**CORONERS COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Samuel Seeto |
| **Hearing dates:** | 10 and 11 August 2017 |
| **Date of findings:** | 21 August 2017 |
| **Place of findings:** | State Coroner's Court, Glebe |
| **Findings of:** | **Deputy State Coroner, Magistrate Teresa O'Sullivan** |
| **Catchwords:** | CORONIAL LAW –<br>Myocarditis<br>Syncope |
| **File number:** | 2015/358872 |
| **Representation:** | Ms T Stevens, Counsel Assisting, instructed by Mr J Herrington, the Crown Solicitor's Office.<br>Mr R O'Keefe, instructed by Carroll and O'Dea Lawyers, for the Seeto family.<br>Mr M Lynch, instructed by Avant Law, for Dr B Patel. |

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| **Findings:** | **Identity of deceased**:<br>The deceased person was Samuel Seeto.<br><br>**Date of death**:<br>He died on 6 December 2015.<br><br>**Place of death**:<br>He died at 100 Cook Street, Forestville, NSW.<br><br>**Cause of death:**<br>He died from florid myocarditis.<br><br>**Manner of death:**<br>He died from natural causes after the medical practitioner treating him the previous day failed to detect his cardiac condition. |
| **Recommendation:** | I recommend that a transcript of these proceedings and a copy of these findings be forwarded to the Health Care Complaints Commission (HCCC) so that consideration may be given to this matter being investigated. |

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*The Coroners Act 2009* (NSW) *in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Samuel Seeto.*

# Introduction

1. Samuel Seeto was 29 years old when he died suddenly at home on 6 December 2015. In the two months before his death, Samuel's father, Lawrence, had noticed that he looked increasingly tired and rundown. He had discomfort around his left shoulder. Samuel was not known to complain about his health, and would only see a doctor if very ill. Samuel's medical records show he had no significant pre-existing health conditions and was in general good health. Samuel consulted General Practitioner, Dr Bhikhubhai Patel, on the day before he died. Dr Patel told Samuel that he had the flu and that he was dehydrated. Samuel's father found Samuel in his bedroom the following day. He was deceased.

# The Inquest

2. An inquest is different to other types of court hearings. It is neither criminal nor civil in nature and the coroner does not make determinations and orders that are binding on the parties, such as in civil litigation, nor determine whether a person is guilty or not guilty of an offence, such as in criminal proceedings.
3. The formal findings that need to be made are: who, when, where, how and in what circumstances a person has died.
4. The focus of this inquest was on Samuel's medical condition in the days leading up to his death and the circumstances of his consultation on 5 December 2015 with general practitioner Dr Patel.
5. For Samuel's family, understanding how he died is important in trying to understand if anything could have been done better or differently.

# The evidence

## *Samuel Seeto*

6. Samuel was born on 8 October 1986 to Lawrence and Jenny Seeto. He worked at a computer company following completion of study in 2008 at the University of Technology in Sydney.[1] Samuel's medical records show he had no significant pre-existing health conditions and was in general good health.

[1] Ex1 Lawrence Seeto, 6 March 2016 at [3], (tab 6).

## *Signs and symptoms leading up to Samuel's death*

7. In the two months leading up to his death, Samuel's father, Lawrence, noticed that Samuel looked tired and worn down. Lawrence also noted that Samuel would never complain about illness.[2]

8. At around 5.30pm on 4 December 2015 Samuel returned home from work, walked into the study and collapsed onto the floor on his back. He had no energy and agreed to see the doctor the following day. Samuel was of the view that he did not have the 'flu' because he did not have a running nose. He also commented that he had a 'trolling' feeling in his chest when he drank water.[3]

9. At around 8.30am on 5 December 2015 Lawrence heard a noise in the bathroom and believed Samuel had fallen over in the shower. Lawrence then drove Samuel to the Chatswood Medical and Dental Centre.[4]

## *The consultation with Dr Patel*

10. At around 9.20am on 5 December 2015 Samuel arrived at the medical centre. Samuel was booked into see Dr Patel as his usual doctor was not available. Samuel had never seen Dr Patel before.

11. At around 10.15am Samuel was called into Dr Patel's room. When walking to Dr Patel's room, Samuel collapsed on the ground in the reception area.[5]

12. Dr Patel was present in the reception area when Samuel collapsed. The incident was captured on CCTV and played in court during the inquest.

