CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF RICHARD ARTHUR HOLDEN

[2026] SACC 33

Inquest Findings of his Honour State Coroner Whittle

21 August 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a generally fit and healthy man who presented to a general practitioner with painful varicose veins and shortness of breath. He presented to the general practitioner twice more, being treated for asthma, before succumbing to a pulmonary embolism. The inquest explored whether the condition should have been detected earlier.

Held:

1. Richard Arthur Holden, aged 74 years of Flagstaff Hill, died at Flagstaff Hill on 29 August 2020 as a result of pulmonary thromboembolism due to right deep vein thrombosis.

2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MR D EVANS

Family: MRS M HOLDEN
Counsel: MS J MURPHY-ALLEN - Solicitor: MILLS OAKLEY

Witness: DR F CHAN
Counsel: MS S DOYLE - Solicitor: WALLMANS LAWYERS

Hearing Date/s: 06/05/2026-07/05/2026

Inquest No: 13/2026 **File No/s: 1739/2020**

INQUEST INTO THE DEATH OF RICHARD ARTHUR HOLDEN [2026] SACC 33

Introduction

1 The Court heard a brief inquest into the death of Mr Holden, particularly to explore whether there are any systemic issues arising with the identification of pulmonary embolism, which can be difficult to detect. I heard evidence from Mr Holden's general practitioner, Dr Fook Chan, who did not diagnose pulmonary embolus and I also received independent expert evidence from Dr Stephen Holmes.

Background

2 Richard Holden was born on 1 November 1945. As a child, he suffered from asthma.[1] He had a career as a schoolteacher. He was married for 52 years and lived at Flagstaff Hill.[2]

3 He went through prostate cancer in the 1990s and suffered from high blood pressure and high cholesterol.[3] He was otherwise generally fit and well.[4]

4 On 24 December 2019, Mr Holden visited his general practitioner, Dr Fook Chan, of the Brighton Medical Centre.[5] Mr Holden reported shortness of breath, a tight chest and dry cough. He said his shortness of breath was limiting his ability to exercise. He said that he was worried about asthma which he had had as a child. Dr Chan examined Mr Holden and diagnosed an upper respiratory tract infection, sinusitis with bronchitis and bronchospasm. He prescribed antibiotics and rest and a Ventolin puffer.[6] The Ventolin puffer contains the drug salbutamol which is short-acting and relaxes the muscles in the airway, opening them when constricted.

5 On Christmas day in 2019, Mr Holden had continued to experience difficulty breathing with a dry cough and was taken to the Ashford Hospital.[7] It was noted that he had no chest pain and got no relief from the use of the puffer prescribed.[8] He was found to have an acute kidney injury and mild thrombocytopaenia.[9] He was discharged home after three days. The doctor who treated Mr Holden wrote a discharge letter that was sent to Dr Chan. It recorded:

> He was admitted with 3-day history of feeling spasms in his chest associated with dyspnoea. He was recently commenced on oral antibiotics and bronchodilators. His chest was clear, no signs of cardiac failure, ECG showed normal sinus rhythm, there was mild pitting oedema of both legs.
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> …

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1 Exhibit C9 at 7
2 Exhibit C1a at [2]
3 Exhibit C1a at [26]
4 Exhibit C6 at [5]
5 Exhibit C11 at 14
6 Exhibit C11 at 46
7 Exhibit C1a at [3]
8 Exhibit C9 at 6
9 Exhibit C11 at 42

> He was reviewed by [a] Respiratory physician [and a] Cardiologist … Viral Bronchitis leading to bronchospasm was thought to be cause of his symptoms …[10]

6 Mr Holden was reviewed by Dr Chan on 4 January 2020 and, while he was still slightly short of breath, he had improved.[11] Mr Holden underwent a lung function test on 28 January 2020 which was reported as 'absolutely normal'.[12] Mr Holden had regular checkups with Dr Chan in February, April and July 2020.

