CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 25th and 30th days of August and the 8th day of September 2021, the 4th day of February 2022 and the 9th day of November 2023, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Branko Jablanovic.

The said Court finds that Branko Jablanovic aged 61 years, late of 9 Max Drive, Paralowie, South Australia died at the Lyell McEwin Hospital, Haydown Road, Elizabeth Vale, South Australia on the 18th day of January 2017 as a result of congestive cardiac failure due to cardiomegaly with left ventricular hypertrophy. The said Court finds that the circumstances of his death were as follows:

1. Introduction and background

1.1. Mr Branko Jablanovic was 61 years of age when he died at the Lyell McEwin Hospital (LMH) on 18 January 2017.

1.2. Mr Jablanovic was of Serbian descent. He married his wife Andelka in 1982 and they had two children together. Mr Jablanovic worked for many years as a cleaner but was a pensioner at the time of his death.

1.3. Mr Jablanovic's medical history included a vitamin D deficiency, cholelithiasis and type 2 diabetes.

1.4. According to Mr Jablanovic's wife, in the weeks leading up to his death his health had started to decline. Mr Jablanovic had no energy and could not breathe properly.

Although he had had diabetes since 1990 and did get sick sometimes, she described this occasion as '*being different*'.

1.5. On Tuesday 17 January 2017 Mr Jablanovic consulted with a general practitioner, Dr Michael Quek, at the Health Matters Medical Centre in Paralowie. Mrs Jablanovic took him to the appointment but did not stay. His daughter picked him up afterwards and took him home.

1.6. At home Mr Jablanovic told his wife that the doctor had given him a prescription for Ventolin and Deralin to bring his heart rate down because it was very high. Deralin contains the active ingredient propranolol hydrocholoride, a beta-blocker. For the purposes of this finding, I will refer to the medicine prescribed by Dr Quek as propranolol rather than the brand name Deralin. Propranolol is used for its effect on the pumping action or rhythm of the heart. It can be used to treat a variety of conditions including high blood pressure, irregular heart rate and anxiety.

1.7. At approximately 6pm Mr Jablanovic took his first propranolol tablet. About one hour later Mr Jablanovic told his wife he did not feel very well. He said he felt like he wanted to vomit and was sweating and leaning against the bed. Mrs Jablanovic contacted her daughter who arrived approximately ten minutes later and contacted an ambulance.

1.8. The first ambulance arrived 15 minutes after the triple-0 call was made and required back-up assistance to manoeuvre Mr Jablanovic through the house. He was then taken to the LMH.

1.9. During the trip Mr Jablanovic suffered a pulseless electrical activity cardiac arrest. He was intubated, given adrenaline and administered cardiopulmonary resuscitation (CPR).

1.10. The ambulance arrived at the LMH at approximately 10:05pm with Mr Jablanovic in cardiac arrest and under CPR. He was transferred to a resuscitation room where resuscitation efforts, including multiple cycles of CPR, regained a cardiac output. An electrocardiogram (ECG) showed only mild ischaemic changes and it was not considered necessary to proceed to cardiac catheterization.

1.11. Mr Jablanovic remained unconscious, however, and was noted to have poor cardiac function. He suffered a further pulseless electrical activity cardiac arrest and further CPR was deemed futile. He was certified deceased at 12:40am on 18 January 2017.

2. Cause of death

2.1. The SAPOL investigating officer seized medication, including propranolol prescribed by Dr Quek, and only one tablet was missing, consistent with the evidence that Mr Jablanovic took one propranolol tablet shortly before his decline on the evening of 17 January 2017. A toxicology report indicates that propranolol was detected in Mr Jablanovic's blood at a non-toxic concentration.[1] I am satisfied, based on the evidence, that Mr Jablanovic only consumed one propranolol tablet prior to the decline of his health in the immediate lead-up to his death.

2.2. An autopsy was undertaken by a Forensic Science SA Senior Forensic Pathologist, Dr Stephen Wills,[2] whose opinion as to the cause of Mr Jablanovic's death was '*congestive cardiac failure due to cardiomegaly*[3] *with left ventricular hypertrophy*'[4]. The pathologist concluded that:

> 'Taking all the findings into consideration, it appears most probable that this gentleman has died as a result of congestive cardiac failure as evident from pericardial, pleural and intra-abdominal serous effusions and bilateral pulmonary oedema. The most likely cause for this is cardiac dysfunction secondary to generalised cardiac enlargement and significant left ventricular hypertrophy.'

2.3. I accept Dr Wills' opinion and find that the cause of Mr Jablanovic's death was congestive cardiac failure due to cardiomegaly with left ventricular hypertrophy.

3. The purpose of the Inquest

3.1. The oral evidence at Inquest explored three main issues: the adequacy of Dr Quek's consultation with Mr Jablanovic in the hours leading up to his death, and in particular whether Dr Quek should have realised that Mr Jablanovic was in cardiac failure; secondly, whether it was appropriate for Dr Quek to prescribe propranolol to Mr Jablanovic at the conclusion of his consultation; and thirdly, whether the propranolol prescribed by Dr Quek, and taken by Mr Jablanovic approximately one hour before his demise, caused or contributed to his death.