13. Dr Patel made notes of the consultation[6] and provided a statement that is contained in the brief.[7] Dr Patel objected to giving evidence at the inquest under s.61 of the *Coroners Act*. I determined that there were reasonable grounds for his objection, however I was not satisfied that the interests of justice required him to give evidence.[8]

## *What Dr Patel recalls of the consultation*

14. Dr Patel says in his statement that Samuel gave a history of dizziness, aches and fever over three days. He said Samuel described feeling faint. Dr Patel said "I observed he stumbled on the way to my room".[9] It is not clear if this statement refers to Samuel collapsing in the waiting area or whether there was another event after the collapse. I say this because I had the opportunity to view Samuel's collapse in the waiting area as it was recorded on CCTV and is

[2] Ex 1 Lawrence Seeto, 6 March 2016 at [4].
[3] Ex 1 Lawrence 2 Seeto, 6 March 2016 at [6].
[4] Ex 1 Lawrence Seeto, 6 March 2016 at [7].
[5] Ex 1 Lawrence Seeto, 6 March 2016 at [7] and see CCTV footage from medical centre.
[6] Ex 1 Medical notes of 5 December 2015 (tab 18 at p.3).
[7] Ex 1 Dr Bhikhubhai Patel, 15 March 2016 at [1] (tab 13).
[8] Section 61(4)(b) *Coroners Act 2009* (NSW).
[9] Ex 1 Dr Bhikhubhai Patel, 15 March 2016 at [1] (tab 13).

contained in the brief of evidence. In my view it could not be described as a "stumble". Samuel appeared to fall backwards onto the ground and remained unconscious on the ground for about 5 seconds.

15. Dr Patel states the following occurred during the consultation:[10]

    a) *Samuel looked unwell with a dry tongue;*
    b) *He took a blood pressure reading of 90/70;*
    c) *His chest was clear (noting no detail of the nature of the chest examination);*
    d) *He had a soft abdomen;*
    e) *There was no neck stiffness;*
    f) *He diagnosed a viral illness combined with dehydration;*
    g) *He advised Samuel take nurofen, drink fluids and attend Royal North Shore Hospital if necessary.*

16. During the consultation Dr Patel did not undertake or recommend any further investigations. On 5 December 2015, X-ray and Electrocardiogram ('ECG') facilities were available at Chatswood Medical and Dental Centre.[11]

## *What Lawrence Seeto recalls of the consultation*

17. Lawrence Seeto provided three statements and gave evidence at the inquest.[12] Below is his description of what happened just prior to the consultation with Dr Patel.

> *"We waited approximately 5 to 7 minutes in the waiting room before we were called by Dr Patel, who was standing about 7 metres from us. Samuel stood up. Dr Patel turned and walked towards the consulting room. Samuel walked no more than 7 metres before he collapsed on his back hitting his head on the floor, there was an audible 'thud' when the back of Samuel's head hit the ground. I went over to Samuel. For approximately the first 30 seconds Samuel's eyes were closed. I saw Dr Patel turn around and he came over to Samuel and I and asked what's wrong. Samuel's eyes were still closed to Dr Patel asked Samuel "what's up, what's up, what's up mate". When Samuel regained consciousness a bystander and Dr Patel assisted Samuel up by each taking hold of one of his arms. When Samuel stood up he was very groggy and shaken. I walked behind Samuel, Dr Patel and the bystander as they walked down to Dr Patel's consultation room. At the door to Dr Patel's consultation room, I thanked the bystander and took over from where the bystander was standing and then the three of us went through the doorway of his consultation rooms sideways. I then put Samuel in a chair."*[13]

[10] Ex 1 Dr Bhikhubhai Patel, 15 March 2016 at [3] – [4] (tab 13).
[11] Ex 1 Dr Manju Rajaratman, 12 July 2017 at [4].
[12] Ex 1 Lawrence Seeto, 6 March 2016, 24 August 2016, 7 August 2017 (tabs 6 and 7).
[13] Ex 1 Lawrence Seeto, 7 August 2017 at [11], (tab 6).