August 2020 illness

7 On Saturday, 22 August 2020, Mr Holden once again experienced shortness of breath.[13] The next day, Sunday, he was not able to walk as far as usual due to light-headedness and thought he might be experiencing hay fever. He spoke on the phone to Dr Chan on Monday. Dr Chan noted shortness of breath and wheeziness with an occasional dry cough. He noted that Mr Holden said these conditions were assisted by Ventolin. Dr Chan explained to Mr Holden that because his symptoms were respiratory, he needed a COVID-19 clearance prior to attending for in-person assessment.[14] This was a requirement at the time to protect everyone from the spread of COVID. Mr Holden underwent COVID testing at 11:15 am on Monday 24 August 2020.[15] The result, reported that night, was negative. In the meantime, Mr Holden's breathing had improved.

8 On Tuesday, 25 August 2020, Mr Holden went to see Dr Chan. Dr Chan recorded an examination which revealed no respiratory distress, a slightly inflamed throat and some generalised crepitations heard on auscultation.[16] He noted painful varicose veins in Mr Holden's right leg and made a referral to a vascular surgeon. Dr Chan advised Mr Holden to continue using Ventolin and also prescribed Pulmicort to help his breathing.[17] Pulmicort contains the drug budesonide which is a long-acting steroid that reduces the occurrence of inflammation in the airways. It can take weeks of consistent use to fully achieve its preventative purpose. After that appointment, Mr Holden still continued to have a persistent cough and some light-headedness.

9 On Friday, 28 August 2020, Mr Holden did not feel that he was improving, and he returned to see Dr Chan again.[18] There was a dispute during the inquest about the date that this consultation actually occurred. Dr Chan said that if the appointment was not on the date that he made his record of it, he would have made a specific record that it was a retrospective note, which he did not do.[19] I think it most likely occurred on 28 August 2020 and not on the previous day, but it is not necessary to resolve this given that the timing is not critical and there is no dispute that the appointment occurred. I shall continue to refer to it as the 28 August 2020 appointment.

10 Mr Holden reported that he continued to feel short of breath and wheezy, that he still could not exert himself physically, and was now getting dizzy and short of breath on

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10 Exhibit C11 at 42
11 Exhibit C11 at 14-15
12 Exhibit C11 at 39-40
13 Exhibit C1a at [4]
14 Exhibit C11 at 16
15 Exhibit C12
16 Exhibit C11 at 16
17 Exhibit C1a at [6]
18 Exhibit C11 at 16-17
19 T76

exertion. He said he had been using the Ventolin and Pulmicort. Dr Chan told Mr Holden that it would take some time for the medication to deal with his asthma.[20] Dr Chan recorded a query as to whether Mr Holden's cholesterol medication was involved in the symptomology.[21] He advised Mr Holden to cease using his cholesterol medication as it can cause asthma-like symptoms. Mr Holden followed this advice.

11 After the consultation, Mr Holden was still a little breathless although he got some relief from using his puffer.[22] That night, his breathing became very laboured even while asleep. In the morning of Saturday, 29 August 2020, Mr Holden said that he was having trouble breathing. He used his puffer and got some relief. When he got up, he did not have the energy to shower and needed to stay seated.

12 At 9 am, he visited Dr Chan again.[23] Dr Chan recorded:

> patient is still feeling very short of breath, also wheezing
> using Pulmicort and Ventolin, not helping
> patient is feeling anxious and uptight

13 On examination, Dr Chan found an increased respiratory rate with wheezing. He recorded that this increased when walking short distances. Dr Chan said that Mr Holden reported no chest pain or sweating and no radiating pains.[24] Dr Chan recorded a diagnosis of asthma and prescribed a new puffer, Seretide to replace the Pulmicort and told Mr Holden to return on the following Monday. Seretide effectively combines the actions of the Ventolin and Pulmicort, providing long-term cause treatment as well as immediate relief. Mr Holden struggled to walk out of the building after the appointment but, stoically, said that he was fine.[25]

14 After returning home with his new medication, Mr Holden ate breakfast and took some Ventolin. Later, he ate lunch. He still did not feel that he had enough energy to shower. He then reported that he felt as though he was going to faint.[26] While his wife went to call the Ashford Hospital, Mr Holden walked to the garage and collapsed. Mrs Holden then went to call an ambulance and Mr Holden got up and moved before collapsing again.[27] When Mrs Holden returned, Mr Holden said 'I hope they're coming soon because it's not good'.

