Coroners Act 1996
[Section 26(1)]

Western  *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 31/18

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Augustinus Clemens Antonius HEESTERS*** *with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 18 September 2018, find the identity of the deceased was* ***Augustinus Clemens Antonius HEESTERS*** *and that death occurred on 15 October 2016 at Fiona Stanley Hospital, Murdoch, as the result of acute myocardial infarct in association with coronary artery atherosclerosis in the following circumstances:-*

Counsel Appearing:

Sergeant L Housiaux assisted the Deputy State Coroner
Ms R Panetta (State Solicitor's Office) appeared on behalf of the Department of Justice (Corrective Services)

Table of Contents

INTRODUCTION

On 15 October 2016 Augustinus Clemens Antonius Heesters (the deceased) was a sentenced prisoner located at Fiona Stanley Hospital (FSH) following a procedure to insert a stent into his right coronary artery (RCA) on 14 October 2016. Initially the deceased appeared to be recovering well, but then developed ventricular tachycardia (VT) and arrested. He was revived, but remained unstable before declining further intervention. He died during the morning of 15 October 2016.

The deceased was 70 years of age.

The provisions of the *Coroners Act 1996* (WA) (the Act) requires the death of any person held in care, including custody, be examined by way of inquest (section 3 (1)(a)) and the coroner conducting that inquest is required to comment on the supervision, treatment and care of that person while held in custody (section 25 (3)).

The brief for the purposes of the inquest comprised two volumes of documentary evidence, exhibits 1 and 2, plus the oral testimony of Richard Mudford, Senior Review Officer, Performance Assurance and Risk, Department of Justice.

BACKGROUND

The Deceased

The deceased was born in the Netherlands on 29 July 1946 and immigrated to Western Australia (WA) with his family in

1951. His parents separated relatively soon after they arrived in WA and the deceased's juvenile record reflects a difficult childhood with frequent offending. This resulted in him being effectively institutionalised from approximately 10 years of age.

The deceased continued to offend once an adult, but at a fairly minor level which did not result in any periods of incarceration, apart from the offences for which he was in custody at the time of his death, although they were historical in nature.

The deceased was employed for most of his adult life, originally as a carpenter on construction sites and later moving to developing his own small businesses.

He finished school in year 10 and claimed to have had three long term relationships. His first marriage lasted in excess of 20 years and he had four daughters from that marriage with grandchildren. When that relationship finished he had another long term relationship. It seems some of his relationships were marred with heavy drinking and domestic violence.

In 2016 the deceased was in a settled relationship and is recorded variously as living in Northam and Bunbury. It

would seem his defacto partner in 2016 worked in Northam, although he lived in Bunbury.[1]

Medical History

The deceased was a heavy drinker and smoker in his earlier years. During the inquest one of his ex-wives asked whether the deceased was still a smoker at the time of his death as he had apparently given up at some prior time. [2] It was confirmed the deceased was smoking cigarettes while in custody, although there is a note in his medical file he was counselled against continued smoking.

The deceased had a long history of ischaemic heart disease with two prior myocardial infarctions in 1985 and 2013. He also recorded lumbar back pain with degeneration to his L3 and L4 vertebra, rotator cuff tear repair surgery to the right shoulder, skin cancer with multiple facial surgeries, bipolar affective disorder (BPAD), hyperlipidemia, gastro-oesophageal respiratory disease (GORD), right inguinal hernia and depression.

The deceased was prescribed multiple medications for his various ailments including Epilim, a mood stabiliser and fluoxetine, antidepressant.[3] The indications are the deceased was not always compliant with medication.

[1] Ex 1, tab 17 & 18
[2] t 18.09.18, p15. tab 10
[3] Ex 1, tab 10 & Ex 9

Incarceration

Despite a fairly consistent record of offending through his adult life the sentence the deceased was serving at the time of his death was the first matter for which he had appeared in the District Court and his first sentence of imprisonment.

