Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 25/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Judy Sonia BOLTON*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***24 – 25 June 2019*** *and* ***1 August 2019*** *find that the identity of the deceased person was* ***Judy Sonia BOLTON*** *and that death occurred on* ***10 December 2016*** *at* ***Royal Perth Hospital****, from* ***acute myocardial infarction due to a coronary thrombosis*** *in the following circumstances:-*

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner.
Ms N Eagling (State Solicitor's Office) appeared on behalf of the Department of Justice (DOJ) and the East Metropolitan Health Service.
Mr S Castan appeared on behalf of Ms Bolton's family.

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INTRODUCTION[1]

1. Judy Sonia Bolton (the deceased) died at Royal Perth Hospital (RPH) on 10 December 2016 from acute myocardial infarction due to a coronary thrombosis.

2. At the time of her death the deceased was in the custody of the Chief Executive Officer of the Department of Corrective Services, as it then was.[2] She had been remanded in custody to Bandyup Women's Prison (the Prison).[3]

3. Accordingly, immediately before her death, the deceased was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) (Coroners Act) and her death was a "*reportable death*".[4]

4. In such circumstances, a coronial inquest is mandatory.[5] Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[6]

5. I held an inquest into the deceased's death on 24-25 June 2019 and 1 August 2019. Members of the deceased's family were in attendance.

6. The documentary evidence adduced at the inquest included independent reports concerning the deceased's death prepared by the Western Australia Police Force[7] and by the Department of Justice[8] respectively. Together, the Brief comprised two volumes. I was also assisted by statements from members of the deceased's family and several former inmates of the Prison.

7. The inquest focused on the care provided to the deceased while she was in custody, the circumstances of her death and some concerns raised by members of the deceased's family.

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[1] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report
[2] Section 16, *Prisons Act 1981* (WA)
[3] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review, pp6-7
[4] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[5] Section 22(1)(a), *Coroners Act 1996* (WA)
[6] Section 25(3) *Coroners Act 1996* (WA)
[7] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report
[8] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review

8. The following witnesses gave oral evidence at the inquest:

i. Ms G Owen (clinical nurse, DOJ);

ii. Ms L Rodney (custodial officer, DOJ);

iii. Mr B Yagmich (custodial officer, DOJ);

iv. Dr J Spiro (Interventional Cardiology Consultant, Royal Perth Bentley Group);

v. Professor P Sullivan [Clinical Services Director, St John Ambulance Western Australia (St John)];

vi. Mr R Mudford (senior performance analyst, DOJ);

vii. Ms C Hall, (custodial officer, DOJ);

viii. Dr J Rowland (Director, Medical Services, DOJ); and

ix. Ms B Lagozzino (shared a cell with the deceased).

THE DECEASED

Background[9,10]

9. The deceased was born in Perth in 1972 and was 44-years of age when she died at RPH from acute myocardial infarction due to a coronary thrombosis.

10. The deceased was the youngest of nine children[11] and when she was growing up, she was exposed to domestic and family violence. Her parents were reported to have consumed alcohol on a daily basis.[12].

11. The deceased reported a happy childhood despite extreme financial hardship. She completed Year 8 at secondary school and was said to enjoy basketball and netball.

12. The deceased said that members of her extended family regularly drank at the family home and that she and her siblings learnt 'protective behaviours' to avoid the risk of being sexually abused.

13. The deceased had her first child at the age of 14-years[13] and she and her partner had a total of 10 children, including two sets of twins. The deceased reported that her partner was "*an alcoholic and drug user*" who inflicted "*severe domestic violence*" on her on a regular basis.[14] When the deceased's partner died unexpectedly in 2015, the deceased said her "*world turned upside down*" and she began using amphetamines on a daily basis.[15]

14. The deceased was described as a kind and humble person who, though not rich in a material sense, was rich in heart. She was said to be a caring mother and grandmother who provided for her family, her mother and her siblings,[16] and was described as the backbone of her family.[17]