3.2. The standard of proof to be applied in making coronial findings is the civil standard, the balance of probabilities. In considering making findings which imply or express

[1] Exhibit C3a
[2] Exhibit 2a, Post-Mortem Report
[3] An enlarged heart
[4] The most common cause of LVH is **high blood pressure (hypertension)**. Other causes include athletic hypertrophy (a condition related to exercise), valve disease, hypertrophic cardiomyopathy (HOCM), and congenital heart disease.

criticism of individuals, I am guided by the principles enunciated in *Briginshaw v Briginshaw*[5] and I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made.

3.3. In this finding I shall not summarise all the evidence tendered or heard at the Inquest but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

4. Witnesses

4.1. Dr Michael Swee-Leong Quek gave oral evidence and also provided evidence by way of an affidavit dated 25 August 2021.[6] He was Mr Jablanovic's general practitioner from 2013 and gave evidence about his management of Mr Jablanovic's medical conditions and, in particular, his consultation on the day before his death. Counsel for Dr Quek submitted that he presented in a concerned and understandably nervous manner and that his cautious approach to answering questions ought to be seen in light of his unfamiliarity with the court process and English as his second language. It was submitted that he endeavoured to assist the Court to the best of his ability and gave evidence truthfully, making concessions where appropriate with respect to his management of the deceased.

4.2. Professor William Heddle, a highly experienced specialist consultant cardiologist, was engaged by the Court as an independent expert to examine the circumstances surrounding the death of Mr Jablanovic. Professor Heddle produced a written report[7] and gave oral evidence. His academic qualifications are MBBS, University of Adelaide 1975 and MD, Flinders University 1985. He became a Fellow of the Royal Australasian College of Physicians in 1980, a Fellow of the Cardiac Society of Australia and New Zealand in 2005 and a Fellow of the Heart Rhythm Society in 2012. He has been practising as a cardiologist in public and private practice since 1982. During his evidence, Professor Heddle expressed opinions about what he would expect and what should be expected of a general practitioner treating Mr Jablanovic. It was submitted by counsel for Dr Quek that I should be careful not to retrospectively judge the reasonableness of Dr Quek's medical management of Mr Jablanovic as his treating general practitioner from the perspective of a cardiologist. However, Professor Heddle

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[5] (1938) 60 CLR 336

[6] Exhibit C9

[7] Exhibit C12a

was asked during the course of his evidence to distinguish between what he would expect from a general practitioner and what he may know from his experience as a cardiologist. Professor Heddle is a medical practitioner of general as well as specialist qualifications and during his many years of practising as a cardiologist, has worked extensively with general practitioners. He is amply qualified to give evidence of the expectations of general practitioners held by the medical profession as a whole, which includes those who practise as cardiologists. I am satisfied that he perfectly understood that this was the context in which he was asked to express his opinions.

5. Affidavit evidence

5.1. The Court received affidavit evidence from:

- Stephen Wills,[8] Forensic Pathologist, dated 20 August 2021 annexing a post-mortem report dated 15 August 2017;
- Lauren Geier,[9] Forensic Scientist, unsigned and undated, annexing Ms Geier's toxicology summary report dated 23 March 2017;
- Andelka Jablanovic,[10] wife of the deceased, dated 18 January 2017;
- Laura McPhillips,[11] nurse at LMH, dated 18 January 2017;
- Senior Constable Joel Manson,[12] SAPOL, dated 1 March 2017;
- Associate Professor Christopher Zeitz,[13] Cardiologist, dated 27 September 2021;
- Dr Desmond Fong Wai Ong,[14] trainee Physician, dated 2 December 2021.

5.2. In addition, the Court had the records of Dr Quek,[15] SAAS and LMH.[16]

6. Mr Jablanovic's consultation history with Dr Quek

6.1. Mr Jablanovic attended the Health Matters Medical Centre from June 2013 and on most of his attendances at the practice he saw Dr Quek. Over those years he presented with a number of medical conditions including back pain, insomnia, anxiety and diabetes,

[8] Exhibit C2
[9] Exhibit C3
[10] Exhibit C4
[11] Exhibit C5
[12] Exhibit C6
[13] Exhibit C14
[14] Exhibit C15
[15] Exhibit C7
[16] Exhibit C8

which were poorly controlled. Mr Jablanovic had longstanding prescriptions for codeine, amitriptyline and temazepam.

6.2. Despite Mr Jablanovic having a number of risk factors for cardiovascular disease for many of the years that he treated him, Dr Quek did not refer him to a cardiologist at any time. Professor Heddle was not critical of Dr Quek's failure to refer Mr Jablanovic to a cardiologist at an earlier time, stating that there was no need for Dr Quek to refer the deceased to a cardiologist prior to 17 January 2017 unless he thought it was appropriate.

7. Consultation with Dr Quek on 17 January 2017

7.1. When Mr Jablanovic presented to Dr Quek on 17 January 2017, he had all of the risk factors for cardiac failure; he had diabetes that was poorly managed, he was obese and he had high cholesterol. Dr Quek's evidence was that he knew at the time of this consultation in January 2017 that Mr Jablanovic was at a high risk of cardiac failure.

