Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 6/142

I, Sarah Helen Linton, Coroner, having investigated the death of ***Anthony Nigel AXTELL*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth****, on* ***4 March 2014****, find that the identity of the deceased person was* ***Anthony Nigel AXTELL*** *and that death occurred on* ***13 September 2012*** *at* ***Royal Perth Hospital****, the cause of death being* ***consistent with heart failure in a man with dilated cardiomyopathy and focal severe coronary artery atherosclerosis*** *in the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner
Mr B Nelson, (State Solicitors Office), appearing on behalf of Department of Corrective Services and the North Metropolitan Area Health Service (Sir Charles Gairdner Hospital)

TABLE OF CONTENTS

INTRODUCTION

1. Anthony (Tony) Nigel Axtell (**the deceased**) died on 13 September 2012 at Royal Perth Hospital after he became seriously ill while a remand prisoner at Casuarina Prison. He was admitted to the Cardiac Care Unit at Royal Perth Hospital, where he eventually died from heart failure.

2. As the deceased was a prisoner under the *Prisons Act 1981* at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996*.

3. Section 22 (1)(a) of the *Coroners Act 1996* requires a coroner who has jurisdiction to investigate a death to hold an inquest if the death appears to be a Western Australian death and the deceased was, immediately before death, a person held in care.

4. I held an inquest at the Perth Coroner's Court on 4 March 2014.

5. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

6. The inquest focused primarily on the care provided to the deceased while a prisoner, both within the custodial environment and while admitted at Royal Perth Hospital.

7. The documentary evidence included two comprehensive reports of the death prepared independently by the Western Australia Police and by the Department of Corrective Services (**the Department**), together comprising five volumes.[1] The authors of both reports were called as witnesses.

[1] Exhibit 1, Vols 1 – 5.

8. In addition to the medical records annexed to the abovementioned reports, detailed medical reports were also provided by Dr Matthew Best, a Consultant Cardiologist at Royal Perth Hospital (**RPH**),[2] and Dr Eric Yamen, a cardiologist at Sir Charles Gairdner Hospital (**SCGH**).[3] Dr Best was also called as a witness. Dr Yamen was excused from attendance as a witness due to ill health.

9. As part of the police report, a statement was provided by the deceased's mother, Elaine Axtell,[4] as well as various correspondence from the deceased's family.[5]

THE DECEASED

10. The deceased was born on 4 March 1974 in Queensland.[6] He spent his early years in Queensland with his parents, brother and two sisters. He was a keen sportsman.

11. After completing Year 10 the deceased left school and initially began an apprenticeship as a screen printer but ultimately undertook an apprenticeship as a brick layer, an occupation in which he excelled.[7] In about 1997 the deceased moved to Western Australia (WA) and worked as a bricklayer.[8]

12. The deceased was an intravenous drug user, in particular amphetamines and heroin. He first began using illicit drugs in his early twenties, following a relationship breakdown. His move to WA was designed to make a fresh start, and he succeeding in abstaining from drug use for approximately four years. He relapsed into drug use when another relationship failed.[9]

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[2] Exhibit 2.
[3] Exhibit 1, Vol 3, Tab 30.
[4] Exhibit 1, Vol 1, Tab 7.
[5] Exhibit 1, Vol 1, Tab 14.
[6] Exhibit 1, Vol 1, Tab 1.
[7] Exhibit 1, Vol 1, Tab 2.
[8] Exhibit 1, Vol 1, Tab 2.
[9] Exhibit 1, Vol 2, Tab 2.

13. Closely associated with the deceased's history of illicit drug use was a history of committing offences. It appears that when the deceased was able to abstain from using drugs, he was also able to cease offending. However, when using drugs, he committed offences, predominantly of dishonesty and drug-related.[10]

14. While living in WA the deceased commenced a de facto relationship, which resulted in a daughter and a son. The deceased also had a son from another relationship.[11]

15. The deceased and his de facto experienced some domestic difficulties and the deceased had been the subject of a violence restraining order in relation to his de facto.[12] On 6 June 2012 the deceased was arrested and charged with an offence of aggravated assault occasioning bodily harm in relation to his de facto.[13] The deceased was initially released on bail for the charge, subject to protective bail conditions that included not having contact with his de facto. The deceased was later alleged to have breached those conditions by attending at his de facto's home on 15 June 2012.[14] He was also charged with an additional two offences of stealing a motor vehicle.[15] As a result, he was remanded in custody and received into Hakea Prison on 16 June 2012.

16. On 26 June 2012 the deceased appeared in the Family and Domestic Violence Court of the Midland Magistrates Court. He was released on bail for an initial assessment report to be completed.[16] However, the deceased was shortly after again arrested by police and charged with a further series of offences, including multiple charges of stealing a motor vehicle, having sold a prohibited drug, offering to sell a prohibited a drug, conspiracy to commit an indictable offence and attempted possession

[10] Exhibit 1, Vol 1, Tab 18; Exhibit
[11] Exhibit 1, Vol 1, Tab 2.
[12] Exhibit 1, Vol 1, Tabs19 – 20.
[13] Exhibit 1, Vol 2, Tab 3.
[14] Exhibit 1, Vol 2, Tab 3.
[15] Exhibit 1, Vol 1, Tab 24.
[16] Exhibit 1, Vol 2, Tab 4.

of a prohibited drug.[17] The latter offence was allegedly committed on the evening he was released to bail. He was taken into police custody and first registered at the Perth Watch House at 10.00pm on 27 June 2012.[18] He was transferred to Hakea Prison the following day.

