IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 5970

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF JASON JOSEPH MIRKO LJEPOJEVIC

Delivered On:	Monday 16 April 2018
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Date:	Monday 12 February 2018
Findings of:	CORONER JACQUI HAWKINS
Counsel Assisting the Coroner:	Leading Senior Constable King Taylor, Police Coronial Services Unit
Representation:	Mr Scott Davison of counsel representing the Ljepojevic family Mr Ben Jellis of counsel representing Dr Yedlapalli

CORONER HAWKINS:

BACKGROUND

1. On 24 November 2015 at approximately 11.25am, Mr Jason Ljepojevic, a 30 year old man serving a term of imprisonment at the Loddon Prison was found collapsed and subsequently died in his cell.

2. Mr Ljepojevic had a medical history of Hepatitis C and poly substance abuse. He was reported by his mother to have a 'heart murmur' diagnosed in childhood, for which he was not symptomatic and did not require ongoing monitoring.

3. On 24 July 2015, Mr Ljepojevic had a nursing review on arrival at Loddon Prison. A prior history of a heart murmur was noted and that Mr Ljepojevic had been cleared as an early teen. There appeared to have been no further check-up since and no indication for any medical review.

4. On 23 November 2015 at 3.44pm, Mr Ljepojevic attended the medical centre reporting chest pain that commenced whilst lifting weights at the gym. He was seen by the registered nurse, Debra Semmens. Mr Ljepojevic described the pain as "*9/10 central chest pain extending up neck and through to back.*" There was mild shortness of breath and pain on movement. Nurse Semmens commented that Mr Ljepojevic was obviously distressed and anxious on presentation and that his pain was worse on movement, which was evidenced in his slow hesitant movements. She conducted an electrocardiography (ECG)[1] which showed a normal sinus rhythm.

5. General Practitioner, Dr Yedlapalli assessed Mr Ljepojevic at 3.47pm, who reported "*muscle pain, doing gym at 1.15pm with weights*" and that the pain was behind and above the sternum. There was no palpitations, shortness of breath or collapse. Dr Yedlapalli recorded that cardiovascular and respiratory examinations were normal and specifically that there was no tenderness or swelling over the carotid arteries and no signs of carotid artery dissection. He recorded that the ECG was normal. Paracetamol and anti-inflammatory medication were administered. Dr Yedlapalli checked Mr Ljepojevic's blood pressure in both arms, which was

[1] The ECG is dated 14 November 2015, however there is no record that Mr Ljepojevic attended the medical centre on this day, so it is assumed the date in incorrect.

found to be normal. Dr Yedlapalli arranged a nursing review of Mr Ljepojevic's condition two hours later.

6. At 5.36pm, Mr Ljepojevic was reviewed by Nurse Semmens. He reported the pain was much improved and he appeared comfortable, was breathing normally and moving freely. Mr Ljepojevic's pulse was 88 beats per minute and blood pressure was 120/90mmHg. His oxygen saturations were recorded as 68 per cent. This is presumed to be a typographical error and should have been 98 per cent.

7. Dr Yedlapalli stated that he called the prison from home at approximately 6pm to enquire about Mr Ljepojevic's condition. He was informed Mr Ljepojevic's pain had settled and his vital signs were normal. He said his plan was to transfer Mr Ljepojevic to Bendigo Hospital if the pain persisted or there were any red flag symptoms. Dr Yedlapalli was not contacted again.

8. At 7.15pm, Mr Ljepojevic spoke to his sister on the telephone and made the following comments: "*I thought I was having a heart attack*", "*it buckled me*", "*I full on buckled to my knees*", "*for two hours I was on my bed and felt like my heart was going to explode, now every time I breathe, I feel like I've been sledge hammered in the chest and my heart's going to tear out.*"

9. On 24 November 2015, Mr Ljepojevic re-attended the medical clinic at 10.25am and was reviewed by Registered Nurse, Stephanie Conway who prescribed more pain relief and advised him to return if he required any further pain relief.

10. At 11.25am, a Code Black was called as Mr Ljepojevic had collapsed in his accommodation unit. Inmates started emergency resuscitation. Nursing staff attended and continued the resuscitation. Ambulance paramedics were called and attended. Despite all best efforts, the paramedics stopped resuscitation attempts and at 11.55am, pronounced Mr Ljepojevic deceased.

