JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Philip John Urquhart, Coroner
HEARD	**:**	21 - 22 March 2023
DELIVERED	**:**	14 SEPTEMBER 2023
FILE NO/S	**:**	CORC 1081 of 2020
DECEASED	**:**	NARRIER, SHANE REYNOLD

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Mr J Tiller assisted the coroner
Ms A Barter, assisted by Ms G Papalia (Aboriginal Legal Service) appeared on behalf of the family
Ms T Omer (State Solicitors Office) appeared on behalf of the Department of Justice
Ms H Cormann (Wotton Kearney) appeared on behalf of Serco Australia Pty Ltd
Ms B Burke (Australian Nursing Federation) appeared on behalf of nurses S Finlay and A de Villiers

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of **Shane Reynold NARRIER** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 21 to 22 March 2023, find that the identity of the deceased person was **Shane Reynold NARRIER** and that death occurred on 5 June 2020 at St John Of God Midland Hospital, 1 Clayton Street, Midland, from coronary artery atherosclerosis in the following circumstances:*

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INTRODUCTION

"About the only thing you should ever assume is responsibility."
J.S. Felts – author

1 On 27 May 2020, the deceased (Shane),[1] a prisoner at Acacia Prison (Acacia), notified a prison nurse that he wanted to see a doctor for his "*chest pains*". The nurse, assuming Shane's complaint was not urgent, failed to have him immediately examined by a health service provider at Acacia. Nine days later, Shane died from coronary artery atherosclerosis without any medical examination of his chest pains. He was 40 years old.

2 At the time of his death, Shane was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (the Department).[2] Accordingly, immediately before his death, Shane was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[3] In such circumstances, a coronial inquest is mandatory.[4]

3 I held an inquest into Shane's death at Perth on 21-22 March 2023. The following witnesses gave oral evidence:

(i) Sinead Finlay (registered nurse at Acacia);

(ii) Ansonette de Villiers (registered nurse at Acacia);

(iii) Pansy Stewart (Health Services Manager at Acacia);

(iv) Dr Catherine Gunson (Acting Director of Medical Services with the Department);

(v) Dr Johan Janssen (cardiologist);

(vi) Daniel Etherington (General Manager, Professional Standards and Integrity, with Serco); and

(vii) Toni Palmer (Senior Review Officer with the Department)

4 At the conclusion of the oral evidence Shane's sister, Chantel, read out a statement that had been prepared by Shane's family.

5 The documentary evidence at the inquest comprised of one volume of the brief that was tendered as exhibit 1 at the commencement of the inquest. During the inquest I raised the matter of what action, if any, had been taken with respect to recommendations regarding disciplinary hearings made by the author of the Post

[1] The family asked that the deceased be referred to as "Shane" at the inquest and in this finding
[2] *Prison Act 1991* (WA) s 16
[3] *Coroners Act 1996* (WA) s 3, s 22(1)(a)
[4] *Coroners Act 1996* (WA) s 25(3)

Incident Review. I invited Serco Australia Pty Ltd (Serco)[5] to provide any additional statements or submissions regarding this aspect.[6] An email response (with attachments) from Serco's solicitor was provided on 18 April 2023. On 12 September 2023, following a further invitation from the Court, written submissions from Ms Cormann, counsel for Serco, were provided.

6 The inquest focused on the medical treatment and care provided to Shane during his final term of imprisonment, with an emphasis regarding the treatment and care he received for the heart disease that caused his death.

7 In making my findings, I must be mindful of the standard of proof set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle).

8 I am also mindful not to assert hindsight bias into my assessment of the actions taken by Shane's prison health service providers in their treatment and care of him. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[7]

SHANE

Background [8]

9 Shane was born on 10 August 1979 at King Edward Memorial Hospital, Subiaco to his parents, Betty Mogridge and Shane Narrier (Snr). Shane was the eldest of five children. He grew up in Moora before moving to Perth when he was a teenager. Shane's family are of the Yued/Ballardong, Nyunga people and the Court acknowledged and paid its respect to these people at the commencement of the inquest.

10 Shane had a large family of his own, being a father to nine children. At the time of the inquest, he had four grandchildren with another who was about to be born.[9] He was known by many as a friendly and sociable man who enjoyed football, basketball and darts.

11 Shane was a heavy smoker of tobacco for much of his life, and he also used cannabis and methylamphetamine.

[5] Although the land and infrastructure at Acacia is publicly owned, Serco privately operates Acacia under an agreement with the Department
[6] ts 22.3.23, pp.154-155
[7] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[8] Exhibit 1, Tab 10, Background information from Betty Mogridge dated 5/8/2020
[9] ts 21.3.23 (Ms Barter), p.2

Offending history [10]

12 Shane had a lengthy criminal history that included offences of violence and dishonesty, and offences that were drug-related. Prior to his final imprisonment, he had been sentenced to five terms of immediate imprisonment between 2010 and 2017. The longest term of imprisonment he received during these incarcerations was 18 months in 2017.

Circumstances of Shane's final imprisonment [11]

13 On 24 June 2019, Shane committed serious offending against his partner who he had been in a short relationship. After having an argument with her, Shane chased his partner with a screwdriver and pressed it into her neck whilst threatening to kill her. He then dragged her by the hair and repeatedly punched her to the head and face. He was subsequently charged with being armed in a way that may cause fear, threatening to kill and aggravated unlawful assault occasioning bodily harm.

14 After being released on bail for those matters on 8 July 2019, Shane failed to appear in court on 5 August 2019. On 1 November 2019, he provided false details to police. He was charged with these two additional offences and was remanded in custody.

15 On 6 December 2019, Shane pleaded guilty to these five offences in Perth Magistrates Court. He was sentenced on that day to a total of 1 year and 8 months imprisonment, with eligibility for parole. The sentence was back-dated to 1 November 2019, which meant Shane's earliest eligible date for parole was 30 August 2020.

Prison transfer history for Shane's final imprisonment [12]

16 Shane had been remanded in custody at Hakea Prison (Hakea) on 1 November 2019. Although he returned to Hakea following his sentencing on 6 December 2019, five days later he was transferred to Casuarina Prison (Casuarina) for prison population management purposes.

17 On 3 January 2020, following the preparation of a management and placement report, Shane's security rating was reduced to medium security. This led to his transfer to Acacia Prison (Acacia) on 7 January 2020.

18 In summary, Shane had the following prison placement and transfers:

(i) Hakea: 1 November 2019 – 11 December 2019 (40 days)
(ii) Casuarina: 11 December 2019 – 7 January 2020 (27 days)

[10] Exhibit 1, Tab 23, Court Outcomes History – Criminal and Traffic
[11] Exhibit 1, Tab 23, Court Outcomes History – Criminal and Traffic; Exhibit 1, Tab 22, Transcript of sentencing proceedings dated 6/12/2019
[12] Exhibit 1, Tab 25, Review of Death in Custody dated January 2023

(iii) Acacia: 7 January 2020 – 5 June 2020 (150 days)

19 Shane received two prison charges during his final imprisonment. One was for an assault on another prisoner in April 2020 for which he was confined to a punishment cell for a short period. The other was in May 2020 for disobeying a prison rule by receiving a tattoo, for which he incurred a loss of gratuities for six days.