17. The deceased's last period of incarceration in prison commenced on 28 June 2012 as a remand prisoner for the charges outlined above. He died before those charges were able to be concluded.

THE DECEASED'S MEDICAL HISTORY

18. As noted above, the deceased was an intravenous drug user. He was also a smoker of both cigarettes and cannabis and a heavy consumer of alcohol. Despite this, the deceased was apparently in functionally adequate good health until late 2001.

19. The deceased developed dilated cardiomyopathy in 2001 after heavy amphetamine use. He was admitted to RPH on 30 March 2002 and was treated for heart failure. Further investigations were planned, but the deceased discharged himself against medical advice on 1 April 2002.

20. The deceased was re-admitted to RPH on 23 April 2002. This was the first time he was treated by Dr Best. The deceased apparently reported that he had run out of one of his heart failure medications and admitted to using amphetamines since his last admission. Following testing, the deceased was diagnosed with extremely severe dilated cardiomyopathy potentially due to his amphetamine use. He was treated with standard medical therapy, including diuretics. Diuretics are standard and necessary treatment for the fluid overload that very commonly occurs in heart failure. After optimizing the deceased's medications, he was discharged personally by Dr Best on 26 April 2002.

[17] Exhibit 1, Vol 2, Tab 4; Exhibit 1, Vol 1, Tabs 22, 25 - 27.
[18] Exhibit 1, Vol 1, Tab 28, Flag 3.

21. When discharging the deceased, Dr Best explained to the deceased that non-compliance with his medication regime and further substance abuse would preclude him from being a candidate for heart transplantation, as per international guidelines.[19] He was advised that he needed to maintain long term abstinence from substance abuse, including cigarette smoking.[20] It appears at that time the deceased understood this advice and intended to follow it. He saw a cardiologist in Queensland on 13 May 2002 and indicated his intention to remain abstinent from drug use.[21]

22. The deceased had one admission to RPH during this period, commencing on 24 April 2003, before he was incarcerated but while on bail. He was admitted in the early hours of the morning with chest pain but later in the day left the ward against medical advice and did not return.

23. Over the next five years the deceased succeeded in abstaining from intravenous drug use and was compliant with his medical therapy, although he apparently continued to smoke cigarettes. It would seem that part of his success was a result of the fact that he was incarcerated for a period of time in 2003 to 2004, limiting his access to illicit drugs.[22]

24. On 29 March 2004 the deceased had an echocardiogram performed that reported that his heart had returned to normal size and function.[23]

25. On 28 February 2007 the deceased sought out Dr Best in his private rooms for consultation with regards to his cardiac status. The deceased appeared well at this consultation and his examination was normal, save for the possibility of a very soft mitral regurgitation murmur. It appeared that the deceased's cessation of amphetamine use and compliance with medical therapy

[19] Exhibit 2, p 1. .
[20] Exhibit 1, Vol 4, Tab 36, Discharge Letter 26.04.2002.
[21] Exhibit 1, Vol 4, Tab 36, Letter of Dr Galbraith to Dr Wilkinson 13.05.2002.
[22] Exhibit 1, Vol 1, Tab 18; Exhibit 1, Vol 2, Tab 7.
[23] Exhibit 2, p 2;

had allowed his heart to return to normal, or near normal.[24] Dr Best suggested the deceased should have a repeat echocardiogram and see Dr Best again but the deceased did not follow Dr Best's advice and did not book in for any follow up.[25]

26. Between 2007 and 2012 there is no record of the deceased seeking any treatment for his heart. His only hospital admission during this time was following a motorbike accident in October 2008, which led to treatment at RPH for his injuries.[26]

27. However, what is now apparent is that, at some time during this period, the deceased relapsed into amphetamine use and ceased taking his medication.

28. On 26 March 2012 the deceased was admitted to Armadale Kelmscott Hospital. He reported that he had used intravenous amphetamines four days prior to his admission. He was diagnosed with pneumonia and heart failure and transferred to RPH for further management. A transoesophageal echocardiogram (**TOE**) performed on 29 March 2012 showed severe dilation of his left ventricle with severe cardiomyopathy and/or dysfunction and severe mitral regurgitation. He was initially ventilated and treated in the Intensive Care Unit but was transferred to a medical ward on 30 March 2012. The deceased gradually began to improve before he discharged himself against medical advice on 3 April 2012.[27]

29. On 19 April 2012 the deceased had an outpatient echocardiograph performed, which again showed his heart to be severely dilated with severe cardiomyopathy and severe mitral regurgitation.[28]

30. On 21 April 2012 the deceased was admitted to RPH Emergency Department with numbness in his left hand

[24] Exhibit 2, p 2.
[25] Exhibit 2, p 2; Exhibit 1, Vol 3, Tab 28XYZ.
[26] Exhibit 1, Vol 5.
[27] Exhibit 2, p 2; Exhibit 1, Vol 5.
[28] Exhibit 2, p 3.