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[9] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review, pp5-6 and ts 14.05.19 (Mudford), p8
[10] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report
[11] Or alternatively one of 10 children, see Statement - Ms B Bolton (24.06.19), para 10
[12] Exhibit 1, Vol. 2, Tab 1-G, Report - Dr Rowland (11.06.19), p2
[13] Or alternatively, at 15-years of age, see Statement - Ms B Bolton (24.06.19), para 13
[14] Exhibit 1, Vol. 2, Tab 1-G, Report - Dr Rowland (11.06.19), p2
[15] Exhibit 1, Vol. 2, Tab 1-G, Report - Dr Rowland (11.06.19), p2
[16] Statement - Mr C Bolton (02.07.19), paras 9-12
[17] Statement - Ms B Bolton (24.06.19), para 25

Offending History

15. During the period 1986 - 2016, the deceased was convicted of numerous offences including stealing, burglary, assault, resisting arrest, vehicle offences, possession of prohibited drugs and breach of bail and community orders. Fines were usually imposed for these offences, but the deceased was sentenced to imprisonment on perhaps 5 occasions.[18,19]

Circumstances of most recent incarceration

16. On 6 August 2016, the deceased was remanded in custody with respect to charges including: aggravated armed robbery, aggravated burglary and stealing.[20]

17. On 19 October 2016, the deceased was charged with further offences, including: trespass, breaches of community orders, possession of stolen property, possession of cannabis and methylamphetamine, gaining a benefit by fraud, breach of bail and possession of drug paraphernalia.[21]

18. During her admission to the Prison on 6 August 2016, the deceased denied any history of self-harm or suicidal ideation. However, she was teary during the admission interview and said she was worried about her children.[22] She later said she felt "*OK*" after a custodial officer helped her phone her daughter.[23] The deceased was not assessed as being at risk and was not placed on the At Risk Management System.[24]

19. The deceased occupied a shared cell (A18) in Unit one[25] at the Prison from 16 September 2016 onwards.[26] She received regular visits from her family with the last visit recorded on 4 December 2016. She also maintained regular telephone contact with her daughter.[27,28]

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[18] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review, p6
[19] Exhibit 1, Vol. 1, Tab 24, Criminal History
[20] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review, pp6-7
[21] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review, pp6-7
[22] Exhibit 1, Vol. 1, Tab 30.4, At Risk Management System - Intake Assessment
[23] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review, pp6-7
[24] Exhibit 1, Vol. 1, Tab 30.4, At Risk Management System - Intake Assessment
[25] Also sometimes referred to as Unit A, see Exhibit 3, Unit plans and photographs
[26] Exhibit 1, Vol. 1, Tab 30.7, Cell Occupancy History - cell A18, unit one
[27] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review, p6
[28] Exhibit 1, Vol.1, Tabs 30.8, TOMS Visits History & 30-9, Prison Telephone System recordings

Overview of Medical Conditions

20. During an admission to prison in early 2016, the deceased was noted to be grieving for her partner who had recently died. She reported using amphetamine and cannabis and was noted to be a heavy smoker of cigarettes. The deceased was diagnosed with high blood pressure and it was noted that during her pregnancies, she had pre-eclampsia with hypertension.[29,30]

21. The deceased was never diagnosed with ischaemic heart disease and was not reported to have complained of chest pains prior to 10 December 2016.[31]

22. The deceased had a number of significant risk factors for cardiac disease. These included: her Aboriginality, history of adverse childhood events, obesity, cigarette smoking, illicit drug use and high blood pressure.[32] A further risk factor that was not picked up until November 2016, was that the deceased had abnormal lipid levels. This, in combination with her other risk factors, led to her being assessed as being at high risk of cardiovascular disease from that time.[33]

23. Blood tests to check her lipid levels had been ordered on 12 August 2016, but samples were not taken as planned on 31 August 2016. On 16 September 2016, blood tests were ordered again, but an attempt to take samples on 28 September 2016 was unsuccessful and the tests were rebooked on 25 October 2016. The deceased did not attend her phlebotomy appointment on 8 November 2016 at which a blood sample would have been taken, and this finally occurred on 16 November 2016.[34]

24. On 5 December 2016, the deceased did not attend an appointment with the prison doctor at which her abnormal lipids would have been discussed. She also did not attend appointments with the prison nurse on 7 or 8 December 2016.[35]

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[29] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review, pp7-8
[30] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p2
[31] ts 25.06.19 (Rowland), p173
[32] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p10
[33] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p9
[34] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), pp7-8
[35] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p9

25. If an earlier blood test had shown abnormal lipid levels, then the deceased's high risk of cardiovascular disease would presumably have been identified at a much earlier stage. Efforts to assist the deceased to curb her smoking, manage her weight and make appropriate food choices would then have been possible, again at a much earlier stage.

