MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Leigh Ronald Roberts

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Leigh Ronald Roberts;

b) Mr Roberts died in the circumstances set out below;

c) Mr Roberts' cause of death was coronary atherosclerosis; and

d) Mr Roberts died on 23 February 2020 at Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Roberts' death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Affidavit of the forensic pathologist Dr Andrew Reid;
- Affidavit of Sarah Marshall;
- Medical records obtained from the Davey Street Medical Centre;
- Reports from Dr Stephen Bennett; and
- Report of Dr Richard Roffe.

Background

Mr Roberts was 56 years of age (date of birth 19 January 1964), married and he was in full time employment on the date of his death. Mr Roberts was born in Hobart and spent the majority of his life in southern Tasmania. He had been married to Jane Roberts but they had divorced some years ago. They had two children together; a son and a daughter. Mr Roberts married Sarah Marshall in 2013. He spent the majority of his working life in management roles.

Mr Roberts was described by his wife as being healthy. He never got sick or needed to see a doctor and he would rarely have a sick day off work. When he was unwell he would often carry on. Ms Marshall says he was overweight[1] and as he was over 50 years of age he regularly had blood tests to check his cholesterol levels and he regularly had his blood pressure checked. He also had annual checkups. She says on multiple occasions the blood test results came back with him having a higher than normal range of LDL cholesterol.[2] His blood pressure was also sometimes high.

Ms Marshall says she is not entirely sure of Mr Roberts' family history however she has spoken to his brother and was told that on his mother's side they had three cousins who had died of heart attacks. Their mother's uncle also died of a heart attack when he was in his early 50s and their mother's grandmother and grandfather both died of heart attacks. Mr Roberts' brother and his father both took medication to manage their cholesterol. His father also has diabetes and a pacemaker. Most of this history was not provided to Mr Roberts' general practitioner (GP) Dr Bennett.

Circumstances leading to death

Ms Marshall says before Mr Roberts passed away he had been unwell with a cold for a few weeks. His cold developed into a cough and he started to cough up clear liquid and mucus occasionally. The cough became progressively worse and she was worried it had developed into a chest infection. She says he also felt exhausted, was short of breath and had a fever to the point that he came home from work early on Wednesday and Thursday,12 and 13 February 2020 which she says was extremely rare for him. She recommended he see a doctor and she believes he saw Dr Stephen Bennett on Friday or Monday, either 14 or 17 February 2020. Dr Bennett intended to prescribe an antibiotic[3] for a chest infection. Mr Roberts previously had the same antibiotic which Dr Bennett intended to prescribe and he had some of it left which he took to the appointment. Mr Roberts asked if he could take this medication, as it was still in date, rather than getting a fresh prescription. Dr Bennett agreed to this course given that was the medication he was going to prescribe anyway.

Three days into the course of taking the medication, Mr Roberts was not improving. He was still coughing regularly, he was short of breath, he had a fever and he felt exhausted. He took 17 and 18 February 2020 off work before he returned to work on the next two days even though he still did not feel well. Ms Marshall convinced him to return to the doctor on

[1]The medical records indicate that as at 10 January 2020 Mr Roberts weighed 114 kg which converts to a body mass index of 35.4.
[2] LDL cholesterol transports cholesterol particles throughout the body where it builds up on the walls of arteries, making them hard and narrow. HDL cholesterol picks up excess cholesterol and takes it back to the liver.
[3] Amoxicillin.

Friday, 21 February 2020. She says Mr Roberts went to work that morning with the intention of booking a doctor's appointment for later in the day. As he was walking from his car to his office he was extremely short of breath and he felt like he was going to faint. He also felt hot and sweaty. He had to stop a few times before he reached his office and made an appointment to see Dr Bennett that morning.