On 1 March 2016 he was sentenced in the Perth District Court to a term of imprisonment of 1 year and 6 months for a series of historic indecent assaults, occurring when he was 33 years of age. The deceased was made eligible for parole which would have occurred in November 2016.[4] He maintained his innocence for the offences, however, it was noted he was very drunk at the time of offending which may have affected his memory.[5]

Following sentencing the deceased was transferred to Hakea Prison and underwent an adult initial health screen. His cardiac history was noted and he was continued on his regular medications, as well as being commenced on an anticoagulant in view of his heart disease.[6]

The following day he was reviewed by the prison doctor and a base line ECG performed with blood tests ordered. His observations were all normal and the doctor indicated that due to his age and his health he was unfit for upper bunking and for sporting activities.

[4] Ex 1, tab 18
[5] Ex 2
[6] Ex 1, tab 18

The deceased began to regularly refuse to take his medication and on 25 March 2016 explained he did not believe it was necessary he continue to be medicated as prior to his incarceration. It was his mental health medications he was most unhappy with using and he was referred for psychiatric review.

While at Hakea the deceased was located in the protected prisoner area due to the nature of the offences for which he had been convicted. He was deemed suitable for participation in the Sex Offender Deniers Program and information technology course, however, those were not available during his time in prison although relevant to any application for parole he may have made.

Due to the deceased's classification as a medium security protection prisoner it was intended to transfer him to Acacia Prison to facilitate visits from his partner, who was working in Northam. The deceased preferred transfer to Bunbury as a mainstream prisoner and then Wooroloo Prison Farm to facilitate contact with his partner. The reason for his preference for Bunbury was to facilitate visits by another friend. As a result the deceased was transferred to Bunbury Regional Prison (BRP) at his request on 7 April 2016 where he remained a sentenced prisoner until 6 October 2016.

Prisoner medical records are kept in both hard copy and EcHO (electronic health record) during the term of a prisoner's incarceration, however, when no longer a patient

of the department all hard copies are scanned onto the departmental EcHO system.

The deceased's EcHO medical file reflects extensive blood test results on 7 April 2016, suitable as a base reference for future comparison.

Once transferred to BRP the deceased was seen on 2 May 2016 for review of his skin lesions and his concerns with his medication. His observations were normal and investigations were carried out with respect to his essential medication, as well as being advised to cease smoking.

On 3 May 2016 the deceased was reviewed by the psychiatrist and his prior diagnosis of BPAD noted at a case conference. It was determined he did not currently display any symptoms or signs of serious mental health issues and as a result his medications for that condition were ceased.

On review following that case conference the deceased was happy to be off the psychiatric medications, was well and working in the metal shop. From the cessation of his mood stabiliser and antidepressant medications the deceased became entirely compliant with his medication regime and from 7 June 2016 was allowed to self-administer his medications.

The deceased was monitored for thyroid function and mental health status in July and August 2016, but there is no

indication bloods were investigated with respect to his cardiovascular disease.

In view of the deceased's known ischaemic heart disease there should have been a cardiovascular care (CVC) plan implemented for the deceased from admission. Note was made on 13 September 2016 that the deceased was to be reviewed, however, no evidence of a CVC plan has been located in either his medical record or on the prison EcHO system.[7] The entry in EcHO is unclear as to whether 13 September 2016 was for the Cardiovascular Care Plan Review visit or reflects a plan as to what the review should consider in light of the expectation he would receive parole in November 2016.

On 16 September 2016 the deceased's security rating was reduced to minimum to facilitate transfer to Karnet Prison Farm and allow an early eligibility for release date of 29 November 2016, however, the issue of an application for parole had not been determined prior to his death.

There was no indication the deceased complained of any symptoms with respect to his heart disease until 5 October 2016.

[7] t 18.09.18, p13

The deceased was always considered to be a model prisoner and there is no record of any prison charges or loss of privileges due to prison behaviour.

The deceased was visited by his partner from Northam and also a friend residing in Bunbury. The deceased had daily contact with his partner via the prisoner telephone system (PTS) and these were unrestricted, but to be of 10 minutes duration.

5 OCTOBER 2016

Nurse Jan Sweetman was called to the deceased's unit at approximately 4.10 pm on 5 October 2016 to assess the deceased. He reported severe chest pain, identified as 9/10 severity, and was pale and sweaty. Nurse Sweetman provided aspirin and GTN spray, without relief, and the deceased's blood pressure was noted to be low. She immediately called an ambulance.