THE PURPOSE OF A CORONIAL INVESTIGATION

11. Mr Ljepojevic's death constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act 2008* (Vic) (Coroners Act), as his death occurred in Victoria, in custody and was unexpected.

12. The jurisdiction of the Coroners Court of Victoria (Coroners Court) is inquisitorial[2]. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

13. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

14. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

15. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

16. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

17. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

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[2] Section 89(4) *Coroners Act 2008*
[3] *Keown v Khan* (1999) 1 VR 69

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

18. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

CORONIAL INQUEST

19. Whilst Mr Ljepojevic's death was a death in custody, it did not require a mandatory inquest, as a forensic pathologist has provided an opinion that his death was due to natural causes.[5]

20. On 14 June 2017, Mr Nicholas Korkliniewski from Arnold Thomas & Becker, lawyers representing the Ljepojevic family, filed a Form 26 – Request for Inquest into Mr Ljepojevic's death.

21. On 23 August 2017, I held a directions hearing and indicated my intention to hold an Inquest and set the scope and the witnesses for an inquest.

Witnesses

22. The following witnesses were called to give *viva voce* evidence:

- Dr Sateesh Yedlapalli, General Practitioner

23. The following expert witnesses participated in giving concurrent evidence.

- Dr Tim Lightfoot, Consultant Physician;
- Associate Professor Christopher Pearce, General Practitioner;
- Dr Peter Habersberger, Cardiologist; and
- Dr James Lynch, General Practitioner.

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[4] (1938) 60 CLR 336
[5] Section 52(3A) & (3B) of the Coroners Act

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased

24. On 24 November 2015, Mr Ljepojevic was visually identified by Ms Rosie Barnes, Operations Manager of Loddon Prison. His identity was not in dispute and required no further investigation.

Medical cause of death

25. On 2 December 2015, Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Ljepojevic and reviewed the Form 83 Victoria Police Report of Death, and the post mortem computed tomography (CT) scan.

26. Post mortem examination revealed a bicuspid aortic valve, which is a form of congenital heart disease, with which Mr Ljepojevic had been born. Dr Parsons explained that "*the aortic valve has two instead of three valves leaflets. Bicuspid aortic valves can lead to dilation of the aorta, aneurysmal formation and aortic dissection as we see here.*" At autopsy, Mr Ljepojevic was found to have myocarditis, the significance of which was uncertain.

27. Toxicological analysis of post mortem specimens detected the presence of therapeutic levels of codeine, ibuprofen and paracetamol.

28. Dr Parsons provided an opinion that the medical cause of death was 1a) HAEMOPERICARDIUM, 1b) DISSECTING AORTIC ANEURYSM, 1c) BICUSPID AORTIC VALVE. Dr Parsons considered Mr Ljepojevic's cause of death was due to natural causes.

Circumstances in which the death occurred

29. The purpose of the inquest was to investigate the following issues:

- The appropriateness of the clinical assessment, diagnosis and management of Mr Ljepojevic.
- Whether Mr Ljepojevic should have been referred to an emergency department.

- Whether a referral to an emergency department would have increased Mr Ljepojevic's chance of survival.

Appropriateness of the clinical assessment, diagnosis and management of Mr Ljepojevic

30. Mr Ljepojevic presented to Dr Yedlapalli on 23 November 2015 at 3.47pm. Dr Yedlapalli recorded that Mr Ljepojevic had been lifting weights at the gym and reported muscle pain in the "*sternal region to suprasternal region*".[6] Dr Yedlapalli's evidence was that he performed a physical examination of his cardiovascular and respiratory systems and found Mr Ljepojevic was breathing normally, speaking spontaneously, had stable vital signs and some pain with movement.[7] The ECG showed normal sinus rhythm.[8] Dr Yedlapalli considered that the reported pain was consistent with the explanation provided by Mr Ljepojevic that he had been working out in the gym. Based on Mr Ljepojevic's presentation and symptoms, Dr Yedlapalli's differential diagnoses were pericarditis, musculoskeletal chest pain and subtle spontaneous pneumothorax.[9]

31. After conducting the examination, Dr Yedlapalli diagnosed musculoskeletal pain and prescribed some pain relief. He advised Mr Ljepojevic to return in two hours so that his symptoms could be reassessed. His evidence is that he explained what red flags to look out for, such as palpitations, syncope or shortness of breath.[10] The plan was to send him to hospital, if pain worsened.[11] Mr Ljepojevic re-presented to the medical centre at 5.36pm and saw Nurse Semmens. He reported that the pain was much improved and he appeared comfortable. At 6pm, Dr Yedlapalli rang the nurse and was provided with an update on Mr Ljepojevic's condition.

