not describe herself at the door in either statement although Ms Erduran and Dr Audish agreed that she was.

59. According to Mrs Hamza's statement of 28 June 2013, when they left the clinic Mr Hamza was *'still complaining of feeling uncomfortable in the chest and was still having difficulty breathing'*. When I asked Mrs Hamza specifically what her husband said about his pain after leaving the clinic she stated *'he just said... "I don't feel right." He just didn't look right...I knew there was something wrong with him I just didn't know what'*.[25]

60. I accept the evidence of Ms Erduran and Dr Audish that Mr Hamza told them he was pain free when they saw him in the treatment room. I am not persuaded Mrs Hamza was able to hear the conversation in that room. In my view, it is inherently likely that Ms Erduran asked Mr Hamza if he had pain, in the way she described. It is also inherently likely that Dr Audish did the same. The coincidence of their accounts suggests either truth or collusion and there is no convincing evidence of collusion.[26] Indeed, Dr Audish denied that she had 'subconsciously or intentionally' included details in her statement that did not happen.[27]

61. Further, the evidence of the expert medical panel indicates that it is not unusual for a patient who has experienced severe cardiac pain to be pain free by the time they present to a doctor. The fact, which I accept, that Mr Hamza's vital signs[28] and appearance were normal, whilst not decisive, is at least consistent with him not experiencing severe pain at the time. The panel evidence was to the effect that severe pain (of any type) could elicit a response of nausea and sweating, whilst severe chest pain could also include shortness of breath. I do not, however, accept Dr Audish's claim that Mr Hamza's normal ECG proved he was pain free, as Dr Hamer specifically contradicted this.[29]

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[25] Transcript page 46 and see page 44.

[26] Counsel for Mrs Hamza drew attention to the fact Dr Audish's statement of 6 March 2012 incorrectly gave her date of birth as Ms Erduran's. Whilst this does indicate some commonality in preparation of the statements, it does not indicate collusion and the rest of their statements and evidence is not suggestive of collusion. For example, the fact Ms Erduran records Mr Hamza as telling her the bruise had nothing to do with his pain tends against collusion.

[27] Transcript page 315.

[28] Blood pressure, pulse and temperature.

[29] Transcript page 320 (Dr Audish) and 256 (Dr Hamer). It is noteworthy that Dr Audish apparently misunderstood Dr Hamer's evidence on this point.

62. Finally, Mrs Hamza's own account of the level of pain Mr Hamza was experiencing when he left the clinic, is not indicative of significant pain.

Dr Audish's consultation and diagnosis

Evidence of the expert medical panel

63. In light of the unresolved factual disputes in this case, the experts were given a number of general questions as well as specific questions relating to Mr Hamza. The evidence of the panel relevant to Mr Hamza's diagnosis and treatment may be summarised as follows:

- Based on known risk factors Mr Hamza was at low risk of coronary pain.
- The fact Mr Hamza had stopped taking his Lipitor for a time was of little significance.
- Change in the nature of chest pain indicates an evolving process and is cause for concern.
- Shortness of breath is non-specific, but suggests an acute problem.
- Absence of pain (or other signs of discomfort) at the time of examination is not a reason to exclude a cardiac cause for chest pain and in fact is common. Classically, unstable angina comes and goes.
- A normal ECG is also not a reason to exclude a cardiac cause for chest pain and short of complete occlusion, ECGs can often be normal.
- Mr Hamza's bruise would have required significant trauma and the injury could possibly cause fluctuating pain and even sudden pain, for example muscle spasm from gardening. However, it could not readily explain central retro-sternal pain or pain radiating to the throat, which are indicative of pain generating from internal organs.
- Pain radiating to the neck, arm or jaw is a classic symptom of cardiac pain and should be assumed cardiac in nature. According to Associate Professor Rawlins a doctor who ignores radiating pain does so at his or her peril.[30]

[30] The Transcript records Dr Hamer saying this, however my note and recollection is that it was Dr Rawlins. IN any event the panel agreed.