18. The following is a summary of what Lawrence Seeto recalls of what happened during the consultation:[14]

    a) *Samuel told Dr Patel he felt very cold at work and had lost his energy;*
    b) *Dr Patel diagnosed the flu;*
    c) *Dr Patel explained that the collapse was due to dehydration;*
    d) *Samuel responded that "it could not be the flu" because he did not have a running nose and he had 'trolling feelings" in his chest when he tried to drink water;*
    e) *Dr Patel instructed Samuel to drink fluids slowly;*
    f) *Dr Patel measured Samuel's blood pressure;*
    g) *Dr Patel placed a stethoscope on the back of Samuel's chest, over Samuel's rugby jersey, for a short period of time;*
    h) *Dr Patel said that Samuel was "young and fit" and that "once his blood pressure comes back up, he should be alright";*
    i) *Dr Patel suggested Samuel take nurofen.*
    j) *Dr Patel did not advise Samuel to attend the Royal North Shore Hospital (either during the consultation or in the follow-up telephone call).*

19. During the consultation Dr Patel completed a medical certificate for Samuel which set out that he was suffering from a 'medical condition' and would be unfit for work from 7 to 8 December 2015.[15]

20. Lawrence then recalled that Dr Patel assisted Samuel up from his chair and back into the waiting room. Lawrence was of the opinion that Samuel was not satisfied with the diagnosis yet Dr Patel signalled the end of the consultation.[16] Dr Patel instructed Samuel to wait at the nearby parking lot near the medical centre while Lawrence retrieved the car. Lawrence then drove Samuel home.[17]

21. I accept the evidence of Lawrence Seeto regarding what happened during the consultation. Based on his evidence, Samuel told Dr Patel that he had fainted the day before and Dr Patel did not ask him any questions about this incident. Despite Dr Patel informing Samuel that he was dehydrated, he did not ask him questions to establish Samuel's input and output of fluids. I accept Lawrence Seeto's evidence that Dr Patel told Samuel that he had the "flu" before taking his blood pressure or checking his lungs with the stethoscope over his rugby jumper.

22. I accept Lawrence Seeto's evidence that Samuel said to Dr Patel "it can't be the flu" because he did not have a "running nose" and he had "trolling feelings in his chest" when he drank water. Dr Patel did not ask Samuel what he meant when he referred to "trolling feelings in the chest". Dr Patel advised Samuel that he had the flu and he should take fluids and take Nurofen. [18]

[14] Ex 1 Lawrence Seeto, 6 March 2016, 24 August 2016, 7 August 2017 (tabs 6 and 7).
[15] Ex 1 Copy of medical certificate (tab 12).
[16] Ex 1 Lawrence Seeto, 6 March 2016 at [9].
[17] Ex 1 Lawrence Seeto, 6 March 2016 at [9].
[18] Ex 1 Lawrence Seeto, 6 March 2016.

## *Factual dispute*

23. Dr Patel's evidence, provided in his statement, is that during the consultation he advised Samuel to attend Royal North Shore Hospital if necessary. He also stated that he rang the Seeto home between 12pm and 1pm on the same day as the consultation and advised Lawrence Seeto that he should take Samuel to hospital if his condition was not improving. The electronic medical notes obtained from the Chatswood Medical and Dental Centre include a record from the consultation for the patient to "attend rnsh prn".[19]

24. Lawrence Seeto was with Samuel during the consultation and took the phone call from Dr Patel later in the day. He was certain that he did not hear Dr Patel make any mention of taking Samuel to hospital. I am not able to make a positive finding that Dr Patel did not mention taking Samuel to hospital if his condition became worse. However, I do find that Lawrence did not hear Dr Patel provide any such advice. In any case, there was no evidence before me that Dr Patel advised Samuel or Lawrence what such a deterioration might look like or feel like. Whether Dr Patel gave the advice or not, it was unlikely to have changed the outcome in the circumstances as there was no knowledge on the part of the Seeto family that Samuel's condition had deteriorated.

## *What happened after the consultation with Dr Patel?*

25. On returning home Samuel rested in the lounge room and then took Nurofen and went to bed. During that day Lawrence gave Samuel some 'cold and flu tablets'. He ate some porridge, drank some water and remained in bed until the following morning.[20]

26. At between 4pm and 5pm that afternoon Dr Patel telephoned the Seeto home to inquire about Samuel's condition. Lawrence told Dr Patel that Samuel had taken nurofen and was sleeping.[21]

## *Samuel's condition on 6 December 2015*

27. At 8am Samuel woke up and had a shower. He required assistance to go to the toilet, he passed urine and moved into the lounge room to rest.[22]

28. Samuel appeared to his father to be improving and he told his father that he was "ok". At about 10am on 6 December 2015, Lawrence and Jenny Seeto left the house to visit the grave of one of their sons who had died some 30 years earlier. It was their custom to visit the cemetery before Christmas.

