QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Matthew Anthony Russo**
TITLE OF COURT:	Coroners Court
JURISDICTION:	TOWNSVILLE
FILE NO(s):	2015/79
DELIVERED ON:	17 April 2020
DELIVERED AT:	Cairns
HEARING DATE(s):	23 May 2019 and 13-15 August 2019
FINAL SUBMISSION:	23 September 2019
FINDINGS OF:	Nerida Wilson, Northern Coroner
CATCHWORDS:	Coroners: inquest, bilateral bronchopneumonia; lower lung crackles; community acquired pneumonia; red flags; blood streaked sputum; haemoptysis; general medical practitioner; failure to record vital signs; misdiagnosis; medical care and treatment; referral to the Office of Health Ombudsman.

REPRESENTATION:

Counsel Assisting:	Mr Joseph Crawfoot
Dr Seyedfakhroddin Sajadi:	Ms Melinda Zerner
Dr Edel Garcia Monteagudo:	Mr David Schneidewin

Contents

Publication

1. Section 45 of the *Coroners Act 2003* ("the Act") provides that when an Inquest is held the Coroners written findings must be given to the family of the person in relation to whom the Inquest is held, each of the persons or organisations granted leave to appear at the Inquest, and to officials with responsibility over any areas the subject of recommendations. These are my 33 page findings in relation to the death of Matthew Anthony Russo. They will be distributed in accordance with the requirements of the Act and posted on the website of the Coroners Court of Queensland.

Relevant Legislation

2. Pursuant to section 45(5) of the Act a Coroner must not include in any findings any statement that a person is, or may be,:

    a) Guilty of an offence; or
    b) Civilly liable for something.

3. The focus of an Inquest is to discover what happened, not to ascribe guilt or attribute blame or apportion liability. The purpose is to inform family and the public of how the death occurred with a view to reducing the likelihood of similar deaths in the future.

Comments and recommendations

4. Pursuant to section 46 of the Act a Coroner may, wherever appropriate, comment on anything connected with a death investigated at an Inquest that relates to:

    (1)(a) public health and safety; and
    (1)(c) ways to prevent deaths from happening in similar circumstances in the future.

The evidence

5. I have relied on and had regard to the following in order to prepare these findings:

    a) A coronial inquest brief exhibited in the proceedings;
    b) The oral evidence of 10 witnesses;
    c) The comprehensive written submissions prepared by:
        - Counsel Assisting the Inquest, Mr Crawfoot;
        - Counsel Ms Zerner appearing on behalf of Dr Seyedfakhroddin Sajadi;
        - Counsel Mr Schneidewin appearing on behalf of Dr Edel Garcia Monteagudo.

Background

6. Counsel were largely in agreement with the factual background of Mr Russo's presenting illness.

7. Mr Russo presented to two general practitioners within three days of each other, different doctors from different medical practices in Townsville.

8. Mr Russo complained of flu like symptoms to both and presented with a cough.

9. Both doctors gave evidence that they undertook preliminary investigations (by way of observations and taking vital signs).

10. Neither doctor recorded the results of the vital signs. Both say that whilst it was their usual practice to take and record vital signs, if those observations are within the 'normal' range they do not necessarily record them (i.e. they only record vital signs that are outside of the normal range or of concern).

11. Mr Russo died of a sepsis on a background of undiagnosed bi-lateral bronchopneumonia within 18 hours of consulting the second in time general practitioner.

12. Significant divergence arose regarding the adequacy and appropriateness of the treatment received by Mr Russo from the second in time general practitioner, Dr Monteagudo. Those issues included whether:

    a) he in fact checked vital signs (he accepted that he did not record vital signs);
    b) he made a correct or reasonable diagnosis (bronchitis);
    c) the prescribing of a broad spectrum antibiotic was appropriate in the circumstances;
    d) he missed an opportunity to diagnose pneumonia (and thereby escalate Mr Russo's care and treatment).

Inquest issues

13. On 8 April 2018 after considering concerns raised by Mr Russo's mother, the State Coroner requested that an Inquest be held into the death of Matthew Anthony Russo and transferred the matter to me in my capacity as Northern Coroner.

14. The Inquest commenced with a pre-inquest conference on 23 May 2019 at Townsville.

15. The inquest issues were ultimately settled in the following terms:

    a. The findings required by s. 45 (2) of the *Coroners Act* 2003; namely the identity of the deceased, when, where and how he died and what caused his death;

    b. Whether in all the circumstances the medical treatment received by Matthew Anthony Russo from Dr Seyedfakhroddin Sajadi on 2 January 2015 was adequate and appropriate; and

    c. Whether in all the circumstances the medical treatment received by Matthew Anthony Russo from Dr Edel Garcia Monteagudo on 5 January 2015 was adequate and appropriate.

16. The inquest was conducted over two days on 14 and 15 August 2019 at Townsville. The inquest heard evidence from the following witnesses:

1. Ms Judith Jensen (next of kin, Mother);
2. Dr Seyedfakhroddin Sajadi (a treating general medical practitioner);
3. Ms Jessica Toohey (medical receptionist);
4. Ms Shantel Rickard (friend, housemate and last to see);
5. Dr Edel Garcia Monteagudo (a treating general medical practitioner);
6. Senior Constable Nichole Rozman (investigating police officer);
7. Dr Christopher Pitt (an expert witness);
8. Dr Mark Little (an expert witness);
9. Professor Grant Waterer (an expert witness); and
10. Mr Ryan Robshaw (friend and housemate).

Background Information

Personal Details of Mr Matthew Anthony Russo

17. Mr Russo was born on 6 July 1977. He died at 4:29am on Tuesday, 6 January 2015.[1] He was aged 37 years at the time of his death.

18. With regards to Mr Russo's general health / social history immediately prior to his death I have had regard to the following:

a) He weighed 113kg, which at 176cm height (BMI exceeding 36), placing him within medical parameters for being obese;[2]
b) He was a known smoker, consuming approximately 25 cigarettes per day;[3]
c) Consistent with his smoking history, Mr Russo's lungs at autopsy indicated "*frequent pigmented macrophages of the 'tobaccophage' type [along with] occasional focal emphysema*";[4]
d) He was "*normally*" a heavy drinker although at the time of his illness had not been consuming alcohol;[5] and
e) Mr Russo had been exposed to methylamphetamine up to three days or more prior to his death[6] . The extent and frequency of previous exposure to the drug is unknown.

19. At the time of his death, Mr Russo was living in suburban Townsville. He shared the house with Ms Shantel Rickard and Mr Ryan Robshaw. Ms Rickard and Mr Robshaw were in a de facto relationship.

[1] Exhibit F1.2 at page 2 of 7
[2] Exhibit A2 at page 1 of 4
[3] Exhibit C1 at page 1 of 24
[4] Exhibit A2 at page 3 of 4
[5] Exhibit B4 Notebook (statement of Ryan Robshaw) No. H127301 at page 122
[6] Exhibit A4 at page 4 of 6

20. Mr Russo and Ms Rickard had known each other for about eight years. They had previously been in a relationship together although that had ceased about five years prior to these events.[7] A close friendship remained between them.

21. Ms Rickard and Mr Robshaw made direct observations of Mr Russo's illness prior to his death. They had been away but returned to the Kelso residence two to three days prior to Mr Russo's death.

Symptomology of Mr Russo Prior to Death

22. Any assessment of the progress of Mr Russo's illness prior to his death is informed by a combination of:

    a) The medical notes taken by Dr Sajadi and Dr Monteagudo (aka Dr Garcia);
    b) Direct observations of non-medical witnesses;
    c) Disclosures by Mr Russo to non-medical witnesses; and
    d) Statements by Dr Sajadi and Dr Monteagudo and medical experts.

23. The first medical records made in relation to Mr Russo's illness were those created by general practitioner, Dr Seyedfakhroddin Sajadi at approximately 8:18am on Friday, 2 January 2015.[8] Those notes recorded Mr Russo's presenting symptoms as:

    a) Cough;
    b) Headaches; and
    c) Body aches.