- Mr Hamza's three to four day history of intermittent mild chest pain was likely unstable angina caused by repeated formation and dissolution of a blood clot in his coronary artery.
- It is totally unpredictable as to when complete blockage might occur from this process.
- Mr Hamza's stabbing pain on 7 December 2011 was likely part of his unstable angina, but the bruise cannot be discounted.
- Unstable angina is more of a concern than stable angina.
- A person experiencing acute myocardial infarction would be in continuous pain until administered pain relief.

64. The panel considered it may be appropriate for a General Practitioner to rule out a cardiac cause for chest pain based on one ECG and clinical evaluation, but not when there were classic symptoms or other indicators of coronary pain.[31] If cardiac pain could not be excluded the appropriate treatment would have been to administer aspirin, oxygen, rest and immediate referral to hospital by ambulance.

Evidence of Dr Audish and Mrs Hamza

65. Mrs Hamza went into Dr Audish's consulting room with her husband. She did not see Dr Audish examine her husband and initially doubted that it occurred. She said Dr Audish lifted his top to listen to his chest, but *'didn't even take his top off'*.[32]

66. Dr Audish explained that her examination occurred in the treatment room, not her consulting room. Mr Hamza still had his shirt off and the leads attached. It was then that Dr Audish noticed the bruise, palpated his chest and performed her physical examination. I accept Dr Audish's evidence as to this. Her examination would not have been visible to Mrs Hamza because of the curtain (and possibly a patient in the first bed). Further, her account is supported by Ms Erduran's evidence that when she took the ECG result in to Dr Audish she left the ECG leads on Mr Hamza in case another test was required.

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[31] Dr Hamer considered that factors other that the nature of the pain could indicate a cardiac cause, so there needs to be a global assessment of the patient, Transcript page 222.

[32] Transcript page 39.

67. Dr Audish stated she obtained a history from Mr Hamza in the treatment room of three to four days of intermittent moderate pain, which felt more like indigestion. In her statement dated 6 March 2012 she said *'He also told me that the pain was central, retro-sternal, radiating to his throat and was worse with deep breathing and movement'*. In evidence, she said he described the pain on that day as *'chest pain going up to the shoulder and going up to the neck'*.[33] She denied being told that he had an episode of severe pain that day. Even though she knew he had no appointment and was therefore seen as an urgent or emergency patient, she maintained the reason he gave for his attendance was *'for check up'*.[34]

68. Dr Audish also maintained she could not recall whether she read the clinical notes of Ms Erduran at any time prior to or during her consultation with Mr Hamza. She maintained this even when shown her referral to Northern Cardiology, which I am satisfied demonstrates she must have seen Ms Erduran's notes.[35] The significance of Ms Erduran's notes is that they make it clear that the pain Mr Hamza experienced on the day differed from his past 3 or 4 days of pain. Ms Erduran's notes record:

> *presented with chest pain*
> *had the chest for 3-4 day comes and goes*
> *but today in the cenral* [sic] *and radiates to his neck*
> *pain feels like stabbing*
> *Physical: BP (Sit): 129/80; Pulse: 92(Regular); Temp: 36.3;*

69. Dr Audish's referral reads:

> *presented with chest pain*
> *had the chest for 3–4 day comes and goes*
> *but today in the centralno*[sic] *ischemic changes and radiates to his neck*
> *pain feels like stabbing*
> *Physical: BP (Sit): 129/80; Pulse: 92(Regular); Temp: 36.3;*

70. I am satisfied that Dr Audish knew that Mr Hamza's pain had escalated and that his radiating central retro sternal pain was the reason for his attendance at the clinic on 7 December 2011.

71. In her 6 March 2012 statement, Dr Audish described the bruise as purple in the centre and with a yellow periphery. She stated:

> *Despite my concern about his elevated cholesterol, I did not believe that Mr Hamza's chest pain was ischaemic in nature. ...*

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[33] Transcript page 367. He also said *'central... going to the neck'* page 370.

[34] Transcript pages 368, 369, 376.

[35] The referral was obviously a 'cut and paste' of Ms Erduran's notes, with slight modification. It was compiled during the consultation and given to Mrs Hamza to take to reception.

I considered that the most likely cause of the pain was musculoskeletal. Nevertheless, to rule out any coronary artery disease, I referred him to the Cardiology Department of Northern Hospital for an exercise stress test. ...