15 At the time, the nearby Flinders Medical Centre was ramping ambulances to deal with overcrowding in the Emergency Department.[28] This has flow-on effects to the availability of ambulances in the community.

16 While waiting for an ambulance, Mrs Holden observed Mr Holden to begin to turn purple.[29] He then began to have fits and was gasping for air. Mrs Holden commenced

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[20] Exhibit C1a at [7]
[21] Exhibit C11 at 17
[22] Exhibit C1a at [8]
[23] Exhibit C1a at [10] and Exhibit C6 at [13]
[24] Exhibit C6 at [12]-[13]
[25] Exhibit C1a at [11]
[26] Exhibit C1a at [14]
[27] Exhibit C1a at [18]
[28] Exhibit C7 at [5]
[29] Exhibit C1a at [20]

CPR and within a minute or so at 2:24 pm[30] SPRINT paramedic, Tina Bolto, arrived and took over. Ms Bolto found mottled skin to Mr Holden's chest area. Defibrillation pads were applied and pulseless electrical activity was found.[31] Minutes later, additional paramedics arrived and assisted.[32]

17 CPR was continued for numerous cycles involving the administration of five doses of adrenaline and 13 attempts at delivering defibrillation, none of which was indicated for discharge.[33] A declaration of life extinct was made at 3:02 pm.[34]

Cause of death

18 A post-mortem examination was conducted by senior specialist forensic pathologist Dr John Gilbert.[35] Dr Gilbert found a massive pulmonary thromboembolism which had resulted from a deep vein thrombosis in the right calf. He also found scattered smaller peripheral thromboemboli in the medium-sized pulmonary arteries which he considered may well account for the earlier symptoms that led to presentations to Dr Chan. Dr Gilbert was satisfied that these thromboemboli establish that the symptoms from 24 August 2020 onwards were the result of pulmonary thromboembolism.[36]

19 Dr Gilbert concluded that Mr Holden's death was as a result of pulmonary thromboembolism due to right deep vein thrombosis, which I am satisfied is a proper reflection of the evidence. I find that to have been Mr Holden's cause of death.

Independent expert evidence

20 The Court received a report from independent expert general practitioner, Dr Stephen Holmes.[37] Dr Holmes works as a rural general practitioner. Rural general practitioners are required to deal with more acute patients with a wider scope of practice than most metropolitan general practitioners. In my view, this makes Dr Holmes well placed as an expert to comment on the actions of a metropolitan general practitioner who is dealing with less complex cases.

21 While Dr Holmes answered questions about the personal choices that he might have made in the circumstances of Mr Holden's presentations, I am not satisfied that I should place much weight on those views. I was more interested in, and have relied on, Dr Holmes' expertise in relation to what best practice and routine practice is and how that aligned with Dr Chan's actions.

22 Dr Holmes said that Mr Holden's presentation in the days leading to his death had several concerning features which indicated a referral to hospital, with the strength of that indication increasing over the repeating attendances. Dr Holmes considered that Dr Chan's care was active and conscientious, but that he did place too much reliance on

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30 Exhibit C5 at [5]
31 Exhibit C5 at [8]
32 Exhibit C5 at [9]
33 Exhibit C10 at 2
34 Ibid
35 Exhibit C2
36 Exhibit C2 at [5]
37 Exhibit C8

Mr Holden self-presenting again if things got worse. He said that referral to hospital was indicated at the first face-to-face consultation and mandated by the time of the second.

