IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005730

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

*Amended pursuant to Section 76(a) of the **Coroners Act 2008** as at 3 April 2025*[1]

Findings of:	Coroner John Olle
Deceased:	Alan John Trevor Deem
Date of birth:	10 September 1953
Date of death:	19 October 2020
Cause of death:	1a: INTRACRANIAL HAEMORRHAGE COMPLICATING CORONARY ARTERY BYPASS GRAFT SURGERY FOLLOWING RIGHT CORONARY ARTERY DISSECTION SUSTAINED IN PERCUTANEOUS CORONARY INTERVENTION FOR THE TREATMENT OF ISCHAEMIC HEART DISEASE
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052
Keywords:	Coronary artery angioplasty, coronary artery dissection, occlusion, inter-hospital transfer delay, deficient medical records

[1] The following amendments are made to clerical errors in my Finding dated 1 April 2025:
i. Quotation marks are removed from the first sentence in paragraph 8 of my Comments. This sentence represents my summary or understanding of paragraphs 7 to 14 of the Royal Melbourne Hospital submissions dated 8 July 2024.
ii. Numbering in the Findings and Conclusion section.

INTRODUCTION

1. On 19 October 2020, Alan John Trevor Deem (**Mr Deem**) was 67 years old when he died at the Royal Melbourne Hospital (**RMH**) in circumstances consistent with intracranial bleeding following a surgical procedure. At the time of his death, Mr Deem lived in Bottlebrush Drive, Hopper's Crossing, 3029, with his partner, Janice Wintle (**Ms Wintle**).

2. Mr Deem's known medical conditions included hypertension and an abdominal aortic aneurysm. He was also reported to have suffered from sleep apnoea. Further, Mr Deem's medical records indicate that he underwent treatment for kidney cancer in 2016.

Events leading to Mr Deem's death

3. On 10 September 2020 at approximately 6 30 am, Mr Deem awoke with pain radiating to his left shoulder and consulted his usual doctor (**GP**) who conducted an electrocardiogram (**ECG**) and diagnosed an anterior infarct. At 8.49 am, the GP called for an ambulance to convey Mr deem to hospital. In short, Mr Deem was having a heart attack.

4. At 9.42 am, Mr Deem arrived at the Sunshine Hospital (**SH**) emergency department (**ED**), where a cardiology team was expecting him after the GP or paramedics activated a "STEMI Call". The ED clinicians diagnosed Mr Deem "with acute anterior ST elevation myocardial infarction" (**STEMI**).[2]

5. Mr Deem was admitted to SH and underwent an urgent procedure 'with stenting to the left anterior descending coronary artery'. When clinicians conducted the procedure on the left coronary artery, clinicians also discovered that Mr Deem's right coronary artery was affected in a similar manner. Consequently, an appointment was made for Mr Deem to return to SH to conduct a similar procedure to his right coronary artery.[3]

6. On 11 September 2020, during a check-up following his procedure, clinicians conducted an echocardiogram and discovered that Mr Deem's left ventricle had "moderate left ventricular dysfunction with a n ejection fraction 40-44%".[4]

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[2] Court File [**CF**], Letter from Western Health (**WH**) Director of Cardiology to the Court dated 4 April 2024.
   i. SH operates under the auspices of Western Health (**WH**).
   ii. STEMI is a type of heart attack which mainly affect the lower chambers of the heart and is indicated by the elevation of the ST-segment on an ECG.

[3] Ibid.

[4] Ibid.

7. On 16 September 2020, Mr Deem was discharged from SH with a heart failure therapy plan and with a follow-up date to conduct the procedure on his right coronary artery. Upon discharge, SH did not note any initial complications from Mr Deem's myocardial infarction.

Subsequent admission to SH

8. On 12 October 2020 at approximately 5.58 am, Mr Deem was readmitted to SH for the planned procedure to his right coronary artery. This procedure, a staged percutaneous coronary intervention to the right coronary artery, was conducted around 9 am. The procedure was intended to achieve complete revascularisation after Mr Deem's anterior myocardial infarction.