20 Although Shane had expressed a willingness to work whilst he was in prison, he was not employed in any prison activity at the time of his death.

OVERVIEW OF SHANE'S MEDICAL CONDITIONS AND TREATMENT OF THOSE CONDITIONS IN PRISON

Greenough Regional Prison [13]

21 After being arrested and charged with the three offences relating to his partner, Shane was remanded in custody in Greenough Regional Prison (Greenough) from 26 June 2019.

22 On reception to Greenough, Shane was medically assessed by a prison nurse who took observations and recorded he was hypertensive. A note was made to review his blood pressure. Shane's blood pressure was subsequently monitored a number of times. On 30 June 2019, Shane had a review with a prison nurse and he was advised he may have elevated blood pressure. He denied that he had any chest pains.

23 On 6 July 2019, a prison nurse tasked administrative staff to organise an ECG.[14]

24 On 8 July 2019, Carnarvon Magistrates Court released Shane on bail. This was before the ECG could be actioned and so it did not take place.

25 Shane failed to appear in court for his charges on 5 August 2019 and a bench warrant was issued for his arrest.

Hakea [15]

26 On 1 November 2019, Shane was remanded in custody at Hakea. On his reception to Hakea, Shane underwent a Reception Intake Assessment.

[13] Exhibit 1, Tab 19, EcHO medical records

[14] ECG is an abbreviation for electrocardiogram, which is a recording of the heart's electrical activity to detect heart rhythm abnormalities and diagnose some cardiovascular diseases

[15] Exhibit 1, Tab 25, Review of Death in Custody dated January 2023; Exhibit 1, Tab 19, EcHO medical records

27 Shane advised reception officers that he did not have any health issues, although he said he expected to experience withdrawal symptoms from his daily use of illicit drugs.

28 Shane's "Problem List" recorded in the Department's Electronic Health Online system (EcHO) indicated that historically Shane experienced chronic in his right shoulder, depression with insomnia, hyperlipidaemia (excess of lipids or fats in the blood) and an iron overload. During his medical reception, Shane advised the nurse he was withdrawing from illicit drugs and that he had a painful knee. He also stated he was feeling depressed and anxious.

29 On 11 December 2019, Shane was transferred to Casuarina.

Casuarina [16]

30 The assessment of the nurse who saw Shane upon his arrival at Casuarina noted that there had been a pathology request from the prison doctor who had viewed Shane at Hakea on 27 November 2019. A pathology appointment was subsequently booked for blood and urine test collection.

31 By 6 January 2020, the day before his transfer to Acacia, Shane's pathology collection still needed to be done and a prison doctor's review was required to examine the pathology results.

32 On 7 January 2020, Shane was transferred to Acacia.

Acacia [17]

33 Shane was assessed by a nurse upon his intake into Acacia. His medication comprising of escitalopram (an antidepressant), atorvastatin (medication for high cholesterol) and amitriptyline hydrochloride (an antidepressant that is also used for neuropathic pain) were rescripted. It was noted that the pathology request was still outstanding and that there was, "*No form to hand*".

34 It was also noted an ECG on 16 November 2017 recorded that Shane had a sinus arrhythmia. This condition is effectively benign and not harmful. It occurs when a person's heart rate relates to their breathing cycle; meaning their heart rate increases when they breath in and decreases when they breath out.

35 On 8 January 2020, the prison doctor undertook an administrative review by examining Shane's EcHO entries.

[16] Exhibit 1, Tab 27, Health Services Summary into the Death in Custody dated 16 March 2023

[17] Exhibit 1, Tab 27, Health Services Summary into the Death in Custody dated 16 March 2023, Exhibit 1, Tab 19, EcHO medical records; Exhibit 1, Tab 25.13, Acacia Health Summary dated 20/10/2020; Exhibit 1, Tab 30, Report of Pansey Stewart dated 14/3/2023; Exhibit 1, Tab 32.1, Statement of Sinead Finlay dated 18/3/2023

36 On 31 January 2020, Shane's pathology results were received. The results were all in normal range, with his cholesterol/HDL ration number indicating an average cardiovascular risk.

37 On 18 February 2020, Shane did not attend his "*DNA nursing appointment*". The note on EcHO was for Shane to re-book his appointment.

38 EcHO entries showed that Shane was seen on several occasions by Acacia health service providers, including a nurse review on 13 May 2020 after he had been punched in the face whilst playing football. Aside from this incident, there were no acute concerns raised by Shane (or by Acacia health service providers) regarding his health until 27 May 2020.

39 On 27 May 2020, Shane sent a message using Acacia's Custody Messaging System (CMS). Prisoners at Acacia can access prison health care services in two primary ways. One way is to directly report a medical issue to custodial officers in the prisoner's unit. The second way was via CMS, a computer communication system which had been in operation at Acacia since February 2011.

40 At 10.11 am on 27 May 2020, Shane used CMS requesting to see a prison doctor. His message read:[18]

> I would like to see the doctor please because I've been getting chest pains and the pain goes through my whole body so can I please see the doctor please.

41 Sinead Finlay (Ms Finlay) was the clinical nurse at Acacia who was assigned to review the CMS health care requests from prisoners sent on 27 May 2020.

42 After reading Shane's request, at 4.35 pm that day, Ms Finlay entered into EcHO that Shane was to be "*referred for a nurse review*".[19] Ms Finlay then wrote a request for a nurse appointment to be booked either the next day or no longer than two days later. The task of allocating a time and date for the appointment with a prison nurse was the responsibility of an administrative staff member.

43 Ms Finlay sent a message back to Shane via CMS at 4.36 pm on 27 May 2020. Her message read: "*Hi Shane, I referred you for a nurse review. Please keep an eye on your CMS for the time.*"

44 Shane's appointment to see a nurse was booked for 2.30 pm on 31 May 2020. Shane failed to attend this appointment. According to the entries in EcHO, Shane did not attend any other appointments with health service providers from

[18] Exhibit 1,Tab 31, Screenshot – CMS Message Summary for Shane
[19] Exhibit 1,Tab 19, EcHO medical records, p.11

27 May 2020 until 5 June 2020 (the date of his death). However, he did continue to attend the medical centre to receive his prescribed medications twice daily.[20]

45 Shane's appointment with a nurse was rescheduled for 11 June 2020.

EVENTS LEADING TO SHANE'S DEATH [21]

46 At about 8.00 am on 5 June 2020, Shane woke up and complained of a headache to his cell mate. At the time, Shane was in a two-man cell in Kilo Block.

47 At 9.44 am, Shane approached a prison officer in Kilo Block and requested Panadol for his headache. Several minutes later, he received two Panadol tablets. Shane returned to the day room in his unit and met up with his cell mate and had a coffee.

48 CCTV footage from within Kilo Block depicted Shane's appearance and movements. He did not display any obvious signs of distress in this footage.