32. Dr Tim Lightfoot, Associate Professor Christopher Pearce and Dr Peter Habersberger all participated in giving concurrent evidence and agreed that Dr Yedlapalli's assessment[12] of Mr Ljepojevic was appropriate. They also agreed that musculoskeletal pain was a reasonable diagnosis. In explaining the reasons for their majority opinion that Dr Yedlapalli's assessment and diagnosis was reasonable, Dr Lightfoot stated that the context in which

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[6] Exhibit 4 – pages 63 and 64 of the medical records in the Coronial Brief.
[7] Transcript of evidence, p10 & Exhibit 1 – Statement of Dr Sateesh Yedlapalli dated 13 January 2017
[8] Transcript of evidence, p13
[9] Transcript of evidence, p17 & Exhibit 1 – Statement of Dr Sateesh Yedlapalli dated 13 January 2017
[10] Transcript of evidence, p14
[11] Transcript of evidence, p19
[12] Transcript of evidence, p29

Mr Ljepojevic presented, having just returned from doing a heavy workout at the gym, is possibly one of the most common causes of chest pain in the prison system, and a likely explanation for this patient's symptoms. Dr Lightfoot felt the main diagnosis was quite appropriate.[13]

33. Pericarditis and pneumothorax were also considered as reasonable potential diagnoses.[14] All of the experts agreed that gastroesophogeal reflex disease, commonly known as heart burn, could have been considered as another possible diagnosis.[15]

34. Dr James Lynch dissented and explained that:

> *Mr Ljepojevic was a 30 year old man [with] post exertional chest pain, central deep seated, radiating down to his neck and through to his back in the circumstances of a man who had previously not complained of chest pain prior and so as a consequence I feel that musculoskeletal chest pain was not the appropriate working diagnosis."*[16]

35. He believed that an appropriate differential diagnosis in these circumstances should have been myocardial ischaemia, until proven otherwise.[17]

Should aortic dissection have been considered as a differential diagnosis?

36. There was general agreement from the expert witnesses that an aortic dissection should not have been considered as a differential diagnosis "*because of its incredible rarity. Rarity in the general population but even more so its rarity in a person of Mr Ljepojevic's age, extraordinarily rare.*"[18] There was also general agreement amongst the experts that it is practically impossible to diagnose a dissecting aortic aneurysm as a general practitioner.[19]

37. Submissions on behalf of the Ljepojevic family suggested there was evidence that Dr Yedlapalli had considered aortic dissection as a differential diagnosis because he had made the following note in the medical records "*no signs carotid artery dissection*".[20] Dr Yedlapalli performed cardiac auscultation as part of his assessment, looking for any abnormal heart sounds and his evidence was that he did not consider the possibility of aortic

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[13] Transcript of evidence, p31-32
[14] Transcript of evidence, p33
[15] Transcript of evidence, p34
[16] Transcript of evidence, p32
[17] Transcript of evidence, p32
[18] Transcript of evidence, p34
[19] Transcript of evidence, p36
[20] Exhibit 4 - pages 63 and 64 of the medical records in the Coronial Brief.

dissection because the examination findings did not fit with that and because "*it's a really, really rare condition.*"[21]

38. Counsel for Dr Yedlapelli submitted that his diagnosis and management of Mr Ljepojevic was reasonable. Further that because aortic dissection is incredibly rare and impossible for a general practitioner to diagnose, there could be no criticism of Dr Yedlapalli's failure to diagnose the condition or to regard it as a differential diagnosis.

Should Mr Ljepojevic have been referred to an emergency department?

39. Dr Yedlapalli's evidence was that he did not consider that Mr Ljepojevic needed to be transported to an emergency department, however had his condition deteriorated, then the plan was for him to be taken to hospital.[22] He said that there were no constraints to this plan.[23] Dr Lightfoot commented from his experience as a GP in the prison system that the decision to send someone to hospital can often be refused by prisoners. He gave two reasons why prisoners often do not like to go to hospital, the first being that they do not like being transported and paraded through emergency departments with security, and the other is that they may have obtained a certain type of prison cell and if they leave the prison, there is a risk they could lose their cell. Therefore "*it's extremely common that even in the face of a recommendation to go to hospital, it is quite common for prisoners to reject and say no.*"[24] Consequently, some prisoners may downplay their symptoms,[25] which could have been the case in relation to Mr Ljepojevic because of the way he described the pain he was experiencing to his sister the night before he died, which was inconsistent with the way he described it to Dr Yedlapalli in the hours before speaking with his sister.