and slurred speech. He was diagnosed as showing early signs of a stroke involving the right side of his brain. It was felt to be due to an embolus from the heart. Admission to hospital for further treatment and cardiological input was suggested but the deceased discharged himself from the Emergency Department against medical advice.[29]

31. The deceased returned to RPH Emergency Department three days later with regards to his neurological symptoms. It appears that his symptoms were resolving, with no new symptoms. He was seen by one of the neurology doctors and discharged later that day, having organised urgent outpatient review.[30]

32. The deceased subsequently attended the Neurology Outpatient Clinic on 1 May 2012. It appears the Neurology team were concerned that his stroke had originated from his heart and organised to admit him under Cardiology for further investigation and treatment. The notes document that the deceased was apparently still actively using intravenous drugs at this time. He left the clinic area while admission was being arranged and, when contacted via mobile telephone, refused to return to hospital.[31] The stroke registrar at RPH, Dr Jacqui Saw, faxed the deceased's general practitioner noting that it was suspected that the deceased had a life-threatening condition and asking him to assist in convincing the deceased to represent to the hospital.[32]

33. The deceased eventually returned to RPH on 22 May 2012 and was admitted under Dr Sharad Shetty, a Consultant Cardiologist. A TOE was performed. This showed the deceased's heart to be severely dilated, with severe cardiomyopathy and severe mitral regurgitation secondary to the dilation of his heart. The deceased

[29] Exhibit 2, p 3; Exhibit 1, Vol 3, Tab 28HI; Exhibit 1, Vol 5.
[30] Exhibit 2, p 3; Exhibit 1, Vol 5.
[31] Exhibit 2, p 3; Exhibit 1, Vol 3, Tab 28F.
[32] Exhibit 1, Vol 3, Tab 28F; Vol 4, Tab 36.

discharged himself from Cardiology against medical advice on 25 May 2012.[33]

34. On 13 June 2012 the deceased presented to RPH following a motor vehicle accident and was investigated for spinal injuries, but none were found.[34]

HAKEA PRISON – 16 - 26 June 2012

35. As mentioned, on 16 June 2012 the deceased was taken into custody following a breach of protective bail conditions and other charges being laid. He was remanded to Hakea Prison.

36. On arrival at prison a medical history is taken from the admitting nurse. If a prisoner brings in their own medication, an e-consult is performed with a doctor, asking for permission to continue with the medications. That is what occurred in relation to the deceased.[35]

37. The Department's medical and nursing directorate, Health Services, has its own electronic medical record system, which is known as EcHO.

38. The EcHO notes for the deceased on 16 June 2012 indicate that the deceased was reviewed on arrival at Hakea Prison by Clinical Nurse Markus Maas. His previous diagnosis of cardiomyopathy secondary to intravenous amphetamine use was noted, and he indicated he had last used amphetamines four months prior. The deceased's medications were listed based on the labels of the boxes the deceased had brought in to prison. He apparently had brought enough of his own medications to last the weekend. The Deputy Director of Health Services, Dr C Fitzclarence, confirmed by email that he could be given his medications as per the labelled boxes, provided there was no evidence of tampering. All of the deceased's medications except

[33] Exhibit 2, p 3; Exhibit 1, Vol 5.
[34] Exhibit 1, Vol 5.
[35] Exhibit 1, Vol 2, Tab 30.

one, which he did not have in his supply, were signed off as administered on 17 and 18 June 2012.[36]

39. On 18 June 2012, the deceased was seen by a medical officer, Dr P Foley. The deceased reported he had been smoking 10 cigarettes a day and a significant quantity of cannabis per week, prior to incarceration, but not using alcohol or amphetamines. Dr Foley noted the deceased's current medications. Dr Foley issued scripts for all the medications, almost all of which came with five repeats.

40. At Hakea, medications are dispensed by the Department's Pharmacy and packed every Saturday into a container known as a Webster pack. The Webster pack has a seven-day supply of medications. Prisoners at Hakea are not permitted to store their own medications for security reasons. The Webster pack is, instead, stored by the nurses at the medical centre. The medication is either dispensed during medication rounds at the unit where the prisoner is housed, for morning and evening, and at lunch time the prisoner is required to attend the medical centre to collect their medication. When the prisoner attends and takes his medication, the nursing staff member initials the relevant column on the chart. It is apparently standard practice to initial "@" in the column if the prisoner does not attend to take the medication.[37] This is consistent with the legend on the bottom left-hand side of the sheet, which indicates that "A" indicates "Absent".[38] Alternatively, it is apparently standard practice to leave a blank space when the prisoner does not attend.[39]

41. The deceased's printed Webster pack sheet for the week 19 June 2012 onwards listed eight different medications, to be variously given at breakfast, lunch or dinner.[40] The Webster pack signing sheet shows that there are signatures for only some of the times when the

[36] Department of Corrective Services EcHO Filing Vol 2.
[37] Exhibit 1, Vol 2, Tab 30.
[38] Department of Corrective Services EcHO Filing Vol 2.
[39] Exhibit 1, Vol 2, Tab 30; ts 49 - 51.
[40] Department of Corrective Services EcHO Filing Vol 2.

deceased was due to be given medications. The Department of Corrective Services' position is that it is ultimately the prisoner's responsibility to attend at the unit (or medical centre) to receive their medication.[41] Prisoners also cannot be forced to take their medication.[42]

42. As Mr Mudford confirmed in oral evidence, it is safe to assume that the blank spaces on the deceased's Webster pack sheet indicate that the deceased did not take his medication at those times.[43] On the basis of the apparent standard practice, it is to be assumed that the deceased did not attend on those occasions, either at the unit round or medical centre.