26. However, noting that at the relevant time the Prison's medical centre was struggling to cope because of staff shortages and the number of high needs prisoners in the Prison, it is perhaps unlikely that comprehensive, proactive health prevention strategies would then have been possible.

27. Given the imponderables in this case, it is impossible to know whether the outcome would have been different had the deceased's blood been tested in August 2016 as opposed to November 2016, although clearly this would have been preferable.

28. The deceased's blood pressure was monitored from time to time while she was in prison and was often high. For example, during her last admission to the Prison, the deceased's blood pressure was subject to close monitoring from 6 – 12 August 2016. However, Dr Rowland, who conducted a review of the deceased's medical file, identified a worrying pattern:

> *On several occasions when Ms Bolton was found to have severe hypertension, repeat measurements are not documented, and nor is a complete symptom check for hypertensive crises documented. Monitoring of Ms Bolton's blood pressure followed a pattern of rapid de-escalation as soon as a 'normal' or 'near normal' reading was obtained – typically with booked nurse checks reverting to an 'as required' process (i.e.: patient initiated) rather than being maintained regularly following a period of frequent monitoring.*[36]

29. The Department properly conceded that the deceased should have been subject to more regular and proactive monitoring of her blood pressure.[37]

[36] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), pp6-7 & p11
[37] ts 25.06.19 (Eagling), p192

30. Had this regular monitoring occurred, nursing staff would also have had the opportunity to deliver more regular and consistent education to the deceased about the importance of cutting down her smoking, managing her weight and making healthy food choices.

31. Although the deceased was generally compliant with her blood pressure medication when she was in prison, this was not the case when she was in the community. For example, on 12 April 2016, the deceased told a prison nurse that she "*took no medication when in the community*".[38]

32. As a result of better medication compliance whilst in custody, the deceased's blood pressure improved during her last incarceration. However, despite seeking help to manage her weight on at least two occasions (and being given advice and food diaries),[39] the deceased seemed resistant to making lifestyle changes. Specifically, she continued to smoke cigarettes, she took little exercise and her dietary choices appear to have been less than ideal.[40]

33. In the period 16 September 2016 to 16 November 2016, the deceased's weight increased by 7.2 kilograms. This was no doubt partly due to the fact that she reported drinking 1.25 litres of Coke per day, but there are other explanations.[41] Dr Rowland noted that people are often malnourished when they come into prison because instead of spending money on food in the community, they spend it on illicit substances. In prison, food is readily available and free and this, coupled the relative lack of activity in prison when compared to the community, can result in weight gain.[42]

34. A further explanation for the deceased's rapid weight gain in the period leading to her death may have been her use of the antipsychotic medication, quetiapine. Post mortem toxicological testing found a therapeutic level of the quetiapine in the deceased's system.[43]

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[38] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p6
[39] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), pp8-9
[40] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p10
[41] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p8
[42] ts 25.06.19 (Rowland), p169
[43] Exhibit 1, Vol. 1, Tab 8, ChemCentre Toxicology Report

35. Dr Rowland confirmed that weight gain is a well-known side effect of quetiapine.[44] The deceased was not prescribed this medication and it is unclear how it came to be in her system.[45] Due to its sedative properties, quetiapine is a desirable drug and is known to be "trafficked" in the prison system. It is therefore possible that the deceased obtained some illicitly.[46]

36. As to the deceased's pattern of non-attendance at scheduled appointments and apparent resistance to making lifestyle changes, Dr Rowland observed:

> *Ms Bolton's pattern of interaction with Health Services and her lifestyle choices are not atypical for patients who come from a background of traumatic childhoods and/or have been exposed to violence of trauma in relationships.*[47]

37. Developing a therapeutic relationship and encouraging lifestyle changes can be difficult with patients such as the deceased. As Dr Rowland noted:

> *When treating patients with such adverse experiences, it can take more time to build trust and to optimise uptake of health services offered, and lifestyle changes are challenging for everyone but more so where the lifestyle, such as cigarette or drug abuse, plays a role in stress management.*[48]

38. Dr Rowland considered that whilst the deceased's cardiovascular risk factors may have prompted "*more aggressive management*", particularly of her blood pressure and cholesterol levels[49]:

> *Even if all known and modifiable risk factors had been addressed whilst Ms Bolton was in custody it is impossible to know if the final outcome would have been altered given the decades of risk relative to this short period of time in custody, the significant non-modifiable risks and the undisclosed risk factors which may have been present – including obtaining and using non-prescribed medications.*[50]

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[44] ts 25.06.19 (Rowland), p169
[45] ts 25.06.19 (Rowland), p169
[46] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p11
[47] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), pp8-10
[48] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), pp8-10
[49] ts 25.06.19 (Rowland), p173
[50] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p11

THE EVENTS OF 10 DECEMBER 2016

39. At about 5.30 pm on 10 December 2016, the deceased developed pain whilst eating dinner and tried to "*walk it off*" prior to seeking help.[51]

40. At about 5.53 pm, she rang her daughter and said she was having chest pains and was going to lie down for a moment. At 5.59 pm, the deceased rang her daughter back to say that her symptoms related to indigestion and that she was feeling better.[52,53]

41. At 6.15 pm on 10 December 2016, the Unit one control officer (Officer Rodney), received a cell call alarm from cell A17 indicating that the deceased was sitting outside her cell not feeling well.[54,55]

42. In her statement,[56] Officer Rodney could not recall if she was told that the deceased was having chest pains, but in a report completed after the incident, Officer Rodney stated:

> *At approximately 1820 hrs I received a cell call from Cell A17 that...*[the deceased]*...was outside her cell not well with chest pains.*[57]

43. Given that the report was submitted almost 2½ years before she made her statement, I find that Officer Rodney was told that the deceased was experiencing chest pains during the cell call she received. It is also clear that the more accurate timings with respect to the cell call records should be taken from the electronic cell alarm log.

44. Just as Officer Rodney was about to react to the cell alarm, she saw Officers Hall and Yagmich approaching the Unit one control room and asked them to check on the deceased. A short time after they left to do so, Officer Rodney heard a 'Code Green' call on the two-way radio.[58]

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[51] Exhibit 1, Vol. 1, Tab 11, St John Ambulance – Patient Care Record, p2
[52] Exhibit 1, Vol. 1, Tab 30.9, Prison Telephone System Recordings
[53] The audio recording of these phone calls doesn't agree with paras 32-33 of Ms B Bolton's statement
[54] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, paras 8-9 & ts 24.06.19 (Rodney), p52
[55] Exhibit 1, Vol. 1, Tab 30.12, Cell Call Log
[56] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, paras 8-9
[57] Exhibit 1, Vol. 1, Tab 17, Incident Description Report - Officer Rodney
[58] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, paras 10-11 & ts 24.06.19 (Rodney), p54

45. The phrase 'Code Green' is used by custodial officers at the Prison to indicate, amongst other things, a non-emergency situation that requires the attendance of a custodial officer, a nursing officer or both, as appropriate.[59]

46. Within a couple of minutes, two custodial officers (known as recovery officers) and Nurse Owen arrived at Unit one. Officer Rodney opened the metal access gate next to the control room to allow them to enter the unit.[60]

47. At the relevant time, the muster at the Prison was much higher than usual and all cells were "doubled up", meaning that two prisoners shared a single cell. The reason for the higher muster at that time was that a new remand facility for female prisoners had yet to open and so the Prison held a greater than usual number of remand prisoners. The new remand facility opened in late December 2016.[61]

48. It appears that as many as 34 prisoners may have been in the Unit one courtyard at the time the 'Code Green' was called.[62] In any case, in accordance with her usual practice, Nurse Owen attended Unit one with a wheelchair and first aid equipment.[63,64]

49. Nurse Owen says she left the wheelchair she brought from the medical centre outside the Unit one control room and went inside the unit to assess the deceased. After making her initial assessment, Nurse Owen helped the deceased walk across the courtyard to the control room and then took her to the Prison's medical centre for further assessment.[65]

Was the prison in lock-down on 10 December 2016?

