IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 0932

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Mr C
Date of birth:	September 1963
Date of death:	February 2020
Cause of death:	1 (a) *Ischaemic Heart Disease* 1 (b) *Coronary Artery Atherosclerosis*
Place of death:	Rochester, Victoria
Other Matters:	*Cardiac risk factors* *Atypical discomfort/pain*

INTRODUCTION

1. Mr C, born 25 September 1963, was 56 years old at the time of his death. He lived with his wife, Mrs C in Rochester.

2. On 18 February 2020, Mr C passed away at his home despite attempts by Mrs C and ambulance paramedics to resuscitate him.

THE CORONIAL INVESTIGATION

3. Mr C'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.

4. 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.

5. 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.

6. The coronial investigation primarily examined the care provided by Mr C's General Practitioner (**GP**), Dr Eji Ekeanyanwu, who saw him the day before his death. To assist with this issue, this case was referred to the Coroners Prevention Unit (**CPU**).[1]

7. Mr C's medical records were also obtained from the Campaspe Medical Centre and the Bendigo Health Group.

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[1] 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.

8. This finding draws on the totality of the coronial investigation into Mr C's death. 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.[2]

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

Circumstances in which the death occurred

9. On 17 February 2020 Mr C consulted with his GP, Dr Eji Ekeanywanu at the Campaspe Clinic in Rochester. The medical records documented: *complains of RUQ discomfort.*

10. According to the police report, on 18 February 2020, Mr C picked up a load of rocks and sand and was outside his home laying concrete footing for a course of cinder blocks around the exterior of his front veranda.

11. The temperature was approximately 34 to 35 degrees Celsius and the humidity was between 43 and 59 percent.

12. At about 12.30pm, Mr C went inside to get a glass of water but did not want lunch. Mr C said that he was uncomfortable and that she suggested he go to the hospital. Mr C subsequently returned to work outside.

13. It was at about 3.30pm that Mrs C found her husband unresponsive on the floor of their main bedroom.

14. Emergency services were called and cardiopulmonary resuscitation (**CPR**) was commenced by his wife.

15. Ambulance services arrived at 3.33pm and continued to perform CPR. Unfortunately, Mr C was unable to be assisted and was pronounced deceased.[3]

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[2] 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.

[3] Verification of Death Form time noted the time as 3.35pm.

16. Police attended at 4.30pm and noted no suspicious circumstances as part of their investigations.

Identity of the deceased

17. On 18 February 2020, DM visually identified her father, Mr C, born September 1963.

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

Medical cause of death

19. Specialist Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted a post mortem examination on 24 February 2020 and provided a written report of his findings dated 28 February 2020.

20. The autopsy showed severe triple vessel coronary artery atherosclerosis and myocardial fibrosis in the heart.

21. Dr Young noted that ischaemic heart disease is a disease process resulting from myocardial ischaemia, which is an imbalance between cardiac blood supply and myocardial oxygen demand. Most cases are due to a reduction in coronary blood flow caused by obstructive atherosclerotic disease (coronary artery atherosclerosis).

22. Mr C's heart showed evidence of previous myocardial infarction. Dr Young said that in this case, the mechanism of death was likely to be a fatal cardiac arrhythmia ("heart attack") leading to a sudden collapse.

23. There was no post mortem evidence of any injuries which may have caused or contributed to his death.

24. Dr Young provided an opinion that the medical cause of death was 1(a) *Ischaemic Heart Disease* and 1(b) *Coronary Artery Atherosclerosis*.

25. He further noted that on the basis of the information available at the time of his examination, the death was due to *natural causes*.

26. I accept Dr Young's opinion.

FURTHER INVESTIGATIONS

27. As already detailed, Dr Ekeanyanwu attended with Mr C on 17 February 2020.

28. Dr Ekeanyanwu provided two statements to the Court to assist with the investigation. In his first statement dated 15 August 2020, Dr Ekeanyanwu said that the 'RUQ pain' described by Mr C was not a 'cardiac complaint' and because Mr C's cholesterol levels and blood pressure were normal, he did not see a reason to investigate further.[4] I note however that Mr C's blood pressure was not taken on 17 February 2020.

29. Dr Ekeanyanwu did not consider that the pain described by Mr C might have been from a cardiac source.

30. Dr Ekeanyanwu referred in his statement to a cardiologist Dr Nim Nadarajah who had been involved in Mr C's care.

31. Based on the available information, the CPU noted that Mr C did have a number of significant risk factors that suggested a low index of suspicion to investigate for ischaemic heart disease and that past coronial cases and education from the Royal Australian College of General Practitioners (**RACGP**) have emphasised the importance of considering ischaemic heart disease even where there are atypical features.