43. There is no indication in the EcHO notes as to any the reason for the deceased's repeated failure to attend and receive his medications. The only EcHO note in this period is entered by Clinical Nurse Angela Greenwood. It reveals on 21 June 2012 the deceased became unwell with flu like symptoms and was reviewed at the medical centre. The deceased apparently stated he had cardiomyopathy and had had pneumonia in the past. He did not raise any issue as to his repeatedly missing doses of his medications. This is to be compared with other occasions documented in the EcHO notes, upon admission to prison, when the deceased raised his need for his medications with clinical nurses and medical officers.[44]

44. On the basis of the above information, it is clear the deceased did not receive some of his doses of medication from 19 to 26 June 2012. Mr Mudford advised the court that he had not come across any evidence in his review that the deceased had been denied his medications.[45] It appears the deceased did not attend at the relevant location at those times to

[41] Exhibit 1, Vol 2, Tab 30; ts 49 – 50.
[42] ts 49 – 50.
[43] ts 49 – 50.
[44] Department of Corrective Services EcHO Filing Vol 2.
[45] ts 53.

receive them. The reason why the deceased did not attend is unknown.

45. As to his attendance at the medical centre on 21 June 2012 with flu-like symptoms, the deceased was advised to drink plenty of fluid, stay warm and stay in bed. He was also advised to return for review the following day; however, he failed to attend.[46]

46. As mentioned, the deceased attended court on 26 June 2012 and was released on bail from the Magistrates' Court in Midland at 3.00pm.

47. The standard practice of the Department's health staff, when they are aware of a prisoner's impending release, is to supply the prisoner with seven days of medication upon leaving the prison, as well as any remaining medications in the Webster pack.[47]

48. In the case of the deceased's release on 26 June 2012, the health staff were apparently unaware he was likely to be released that day. Accordingly, his medication was not prepared in advance and he was released into the community without a supply of his medication.[48]

49. Whilst this is clearly not ideal, and contrary to the Department's standard practice, the deceased could, of course, have attended at a medical practice or hospital to obtain more medication at this time.

50. As noted below, it does not appear that he did so. Instead, he failed to obtain more of his medications while released and instead, chose to use amphetamines on the day of his release from custody.

[46] Department of Corrective Services EcHO Filing Vol 2.
[47] Exhibit 1, Vol 1, Tab 30.
[48] ts 46.

HAKEA PRISON – 28 June – 1 July 2012

51. The deceased was registered in custody late in the evening of 27 June 2012 at the Perth Watch House and returned to Hakea Prison on 28 June 2012.[49]

52. In his "At Risk Management System – Reception Intake Assessment" at Hakea, the deceased reported that he had used amphetamines two days prior, being the day he was released on bail.[50]

53. He was seen by Clinical Nurse Helen Rowbottam that day at about 5.30pm, where it was noted that he took a number of medications for his cardiomyopathy but he couldn't remember all of them. The notes indicate he had last received a dose of some of them that morning.[51] That is consistent with the records of the Perth Watch House, which record the deceased receiving six medications at 5.00am on 28 June 2012.[52]

54. The deceased was booked for a medical review the following day. It does not appear that he was given any medications in the prison that evening.

55. As mentioned above, the deceased saw Clinical Nurse Muir McPherson in the early afternoon on 29 June 2012 and at that time he raised concerns about his need for his medications. According to the EcHO note the deceased was told he would see the doctor for his prescriptions. Dr Kusumawardhani then saw the deceased and noted the deceased reported he had not taken his medication during the time he was released from prison and he had not attended his Royal Perth Hospital appointment on 26 June 2012 as he was at Hakea at the time. The deceased was apparently keen to have at least some of his medications that night. The deceased's medications were re-prescribed by Dr Kusumawardhani, although two were prescribed at

[49] Exhibit 1, Vol 1, Tab 28, Flag 3.
[50] Exhibit 1, Vol 1, Tab 28 Flag 13.
[51] Department of Corrective Services EcHO Filing Vol 2.
[52] Exhibit 1, Vol 1, Tab 28, Flag 3.

lower doses than previously, presumably based on the medications he brought in with him. The medications are recorded as given to the deceased that night and on 30 June and 1 July 2012.[53]

56. On 1 July 2012 the deceased became unwell and was taken from his unit to the medical centre by wheelchair with breathlessness and cyanosis.[54] His blood pressure was low and his pulse rate was high. He was transferred to RPH by Priority 1 ambulance[55] and was admitted under Dr Shetty.

