



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001001

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Dimitra Dubrow
Deceased:	Ferenc Adam
Date of birth:	22 March 1962
Date of death:	20 February 2024
Cause of death:	1a: Coronary artery disease
Place of death:	83 Truemans Road Capel Sound Victoria 3940

INTRODUCTION

1. On 20 February 2024, Ferenc Adam (**Ferenc**) was 61 years old when he died in circumstances suggestive of a medical episode. At the time of his death, Ferenc lived alone in Narre Warren.
2. Ferenc is survived by his older brother, Laszlo Adam. Ferenc was previously married but had no children.
3. Not much is known about Ferenc's medical history. Laszlo reported that Ferenc was a heavy smoker and consumed alcohol moderately. Laszlo recalled that, in recent years, Ferenc began complaining of symptoms similar to gastro-oesophageal reflux (**GORD**). It did not appear that Ferenc had any known cardiac conditions.
4. Ferenc was working as a glazier and held an unrestricted and valid Victorian driver licence at the time of his death.

THE CORONIAL INVESTIGATION

5. Ferenc's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
8. Then Coroner Katherine Lorenz initially held carriage of this investigation until it came under my purview in September 2024 for the purposes of obtaining material, finalising the investigation and handing down this finding.
9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ferenc's death. The Coronial Investigator conducted inquiries on my behalf, including taking

statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Ferenc Adam including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.¹

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

Circumstances in which the death occurred

Background circumstances

11. On 7 February 2024, Ferenc attended Parkhill Medical Centre and consulted a general practitioner (GP), Dr Kaylani Thunuguntla regarding heartburn. He reported that he had previously taken pantoprazole but had stopped the medication about a year earlier after his symptoms improved. He told Dr Thunuguntla that his heartburn had since recurred and that, on the previous day, he experienced tightness in both forearms accompanied by sweating for about five minutes.
12. Ferenc also reported experiencing two episodes of heartburn the previous night, each lasting about five minutes and resolving after he drank Coca-Cola. The GP performed a series of assessments, including heart rate and blood pressure checks and an abdominal examination. The results were within normal limits, except for Ferenc's blood pressure, which was slightly elevated. Based on these symptoms, Dr Thunuguntla recorded a working diagnosis of GORD.
13. Dr Thunuguntla stated that notwithstanding this, given Ferenc's atypical chest pain symptoms and other risk factors, he discussed with Ferenc the need to exclude serious causes for his symptoms relating to his heart. An electrocardiogram (ECG) was performed by Dr Thunuguntla at the clinic which was normal and blood tests were arranged for that day with a plan for Ferenc to return the next day to review the results and discuss a follow-up plan. Dr Thunuguntla also prescribed Ferenc pantoprazole 40mg and advised him to attend an

¹ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

emergency department (**ED**) if he experienced any chest pain that did not resolve within 10 minutes.

14. Ferenc did not subsequently attend Dr Thunuguntla. Dr Thunuguntla said he reviewed the blood test results the next day and noted that the troponin test² was normal as was the full blood count and kidney function test. As the test results were not of immediate concern, a recall notice for Ferenc to attend the clinic was not sent.
15. Ferenc's Medicare and Pharmaceutical Benefits Scheme (**PBS**) records indicated that he filled the pantoprazole prescription on 7 February 2024. There were no records of him attending other medical practitioners after that date.

Immediate circumstances

16. On the morning of 20 February 2024, Ferenc attended a client's home in St Andrews Beach to measure some windows for a quotation. Ferenc told the client that he "*didn't feel too good*" and complained of chest pain while working. After a brief conversation about whether Ferenc had previously experienced similar symptoms, the encouraged him to attend the ED at Rosebud Hospital, and Ferenc agreed. Ferenc left St Andrews Beach at approximately 10.20am.
17. At approximately 10.35am, Ferenc was driving his blue Holden Commodore sedan ('**the Commodore**') in a northerly direction on Truemans Road, Capel Sound. Truemans Road was a two-way suburban road running generally in a north-south direction. Both sides of the road were bordered by an unsealed road reserve extending to the sealed carriageway to the adjoining residential property. Bona Street, Tootgarook, formed a T-intersection with Truemans Road from the west.
18. At a point approximately 40 metres before reaching the Bona Street intersection, the sedan veered to the left and departed the roadway. It continued travelling along the western road reserve, where it collided with two mobile garbage bins in front of 64 Truemans Road. It then collided head on with the driver's side of a blue Holden Cruze sedan ('**the Cruze**'), which was stopped at the T-intersection. The Commodore subsequently crossed to the eastern side of Truemans Road and travelled approximately 33 metres on the road reserve before coming to a stop near 83 Truemans Road.

² A test that measures the level of the protein troponin in the blood stream which, if elevated, may indicate damaged heart muscle and assists in the diagnosis of a heart attack.

19. Witnesses immediately came to Ferenc's aid and the vehicle owner of the Cruze and contacted emergency services. Upon attending the Commodore, a witness observed cigarette smoke coming from the driver's seat, and the vehicle's ignition was still on. Ferenc was in the driver seat, wearing a seatbelt, unresponsive and unable to be roused.
20. Victoria Police was the first to attend and attending officers commenced cardiopulmonary resuscitation (**CPR**). Ambulance Victoria paramedics attended, took over CPR, and administered treatment, including intravenous lignocaine³ and amiodarone⁴. Despite these efforts, paramedics were unable to detect any cardiac activity and declared Ferenc deceased.
21. Police later commenced an investigation, including an examination of the scene and an inspection of the Commodore. Police noted that the road was dry and that the weather was fine and sunny. The road was in good condition. Police observed that there were no skid marks or indications of braking at the scene. There was also no evidence of mobile phone use at the time of the collision. Police further observed that the Commodore sustained severe front-end damage. Both front airbags of the Commodore had deployed as a result of the force of the collision.
22. Police also noted that, having regard to the direction of Ferenc's travel, he appeared to have been heading to Rosebud Hospital, as he had indicated in his conversation with the client.