24. Upon examination by the GP the following additional symptoms were identified:

    a) Red throat; and
    b) Clear chest.

25. On Saturday, 3 January 2015 Mr Russo's mother, Ms Judith Jensen, had a telephone conversation with him during which he told her that he had been sick with fevers and coughing (and that he was prescribed cough medicine).

26. Both Ms Rickard and Ms Robshaw deposed to having observed Mr Russo continue to exhibit 'flu-like' symptoms in the days following his presentation to Dr Sajadi. (notebook statement provided to QPS on 6 January 2015).

27. It was accepted at the inquest that at some stage prior to Mr Russo's presentation to Dr Monteagudo, he developed an additional symptom of haemoptysis (although there was a dispute as to the volume of haemoptysis).

[7] Exhibit B2.1 Notebook (statement of Shantel Rickard) No. H127307 at page 46
[8] Exhibit B3.1 Statement of Dr Sajadi (21/05/2015) at page 3 of 3

28. Ms Rickard first became aware that Mr Russo was coughing blood on the morning of Monday, 5 January 2015 at approximately 7:45am[9], immediately prior to his consultation with Dr Monteagudo.

29. Ms Jensen deposed to a further telephone conversation with her son on the afternoon of Monday, 5 January 2015. During that conversation he told Ms Jensen that: "*he had gone to another doctor that day as he had been coughing up blood*".[10] At Inquest, Ms Jensen confirmed this was the first occasion Mr Russo had disclosed coughing any amount of blood.

30. I accept the symptom of haemoptysis first presented on or about the morning of Monday 5, January 2015, just prior to Mr Russo's appointment with Dr Monteagudo.

31. Mr Russo presented to Dr Monteagudo shortly after 8:00am on 5 January 2015.

32. Dr Monteagudo noted the following presenting symptom:

    a) Cough, phlegm last few days getting worse

33. Upon examination the following symptoms were recorded:

    a) Well hydrated;
    b) No SOB (shortness of breath);
    c) Congested throat;
    d) Normal neuro; and
    e) No skin rash.

34. Dr Monteagudo further noted "*resp some crackles in L base*". It was accepted that the reference to 'lower L base' was a reference to the lower left lung. In his statement dated 13 June 2016, Dr Monteagudo also recalled Mr Russo disclosing "*streaking of blood in the sputum*". This was not recorded in the medical notes.

35. With regard to the 'worsening cough' and the development of two additional symptoms of 'blood streaked sputum' (haemoptysis) and crackles on the lower left lung I accept that Mr Russo's condition had deteriorated in the three days between his doctor's appointments on 2 January 2015 and 5 January 2015.

36. Upon review of the evidence I have concluded that Dr Monteagudo did not inform himself, nor was he informed by Mr Russo, that Mr Russo had attended another general practitioner three days prior, on 2 January.

37. It was apparent however that Dr Monteagudo was aware that Mr Russo had been affected by his condition for a period (of at least days), that the condition was worsening and he had not responded to symptomatic treatments.

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[9] Exhibit B2.4 Statement of Shantel Rickard (22/05/15) at paragraph 2.
[10] Exhibit E5

38. Had Dr Monteagudo pursued a line of questioning and not relied solely (it seems) on the self-report of the patient he may have established that:

    a) Mr Russo had been ill since Christmas Day (Mr Robshaw's statement refers);
    b) He attended a GP three days prior;
    c) Was not assisted by symptomatic treatment (presumably cough medicine).

39. Dr Monteagudo did not establish a detailed medical or social factors history from Mr Russo, and had he done so he may (accepting the patient may not have been entirely forthcoming about (c) have established that Mr Russo was:
    a) A heavy smoker;
    b) A heavy drinker;
    c) A (recent) user of illicit substances.

40. In combination, the factors described in paragraphs 38 and 39 above, in conjunction with his obesity and noted symptoms (crackles lower left lung, blood streaked sputum) placed Mr Russo in a high risk category for pneumonia. Had those factors been elicited they are likely to have alerted Dr Monteagudo to conduct a thorough medical examination, including taking all vital signs. For reasons outlined below I will find that a thorough medical examination did not occur.

Post medical consultation observations

41. Following his consultation with Dr Monteagudo, Mr Russo returned to the Carbine Close residence. Mr Robshaw observed (notebook statement provided to police) that Mr Russo "*seemed okay for the rest of the day*" although lying down would cause him to cough again. In the later '000' call Mr Robshaw informed the Operator that Mr Russo had been "*struggling all day*".[11]

42. In oral evidence at inquest, Mr Robshaw gave evidence that when Mr Russo returned from the doctors with Ms Rickard on 5 January, he and Mr Russo later attended the shops together to purchase food for hamburgers (during daylight hours). He then revised his evidence and said perhaps it could have been 'that day, or the day before'.

43. I am inclined to the view, given the fall of evidence that Mr Russo accompanied Mr Robshaw to the shops sometime during the day of 5 January. Mr Robshaw had a clear memory of leaving that house that same evening with Ms Rickard to visit his parents and seemed to situate both events on 5 January. I also note in the Form 1 Report of Death to Coroner exhibited in these proceedings that Mr Robshaw came home and prepared hamburgers when he returned at around 8.00pm.

44. That would also fit with a scenario that Mr Russo appeared to all who saw him that day (Dr Monteagudo, Ms Toohey, Ms Rickard and Mr Robshaw) as appearing to be not as sick, as he in fact was.

[11] Exhibit F1.4 at T1.67/10

45. It was accepted by both Mr Robshaw and Ms Rickard that they left the Carbine Close residence for approximately three hours to visit family members on 5 January (between 5pm and 8pm). Mr Russo remained in the house.

46. I expressed concern to Mr Robshaw during the course of his evidence that neither he, nor Ms Rickard, contacted Mr Russo's mother (on 5 January or prior) advising her how ill he was, nor did they independently assess a need to arrange further medical help for Mr Russo (on 5 January).

47. Mr Robshaw's rationale for not getting help sooner was expressed as

> "*possibly yes, but on saying that Matthew believed he might have been feeling a little better due to the relief he was getting*" and "*we just chose to monitor it and see if comes any better or worse*" (after the visit to the GP on 5 January) and, "*Matthew was still conscious and coherent and the rest of it…. still talking at the time, apart from being very ill, coughing and whatnot, I mean when I say talking, he didn't talk much because every time he spoke he'd cough, but he knew, you know, he'd nod his head or you know what I mean, like, when having conversations "Are you ok" and he'd like give you the indication that he's okay…….*"

48. Mr Robshaw did not make any further observations of Mr Russo when he retired for the evening after about 10:00pm on the night of 5 January 2015.

49. According to Ms Rickard, Mr Russo "dozed off" in a lounge chair.

50. Ms Rickard deposed to having had a conversation with Mr Russo at 1:20am on the morning of 6 January 2015. She went into the kitchen and saw that Mr Russo was sitting outside on the back verandah having a smoke. He asked her to get him a drink. Ms Rickard sat with him and had a smoke. He told her he was "*really weak*". Ms Rickard told Mr Russo to wake her up if he felt he wanted to go to hospital. Matthew didn't say anything but "*didn't seem himself*", he was "*half asleep and talking about oil*" (a reference to his job). I note expert evidence in relation to the onset of confusion and delirium in the setting of pneumonia / sepsis.

Circumstances of Mr Russo's Death

51. Ms Rickard woke at approximately 3:05am when she heard Mr Russo making "*gurgling*" or "*mumbling*" sounds. When she went into the lounge room, she observed Mr Russo on his mattress on the lounge room floor and blood coming from his mouth. He appeared discoloured. She called Mr Robshaw and rang Triple 0. Ms Rickard told police that she took him to the doctors yesterday – "*the doctor gave him antibiotics and said Matty had a very rattly chest. Matty was still really sick and he lay down all day but he kept having coughing fits and had to get up*."