32. It was noted that the paucity of clinical notes recorded in both the GP practice notes and within Dr Ekeanyanwu's first statement did not provide supporting evidence as to the clinical rationale that favoured a non-cardiac cause of Mr C's pain.

33. The Court contacted Dr Nimalam Nadrarajah's office and it was established that Mr C had not seen him since 25 February 2014. He noted in correspondence to Dr Ekeanyanwu:

Mr C came to see me today. He has a holter monitor, it has picked up some background infrequent nocturnal bradycardia but otherwise there are no concerning issues. He remains asymptomatic, in fact he is really fit and well. I am happy that we don't need to intervene further. His blood pressure remains excellent and clinically as

[4] In fact, Dr Ekeanyanwu did suggest an upper abdominal ultrasound.

I said he is well. He will see you for a follow up review, I would be grateful if you can continue to keep an eye on both blood pressure and his lipid status and periodically keep an eye on his heart rate. In light of the fact that he had a past history of coronary artery disease and stenting I would recommend looking at repeating his stress echocardiogram probably every two to three years but I will leave this in your hands.

34. The CPU noted that the cardiologist suggesting vigilance for ischaemic heart disease added further weight to the high index of suspicion that Mr C was at risk of ischaemic heart disease and the GP should have been aware of this.

35. It was also noted however that the specialist did not *mandate* the regular stress echocardiogram tests and it was unclear whether they had been ordered by Dr Ekeanyanwu.

36. Accordingly, a further statement was requested from Dr Ekeanyanwu which sought addiotnal information regarding the clinical rationale for his decision making.

37. Dr Ekeanyanwu subsequently provided a second statement dated 2 March 2021, which amongst other things noted that,

- Dr Nadarajah did not indicate that he would see Mr C in future, thereby indicating that he was satisfied that Mr C was doing very well.
- That subsequently, he did not see Mr C for approximately 9 months until 20 November 2014 but had always advised Mr C to attend every 6 months for review appointments and he had been due to see him in March 2014.
- He said that he recognised in hindsight (given the potential for a delayed appointment) it would have been prudent to log a recall for stress echocardiograms in Medical Director to act as a reminder and in that way he could at least discuss the cardiologist's recommendation with Mr C when the time arrived.
- At the consultation on 20 November 2014 he took Mr C's blood pressure and pulse and sent his bloods (including lipids) for testing but said, *I imagine that because I had read the specialist's letter 9 months prior and the patient*

was fit and well and not complaining of any cardiac related symptoms, the recommendation for ongoing stress echocardiograms would have not been at the forefront of my mind.

- He did not consider that ongoing stress echocardiograms were necessarily required in the absence of any other cardiac related symptoms, that Mr C was discharged from cardiac care completely, and that he actively monitored for cardiac related symptoms during consultations and he remained generally fit and healthy.

- Mr C presented without symptoms suggestive of cardiac issues for approximately 6 years.

- Mr C had lifestyle risks including smoking and high cholesterol however worked full time, maintained a healthy diet and was slender.

- Whenever Mr C reported cardiac related symptoms, he sought specialist care and was *very aware* of his cardiac history and was actively monitoring for symptoms.

- He was aware of his cardiac history and was actively monitor it.

38. In relation to the clinical rationale for not considering the possibility of a cardiac source and not investigating this matter further, Dr Ekeanyanwu noted amongst other things that,

- Mr C attended for the purpose of reviewing a scan of his previously diagnosed abdominal aneurysm, which took months to arrange.

- He corrected his earlier statement where he said that Mr C referred to right upper quadrant (RUQ) *pain*, saying that it was instead *discomfort*, as if he had reported pain, it would have been his usual practice he would have recorded that symptom.

- Based on his examination he considered that an abdominal ultrasound was required to ascertain the cause of the tenderness/discomfort (there was no

sharp pains, no shortness of breath, nausea, vomiting or generally feeling unwell).

- It was his experience that it is very uncommon for cardiac related issues to present as RUQ discomfort/tenderness, and this is an atypical presentation and there was really no index of suspicion for cardiac causes, Mr C had no cardiac symptoms for 6 years and been the subject of regular monitoring.

- He ordered blood tests which were part of monitoring his cardiac risk but admitted in hindsight that he ought to have checked his blood pressure and pulse as he had not attended for approximately 10 months – *this was an oversight on my part although I note routine monitoring showed they had been within an acceptable range for many years.*

- If he had suspected an acute cardiac cause he would have referred Mr C directly to the emergency department (**ED**).

- Mr C should have understood from previous discussions that if he experienced any shortness of breath, chest pain, nausea or otherwise felt unwell he should present to ED.