7.2. Dr Quek took notes during the appointment[17] and was questioned extensively about the content of those notes. I will return to address the adequacy of his notes of this consultation. In addition to those contemporaneous notes, Dr Quek stated that he had an independent recollection of his consultation with Mr Jablanovic on 17 January 2017 and that his evidence was based on his recollection of those events.

7.3. The record of the appointment indicates that the duration of the appointment was 9 minutes and 32 seconds.

7.4. Dr Quek gave evidence that Mr Jablanovic came to the appointment complaining of shortness of breath that had been constant for four to five days and worse on exertion.[18] Dr Quek said that, although Mr Jablanovic complained of shortness of breath, his assessment, based on observations which commenced from the time he greeted him in the waiting room, was that Mr Jablanovic was not experiencing actual shortness of breath, but rather the sensation of shortness of breath. He observed that Mr Jablanovic did look unwell.

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[17] Exhibit C7, page 3
[18] Transcript, page 39

7.5. Dr Quek noted that Mr Jablanovic was tachycardic[19] with a heart rate 120 beats per minute. Professor Heddle's evidence was that the observed tachycardia should have been concerning to Dr Quek. He stated that:

> 'You expect when anybody is resting quietly, the resting pulse rate should be in the range of 60-80 beats a minute; a pulse rate of 120 suggests something abnormal making the heart go fast, whether it's an abnormal rhythm or whether it's the heart having to work hard because the body is telling it to work hard because it's not coping with the demands of the body for blood flow.' [20]

7.6. Professor Heddle said his expectation would be that when confronted with a patient with this observed tachycardia and a complaint of shortness of breath, a general practitioner would ask particular questions and undertake a particular physical examination.

7.7. Professor Heddle said there were two crucial questions which Dr Quek did not ask. Despite Mr Jablanovic's report that he had been unable to sleep properly, Dr Quek did not ask whether there was a connection between his inability to sleep and his shortness of breath being worse when laying down. According to Professor Heddle:

> 'In somebody presenting with tachycardia and shortness of breath, the question of whether or not the shortness of breath is worse when you're supine, is a very clear discriminator between shortness of breath due to heart failure and shortness of breath due to other causes, but with the shortness of breath when you try and lie supine being very particular for heart failure associated shortness of breath.'[21]

7.8. Of note is that the ambulance officers who transported Mr Jablanovic to the hospital have later that evening recorded in their notes '*difficult breathing – upon exertion and laying down*'.[22] By failing to ask Mr Jablanovic this important question, it seems Dr Quek missed an opportunity to be informed that that the shortness of breath was worse when laying down, if indeed that had been the case. Dr Quek appropriately conceded that he should have asked Mr Jablanovic about that important detail.

7.9. Professor Heddle said the next important question to ask a patient who presents with the symptoms of Mr Jablanovic, was whether there had been any swelling of the ankles or legs, as swelling can come and go and usually gets better and night and worse as the day progresses.[23] Dr Quek stated that although he observed Mr Jablanovic's ankles and

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[19] A heart rate of more than 100 beats per minute
[20] Transcript, page 107
[21] Transcript, page 118
[22] Exhibit C8, page 7
[23] Transcript, page 109

noted no swelling, he did not ask Mr Jablanovic whether there had been any swelling of the ankles.[24]

7.10. Due to the lack of appropriate questioning, the history obtained by Dr Quek from Mr Jablanovic was inappropriately limited and I so find. Dr Quek conceded that he should have asked further questions to elicit more information from Mr Jablanovic during the appointment.[25]

7.11. Professor Heddle gave evidence that in addition to asking a series of questions to elicit important information from the patient, certain important physical examinations need to be undertaken on a patient presenting to a general practitioner with Mr Jablanovic's symptoms; they can broadly be described as respiratory examination, cardiovascular examination, and abdominal examination.

7.12. Professor Heddle described the components of a respiratory examination, given Mr Jablanovic's presenting complaint and symptoms, required an auscultation of the lungs to determine if any crepitations could be heard,[26] and percussion, that is tapping on the back of the chest to check the resonance or dullness.[27]

7.13. Dr Quek's evidence was that he did conduct such a respiratory examination. Although he did not record a respiratory rate, which Professor Heddle said should have occurred,[28] he described '*observing*' Mr Jablanovic's rate of respiration.[29] He said both in his affidavit and oral evidence that although his respiratory examination of Mr Jablanovic was not documented, he knows it was performed as that is his usual practice when presented with a respiratory problem such as shortness of breath, and he has documented Mr Jablanovic's oxygen saturations which are taken as part of the respiratory examination. Mr Jablanovic's oxygen saturation level was 95%, and Dr Quek considered anything above 95% to be considered normal. Dr Quek described the respiratory examination he performed on Mr Jablanovic[30] including percussion[31]