50. The deceased's family raised a concern about whether the Prison in general, and the deceased in particular, were in "*lock down*" at the relevant time.[66] When the Prison is in "*lock down*", prisoners are confined to their cells.

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[59] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, paras 12 & ts 25.06.19 (Hall), p116
[60] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, para 13 & ts 24.06.19 (Rodney), p55
[61] ts 24.06.19 (Owen), p11 and ts 25.06.19 (Rowland), pp155-156
[62] Exhibit 1, Vol. 1, Tab 28, Statement - Nurse Owen, para 22
[63] Exhibit 1, Vol. 1, Tab 28, Statement - Nurse Owen, para 20 & ts 24.06.19 (Owen), p12
[64] ts 24.06.19 (Rodney), p55
[65] ts 24.06.19 (Owen), p16
[66] Statement Mr C Bolton (02.07.19), para 18(a)

51. The family's understandable concern appears to be directed to whether the deceased received appropriate care at the time she reported feeling unwell.

52. It appears that prisoners in Unit one were in "*lock down*" from sometime after breakfast on 10 December 2016 to about mid-afternoon. When they were unlocked, prisoners on Unit one were given the choice to remain in the unit, or to go to a recreation area.[67]

53. The dinner muster occurred at about 5.00 pm, at which time, prisoners were still out of their cells.[68] As noted, the deceased first complained of feeling unwell at about 5.30 pm and she called her daughter twice just before 6.00 pm.[69,70]

54. The evidence of Officer Rodney, Nurse Owen and Ms Lagozzino (who was sharing a cell with the deceased at the relevant time) makes it clear that at the time the 'Code Green' was called, prisoners in Unit one were not in lock down.[71,72,73]

55. When the 'Code Green' was called, Officer Rodney used the PA system in the control room to tell all prisoners in Unit one to return to their cells, but this direction was not complied with and prisoners remained in the courtyard.[74]

Was Nurse Owen's initial assessment appropriate?

56. Officer Hall said that the deceased was sitting outside cell A17 and when she approached, the deceased told her that she had been experiencing a tight chest for "*20 minutes*". Officer Hall, who called the Code Green emergency, could not recall if she used the words "*chest pains*" during that call.[75]

57. Nurse Owen recalled hearing the 'Code Green' with respect to the deceased, but did not recall hearing the words "*chest pains*" being used to describe the nature of the emergency.[76]

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[67] ts 01.08.19 (Lagozzino), pp4-5 & p23
[68] ts 01.08.19 (Lagozzino), p5
[69] Exhibit 1, Vol. 1, Tab 30.9, Prison Telephone System Recordings
[70] The audio recording of these phone calls does accord with paras 32-33 of Ms B Bolton's statement
[71] ts 01.08.19 (Lagozzino), p23
[72] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, para 8 & ts 24.06.19 (Rodney), p57
[73] Exhibit 1, Vol. 1, Tab 33 Statement - Nurse Owen, para 20 & ts 24.06.19 (Owen), p12
[74] ts 24.06.19 (Rodney), p57 and ts 24.06.19 (Owen), p17
[75] Exhibit 1, Vol. 1, Tab 34, Statement - Officer Hall, para 6 & ts 25.06.19 (Hall), p115
[76] ts 24.06.19 (Owen), p36

58. However, Officer Yagmich, who was standing next to Officer Hall when she called the 'Code Green', recalled hearing Officer Hall say "*code green medical - chest pains*".[77]

59. After careful consideration of the evidence, I am satisfied that the words "*chest pain*" were used when the 'Code Green' was called.