It is my usual practice to adopt a cautious approach to diagnosis and refer many cases straight to hospital by ambulance on the assumption that they might be ischaemic in nature. However, in Mr Hamza's cases [sic] I did not consider that he had an ischaemic cardiac problem based on his description of the pain, that the pain resolved spontaneously, that he was well, that there was a bruise and a past history of reflux. [36]

72. Dr Audish provided a supplementary statement dated 4 December 2014, in relation to the specific question of whether Mr Hamza should have been referred to hospital. In that statement Dr Audish explained:

I was initially concerned that I had misdiagnosed him, until I received a copy of the autopsy report and saw that he had not suffered an infarction but a sudden cardiac event such as an arrhythmia. ...

It is important to exclude the critical in the diagnostic process. ...

In Mr Hamza's case, I reviewed him and considered a cardiac cause for his history of chest pain. However, his overall presentation was not consistent with a cardiac event.[37] *He reported no pain in the treatment room during his ECG and again denied any current pain during my examination of him. He was not short of breath and he was not sweaty or clammy. He had a bruise on his chest which was tender to touch.*

...

It is the role of the GP, as the front line practitioner, to examine the patient and exclude the critical. If it cannot be excluded, a referral may then be necessary.

73. Dr Audish's evidence was that when told the next day that Mr Hamza had died she thought of the bruise straight away and realised she had not recorded it in her clinical notes. She considered the bruise significant and its apparent age accorded with his history of 3 to 4 days of pain.

74. Dr Audish's stated reason for not making more detailed clinical notes was her confidence that Mr Hamza's condition was not critical. However, she denied Mrs Hamza's assertion that she had said she was 100% certain it was not Mr Hamza's heart and that it was a muscular

[36] My underlining.

[37] My underlining.

problem. Rather, she claimed to have said *'It does not look like it's heart attack at this moment'*. [38] She also denied Mrs Hamza's assertion that she ordered the stress test only upon Mrs Hamza's urging. She said she ordered it because she considered that Mr Hamza's pain might have been angina.

75. It is difficult to reconcile Dr Audish's evidence. The exercise is compounded by the fact she did not record a diagnosis in her clinical notes. It is also worthy of note that Dr Audish's evidence was interrupted by the concurrent evidence of the panel of expert witnesses. Prior to their evidence, she said she considered the possibility of angina because of his risk factor of *'of cholesterol'*.[39] After their evidence, she also said his description of the pain - central and radiating to his neck and shoulder – indicated possible angina. She at first said stable angina, then unstable, then said she preferred simply to say ischaemia.[40] In any case, whilst she considered his pain might have been cardiac she did not consider it urgent.

76. Except for the fact she ordered a stress test, it appeared from Dr Audish's two statements that she had ruled out a cardiac cause for Mr Hamza's pain. She appeared to believe absence of pain was inconsistent with ischaemia. However, in her oral evidence Dr Audish indicated she had not ruled out a cardiac cause at all, only that she considered the situation non-urgent. She sought to explain her statements by saying she meant *'cardiac at that moment'* or *'heart attack'*.[41] Whatever the case, Dr Audish considered Mr Hamza's absence of pain very significant and repeatedly stated that if he had been in pain she would have run to the treatment room and sent him to hospital.

77. Dr Audish also claimed to rely upon the fact he was at low risk of coronary pain in deciding that the situation was non-urgent.[42] I think this more likely a reconstruction than contemporaneous reasoning. In any event, the logic does not bear scrutiny. His low risk could only be relevant to the likelihood of him experiencing coronary pain, not the urgency of any pain experienced.

78. If Dr Audish had not ruled out the possibility of a cardiac cause for Mr Hamza's chest pain then according to the expert panel she should have referred him immediately to hospital. A

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[38] Transcript page 200.

[39] Transcript page 200.

[40] Transcript pages 322 – 329.

[41] Transcript page 347.

[42] Transcript page 333.

non-urgent stress test was wholly inadequate. The absence of pain simply proved Mr Hamza was not then suffering a heart attack. To that extent, Dr Audish was right. However, it did not detract from the urgency of the situation. Dr Audish failed to appreciate this.