49 At about 10.05 am, Shane went to an outside area where he met up with two other prisoners who were walking laps in this area. Shane and the other two prisoners spoke briefly before the two prisoners continued their walking. Shane appeared to be a bit quieter than normal but otherwise seemed to be his usual self. After he spoke to the other two prisoners, he went and sat down on a small limestone wall of a garden bed. He was by himself. No CCTV cameras covered this outside area.

50 A short time later, the other two prisoners noticed Shane face down on the ground with his body positioned next to the limestone wall. They immediately went over to him and observed he was struggling to breath and making gasping noises with seizure-type movements.

51 The two prisoners rolled Shane onto his right side and tilted his head back and cleared his airway. There was nothing in his mouth or throat.

52 In response to the prisoners' cries for help, a prison officer attended the outdoor area and saw that Shane was in a recovery position and unresponsive. The prison officer used his radio to broadcast a Code Blue medical emergency (Code Blue).

53 Prison officers attending in response to the Code Blue observed that Shane was shaking slightly and had some abrasions to his forehead consistent with him making contact with the path. The duty nurse, Ansonette de Villiers (Ms de Villiers), heard the Code Blue on the radio and immediately collected the

[20] Exhibit 1,Tab 25.13, Acacia Health Summary dated 20/10/2020, p.4

[21] Exhibit 1, Tab 2, Coronial Investigation Squad Report from Senior Constable Naomi Arnold dated 8/9/2020; Exhibit 1, Tab 25.13, Acacia Health Summary Report dated 27/10/2020; Exhibit 1, Tab 25.14, Serco Post Incident Review Report dated 15/7/2020; Exhibit1, Tabs 17.2 and 17.3, Patient Care Records – St John Ambulance WA

medical emergency bag and used the internal ambulance buggy to get to Kilo Block. Ms de Villiers arrived at the outdoor area at about 10.12 am.

54 Ms de Villiers observed that although Shane was unresponsive, he was breathing. When he was rolled onto his back, Shane made a groaning noise. Shane's carotid pulse was weak, but present. To provide Shane with an open airway so he could breathe more easily, Ms de Villiers inserted the Guedel[22] from the emergency bag into his mouth. She also applied an oxygen mask to his face to assist his breathing.

55 Shane was placed onto a stretcher which was then put on the ambulance buggy and he was taken to the medical centre. The ambulance buggy departed the garden area at about 10.14 am and arrived at the medical centre approximately three minutes later.

56 At about 10.20 am, cardiopulmonary resuscitation (CPR) commenced when it was noted Shane had stopped breathing. This was the first time CPR was administered. Defibrillator pads were placed on Shane's chest with the first shock being administered at 10.24 am. At 10.25 am, a telephone call was made requesting an ambulance.

57 Health service providers and custodial staff continued to administer CPR and medical treatment to Shane. A total of 19 shocks with the defibrillator pads and nine doses of adrenaline were administered prior to the arrival of ambulance officers at the medical centre at about 11.05 am.

58 Notwithstanding the intensive medical treatment Shane was receiving, he was in ventricular fibrillation and it was decided to urgently transport him by ambulance to hospital.

59 The ambulance departed Acacia at 11.25 am. Four more shocks were delivered by ambulance officers enroute to St John of God Midland Hospital (SJOGMH). At 11.33 am, Shane's heart ceased to beat (asystole). CPR continued and Shane remained asystole when he arrived at SJOGMH at 11.52 am.

60 CPR was maintained by hospital staff and despite their best efforts, Shane could not be revived. Life extinct was declared by a doctor shortly after midday on 5 June 2020.[23]

[22] A rigid plastic tube which sits along the top of the mouth and ends at the base of the tongue
[23] Exhibit 1, Tab 5.1, Assessment of Life Extinct dated 5/6/2020

CAUSE AND MANNER OF DEATH [24]

61 On 15 June 2020, two forensic pathologists, Dr Victoria Kueppers (Dr Kueppers) and Dr Joe Ong (Dr Ong), conducted a post mortem examination on Shane's body.

62 The post mortem examination found severe hardening, thickening and narrowing of the vessels supplying the heart muscle (coronary atherosclerosis). This was also confirmed by a microscopic examination.

63 There was also evidence of medical intervention, including CPR. There were minor abrasions to Shane's forehead and right shoulder, consistent with having been sustained in a fall. There was no evidence of any significant injuries.

64 A macroscopic ("naked eye") specialist neuropathological examination of Shane's brain showed evidence of complicated cerebrovascular atherosclerosis with no other significant abnormality.

65 Toxicological analysis detected the presence of medications that had been prescribed to Shane. Paracetamol was also detected. Alcohol and common illicit drugs were not detected.

66 The forensic pathologists noted that it was most likely that Shane died as a result of a sudden disturbance in the normal beating rhythm of his heart (cardiac arrhythmia) on a background of coronary artery atherosclerosis.

67 At the conclusion of their examination, Dr Kueppers and Dr Ong expressed their opinion that the cause of death was coronary artery atherosclerosis.

68 I accept and adopt the conclusion expressed by the two forensic pathologists as to the cause of Shane's death.

69 Given that I have found the cause of death was coronary artery atherosclerosis, I find that Shane's death occurred by way of natural causes.

ISSUES RAISED BY THE EVIDENCE

Was there an appropriate response to Shane's complaint of chest pains on 27 May 2020?

70 As already outlined above, Ms Finlay arranged for Shane to be reviewed by a nurse following his CMS request to see a doctor for "*chest pains*". I accept that this request should not have been conveyed via CMS. However, for the reasons I have outlined below, I am satisfied to the required standard that the response of

[24] Exhibit 1, Tabs 6.1-6.3, Supplementary Post Mortem Report, Final Post Mortem Report and Interim Post Mortem Report; Exhibit 1, Tab 7, Neuropathology Report dated 22/6/2020; Exhibit 1, Tab 8, Toxicology Report dated 23/6/2020

Ms Finlay was not only inappropriate but demonstrated a serious error of judgement.

71 As explained by Pansey Stewart (Ms Stewart), the Health Services Manager at Acacia, CMS operated in the following manner:[25]

> Using a combination of PIN input and biometric scanning, prisoners can securely access their own details, manage their money, and find answers to frequently asked questions. The CMS is a system that allows the prisoners to communicate with custodial and non-custodial staff, and vice versa.

72 Through CMS, prisoners have access to various prison services in addition to health care. With respect to health care, CMS provides prisoners an "*automated prisoner application system that enables them to request doctor's appointments and health checks*."[26] CMS was to be used for non-urgent requests for medical appointments and general health enquiries.[27]

73 Initially, CMS did not allow prisoners to communicate the nature of their health care enquiry unless an appointment was allocated to them. However, from early May 2020, in an effort to improve communications between the prisoner and the health service provider triaging the request, CMS was updated to enable prisoners to input specific details such as the nature of their complaint or the reason for the requested appointment. As explained by Ms Stewart: "*Prior to then, there was no feature to include information to accompany a request and no capacity to 'triage' requests, nor escalate a request for a more urgent response*."[28]

74 Sadly, within a matter of weeks of the introduction of this update, its purported aim to triage requests requiring "*a more urgent response*" failed with respect to Shane.