St John Ambulance Service (SJA) received a call at 4.18 pm and the Priority 1 ambulance arrived at 4.52 pm. The deceased was transferred to Bunbury Regional Hospital (BRH) and arrived at 5.21 pm.[8]

Bunbury Regional Hospital

The deceased remained in BRH for long enough to be assessed and stabilised. His observations were stable on

[8] Ex 1, tab 16

arrival in the ED, but he had ongoing chest pains. An ECG showed ST elevation in the anterior leads, confirming an anterior myocardial infarction (MI). The deceased was administered a thrombolytic agent (tenectaplase) to dissolve clots in the coronary arteries, but his chest pain continued and he became hypotensive.

The deceased was provided with IV fluids and a heparin infusion, but developed acute pulmonary oedema requiring diuretic treatment. At the direction of the cardiologist he was transferred to Fiona Stanley Hospital (FSH) via the Royal Flying Doctor Service (RFDS) for further management.[9]

The RFDS report indicated the deceased failed to normalise post thrombolysis and developed cardiogenic shock while in the ED at BRH.[10]

The deceased vomited on leaving Bunbury Airport and refused an antiemetic. He remained hypotensive during the flight, but did not receive any inotropic support for his hypotension following instructions from the cardiologists at FSH.

The deceased was recorded as being fairly comfortable despite his persistent mild chest pain and repeat ECGs after thrombolysis showed persistent ST elevation in the anterio-

[9] Ex 1, tab 11
[10] Ex 1, tab 15

lateral leads. He was able to maintain his own airway, but had bilateral crepitations on lung auscultation.

The deceased's respiratory rate was 20, oxygen saturations 95% on 15 litres non-rebreather and he kept removing his mask. His pulse was 102, BP 92/64 and he was transferred with full cardiac monitoring and non-invasive BP monitoring. His glasgow coma score (GCS) remained at 15 showing he was alert and orientated to time/place/person. His temperature was 36 celcius and there were no obvious physical signs of life threatening injury or illness. He was showing adequate urine output and his Heparin infusion post thrombolysis was at 27ml/hr.

The RFDS landed at Jandakot Airport at 3.05 am on 6 October 2016 and the deceased's observations at that time remained a GSC of 15, maintaining his own airway, but still with bilateral crepitations on lung auscultation. His respiratory rate was 23, oxygen saturation 93% on 15 litres oxygen non-rebreather and he still attempted to remove the mask. He was in sinus tachycardia and his BP was 95/68. He was pink and well perfused. He was handed to SJA for transport to FSH.[11]

FIONA STANLEY HOSPITAL

Following transfer to FSH the deceased was admitted to the coronary care unit (CCU) on 6 October 2016. An

[11] Ex 1, tab 15

echocardiogram showed severe, segmental, systolic dysfunction with impairment of movement of the entire anterior and anteroseptal wall. A coronary angiogram confirmed severe coronary artery disease with complete occlusion of the mid-left anterior descending (LAD) coronary artery and 90% occlusion of the right coronary artery (RCA). A stent was not inserted due to concern as to whether it would be possible to revascularise the heart muscle.

The deceased's custody was transferred from BRP to the Casuarina Prison muster on 6 October 2016, and he was at all times, while in hospital, under guard.[12]

The deceased remained in CCU and was continued on anticoagulant therapy to prevent blood clots forming within the heart chambers.

On the morning of 10 October 2016 the deceased's oxygen saturations were noted to be dropping and his blood pressure remained low. He showed signs of pulmonary oedema and his diuretic was increased.

An MRI on 12 October 2016 to evaluate his heart showed severe systolic dysfunction with estimated ejection fraction (EF) of only 14%. The area perfused by the LAD showed no residual viability and it was thought there may be a blood clot in the apex of his heart. It was decided it would now be

[12] Ex 2 – EcHO Filing & Ex 1, tabs 8 & 9

appropriate to attempt to re-vascularise the inferior wall of the heart.

