IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4491

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**MATTEO GEMINIAN**
Date of birth:	6 OCTOBER 1982
Date of death:	7 SEPTEMBER 2017
Cause of death:	1(A) HAEMOPERICARDIUM 1(B) DISSECTING THORACIC AORTIC ANEURYSM
Place of death:	WESTERNPORT HIGHWAY, DANDENONG SOUTH, VICTORIA 3175

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HIS HONOUR:

BACKGROUND

1. Matteo Geminian was 34 years old when he died on 7 September 2017 from haemopericardium[1] and a thoracic dissecting aortic aneurysm.[2] Immediately prior to his death, Mr Geminian lived at 9, Botanic Ridge Boulevard, Botanic Ridge with his partner, Svetlana Panfilova and their children, aged twelve and nine.

2. Mr Geminian and his brother, Mauro Geminian, owned a chicken harvesting business and Mr Geminian was responsible for the operation and maintenance of the business's machinery.

3. Mr Geminian was described as fit and healthy. He enjoyed fishing and hunting and was actively involved in caring for his children. Ms Panfilova provided a statement to police in which she said that, on 5 September 2017, Mr Geminian awoke at approximately 6.30am and told her that he had chest pain and felt very unwell:

> *"…as though he had no energy which was totally out of character for him.". He said that he wanted to go to hospital" ...*
>
> *I asked him if he wanted me to drive but he said he should be okay and was concerned that we might be delayed and the kids wouldn't be able to get to school."...*

Treatment at Frankston Hospital

First Attendance

4. Mr Geminian drove himself and arrived at the Emergency Departement of the Peninsula Frankston Hospital (**ED**) at 7.59am. He complained of chest pain radiating to his jaw and was triaged as Category 2[3]. Nursing staff commenced him on a treatment pathway for patients who present with chest pain.

5. In accordance with the treatment pathway, an electrocardiogram[4] (**ECG**) was performed at 8.16am and blood tests at 8.41am by nursing staff. The ECG was reviewed by the supervising consultant on duty who noted that it did not show any concerning features of Acute Coronary

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[1] The presence of blood in the sac which surrounds the heart.
[2] An aneurysm is a bulging, weakened area in the wall of the aorta. Dissection means a process whereby blood enters the wall of the aorta via a tear in the inner layer or splits in the middle layers.
[3] Category 2 on the Australasian Triage Scale is for conditions requiring urgent care such as chest pain. It is recommended that category 2 patients be seen within 10 minutes of arrival in the ED by medical staff.
[4] A test to measure the electrical activity of the heart as it contracts.

Syndrome.[5] The blood tests results revealed a mildly elevated white cell count. At 8.25am, Mr Geminian's observations were taken by nursing staff and noted to be within normal limits. He complained of ongoing chest pain with a score of 4/10. The pain was recorded as bilateral across his chest "*with resolved jaw pain*". Analgesia (paracetamol and indomethacin) was administered at 9.00am.

6. As the ED was at full capacity, Mr Geminian was returned to the waiting room to await a bed/cubicle to become available in the ED. A chest x-ray was ordered. By 10.39am, Mr Geminian had been called twice when cubicles became available, however; he had apparently left the ED sometime after he returned to the waiting room and before the chest x ray could be performed, apparently without telling anyone.

7. In her statement Ms Panfilova stated that Mr Geminian arrived home at "*about 11 o'clock in the morning*" and told her that:

> "*...he had some blood tests and that they had checked his heart. They told Matteo that his blood results would be about 2-3 hours. Matteo asked if he could go home as he was not feeling well enough to wait in the waiting room and they said would be OK*".

Second Attendance

8. At 3.33pm on the same day, Mr Geminian re-presented to the ED. He complained of ongoing chest pain on inspiration and vomiting. He sought the results of blood tests performed earlier that day. The ED was still at capacity with no available cubicles. At 4.34pm Mr Geminian stated that he had bilateral chest pain on inspiration with a pain score of 2/10. At this time, nursing staff also recorded that Mr Geminian told them that, at the earlier presentation that morning, he decided to go home "*for a rest*".

9. At 5.42pm, the doctor assigned to Mr Geminian's care went to find him in the waiting room, but Mr Geminian had left.

10. In her statement Ms Panfilova said that Mr Geminian told her that:

> "*...the hospital told him that he had a chest infection and advised him to have a hot Lemsip drink and to rest.*".

[5] Any condition brought on by sudden reduction in or blockage of blood flow to the heart.