57. In 2012 the RPH Advanced Heart Failure and Cardiac Transplant Unit (**RPH Cardiac Unit**) had five consultants, who were responsible for the day to day care of all the admitted patients in the unit one week at a time, with the roster prepared 12 months in advance. Each week the multi-disciplinary staff of the Cardiac Unit (including cardiologists, cardiac surgeons, nursing staff, physiotherapy and dietetic staff as well as others) met to discuss the management of each patient, so all the consultants would continue to have input and knowledge of the patients' cases whilst not on roster. This explains why on different occasions the deceased was admitted under different cardiologists' care at RPH.[56]

58. At RPH the deceased was diagnosed with severe heart failure. He was started on intravenous antibiotics and blood cultures were taken. It was necessary to treat the deceased with supportive drugs for his heart called inotropes. These drugs stimulate the heart to beat faster and stronger. They are only used as a last resort as they have been proven to worsen survival/prognosis in heart failure in the long term, but they can lessen symptoms and improve haemodynamics acutely. Beta-blockers cannot be given with most inotropes as they block/reduce the effect of them.[57]

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[53] Department of Corrective Services EcHO Filing Vol 2.
[54] Exhibit 1, Vol 2, Tab 18.
[55] Department of Corrective Services EcHO Filing Vol 2.
[56] ts 25, 39 – 40.
[57] Exhibit 2, p 3.

59. An entry in the EcHO notes on that same date by Clinical Nurse Mary Stuart indicates the deceased's mother, Elaine Axtell, telephoned the prison regarding the deceased's compliance with his medication. She was assured by Nurse Stuart that the deceased's medications had been given and taken.[58] It seems from Mrs Axtell's statement that she had been told by the deceased that he had not been given his medication on 29 and 30 June 2012, prior to his admission to hospital on 1 July 2012. This is contrary to the prison records, which show he was consistently receiving his medications following his re-incarceration.[59]

60. I note that the medical notes for RPH on 1 July 2012 record the deceased's complaint to be that he had been in custody for 3 and a half weeks and had been without his medications and then given the wrong doses.[60] This is more consistent with the medical records, which as mentioned above, show the deceased did not receive all of his doses of medication during his first period on remand in June 2012. It also encompasses the period of time on release, when the deceased reported he did not take his medications, and his re-admission, when there was an alteration to his doses of some medication.

61. Eventually the deceased was able to be weaned off the inotropes and stabilised. His beta-blockers were re-introduced and he was ready for discharge. As noted in the EcHO notes on 6 July 2012, Dr Fitzclarence instructed that the deceased was to be discharged to the infirmary at Casuarina Prison, rather than back to Hakea Prison.[61] Accordingly, when the deceased was discharged from RPH on 9 July 2012 he was taken to the Infirmary at Casuarina Prison. His daily fluid intake was restricted to 1.5 L and he needed weekly weighing.

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[58] Department of Corrective Services EcHO Filing Vol 2.
[59] Department of Corrective Services EcHO Filing Vol 2.
[60] Exhibit 1, Vol 1, Tab 10; Exhibit 1, Vol 5.
[61] Department of Corrective Services EcHO Filing, Vol 2.

EVENTS LEADING TO THE DEATH – CASUARINA PRISON AND RPH

62. On 10 July 2012 the deceased was seen by a prison medical officer, Dr P Chuka. There had been some changes to his medications by the RPH doctors and he was also authorized to commence on nicotine patches to assist him to cease smoking, which the deceased pledged to do.[62]

63. Medications were given as prescribed and the deceased remained settled until 13 July 2012. On that date he was seen in the clinic complaining of congestion and a cough. He looked pale but was not distressed. He was given a nasal spray and antihistamines and a blood count and kidney function tests were performed.[63]

64. On the morning of 15 July 2012 the deceased reported being unwell and an e-consult was made by a nurse to the medical officer on call. As a result, it was decided to transfer the deceased to RPH for review.[64] He was admitted to RPH with worsening of his cardiomyopathy, again under Dr Shetty. His beta-blocker and rampiril were withheld. He was given diuretics and his fluid intake was limited to 1.2 L a day (previously 1.5 L a day).

65. Dr Best was asked to see the deceased on 18 July 2012, which he did immediately. According to Dr Best, on reviewing the deceased, his situation seemed desperate. His cardiomyopathy was severe and he was in a very poor functional state. The deceased told Dr Best he had not been taking his heart medications for three years as part of a prolonged indifference to survival, but he no longer felt that way and expressed regret. Dr Best explained to the deceased that unfortunately he had an extremely poor prognosis and was not at that time a

[62] Department of Corrective Services EcHO Filing, Vol 2.
[63] Department of Corrective Services EcHO Filing, Vol 2.
[64] Department of Corrective Services EcHO Filing, Vol 2.

candidate for cardiac transplantation due to his long history of non-compliance and poly-substance abuse.[65]

66. Dr Best thought the deceased's chance of survival at this admission was minimal, and he told the deceased that was his view.[66] Dr Best thought the deceased's best chance of survival was to continue his medical therapy with ACE inhibitors and diuretics but not to restart beta blockers at that time as he had no cardiac "reserve" to tolerate them. Dr Best also noted at that time that one option to consider for treatment was a "desperation" mitral valve clip.[67]