52. As to the exact observations made by Ms Rickard or Mr Robshaw to the Queensland Ambulance Service, I have the benefit of the transcript of the 'Triple 0' call. During that call the Operator was informed that:

    a) Mr Russo "*had a bad flu*" and was not conscious;[12]
    b) Mr Russo was breathing but it was very weak;[13]
    c) Mr Russo was actively producing sputum in his mouth;[14] and
    d) Mr Russo had bitten down on his tongue;[15]

53. The call to 'Triple 0' was picked up at 3:33:52am with the first keystroke occurring at 3:34:00am. Dispatch pages were sent to two ambulance crews (Unit 1513 and Unit 1112). Those dispatches were sent at 3:36:17am, 2 minutes and 17 seconds after the first keystroke.[16]

54. Unit 1112 responded to the dispatch and arrived at 3:44:33am, 10 minutes and 33 seconds after the first keystroke.[17] Crew members then took conduct of attempts at resuscitation.

55. Ambulance crews continued attempts to resuscitate Mr Russo. Those attempts were unsuccessful and at 4:27am, 43 minutes after crew arrival, resuscitation was ceased. Mr Russo was declared deceased at 4:29am.

Autopsy

56. A Forensic Pathologist conducted an autopsy on 7 January 2015.

Respiratory System

57. An examination of the respiratory system noted that Mr Russo's epiglottis and back of the throat were "markedly red" as were the interior of the larynx and trachea. The main bronchi were also noted to be red in colour.[18]

Lungs

58. Both lungs were both noted to have basal consolidation bilaterally. A section taken of the lungs confirmed bilateral bronchopneumonia that was noted to be "*focally haemorrhagic*". The lungs also had "*frequent pigmented macrophages*" associated with smoking and "*occasional*" emphysema.[19]

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[12] Exhibit F1.4 at T1.3/1-2
[13] Exhibit F1.4 at T1.5/46 and T1.5/1-20
[14] Exhibit F1.4 at T1.5/22-24
[15] Exhibit F1.4 at T1.6/25-27
[16] Exhibit F1.1
[17] Exhibit F1.1
[18] Exhibit A2 at page 2 of 4
[19] Exhibit A2 at page 3 of 4

Cause of Death

59. The forensic pathologist noted the cause of death as:

    1(a). Bilateral bronchopneumonia
    Due To
    1(b). Flu
    2. Amphetamine abuse

60. The finding with respect of 'amphetamine abuse' was made on that basis that it contributed to death but was not related to the underlying cause of death.

Expert Evidence

61. During the cause of the inquest, expert evidence was obtained from Professor Grant Waterer Professor of Respiratory Medicine at the University of Western Australia, Northwestern University Chicago, and Curtain University. He is the co-Chair of the American Thoracic Society and Infectious Diseases Society of America (community acquired pneumonia management guideline committee).

62. Professor Waterer gave evidence that in his opinion Mr Russo's cause of death was not respiratory failure, rather it was sepsis and the failure of the circulatory system due to the presence of bacterial toxins and the immune response to that (a cardiac event or cardiogenic shock on the background of sepsis and bilateral bronchopneumonia).

63. Professor Waterer considered that the observations made by Ms Rickard at about 1:20am on 6 January 2015 when Mr Russo appeared confused, was also consistent with progressive sepsis.

64. I accept the conclusions of Professor Waterer as to the cause of death and find the cause of death was cardiac failure as a consequence of sepsis on the background of bilateral bronchopneumonia.

EXTENT OF HAEMOPTYSIS

Overview

65. A significant issue for Inquest was the observation (or lack thereof) of haemoptysis – the coughing up of blood by Mr Russo. Mr Russo's mother provided a description of haemoptysis (as conveyed to her by Ms Rickard) in her letter of concerns to the State Coroner, and that conveyed that the 'frank' condition with which her son presented, was not acknowledged / taken into account by Dr Monteagudo.

66. Ms Rickard and Mr Russo provided different descriptions as to the amount of blood Mr Russo was coughing up. Mr Russo described blood streaked sputum to Dr

Monteagudo. The doctor did not accept a 'frank', 'acute' or 'gross' haemoptysis as asserted by Ms Rickard to have been directly observed by her.

67. In this regard, I have considered the autopsy report, the evidence of Ms Jessica Toohey, clinic receptionist at the Pinnacle Medical Centre, and the evidence of four experts; Dr Christopher Pitt, Dr Les Griffiths, Professor Grant Waterer and Dr Mark Little.

68. Mr Russo's lungs were noted to be showing focally haemorrhagic changes at the time of autopsy.

69. Both Dr Monteagudo and Ms Toohey gave evidence of the clinic policies that were in place at the Pinnacle Medical Centre at the time of these events. Specifically, there was a policy in place whereby any patient that presented with an acute medical condition such as chest pain, shortness of breath or bleeding would be treated as an emergency and given immediate access to a GP.

70. On the basis of the version given by Ms Rickard, the policy of the Medical Centre would have been activated however, both Dr Monteagudo and Ms Toohey gave evidence that this did not occur.

71. Ms Toohey gave evidence of directly observing Mr Russo when he attended the clinic both before and after his consultation with Dr Monteagudo. She observed that he was "*clammy*" in appearance [20] and described hearing Mr Russo clear his throat on two occasions. [21] She clearly distinguished that from a cough.

72. Ms Toohey recalled a brief conversation with Mr Russo after his consultation and did not note anything of difference in his physical appearance. She then observed him leave the clinic with a female person.

73. At inquest, Ms Toohey was asked to recall if Mr Russo was carrying anything with him during his presentation. She recalled he had personal items but indicated he was not carrying items such as a towel or tissues with any blood stains.

74. Whilst Ms Toohey did not know the identity of the female person that attended with Mr Russo, I accept that it was Ms Rickard.

75. Noting the emphasis that Ms Rickard placed on the presence of observable haemoptysis whilst Mr Russo was at the medical centre (and later conveyed to Mr Russo's mother by her), any inconsistencies between her written or oral testimony bears scrutiny.

[20] Exhibit B7 Statement of Jessica Toohey at paragraph 16
[21] Exhibit B7 Statement of Jessica Toohey at paragraph 16-17

76. Ms Rickard gave diverging accounts of Mr Russo's presentation at the clinic. In her statement dated 21 January 2015 she deposed to having told Dr Monteagudo about the 'bloodied towel' she had observed back at the residence. She stated:

> "*I told Dr Garcia that the blood was bright red just like he had cut himself and had filled a towel with blood that bad* ***I had to throw it away***"

77. The clear inference to be drawn from the statement was that the towel had been disposed of prior to the consultation with Dr Monteagudo.

78. In her police statement dated 22 May 2015, Ms Rickard referred to having observed the towel at the residence prior to the consultation. She then stated Mr Russo had a "*handful*" of tissues to his mouth when he was waiting the reception area prior to the consultation.[22]

79. Ms Rickard further deposed to having been in the consultation room with Mr Russo when he was seen by Dr Monteagudo. Ms Rickard states that during that consultation Mr Russo had tissues with him which contained 'frothy' blood that was "*bright pink*" in colour.[23]

80. It was Ms Rickard's recollection that, during the consultation, **she told** Dr Garcia about the towel she had observed Mr Russo use earlier at the residence and described to him the amount of blood that was contained in it.[24] The only reasonable inference to be drawn from that recollection is that the towel was not present in the consultation room at the time of the conversation.

81. As against her statements Ms Rickard, during her oral testimony, deposed that Mr Russo had brought the towel with him to the medical centre.

82. All expert witnesses proffered an opinion as to whether the autopsy results tended to resolve the difference between the accounts given by Dr Monteagudo and Ms Rickard.

83. Dr Griffiths (Forensic Medical Officer), with regard to the autopsy results, noted that:

> "*An erosion into a major blood vessel, (as sometimes occurs in tuberculosis) which could account for the apparent large amount of frank blood which [Ms Rickard] said she had observed, was not detected*".[25]

84. Dr Christopher Pitt (Royal Australian College of General Practitioners – Assessment Panel Chair) considered that if the gross haemoptysis described by Ms Rickard was present, it would have corresponded with the presence of

[22] Exhibit B2.4 Statement of Shantel Rickard (22/05/15) at paragraph 7
[23] Exhibit B2.4 Statement of Shantel Rickard (22/05/15) at paragraph 13-15
[24] Exhibit B2.4 Statement of Shantel Rickard (22/05/15) at paragraph 16
[25] Exhibit A4 at page 4 of 6

"*macroscopic haemorrhage*". There were no macroscopic haemorrhages detected at autopsy.