60. When Nurse Owen arrived at Unit one, she observed the deceased sitting outside on a chair. The deceased appeared to be calm and said she had indigestion as a result of eating some chilli tuna and noodles for dinner. Nurse Owen initially thought the deceased may have gall bladder pain or gastritis.[78]

61. Nurse Owen did not consider that the deceased was having heart issues, or indeed a heart attack, noting the deceased:

> *wasn't cold, she wasn't sweaty, she didn't look pale, she wasn't in extreme pain, she was speaking in full sentences, having a discussion with me.*[79]

62. At the inquest, Nurse Owen was asked whether it would have made any difference to her assessment of the deceased if she had been aware the deceased had chest pains and her response was:

> *if I thought that she was physically compromised there and then, which she didn't look because she wasn't cold and clammy, she wasn't sweaty, she was talking in full sentences to me, she was not in any way saying she had excruciating pain, she didn't present as someone who, typically, was having an MI…*[i.e.: myocardial infarction]…*which is what she had. If she had presented with any of those other symptoms or she looked at all physically compromised, perhaps I would have, then, asked the officers to put the prisoners away and assess her there and then. But the fact is the prisoners were all milling around and she didn't present that way.*[80]

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[77] Exhibit 1, Vol. 1, Tab 32, Statement - Officer Yagmich, para 10 & ts 24.06.19 (Yagmich), pp68-69
[78] ts 24.06.19 (Owen), pp15-16
[79] ts 24.06.19 (Owen), pp15-16
[80] ts 24.06.19 (Owen), p36

63. Nurse Owen confirmed that her clinical response to the deceased would not have been based on whether she had heard the words "*chest pains*" mentioned during the 'Code Green' call, but rather on the signs and symptoms the deceased displayed when she (Nurse Owen) assessed her.[81]

64. The temperature in the courtyard at the relevant time was still very hot and there were a number of prisoners milling about. As a consequence, Nurse Owen decided to take the deceased to the medical centre for further assessment. Apart from the fact that the medical centre was air-conditioned, it contained all of the equipment needed to thoroughly assess the deceased.[82]

65. Nurse Owen's evidence about her initial assessment of the deceased[83] is corroborated by Officer Yagmich who said that when he and Officer Hall checked on the deceased at Officer Rodney's request, the deceased was apologetic for "*causing a fuss*". Officer Yagmich said that at the time he spoke with the deceased, she:

> *was very relaxed and was not showing any symptoms which caused me to think she was unwell or having a suspected heart attack.*[84]

66. In passing, I note that since July 2018, a 'Code Red Medical Emergency' is now called at the Prison in relation to all incidents relating to any chest pain (ischaemic or otherwise). A 'Code Red Medical Emergency' requires an immediate response (at speed) and involves all available medical and nursing staff.[85]

67. It is unclear whether this practice is being followed in all Western Australian prisons, although there was evidence at the inquest that a 'Code Red Medical Emergency' is called for chest pain at Wooroloo Prison. There would appear to be no good reason why a prisoner experiencing chest pain in any prison in Western Australia, ought not to be treated in the same way.

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[81] ts 24.06.19 (Owen), p36 & p41
[82] ts 24.06.19 (Owen), p16
[83] ts 24.06.19 (Owen), p17
[84] Exhibit 1, Vol. 1, Tab 32, Statement - Officer Yagmich, paras 9 & 11 & ts 24.06.19 (Yagmich), p64
[85] ts 24.06.19 (Owen), p42 & Incident Response Emergency Procedures (June 2019), p9

68. I would therefore urge the Department to consider introducing the 'Code Red' protocol for chest pain in all prisons in Western Australia, if this has not already been done.[86]

69. Relevantly, Dr Rowland noted that there was a difference in the way some men and women experience symptoms of "heart attack":

> *Females tend to have more subtle symptoms and not realise how serious the pain is and believe the pain to be something else like, you know, indigestion or shoulder pain or eating too much, etc…partly because they don't consider themselves at risk of heart attack, whereas men get a pain and they tend to catastrophise a little bit faster…*
>
> *But it is known that females can have subtle symptoms, can frequently miss their presentation, and in emergency departments on risk management, being female does change your threshold for assessment for chest pain.*[87]

70. This gender difference may explain why the deceased did not seek help for her chest pains for almost 50 minutes. As noted, the evidence is that the deceased first experienced chest pains at around 5.30 pm on 10 December 2016, and she appears to have assumed they were caused by indigestion.[88]

71. After carefully considering the evidence, I am satisfied that Nurse Owen's initial assessment of the deceased was reasonable. The signs observed by Nurse Owen and the symptoms reported to her by the deceased did not suggest that the deceased was having heart issues or indeed, a heart attack at that time.