67. A mitral valve clipping procedure is a procedure performed by Dr Yamen and his team at SCGH. It is used to treat functional mitral regurgitation. It is less invasive than open heart surgery but is technically challenging in many cases and routinely requires a prolonged general anaesthetic.[68] It is not a treatment that is primarily aimed at treating cardiomyopathy and does not feature in the current Australian Heart Failure Guidelines. It could have reduced the deceased's mitral valve leak and consequent symptoms of breathlessness, but Dr Best did not consider it had a role in the deceased's prognosis from his cardiomyopathy.[69]

68. The procedure had apparently been considered previously for the deceased, back in May 2012.[70] The recommendation of a consultant cardiologist, Dr Xu, who performed the TOE at that time, suggested that although mitral valve clip could be considered for the deceased if aggressive medical management and lifestyle modification failed to provide favourable improvement, the success of the procedure might be challenging.[71] In any event, that was one of the occasions where the deceased discharged himself from hospital against medical advice

[65] Exhibit 2, p 3; Exhibit 1, Vol 5; ts 26.
[66] ts 27.
[67] Exhibit 2, p 3; Exhibit 1, Vol 5.
[68] Exhibit 1, Vole 1,
[69] Exhibit 2, p 3.
[70] Exhibit 2, p 3.
[71] Exhibit 1, Vol 4.

69. At the time Dr Best saw the deceased on 18 July 2012, he considered the deceased had no immediate cardiac reserve to survive such a procedure[72] and would likely have died on the operating table.[73] However, despite his reservations, Dr Best did arrange for the deceased's TOE images to be couriered to Dr Yamen at SCGH on 19 July 2012 and he discussed the deceased's case with Dr Yamen by telephone.[74]

70. Once the deceased's condition had stabilised he was discharged back to the Casuarina infirmary on 27 July 2012. He was prescribed various medications as set by the RPH doctors, which appear to have been given as prescribed. His restricted fluid intake of 1.2 L a day was to continue.

71. The EcHO notes for the period 27 July 2012 to 7 August 2012 show the deceased was feeling reasonably well and was interacting well with peers and staff, volunteering to assist around the infirmary as he was keen to keep occupied. He had succeeded in stopping smoking via use of the nicotine patches and was keeping to his fluid restriction and maintaining a stable weight.

72. On 1 August 2012 a medical officer, Dr Wee, discussed with the deceased being placed on the Terminal Illness Policy list, as per the Department's Prisoners with a Terminal Illness Policy Directive. The deceased was agreeable[75] and he was placed on the Terminally Ill Offenders List on 6 August 2012 as a Phase 1 Terminally Ill Prisoner.[76]

73. His condition appeared to remain settled until 4 August 2012 when he began to feel unwell, with some breathlessness, nausea and abdominal discomfort. His condition was monitored by medical staff and by

[72] Exhibit 2, p 4.
[73] ts 29.
[74] Exhibit 2, p 4.
[75] Department of Corrective Services EcHO Filing, Vol 2.
[76] Exhibit 1, Vol 2, Tab 31 and 16.

7 August 2012 he was felt to be in heart failure and was transferred again to RPH by ambulance and admitted under the Cardiac Care Unit.

74. Although there was little evidence of fluid overload on admission, Dr Best felt it prudent to expedite the deceased's review by Dr Yamen. Accordingly, the deceased was seen by Dr Yamen on 8 August 2012. Dr Yamen thought the deceased might be a candidate for the Mitraclip procedure once he was stabilised medically, in the context that he had a critical cardiac illness and no other invasive therapies were available to him.[77]

75. On 10 August 2012, the deceased was seen by Dr Dembo, as he had taken over the consultant rotation in the Cardiac Unit that week and was therefore primarily responsible for the deceased's care that week. Dr Dembo thought that the deceased may be over-diuresed, where the dose of diuretics was too great for his fluid intake, so the diuretic dose was altered. It was thought the deceased may be discharged the following day.[78]

76. However, on 11 August 2012 the deceased's blood tests of liver function became markedly and suddenly worse, indicating a lack of blood flow to the liver due to the heart not pumping enough blood. This showed the deceased's "cardiac reserve" was completely gone and his heart had stopped delivering enough blood to other organs. This condition is known as cardiogenic shock and carried a terrible prognosis. He was started again on inotropes.[79]

77. On 23 August 2012 a second inotrope was added by Dr Baumwol, the rostered consultant cardiologist. This indicated a worsening of the deceased's overall status.

[77] Exhibit 2, P 4; Exhibit 1, Vol 3, Tab 28XYZ and Tab 30.
[78] Exhibit 1, Vol 5; Exhibit 2, p 4.
[79] Exhibit 1, Vol 5. Exhibit 2, p 5.