79. Further, based on the expert evidence I am satisfied Dr Audish would have been wrong to rule out a cardiac cause for Mr Hamza's pain. This is because his radiating pain was a classic symptom of cardiac pain; his bruise did not explain central retro-sternal radiating pain; the change in pain indicated an evolving process and the absence of pain and a single normal ECG were inconclusive.

80. After the expert panel's evidence, Dr Audish offered 'shingles' as an explanation for pain radiation[43]. This appeared to be an attempt to retrospectively justify her failure to recognise the significance of Mr Hamza's radiating pain.

81. When asked about her medical management after hearing the expert panel evidence, Dr Audish said *'...my decision was right, but now I change not because it was wrong, but to avoid sitting here and explaining myself over and over and over...I need to be very selfish'*.[44] The stress of giving evidence cannot be underestimated. No doubt the stress contributed to this response by Dr Audish. I accept that she has been affected by Mr Hamza's death and genuinely feels sympathy for Mr Hamza's family. Nevertheless, it is unfortunate that Dr Audish was not able to demonstrate appropriate professional reflection when given the opportunity.

Was Mr Hamza's death preventable?

82. As indicated, there was no evidence of infarction at autopsy. According to Dr Burke, infarction would not be observed at autopsy unless a person survived between 12 to 24 hours after suffering a complete occlusion. Further, an individual may suffer a sudden cardiac arrhythmia at any time from the commencement of complete occlusion of the coronary artery up to complete resolution of the infarction by fibrosis.

83. The expert panel confirmed that Mr Hamza's complete occlusion must have occurred after his consultation with Dr Audish. Otherwise, his symptoms would have been persistent and extreme and the ECG would not have been normal.

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[43] Transcript pages 275 – 276.

[44] Transcript pages 349 – 350.

84. If Mr Hamza had been administered aspirin by Dr Audish or upon his attendance at hospital, it is possible the blood clot that caused the total occlusion would not have formed.

85. The thrust of the expert panel's evidence was that it could not be determined how Mr Hamza would have been treated had he attended hospital. His treatment would depend on his presentation and the individual doctor's assessment in the Emergency Department. However, the panel agreed that a patient referred by a doctor is more likely to be admitted than a patient presenting directly to hospital. In particular, Associate Professor Thomson agreed with Dr Hamer's assessment that it was unlikely that an emergency department would turn away a patient where a general practitioner considered there might be a cardiac cause of chest pain.

86. Further, the Northern Hospital protocols suggest that even as a low risk patient Mr Hamza would have been admitted for observation, with serial ECGs and troponin assays, for at least 8 hours.[45] According to Dr Hamer, such testing should either diagnose coronary insufficiency or exclude it to a high degree of certainty.

87. Based on the Northern Hospital protocols and the evidence of Dr Hamer and Associate Professor Thomson, I am satisfied that had Mr Hamza been referred to hospital by Dr Audish it is likely he would still have been there at the time he experienced the occlusion and cardiac arrhythmia. Had he attended hospital without such a referral the situation is less clear. However, as Dr Hamer noted even if *'nothing had been done because [the emergency doctors] were still just thinking and observing, I think physically he still would have been - by serendipity he would have been in the department and been able to be resuscitated'*.[46]

88. I accept Dr Hamer's opinion that in the hospital setting with immediate access to resuscitation equipment it is likely Mr Hamza would have been resuscitated from his cardiac arrhythmia and his impending myocardial infarction managed effectively.

CONCLUSIONS AS TO CAUSE AND CIRCUMSTANCES OF DEATH

89. The evidence is unclear as to precisely what training or instructions were given to SRMC staff in 2011 (and even now) as to how to handle patients who telephone complaining of chest pain. It is surprising that Ms Tabacco as practice manager and Dr Audish as employee doctor, were not more *au fait* with these matters. Whilst inadequate procedures might explain their lack of

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[45] Northern Hospital protocol titled NON S-T SEGMENT ELEVATION ACUTE CORONARY SYNDROME.

[46] Transcript page 241.

knowledge, I cannot safely conclude that this is so given I have no evidence from the owners of SRMC.