75 A screen shot of Shane's use of CMS showed he had accessed it on a number of occasions, using it 27 times from 9 January 2020 to 27 May 2020. Although he only accessed health care on two occasions during that time.[29]

76 The second way a prisoner could access health care was to report a medical concern to a prison officer in person. If a prisoner required urgent medical care or assistance, then they are encouraged to seek direct assistance which is then actioned by custodial staff as a Code Blue over the prison radio. This includes reports of chest pain.[30] In the case of a Code Blue, a nurse is to immediately attend the prisoner to assess the complaint and then, in the case of chest pain, "*transfer*

[25] Exhibit 1, Tab 25.13, Acacia Health Summary dated 20/10/202, p.6
[26] Exhibit 1, Tab 25.13, Acacia Health Summary dated 20/10/202, p.6
[27] Exhibit 1, Tab 25.13, Acacia Health Summary dated 20/10/202, p.6
[28] Exhibit 1, Tab 30, Report of Pansey Stewart dated 14/3/2023, p.2
[29] Exhibit 1, Tab 31, Screenshot – CMS message summary for Shane
[30] Exhibit 1, Tab 30, Report of Pansey Stewart dated 14/3/2023, p.2

him immediately to the medical centre for investigation and appropriate steps, including observations and ECG."[31] A report of chest pain is to be treated as a possible cardiac episode until investigations (including an ECG) indicates otherwise.[32]

77 The policies and procedures that applied when a prisoner reported chest pain did not make a distinction as to how the report was communicated to Acacia staff. Whatever way Acacia staff were advised that a prisoner was experiencing chest pain, it was to be urgently treated as a possible cardiac episode.[33]

78 Ms Finlay did not treat Shane's complaint of chest pains as a medical emergency. She therefore did not regard it as a possible acute cardiac event warranting immediate medical attention. Her reasons for making that decision included her view that the information she received did not indicate to her that Shane was experiencing chest pains "*at that time*".[34]

79 In her interview during Serco's Post Incident Review (PIR), Ms Finlay was questioned whether she considered a Code Blue when she assessed Shane's CMS message. She answered: "*Based on the language that he used in his request and the information he provided, no.*"[35]

80 After making that assessment, Ms Finlay said she wrote a request that a nurse review for Shane was to be scheduled for the next day, or no longer than two days later.[36] The scheduling of appointment times for nurse reviews was handled by administrative staff.[37]

81 Ms Finlay gave the following evidence at the inquest:[38]

> So Shane wrote that he had been getting chest pain and that pain went through his whole body. So CMS is for non-urgent requests so that sounded like it wasn't happening at that time, because if it was he would go and see an officer as was the known process. And saying that the pain went through his whole body, that's not generally a cardiac presentation.
>
> **CORONER:** Well, what about chest pains, though, Ms Finlay?---Yes.
>
> That's an indicator that there could well be a cardiac problem?---Yes.
>
> Did you just assume that Shane's communication was non-urgent?---I think that would have been part of my formulation. Yes. It was a CMS request. He wasn't identifying – he didn't

[31] Exhibit 1, Tab 30, Report of Pansey Stewart dated 14/3/2023, p.2
[32] Exhibit 1, Tab 30, Report of Pansey Stewart dated 14/3/2023, p.3
[33] ts 21/3/2023 (Ms Stewart), p.84
[34] Exhibit 1, Tab 32.1, Statement of Sinead Finlay dated 18/3/2023, p.4
[35] Exhibit 1, Tab 32.2, Transcript of Serco interview with Sinead Finlay dated 9/7/2020, p.8
[36] Exhibit 1, Tab 32.1, Statement of Sinead Finlay dated 18/3/2023; Exhibit 1, Tab 32.2, Transcript of Serco interview with Sinead Finlay dated 9/7/2020
[37] ts 21/3/2023 (Ms Finlay), p.20
[38] ts 21/3/2023 (Ms Finlay), pp.17-19

> identify any urgent need and [for] any urgent concerns the guys go straight to the officers or a friend.
>
> What if you had heard through an officer that Shane was complaining of getting chest pains, would that mean that you would regard the matter as urgent?---Yes. That would have been presented as it was an urgent request, an urgent concern and then it would have been determined whether we went down to the Block to assess and retrieve or whether we would have asked for the prisoner to be brought to the medical centre.
>
> So you're placing a great deal of emphasis on the way in which the complaint is communicated, is that fair to say?---Well, it – it is heavily considered. Yes.
>
> Is that appropriate?---It is considered.
>
> Well, is that an appropriate approach to take?---Well, I guess if the CMS is for non-urgent requests so it sounds like he, Shane, it wasn't – he wasn't experiencing chest pain at the time. That's how it came across in the CMS request. Whereas when a prisoner goes to an officer that's a more pressing presentation, I guess.
>
> Well, it might have been the case that Shane wasn't aware or had forgotten that he should only use the CMS for a non-urgent request, isn't that something you should have considered given the fact that he is stating he is getting chest pains?---On reflection, yes.
>
> But not at the time?---Yes. Looking back I should have. Yes.
>
> But even without the benefit of hindsight - - -?---Mmm.
>
> - - - Ms Finlay, isn't it something that you should have done? That at the very least you ought to have had a conversation with a prison officer on Shane's Block?---Yes. I should have.

82 Ms Finlay admitted there was nothing that she was aware of that would have prevented her from contacting a prison officer on 27 May 2020 and asking that person to speak with Shane regarding his complaint of chest pains.[39]

83 Although Ms Finlay had no specific recollection of examining Shane's medical record on EcHO, she made it clear that was her usual practice and she would not have recognised any cardiovascular risk factors for Shane from that examination.[40]

84 At the inquest, Ms Finlay agreed that she would have looked at Shane's "Problem List" that appeared in EcHO.[41] Ms Finlay also agreed she would have known Shane was a First Nations person and that this was a potential cardiovascular risk factor.[42] She then accepted that the following conditions listed on the first two pages of the hardcopy version of Shane's EcHO medical records were all cardiovascular risk factors:[43]

[39] ts 21/3/2023 (Ms Finlay), p.21
[40] ts 21/3/2023 (Ms Finlay), p.22
[41] ts 21/3/2023 (Ms Finlay), p.22
[42] ts 21/3/2023 (Ms Finlay), pp.22-23
[43] ts 21/3/2023 (Ms Finlay), pp.22-23. Exhibit 1, Tab 19

- Depression
- Hyperlipidaemia
- Iron overload
- Smoking (tobacco) addiction
- User of illicit drugs
- Family history of diabetes and hypertension[44]

85 After those factors were identified, Ms Finlay accepted that she did not attach enough weight to this material when she decided to take the course of action that she did for Shane's complaint of chest pains on 27 May 2020.[45]

86 Having carefully considered the evidence, and been mindful not to insert hindsight bias, I am satisfied to the required standard of the following:

- Ms Finlay placed an undue emphasis on the way Shane communicated that he was having chest pains i.e. through CMS;
- Ms Finlay placed insufficient weight on Shane's cardiovascular risk factors that were listed in EcHO;
- It was entirely inappropriate for Ms Finlay to assume Shane's chest pains were not current without, at the very least, asking for more information from custodial staff through a telephone call to Shane's unit.