9. During the procedure, however, treating clinicians identified that Mr Deem's right coronary artery was dissected, or occluded. Consequently, the planned coronary intervention procedure to the right coronary artery was unsuccessful.

10. According to WH, the 'blockage resulted in a second acute myocardial infraction with associated ST elevation and chest pain'. Although an unfortunate outcome, a complication of this nature was a known risk associated with the procedure.[5]

Medical management of Mr Deem's condition

11. SH records indicate that, after the procedure, Mr Deem was conscious and haemodynamically stable. Clinicians noted, however, that he was experiencing mild arm and jaw pain. Mr Deem's treating team planned to manage this further complication to his condition with analgaesic and vasodilatory medication to treat and prevent his chest pain. Mr Deem's treating team also planned to monitor him closely at the time.

12. At approximately 12.45 pm, when SH's Director of Cardiology (**DOC**) reviewed Mr Deem, he was still experiencing persistent pain and ST segment elevation (**STE**). The DOC then consulted the RMH counterpart to determine whether it was appropriate for Mr Deem to be treated by cardiothoracic surgery, a procedure not available at WH. Consequently, the decision was taken transfer Mr Deem to the RMH for further care.

13. At approximately 1.20 pm, when a senior WH staff member contacted the RMH counterpart in their Cardiology Department to make the referral, a verbal handover was provided to RMH. According to WH, verbal handovers were standard practice and per agreed process between

[5] Ibid.

the two institutions. When RMH accepted the referral, WH arranged to transfer Mr Deem to RMH.

14. At approximately 3 pm, Mr Deem was transferred from SH to RMH by ambulance.

THE CORONIAL INVESTIGATION

15. Mr Deem's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

16. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

17. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

18. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Deem's death. The Coronial Investigator conducted preliminary inquiries on my behalf.

19. This finding draws on the totality of the coronial investigation into the death of Alan John Trevor Deem. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[6]

[6] Subject to the principles enunciated in Briginshaw v Briginshaw (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

20. On 12 October 2020 at approximately 3.45 pm, Mr Deem arrived at the RMH and was taken to the operating theatre directly. At approximately 4.47 pm, RMH clinicians commenced Mr Deem's surgery.

21. During the procedure, however, the induction of anaesthesia was complicated when Mr Deem suffered three episodes of cardiac arrest which required shock therapy. When the procedure resumed, Mr Deem's treating team performed two coronary artery bypass grafts (**CABG**) to two sections of his coronary artery—to both the left anterior descending (**LAD**) and the posterior descending artery (**PDA**). The surgeon's contemporaneous notes of the procedure indicate concern about the approximate six-hour delay in the referral to RMH after the coronary occlusion was first detected.

22. Over the next 24-hour period, on 13 October 2020, Mr Deem required extra care to monitor his blood flow, or haemodynamic support, because of the failure of the right ventricle which is one of the four chambers of the heart. Consequently, Mr Deem was placed on extra corporeal membrane oxygenation (**ECMO**)—an artificial heart-lung machine to manage his condition.

23. Mr Deem's medical records indicate that his post-operative course was complicated by kidney failure, ischaemic hepatitis, ventilator acquired pneumonia and post-operative bleeding. His course of treatment including dual ani-platelet agents for the coronary stents and anti-coagulant therapy for the heart-lung machine circuit, both of which are associated with an increased risk of bleeding.

24. The medical records indicate further that there may have been some difficulty in optimising Mr Deem's coagulation, despite taking precautions by extensive testing and by consulting with clinicians in their Haematology Department. Over the course of the next few days, RMH clinicians noted that several attempts to wean Mr Deem from the heart-lung machine were unsuccessful. The evidence indicates that Mr Deem's condition was deteriorating,

25. On 18 October 2020, after numerous attempts to wean Mr Deem from the heart-lung machine had failed, his RMH treating team conferred with their counterparts at The Alfed Hospital. Consequently, Mr Deem's treating team concluded that, if Mr Deem's heart function did not improve in the days that followed and he could not be taken off the heart-lung machine, it

would be reasonable to palliate their patient. Mr Deem's inability to be taken off the heart-lung machine indicated that his level of residual cardiac function was incompatible with survival.