85. Dr Pitt did however consider that the presence of the microscopic focal haemorrhages (detected at autopsy) was consistent with the "*pink frothy sputum*" that was observed acutely pre-mortem[26] and photographed by police.[27]

86. Dr Pitt also considered the focal haemorrhagic change that was detected at autopsy was a "*late sign of pneumonia*" making it less likely that Mr Russo had productive 'pink frothy sputum' at the time of his consultation with Dr Monteagudo.[28]

87. Whilst Professor Waterer's report did not reflect on the likelihood of the haemoptysis as described by Ms Rickard, it was his opinion in oral evidence that if Mr Russo genuinely had a significant haemoptysis then that would have been reflected in the autopsy by the presence of blood in the airway.

88. Whilst Dr Mark Little (Consultant Emergency Physician and Clinical Toxicologist) did not directly consider the likelihood of one scenario against the other, he observed that the autopsy did not identify where a significant haemoptysis would have come from.[29]

89. It was generally accepted by the expert medical witnesses, that the presence of blood can come to assume greater significance as a symptom by lay witnesses as opposed to health practitioners. Equally, the volume of blood presenting may, on appearance, seem greater to a lay witness. I took from this evidence that in simple terms, to a lay observer, a little bit of blood can go a long way.

Findings re haemoptysis

90. I did not consider Ms Rickard to be a reliable witness in relation to her observations of 'blood'. In her evidence she provided three different versions in regard to haemoptysis:

    a) that she told Dr Garcia about the blood-stained towel used by Matthew at the home earlier (disposed of by her);
    b) that Matthew bought the towel (previously said to be disposed of by her) to the consultation; and
    c) that Matthew had blood stained tissues with him at the consultation.

91. I **find** that Ms Rickard was not present during the consultation between Mr Russo and Dr Monteagudo and so I discount version (a) above.

[26] Exhibit A7.1 at paragraph 4
[27] Exhibit G1 at page 41 of 53
[28] Exhibit A7.1 at paragraph 5
[29] Exhibit A9 at page 6 of 5

92. That given Ms Rickard had already apparently disposed of the towel at home prior to the consultation, and that the receptionist did not see Mr Russo with a towel I also discount version b) above.

93. Notwithstanding that neither Ms Toohey nor Dr Monteagudo do not recall seeing Mr Russo with blood stained tissues, I accept that it is possible they were on his person (perhaps his pocket) and used outside times he was observed by others.

94. I am unable to establish on the evidence, that Mr Russo presented at the medical surgery on 5 January with a 'frank' haemoptysis. I accept Dr Monteagudo was aware that Mr Russo, had been coughing up blood because Mr Russo told him.

95. Ms Toohey's recall of the day Mr Russo presented for his consultation was remarkable and credible. She accurately described the vehicle in which Ms Rickard and Mr Russo arrived, the clothes Mr Russo was wearing, and thought it strange that Ms Rickard did not accompany Mr Russo into the consultation because:

> "*I recall that it stuck in my mind that it was weird that she did not go in. She rang up so concerned about his health and made him come in but then didn't go in with him… at the time I presumed they were in a relationship together. Normally in my experience the wife or partner will usually accompany the husband into the appointment."*

96. I accept that evidence of Ms Toohey that Ms Rickard did not accompany Mr Russo into the consultation with Dr Monteagudo.

97. I **find** as follows:

a) Mr Russo coughed up blood prior to the consultation with Dr Monteagudo;

b) Ms Rickard saw Mr Russo coughing up blood streaked sputum but misconstrued its volume and significance;

c) Ms Rickard attended the Pinnacle Medical Centre with Mr Russo on the morning of 5 January 2015, although did not attend the consultation and remained in the waiting room;

d) Mr Russo was presenting with a congested throat, and 'cough, phlegm last few days getting worse'[30];

e) Mr Russo did not have a blood-stained towel with him;

f) Mr Russo informed Dr Monteagudo of blood streaked sputum (Dr Monteagudo later recalls receiving this history although it was not noted at the time). Dr Monteagudo placed no weight on that symptom at the time of the consultation.

[30] Consultation notes made by Dr Monteagudo

98. The symptom of blood streaked sputum most likely presented again during the course of the day having regard to the overall progression of Mr Russo's illness.

99. When reflecting upon Ms Rickard's evidence during the inquest I was left with the impression that she may have at times, embellished important aspects of Matthew's condition and presentation. Ms Rickard may have influenced Mr Russo's mother with her early version/s of events, certainly in regard to haemoptysis. Ms Rickard's heightened impression of a severe haemoptysis may of course, also have arisen because she was not a medical person and that any amount of blood was overwhelming to her.

100. Ms Rickard did not consider Matthew so chronically unwell so as to call an ambulance, or drive him directly to an emergency department, in the time that lapsed between his GP consultation on 5 January (around 8.00a.m.) and his death (declared at 4.29a.m. on 6 January).

Vital signs

Overview

101. The checking of vital signs is regarded as necessary to establish the baseline health of a person. In the case of pneumonia it is critical to determining whether a patient is treated as an inpatient or an outpatient. The recording of those observations is an essential step in the overall clinical assessment of a patient.

102. Professor Waterer gave evidence that the internationally accepted guidelines for vital sign measurements that would initiate inpatient care include:

    a) Heart rate greater than 120 beats per minute (or possibly 100);[31]

    b) Respiratory rate greater than 30 beats per minute;

    c) Systolic blood pressure below 90mmHg / Diastolic blood pressure below 60mmHg;

    d) Oxygen saturation less than 92% on room air.

103. Any one of those indications being present would have been sufficient to raise consideration of inpatient care. There was also clear evidence that a person may otherwise present as 'well' but their underlying vitals may be flagging on any one of those four vital signs.[32]

104. Professor Waterer stated that the appearance of being well could include a person being able to walk and converse easily.

[31] Exhibit A8 at page 4 of 6 and Exhibit A7 at paragraph 31
[32] Exhibit A8 – Report of Professor Waterer and Exhibit A9 – Report of Dr Mark Little

105. Dr Pitt's considered that Mr Russo, on being able to walk into Dr Monteagudo's surgery, without shortness of breath and ability to converse coherently, made it "*highly unlikely*" that Mr Russo respiratory rate, blood pressure or oxygen saturation were flagging at that time.[33]

Dr Seyedfakhroddin Sajadi

106. At the time of his consultation with Dr Sajadi, Mr Russo was not presenting with any pathology in his lower respiratory system. Dr Sajadi checked Mr Russo's chest and noted that it was clear.

107. There was broad consensus amongst the expert witnesses that Dr Sajadi's diagnosis of an upper respiratory tract infection (viral) was reasonable having regard to the symptoms Mr Russo then presented with.

108. Dr Sajadi's prescription of dextromethorphan was also considered appropriate although it was noted that would only relieve the symptom as opposed to treating the infection.

109. As to whether Dr Sajadi checked Mr Russo's vitals I have had regard to the statement he provided on 25 February 2015 in response to a letter from the Office of the Health Ombudsman.

110. Dr Sajadi informed the Ombudsman that:

> "*Mr Russo presented with a dry cough, headache and body aches. As is my usual practice I conducted a physical examination which involved checking his vital signs, listening to his chest with a stethoscope, looking inside his throat and ears and feeling the lymph nodes in his neck*".

111. Dr Sajadi did not note having checked the lymph nodes or vital signs and did not record results of the vital signs in the medical record. He did not particularise which vital signs were taken by him.

112. When responding to the Ombudsman Dr Sajadi was relying on an independent recollection of events almost two months after the consultation, without the benefit of his own record of vital signs.