11. There is no evidence in the hospital records that any such advice (including the advice referred to in paragraph 7) was given to Mr Geminian by hospital staff.

12. Mauro Geminian provided a statement to police in which he noted that, at some time on the morning of 5 September 2017, he called his brother to ask for assistance with a job. He stated that Mr Geminian told him that:

> *"He was unable to help me as he had just got out of hospital as he was there with a lung infection"*, (having gone to hospital because he felt as though he was having a heart attack.)

6-7 September 2017

13. Ms Panfilova reported that, on 6 September, Mr Geminian continued to complain of chest pain and lack of energy. He did not eat much during the day. She stated that, on the evening of 6 September 2017, Mr Geminian, Ms Panfilova and their son went to their farm to inspect a container of machinery which had been delivered. Mauro Geminian also attended and stated that Mr Geminian appeared to be *"fine"*.

THE CORONIAL INVESTIGATION

Coroners Act 2008

14. Mr Geminian's death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because his death having occurred in Victoria, was unexpected, appears to have resulted from an accident or injury and not from natural causes.[6]

15. The Act requires a coroner to investigate reportable deaths such as Mr Geminian's and, if possible, to find:

    (a) The identity of the deceased;

    (b) The cause of death; and

    (c) The circumstances in which death occurred.[7]

16. For coronial purposes, "*circumstances in which death occurred*",[8] refers to the context and background to the death including the surrounding circumstances. Rather than being a

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[6] *Coroners Act 2008* (Vic) s 4.
[7] *Coroners Act 2008* (Vic) preamble and s 67.
[8] *Coroners Act 2008* (Vic) s 67(1)(c).

consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

17. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[9] It is not the Coroner's role to determine criminal or civil liability,[10] nor to determine disciplinary matters.

18. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

19. Coroners are also empowered to:

    (a) Report to the Attorney-General on a death;[11]

    (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[12] and

    (c) 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.[13]

Standard of Proof

20. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[14] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[15] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[16]

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[9] *Keown v Khan* [1999] 1 VR 69.
[10] *Coroners Act 2008* (Vic) s 69 (1).
[11] *Coroners Act 2008* (Vic) s 72(1).
[12] *Coroners Act 2008* (Vic) s 67(3).
[13] *Coroners Act 2008* (Vic) s 72(2).
[14] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[15] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[16] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].

21. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[17] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[18] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[19]

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

Identity of the Deceased - Section 67(1)(a) of the Act

22. On 7 September 2017, Mauro Geminian identified the deceased as his brother, Matteo Geminian.

23. Mr Geminian's identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

24. On 22 September 2017, Dr Sarah Parsons, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted a post-mortem examination on the body of Matteo Geminian. Dr Parsons provided a written report, dated 9 November 2017, in which she opined that the cause of Mr Geminian's death was '*1(a) Haemopericardium; 1(b) Dissecting Thoracic Aortic Aneurysm*'. I accept Dr Parsons' opinion.

25. Toxicological analysis of post -mortem samples detected the presence of paracetamol at levels consisted with therapeutic use. 11 nor-delta-9 carboxytetrahydrocannabinol (cannabis) was detected in urine. Ethanol (alcohol) was not detected.

26. Dr Parsons made the following comments:

> *"Thoracic aortic aneurysms often grow slowly and usually without symptoms making them difficult to detect. Aortic aneurysms weaken the wall of the wall of the aorta which is the main vessel taking blood from the heart and can lead to a tear (dissection) as we see here. This is a medical emergency and has a high mortality.*

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[17] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[18] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[19] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

Factors that can contribute to an aneurysm include atherosclerosis, genetic conditions, problems with the heart's aortic valve, untreated infection and trauma.

The deceased had no evidence of significant atherosclerosis at autopsy. The deceased does however, have a bicuspid valve which he would have been born with that increases his risk of aneurysm. Given his very young age a genetic condition should be considered. Genetic condition [sic] *should be considered such as Marfan syndrome, Ehlers Danlos syndrome and Loeys-Dietz syndrome can contribute to thoracic aortic aneurysm. It is recommended that immediate family members are assessed in regard to this".*

Circumstances in which the death occurred - Section 67(1)(c) of the Act

27. Ms Panfilova stated that, on the morning of 7 September 2017:

"Matteo received a phone call at about 5.00 to 5.30am from an employee who told Matteo that he was feeling unwell and couldn't continue to work. The employee was responsible for driving a truck...Matteo tried to call his brother Mauro twice that morning but could not get him. Matteo contacted another employee to drive the truck which was in Ballarat but Matteo still had to help out with the harvesting machine. As Matteo could not get Mauro he had to go himself. Matteo left home that morning at about 6 to 6.30am..."