26. On 19 October 2020, upon examination, Mr Deem's pupils were unequal and dilated. A subsequent computed tomography (**CT**) scan identified a large intracranial bleed which his treating team deemed terminal.

27. In consultation with his family, life support was withdrawn. At 5.01 pm, Mr Deem was declared deceased.[7]

Identity of the deceased

28. On 19 October 2020, Alan John Trevor Deem, born 10 September 1953, was visually identified by his partner, Janice Wintle, who signed a formal Statement of Identification.[8]

29. Identity is not in dispute and requires no further investigation.

Medical cause of death[9]

30. Forensic Pathologist Dr Gregory Young of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination upon the body of Alan John Trevor Deem on 21 October 2020 and provided a written report of his findings dated 20 October 2020.

31. In the execution of his duties, Dr Young the following source documents:

    i. Discharge summary from the RMH;
    ii. Coroners Court of Victoria E-Medical Deposition Form completed by the RMH;
    iii. Postmortem CT scan; and
    iv. Victoria Police Report of Death, *Form 83*.

32. The post-mortem examination revealed signs of 'medical and surgical intervention, but no *unexpected* signs of trauma'. According to Dr Young, the postmortem CT scan confirmed the presence of a right frontal lobar haemorrhage in the brain with hypodensity and associated with subarachnoid and intraventricular haemorrhage. Dr Young commented that intracranial

[7] CF, E-Medical Deposition Form completed by RMH and submitted to the Court.
[8] CF, Statement of Identification.
[9] CF, Medical Examiner's Report. By Form 9 dated 21 October 2020, I directed the VIFM not to perform an autopsy and further, not to retain any biological material for forensic testing because I was satisfied on the evidence available to me at the time that a reasonable medical cause of death could be established.

bleeding in the brain is a known complication in people who are on anticoagulant medication following cardiac surgery which may lead to death when there is compression of essential centres in the brain.

33. Dr Young provided an opinion that the medical cause of death was 1(a) INTRACRANIAL HAEMORRHAGE COMPLICATING CORONARY ARTERY BYPASS GRAFT SURGERY FOLLOWING RIGHT CORONARY ARTERY DISSECTION SUSTAINED IN PERCUTANEOUS CORONARY INTERVENTION FOR THE TREATMENT OF ISCHAEMIC HEART DISEASE.

INVESTIGATIONS

34. Given my role as an investigating coroner to contribute to a reduction in the incidence of preventable deaths in Victoria and, in the context of the concerns expressed by the RMH surgeon about the delayed referral to the RMH, I resolved to ascertain whether that delay was connected with or had contributed to Mr Deem's death.

35. In my review of the evidentiary material at this juncture of my investigation, I was satisfied that the available evidence indicated that the delay in transfer from SH to RMH resulted from a delay in the making the referral itself or a delay in arranging an ambulance to convey Mr Deem to the RMH after the referral had been made, rather than a delay in the recognition of the coronary artery dissection. In my view, this delay appears to have manifested in an opportunity lost to alter the outcome for Mr Deem.

36. Consequently, assisted by the Coroners Prevention Unit (**CPU**), WH and the RMH were requested to provide further information, including statements and medical records, in the form of directed statements.[10]

Gravamen of the WH and RMH response

37. My review of the response from WH indicates the following:

[10] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

i. There are no existing record or notes on the handover between the first cardiologist and the second cardiologist who treated Mr Deem at SH;

ii. Although the medical records indicate that Mr Deem was experiencing ongoing pain at the time, the records do not indicate who, or if any clinician, reviewed Mr Deem after his procedure;

iii. With regard to the decisions taken and the rationale for taking them, the first cardiologist identifies himself, in his statement, as the clinician who took the decisions regarding Mr Deems medical management. On closer scrutiny of the medical records, however, I was unable identify any entry in the notes to indicate that the first cardiologist took the decisions as stated in in his subsequent statement to the Court;

iv. The second cardiologist who was SH's Director of Cardiology at the time, changed Mr Deem's management plan and decided to transfer him to the RMH. Having reviewed the medical records, however, I was unable to identify any reference to the rationale for taking that decision or the exact time when that decision was taken;

v. There is no contemporaneous note(s) of the contents of the call to RMH or reason for the referral in the medical records of the SH, the referring hospital; and

vi. There is no contemporaneous note(s) of the contents of the call from SH or the reason for accepting the referral in the medical records of the RMH, the receiving hospital.