Mr Roberts told his wife that he described his symptoms to Dr Bennett including what had occurred on his walk from his car to his office. He advised her Dr Bennett checked his lungs with a stethoscope and said he could not hear anything but would instead prescribe a different antibiotic which Mr Roberts started taking as soon as he got home. Mr Roberts rested for the balance of that day and on the Saturday. However by Saturday evening he was feeling worse. At around 9:30pm Ms Marshall spoke to Mr Roberts about taking him to the Emergency Department and although he was worried he indicated he wanted to wait until the next morning.

The next morning he woke up and was finding it hard to breathe. He appeared to be in pain. Ms Marshall immediately called an ambulance which arrived approximately 15 minutes later. Mr Roberts went into cardiac arrest. Paramedics attempted to resuscitate him but they were unsuccessful.

Investigation

The forensic pathologist Dr Andrew Reid conducted a post-mortem examination on 24 February 2020. As a result of his examination of Mr Roberts and after consideration of the results of microscopic and microbiological examination he determined the cause of death to be coronary atherosclerosis. Interstitial oedema[4] with mixed lymphocytic and eosinophilic inflammation is another significant condition which contributed to Mr Roberts' death, but it was not related to coronary atherosclerosis or any condition which caused that disease. The autopsy revealed coronary atherosclerosis affecting all three main coronary arteries with stenosis of up to 90% in the middle third of the right coronary artery. This was confirmed histologically. Features of ischaemic heart disease secondary to coronary atherosclerosis were seen in histological sections of the myocardium. Dr Reid says the antemortem symptoms described in the police report of death to the coroner are consistent with ischaemic cardiac pain secondary to ischaemic heart disease from coronary atherosclerosis. In addition Dr Reid says the following:

[4] The early stage of severe swelling.

"Coronary atherosclerosis and ischaemic heart disease (IHD) are known to cause sudden cardiac death (SCD). SCD may occur without any antemortem diagnosis of ischaemic heart disease and SCD is a common presentation of a previously latent or undiagnosed IHD.

The common mode of death in SCD is a fateful irreversible abnormality of cardiac rhythm (arrhythmia). The arrhythmia cannot be reversed by the bystander cardiopulmonary resuscitation (CPR) or resuscitation by emergency medical services as was the case for this man.

The findings in the lung features of diffuse mild and vocally prominent interstitial oedema and mixed lymphocytic and eosinophilic inflammation [are] non-specific but consistent with viral pneumonia. There were no florid pan lobar pneumonic changes or evidence of other microbial pneumonia.

The possibility of a mild early viral pneumonia cannot be excluded. This could be related to the upper respiratory tract infection (URTI) symptoms from which the deceased was described as suffering. There is no evidence to suggest that the deceased was suffering from SARS – COV – 2 viral infection (COVID – 19). In cases where COVID – 19 has been fatal the lungs are overwhelmed, and the clinical picture is of a florid viral pneumonia with the nature and degree of hypoxia suggesting an element of vascular cellular damage (vasculitis). Equally, the possibility that the changes are related to another viral infection causing URTI cannot be excluded. The first confirmed case of SARS-COV-2 (COVID – 19) in Tasmania was reported on 2 March 2020.

The lung disease probably contributed to the death by adversely affecting the deceased breathing and therefore contributing to a fatal cardiac arrhythmia in the context of ischaemic heart disease due to coronary a theory oh sclerosis. There is insufficient evidence from which it would be appropriate to conclude that the lung disease was the primary cause of death."

There were incidental thyroid and pericardial nodules found but Dr Reid says they did not cause or contribute to Mr Roberts' death. I note Dr Reid's opinion which included pulmonary and cardiac histology was peer reviewed by Dr Don Ritchey the then State forensic pathologist. I accept Dr Reid's opinion.