[24] Transcript, page 45
[25] Transcript, pages 42-46
[26] Transcript, page 111
[27] Normal lungs are resonant because it is air-filled, but if you have fluid there you get a dullness of percussion because there is fluid around the lung, which means you get a dull percussion note. A dull percussion is a cause for concern in terms of there potentially being cardiac failure; Transcript, page 111
[28] Transcript, page 167
[29] Transcript, page 199
[30] Transcript, page 12
[31] Transcript, page 13: Percussion involves tapping on a patient's chest with your fingers, covering the entire part of their chest, their lungs. The idea behind it is to basically hear the actual sound of the tapping itself and the sound will give you an idea of what possible condition the lung may be in.

and auscultation,[32] with normal findings and nothing of note, despite Mr Jablanovic's complaint of shortness of breath.[33]

7.14. Professor Heddle opined that it is probable that if Dr Quek had conducted a proper respiratory examination of Mr Jablanovic, he would have detected an abnormality, namely pleural effusions.[34] This opinion was based on the fact that at autopsy there were bilateral effusions noted in the lungs. Professor Heddle said that upon the earlier examination, '*It's most likely that would have been evident with impaired percussion over the lung bases, indicative of the fluid outside of the lung or pleural effusions*.'[35]

7.15. It was submitted by counsel for Dr Quek that the Court should not conclude, based on the fact an unknown quantity of pleural effusions was present at autopsy, that Mr Jablanovic would have presented with crepitations at the time of Dr Quek's examination. It was submitted that Professor Heddle's opinion in relation to the likelihood of impaired percussion needs to be considered in light of his following comment:

> 'One of the problems we have is the clinical signs of heart failure sometimes are not apparent. You can have patients with - it's severe heart failure and when you listen to the lungs you cannot find any clinical evidence of heart failure on auscultation of the lungs. That is because the noises in the lungs come at a very late state of heart failure and you can still have significant heart failure without that. We have lots of corroborative evidence from other investigations we do, that that is the case.' [36]

7.16. There was some questioning of Professor Heddle by Dr Quek's counsel about the fact that there is a diagram[37] from the time of Mr Jablanovic's presentation to the LMH, which Professor Heddle agreed,[38] records a normal lung examination. However, I am of the view that any comparison between what would potentially have been observed by Dr Quek and what was observed at the hospital many hours later is unhelpful. Professor Heddle was quite clear on the limitations of a lung examination in an emergency hospital setting when Mr Jablanovic was intubated. Further, Dr Ong who drew that diagram asserts in his affidavit[39] that the ability to conduct a chest and abdominal examination in this setting was limited due to the intubation and what was

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[32] Transcript, page 14
[33] Transcript, page 15
[34] Transcript, page 114
[35] Transcript, page 114
[36] Transcript, page 149
[37] Exhibit C8, LMH notes
[38] Transcript, page 179
[39] Exhibit C15

occurring in that emergency hospital setting, none of which were limitations present at the time of Dr Quek's examination.

7.17. Whilst I am mindful of Professor Heddle's evidence, based on findings at autopsy that it was highly probable there would have been abnormalities on a comprehensive examination of the lungs,[40] I accept Dr Quek's evidence that he did not hear any impaired percussion.[41]

7.18. As to the expected cardiovascular examination, Professor Heddle said that when a patient presents to a general practitioner with the symptoms described by Mr Jablanovic, an examination should occur in which the patient is placed supine at a 45-degree angle to listen for any abnormal heart sounds. He explained that this examination entails listening for what is referred to as the '*third heart sound*', a sound associated with rapid ventricular filling, and a '*fourth heart sound*', a sound associated with increased force of atrial contraction. This examination should also involve listening for heart murmurs, as often when patients have heart failure, they have heart murmurs as a consequence. Professor Heddle's evidence was that although he would not always expect a general practitioner to be able to detect third and fourth heart sounds, he would expect a general practitioner to be able to determine whether heart sounds are normal and whether there are any murmurs present. The physical examination should also have entailed observations for any swelling in the ankles or a raised jugular venous pulse.[42] Professor Heddle said that if Dr Quek did not perform a cardiovascular examination on Mr Jablanovic during this appointment, that would have been unsatisfactory.

7.19. Although there is no reference in his notes to such examination, Dr Quek's evidence was that he did perform a cardiovascular examination.[43] He described what he did, including using a stethoscope to listen to the heart, observing the ankles for any swelling[44] and checking the jugular venous pulse.

7.20. Dr Quek's evidence was that there was no abnormality noted upon these examinations.[45] As to whether it was possible for Mr Jablanovic to have had a normal

[40] Transcript, page 172
[41] Transcript, page 14
[42] Transcript, page 111
[43] Transcript, page 103
[44] Transcript, page 16
[45] Transcript, page 18

cardiovascular examination at this time, given his death from cardiac failure merely hours later, Professor Heddle stated that there was nothing in the autopsy that indicates that there necessarily would have been abnormalities detected in a cardiovascular examination during this appointment. His evidence was that the heart sounds may well not have indicated evidence of heart failure.[46]

7.21. Professor Heddle also detailed the abdominal examination that should have occurred to ascertain if Mr Jablanovic was suffering from cardiac failure, including examining for ascites (free fluid in the abdomen) and for enlargement and congestion of the liver. Although Professor Heddle opined that an examination of the abdomen would likely have revealed ascites, he conceded that he did not consider general practitioners would undertake that examination very often.[47] Indeed, Dr Quek's evidence was that he did not examine for ascites because it was not something that he had been trained to do as a general practitioner and it was also difficult in his experience to examine for ascites in an obese patient, which Mr Jablanovic was. Dr Quek's evidence was that he did palpate the abdomen to check for any enlarged organs, in particular liver or spleen,[48] and that he did not feel any enlarged organs in the abdomen.