40. Dr Lightfoot, Professor Pearce and Dr Habersberger agreed that the treatment was appropriate given the differential diagnosis and they did not think any other management was required at the time.[26] Dr Habersberger said that in clinical practice you have to make judgements all the time.[27]

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[21] Transcript of evidence, p16
[22] Transcript of evidence, p19
[23] Transcript of evidence, p15
[24] Transcript of evidence, p54
[25] Transcript of evidence, p55
[26] Transcript of evidence, p32
[27] Transcript of evidence, p53

41. Therefore,

> *doctors are taught to make clinical judgements, taken at a time, on the best of their abilities, recognising, and we all keep our fingers crossed, recognising that we hope we got it right. Most of the time we do, occasionally we don't. This was a case where it wasn't right, but I believe it was an appropriate diagnosis under the circumstances by the doctor who was seeing a patient for the very first time with chest pain.*[28]

42. The logical consequence of their evidence that the medical management was appropriate was that they did not consider that Mr Ljepojevic needed to be referred to an emergency department.[29]

43. Dr Lynch differed and stated that Mr Ljepojevic should have been given aspirin and transported to an emergency department for further investigations because of the mere fact that an ECG had been performed, which indicated that at the time of his original presentation there was some concern about his cardiovascular status and coronary artery pathology.[30] Dr Lynch considered that appropriate management of Mr Ljepojevic required further investigation at an emergency department because of the significant number of potential serious differential diagnoses, including myocardial infarction.[31]

44. Consistent with Dr Lynch's evidence, Counsel for the Ljepojevic family submitted that due to the possibility that Mr Ljepojevic's pain may have been cardiac in origin, then he should have been referred to an emergency department. [32]

Would a referral to an emergency department have increased Mr Ljepojevic's chance of survival?

45. The evidence is that even if Mr Ljepojevic had been transferred to an emergency department there is a likelihood that an aortic dissection may not have been detected, as it is not generally detected by routine investigations. Dr Lightfoot added that if the clinical suspicion was high enough, then one of two tests would have been ordered in order to make a diagnosis. The

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[28] Transcript of evidence, p53
[29] Transcript of evidence, p37
[30] Transcript of evidence, p33
[31] Transcript of evidence, p38
[32] Submissions in Reply of the Ljepojevic family dated 20 March 2018, p3

most commonly available tests in an emergency department is a CT aortogram or an ECG.[33] The evidence was that it is often missed with a chest x-ray.[34]

46. Both Dr Lightfoot and Dr Habersberger agreed that even if Mr Ljepojevic had presented to an emergency department, it is likely that he would have been assessed as not needing any further investigation.[35] Dr Lynch disagreed and stated that if he had presented at an emergency department, Mr Ljepojevic would have likely been seen by a senior physician, which would have led to a higher level of assessment because of the circumstances of his presentation, for example being transported from prison. Dr Lynch believed that this would have led to a more thorough and comprehensive investigation of Mr Ljepojevic.[36]

47. Associate Professor Pearce agreed that Mr Ljepojevic may well have been reviewed by a more senior and experienced practitioner, but did not agree that it may have led to further investigations. He said in his opinion:

> *it would be the reverse, inexperienced practitioners are the ones who are more likely to order tests and it's the experienced practitioners who are more likely to make a discerning judgement and choose not to investigate on the basis of their experience and the presence or absence of – I don't actually deal with people in prisons but certainly police and people shackled quite a bit and that makes no difference. The intent is to treat them just the same as everybody else."* [37]

48. Dr Lightfoot agreed and said in his experience working at St Vincent's Hospital, emergency department, prisoners are treated no differently.[38] He said there are practical differences but in terms of attitude and clinical oversight, there is no difference.[39]

49. Dr Lightfoot noted that there is general consensus that a lot of people die from aortic dissection before even presenting to hospital, even in metropolitan areas. One consideration for a positive outcome is access to immediate cardiac surgical intervention, which was not available either at the prison or at the local hospital in this case. He said in general 50 per cent of people die within 24 hours of a diagnosis being made and 75 per cent of them have died within a week of the diagnosis being made. Dr Lightfoot noted the diagnosis is nearly

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[33] Transcript of evidence, p42
[34] Transcript of evidence, p40
[35] Transcript of evidence, p34-45
[36] Transcript of evidence, p40
[37] Transcript of evidence, p41-42
[38] Transcript of evidence, p42
[39] Transcript of evidence, p42

always made at the larger hospitals such as The Alfred, St Vincent's and the Royal Melbourne Hospital.[40]

50. Counsel for Dr Yedlapalli submitted that it follows that even if he had been referred to an emergency department there may have been no difference in outcome, as an aortic dissection may not have been detected in any event and the survival rate is poor.