72. Further, I find that Nurse Owen's decision to take the deceased to the medical centre for further assessment was appropriate in all of the circumstances.

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[86] ts 25.06.19, p194
[87] ts 25.06.19 (Rowland), pp172-173
[88] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record, p2

Did the deceased walk to the medical centre?

73. After making an initial assessment of the deceased and deciding to take her to the medical centre for further assessment, Nurse Owen decided that it was not necessary to bring the wheelchair from the control room (where she had left it) to where the deceased was sitting because:

> *Ms Bolton didn't present as being acutely unwell. She presented as a person who was suffering indigestion and was happy to walk with me across to where the wheelchair was at the gate.*[89]

74. Nurse Owen said that the deceased walked about 15 metres to the unit control room where the wheelchair had been left.[90]

75. The cells in Unit one are arranged in a hollow square around a central courtyard. A control room, which looks into the courtyard, is located in the north-west corner of the courtyard. On the basis of the Unit one plan, I conclude that the straight-line distance from cell A17 to the control room is about 30 metres.[91]

76. When pressed as to why she didn't bring a wheelchair to the deceased, Nurse Owen said that she didn't feel this was necessary. She said she was responding to a Code Green, indicating that the situation was not acute. Nurse Owen had noted the deceased's symptoms were consistent with indigestion and also said she didn't feel it was safe to manoeuvre the wheelchair across the courtyard given the number of prisoners milling about and the various obstacles (e.g.: chairs, plants, tables) in the courtyard.[92]

77. Once she got the deceased to the control room, Nurse Owen says that she placed her into the wheelchair and wheeled her back to the medical centre escorted by the two recovery officers.[93]

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[89] ts 24.06.19 (Owen), p16
[90] ts 24.06.19 (Owen), p15
[91] Exhibit 3, unit one plan and photographs
[92] ts 24.06.19 (Owen), p16 & p 17
[93] ts 24.06.19 (Owen), pp17-18

78. To access the Prison's medical centre, a prisoner in Unit one needs to exit through the access gate next to the control room and turn right. They would then proceed along a covered walkway to the medical centre. Once a prisoner leaves the unit to head to the medical centre, they cannot be seen by those in the courtyard.[94] Nurse Owen estimated the distance to the medical centre from Unit one was 200 metres.[95]

79. Officer Rodney said that she saw the deceased leave Unit one and head in the direction of the medical centre in a wheelchair.[96] Further, one of the two recovery officers who accompanied the deceased and Nurse Owen to the medical centre, confirmed that the deceased was taken to the medical centre in a wheelchair.[97]

80. Nurse Corcoran, the other nurse on duty at the Prison at the relevant time, first became aware of the deceased on 10 December 2016, when she saw the deceased arrive at the medical centre in a wheelchair.[98]

81. In contrast, several inmates housed on Unit one at the relevant time either said that the deceased was not offered a wheelchair, or that they did not see a wheelchair. Counsel for the deceased's family, Mr Castan, explained, that these prisoners gave statements to the National Justice Project following the deceased's death.[99]

82. For various reasons, the statements were never signed, but I agreed to accept them given that they were clearly relevant to the circumstances surrounding the deceased's death.[100]

83. Prisoner RM says that she heard the deceased vomiting in her cell after dinner. Another prisoner activated the call bell and a nurse (clearly Nurse Owen) arrived on the unit and assessed the deceased.[101]

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[94] Exhibit 3, unit one plan and photographs
[95] ts 24.06.19 (Owen), p18
[96] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, para 16 & ts 24.06.19 (Rodney), p57-58
[97] Exhibit 1, Vol. 1, Tab 39, Statement - Officer Boyd, para 6
[98] Exhibit 1, Vol. 1, Tab 40, Statement – Nurse Corcoran, para 11
[99] ts 25.06.19 (Castan), pp109-111
[100] ts 25.06.19 (Castan), pp109-111
[101] Unsworn statement RM, prisoner on unit one (18.01.18) paras 8, 12-14

