MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of FG.

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

a) The identity of the deceased is FG.

b) FG was 53 years old, was in a relationship, and did not have children. He lived in East Devonport and worked as a carpenter. On 4 March 2022, FG visited his general practitioner, Dr Rohit Sood of East Devonport Medical Centre (EDMC). He advised Dr Sood that he had had chest pain for 2-3 months, with the episodes lasting a few minutes and brought on by exercise. Dr Sood ordered blood tests and chest x-rays, which were both completed by FG by 17 March 2022. FG did not attend his follow-up appointment with Dr Sood until 8 July 2022. In that appointment, Dr Sood noted that "FG *was more concerned about his persistent lower back pain radiating to the lower left limb*". Dr Sood arranged for him to undergo an MRI scan of his spine and also went through the results of his blood tests and chest x-ray with him. FG was referred to the cardiologist at the North West Regional Hospital (NWRH) for further evaluation with an early appointment requested.

   The EDMC sent FG several reminders to book an appointment with Dr Sood to discuss the results of the MRI scan. FG returned on 5 August 2022. During this appointment, FG mentioned that he had missed an appointment with the cardiologist and that the NWRH has contacted him to book another appointment with the cardiologist. Dr Sood emphasised the importance of the cardiac evaluation to FG.

FG attended the Cardiology Clinic at the NWRH on 22 August 2022 and was seen by a Staff Specialist Cardiologist (SSC). An exercise stress test was arranged, and FG was advised to commence a statin. The SSC planned to review FG in four months' time. EMDC sent reminders to FG to book an appointment and discuss commencing rosuvastatin 40mg to control his lipids. FG did not respond.

On 29 November 2022, FG undertook his exercise stress test.

On 27 January 2023, FG attended the NWRH Cardiology Clinic for review and was seen by a locum cardiologist. The locum cardiologist formed the view that FG had no cardiovascular risk factors of note but had ongoing exertional chest pains which sound very suspicious for exertional angina. The locum cardiologist reviewed the results of FG's recent exercise stress test and described them as equivocal. The locum cardiologist advised Dr Sood of his findings and the medications that he had prescribed him.

In addition, the locum cardiologist referred FG for an echocardiogram and CTCA (coronary artery calcium score CT scan).[1]

The locum cardiologist intended to review FG in 3 months' time to then consider the need for coronary angiography.[2] The locum cardiologist sent a referral to I-MED radiology for FG's CTCA. This referral was cancelled but the reason for the cancellation was not recorded. It is possible that the significant gap cost ($500) may have caused FG to cancel it but, despite extended investigation, I cannot make any finding regarding why it was cancelled. I also note that FG died close to the time that he was due for cardiac review and therefore there was no guarantee that his appointment would have occurred before his death.

On 8 February 2023, FG underwent the echocardiogram at the Charles Clinic. He did not further attend any Tasmanian Health Service hospital or facility (including for review or imaging review) before his death.

FG visited Dr Sood on 22 February 2023 and advised that he had commenced aspirin, atorvastatin and metoprolol but not the prescribed

[1] A coronary artery calcium score is a non-invasive screening test to estimate the patient's risk of heart attack or stroke.
[2] Coronary angiography requires insertion of a catheter into an artery for diagnosis as well as cardiac stenting. This occurs in suitably equipped centres and is performed by interventional cardiologists.

isosorbide. He also mentioned he had undergone the echocardiogram and was awaiting the CTCA to be conducted. The results from the echocardiogram demonstrated a decreased left ventricular range of motion (hypokinesia) likely due to coronary artery disease. However, Dr Sood was unaware of these results as they had not been sent to him.

On the evening of 10 April 2023, FG was assisting his parents with gardening. He had brought his trimmer from home to trim the hedges. While he was working on the hedges, he complained to his father that he was having chest pains when lifting his hands above his head. He then spoke with a friend at the rear of the property for approximately 30 minutes. FG did not mention pain or anything abnormal.