Conclusions

51. Counsel for the Ljepojevic family submitted that there should be an adverse finding or comment made in relation to the medical care and management of Mr Ljepojevic. It was submitted that given the way in which Mr Ljepojevic originally presented to Nurse Semmens with a pain scale of 9 out of 10, they consider it incongruent that Dr Yedlapalli assessed Mr Ljepojevic as comfortable and breathing and talking normally and they raised doubt as to whether Dr Yedlapalli investigated the collateral history provided by Nurse Semmens. Further, that because an ECG was ordered, means that there was an underlying concern that his pain was cardiac in nature. Accordingly, a differential diagnosis of possible myocardial infarction or ischaemia ought to have been considered, and therefore, he should have been referred to an emergency department.[41]

52. Counsel for Dr Yedlapalli submitted that in light of the overwhelming cogent and reasonably expressed expert evidence of Dr Lightfoot, Associate Professor Pearce and Dr Habersberger, there should be no adverse findings or comments made in respect of Dr Yedlapalli's medical care and management.[42]

53. Having considered all of the evidence, I am satisfied on the balance of probabilities that Dr Yedlapalli conducted a thorough physical examination and assessment of Mr Ljepojevic on 23 November 2015. The majority of expert witnesses, Dr Lightfoot, Associate Professor Pearce and Dr Habersberger, agreed that Dr Yedlapalli's assessment, diagnosis and management was reasonable and I was persuaded by their consistent and cogent evidence. Consequently, I am also satisfied that the treatment plan for Mr Ljepojevic was appropriate, and that with the knowledge and information that Dr Yedlapalli had at the time of his

[40] Transcript of evidence, p43-44
[41] Submissions in Reply of the Ljepojevic family dated 20 March 2018, p3
[42] Submissions on behalf of Dr Yedlapalli dated 5 March 2018, p7

consultation, was consistent with his diagnosis, and therefore, Mr Ljepojevic did not require transfer to an emergency department.

54. Based on the information and assessment Dr Yedlapalli had made, I find the fact that Mr Ljepojevic died from an aortic dissection the following day was not a reasonably foreseeable event. The evidence is that aortic dissection is an extraordinarily rare condition, particularly in a man of Mr Ljepojevic's age and it is impossible for a general practitioner to diagnose. I therefore do not propose to make an adverse comment in relation Dr Yedlapalli's medical care and management.

FINDINGS

55. Having investigated the death of Mr Ljepojevic and having held an Inquest in relation to his death on Monday 12 February 2018 at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Jason Ljepojevic born on 3 May 1985; and

    (b) that Mr Ljepojevic died on 24 November 2015, at the Loddon Prison from 1a) HAEMOPERICARDIUM, 1b) DISSECTING AORTIC ANEURYSM, 1c) BICUSPID AORTIC VALVE;

    (c) in the circumstances described above.

56. I find on the balance of probabilities that that Dr Yedlapelli's medical care and management on 23 November 2015 at the Loddon Prison was reasonable and appropriate in the circumstances.

57. I wish to express my gratitude to the medical experts who participated in providing concurrent evidence. Their professionalism and expertise enabled me to better understand the medical evidence in this case.

58. I wish to express my sincere condolences to Mr Ljepojevic's family. I acknowledge the grief that you have endured as a result of your loss.

59. Pursuant to section 73(1) of the Coroners Act 2008, I order that the finding be published on the internet.

60. I direct that a copy of this finding be provided to the following:

- Ljepojevic family
- Dr Sateesh Yedlapalli
- Correct Care Australiasia Pty Ltd
- Dr Tim Lightfoot
- Associate Professor Christopher Pearce
- Dr Peter Habersberger
- Dr James Lynch

Signature:

JACQUI HAWKINS
CORONER
Date: 16 April 2018