87 In light of the above findings, I am satisfied Ms Finlay's failure on 27 May 2020 to make arrangements for Shane to have an immediate medical examination of his chest pains was a serious error. Accordingly, I make that finding.

88 I am also of the view that Ms Finlay's decision not to treat Shane's complaint on an urgent basis was influenced by her experience of the high number of Code Blue matters called for chest pains that do not end up as cardiac-related. As she said at her Post Incident Review interview when she was asked what sort of treatment prisoners received when Code Blues are called for chest pains:[46]

> Observations would be done on them and they'd have an ECG done. If needed, the doctor would be consulted with. Nine times out of ten, the chest pain is muscular or respiratory or something else. But if it's felt cardiac then its escalated. (underlining added)

89 Notwithstanding Shane's incorrect use of CMS, he clearly identified a potentially serious medical issue that should have warranted an immediate medical response. Unfortunately, as the evidence below demonstrates, the manner in which Shane's complaint was dealt with following Ms Finlay's error did not improve.

[44] The first five of these factors appeared at the front of Shane's EcHO records under the heading "Problem List"
[45] ts 21/3/2023 (Ms Finlay), p.23
[46] Exhibit 1, Tab 32.2, Transcript of Serco interview with Sinead Finlay dated 9/7/2020, p.7

90 There was an obvious miscommunication regarding Ms Finlay's intentions to have Shane reviewed within two days of his CMS message and the scheduling of the date for that review by an unidentified administrative staff member at Acacia. That is because the nurse review of Shane's chest pains was not listed to take place the next day or even the day after. It was scheduled for 2.30 pm on 31 May 2020, four days after Shane's request on CMS.[47]

91 Ms de Villiers was the clinical nurse at Acacia who was allocated to review Shane on that day, together with nine other prisoners.[48] Shane did not attend that appointment. Ms de Villier's evidence at the inquest was her practice if a prisoner did not attend was to contact the prisoner's unit and ask that a prison officer arrange for the prisoner to attend the medical centre for their appointment. She also said if the prisoner still does not attend then an entry is made in EcHO that the prisoner was called and failed to attend. The appointment is then rebooked for another date.[49]

92 As to making the call to Shane's unit on that day, Ms de Villiers was asked the following questions at the inquest:[50]

> Do you recall doing that, making that telephone call, or is it that's your standard practice and so that's what you understand has happened or believe has happened?---That is our standard practice to do that, yes.
>
> Would you be able to say independently of notes whether you are certain that that occurred on that day?---I believe it did.

93 I am satisfied Ms de Villiers did make the call as she had made a handwritten entry next to Shane's name on the Appointment List for 31 May 2020 that said "*C/P*".[51] As Ms de Villiers explained at the inquest, this stands for "*call patient*" and means that she had telephoned Shane's unit.[52] However, Ms de Villiers no longer had a memory of what happened after that call was made, other than Shane did not attend.[53]

94 Despite Ms de Villiers' evidence that she would make an entry in EcHO if a prisoner does not attend his appointment, no such entry was in EcHO regarding Shane's failure to attend his appointment on 27 May 2020.[54] When asked why that

[47] Exhibit 1, Tab 25.15, Appointment List dated 31/5/2020
[48] ts 21/3/2023, (Ms de Villiers), p.35; Exhibit 1, Tab 25.15, Appointment List dated 31/5/2020
[49] ts 21/3/2023, (Ms de Villiers), pp.36-37
[50] ts 21/3/2023, (Ms de Villiers), p.37
[51] Exhibit 1, Tab 25.15, Appointment List dated 31/5/2020
[52] ts 21.3.23 (Ms de Villiers), p.54
[53] ts 21.3.23 (Ms de Villiers), p.54
[54] Exhibit 1, Tab 19, EcHO medical records, p.11

might have happened, Ms de Villiers said it could have been she was called away to do something else.[55]

95 It was Ms de Villiers' practice to only look on EcHO to find out the reason for a prisoner's appointment once the prisoner had attended. If she had time she would do it before; however, for Shane's appointment on 31 May 2020 she did not do that.[56] Had she known the appointment was due to chest pains, Ms de Villiers would have made "*double sure*" a prison officer had contacted him to attend.[57] And, if necessary, she would have asked prison officers attached to the medical centre to get Shane and bring him to the medical centre on the ambulance buggy.[58]

96 Had Ms de Villiers examined EcHO she would have seen Ms Finlay had entered the reason for the appointment as "*via CMS requesting to see a Dr as he gets chest pains that go all through his body*".[59]

97 It was unfortunate that Ms de Villiers was not aware that Shane's request for a medical appointment was due to his chest pains. It meant there was no concerted action to make sure he attended on 31 May 2020, and there was no urgency regarding the rescheduling of the appointment. I am satisfied to the required standard that this was a missed opportunity to correct the serious error made by Ms Finlay.

98 Shane's appointment was administratively rebooked for 11 days later on 11 June 2020.[60] But by then it had been six days since Shane had died.

Was appropriate treatment provided to Shane following his collapse on 5 June 2020?

99 Dr Johan Janssen (Dr Janssen) provided an independent report for the Court in his capacity as a cardiologist. Dr Janssen has recently retired with nearly 40 years' experience as a cardiologist. He also had prior experience treating prisoners and First Nations people for cardiac disease. Dr Janssen was asked to provide his opinion as to the medical care provided to Shane following his collapse on 5 June 2020.

100 At the inquest, Dr Janssen confirmed that the actions taken with respect to the medical treatment provided to Shane on 5 June 2020 were reasonable and appropriate. That included Ms de Villiers' use of the Guedel and that given her

[55] ts 21/3/2023, (Ms de Villiers), p.37
[56] ts 21/3/2023, (Ms de Villiers), p.39
[57] ts 21/3/2023, (Ms de Villiers), p.39
[58] ts 21/3/2023, (Ms de Villiers), p.54
[59] Exhibit 1, Tab 19, EcHO medical records, p.11
[60] Exhibit 1, Tab 27, Health Service Summary into the Death in Custody dated 16/3/2023, p.6

assessment Shane was breathing, albeit with a weak pulse, it was not necessary for her to commence CPR before taking him to the medical centre.[61]

101 Nor was Dr Janssen critical of the time it took before a call was made for an ambulance to attend at 10.25 am. As pointed out by Dr Janssen, for the five minutes prior to that call Shane had stopped breathing and resuscitation was in process, including the placing of defibrillators. Asking a rhetorical question at the inquest, Dr Janssen said that in those circumstances, "*Who has time to call the ambulance?*".[62]

102 Having carefully considered the evidence of Dr Janssen, I am satisfied Shane was appropriately cared for following his collapse. Unfortunately, by the time he had collapsed there was very little that could be done to save Shane's life.[63]

103 Sadly, had Shane's complaint been correctly actioned on 27 May 2020, the outcome was very likely to have been different. I will now address this aspect.