Mr Roberts medical records indicate he was diagnosed with hyperlipidaemia[5] and hypertension[6] in 2013. They were said to be current active problems. Mr Roberts had undergone lap band surgery in 2017 and in 2019 it is noted he had lost 8 kg. His current

[5] High cholesterol or too many lipids or fats in the blood.
[6] High blood pressure.

medications were said to be Cialis[7], Keflex[8] and Temaze[9]. A family history of cholesterol in so far as Mr Roberts' brother is concerned is noted. The records cover the period from October 2010 until February 2020. The first appointment on 20 October 2010 notes a family history of dyslipidaemia and the need for tests. It was noted he was due for tests on 12 September 2012. On June 5, 2013 his blood pressure was noted to be very high (148/100). Bloods were ordered. These results were discussed at the next appointment on 19 July 2013 at which time both hyperlipidaemia and hypertension were first diagnosed and Mr Roberts was commenced on a statin. His blood pressure on that occasion was 171/98. I note each time blood tests were ordered they included lipids testing for cholesterol. His next three appointments on 18 and 31 December 2013 and 10 January 2014 were for hypertension. Further biochemistry tests were conducted and the results were discussed with Mr Roberts at an appointment on 22 October 2014. At an appointment on 19 February 2015 it was noted his blood pressure was elevated and there was a need to review it every few months and sleep was an issue because his stepson had been in a motor accident the previous November and he and his wife were caring for the stepson. Blood tests were taken again on 1 July 2016 and 13 July 2017. On 3 October 2017 the results were discussed and a referral was provided for lap band surgery. Further blood tests were taken on January 15, 2019 and Mr Roberts was reviewed a week later. The next time blood tests were done was on 10 January 2020 and six days later at an appointment it was noted the results were good and his lipids were to be checked again in six months.

The records disclose Mr Roberts' first appointment with Dr Stephen Bennett in February 2020 was on 17 February 2020. It appears from the records Dr Bennett took over Mr Roberts' care in 2016 after he had previously seen Dr Gregor and Dr Sadruddin. The notes for the attendance on 17 February 2020 are as follows:

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Monday February 17 2020 11:01:24
Dr Stephen Bennett

History:
Has had URTI - home Thursday and Friday.
Wife wanted chest check. Green sputum and wheeze.

HAs Aug. Duo forte from South Africa trip last year
Examination:
LLL some rhonchi

Patient Name: Mr Leigh Roberts

[7] A medication used to treat erectile dysfunction.
[8] An antibiotic prescribed to treat bacterial infections.
[9] A benzodiazepine used on a short time basis to treat insomnia.

Reason for contact:
RTI (Respiratory Tract Infection)

Management:
Advice - take the antibiotics.
Actions:
Letter Created - re. Certificate - (>1day) - D to .
Letter Printed - re. Certificate - (>1day) - D to .
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Mr Roberts next saw Dr Bennett on February 21, 2020. The notes are as follows:

Friday February 21 2020 08:57:04
Dr Stephen Bennett

History:
Feels chest went backwards yesterday.
This morning SOBOE
Persisting cough.
Yesterday minor specks blood.
Examination:
Chest - no signs noted.

Reason for contact:
RTI, Dyspnoea on exertion.
Actions:
Prescription added: KEFLEX CAPSULE 500mg 2 b.d. a.c.
Prescriptions printed:
KEFLEX CAPSULE 500mg 2 Twice a day Before meals
Diagnostic Imaging requested: X-ray - Chest. Send imaging reports to My Health Record. If persists

Review:
p.r.n.
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Dr Bennett was contacted by my office for comment and he advised he had been a general medical practitioner for 40 years after having qualified in 1975. He indicated his normal practice is to record all symptoms a patient reports in a consultation and that it was noted his notes do not refer to chest pain. Dr Bennett says Mr Roberts, *"should he have referred to chest pain, I would have recorded the symptom and managed appropriately."*
Dr Bennett also provided the following information:

5. The symptom of haemoptysis (coughing minor specks of blood) is not an unusual symptom with respiratory infections. "SOBOE" is an abbreviation for shortness of breath on exertion and, with "persisting cough", can be consistent with a developing pneumonia.