*29.* At 10.57am Samuel sent an email to his employer with the medical certificate. He informed his employer he was feeling unwell and would not be at work on the Monday or Tuesday. In the email he said that on Thursday (3 December) he was cold and "shivering in my seat", Friday (4 December) was "not much better" and *"came home Friday, and just fainted landing on the back of my head. Have fainted several other times too including in public. Got no appetite, continually*

[19] Ex 1 Medical notes of 5 December 2015 (tab 18 at p3).
[20] Ex 1 Lawrence Seeto, 6 March 2016 at [10].
[21] Ex 1 Lawrence Seeto, 6 March 2016 at [10].
[22] Ex 1 Lawrence Seeto, 6 March 2016 at [11].

*fatigued. It's not logical when not sick for the whole year, and the first week of summer you get a bad winter disease. Doc certificate attached."* [23]

30. When Lawrence and Jenny returned home at 2pm, Samuel's mother, Jenny, checked on Samuel. By this stage Samuel had moved to his bedroom. Samuel told his mother that he was "alright" and she checked on his water and she could see that he had been drinking. She gave Samuel two cold and flu tablets. Samuel had not complained about his health that day. Lawrence went to pick up some Hydrolyte from his daughter-in-law and returned home.

## *Samuel is discovered by Lawrence on 6 December 2015*

31. At 4pm Lawrence Seeto went upstairs into Samuel's bedroom to give him the Hydrolyte. He found Samuel sitting on his bed with his back to the wall. He was not breathing but his eyes were still moving. Mr Seeto called his other son, Edward, who lived in the same street. At 4.19pm Edward's wife, Kate, called an ambulance.[24] The family performed CPR on Sam until paramedics arrived. At 4.26pm paramedics arrived and attended to Samuel. Tragically, Samuel was not able to be resuscitated and he was pronounced deceased.

## *Autopsy*

32. An autopsy was conducted by forensic pathologist, Dr Othusitse Mokgwathi at 9.30am on 8 December 2015. According to the autopsy report, Dr Mokgwathi found fluid in both of Samuel's lungs. Samuel's heart was enlarged and mottled. The right ventricle was dilated. Microscopic examination of the heart showed florid myocarditis in both the left and right ventricles. The direct cause of death was determined by Dr Mokgwathi to be myocarditis.[25]

## *The expert evidence*

33. Oral and documentary expert evidence was admitted in the Inquest from the following three experts:

    i. Dr Mark Herman, Cardiologist.[26]
    ii. Dr Hester Wilson, General Practitioner[27]
    iii. Dr Ann Keogh, Cardiologist.[28]

34. Dr Herman and Dr Wilson gave evidence at the inquest.

35. Dr Herman is a cardiologist with relevant experience in regard to the manifestations of myocarditis. He provided this inquest with two expert reports.[29]

36. Dr Harman set out that the clinical manifestations of myocarditis. Myocarditis is an inflammatory disease of the myocardium (the muscular tissue of the heart). The manifestations are variable and include fatigue, chest pain, heart failure,

[23] Ex 1 Senior Constable Luskan, 10 April 2016 at [24] and copy of email and attached doctor's certificate (tab 12).
[24] Ex 1 Senior Constable Luskan, 10 April 2016 at [4].
[25] Ex 1 Autopsy report (tab 3).
[26] Ex 1 Report of Dr Mark Herman.15 June 2016, 1 March 2017 (tabs 15,16).
[27] Ex 1 Report of Dr Hester Wilson, 30 March 2017.
[28] Ex 1 Report of Dr Anne Keogh, 30 July 2017, (tab 20).
[29] Ex 1 Dr Mark Herman, 15 June 2016 and 1 March 2017 (tabs 15 and 16).

cardiogenic shock and arrhythmias. Cardiogenic shock can present as pallor, fatigue, cold and low blood pressure. Samuel presented as a *"cold gentleman feeling extremely fatigued and presenting with low blood pressure".*[30] In Dr Herman's opinion, Samuel was clearly unwell and presented with recurrent syncope and evidence of 'forward' cardiac failure (fatigue, feeling cold, low blood pressure and recurrent falls).[31]

37. Dr Herman accepted that myocarditis is a rare event and, and in his words, is *"certainly not on the top of the differential diagnosis of a young man presenting with low blood pressure to a general practitioner on a Saturday morning."* [32] However, his evidence was unequivocal in that a patient with multiple episodes of fainting or syncope over a short period of time is concerning and this may be symptomatic of a more serious underlying disorder. I accept his evidence that the initial evaluation of patients with syncope should include taking a careful history, a physical examination and an ECG.