What was the likely outcome for Shane had his complaint of chest pains been correctly actioned?

104 At the inquest, Ms de Villiers outlined what would have been done had she reviewed Shane on 31 May 2020:[64]

> At that moment if he tells me he has got chest pains, I will do observations, blood pressure, temp, pulse, saturation. And I will put him on our treatment room bed and do an ECG, a heart test, and I will then look at it and if the doctor is on duty I will take it straight to the doctor to read it. If it is abnormal and I can see – and there's no doctor, we will call an ambulance straightaway and get him to hospital.

105 I am satisfied these same actions would have occurred had Ms Finlay made arrangements for Shane to attend the medical centre on 27 May 2020 for an examination of his chest pains.

106 Had Shane been taken to hospital due to the results of an ECG, Dr Janssen outlined how he would have been treated:[65]

> … it's important to know that he has a very tight narrowing [of the vessels supplying the heart muscle]. You would definitely have found that on the stress test. A normal stress test or a nuclear stress test. You would have found that. So then you would have been able to treat it.
>
> And in regard to the circumstances or his health at or around that time, you made a comment on the potential impact that treatment at that stage might have had?---Well, if – if he would have had the appropriate test and they would have diagnosed him with coronary

[61] ts 22/3/2023 (Dr Janssen), pp.121-122
[62] ts 22/3/2023 (Dr Janssen), p.132
[63] ts 22/3/2023 (Dr Janssen), p.123
[64] ts 21/3/2023 (Ms de Villiers), p.53
[65] ts 22/3/2023 (Dr Janssen), pp.117-118

> artery disease, he would have had the appropriate treatment. He would have medication. If the test would have shown a large area of ischemia, which is lack of oxygen, because of this lesion. And that could have been because it was very high up in the right coronary artery and it was a dominant vessel. So, he would have had at least 40 per cent of his heart muscle in jeopardy. Then he would probably have received a stent, and he would have, you know, he might still be with us.

107 Had prompt action been taken after Shane's complaint of chest pains, Dr Janssen was of the view the treatment outlined above would have been completed in the public system before 5 June 2020. And had that treatment occurred, Shane, "*would have had a good chance that he would still be alive*."[66]

Failure to notify Shane's family of his death

108 It was extremely unfortunate that Shane's family did not know of his death until the day after, on 6 June 2020. What is also very concerning is that his family only became aware due to other prisoners in Acacia calling their own families to advise them of Shane's death.[67]

109 The inquest was told that upon the death of a prisoner in custody, the prison will notify the details of the recorded next of kin for that prisoner to the WAPF.[68] It is then the responsibility of the WAPF to notify the next of kin.[69]

110 Under the heading "Next of Kin", Acacia's records listed Shane's mother with her address. There were no details as to her telephone number. Under the next heading, "Contact Details", the name of Shane's mother was listed as was the name of a non-relative with her mobile telephone number.[70] All this information would have been forwarded to the WAPF.[71]

111 Following the death of a prisoner, the prison also shuts down the Prisoner Telephone Service (PTS) until such time the WAPF advises the prison that the next of kin has been notified.[72]

112 In this instance, it was the non-relative listed as a next of kin by Shane who was notified by police. This took place at 4.35 pm on the same day that Shane died.[73] This meant that the PTS was resumed at Acacia shortly after that.[74] As Shane's

[66] ts 22/3/3023 (Dr Janssen), pp.127-128
[67] Exhibit 1, Tab 11, Statement of Betty Mogridge dated 5/9/2020
[68] Western Australian Police Force
[69] ts 22/3/2023 (Mr Etherington), pp.158-159
[70] Exhibit 1, Tab 26, Acacia Offender Summary, p.2
[71] ts 22/3/2023 (Mr Etherington), p.159
[72] ts 22/3/2023 (Closing Submissions by Ms Cormann), pp.188-189
[73] P98 Mortuary Admission Form for Shane
[74] ts 22/3/2023 (Closing Submissions by Ms Cormann), p.189

family were not known to the non-relative, this person did not advise any member of the family that Shane had died.[75]

113 It is a most unfortunate state of affairs that Shane's family became aware of his death in the manner they did. I note the WAPF did have a contact number for Shane's mother as well as her address.[76] A simple telephone call or visit to Shane's mother on 5 June 2020 would have avoided her from finding out about her son's death the next day through third parties.

Failure by Serco to commence disciplinary hearings

114 As with all prisoner deaths in Acacia, Serco prepared a Post Incident Review (PIR) dated 15 July 2020 into Shane's death.[77] Following a comprehensive analysis by Serco's Assurance and Integrity Manager, the report from the PIR recommended, amongst other things, that an internal disciplinary hearing be convened to determine whether Ms Finlay had contravened any aspect of Acacia's or Serco's Code of Conduct.[78]

115 Once a PIR is completed, the usual process is for the report to be sent to the Director of Acacia who, in turn, tasks the Deputy Director, "*to pick up the recommendations and implement them where appropriate.*"[79] On 28 October 2020, an entry was made by the Assurance Officer at Acacia on Serco's PIR tracker system which is used to record progress, decision-making and outcomes following any recommendations made in a PIR report.[80] This entry included the following:

> It was determined during [the] interview with CN Finlay that her actions were based on her clinical assessment of the patient's medical history which contained no red flags, such as cardiac history. Based on this, it was concluded that CN Finlay did not contravene any aspect related to the Code of Conduct. CN Finlay was provided guidance and support in regards to the incident to assist her in identifying and escalating incidents when indicated.

116 Daniel Etherington, Serco's General Manager, Professional Standards and Integrity, noted that this entry indicated consideration had been given to the recommendations regarding disciplinary action but it "*was not thought to be the appropriate action*".[81]

117 As the author of PIR had not identified any precise provisions that had been breached in the Code of Conduct, Mr Etherington said it would have been

[75] Exhibit 1, Tab 11, Statement of Betty Mogridge dated 5/9/2020
[76] Exhibit 1, Tab 1, P100 – Western Australia Police Report of Death
[77] Exhibit 1, Tab 25.14, Post Incident Review Report dated 15 July 2020
[78] Exhibit 1, Tab 25.14, Post Incident Review Report dated 15 July 2020, p.29
[79] Exhibit 1, Tab 29, Report of Daniel Etherington dated 17/3/2023, p.1
[80] Exhibit 1, Tab 29, Report of Daniel Etherington dated 17/3/2023, p.2; Letter from John Hayes to counsel assisting dated 18/4/2023, p.1
[81] Exhibit 1, Tab 29, Report of Daniel Etherington dated 17/3/2023, p.2

appropriate for the Deputy Director to confer with "*health staff to find out specifically where they may have breached their own processes.*"[82] However, in this case, that was not done. It was disquieting to read that Ms Stewart did not even receive a copy of the PIR report until 6 October 2022.[83] This was nearly two years after the entry on the PIR tracker system was made. As of 6 October 2022, Ms Finlay was no longer employed by Serco.[84]

118 Had Ms Stewart been consulted, as she should have been, I expect she would have informed those responsible for determining whether disciplinary action be taken that (i) Ms Finlay failed to apply policy and procedure that required Shane's complaint of chest pains be given urgent medical attention and (ii) a proper review of EcHO by Ms Finlay would have identified a number of cardiovascular risk factors for Shane.