Given his presentation 17.2.2020 describing preceding URTI (upper respiratory infection) symptoms followed by lower respiratory tract infective symptoms with green sputum and wheeze and the clinical findings of "some rhonchi LLL" ie wheeze in the region of the left lower lobe of the lung, I summarised the reason for consultation as a RTI (a less specific term taken from the Medical Director softwear) which applies to both upper and lower respiratory tract infection. However, the implication was that he was potentially developing a pneumonia secondary to his initial viral like symptoms and I concurred with his suggestion he took the antibiotic Augmentin Forte Duo which had been prescribed for his travel medical kit.

His presentation 21.2.2020 suggested progression of the chest infection but I noted no signs in his chest ie the rhonchi were not present. I suggested the usually well tolerated Keflex (cephalexin) antibiotic to be started and issued him with a request for a chest X Ray should his symptoms persist or worsen and to be reviewed. He did not report chest pain.

Mr. Roberts suffered comorbidities of obesity, raised blood pressure and raised cholesterol (lipids) noted in 2013 . He was an ex smoker, also a risk factor. A colleague Dr. Amin prescribed diet and lifestyle modifications, a blood pressure tablet (Olmetec Plus) and a lipid lowering tablet (the statin Lipitor). He had a Lap Band in 2018 to assist management of his obesity.
It is noted that his brother also had "raised cholesterol" (ie lipids).

It appears Mr. Roberts was intolerant of the lipid lowering tablet and ceased taking it. It also appears he ceased the Olmetec.

He also had been prescribed Viagra and then Cialis for erectile dysfunction, commencing in 2013. There is a correlation of coronary artery disease with vascular erectile dysfunction.

The post mortem suggesting cause of death as coronary atherosclerosis (I assume coronary occlusion is implied. But I am familiar that an occlusion is not always demonstrated in the coronary arteries at post mortem examination) is consistent with his risk factors.

The medical records and Dr Bennett's response were considered by the general practitioner Dr Roffe. He noted Mr Roberts' past medical history of significance and the medication he was prescribed at the time of his death. He also noted the summary of the history from Ms Marshall which is set out in Dr Reid's report and which is as follows:

> *"He had presented to his GP on 21 February 2020 with symptoms of shortness of breath and chest pain which he had been experiencing since 17 February 2020 and cold symptoms for about a week. His GP diagnosed a possible chest infection and prescribed antibiotics and planned to review him again on 24 February 2020."*

Dr Roffe notes the history set out in Dr Bennett's notes, although brief, does not mention any chest pain. When seen on 17 February 2020 a note was made of an upper respiratory

tract infection, that Mr Roberts had been home for two days and there was a history of green sputum and a wheeze. On examination there were some signs indicating the wheeze was coming from the left side of the lung. Dr Roffe noted Mr Roberts was advised to take some antibiotics that he had left over from a previous overseas trip. In the notes for the attendance on 21 February 2020 it is recorded Mr Roberts felt like his chest went *"backwards yesterday"*. Again there is no report of chest pain. He was short of breath on effort, he had a persistent cough and he had some minor specks of blood, presumably in his sputum. There were no symptoms or signs recording ankle swelling, nor calf tenderness. His chest was clear and a further course of antibiotics was prescribed. At the second consultation Mr Roberts was advised to have a diagnostic chest x-ray *"if persists"*. Dr Roffe presumes this to mean that if his symptom complex persists however this is not recorded. It is noted Mr Roberts passed away two days later.

Dr Roffe noted Mr Roberts first consultation with Dr Bennett was on 1 July 2016 and that he was seen on a fairly regular basis after that date up until he died. The majority of these consultations were in relation to his lap band and the intermittent review of general blood tests. Some of the blood tests included cholesterol measurements and blood pressure. According to the records his blood pressure was last recorded on 13 July 2017 and it was elevated. At the consultation on 16 January 2020 there is a comment that the *"results good, check lipids in six months"*. However the lipids recorded on 10 January 2020 were abnormal and had deteriorated since their previous measure on 15 January 2019. It was noted Mr Roberts was previously on antihypertensive and cholesterol-lowering medication but for whatever reason these had not been continued for an extended period of time.