23 Notwithstanding his view that referral to hospital was indicated on 25 August 2020, Dr Holmes was understanding of various factors at play and considered it was reasonable for Dr Chan to treat asthma until 28 August 2020 when a failure to refer to hospital was clearer.[38]

24 Dr Holmes said that Mr Holden's presentation raised a number of possible causes, including asthma, pulmonary embolism and silent myocardial infarction.[39]

Dismissing or not considering uncommon alternative diagnoses despite serious consequences

25 Dr Holmes explained that most medical practitioners will naturally reach a working diagnosis very quickly as they commence assessing a patient. However, during his evidence, Dr Holmes also spoke about the sound of 'hoof beats'.[40] He explained:

> Q. Is it important to consider the very high risk potential differentials before moving on to treat the more common less risky differentials.
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> A. … I had a mentor that taught me when I was a young doctor and he said, 'When you hear hoof beats you expect horses, not zebras', so that sums up that we tend to focus on the common things because that's where the biggest dividend is. But saying that you need to be aware of potential serious consequences if there is something else that's going on. I think in this case it's, in retrospect it's easy to be aware but sitting in that position at that time I think the presentation was initially asthma, which is a common condition and not an uncommon condition such as pulmonary embolus.

Dr Holmes elaborated:

> A. …common things happen commonly and your mind is attuned to common things and bang for buck ... but we need not to underestimate the serious consequences of uncommon things.

26 Clinicians' failures to consider or exclude very high risk potential differential diagnoses before deciding upon a working diagnosis with much less serious consequences is a recurring theme in coronial inquests. I made similar observations in *Inquest into the death of Ronald Bromage* in 2023 where Dr Heddle said that clinicians must think of the worst possible diagnosis first and exclude it before thinking of a more likely common diagnosis.[41] Dr Chan appears not to have taken that approach in Mr Holden's case.

Assessment of Dr Chan's approach

27 Dr Chan and Dr Holmes both spoke about the impact of COVID at the time of Mr Holden's presentations.[42] Those matters were not disputed, other than to the extent of establishing that things were different in the metropolitan area in comparison to rural areas. The Court is required to assess the actions of Dr Chan in the circumstances in which they occurred. Those circumstances necessarily involved COVID which dictated

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38 T120
39 T128
40 T92
41 See pages 12-13
42 T28 and T101

so much about healthcare at the time. It must be observed that Mr Holden had respiratory issues in the week of his death. Referral to hospital would have placed him at great risk of infection with COVID, on top of an existing respiratory condition, which was a general concern at the time.[43] If the seriousness of the condition was properly appreciated, then that risk would pale in comparison, but the true seriousness of Mr Holden's condition was not understood. That there would have been hesitation in exposing him to a COVID hotspot is therefore not unreasonable, however it is difficult to conclude that Mr Holden would not have attended hospital for help if he was directed.

28 Dr Holmes said that Dr Chan not considering a potential differential diagnosis of pulmonary embolism on 25 August 2020 was in keeping with what he would expect most general practitioners to have done.[44] In particular, Dr Holmes said that he would expect most general practitioners to consider Mr Holden's painful varicose veins as a separate issue to the respiratory problems.[45] Medicine involves weighing different symptoms and it must be remembered that there needs to be a sufficient basis to fairly strongly suggest a condition before the Court could criticise a general practitioner for not turning his mind to that particular condition. While Dr Chan might have been more cautious and thought about wider possibilities, Dr Holmes' clear evidence was that Dr Chan's approach was consistent with the standard of care expected from general practitioners. Given that Mr Holden's prescription for atenolol could contribute to respiratory symptoms in a patient with a history of asthma, it was reasonable to cease this and see whether that brought about an improvement.

29 While there were questions asked during the inquest about the size of Mr Holden's calves and whether they were measured by Dr Chan, I am not satisfied that a size difference, measured at less than 5% during post-mortem examination, was of true significance in vivo,[46] although Dr Holmes agreed it was 'probably' significant if you could rule out post-mortem thrombolisation, which he could not do.[47] He then went on to explain that such a difference might in any event be difficult to detect. I consider that anatomical symmetry is rare and that in the context of all of the evidence, this piece of evidence at post-mortem is not meaningful.