Dr Baumwol discussed with the deceased and family his very poor prognosis.[80]

78. By 30 August 2012 little had changed. The deceased's heart remained very dependent on inotropes and he was starting to lose consciousness transiently due to cerebral hypoperfusion, where not enough blood was being pumped by the heart to the brain.[81]

79. On 2 September 2012 the deceased was transferred to SCGH for the MitraClip procedure to be performed the following day. He was reviewed shortly after admission by Dr Yamen. The deceased revealed a fluctuating mental state and appeared to be experiencing hallucinations. He was noted to have gained 3 kg in weight overnight and his sodium had fallen, a sign of fluid overload. This suggested that he had not been compliant with his strict fluid restrictions.[82] Dr Yamen asked that his fluid restriction and diuretics be continued and arranged a brain CT scan, with the plan to review him the following day.[83]

80. Overnight the deceased was restless, verbally abusive and making sexually explicit comments to the nursing staff, suggestive of cognitive deterioration due to worsened heart failure.[84]

81. On the morning of 3 September 2012 Dr Yamen reviewed the deceased and felt that he was not medically fit for the MitraClip procedure as he would be unlikely to survive the anaesthetic and the booking for the procedure were cancelled. The deceased was transferred back to RPH for ongoing management.[85]

82. After readmission to the RPH Cardiac Unit, the deceased was noted over the next few days to continue to be confused and impulsive and apparently

[80] Exhibit 1, Vol 5, Exhibit 2, p 5.
[81] Exhibit 1, Vol 5, Exhibit 2, p 5.
[82] Exhibit 1, Vol 2, Tab 16; Exhibit 2, p 7.
[83] Exhibit 1, Vol 3, Tab 30.
[84] Exhibit 1, Vol 3, Tab 30.
[85] Exhibit 1, Vol 3, Tab 30.

hallucinating. Dr Baumwol spoke with the deceased's mother on 7 September 2012 in relation to his limited prospects for recovery.[86]

83. On 10 September 2012 the deceased's condition worsened with fever and probable infection/sepsis. He was noted to be drowsy and confused and comfort measures were instigated and later palliative care.

84. On 13 September 2012 the deceased's cardiac monitor was switched off at the request of his family and he died soon afterwards.

CAUSE AND MANNER OF DEATH

85. On 18 December 2012 Forensic Pathologist Dr D M Moss carried out a post mortem examination of the deceased. He found changes in the heart consistent with the history of dilated cardiomyopathy. There was also evidence of focal severe hardening and narrowing of the blood vessels over the surface of the heart (coronary artery atherosclerosis. Evidence of heart failure was noted. The lungs also showed widespread congestion and oedema and there was an area of infarct.

86. Dr Moss concluded that the cause of death was consistent with heart failure in a man with dilated cardiomyopathy and focal severe coronary artery atherosclerosis.[87]

87. I accept and adopt Dr Moss' conclusion as to the cause of death.

88. I find that the manner of death was natural causes.

[86] Exhibit 1, Vol 5; Exhibit 2 p 5.
[87] Exhibit 1, Vol 1, Tab 5.

QUALITY OF SUPERVISION, TREATMENT AND CARE

89. No issues arose in the evidence relevant to the quality of the *supervision* of the deceased from a security management perspective. In other words, it appears to me that no criticism can be made of the way in which the deceased was managed. As the deceased's cardiac condition deteriorated, he was placed on the Terminally Ill Offenders List and upgraded as his medical status changed.

90. As to the quality of *treatment and care* of the deceased, on the whole I find the treatment and care of the deceased was appropriate and of a high standard.

91. The only issue which is apparent that, in hindsight, could have been done better relates to the prescribing of the deceased's medications and recording of their administering.

92. The Department's 'Death in Custody Review', which is the formal name for the report authored by Mr Mudford, made no recommendations for improving the standard of custodial management overall.[88] The Death in Custody Review, and the Independent Medical Review report obtained from Emeritus Professor Kamien for that review,[89] do not appear to have given consideration to the question of the prescribing, and administering, of the deceased's medications for the period from 16 June to 28 June 2012. Mr Mudford did, however, tell the court that there was no evidence the deceased was denied medications.[90]

93. Upon request from counsel assisting to the Department, Assistant Commissioner of Professional Standards Terry Buckingham provided further information in relation to the procedures that were in place for ascertaining the deceased's current prescribed medication on admission

[88] Exhibit 1, Vol 2, Tab 32.
[89] Exhibit 1, Vol 2, Tab 1.
[90] ts 53.

into prison and what measures were in place to ensure the accuracy, as well as why the deceased's Webster pack sheet entries were not all signed between 19 and 26 June 2012.[91]

94. It would seem from Assistant Commissioner Buckingham's response that the standard practice to request a patient's medical history and records was not performed on his admission on 16 June 2012, but did occur as per requirement on his second admission, on 29 June 2012.

95. As to the recording on the Webster pack, the leaving of blank entries is apparently standard practice according to Assistant Commissioner Buckingham, although the entering of an "@" when the prisoner does not attend to take their medications appears to comply more strictly with the form suggested on the Webster pack. In my view, staff should be encouraged to make an entry indicating the reason why a medication was not dispensed, as per the legend on the Webster pack, rather than leaving the space blank. This eliminates any doubt as to whether the medication was dispensed and provides at least some indication as to the reason why it was not dispensed for future reference.