119 At the inquest, I expressed the view that the response to the PIR report's recommendations was "*entirely unsatisfactory*", and I gave Serco the opportunity to obtain a statement from the Deputy Director of Acacia to explain the course of action (or it seemed lack of action) that he took.[85] The Court received a response by email from Serco's solicitor with various attachments, including a letter dated 18 April 2023 from John Hayes, Serco's General Manager, Operational Performance.[86] On 12 September 2023, following another invitation from the Court, further submissions from Ms Cormann, counsel for Serco, were provided to the Court. I have also read and considered those submissions.

120 Regrettably, this additional material shed little light on what I wanted to find out. In his letter, Mr Hayes noted that the two Serco employees responsible for the decision, namely the Deputy Director and the Assurance Officer at Acacia, were no longer employed by Serco. Mr Hayes then stated: "*Despite searches, we have been unable to locate any other records (e.g. meeting minutes or otherwise) that document the basis of the decision and how it was reached.*"[87]

121 Mr Hayes accepted, correctly in my view, that Ms Finlay's decision on 27 May 2020, "*could be considered a breach of the Acacia Prison Code of Conduct, whereby clause 19.1.2 requires that all staff comply with 'policies and procedures'.*"[88]

122 He also conceded:[89]

[82] ts 22/3/2023 (Mr Etherington), p.154
[83] Exhibit 1, Tab 25.17, Email from Pansey Stewart dated 6/10/2022
[84] Exhibit 1, Tab 25.17, Email from Pansey Stewart dated 6/10/2022
[85] ts 22/3/2023, p.154
[86] Email dated 18 April 2023 from Diviij Vijayakumar to counsel assisting dated 18/4/2023 with attachments
[87] Letter from John Hayes to counsel assisting dated 18/4/2023
[88] Letter from John Hayes to counsel assisting dated 18/4/2023, p.2
[89] Letter from John Hayes to counsel assisting dated 18/4/2023, p.2

> We at Serco remain unable to explain why it was determined that the nurses' conduct, and in particular, Nurse Finlay's decision on 27 May 2020, was not a breach of the Code of Conduct, nor why it was concluded that disciplinary hearings to ascertain the answer to that question (as recommended) were not thought to be required.

123 Mr Hayes made the fitting concession that he considered it was not only appropriate for Serco to have implemented all recommendations but, at the very least: [90]

> I consider it would have been necessary to have a thorough, documented and transparent record of the consideration given to the [PIR] report and recommendations, as well as documentation of any consultation including with health care management, if any decision contrary to the recommendations was contemplated.
>
> That this does not appear to have happened in this case is unacceptable.

124 I completely agree with Mr Hayes' conclusion that what occurred following the PIR, or more accurately did not occur, was "*unacceptable*".

125 Mr Hayes outlined the changes that have been made at Serco since Shane's death to the structure and responsibilities in the integrity and professional standards, investigative, audit and reporting processes. This includes the post-incident review process.[91] Those changes are encouraging and if followed, I would not expect to see another unedifying outcome like the one from the PIR into Shane's death.

126 A question that arises from the failure by Serco to initiate its own disciplinary procedures is whether I should exercise my powers under section 50(1) of the *Coroners Act 1996* (WA) and refer Ms Finlay's conduct not to assess Shane's complaint of chest pains as requiring urgent medical attention to the Australian Health Practitioner Regulation Agency (AHPRA).

127 Having carefully considered the matter, and noting the passage of time and that Ms Finlay is no longer employed by Serco, I have decided not to make a referral to AHPRA.

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF SHANE

128 As already noted, the inquest primarily focused on Shane's treatment and care with respect to the cardiac disease which eventually caused his death.

129 Dr Janssen noted that given what was found during the post mortem examination, Shane's heart disease was, "*probably something that has been and [was] accumulating for years*".[92]

[90] Letter from John Hayes to counsel assisting dated 18/4/2023, p.2
[91] Letter from John Hayes to counsel assisting dated 18/4/2023, p.2
[92] ts 22/3/2023 (Dr Janssen), p.118

130 Although active cardiac disease had not been diagnosed before Shane's final imprisonment, Dr Catherine Gunson (Dr Gunson), Acting Director Medical Services with the Department, noted that he did have cardiac risk factors such as his First Nations ethnicity, and family history of hypertension and type 2 diabetes. In those circumstances, Dr Gunson was of the view: "*It could have been considered appropriate to place him on a Cardiac Care Plan.*"[93]

131 Additionally, Dr Gunson noted that there was no updated ECG requested for Shane, and that his last ECG was on 16 November 2017. Dr Gunson expressed the view: "*Best practice would be for an ECG to be taken at least annually, given that [Shane] had significant risk factors.*"[94] Dr Gunson did point out that during Shane's previous period in Greenough from 27 June - 8 July 2019, a task was sent to administrative staff to organise an ECG on 6 July 2019. However, as Shane was released two days later, this was not completed.[95] I note that although this task was recorded on EcHO,[96] it was never followed up when Shane returned to prison less than four months later.

132 In light of those observations, I am satisfied Shane's treatment and care with respect to his undiagnosed heart disease was sub-optimal even before his complaint of chest pains on 27 May 2020.

133 The standard of care and treatment Shane received after he had alerted Acacia health service providers of his chest pains on 27 May 2020 fell substantially short of being an appropriate standard. Arrangements ought to have been made for an urgent medical examination of his chest pains as soon as Ms Finlay read his CMS entry on the afternoon of 27 May 2020. That did not occur and I have found this was a serious error.

134 Then, when Shane did not turn up to his nurse appointment with Ms de Villiers on 31 May 2020, there should have been an immediate follow-up and every effort made to have him medically examined. That did not occur and I have found this was a missed opportunity. This meant Shane's complaint regarding his chest pains remained untreated before he collapsed on the morning of 5 June 2020.

135 Although the treatment and care provided to Shane in the aftermath of his collapse was of an appropriate standard, it was far too late to save him from his cardiac disease.

[93] Exhibit 1, Tab 27, Health Service Summary into the Death in Custody dated 16/3/2023, p.7
[94] Exhibit 1, Tab 27, Health Service Summary into the Death in Custody dated 16/3/2023, p.7
[95] Exhibit 1, Tab 27, Health Service Summary into the Death in Custody dated 16/3/2023, p.7
[96] Exhibit 1,Tab 19, EcHO medical records, p.34

CHANGES AND IMPROVEMENTS SINCE SHANE'S DEATH

136 As would be expected with all organisations and governmental departments, Serco and the Department are always on pathways to continual improvement with respect to the operations of prisons.

137 As there is often a gap of some duration between the date of a prisoner's death and the date of the mandatory inquest, often changes have already been introduced before the inquest is heard that are designed to improve practices and procedures.

138 In this matter, there have been changes made by Serco (and also the Department) since Shane's death that are designed to ensure the serious error and missed opportunity that arose in his death do not occur again.