113. Given the lack of specificity provided by Dr Sajadi I am unable to determine which of vital signs he took on the day, although I accept he took some. The observations he did make were presumed to be normal.

[33] Exhibit A7 at paragraph 31(b)

114. Overall, the medical treatment received by Mr Russo from Dr Sajadi was reasonable taking into account the absence of any pathology in the lower respiratory system.

115. The failure to record Mr Russo's vital signs does not meet minimum standards required of a general practitioner. Dr Sajadi has since undertaken professional development in the area medical record keeping.

Dr Edel Garcia Monteagudo

116. A significant issue at inquest was whether in fact Dr Monteagudo took any of Mr Russo's vital signs as none were recorded by him.

117. Mr Russo was, by this time, presenting with crackles in the lower left lung detected under stethoscope by Dr Monteagudo on 5 January.

118. I accept Dr Waterers expert evidence that "*vital signs are not required to make the diagnosis of pneumonia… they are required to determine the severity of the pneumonia*" and further.. "*vital signs are sufficient to make a determination of inpatient or outpatient care*".

119. Dr Waterer did not accept the proposition that Mr Russo should have been treated for an upper respiratory tract infection because the doctor was not convinced on his clinical assessment that he presented with pneumonia. Dr Waterer responded as follows[34]:

> ".. *in the absence of Dr Garcia providing an alternative diagnosis for the crackles in the lung, the primary diagnosis remains pneumonia. Crackles in the lung require a pathology and they require an explanation. You can't have an upper respiratory tract infection if you have lower respiratory tract signs… I think Dr Garcia is confusing upper and lower respiratory tract infections. Bronchitis is a lower respiratory tract infection, it's not an upper respiratory tract infection. Again, bronchitis, you can sometimes hear crackles in the lungs that tend to shift and diminish when people cough because just due to the bubbling and secretions in the airtubes. But again, I would firmly suggest that if you hear crackles you must retain pneumonia as the diagnosis until you have a chest x-ray saying there isn't pneumonia"*.

120. Dr Monteagudo documented a diagnosis of upper respiratory tract infection (bacterial), although in subsequent statements he identified his diagnosis as "*bacterial respiratory tract infection with bronchitis*".

121. In assessing whether Dr Monteagudo did check Mr Russo's vitals it is relevant to look at the chronology of his statements.

[34] Transcript page 2-16 lines 5-40 and page 2-17 line 3

Chronology of Statements Given by Dr Edel Garcia Monteagudo

122. The first statement given by Dr Monteagudo was on 16 February 2015, 42 days after Mr Russo's consultation. This statement was in response to an enquiry from the Office of the Health Ombudsman. In it, Dr Monteagudo informed the OHO that he had "*very limited contact with Mr Russo*".

123. Dr Monteagudo referred to the symptoms he noted from Mr Russo's presentation. He also stated "*Mr Russo did not describe having fever or bleeding including haemoptysis*".

124. Dr Monteagudo did not make reference to checking any of Mr Russo's vital signs.

125. Dr Monteagudo informed the OHO that he had proceeded with a diagnosis of a "*bacterial respiratory tract infection with bronchitis*".[35]

126. The second statement in time was on 20 April 2015, 105 days after Mr Russo's consultation. This response was given to a Form 25 requirement for information issued by the Office of the Northern Coroner requiring Dr Monteagudo to provide a "*comprehensive statement recalling [his] consultation with Mr Russo, including his history, complaints, clinical observations, diagnosis [and] treatment*".

127. In responding, Dr Monteagudo substantially adopted (verbatim) the statement he had provided to the OHO. Although requested to provide a 'comprehensive statement' by the Coroner, detailing his 'clinical observations', Dr Monteagudo did not make any reference to having checked Mr Russo's vitals.

128. Dr Monteagudo again confirmed that he had proceeded with a diagnosis of a "*bacterial respiratory tract infection with bronchitis*".[36]

129. A third statement, given on 13 June 2016 (one year and five months after the consultation) was made in response to a further Form 25 requirement for information issued by the Coroner, asking Dr Monteagudo to respond to the 22 May 2015 statement of Ms Rickard (exhibit B2.4), Clinical Forensic Medicine Unit (CFMU) report of Dr Griffiths and the autopsy report.

130. The report of Dr Griffiths made specific reference to the absence of any measurements of temperature or pulse, noting that the latter would have informed one of the vital signs (heart rate). Dr Griffiths highlighted these as "*important fundamental observations*".

131. Dr Monteagudo's third statement did not make any reference to having checked Mr Russo's vitals including his pulse. It was however in this statement that he referred to the disclosure by Mr Russo of the blood-streaked sputum. The

[35] Exhibit B1 – Statement of Dr Edel Monteagudo (16 February 2015) at page 2
[36] Exhibit B1.1 – Statement of Dr Edel Monteagudo (20 April 2015) at page 2

reference on this occasion is at odds with the two earlier statements. The doctor stated, "*Mr Russo did not describe fever or bleeding including haemoptysis*".

132. Dr Monteagudo stated: "*I believed Mr Russo had bacterial bronchitis which is why I prescribed Amoxicillin three times daily*".[37]

133. In the course of the coronial investigation, expert reports were obtained from Professor Waterer and Dr Pitt. Both practitioners had the benefit of the three statements given by Dr Monteagudo along with his clinical notes.

134. Copies of the expert reports were disclosed to Dr Monteagudo through his legal representatives on 1 May 2019.

135. On 3 July 2019 Dr Monteagudo provided a fourth statement concerning his treatment of Mr Russo. Dr Monteagudo deposed that "*for all patients presenting to me with respiratory symptoms, I apply a pulse oximeter. This is a simple, non-invasive device usually placed on the patient's index finger or thumb which measures the patient's heart rate (pulse) and oxygen saturation levels*".[38]

136. Dr Monteagudo further deposed, "*I would have applied the pulse oximeter to Mr Russo because he presented with respiratory symptoms*".[39] Dr Monteagudo's statement should be understood on the basis that it was likely that he did apply the pulse oximeter because that was his usual practice.

137. This was the first occasion at which Dr Monteagudo deposed to having checked any of Mr Russo's vitals.

138. Dr Monteagudo accepts that he did not check Mr Russo blood pressure[40] and did not conduct a 'formal assessment' of Mr Russo' respiration rate[41] although he deposed to observing Mr Russo's breathing, ability to speak in coherent and complete sentences and absence of using his accessory muscles of respiration.[42]

139. Professor Waterer considered that whilst Dr Monteagudo's method might have excluded a very high respiratory rate, that particular vital sign could sometimes be misleading, and it was therefore preferable to check the respiration rate by counting the breaths per minute.

140. Dr Monteagudo's evidence at its highest, is that he formally checked (but did not record) two of Mr Russo's four vital measurements (heart rate and oxygen saturation), and that indications were within a normal range.

[37] Exhibit B1.2 – Statement of Dr Edel Monteagudo (13 June 2016) at paragraph 13
[38] Exhibit B1.3 – Statement of Dr Edel Monteagudo (3 July 2019) at paragraph 28
[39] Exhibit B1.3 – Statement of Dr Edel Monteagudo (3 July 2019) at paragraph 28
[40] Exhibit B1.3 – Statement of Dr Edel Monteagudo (3 July 2019) at paragraph 30
[41] Exhibit B1.3 – Statement of Dr Edel Monteagudo (3 July 2019) at paragraph 29
[42] Exhibit B1.3 – Statement of Dr Edel Monteagudo (3 July 2019) at paragraph 30

141. Dr Monteagudo also conducted an informal assessment of Mr Russo's respiratory rate (observation of speech – not overtly short of breath and not using his accessory muscles of respiration).

142. Dr Waterer indicated that such assessment would provide some information about respiratory rate "*it **excludes a very, very high respiratory rate**... but you know respiratory rate can be misleading, **it's always better to count it**, but I accept it gives some information".*

143. I accept Dr Waterers evidence (and also note both Dr Pitt and Dr Little indicated best practice was a formal assessment by counting the breaths) and therefore cannot discount the possibility that had he checked Mr Russo's respiration by counting breaths per minute, indications may have indicated a flagging respiratory rate.