96. In relation to the impact of the deceased's missed doses and changes to his prescribed medication, the question was put to the RPH Cardiac Unit in writing by counsel assisting as to whether these matters would have had any impact on the deceased's deteriorating health and subsequent death. Five Consultant Cardiologists at the Multidisciplinary Advanced Heart Failure and Cardiac Transplant Unit of RPH, who were familiar with the deceased's case, considered this question and, in their expert opinion, they do not believe that the initial confusion about his medication prescribing and missed doses would have had any major impact on the deceased's deteriorating health and subsequent death.[92]

[91] Exhibit 1, Vol 2, Tab 30.
[92] Exhibit 1, Vol 1, Tab 9.

97. As noted by Dr Best in oral evidence, the missing of medication doses was in the midst of many months where the deceased did not comply with medical treatment, from as far back as March 2012, a decision that was extremely deleterious to his health.[93]

98. As to the rest of the deceased's care and treatment while in custody, I accept the opinions of Professor Kamien and Dr Best that, if anything, the deceased's health care was probably slightly better than it might have been in the community, given his close proximity to medical help and enforced abstention from illicit drugs and encouragement to cease smoking.[94]

99. Both Dr Best and Mr Mudford were asked in court whether, in their view, the standard of care provided to the deceased, or any remand prisoner, was different to that provided to a sentenced prisoner/a member of the public. I accept the evidence of both witnesses that there is no differentiation in the care provided, subject to any security limitations such as restraints.[95]

100. Dr Best was also asked whether, in hindsight, there were aspects of the deceased's medical care that could have been done differently. As Dr Best noted in his evidence to the court, the deceased had had a fortunate outcome the first time he developed heart failure in 2002. Dr Best described it as a "miracle"[96] that the deceased's heart recovered the first time, and his chance of survival a second time was less as the heart has a limited capacity to regenerate.[97] Nevertheless, the deceased was put on the same treatment regime that resulted in his complete recovery the first time.[98] Sadly, in the context of the deceased's inability to maintain abstention from drug use, difficulties with compliance with medical treatment until 18 July 2012 and reduced ability of his heart to recover after the previous episode,

[93] ts 24.
[94] Exhibit 1, Vol 1, Tab 1; ts 38.
[95] ts 38, 51.
[96] ts 27.
[97] ts 27.
[98] ts 30, 37 - 38.

the medical therapy did not save the deceased's life a second time. However, I accept the evidence of Dr Best that the deceased's care was optimal.[99]

101. In these circumstances, I am satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death.

OTHER CONCERNS

102. The deceased's family raised concerns about the diuretic and fluid restriction regime imposed upon the deceased, and whether it had any impact on his subsequent organ failure. As explained by Dr Best, diuretics are a standard and necessary treatment for fluid overload that very commonly occurs in heart failure. Fluid accumulates in the lungs causing pulmonary oedema (as was noted as present in the deceased's post mortem examination). Fluid can also accumulate in the abdomen and peripheries. Diuretics stimulate the kidneys to produce more urine and reduce the fluid overload syndrome of heart failure.

103. The deceased was placed on diuretics in 2002 and it formed a standard part of his treatment for heart failure thereafter.[100] The diuretic therapy was linked to fluid restriction, a regime which it is apparent the deceased found difficult.[101] There was strong circumstantial evidence that the deceased was not always compliant with that regime.[102] For example, there is an entry in the medical notes on 17 August 2012 by a nurse at RPH recording the deceased continued to drink fluids and ice even though he was advised that he was on fluid restrictions. He also had significant unexplained increases in weight at times.[103]

104. As to the conclusion of Dr Dembo on 10 August 2012 that the deceased was over-diuresed, Dr Best explained

[99] ts 41.
[100] Exhibit 2, p 1; ts 25.
[101] ts 33 - 34.
[102] ts 33.
[103] Exhibit 2, p 6.

that the diuretic dose is continually fine tuned versus the fluid intake in an attempt to keep patients' fluid status level.[104] It depends upon how much the patient drinks. It is clear, as mentioned above, that there were questions raised about the deceased's compliance with his fluid restriction. In any event, as Dr Best told the court, the management of the deceased's fluid intake and diuretics regime was a minor part of the deceased's cardiac management and did not contribute to his death.[105]

105. The deceased's family have also asked this court to consider the issue of any possible reimbursement of the cost borne by the deceased's family in transporting his body home to Queensland for burial. I understand this issue has been raised with the relevant Minister previously, and it is not a matter that comes within the jurisdiction of this court for comment.[106]

CONCLUSION

106. The deceased was a mature man, with a longstanding history of cardiac disease, when he died from heart failure. During his life he had received medical advice to abstain from illicit drug use and comply with his medical therapy. His success in doing so in the early 2000's was rewarded by a surprising return to cardiac normality by 2007. Regrettably, the deceased was unable to continue his abstinence and returned to illicit drug use and ceased taking his medication. When his heart condition deteriorated, he failed to immediately heed medical advice and continually discharged himself against medical advice.

107. I accept that, shortly prior to his death, the deceased regretted these decisions. Unfortunately, by that stage the deceased's cardiac deterioration was too severe to respond to treatment.

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[104] Exhibit 2, p 4; ts 32.
[105] ts 33, 41.
[106] ts 51 -52.

108. The deceased was in the custody and care of the Department immediately before he died. In my view the Department could not have prevented his death

S H Linton
Coroner
March 2014