38. Dr Herman gave evidence that a reasonable practitioner would have been able to hear signs of the pleural effusion that was later found at autopsy, particularly given its size (450mls in the right lung).[33] Dr Herman's evidence was that he had no doubt that this effusion would have been present on 5 December 2015.[34]

39. Dr Herman stated in evidence that given Samuel's history, the carrying out of an Electrocardiogram (ECG) was imperative and in 40%-50% of patients a doctor would be able to make a diagnosis straight away. It was also his opinion that Samuel's history and presentation was sufficient to mandate the GP sending the patient to hospital. Dr Herman agreed with the content of Dr Keogh's report.[35]

40. Dr Wilson, expert general practitioner, gave evidence on the significance of syncope. She confirmed that the important question of whether a patient has cardiac syncope must always be answered, and, in the majority of cases, this can be done with a thorough history and an ECG. Her view was that had Samuel been investigated by way of an ECG and chest x-ray, an abnormality consistent with myocarditis would likely have been revealed. If diagnosed with the condition, Samuel would have been admitted to hospital.

## *Was the medical care and treatment provided by Dr Patel adequate?*

41. The expert evidence detailed above supports the finding that Dr Patel's consultation with Samuel was significantly inadequate and, had the appropriate investigations been undertaken around the time of the consultation, it is more likely than not that Samuel would have survived.

42. In closing I would like to thank senior constable Mitchell Luskan, the officer in charge for his investigation. I would like to thank my counsel assisting, Ms Tracey Stevens and her instructing solicitor, Mr James Herrington from the Crown Solicitor's Office for their excellent work.

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[30] Ex 1 Dr Mark Herman.15 June 2016 at p5.
[31] Ex 1 Dr Mark Herman.15 June 2016 at p5.
[32] Ex 1 Dr Mark Herman 15 June 2016 at p5.
[33] Ex 1 Autopsy report (tab 3) at p 3.
[34] Dr Herman's oral evidence, 11 August 2017.
[35] Ex 1 Dr A Keogh, (tab 20).

43. Finally, I would like to offer my condolences to Samuel's family. To lose a son and a brother in such a sudden and unexpected way must have been terribly difficult. I would like to thank them for participating in this inquest. Whilst I know that their feelings of loss and grief continue, I hope that some of their questions have been answered.

## Findings required by s81(1)

44. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to make the following findings:

**Identity of deceased:**

Samuel Seeto.

**Date of death:**

6 December 2015.

**Place of death:**

100 Cook Street, Forestville, NSW.

**Cause of death:**

Florid myocarditis.

**Manner of death:**

Samuel Seeto died from natural causes after the medical practitioner treating him the previous day failed to detect his cardiac condition.

## Power to make Recommendations

45. Section 3(e) of the Coroners Act 2009 provides that one of the objects of the Act is to enable a coroner to make recommendations in relation to matters in connection with an inquest, including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies. Clearly, preventing future deaths is a primary function of the coronial system.

46. The power to make recommendations is specifically outlined in s.82(1). A coroner may make such recommendations as are considered necessary or desirable to make in relation to any matter connected with the death, with which an inquest is concerned. Without limiting the scope of subs. (1) the following matters are specified in subs. (2) as being appropriate subjects of recommendations:

a) public health and safety, and

b) that a matter be investigated or reviewed by a specified person or body.

## *Recommendations*

47. I have been asked by those representing the Seeto family to consider a recommendation that this matter be referred to the Health Care Complaints Commission (HCCC) for investigation. I am of the view that it is desirable to make such a recommendation in this case.

48. I recommend that a transcript of these proceedings and a copy of these findings be forwarded to the Health Care Complaints Commission (HCCC) so that consideration may be given to this matter being investigated.

49. I close this inquest.

Magistrate Teresa O'Sullivan
**Deputy State Coroner**

**Date 21 August 2017**