A repeat angiogram on 14 October 2016 inserted a stent into the RCA and the deceased appeared to recover after the procedure. Later that evening he developed VT and arrested. A MET call was made and CPR commenced. The deceased was given magnesium and amiodarone and had a spontaneous return of his circulation, but remained unstable with low blood pressure and intermittent VT. The deceased required increasing amounts of support, but declined further resuscitation.

The deceased had a telephone discussion with his partner as he deteriorated and he passed away in the morning of 15 October 2016.[13]

POST MORTEM EXAMINATION

The post mortem examination of the deceased was performed on 19 October 2016 by Dr Moss, Forensic Pathologist, PathWest Laboratory of Medicine WA.

Dr Moss noted the examination revealed a large acute 'heart attack' (MI) with extensive old scarring to the heart muscles. There was severe hardening and narrowing of the blood vessels over the surface of the heart and a patent metal stent

[13] Ex 1, tab 8 & 9

was in-situ in the RCA. There was evidence of pulmonary oedema and congestion.

Microscopic examination of the tissues confirmed the presence of an acute myocardial infarction as well as older infarcts. The presence of calcified atherosclerosis was confirmed within the coronary arteries.[14]

Toxicology showed multiple prescription medications in keeping with the medical care recorded for the deceased.[15]

At the conclusion of his investigations Dr Moss determined the deceased died as the result of an acute myocardial infarct in association with his coronary artery atherosclerosis.

MANNER AND CAUSE OF DEATH

I am satisfied the deceased was a 70 year old sentenced prisoner who had suffered serious physical illnesses for much of his life. While he reportedly had BPAD diagnosed in the mid 1980s, it would appear by the time of his incarceration in 2016 he was not displaying any signs of bipolar traits and was compliant with medications for his other medical issues, once removed from the medications aimed towards his mental health.

[14] Ex 1, tab 6
[15] Ex 1, tab 7

The deceased had a difficult childhood spending much of his youth in state facilities, and once becoming adult maintained a level of petty offending which provided him with a lengthy criminal record, but none of such seriousness as would warrant imprisonment. He was known to drink and smoke heavily.

He was employed for most of his adult life and appears to have had a number of long term relationships with varying degrees of stability. He had four daughters to his first marriage and it was around that period of his life to which his incarceration in 2016 related.

While in the community the deceased appears to have maintained a reasonable level of medical intervention, but was noncompliant with a number of his medications especially those aimed towards his BPAD diagnosis.

His severe ischaemic heart disease had resulted in MIs while in the community and he appears to have been surprisingly well from his heart perspective once incarcerated. There is no doubt the deceased was reviewed both on admission and periodically with respect to his physical fitness and he adapted well to prison life. He appeared to be relatively comfortable until the onset of his severe chest pain on 5 October 2016.

The deceased was promptly assessed by the BRP medical officers and immediately transferred to BRH from where he

was transferred to FSH following stabilisation and transfer by RFDS.

Once in FSH the deceased was assessed and treated as considered appropriate by the specialist consultants. Initially stenting was avoided due to a concern his heart muscle was not strong enough to withstand the pressure of revascularisation, but ultimately it became necessary in order to prevent further ischemia. However, once stented the deceased deteriorated rapidly.

The deceased declined further intervention or treatment and passed away on the morning of 15 October 2016 following a conversation with his partner on the telephone.

I am satisfied the deceased's naturally occurring coronary atherosclerosis was appropriately dealt with during his incarceration and he died as the result of a serious MI, the effects of which could not be reversed.

I find death occurred by way of Natural Causes.

SUPERVISION, TREATMENT AND CARE OF THE DECEASED WHILE IN CUSTODY

The deceased was only in prison for seven months and in that time was treated for his ischaemic heart disease. While there is no evidence of a cardiovascular care plan on EcHO it is clear the deceased was treated and medicated in accordance

with acceptable medical management during his time in custody.

Once the deceased was satisfied with his general level of medication he was compliant with his medication and showed no signs of distress until he complained of chest pain on 5 October 2015. At that point he was transferred immediately to hospital and from then on was treated in accordance with consultant cardiologist input.