38. Having considered the response to my queries, I was concerned by the apparent lack of records kept to reflect clinician monitoring immediately after the procedure until the time the decision was taken to refer Mr Deem to the RMH. In my view, the evidence indicates that the lack of written documentation and the reliance on verbal communication between the broader SH staff complement increased the likelihood of less precise and, possibly, second hand verbal communication between the SH Registrar and the RMH when the referral was made.

39. Further, given that neither SH nor RMH could produce any notes to document the referral request, or the acceptance of the request, supports a reasonable belief that the Registrars at both SH and RMH may have misunderstood the reason for the referral. I was therefore satisfied that the available evidence indicated that the referral systems and procedures used by WH and the RMH were suboptimal and may not have been in accordance with best practice procedures and protocols.

40. Having considered the factual matrix of this matter and the manner in which the transfer from SH to RMH had occurred, I was satisfied that the weight of the available evidence supports a conclusion that Mr Deem's death may have been preventable in the circumstances.

41. Consequently, on 20 February 2024, I informed both WH and the RMH that in finalising my investigation into Mr Deem's death, the available evidence supports my making adverse comments about, findings against or recommendations to their intuitions respectively. Further, I invited WH and RMH to make submissions in mitigation of my proposed adverse comments, findings or recommendations.[11]

WH submissions

42. On 4 April 2024, WH submitted their response for my consideration.

43. In summary, WH acknowledged that their record keeping practices of the time were deficient but impressed upon me that those deficiencies did not detract from the care Mr Deem received at their SH facility. WH submitted that the medical care Mr Deem received was reasonable and appropriate. Acknowledging that more detailed records would have been ideal, WH submitted that the lack of adequate records did not have any bearing on the standard of care they provided to Mr Deem.

44. Further, WH assured me that, in collaboration with the RMH, they would take action to put appropriate measures in place to ensure that their inter-hospital transfer process is sufficiently improved to alter the outcome for transferring patients.

45. I commend WH for taking steps to improve the outcome for their patients.

RMH submissions

46. On 8 July 2024, the RMH submitted their response for my consideration.

47. In a similar vein, the RMH acknowledge that 'there is no clinical entry' reflecting the referral conversation between the respective WH and RMH registrars which predicated Mr Deem's transfer from SH to the RMH.

48. In summary, the RMH submitted that they engage actively with their staff about the importance of keeping accurate clinical records. The RMH sought to reassure me that their

[11] CF, Natural Justice Letters from the Court to WH and RMH. The letters set out my proposed comments and recommendations and are reflected later in my Finding.

current referral practices, including their use of the Electronic Medical Record (**EMR**) system, are not sub-optimal and proffered their current policies and procedures in support of their submission for my perusal and consideration.

49. I have considered the responses of WH and the RMH to my proposed adverse comments and findings in the context of all the available evidence. I now make the following comments.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. Mr Deem suffered a recognised complication of a coronary artery angioplasty procedure, a dissection of the coronary artery at SH. As a result of this complication, Mr Deem had to be transferred to the RMH for cardiothoracic surgery. Mr Deem's condition was complicated further by heart failure requiring the use of a heart-lung machine from which he could not be weaned before he was found to have suffered a massive intracranial bleed.

2. I have reviewed the response provided by both WH and the RMH in mitigation of my proposed adverse comments and findings and considered their response in the context of the available evidence and the advice of the CPU. Mr Deem's medical management appears to have been appropriate overall.