144. Dr Monteagudo did not take Mr Russo's blood pressure. I therefore cannot discount the possibility that Mr Russo's blood pressure was outside acceptable limits (a red flag).

145. Professor Waterer reiterated this, advising that the blood pressure may have been the only abnormal vital sign, "*particularly in early septic shock, although you would often expect some elevation of heart rate. It may not reach 125 but it might be 100 or 110, so I do believe in the setting of pneumonia, the guidelines are very clear, blood pressure must be taken".* [43]

146. Professor Waterer did not accept the proposition put to him that Mr Russo's other presenting symptoms might be used to infer that his blood pressure was otherwise normal. It was Dr Waterer's opinion that blood pressure must be checked. I accept the evidence of Dr Waterer in this regard.

147. It was the evidence of Professor Waterer that any one vital sign, indicating a measurement within the accepted guidelines, could provide a validated signal of severe pneumonia.[44] In oral evidence at the inquest Professor Waterer considered that whilst it was possible none of Mr Russo's vital signs were flagging a concern as against the guidelines, in likelihood, at least one of them was[45].

> "*So I think it's very unlikely that he didn't have some **warning signs on at least one of his vitals**, but is it possible, Yes. You know so, it's a balance of probability thing. I suspect he certainly would have a significantly elevated heart rate, respiratory rate, and probably his oxygen was you know, heading down to you know the 90's or low 90's. But we have had people present with relatively normal looking vitals and died within 24 hours, yes. **So it is a possibility they were normal, but the likelihood is they were not***".

[43] Transcript 2-15 line 35
[44] Exhibit A8 – Report of Professor Grant Waterer at page 4
[45] Transcript 2-11 line 15

148. I accept the evidence of Dr Waterer in this regard.

149. Dr Monteagudo did not take Mr Russo's temperature.

Circumstances of the Consultation

150. Mr Russo was the first patient to be seen by Dr Monteagudo on 5 January 2015.

151. There were no other patients in the medical centre at the time he presented.

152. It was accepted by Dr Monteagudo and Ms Toohey that a standard consultation would take 15 minutes. It was also accepted that in Mr Russo' case that he did not take the full 15 minutes and his consultation was possibly less than 10 minutes.

153. Dr Monteagudo was in effect seeing Mr Russo as a new patient. Mr Russo had a medical file that was held at the Upper Ross Medical Centre. The Pinnacle Medical Centre was owned by the same person and such it appeared there was information sharing between the two clinics.

154. Mr Russo did not have an existing medical record with the Pinnacle Medical Centre they were able to reactivate his records from the Upper Ross Medical Centre.[46] It was the evidence of Ms Toohey at the inquest that she reactivated Mr Russo's medical file after she confirmed his identification.

155. The most recent entry in Mr Russo's patient health summary (Exhibit C2) was dated 28 April 2014. This record originated from the Upper Ross Medical Centre. The Upper Ross Medical Centre records noted Mr Russo had an allergy to Lyrica but otherwise did not note family or social history other than Mr Russo smoking 25 cigarettes per day.

156. Whilst there was some evidence from Dr Monteagudo that fresh history was taken from Mr Russo, his notes of the consultation on 5 January 2015 do not reflect this.

The state of Dr Monteagudo's evidence

157. The notes recorded by Dr Monteagudo, and the first three statements given by him, do not reflect that he included or excluded any possible diagnosis of pneumonia, nor do they reflect the checking of any vitals.

158. The fourth statement given by Dr Monteagudo was provided four and half years after the 5 January consultation, and in response to the matters raised in the expert reports provided by Dr Pitt and Professor Waterer.

159. I accept that Dr Monteagudo had little independent, specific recollection of his consultation with Mr Russo. Any conversations that he had with Ms Toohey

[46] Exhibit B7 – Statement of Ms Jessica Toohey (7 June 2019) at paragraph 14

informed his understanding of events concerning Ms Rickard's presence at the clinic.[47]

160. My overarching assessment of the evidence is that at all times Dr Monteagudo proceeded on the basis that Mr Russo presented with bronchitis (potentially bacterial, hence the prescribing of antibiotics).

161. I am prepared to accept Dr Monteagudo's evidence in respect of applying the pulse oximeter at its highest – that it was his normal practice to do so, and that that he considered Mr Russo's results were normal or not concerning and therefore he did not record the results. Dr Monteagudo deposes to not always recording normal results, although he usually does.

162. I am prepared accept that Dr Monteagudo that he made an informal assessment of respiratory rate and that he considered the result was within normal limits.

163. I therefore **find** that Dr Monteagudo took three of the four vital signs being oxygen saturation and pulse rate (via pulse oximeter) and respiratory rate (by observation).

164. I **find** that none of the three vital signs taken by Dr Monteagudo were recorded in his consultation notes.

165. I **find** that (on his own evidence) Dr Monteagudo did not take Mr Russo's blood pressure. In written submissions on behalf of Dr Monteagudo I am asked to find that with reference to the balance of vital signs being accepted within normal limits that I should accept Mr Russo's blood pressure was also so. I do not so find. I also accept on the evidence that it may have been the only vital sign indicative of concern. The vital sign was not taken and not documented and I cannot infer blood pressure was normal.

166. I accept that Dr Monteagudo (later) recalled a history of blood streaked sputum provided by Mr Russo at the time of the consultation (deposed to by the doctor in a statement provided one month prior to the 2019 inquest). Dr Monteagudo does not provide a reasonable explanation for the presence of blood streaked sputum.

167. Dr Waterer's expert opinion was that blood streaked sputum in a smoker required investigation.

168. I **find** that the overall observation and assessment by Dr Monteagudo of Mr Russo's vital sign measurements was deficient because they were not considered as a whole. Three of four vital signs were taken, and one of those was by observation only. Dr Monteagudo omitted to take Mr Russo's blood pressure and it is probable that indication of itself may have been outside acceptable limits, and read in conjunction with other vital sign observations the overall clinical impression of a 'flagging' patient.

[47] Exhibit B1.3 – Statement of Dr Edel Monteagudo (3 July 2019) at paragraph 11

169. At no time did Dr Monteagudo take Mr Russo's temperature although it is not required to meet the guidelines for assessing pneumonia, I note that Dr Pitt a general practitioner (called as an expert in the field of general practice at this inquest) in his evidence said this:

> " *I would certainly be* ***checking temperature*** *at the very least, you can have a fairly good idea of whether the patient is well or unwell by looking at them, but certainly you could make the argument, put people on the* ***blood pressure cuff, getting a pulse*** *that way, that's fairly easy to do and it's certainly not difficult to count someone's* ***respiratory rate to see whether it is below 30****, which is another red flag, a lot of stuff can be quite quickly and easily be .. you could certainly make the argument he should have, but I must admit most general practitioners would not necessarily do so*"

170. I take from the above (emphasis added by me) that best practice in a general practice setting, (notwithstanding that most GP's would not do so), is to check temperature and blood pressure and to count respiratory rate. In Mr Russo's case none of these measures were undertaken by Dr Monteagudo.

171. Dr Little an emergency department specialist was called to give expert evidence and stated as follows in evidence

> *" .. the recognition of someone who is feeling unwell with pneumonia is based around predominately clinical observations: so pulse, the blood pressure, the oxygen saturation, the respiratory rate… whether they were normal which is what Dr Garcia said they were would confirm his clinical impressions that Matthew wasn't significantly unwell."*

172. I note the above evidence of Dr Little is premised on Dr Monteagudo (Garcia) taking Mr Russo's blood pressure and that it was normal. As already indicated, Mr Russo's blood pressure was not taken by Dr Monteagudo and I am unable to make any such finding.