30 In any event, I accept that Dr Chan did examine Mr Holden's calves on 25 August 2020 in accordance with his evidence about his usual practice.[48] I take into account that I consider it unlikely that any doctor would make a referral to a surgeon without having examined the area of concern.[49] Dr Holmes said that it would be common for a general practitioner to consider the calves as a separate concern to the respiratory issues. Dr Chan said that it is only with the benefit of hindsight that the two can be easily linked.[50] Dr Holmes described the nature of the connection being that the venous issue is a 'risk factor' or 'a little red flag' for pulmonary embolism.[51] In that light, I do not strongly criticise Dr Chan for failing to draw the connection at that time.

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43 T58
44 T105
45 T106
46 T68
47 T116
48 T33 and T76
49 T76
50 T77
51 T107-108

31 Dr Chan was asked about his reference to 'advice' in his medical notes and explained that this note encompassed his discussion with Mr Holden about what would happen next and what to do if things got worse, which would vary depending on the condition.[52] I am satisfied that Dr Chan gave Mr Holden advice on this topic, as he said he had. I have no concerns based on the brevity of the notes, which are expected for a busy general practitioner.

32 Dr Holmes said that while there were further 'red flags' at the 28 August 2020 presentation, there were also comforting factors for a general practitioner, namely the normal heart rate and blood pressure.[53] Dr Holmes agreed that this consultation was an opportunity to reconsider Dr Chan's commitment to asthma as the condition he was observing.[54] Dr Holmes maintained, as stated in his written opinion, that hospital referral was warranted, or 'strongly indicated' following this consultation.[55] However, Dr Holmes was mindful of the benefit of hindsight and thought there was a defensible argument that altering the asthma treatment by stopping the beta blocker and monitoring symptoms was reasonable on 28 August 2020.[56]

33 Dr Holmes again expressed reservations about access to care during COVID but conceded that such considerations do not alter the role of the general practitioner to make appropriate escalations.[57] Dr Chan spoke of the impact that COVID had on his practice as a general practitioner. He described there being a 'real hysteria' before treatments and vaccinations were available and that this affected the manner in which patients with respiratory conditions were treated.[58] In particular, he highlighted a real reluctance on the part of patients to attend hospital unless absolutely necessary.

34 Even so, Dr Chan accepted, in retrospect and with the benefit of hindsight, that he should have referred Mr Holden either to hospital or for doppler ultrasound on 28 August 2020.[59] This was the point at which escalation of the presentation had occurred and a lack of response to first-line asthma treatments was evident. While there was still asthma medication untried, there was a distinct possibility at this point that something other than asthma might be going on.

35 Although Dr Chan made that concession, I am satisfied that it was not unreasonable for Dr Chan to prescribe Seretide, effectively taking the next step on the path of asthma treatment, but that he should also have referred Mr Holden to hospital to ensure that any more serious causes of his condition were able to be excluded.

36 There were suggestions that an ambulance might have been called, but I am not satisfied that that was required without the benefit of hindsight. That would have been an extreme step for a patient who was in a condition to get himself to hospital, which is what should have been recommended.

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52 T57
53 T108
54 T109
55 T120 (Transcript incorrectly records '**wasn't** warranted'), T124.5 and T125.8
56 T124
57 T121 and T123
58 T102
59 T84

37 I am satisfied that Dr Chan acted under a commitment bias and failed to consider alternative explanations for Mr Holden's presentation. Dr Chan accepted this criticism.[60] It was unfortunate that that commitment bias arose without Dr Chan even having earlier given consideration to more serious potential diagnoses.[61] It was effectively a commitment to an assumption formed without full consideration. Mr Holden's repeated presentations with the same and worsening symptoms ought to have prompted a rethinking of the initial diagnosis.

38 To be clear, I make no criticism of Dr Chan's treatment of asthma. That was adequate. The failure was to continue to treat asthma without consideration of alternative diagnoses, particularly as they were alternatives with potentially threatening serious consequences.