8. The adequacy of the notes of this consultation

8.1. The consultation notes from this appointment do not record the findings of Dr Quek's cardiovascular, respiratory and abdominal examinations of Mr Jablanovic. Plainly it is standard medical practice to record such things if they performed. Professor Heddle explained the reasons that documenting such observations is important include so that there is a record for anyone who may be looking after the patient after you and for your own recollection of what you did and did not do at the time.[49]

8.2. The absence of any detail in the notes about these physical examinations having taken place left a question mark over whether they in fact occurred. Counsel for Dr Quek submitted that it should not be inferred from the brevity of his notes that he did not undertake an appropriate examination of Mr Jablanovic. Dr Quek denied any suggestion that the reason his consultation notes do not reflect these examinations was because he failed to undertake them.[50] He offered different explanations for why he did not record these details. He firstly suggested he only recorded abnormal findings, but

[46] Transcript, page 115
[47] Transcript, pages 175-177
[48] Transcript, page 18
[49] Transcript, page 113
[50] Transcript, pages 83, 86

once it was pointed out that he had recorded oxygen saturations and blood glucose which were not abnormal, he clarified that rather than '*abnormal*' findings what he meant was that he only recorded key findings that would suggest whether or not there was something wrong there.[51] He also explained that he had very little time to write an extensive note of the consultation as he was already running late by the time of Mr Jablanovic's appointment.[52]

8.3. I bear in mind that one reason for the unsatisfactory nature of Dr Quek's evidence on this topic might be that he was embarrassed about his failure to keep satisfactory notes, despite undertaking the appropriate examinations. Neither does the failure to make appropriate notes necessarily mean that the examinations did not take place. The situation emphasises the fact that keeping proper notes is not only in the interests of patients, but also in the interests of doctors. In this case, I accept Dr Quek's evidence that these examinations took place, and on that basis conclude that his physical examination of Mr Jablanovic was reasonable in the circumstances. However, I find that his failure to make a note of these physical examinations was not good medical practice.

9. Diagnosis of anxiety

9.1. Despite the physical examination, history reported, and symptoms observed, Dr Quek said that ultimately, he did not come to a conclusion about the reason for Mr Jablanovic's presentation. His evidence was that he thought the likelihood was that Mr Jablanovic was presenting with anxiety. Other differential diagnoses he considered included respiratory issues such as asthma, and cardiac failure. He placed anxiety higher on the list of differential diagnoses than cardiac failure.[53]

9.2. Dr Quek elaborated on why he felt anxiety was more likely than cardiac failure stating:

> '… first of all there were not a lot of clear-cut findings to support cardiac failure on examination and clinical assessment. Secondly, he is a person who was familiar to me as an anxious person, his personality and the way he came across was one of a person who was worried and anxious quite a fair bit.' [54]

9.3. Dr Quek's reliance on the fact that there were not a lot of clear-cut findings to support cardiac failure on examination and clinical assessment suggests Dr Quek failed to give

[51] Transcript, pages 47-48
[52] Transcript, page 50
[53] Transcript, page 49
[54] Transcript, page 35

appropriate consideration to the fact explained by Professor Heddle that '*patients can have heart failure with minimal clinical signs and yet have quite severe heart failure*'.[55] Professor Heddle agreed that the absence of physical findings in combination with the shortness of breath on exertion and tachycardia would make cardiac failure slightly less likely, but not excluded.[56] On that basis the physical examinations undertaken by Dr Quek with no remarkable findings should not have offered any degree of reassurance about whether there was cardiac failure or not.

9.4. The second reason Dr Quek gave for placing anxiety higher on the list of differential diagnoses than cardiac failure was the fact that Mr Jablanovic was familiar to him as an anxious person.

9.5. Dr Quek had previously treated Mr Jablanovic for anxiety on a number of occasions.[57] Of note however was that Mr Jablanovic's presentation to Dr Quek on the day of his death was different than the occasions where he had presented with anxiety, with Dr Quek himself stating that:

> '… his shortness of breath when he presented, it's not something that I had seen before. And the other thing was 120 beats per minutes is you know remarkably different from how I've seen him in the past and it to me was significantly abnormal'.[58]

Despite that, Dr Quek still favoured anxiety as a likely diagnosis, and a more likely diagnosis than cardiac failure.

9.6. According to Professor Heddle:

> '… one of the traps in clinical medicine is to attribute patients' symptoms to what has been that ongoing problem, when it might be a new problem, so every time a patient presents you have to not just say it's the same problem, you have to go back to the baseline and go through your full clinical differential diagnosis.' [59]

It seems however that what Dr Quek did was to assume Mr Jablanovic's symptoms were likely attributable to the anxiety for which he had treated him on numerous previous occasions.