90. Evaluation of Dr Audish's medical management must be according to the standards of a general medical practitioner with her level of experience. Whilst the expert medical panel included a cardiologist and emergency physician, I have paid particular regard to the views of the panel general practitioners as to appropriate medical management. I have also applied the standard of proof for coronial findings and paid heed to the principles of *Briginshaw*, particularly as they apply to medical professionals.

91. Assessing all the evidence I find as follows:

- When Mrs Hamza called SRMC she should have been advised to call an ambulance or her call should have been transferred to a nurse or doctor to assess the urgency of the situation.
- Dr Audish's assessment and treatment of Mr Hamza was lacking in that she either incorrectly ruled out a cardiac cause for Mr Hamza's chest pain, or not having ruled out a cardiac cause for his chest pain, she failed to appreciate the urgency of the situation.
- Had Dr Audish arranged for Mr Hamza's immediate transfer to hospital it is likely he would have survived by virtue of his presence in the hospital at the time the total occlusion and arrhythmia occurred.
- Administration of aspirin by Dr Audish or the hospital may even have prevented formation of the blood clot that caused the total occlusion.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comment(s) connected with the death:

Adequacy of clinical notes

1. As already noted there was a great deal of cross-examination about the differences between the statements of Ms Erduran and Dr Audish and their respective clinical notes. There is an obvious and unavoidable tension between the demands of a busy clinical practice and the obligation to make notes. It is understandable that sometimes notes are less than comprehensive. However, clinical notes are usually the only contemporaneous record of a

consultation. The absence of comprehensive notes renders retrospective analysis difficult. Notes are important not just to allow scrutiny; they serve as a means of communication and can also protect medical professionals from unwarranted criticism.

2. The consensus of the experts was that Dr Audish's notes were satisfactory despite omitting the bruise and lack of contemporaneous pain. The exception was Dr Chambers who believed they were deficient in not giving a diagnosis. Given the majority view, I am not satisfied that Dr Audish (or for that matter Ms Erduran) fell short of the prevailing standards of note taking in their professions.

3. That said, in my view it should be incumbent on medical professionals to record all material observations (including so-called negative observations) as well as their actual diagnosis. At the very least recording a diagnosis would prevent subsequent debate as to what the diagnosis was (as occurred here). More importantly, it might ensure a more rigorous approach to diagnosis with consequential benefits to treatment.

Triage procedures and training at SRMC

4. As previously adverted to, during the Inquest it became apparent that the witnesses were unable to testify as to details of the training SRMC gave to its staff in relation to telephone triage in 2011. Subsequently, I decided there was little utility in enquiring with the owners of SRMC as to what training they provided their staff four years ago. As I have not heard from the owners, I make no adverse comment in relation to their training or triage procedures at that time. Suffice to say if staff were instructed to advise patients who called complaining of chest pain to call 000, or to refer such patients to a doctor or nurse, it did not happen in this case. It is also somewhat surprising that SRMC's practice manager and an employee doctor were not aware of details of training programs for staff.

5. SRMC owners should review their triage procedures and training to make sure they are appropriate in the light of this Finding and Heart Foundation published literature. This literature advises patients with pain in one or more of chest, neck, jaw, arm, back or shoulder, which is severe or has lasted more than 10 minutes to call 000.

RECOMMENDATIONS

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

1. That the Royal Australasian College of General Practitioners considers the need to advise its members to implement protocols to give effect to the Heart Foundation's Action Plan so that any patient calling a general practice with chest pain matching the description in the Action Plan is advised to call an ambulance.
2. That the Royal Australasian College of General Practitioners considers the need to train its members in relation to the significance of the absence of pain and a normal ECG in determining whether a person is suffering an acute coronary episode.
3. That the Royal Australasian College of General Practitioners considers the need to advise its members that any patient with chest pain matching the description in the Heart Foundation's Action Plan should be immediately referred to an emergency department.
4. That the Royal Australasian College of General Practitioners considers the need to remind its members of the importance of comprehensive clinical notes.

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

Mr Hamza's family;

Royal Australasian College of General Practitioners;

The Australian Health Practitioner Regulation Authority; and

Interested Parties.

Signature:

ROSEMARY CARLIN
CORONER
Date: 21 August 2015