Was there a missed opportunity for earlier recognition and treatment of progressive ischaemic heart disease?

39. The CPU considered that there was a missed opportunity for Dr Ekeanyanwu to consider a cardiac source of Mr C's atypical[5] discomfort/pain on the day prior to his death. However, it is not possible to definitively conclude that the symptom that Mr C described in the 24 hours prior to his death were from his underlying cardiac condition rather than musculoskeletal discomfort/pain. Of note, the autopsy report did not find an acute thrombosis[6] within any of the narrowed coronary vessels.

40. If Dr Ekeanyanwu had considered a cardiac source, he may have ordered an ECG, cardiac enzymes or advised Mr C to seek immediate medical attention if he

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5 The 'typical' ischaemic chest pain is described as crushing or a tight band across the chest that worsens with exertion and does not change with posture or respiration. Atypical pains may be atypical in their description, site, radiation or intensity of the pain.

6 Suggesting that one of the coronary arteries had completely occluded leading to an acute myocardial infarction.

remained symptomatic, and a diagnosis of advanced triple vessel disease may have been made prior to the development of a fatal cardiac arrhythmia even if the discomfort/pain was, indeed, non-cardiac.

41. I agree with CPU's assessment on this matter.

Was Dr Ekeanyanwu's care of a reasonable standard?

42. Mr C did have a number of significant risk factors that suggested a low index of suspicion to investigate for ischaemic heart disease and as previously noted, past coronial cases and education from the RACGP have emphasised the importance of considering ischaemic heart disease even where there are atypical features.

43. The paucity of clinical notes recorded in both the GP practice notes and within Dr Ekeanyanwu's first statement did not provide supporting evidence as to the clinical rationale that favoured a non-cardiac cause of Mr C's discomfort/pain. The second statement provided further details which outlined the GP's decision making, as noted above.

44. Additional matters to be considered include that Mr C only attended as a 'routine' appointment to collect his results after he had missed previous appointments, that Dr Ekeanyanwu had the benefit of being there on the day to hear exactly what was being said during the consultation and that Mr C was also urged by his wife to seek hospital care on the day of his death which he declined.

45. Having considered all the evidence available, I am not able to conclude that the standard of care provided to Mr C fell short of reasonable expectations.

46. I note however that Dr Ekeanyanwu has acknowledged his oversights in not recalling Mr C for a stress echocardiogram and not taking his blood pressure and pulse on 17 February 2020.

Further concerns

47. On 5 July 2021, Mrs C raised further concerns that as her husband's blood pressure had not been taken on 17 February 2020, this may constitute a failure of the GP's duty of care.

48. Following further advice from the CPU, it was noted that there is no duty of care to perform vital signs at every consultation if a patient is not obviously unwell. GPs would normally perform a set of vital signs at least annually as part of a check-up (sometimes combined with blood tests such as cholesterol levels). More frequent observations and blood tests are performed if some intervention has occurred.

49. There is no way to ascertain what Mr C's blood pressure would have been on that day, had it been taken. The CPU noted that Mr C had a year-long history of stable blood pressure on the medication he was prescribed. Further, that a higher than normal blood pressure would not have indicated that a heart attack was imminent and that he would have been sent to ED. A single high blood pressure reading of itself is usually just reassessed in a few weeks (noting that a patient's blood pressure goes up and down just like heart rate).

50. The CPU also noted that people with a history of ischaemic heart disease who have perfectly controlled and monitored blood pressure and cholesterol can still suffer heart attacks. In addition, not taking a blood pressure reading is, as the GP admits, perhaps not optimal, but it would not be considered a failure of the GP's duty of care.

COMMENTS

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

51. Mr C's death highlights the importance of,

- General Practitioners considering the past medical history and cardiac risk factors when a patient presents with atypical discomfort/pain;
- General Practitioners taking and documenting a thorough history regarding the nature of any presenting symptoms; and
- The advice to patients to have a low threshold for seeking further medical attention if symptoms persist especially where the diagnosis is not clearly evident.

FINDINGS AND CONCLUSION

52. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the Deceased is Mr C, born September 1963;

(b) the death occurred February 2020 at Rochester, Victoria, Victoria, from 1(a) *Ischaemic Heart Disease* and 1(b) *Coronary Artery Atherosclerosis*, and

(c) the death occurred in the circumstances described above.

53. I convey my sincere condolences to Mr C's family for their loss.

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

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

Mrs C, Senior Next of Kin

Avant Law on behalf of Dr Eji Ekeanyanwu

Royal Australian College of General Practitioners (RACGP)

Signature:

SARAH GEBERT

Date: 23 October 2021

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.