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[55] Transcript, page 127
[56] Transcript, page 177
[57] At a consultation on 18 March 2015 in relation to his anxiety, Mr Jablanovic complained of palpitations described as a sensation of an abnormal heartbeat. There were multiple subsequent presentations with complaints of anxiety and insomnia, including a long consultation on 8 April 2016 (Exhibits C7, C7a).
[58] Transcript, page 46
[59] Transcript, page 170

9.7. According to Professor Heddle, Mr Jablanovic was presenting with two of the most common symptoms of cardiac failure (shortness of breath on exertion and tachycardia). Whilst Professor Heddle's evidence was that it is possible that the shortness of breath on exertion and tachycardia could relate to an anxiety presentation,[60] he said that is probably the least serious of the potential causes for the presentation, also noting that '*there's more likely to be a long history of intermittent shortness of breath and tachycardia in situations of stress*'.[61]

9.8. Professor Heddle pointed out that when there are differential diagnoses, the patient's history and a physical examination help clarify the final diagnosis, and you can usually limit the differential diagnoses by examination. However, it may not be possible to come to a final conclusion without further investigations.[62]

9.9. I find that Dr Quek erred in his assessment of Mr Jablanovic as more likely suffering from anxiety than from cardiac failure, and then excluding it as a differential diagnosis. Cardiac failure should have been found to be, and then remained, a differential diagnosis. Dr Quek had no proper basis for excluding cardiac failure from the differential diagnoses.

9.10. Professor Heddle's evidence was clear that the appropriate course of action for Dr Quek to have taken at this appointment - based purely on the shortness of breath and tachycardia, and even in the absence of any findings on physical examination - was to send Mr Jablanovic to hospital without delay.[63] Dr Quek stated that he did not consider it necessary to refer Mr Jablanovic to hospital based on his findings[64] but, as I have found, Dr Quek had not properly excluded cardiac failure.

10. Prescribing of propranolol

10.1. Rather than doing what Professor Heddle stated he should have done which was to send Mr Jablanovic to hospital, what Dr Quek did was prescribe propranolol.

10.2. Dr Quek explained his reasons. He was concerned about Mr Jablanovic's elevated heart rate, which was the only cardiac-related symptom that Dr Quek observed during

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[60] Transcript, page 120
[61] Transcript, page 120
[62] Transcript, page 121
[63] Transcript, pages 127-129
[64] Transcript, page 100

the consultation. His intention in prescribing propranolol was to help him with his elevated heart rate and provide him with some relief.

10.3. Dr Quek stated he considered that, even if Mr Jablanovic was experiencing cardiac failure, the propranolol would be protective or assist Mr Jablanovic, or alternatively there would not be a significant adverse effect. The basis for this was Dr Quek's view that if Mr Jablanovic had heart disease, he would have only had a small degree. He said that based on the history and physical examination he was 99.99% certain that there was no degree of cardiac failure,[65] and if there was, it would only have been slight. He stated:

> '… based on the clinical assessment that I performed on Mr Jablanovic when he presented to me at the consultation, I had a level of confidence that, even if there were cardiac failure, it was such a small degree that propranolol wouldn't have had an adverse effect that is that severe.' [66]

10.4. Dr Quek was of the view that propranolol was only contraindicated in the case of heart failure if it was category 3 or 4 heart failure, but not a risk if it was a category 1 or 2 heart failure.[67] Yet Professor Heddle's view was that Mr Jablanovic's symptoms in fact would have put him in the category of class 3 or class 4 cardiac failure, both of which are not slight, but are in fact severe.[68]

10.5. Furthermore, Professor Heddle's evidence was that it is inappropriate for a general practitioner to prescribe propranolol if there is any chance of there being any degree of heart failure and that it was inappropriate for Dr Quek to have prescribed it to Mr Jablanovic at the conclusion of this appointment.[69] This opinion was supported by the affidavit of Professor Zeitz who stated in his affidavit:

> 'I certainly agree with Professor Heddle that the prescription of beta blockers in a patient who is unstable or unwell without proper investigation is a very risky measure to take. I note that Mr Jablanovic's vital signs at the time he attended Dr Quek, in particular his pulse rate of 120, are abnormal. In the hospital setting such an observation would stimulate a call for a medical emergency team to attend the patient.' [70]

10.6. Dr Quek also prescribed the propranolol in circumstances in which the MIMS guidelines indicate prescribing was contraindicated, as the MIMS guidelines specify

[65] Transcript, page 99
[66] Transcript, page 96
[67] Transcript, page 97
[68] Transcript, pages 152, 193
[69] Transcript, page 123
[70] Exhibit C14, paragraph 13

‘*Do not take Inderal*[71] *if you have certain other heart problems for example heart failure*’.[72] Dr Quek said he did not refer to the MIMS guidelines in prescribing the propranolol, but rather his decision to prescribe it was based on his knowledge and training. He stated he knew that propranolol was contraindicated in cardiac failure but did not consider whether it was contraindicated for Mr Jablanovic. With any degree of cardiac failure contemplated by Dr Quek, the MIMS guideline clearly dictates that propranolol should not have been prescribed.