Changes to CMS

139 After Shane's death, Serco added a disclaimer when prisoners accessed CMS for a health care appointment which read:[97]

> The CMS App for health care is an enquiry system only. If your issue is urgent, please let your officers know and they will contact medical to arrange an urgent appointment. Please advise your officer immediately if you have chest pain, shortness of breath or a flu-like illness.

140 Unlike the once daily review of CMS by a health service provider at the time of Shane's death, the CMS enquiry system is now reviewed and responded to three times a day, seven days a week. This three times daily review, "*provides greater assurance and coverage of risk, should a prisoner not follow the parameters of raising urgent health issues with custodial staff for immediate assessment.*"[98]

141 In addition, Serco has provided relevant health service providers at Acacia with additional education and guidance when responding to CMS requests.[99] This training has included the implementation of a CMS Nurse Triage Form to assist nurses to categorise requests. A complaint of chest pain is expressly included in category 1 which mandates an urgent medical response.[100]

142 The health care pamphlet given to prisoners who are transferred to Acacia has been updated to include information about the use of CMS.[101]

143 One aspect of CMS that has not changed is the requirement for a prisoner to check CMS for when their requested medical appointment has been scheduled. It is not known whether Shane was aware of his scheduled appointment on 31 May 2020,

[97] Exhibit 1, Tab 25.13, Acacia Health Summary dated 20/10/2020, p.7
[98] Exhibit 1, Tab 25.13, Acacia Health Summary dated 20/10/2020, p.7
[99] Exhibit 1, Tab 25.13, Acacia Health Summary dated 20/10/2020, p.7
[100] Exhibit 1, Tab 30, Report of Pansey Stewart dated 14/3/2023, p.3; Exhibit 1, Tab 25.16, CMS Enquiry Nurse Triage
[101] Exhibit 1, Tab 30, Report of Pansey Stewart dated 14/3/2023, p.3

and the evidence before the inquest was that no check can be made to confirm whether the prisoner has actually accessed CMS to see when their appointment has been scheduled.[102]

144 However, there is another safeguard that involves administrative staff each evening delivering white slips of paper to a unit identifying those prisoners in the unit who have a medical appointment the next day.[103]

145 The course of action if a prisoner does not attend his appointment is for a call to be made to the prisoner's unit. That was the system in place in May 2020 and, as I understand it, is the system that is still in place. Although this system is not perfect, as illustrated by Shane's failure to attend his appointment on 31 May 2020, I note that medical appointments booked through CMS are for non-urgent matters. So the consequence of not attending an appointment should no longer be as catastrophic as it was for Shane.

146 I am satisfied that the measures now in place at Acacia should significantly reduce the risk of a prisoner being left untreated for chest pains that he has reported to prison staff.

Chronic Diseases Co-ordinator

147 For some time now, there has been a Chronic Diseases Co-ordinator employed by the Department who conducts reviews of case notes in order to identify prisoners who will benefit from being placed onto the Chronic Disease Management Plan. These plans include prisoners who are identified with a cardiac disease.[104] Placement on the plans, "*is designed to flag patients who have risk factors for the development or worsening of their health conditions, and assigns reminder prompts in files so that regular appointments are generated for monitoring.*"[105]

148 A cardiac care plan includes three annual reviews, comprising of a nurse review at three months and nine months, and a doctor's review at six months. There are also blood tests and ECGs routinely performed.[106]

CONCLUSION

149 Shane was only 40 years old when he died at Acacia on 5 June 2020. He was a much loved member of his family.

[102] Exhibit 1, Tab 25 Review of Death in Custody dated January 2023, p.12; Exhibit 1, Tab 25.16, Email from Toni Palmer dated 5/1/2023
[103] ts 21.3.23 (Ms Finlay), p.15
[104] Exhibit 1, Tab 27, Health Services Summary into the Death in Custody dated 16/3/2023, p.8
[105] Exhibit 1, Tab 27, Health Services Summary into the Death in Custody dated 16/3/2023, p.8
[106] ts 21/3/2023 (Dr Gunson), p.99

150 Shane had not accessed any health care in the community. Consequently, his health care when he was imprisoned was particularly important, as his periods of imprisonment presented opportunities to identify health issues that could be treated.[107]

151 Unfortunately, Shane had a significant cardiac disease that was not identified. His last ECG in November 2017 did not find any evidence of the cardiac disease that was to cause his death less than three years later.

152 On 27 May 2020, Shane made his first recorded complaint to prison medical staff that he was experiencing chest pains. Although such a complaint should have received an urgent medical response, that did not occur. Instead, an appointment was made for Shane to see a prison nurse four days later. He did not attend that appointment and, regrettably, there was no follow-up to ensure his chest pains were examined promptly.

153 On the morning of 5 June 2020, Shane suddenly collapsed and became unresponsive. Despite an appropriate medical response to Shane's collapse, he died a short time later of coronary artery atherosclerosis.

154 I have found that a serious error was committed by the nurse who reviewed Shane's complaint of chest pains on 27 May 2020. She should have arranged an urgent medical examination for Shane once she had read his CMS request to see a prison doctor. I have also found there was a missed opportunity in not having Shane medically examined as a matter of priority when he failed to attend his nurse appointment on 31 May 2020.

155 I accept the two nurses involved in these matters were "*long term, experienced nurse employees of Serco at Acacia* " and that they were *"thorough and dedicated clinicians who were careful in their patient assessments and conduct, and care of all patients*".[108] I am therefore satisfied that the serious error made by Ms Finlay on 27 May 2020 was an aberration and was in no way a reflection of her usual high standards of prisoner care.

156 Nevertheless, it was an error that meant Shane's cardiac disease was left untreated, and he died nine days later from this disease. Based on the evidence of Dr Jansson, there was every likelihood that Shane would have survived his heart disease had he received prompt hospital treatment immediately after 27 May 2020.

157 Serco has made a number of changes to its CMS at Acacia that ought to eliminate the risk of what happened to Shane occurring again with another prisoner who

[107] Exhibit 1, Tab 27, Health Services Summary into the Death in Custody dated 16/3/2023, p.9
[108] Exhibit 1, Tab 30, Report of Pansey Stewart dated 14/3/2023, p.4

complains of chest pains. In those circumstances, I have not deemed it necessary to make any recommendations.

158 On the last day of the inquest, Shane's sister read out a statement from Shane's family. Included in that statement was the following:[109]

> Shane was a person who loved and cared for his family. He was a loving son, brother, brother-in-law, father-in-law, uncle, cousin and friend. Shane was a kind person and respected everyone. He had a smile that lit up the room.
>
> …
>
> When Shane found out that he was going to be a Pop he was so happy.
>
> Shane would always be missed and loved by his family, cherished in our hearts forever.

159 On behalf of the Court, and as I did at the conclusion of the inquest, I extend my condolences to Shane's family and loved ones, particularly his mother and his nine children, for their sad loss.

P J Urquhart
Coroner
14 September 2023

[109] ts 22/3/2023 (Ms Narrier), p.174