Dr Roffe says in summary Mr Roberts was reviewed by Dr Bennett in February 2020 with respiratory symptoms, suggestive of viral illness for which he was prescribed an antibiotic. A chest x-ray was advised if the clinical situation deteriorated. Dr Roffe notes the absence of chest pain symptoms in Dr Bennett's records. He said had this been detected this would be:

> *"quite concerning for a patient with significant [cardiovascular] risk factors, as one would usually refer the patient to hospital or at least undertake cardiac investigations such as an ECG. Also if the patient had reported that he had chest pain as well as coughing up blood and had significant shortness of breath, it would make one consider a pulmonary embolism as a diagnostic possibility, which would also require immediate investigation and/or hospitalisation."*

As a result of Dr Roffe's report further advice was sought from Dr Bennett. He was asked the following:

1. What if any alternatives were discussed with Mr Roberts in relation to intolerance of the lipid lowering tablet?
2. Why did Mr Roberts cease taking the Olmetec medication?
3. It appears Mr Roberts heart condition was left untreated, is this correct? If so, can you please provide your reasoning as to why?

Dr Bennett's answers were as follows:

1. The consultations with Dr. Sadruddin and Dr Gregor do not record if alternatives were discussed.

19 July 2013 Dr. Sadruddin records -

"2/When started lipitor he had aches/pains for a few days. They have now settled completely. Suggest we check CK anyway."

It appears Mr. Roberts continued on the statin Lipitor. There was no record of it being ceased in that consultation. His CK (muscle enzyme) 19.10.2013 was normal. Also, as his pathology requested by Dr Gregor 11.10.2014 showed his lipid profile had improved, it suggests he was taking the statin.

30 September 2014 Dr. Gregor recorded -

OLMETEC PLUS TABLET 20mg/12.5mg ceased.
LIPITOR TABLET 20mg ceased.

22 October 2014 Dr. Gregor recorded -

"1. Results discussed - Vit D low only abnormal result"

I assume Dr. Gregor considered that initial response to diet and lifestyle was satisfactory. As noted above, he recorded cessation of the statin Lipitor.

I cannot see a further record in Mr. Robert's notes in relation to statin therapy or alternatives.

2. Dr. Gregor recorded 19 February 2015 -

"3. BP elevated - needs review few month.s" (sic)

There is no subsequent record indicating cessation of Olmetec or discussion.

3. There is no record of Mr. Roberts suffering or reporting a "heart condition". I note that he underwent a gastric banding on 11 January 2018 with Mr. Wilkinson. I assume he would have had pre-operative anaesthetic assessment, usually including an ECG. There was no report of any cardiac issue .

Dr Roffe commented that Mr Roberts had a number of cardiovascular risk factors which *"for a number of reasons were not managed/treated to recognise target levels specifically his blood pressure and cholesterol"*. He says the addition of any other illnesses such as diabetes or even a less significant illness such as a respiratory infection adds to the overall cardiovascular risk. Accordingly he says with *"this patient's presentation on 21 February 2020 I think it would have been relevant to ask about pains in the chest even if that symptom was not divulged by the patient"*. Although I accept opinions of general practitioners will differ when confronted with a patient

with the same symptom complex and Dr Roffe was looking at the case in hindsight I agree with Dr Roffe's opinion. This is especially so given Mr Roberts had not improved between the first consultation on 17 February 2020 and the subsequent consultation on 21 February 2020. In addition, I note Dr Reid has said the antemortem symptoms described in the police report of death to the coroner are consistent with ischaemic cardiac pain secondary to ischaemic heart disease from coronary atherosclerosis. Had the question been asked and answered in the affirmative I suspect Mr Roberts would have been referred to hospital for investigation and treatment.

A copy of my decision in this matter was forwarded to Dr Bennett for comment. In his reply Dr Bennett indicted he did not have any further comments.

Comments and Recommendations

The circumstances of Mr Roberts' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Roberts.

Dated: 27 September 2024 at Hobart in the State of Tasmania.

Magistrate Robert Webster
Coroner