173. Dr Little went on to say:

> " *I would have expected at least oxygen saturations which is done very easily with something called a pulse oximeter… and you should be able to* ***count the respiratory rate*** *by examining the patients chest…I would have thought a doctor examining someone would have at least recorded, or observed those observations."*

174. I note all three experts (Pitt, Waterer and Little) indicated that they would count the respiratory rate. I accept Dr Monteagudo's evidence that he made an informal assessment of Mr Russo's respiratory rate (notwithstanding it was not documented).

175. Mr Russo's social factors (smoking, alcohol consumption and illicit substance use) combined with his presenting medical markers (obesity, blood streaked sputum and crackles in lower lung, unwell for several days, persistent cough) required the general practitioner in this case to thoroughly examine the patient so as to include or exclude pneumonia. These risk factors negated the advantage of Mr Russo's relative youth (37 years). Mr Russo was, although young, not an otherwise well (enough) person for a GP not to exercise a clinical vigilance that may not have been required for a similar aged non-smoker, non-drinker, non-drug taker, within a healthy weight range. Although even that is arguable when lower lung crackles and blood streaked sputum are present

176. I **find** that Matthew Russo was misdiagnosed by Dr Monteagudo as having bronchitis when in fact he had pneumonia. The crackles alone were suggestive of a pneumonia. Dr Monteagudo did not provide a reasonable explanation for the presence of crackles in the lung, and did not positively exclude pneumonia.

177. Mr Russo may also have been in the early stages of septic shock at the time of consultation. The testing and recording of all accepted vital signs was essential to assessing the severity of the pneumonia, and to detect possible sepsis.

Diagnosis

178. It was the opinion of Professor Waterer that an upper respiratory tract infection (as noted by Dr Monteagudo in his consultation notes) does not, by definition, involve the lower parts of the respiratory system. An upper respiratory tract infection is an infection of the trachea, sinuses and pharynx. The presence of pathology in the lung implied a pathology in the alveoli.

179. Professor Waterer was of the opinion that the "*primary diagnosis*" that should have been reached, with particular regard to the presence of crackles, was pneumonia. This, in his opinion, was, "*basic medicine*".

180. Professor Waterer qualified that statement to the extent that: "*If you hear crackles in the lung you need to presume there is a lung pathology and you need to exclude pneumonia*".

181. Professor Waterer further opined that: "*If there had been haemoptysis then you would require as a minimum, a chest x-ray*". Professor Waterer confirmed the medical definition of haemoptysis was the presence of "*any blood"* from which the haemoptysis is then categorised by volume to give an appreciation of what the pathology or severity of haemoptysis might be.

182. Professor Waterer opined that Mr Russo was someone who did not usually cough up haemoptysis in the setting of being unwell. Professor Waterer therefore considered that in Mr Russo's case, a chest x-ray was appropriate (although not

required immediately) even though the haemoptysis was only to the extent of the 'blood-streaked sputum'.

183. Professor Waterer qualified his position with respect to the taking of x-rays noting it is the vital signs that inform the decision of the inpatient or outpatient care. The x-ray would provide supplementary data about the extent of the pathology or the presence of an otherwise undetected pathology.

184. Dr Monteagudo proceeded incorrectly, on the basis of bronchitis, and as such did not undertake a thorough enough examination so as to exclude pneumonia.

Analysis of the coronial issues

Whether in all the circumstances the medical treatment received by Matthew Anthony Russo from Dr Seyedfakhroddin Sajadi on 2 January 2015 was adequate and appropriate

185. Dr Sajadi proceeded with a primary diagnosis for Mr Russo of an upper respiratory tract infection (viral). That diagnosis was appropriate having regard to the presenting symptoms.

186. On the basis of that diagnosis Dr Sajadi prescribed Mr Russo with dextromethorphan cough syrup. Dextromethorphan would have provided symptomatic relief (for the cough). It was not unreasonable for Dr Sajadi to withhold antibiotic treatment in the absence of any clinical features of significant bacterial infection.

187. Dr Sajadi's notes of the consultation were deficient. Dr Sajadi conceded this point and prior to inquest undertook accredited professional development in the area.

188. Dr Sajadi's treatment of Mr Russo was otherwise adequate and appropriate.

189. I intend to refer Dr Sajadi to the OHO on the basis of inadequate notetaking alone. I accept the evidence of Dr Pitt as follows:

> "*In hindsight, the presentation to Dr Sajadi represented the early stages of a fatal illness, but given the presenting signs and symptoms, it would be unreasonable for any general practitioner to be expected to predict the subsequent clinical course… and thus his assessment and management of Mr Russo to be of the standard of a reasonable and prudent general practitioner practicing to the standard of his peers*"

And further:

> "*In my opinion Dr Sajadi's documentation should have better reflected the consultation by documenting his negative findings (such as assumed normal vital signs and lack of lymphadenopathy) as well as providing more detail in*

relation to the presenting complaint. Nevertheless his basic clinical reasoning, diagnostic formulation and management were fundamentally sound."

Whether in all the circumstances the medical treatment received by Matthew Anthony Russo from Dr Edel Garcia Monteagudo on 5 January 2015 was adequate and appropriate.

190. I have provided Dr Monteagudo with the benefit of the doubt and accepted his evidence at its highest in relation to vital sign observations made by him - that is that he checked oxygen saturation and pulse rate by formal testing via pulse oximeter and that, notwithstanding they were not recorded, those results were 'normal'; that he checked respiratory rate via observation (and not by breath count) and that whilst not documented, those indications did not raise concerns, and were therefore within 'normal' limits.

191. Notwithstanding these 'normal observations' as a starting premise I am unable to disregard what Dr Monteagudo did not do to inform himself of the accurate clinical picture, and which has been traversed extensively in these findings.

192. Dr Monteagudo proceeded with a documented diagnosis of an upper respiratory infection. In later statements and evidence he qualified his diagnosis as bronchitis. That diagnosis was not consistent with all of the symptoms with which Mr Russo had presented notably, blood-streaked sputum, a worsening cough and crackles in the lower left lung. The diagnosis was incorrect.

193. Dr Monteagudo's failure to assess Mr Russo's blood pressure, and his failure to provide an adequate or correct explanation for crackles on the chest and blood streaked sputum led him into error.

194. In the circumstances, noting crackles in lower lung, the primary diagnosis should have been pneumonia. Crackles are an indication of pneumonia.

195. At the conclusion of all the evidence I am no clearer as to how Dr Monteagudo misunderstood the significance of the lower lung crackles. He is a doctor with significant experience who has worked in developing countries and has treated serious lung conditions (such as tuberculosis). I have enormous regard for Dr Monteagudo's experience, and I might add, the considerable empathy he has demonstrated to Mr Russo's family throughout these proceedings.

196. The notation by Dr Monteagudo of lower lung crackles is contradicted by him recording an URTI in the notes for the same consultation. I am left with an impression that Dr Monteagudo mistook or misunderstood (which would seem implausible based on his experience) one from the other, or incorrectly recorded an URTI (noting the crackles were indicative of a LRTI).

197. The failure to consider a possible pneumonia, led to a failure to follow accepted international guidelines for (quickly) assessing the severity of pneumonia.

198. Notwithstanding the incorrect diagnosis Dr Monteagudo, did provide the correct treatment to Mr Russo by way of prescribing antibiotics in the first instance.

199. An assessment as to whether Mr Russo should have been treated as an inpatient or outpatient for community acquired pneumonia, or treated by any other means, required Dr Monteagudo to, check and assess heart rate, respiratory rate, oxygen saturation and systolic blood pressure and consider them in conjunction with each other and against his medical risk factors. By not doing so Dr Monteagudo missed an opportunity to detect Mr Russo's deteriorating condition. By failing to appreciate his deteriorating condition, Dr Monteagudo did not therefore consider any need to escalate Mr Russo's care and treatment.

200. The treatment of Mr Russo on an outpatient basis with amoxicillin (although correctly prescribed) , without additional measures, may have been adequate and appropriate if, the results of all the required vital signs were within the ranges provided for in the guidelines, and if there were reasonable clinical explanations for lower lung crackles and blood streaked sputum.