AHPRA

39 In reaching my findings, I have disregarded the actions taken by AHPRA in response to a complaint by Mr Holden's family. That another organisation assessed different evidence under non-judicial processes and potentially reached different views is not generally a consideration of weight in reaching coronial findings. Specific facts revealed by a different investigation might be helpful in assessing coronial issues, but the outcome of a different investigation is simply not, especially where the reasoning for that outcome is not able to be scrutinised.

Preventability

40 Given the evidence I heard and received[62] I am satisfied, on the balance of probabilities, that Mr Holden's death would have been prevented by the identification by Dr Chan on 28 August 2020 that Mr Holden needed to be assessed for more serious potential conditions and by telling him to proceed directly to hospital or at least to a medical imaging facility for an ultrasound.

41 While Dr Chan spoke about the reluctance of patients to attend hospital, and Dr Holmes expressed reservations about access to care at the time due to COVID, in my view, while there were pressures and delays, emergency care would still have been available for Mr Holden. In my view, if the potential seriousness of his condition was appreciated and conveyed to him, he would have been likely to attend hospital. In reaching that conclusion, I place weight on the fact that he had attended the clinic multiple times with the same concern, clearly wishing to have it addressed. In my view, had a patient presented during COVID times to either a hospital or a medical imaging facility, with an ultrasound requested on a background of painful leg veins and shortness of breath, this would have been facilitated. I am satisfied on the balance of probabilities therefore that he would have received the assessment and care necessary to identify and treat his true condition. I am satisfied that it is more likely than not that this would have prevented the progression of his illness to an irretrievable point, with his death not occurring until 3 pm the following day, some 30 hours later.

42 Whether Mr Holden's death could have been prevented by referral to hospital on the morning of his death is much less certain. I am not able to reach a finding that any

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60 T81 and T83
61 T83 and T85
62 T112

different action by Dr Chan on that morning would have changed the outcome. There was simply not enough time available to be certain enough to reach such a finding.

Recommendations

43 Dr Chan explained in his evidence that he was acting under a misapprehension. That is, he considered that pulmonary embolism always presents with chest pain.[63] That is not so.[64] He said that he learned that following Mr Holden's death.[65]

44 Dr Holmes gave evidence that medical training in decades past was not clear on this issue,[66] focusing instead on the classic presentation, as once understood, with chest pain and it was therefore not unreasonable for Dr Chan to continue his practice unaware of a development in the contemporary understanding of pulmonary embolism. Dr Holmes said that pulmonary embolism is now known as 'the great masquerader' but Dr Chan did not know that.

45 Given that Dr Chan had no awareness that pulmonary embolism can present without chest pain, I am not able to criticise him for not considering it as a differential. I am critical of his failure to consider any differentials at all other than asthma, but specific criticism that he did not turn his mind to pulmonary embolism is not logically open.

46 Given this misapprehension and given that Dr Holmes said that pulmonary embolism can commonly be confused for asthma,[67] I make the following recommendation to the Royal Australian College of General Practitioners and to the Australian College of Rural and Remote Medicine:

> *One* That a communique be sent to all members drawing attention to this Finding and raising awareness of the subtlety with which pulmonary embolism can present. Members should be reminded to first consider and exclude diagnoses of very high risk and be alert to the potential for diagnostic commitment bias following a failure to improve with treatment.

47 I am satisfied that this recommendation should be made in these terms without specifying a greater level of detail about particular symptoms that may or may not present, as this tends to distract from the notion that pulmonary embolism can present different symptoms in different people.

Condolences

48 Although Mr Holden's death was sudden, indications of his condition were present when he sought medical assistance, and if diagnosed it was treatable. These are difficult circumstances for Mr Holden's family to deal with. I express my condolences to them for their loss.

Keywords: *General Practice; Pulmonary Embolism*

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63 T78 and T79
64 T94
65 T78
66 T94
67 T95