3. However, noting that the RMH Cardiothoracic Surgeon commented, "what was not appreciated at the time of the referral was that the coronary occlusion had occurred at 9:12 AM, whereas the referral occurred shortly before 3 PM" and further, noting that WH commented that there 'was a poorly documented 'original plan by [their cardiologist] to manage Mr Deem conservatively at Western Health [and] b) the change in treatment plan to refer Mr Deem to Royal Melbourne Hospital and the reasoning behind the change in plan', I am satisfied that the evidence indicates that that the record-keeping practices of both institutions was deficient at the time.

4. I acknowledge WH's submission that both conservative and surgical management of Mr Deem's health concerns were reasonable options at the time. However, by my review of the evidence, the lack of documentation makes it difficult to determine, in retrospect, whether conservative or surgical management was more appropriate for Mr Deem at the time or whether there was simply a delay in making any decision.

5. The evidence indicates further that the ongoing clinical care and review is made more difficult by the lack of documentation. Moreover, given the lack of medical records, I am unable to determine with any degree of certainty whether the delay in the referral to the RMH is connected with or had contributed to Mr Deem's death.

6. I note that both WH and RMH acknowledge the importance of a verbal handover in urgent, time-critical events and transfers as in this matter. However, as the evidence indicates, only two people ever knew what was said and both could have faulty recollections of what they had discussed. Hence the need for proper recordkeeping for clinical use by other clinicians in the short term or, as this matter accentuates, to explain what or how events unfolded leading to a death. While I acknowledge that writing notes, whether on paper or in the EMR is a time-consuming process and may be a distraction from actively providing treatment to patients, in my view it remains imperative for clinicians to make clinical notes in a timely manner.

7. In summary, both WH and the RMH accept the deficiencies in their record-keeping practices. RMH is unable to ascertain when they received notes or records from WH or why their registrar did not make any contemporaneous notes. In my view, all these unknown facts could have been avoided if the clinicians had adopted better record-keeping practices.

8. With regard to the lack of contemporaneous notes by their registrar, the RMH sought to explain that those sorts of doctors are really busy, with lots of sick patients, taking lots of phone calls, and there's no facility in the (paper or EMR) to write notes before the patient has arrived. While I acknowledge and accept that this may be a plausible reason for not taking contemporaneous notes in the circumstances, the weight of the available evidence supports a conclusion that the lack of adequate record-keeping is why there is no record of the critical period, an inter-hospital transfer, where Mr Deem's health concerns and his prognosis ought to have been documented. In this regard, the CPU has advised me that the traditional means of dealing with this would be to write a 'retrospective note' or to include the pertinent details in the admission note or the registrar could have included it in the operation note. In my view, the ramifications of clinicians not making contemporaneous notes have far reaching consequences, as evidenced by this matter.

9. In support of the CPU's contention above and, in the context of the RMH relevant policy which they themselves brought to my attention, I note that, by not making a contemporaneous note, the RMH registrar was in breach of their policy on several key requirements in the policy document. I therefore consider that hospitals ought to put systems in place to optimise and facilitate clinician record-keeping practices, in accordance with their own policies, including an improvement to current tool they provide for documentation, especially with regard to inter-hospital transfers.

10. I note further that both the RMH and WH have brought to my attention the EMR model which had been introduced into hospital systems in Victoria fairly recently before Mr Deem's death or about that time. The RMH then highlighted the impactful effects of the COVID-19 pandemic at the time. While I commend the use of the EMR as a means to improving clinical record-keeping and while I acknowledge the difficult circumstances healthcare professionals were subjected to during the COVID-19 pandemic, I also note that neither the RMH nor WH have provided any evidence of the efficacy of the EMR in facilitating clinician record-keeping. Similarly, neither the RMH nor WH have provided any evidence on how they have improved their record-keeping practices, or any evidence of any other initiatives undertaken to advance or improve their record-keeping practices.