FG later commented to his father that he did not feel too good and went inside the residence. His father, having not seen FG for about 30 minutes went to check on him. He opened the door to the toilet and located FG, unresponsive, on the ground blocking the door. FG's mother came upstairs and felt FG who was cold to the touch. She attempted to find a pulse and could not. She called 000 and paramedics attended. They removed FG from the bathroom and undertook resuscitation measures before pronouncing FG deceased.

c) Following full autopsy, the forensic pathologist, Dr Christopher Lawrence, concluded that FG died of acute myocardial infarction ("heart-attack"). Dr Lawrence noted that FG suffered extensive heart disease (triple vessel atherosclerosis and thrombosis of the left anterior descending coronary artery). Hypertension, hyperlipidaemia and obesity contributed to his cause of death.

d) FG died on 10 April 2023 at Spreyton, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into FG's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Report from Dr Elizabeth Deards, Executive Director Medical, Services of Hospitals North West;

- Report from Dr Rohit Sood, East Devonport Medical Centre, FG's general practitioner;
- Review of medical issues by Dr Anthony Bell MD FRACP FCICM, Coronial Medical Consultant; and
- Medical chronology prepared by prepared by Kevin Egan, Coronial Nurse.

Comments and Recommendations

In this case, the investigation focused upon a lack of urgency in diagnosing and treating FG's heart disease. In his report, the coronial medical consultant, Dr Anthony Bell stated:

> *"In this case the major diagnosis concerns coronary artery disease. The major concerns come in the review by the cardiologist on 27. 01. 2023. The stress test in November suggested subtle changes of cardiac ischaemia at 6 minutes into the exercise protocol (as decided by the cardiologist). At the appointment of 27.01. 2023 the patient had risk factors for coronary artery disease. Also the patient had exercise induced angina on a short distance walking. On 08.02.2023 an echocardiogram was performed, there was a decreased left ventricular range of motion (hypokinesia). The zones of hypokinesia during echocardiography indicate either acute or previous myocardial infarction (post infarction cardio sclerosis) or myocardial ischemia.*
>
> *Thus by 08.02.2023, if not 27.01.2023 the patient clinically had exercise induced angina and required coronary angiography to assess the extent and management plan."*

Dr Bell was particularly critical of the delay caused by ordering the CTCA. He stated that this screening test was unnecessary because of FG's risk factors for heart disease, confirmed by the results of the echocardiogram. He concluded that he should have been referred straight for coronary angiography.

In the investigation I have received a report from Dr Elizabeth Deards, Executive Director Medical Services Hospitals North West Tasmanian Health Service. Dr Deards provided a response to Dr Bell's opinion. In the response, she was assisted by Professor Robert Fassett, Clinical Director Acute Medicine, Nephrologist and General Physician.

Professor Fassett agreed with Dr Bell that the medical investigation trajectory for FG was slow. Dr Deards agreed that there were significant delays, observing that FG

had high cholesterol, high blood pressure and was overweight. He also had chest pain on lifting and exertion. She reported "*this required more urgent attention at age 53 with risk factors*", stating "*I would have proceeded straight to a stress echocardiogram at the initial consultation*". She stated that FG's equivocal exercise stress test and echocardiogram showing abnormal wall motion should have led to a diagnosis of coronary artery disease and a request for coronary angiography. She said that the requested CTCA may have been helpful but this plan delayed the investigation.

Both Dr Deards and Professor Fassett emphasised issues with access to coronary angiography for cardiology patients in the north-west of the state. Dr Deards stated *"it is often very difficult to access coronary angiography at LGH due to bed availability. This difficulty with access may influence the approach to investigation in the NW. There has been a recent review of cardiology services and we expect a new model of care will address some of these issues."*

In conclusion, I find that FG should have been referred to coronary angiography as a matter of priority at the latest following the abnormal echocardiogram on 8 February 2023. Depending upon availability of the appointments at the Launceston General Hospital, there may have been a chance to correctly diagnose and treat FG's cardiac disease before his death.

I recognise that FG, at various times in the trajectory of his cardiac investigations, was reluctant to undergo investigations and attend appointments. I note that he also did not commence all medications advised by the cardiologist. However, if the likely severity of his cardiac disease had been impressed upon him, he would have submitted to urgent investigations and treatment.

I do not make any criticism of Dr Sood. He treated and monitored FG thoroughly and provided a detailed report for the coronial investigation. Dr Sood was, understandably, guided by the specialist cardiology assessments of FG and the resulting recommendations for tests and treatment. He could not have done any more than he did.

I do not make recommendations but comment that patient access to cardiology services on the north-west coast was an underlying issue in this case. Hopefully, significant improvements will result from the anticipated new model of care arising from the review.

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

Dated: 24 April 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner

These findings were amended by an order pursuant to s 58(1)(c) of the *Coroners Act* 1995 dated 30 April 2025 to correct factual errors regarding FG's relationship status and the place of death.