In view of his relatively difficult childhood it is worth noting the deceased's offending once an adult, although consistent, was minor other than the offences for which he was incarcerated in March 2016, which were historic in nature and related to a time when he was 33 years of age, drinking heavily and involved in a relationship which appears to have involved domestic violence. While the nature of his offending at that time was serious and seriously affected his family and relationships, he appears to have attempted to make the best of his life without the benefits of a supportive family of origin.

It is clear there must have been some aspects of the deceased's life which were commendable in view of his continued support by his defacto and, indeed, the presence of a concerned ex-wife at the inquest.

I am not convinced the deceased would have received such prompt and efficient input had he been in the community at the time of the onset of his serious MI on 5 October 2016. As

it was he survived until 15 October 2016 when he declined further intervention, probably realistically, of his own accord. In all the circumstances I find the deceased's supervision, treatment and care while in custody to have been of a good standard.

Care Plans

During the time the deceased was in prison it is clear from the records he was frequently reviewed with respect to his various illnesses despite there being no obvious cardiovascular or respiratory disease care plans in his medical file on EcHO. Following his transfer to BRP and the difficulty with his medication compliance solved, the deceased self-medicated and received medical reviews until he declined further review in July 2016.

In August 2016 he was reviewed by the mental health team and no current mental health issues were identified.

There is no indication from EcHO the deceased made any complaints about chest pain until 5 October 2016.

The fact the deceased had known long standing severe ischaemic heart disease, however, makes it imperative there is demonstrable monitoring and management of his health care, especially where it is relevant to his cause of death while in custody. *Health Services Policy: PM07 Continuity and*

Coordination of Care[16] outlines the expectation prisoners, such as the deceased, have care plans and those care plans provide for continuity of management of any relevant condition.

The deceased's mental health issues while incarcerated do indicate a level of ongoing review related to his medication compliance and his progress thereafter, but the issue of monitoring for his cardiac issues is not reflected in EcHO.

There is no evidence of a CVC plan following admission although it is clear the deceased was reviewed in the period following admission. He had admission blood tests and investigation in March 2016 but I can find no indication he was referred for, or declined, further blood investigation following changes to his medication, or following the decision he be allowed to self-medicate to ensure his appropriate progress.

While there is reference to a CVC plan review visit on 13 September 2016 there is no indication as to whether that occurred and if it did, as to the outcome. There is no indication it related to standard observations (not recorded) or blood testing of, for example, lipids.

The note of a review in September 2016 implies there was an expectation there was to be a 6 month follow up from

[16] Ex 2, tab 11

admission to ensure appropriate progress, rather than annual. Without a care plan and some indication of the level of monitoring envisaged, it is impossible to determine whether the deceased was actually monitored, notwithstanding he made no complaint of chest pain until 5 October 2016.

It is impossible to determine whether earlier investigations may have seen a change to his medication with a different outcome, which is presumably the intention of the care plans.

While I do not believe the lack of an identifiable CVC plan to be critical to the death of the deceased in the circumstances of this case, where there is evidence he was seen by medical practitioners with regard to some continuity of his care; I am concerned there should be identifiable care plans for all prisoners suffering serious conditions. Not only should the care plan identify the plan for the individual, but also evidence appropriate monitoring in the format specified in the care plan. For example, the type of follow up and investigations considered necessary to ensure appropriate continuity of care while in custody.

In the event the prisoner declines further review that should also be noted as should periodic attempts to encourage compliance. Without these it becomes difficult to realistically comment on supervision, treatment and care as specified in section 25 (3) of the Act.

Prison Programs

I also note in passing the issues of the deceased being eligible for parole and suitable for programs related to his offending while in custody. Completion of those types of programs can affect a prisoner's application for parole and the fact prisoners are unable to participate in programs aimed at their reintegration into the community on release is of concern.

In the circumstances of this case it is not clear, due to the deceased's death, if his inability to participate in relevant programs would have affected any parole application he may have wished to submit, had he not died. I appreciate resourcing is an issue for all programs, but continued incarceration where a prisoner has not been able to participate in relevant programs is also a resource issue.

E F Vicker
Deputy State Coroner
12 October 2018