10.7. Dr Quek also prescribed Ventolin to Mr Jablanovic during this appointment. Professor Heddle opined that the prescription of Ventolin and propranolol at the same time raises questions about what the working hypothesis was of the diagnosis - was it asthma or an airways disease, or was it cardiac related.[73] Professor Heddle was not concerned about the potential for interaction between the Ventolin and the propranolol.

10.8. In addition to the prescriptions issued, Dr Quek also ordered blood tests and an ECG. Dr Quek gave evidence that he would not have prescribed propranolol if Mr Jablanovic had acceded to Dr Quek’s request to get the testing done that day, the results of which would have been available later that evening. However, because Mr Jablanovic did not want to get those tests done that day, he did not want to send Mr Jablanovic away having done nothing to alleviate his symptoms, which is why he prescribed propranolol.

10.9. Dr Quek conceded that he should not have prescribed propranolol until he had the results of the blood tests, and the ECG and cardiac failure was no longer a possibility in his mind. Unfortunately, Dr Quek’s eagerness to do something to alleviate Mr Jablanovic’s symptoms at that time resulted in him doing something that was actually more dangerous for Mr Jablanovic than doing nothing until he had the benefit of the blood tests and ECG, which Mr Jablanovic had said he would return for the following morning.

10.10. I accept the opinion of Professor Heddle that Dr Quek should not have prescribed propranolol in circumstances where Mr Jablanovic was known to him to be at a high risk of cardiac failure, was exhibiting the two most common symptoms of cardiac failure, and where Dr Quek knew that propranolol was contraindicated in cardiac

[71] A brand name of propranolol
[72] Exhibit C11
[73] Transcript, page 156

failure. Dr Quek failed to exercise appropriate caution when prescribing propranolol to Mr Jablanovic in circumstances where it posed a real danger to him.

11. **Did the propranolol prescribed by Dr Quek cause or contribute to Mr Jablanovic's death?**

11.1. Professor Heddle concluded in his written report that the propranolol was a major contributor to Mr Jablanovic's death.[74] Professor Heddle elaborated on this in his oral testimony, stating:

> 'We know that if you have heart failure which is not controlled and you give a beta-blocker, you can get rapid clinical deterioration. The temporal sequence of him taking the propranolol and becoming very unwell one hour after, is consistent with that. It doesn't prove it was the cause, but it is probable that it was the cause.' [75]

11.2. Professor Heddle pointed to further support for his conclusion that the propranolol contributed to Mr Jablanovic's death, that being that both within the ambulance and at the LMH Mr Jablanovic's heart rate was relatively slow, which is not what would you expect in a patient who is having circulatory collapse,[76] and was also out of the ordinary for Mr Jablanovic who had previously (on that date and at previous consultations) had a fast heart rate.[77]

11.3. Professor Heddle explained the mechanism by which propranolol may adversely impact a patient with cardiac failure:

> 'In the setting of impaired circulation, one of the body's compensations for that is to turn on the so-called adrenergic or the sympathetic nervous system to its maximum which means the release of adrenaline and noradrenaline to all the receptors to keep the circulation going which is what the doctors in intensive care unit do. And what propranolol does is it is a beta-blocker, it blocks that effect of adrenaline and noradrenaline on those receptors and if a patient is unwell and they're running on the sympathetic drive to keep the circulation going, if you give a beta-blocker you stop that sympathetic drive and you can lead to circulatory collapse. And it's something we do see on a frequent basis in teaching hospitals in patients given beta-blockers in a setting where they're not particularly well and within 30 minutes they have to go to the intensive care unit because the circulation has basically collapsed.' [78]

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[74] Though Professor Zeitz did not comment specifically on whether propranolol could have contributed to the death, he stated 'I have reviewed the report provided by Dr William Heddle dated 20 January 2018 in this matter. I have no reason to disagree with the conclusions of Professor Heddle in this matter and he has had the benefit of reviewing all of the relevant information and history relating to Mr Jablanovic'.

[75] Transcript, page 148

[76] Transcript, page 195

[77] Transcript, page 195

[78] Transcript, page 139

11.4. Counsel for Dr Quek has submitted that while there is no question that the administration of propranolol and Mr Jablanovic's decline were temporally connected, it does not provide a sufficient basis for the Court to find that propranolol was a major contributor or cause of the Mr Jablanovic's decline and death. Counsel for Dr Quek submitted that Professor Heddle was unfamiliar with propranolol, it not being a drug he prescribed in his treatment of patients for heart related conditions, and his unfamiliarity with propranolol was also apparent from his concession under cross-examination that whilst he had initially considered the dose prescribed to Mr Jablanovic - 40mg - to be a relatively large dose, that was not in fact the case and was in accordance with the recommended dose.[79] In the context of Professor Heddle's evidence as a whole, my confidence in his opinion about the appropriateness of propranolol being prescribed in the circumstances was unaffected by evidence that Professor Heddle could not cite the recommended dose as stated in the MIMS guidelines.

11.5. A finding that the propranolol contributed to Mr Jablanovic's death essentially amounts to a finding that the actions of Dr Quek contributed to Mr Jablanovic's death on that evening. I am mindful of the principle in *Briginshaw v Briginshaw*[80] that where a serious allegation is made, which it is necessary to determine, and the determination of that allegation will (or could) reflect adversely on a person:

> '…reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. 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 issue has been proved to the reasonable satisfaction of the tribunal.'