28. At approximately 6.50am, a man later confirmed to be Mr Geminian, was observed (by witnesses in two cars travelling behind his vehicle) driving a Mercedes Benz Vito van **(the van)** north along Westernport Road between Bayliss Road and Northey Road, in the right lane of two northbound lanes. A short distance after Bayliss Road, the van was seen to brake and drift across from the right to the left lane, colliding with the Armco safety barrier on the left side of the road, coming to rest against a concrete boulder. No other vehicle was involved and there was minimal damage to the van.

29. One of the witnesses drove past the stationary van, observing Mr Geminian in the driver's seat, slumped to the left with his head back. She pulled over, stopped and went to render assistance finding Mr Geminian to be unresponsive.

30. Another witness also pulled over to assist and between them, they removed Mr Geminian from the van and laid him on the ground. They commenced CPR and notified emergency services.

31. Emergency crews, including MICA paramedics attended shortly afterwards but their resuscitation attempts were unsuccessful. Mr Geminian was declared deceased at the scene

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

32. Given family concerns about the medical care provided to Mr Geminian at Frankston Hospital, I directed that the medical records from Peninsula Health/Frankston Hospital relating to Mr Geminian's attendances on 5 September 2017 be reviewed by the Coroners' Prevention Unit (**CPU**).[20]

33. Following its review of the medical records, the CPU recommended that a detailed statement be obtained from Dr Shyaman Menon, Director of ED at Peninsula Health/Frankston Hospital in response to specific questions regarding Mr Geminian's presentations at the hospital on 5 September 2017.

34. In a detailed statement dated 27 March 2019, Dr Menon explained that at the time of Mr Geminian's first attendance to ED at 8.00am on 5 September 2017, the ED was at capacity. There were fourteen patients waiting to be seen and twenty-four patients in the ED awaiting a ward bed for hospital admission. At the time of Mr Geminian's second presentation at 3.33pm, the ED was again at capacity with no cubicles available. There were sixty-one patients in the ED, seventeen admitted patients awaiting ward beds and twenty-nine patients waiting to be seen including seventeen in the waiting room. I note that the Emergency Department at Frankston Hospital, is one of the busiest emergency departments in Victoria with around 75,000 patient attendances per year. [21]

35. The CPU advised me that this situation is referred to as "*Access Block*" i.e the hospital is at capacity, so there are no beds available for patients waiting in ED. This in turn blocks ED beds and cubicles so there is no space available in the ED to assess new patients presenting to the ED.

36. The CPU advised me that Access Block is the single most serious issue affecting emergency departments in Australia because it directly negatively affects the provision of safe, timely and quality medical care.

37. The Australasian College of Emergency Medicine (**ACEM**) released a position statement[22] in relation to Access Block, which it states is:

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[20] The role of the CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. It is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration.

[21] Peninsula Health website: Frankston Emergency Department

[22] *https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849-442feaca8ca6-S127_v01_Statement_Access_Bloack_Mar_14.aspx.*

"The principal factor responsible for ED overcrowding and adversely impacts on all aspects of acute medical system performance, including increased patient harm and mortality, increased patient waiting times, increased patient hospital length of stay and increased ambulance turnaround times.

Continues to be a significant challenge for staff to provide safe care in the ED and required constant review by the hospital executive to monitor and respond to instances of increased patient demand.

Has historically been considered to be an ED only problem. It is however symptomatic of a health system in crisis – a relative lack of of hospital inpatient bed capacity compared to demand, which cannot be solved solely by ED based interventions.

Requires multifactorial, evidence based sustainable solutions primarily related to increasing capacity throughout the public health system through investment in hospital infrastructure, clinical workforce and efficiencies in patient care.

Requires constant monitoring within the hospital and across the broader acute health system in order to adequately review health policies and processes to deliver system improvements."

38. In his statement Dr Menon referred to action taken following a review of the circumstances surrounding Mr Geminian's death in accordance with the hospital's Mortality and Morbidity screening process. The following recommendations were implemented:

(a) A formal process for follow up of patients who leave without being seen by a doctor has been put in place. When patients assessed as triage category 1-3 leave the ED without being seen by a doctor, they are now followed up with a telephone call from a senior nurse. A pilot process is being developed which involves a question template and online clinical guidelines for the giving of advice. Information about the call is documented in ED.