Identity of the deceased

23. On 22 February 2024, Ferenc Adam, born 22 March 1962, was visually identified by his brother, Laszlo Adam.
24. Identity is not in dispute and requires no further investigation.

Medical cause of death

25. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 22 February 2024 and provided a written report of his findings dated 19 March 2024.

³ Lignocaine is indicated for the production of local or regional anaesthesia by nerve block, infiltration injection, caudal or other epidural blocks. Treatment or prophylaxis of life-threatening ventricular arrhythmias.

⁴ Amiodarone is used to treat life-threatening heart rhythm problems called ventricular arrhythmias.

26. The post-mortem examination revealed evidence of coronary artery disease. Dr Burke explained that coronary artery disease is a common cause of sudden death, which may lead to myocardial ischaemia and a sudden cardiac arrhythmia colloquially known as a heart attack.
27. The post-mortem examination also revealed heavy oedematous lungs. Dr Burke explained that this likely occurred secondary to sudden left ventricular failure associated with a cardiac arrhythmia.
28. The post-mortem computed tomography (CT) scan revealed evidence of coronary artery calcification and increased lung markings. There was no evidence of skull fracture, intracranial haemorrhage, or skeletal trauma.
29. Toxicological analysis of post-mortem samples identified the presence of lignocaine. No ethanol (alcohol) was detected.
30. Dr Burke provided an opinion that the medical cause of death was *1(a) coronary artery disease*. He considered that the death was due to natural causes.
31. I accept Dr Burke's opinion.

CORONERS PREVENTION UNIT REVIEW

32. Given the cause of and the circumstances surrounding Ferenc's death, the matter was referred to the Coroners Prevention Unit (CPU)⁵ for review of his clinical care and management proximate to his death.
33. The CPU reviewed the available materials and provided its advice accordingly. The CPU noted that during the consultation on 7 February 2024, Dr Thunuguntla considered Ferenc's symptoms and reasonably excluded acute coronary syndrome (ACS) and coronary artery disease (CAD) as the most likely diagnoses. The CPU further considered that the overall assessment, management by Dr Thunuguntla of Ferenc's presentation and clinical advice were reasonable.

⁵ The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

34. The CPU observed that although Ferenc's ECG reading was normal and did not indicate an ST-elevation myocardial infarction (**STEMI**), the most severe form of heart attack, a normal ECG cannot exclude ACS or CAD. This is because an ECG records the heart's electrical activity at a single point in time and does not necessarily rule out the presence of ACS or CAD.
35. The CPU further observed that the results of Ferenc's other investigations on 7 February 2024 were normal. In those circumstances, it would not be standard practice for a GP to proactively follow up a patient, even where the patient had been advised to return for further review if symptoms persisted or worsened.
36. I accept and adopt the advice of the CPU.

FINDINGS AND CONCLUSION

37. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Ferenc Adam, born 22 March 1962;
 - b) the death occurred on 20 February 2024 at 83 Truemans Road Capel Sound Victoria 3940, from coronary artery disease; and
 - c) the death occurred in the circumstances described above.
38. Having considered all of the circumstances, I am satisfied that a medical episode, most likely cardiac in nature, likely preceded the motor vehicle incident. There is no evidence to suggest that Ferenc deliberately caused the collision.
39. Further, I am satisfied that the clinical management and care provided by Dr Thunuguntla to Ferenc on 7 February 2024 was appropriate in the circumstances. I make no adverse comments in relation to Dr Thunuguntla. Instead, I make the following comments to raise awareness of available health information concerning chest pain and the importance of timely medical attention.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

40. Although I have not identified any prevention opportunities in relation to the healthcare provided to Ferenc proximate to his death, this matter highlights the importance of recognising chest pain as a symptom that may require urgent medical attention. Chest pain can arise from a range of causes, including potentially life-threatening cardiac conditions, and it may not always present with the classic feature of a heart attack.
41. As outlined by the Better Health Channel, the warning signs of a heart attack may vary from person to person and may not always be sudden or severe. Individuals may experience a single symptom or a combination of symptoms. The Better Health Channel further advises that chest pain caused by a heart attack requires emergency treatment to restore blood flow to the heart, and the sooner the treatment is provided, the less damage is likely to occur to the heart muscle.⁶ Accordingly, anyone experiencing severe worsening or persistent chest pain lasting more than 10 minutes should call Triple Zero immediately and request an ambulance rather than driving themselves to hospital.

I convey my sincere condolences to Ferenc's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

⁶ Better Health Channel – Chest pain, available at <https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/chest-pain> accessed on 6 October 2026

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

Laszlo (Les) Adam, Senior Next of Kin

Dr Kaylani Thunuguntla C/-o Avant Law Pty Ltd

Leading Senior Constable Robert Dukes, Coronial Investigator

Signature:



Coroner Dimitra Dubrow

Date: 06 October 2026

NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