11.6. Bearing that in mind and having carefully considered all of the evidence, I am satisfied that the propranolol Mr Jablanovic took (in accordance with what was prescribed to him by Dr Quek) contributed to Mr Jablanovic's decline on the evening of his death. Professor Heddle pointed to ample support for his opinion that it was probable that the propranolol contributed to Mr Jablanovic's demise.[81] The other factor which obviously may have contributed to Mr Jablanovic's decline on this evening, was his underlying heart failure.

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[79] Transcript, page 190
[80] (1938) 60 CLR 336 at 362
[81] Transcript, page 196

11.7. I find that the taking of propranolol prescribed to him by Dr Quek contributed to Mr Jablanovic's decline on the evening of his death. The extent of that contribution cannot be established, nor can it be concluded whether or not he would have succumbed in any event to his cardiac failure if he did not take propranolol that evening.

12. Ambulance attendance

12.1. Although not examined in detail through the oral evidence at Inquest, Professor Heddle expressed his opinion that the ambulance management of Mr Jablanovic was correct, and that the time delay of 1½ hours at Mr Jablanovic's house, which was associated with difficulties extracting him from the home, would not have contributed to his death later that evening.[82]

13. Attendance at the LMH Emergency Department

13.1. Mr Jablanovic's presentation at the LHM was markedly different from his presentation to Dr Quek, with his condition having changed drastically in the interim.[83]

13.2. Of note was that Associate Professor Christopher Zeitz, current Head of Unit of the Cardiology Department at the Queen Elizabeth Hospital, who assessed Mr Jablanovic in the LMH ED, also did not diagnose cardiac failure. However, I am of the view that the failure to positively diagnose Mr Jablanovic with cardiac failure during his presentation to the LMH ED does not validate Dr Quek's failure to diagnose, or at least strongly suspect, cardiac failure during his consultation with Mr Jablanovic. Any comparison between what occurred at the LMH and what occurred during the consultation with Dr Quek is unhelpful due to the marked change in Mr Jablanovic's presentation in the interim, the difficulties associated with diagnosing cardiac failure in a patient on whom active resuscitation is being attempted,[84] and a lack of detail about what information Professor Zeitz had available to him about Mr Jablanovic's history when he was assessing him.[85]

13.3. Having reviewed all of the relevant material, Professor Heddle made no criticisms of the management of Mr Jablanovic at the LMH, and accordingly I find that the management of Mr Jablanovic at the LMH was appropriate.[86]

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[82] Transcript, page 150
[83] Transcript, page 131
[84] Exhibit C14, paragraph 14; Exhibit C15
[85] Transcript, page 188
[86] Transcript, page 146

14. Findings

14.1. As to Dr Quek's examination:

- Dr Quek failed to obtain an adequate history from Mr Jablanovic. In particular, he did not ask the important question about whether his shortness of breath was worse laying down;
- Dr Quek completed most of the appropriate physical examinations which would have been expected of a general practitioner in the circumstances;
- Despite Dr Quek adequately completing these examinations, he was unable to identify any symptoms which were consistent with Mr Jablanovic suffering from cardiac failure;
- Dr Quek should have made more extensive notes of his examinations to provide a more complete picture of the consultation;
- There was no proper basis for Dr Quek to exclude cardiac failure. Cardiac failure should have remained on the list of differential diagnoses;
- As to the prescription of propranolol, this should not have been done in circumstances where cardiac failure was not excluded from the list of differential diagnoses; and
- Rather than prescribing propranolol and allowing Mr Jablanovic to go home, Dr Quek should have sent Mr Jablanovic to a hospital emergency department for further examination.

14.2. As to the cause of death:

- The cause of death was congestive cardiac failure and cardiomegaly with left ventricular hypertrophy; and
- the propranolol taken by Mr Jablanovic as prescribed by Dr Quek contributed to his death at that time.

14.3. As to whether the death was preventable:

- Although I am satisfied that the taking of propranolol contributed to Mr Jablanovic's decline on the evening of his death, I cannot say whether or not he would have succumbed in any event to his cardiac failure if he did not take propranolol that evening.

- Furthermore, I observe Professor Heddle's evidence that Mr Jablanovic's long-term outlook was not favourable, and there was at best a one in two chance of him surviving about two years after his actual time of death.

15. Conclusion and recommendations

15.1. Pursuant to Section 25(2) of the Coroners Act 2003 the Court is empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest. I wish to make a recommendation similar to that made in the Inquest into the death of Roswitha Maria Osang,[87] regarding a beta blocker named sotalol.

15.2. I recommend that the Cardiac Society of Australia and New Zealand, in conjunction with the Royal Australian College of General Practitioners, consider whether it is necessary to alert the general practice community to the risks involved in the prescription of propranolol in untreated cardiac failure.

Key Words: Heart Disease; Medical treatment - medical practitioner; propranolol

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 9th day of November, 2023.

State Coroner

Inquest Number 17/2021 (0109/2017)

[87] [2016] SACorC 5 (11 April 2016)