(b) The Emergency Model of Care has been changed so that there are clear lines of escalation to the team leader. The consultant in charge is notified of any category 2 patients who leaves the ED prior to being seen.

39. Dr Menon stated that:

"Peninsula Health continues to strive to ensure that presenting patients have timely access to care. A whole of hospital approach to improving patient flow has and continues to be undertaken to ensure a safe and timely progression of care and creating capacity within the ED to respond in a timely manner.

This, along with a new Model of Care within the Emergency Department which was implemented in March 2018 has reduced the "did not wait "for patients presenting to the FED[23]. The new team-based care model which starts at the point of triage provides a clear line of escalation for staff to be able to raise and address concerns".

40. The CPU advised me that it is not possible to say whether Mr Geminian's death would have been prevented had Mr Geminian waited long enough to be seen by a doctor on 5 September 2017.

41. It is well recognised that dissection of an aortic aneurysm can be difficult to diagnose, particularly if the patient, as in this case, does not have typical or suggestive features of such a disection. Blood tests and ECG are not usually helpful in aiding the diagnosis.

42. The CPU advised me that for patients presenting with chest pain, a chest x ray is usually performed to look for pneumothorax, abnormal mediastinum, the aortic outline, and cardiac and lung conditions. One study[24] conducted regarding the difficulty of diagnosing acute thoracic aortic dissection found that plain chest x ray results can be abnormal in the presence of thoracic aortic dissection. Hence, the presence (on chest x ray) of a normal aorta and mediastinum decreases the probability of dissection. Mr Geminian did not wait long enough to undergo the ordered chest x ray; had he done so there is at least the possibility that an abnormality on the x ray may have alerted medical staff to the diagnosis.

43. It appears likely that the chest pain of which Mr Geminian complained on 5 September was due to the dissection of the thoracic aortic aneurysm and there was a potential missed opportunity for diagnosis.

44. The CPU considered that the triage assessments and the nurse-initiated assessment performed in the ED were all appropriate. It is seriously regrettable that, at the times Mr Geminian presented, the ED was experiencing significant Access Block; there were simply no available cubicles in which he could have been medically assessed by a doctor.

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[23] Frankston (hospital) Emergency Department

[24] Klompas M. Does this patient have an acute aortic dissection? *JAMA (2002) 287 (17) 2262-2272*

45. That said, had Mr Geminian waited to be seen the first time he went to the ED, on one view [25] he may have been seen, within at most two hours and thirty-nine minutes of his presentation to the ED and at the second attendance, had he waited he would have been seen within at most two hours and nine minutes of his presentation. By leaving the ED on both occasions, Mr Geminian deprived himself of the opportunity of this consultation and assessment.

46. I acknowledge the recommendations implemented at Frankston Hospital ED in relation to a formal follow-up process for patients who leave without being seen and the process for escalation of patient care. I also acknowledge the danger that Access Block and ED overcrowding pose to the lives of people who attend the ED.

47. I direct that a copy of this finding be forwarded to the Australasian College of Emergency Medicine acknowledging the College's efforts to bring the issue of Access Block to the attention of the Victorian Minister for Health and Human Services.

48. I further direct that this finding be forwarded directly to the Victorian Minster for Health and Human Services for consideration.

49. I am satisfied, having considered all of the available evidence, that there are no suspicious circumstances, that Mr Geminian's death was due to natural causes and that no further investigation is required.

FINDINGS AND CONCLUSION

50. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Matteo Geminian, born on 6 October 1982;

    (b) Mr Geminian's death occurred;

        i. on 7 September 2017 at Westernport Highway, Dandenong South;

        ii. from 1(a) Haemopericardium; 1(b) Dissecting Aortic Aneurysm; and

        iii. in the circumstance described in paragraphs

[25] Based on recorded arrival times at triage and times when Mr Geminian found to have left ED. See medical records Peninsula Health and Dr Menon's statement 27 March 2019.

iv. in the circumstances described in paragraphs 5 -14 & 28-32 above.

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

(a) Ms Svetlana Panifilova, senior next of kin;

(b) Ms Amber Salter, Peninsula Health;

(c) The Hon. Jenny Mikakos, Minister for Health, Victoria;

(d) The Australasian College of Emergency Medicine; and

(e) Senior Constable Darren Barnard, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 16 March 2020