201. I cannot be satisfied on the evidence that all relevant vital signs were outside the 'clinical red flags', (that blood pressure was not taken and none of the actual results were available to be read in conjunction with each other, which may have resulted in a clinical impression that was different to each being read or taken in isolation) or that that Dr Monteagudo has provided a reasonable clinical explanation for the lower lung crackles and the blood streaked sputum. I further am not satisfied that he appraised himself of a sufficient history of this patient so as to alert him to Mr Russo's increased risk factors.

202. I am unable to make a finding that Dr Monteagudo's care and treatment of Mr Russo was adequate and appropriate.

203. Whilst I understand that patients can present as more well than they really are, it is necessary for general practitioners to independently assess, by all reasonable and available means, the true state of the patient. Mr Russo clearly did not (by observation alone) fit the picture of a patient in extremis and yet he died within 18 hours of the consultation from an aggressive onset sepsis. It is more probable than not that at least some clinical marker/s of his condition would have been apparent at the time of his consultation.

204. The failure to record, and / or inaccurately record, or simply not undertake observations and findings mitigated against Dr Monteagudo obtaining a full clinical picture and precluded third party scrutiny of his interpretation of the vital signs and observations.

205. This inquest has borne out (via a number of experts) that doctors in general practice are encouraged, if not required, take some time, to ask questions, gather enough of a social and medical history to categorise patient risk factors (of which Mr Russo had a number), not rely primarily on patient self-reports, check and

record contemporaneously in writing all vital signs, make additional observations via stethoscope, observation, hands on assessment; whatever is required to provide the most accurate clinical picture and then accurately record all measurements, outcomes and observations as a basis for a diagnosis and treatment. Have a reasonable explanation for symptoms (blood streaked sputum, crackles on lungs), and understand the pathology of those symptoms within the clinical context. In other words, do all that can be done to adequately assess the health of the patient.

206. The failure to proceed on the correct primary diagnosis and formally assess all of the required vital signs meant that the medical care Mr Russo received from Dr Monteagudo was not adequate or appropriate.

207. I again have regard to Dr Pitt as follows:

> "*Based on the information from clinical notes and from Dr Garcia's statements to the Coroner, Dr Garcia's assessment and management was deficient but not incompetent. Thus I would consider that Dr Garcia's consultation with Mr Russo to be of a minimum standard acceptable for a general practitioner in Australia*."

208. Based on the deficiency in Dr Monteagudo's assessment and management (for the reasons described herein) of Mr Russo, I **find** that the medical treatment Mr Russo received from Dr Monteagudo was not adequate or appropriate (notwithstanding that it may not be incompetent, and at a minimum standard acceptable for a general practitioner).

209. I intend to enter the following as the cause of death into the record (noting this amends the cause of death provided at autopsy):

    1(a) Cardiac failure due to or as a consequence of
    1(b) Sepsis due to or as a consequence of
    1(c) Bilateral bronchopneumonia

210. I have not gone so far as to suggest or find that Mr Russo's death could have been prevented. I have had regard to the research provided within the statement of Dr Little and note the high rate of deaths as a result of community acquired pneumonia (both in and out of hospital).

211. I have also had regard to the evidence of Dr Waterer in regard mortality rates for those presenting to an emergency department / intensive care unit with cardiogenic shock on the background of pneumonia, and those presenting with 'pure' respiratory failure.[48]

[48] Transcript 2-19 at line 10

212. It is impossible to know whether Mr Russo would have responded to treatment even if he had presented to a tertiary hospital emergency department, noting the aggressive progression of his life threatening sepsis. Identification of pneumonia and / or sepsis on 5 January may not have altered the outcome.

Findings Pursuant to s45 of the Coroners Act 2003

213. Pursuant to s.45(2) of the *Coroners Act 2003* I find as follows:

Identity of the deceased - The deceased is Matthew Anthony Russo.

How he died - Matthew Anthony Russo died from cardiac failure due to or as a consequence of undiagnosed sepsis due to or as a consequence of bilateral bronchopneumonia. He attended upon two general practitioners within the preceding three days, most recently 18 hours prior to his death. Mr Russo was clinically obese, a heavy smoker, a heavy drinker (of alcohol) and a user of illicit substances, this history was not obtained by the last in time doctor. Mr Russo presented with significant risk factors that were not negated by his relative youth (37 years). Mr Russo presented at the consultation with crackles in his lower left lung (recorded in consultation notes), blood streaked sputum (not recorded in consultation notes). A pulse oximeter was applied and visual observations were made of his respiratory function, the results of which were within a normal range. The doctor did not record those results. The doctor did not formally assess respiratory rate by breath count. The doctor did not take Mr Russo's blood pressure or temperature. The doctor incorrectly diagnosed bronchitis. The diagnosis was not recorded. The doctor recorded an URTI within the consultation notes (upper respiratory tract infection). The doctor prescribed antibiotics and Mr Russo was sent home. The doctor did not provide a reasonable explanation for the failure to diagnose pneumonia nor did he positively exclude the diagnosis after confirming crackles on the lung. The application of accepted international guidelines for assessing the severity of the pneumonia were not enlivened by the doctor (because he incorrectly diagnosed bronchitis). He did not take and record all accepted vital signs, omitting to take Mr Russo's blood pressure (and assessing respiratory rate by breath count). Given that blood pressure was not taken, and none of the actual results of the vital signs taken by the doctor were recorded or could be recalled by

him (save and except for being within a normal or acceptable range) they cannot now be read in conjunction with each other to provide an overall clinical picture. The doctor failed to avail himself of an accurate clinical picture of the patient and the limited results that formed the basis for his diagnosis cannot now be properly independently assessed because the exact results are not known. I find that the general practitioners medical treatment of Matthew Anthony Russo was deficient and was not adequate or appropriate. I am unable to conclude that Mr Russo's death could have been avoided. It is impossible to know whether Mr Russo would have responded to treatment even if he had presented to a tertiary hospital emergency department, noting the aggressive progression of his life threatening sepsis. Identification of pneumonia and / or sepsis on 5 January may not have altered this outcome. The focus of the inquest was whether the care at first instance by the general practitioner was adequate and appropriate.

Date of death - Matthew Anthony Russo died on 6 January 2015.

Place of death - Matthew Anthony Russo died at Kelso, Queensland.

Cause of death - Matthew Anthony Russo died due to:

1(a) Cardiac failure due to or as a consequence of
1(b) Sepsis due to or as a consequence of
1(c) Bilateral bronchopneumonia

Coroners Act 2003
Comments in accordance with s46 and referrals pursuant to s48(4)

214. I have had regard to sections 8.4.1 and 8.4.4 of the Good Medical Practice Code of Conduct in regard to record keeping by health practitioners.

215. I have determined that Dr Edel Garcia Monteagudo and Dr Seyedfakhroddin Sajadi should be referred to the Office of the Health Ombudsman pursuant to its mandate for promoting professional, safe and competent practice by health practitioners and promoting the health and safety of the public.

216. I intend to provide a copy of the findings to the following stakeholders for information, and to assist them in the development of professional training content

with an emphasis on the taking and the recording of vital signs and observations and the requirement for taking and maintaining clinical notes by general practitioners:

a) Office of the Health Ombudsman;
b) Australian Health Practitioner Regulation Agency; and
c) Royal Australian College of General Practitioners.

Acknowledgements

I thank Counsel Assisting the inquest Mr Crawfoot, and Counsel appearing for each of the general practitioners, Ms Zerner and Mr Schneidewin, for their careful consideration of the matters before the court and for the courtesy displayed to Mr Russo's next of kin at all times.

I conclude by extending my sincerest condolences to Matthew's mother Mrs Judith Jensen who has been a tireless advocate for Matthew, and his sister, Danalee Jaswinsky. In their combined statement to the court at the conclusion of the inquest they shared their fondest memories of Matthew, describing him as a *"grizzly bear with a love of wood turning, pranks, and food".* I was left in no doubt that he is an irreplaceable loss to their family and I wish Matthew's family well in their healing.

I close the inquest.

Nerida Wilson
Northern Coroner
17 April 2020