11. Further, I have reviewed the RMH clinical handover policy and, although this policy appears to be reasonable overall and refers to the standard ISBAR approach to handover, it does not appear to envisage the circumstances which arose in this matter—inter-hospital transfer.[12]

12. Similarly, the RMH has brought the Victorian Government's *CareSync Exchange* system to my attention and I note that this system is a patient information sharing platform. In the context of the available evidence in this matter, I am satisfied that this system would be beneficial as a prevention tool in future. However, the CPU has advised me that, although the Victorian Department of Health's website reports that 'The rollout of the *CareSync Exchange* to public health services across Victoria is due to commence in late 2024', it does not appear to have been implemented yet.

[12] CF, paragraphs 33-36 of the RMH letter dated 8 July 2024. ISBAR is a structured communication tool used to transfer patient information between healthcare professionals.

13. I am therefore satisfied that the following recommendations are appropriate in the circumstances.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that Western Health determine whether the delay in the referral was exacerbated by the lack of documentation or medical records; and

2. In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that Western Health develop and implement measures to ensure referrals are expedited or completed in a timely manner; and

3. In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that The Royal Melbourne Hospital develop and implement a process to ensure that their clinicians comply with their own record-keeping policy(ies); and

4. In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that The Royal Melbourne Hospital develop a toolkit to facilitate their clinicians' compliance with the own policy(ies); and further

5. In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that the Victorian Department of Health encourage and facilitate the roll-out of *CareSync Exchange* system or program with a functionality to facilitate inter-hospital transfer documentation where the referring hospital is able to write a referral to which the receiving hospital is able to respond in real time.

6. I now make pertinent findings in this matter.

FINDINGS AND CONCLUSION

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[13] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

2. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Alan John Trevor Deem, born 10 September 1953;

   b) the death occurred on 19 October 2020 at the Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052; and

   c) I accept and adopt the medical cause of death as ascribed by Dr Young and I find that Alan John Trevor Deem died from intracranial haemorrhage complicating coronary artery bypass graft surgery following right coronary artery dissection sustained in percutaneous coronary intervention for the treatment of ischaemic heart disease.

3. Having considered all the circumstances, I am satisfied that that the weight of the available evidence supports a conclusion that the record-keeping practice at Sunshine Hospital, Western Health at the relevant and material time was suboptimal. Accordingly, I find that medical records held on Alan John Trevor Deem's file at Western Health were materially deficient.

4. Similarly, I am satisfied that the weight of the available evidence supports a conclusion that the record-keeping practice at the Royal Melbourne Hospital at the relevant and material time

[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 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…'.

was suboptimal. Accordingly, I find that the medical records held on Alan John Trevor Deem's file at the Royal Melbourne Hospital were materially deficient.

5. Having considered the factual matrix of this matter, I am satisfied that that the weight of the available evidence supports a conclusion that there was a significant lapse of time at Sunshine Hospital between the time when Alan John Trevor Deem's right coronary artery dissection was first detected and his referral and subsequent transfer to the Royal Melbourne Hospital. Accordingly, I find that there was a delay between the time when Alan John Trevor Deem was first diagnosed with a right coronary artery dissection and the time when the referral was made.

6. On the evidence available to me, I am unable to discern any reason for this delay which remains unexplained. Accordingly, I am satisfied that the delay was not reasonable in the circumstances.

7. However, given the deficiencies in the medical records, I am satisfied that the available evidence is not sufficiently cogent to enable me to definitively find that this delay is connected with or had contributed to the death. Accordingly, I am unable to determine whether Alan John's Trevor Deem's death was preventable in the circumstances.

8. Having considered all the evidence, given that coronary artery dissection is a recognised complication of a coronary angioplasty procedure, I am satisfied that the weight of the available evidence supports a conclusion that Alan John Trevor Deem received appropriate medical treatment at Sunshine Hospital and at the Royal Melbourne Hospital during his procedures performed at both institutions and I find that the medical management of Alan John Trevor Deem's health concerns at both Sunshine Hospital and the Royal Melbourne Hospital was reasonable in the circumstances.

I convey my sincere condolences to Alan's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Janice Wintle, Senior Next of Kin

Western Health

Royal Melbourne Hospital

Department of Health, Victoria

Sergeant Matthew Slaney, Coroner's Investigator

Signature:

Coroner John Olle

Date: 3 April 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.