84. Prisoner RM says that the deceased:

> *walked back to the medical centre with the nurse and the officer. No-one offered her a wheelchair. I didn't see a wheelchair anywhere.*[102]

85. Prisoner VJ saw the deceased after dinner and before lockdown and thought she looked really pale and unwell. The deceased told her "*I feel really funny, I have a pain*" and VJ saw the deceased rubbing her chest as if in a lot of pain.[103]

86. Prisoner VJ says she knew straight away that the deceased was having a heart attack and that she (VJ) activated her cell alarm button and told the control officer that the deceased was "*having chest pains*". Prisoner VJ says that she took the deceased's pulse and noticed a change in rhythm and that the deceased vomited again.[104]

87. With respect to whether a wheelchair was used, Prisoner VJ said:

> *There was no wheelchair brought for…*[the deceased]*… I didn't see any wheelchair or they could have got a golf buggy. There was nothing. Judy had to walk to Unit A control room – that was as far as I could see.*[105]*…Afterwards we found out she had died, we were pulled into the medical office. We hear you are upset 'yes – not everything was done for her, there was no wheelchair'. Yes there was a wheelchair at Control. 'We didn't see one'. They made her walk out. No one saw a wheelchair.*[106]

88. Ms Lagozzino, who was also an inmate on Unit one at the relevant time, provided an unsworn statement and gave evidence at the inquest. Unfortunately due to an error on the Court's part, when Ms Lagozzino answered her summons on 26 June 2019, the Court was not sitting.

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[102] Unsworn statement RM, prisoner on unit one (18.01.18) paras 8, 12-14
[103] Unsworn statement VJ, prisoner on unit one (21.12.17) paras 8-11
[104] Unsworn statement VJ, prisoner on unit one (21.12.17) paras 12-14
[105] Unsworn statement VJ, prisoner on unit one (21.12.17) para 18
[106] Unsworn statement VJ, prisoner on unit one (21.12.17) paras 26-27

89. Ms Lagozzino's evidence was rescheduled for 1 August 2019. Unfortunately, an administrative error meant that counsel for the Department and counsel for the deceased's family were not advised, and therefore did not attend the Court on that day.

90. In order not to inconvenience Ms Lagozzino further, I determined that I should hear her evidence in the absence of counsel. I ordered that counsel for the Department and counsel for the deceased's family be provided with a copy of Ms Lagozzino's, and I indicated that I would be prepared to consider any written submissions from counsel about her evidence that I received prior to close of business on Thursday, 15 August 2019.

91. By way of an email to the Court dated 8 August 2019, counsel for the Department, Ms Eagling, indicated that the Department did not intend to make any written submissions about Ms Lagozzino's evidence.

92. As at close of business on 19 August 2019, the Court had received no communication from counsel for the deceased's family, Mr Castan. I therefore proceeded on the basis that the deceased's family did not wish to make written submissions about Ms Lagozzino's evidence.

93. In her statement, Ms Lagozzino confirmed that Prisoner VJ pressed the cell alarm button in her (VJ's) cell because the deceased said she "*didn't feel right*". Ms Lagozzino said that after the cell call alarm button was pressed, there was no response and she approached a custodial officer in the unit courtyard and told the officer that the deceased was unwell. Ms Lagozzino says that the officer then called a 'Code Green'.[107]

94. At the inquest, Ms Lagozzino said that the cell alarm bell was pressed twice because of a lack of response by custodial staff.[108]

[107] Unsworn statement Ms Lagozzino, (undated), paras 22-25
[108] ts 01.08.19 (Lagozzino), p9-10

95. However, given the sequence of events established by the evidence of Officers Rodney, Hall and Yagmich,[109,110,111,112] I prefer the evidence in Ms Lagozzino's unsworn statement (which is consistent with the evidence of the officers) to her evidence at the inquest (which is not).

96. Clearly, the officer that Ms Lagozzino spoke to in the courtyard was Officer Hall, who was the officer who called the Code Green. Officer Hall had come to check on the deceased with Officer Yagmich – at the request of Officer Rodney, who in turn was responding to the cell call alarm activated by Prisoner VJ.[113]

97. It is understandable given the tragic outcome in this case, that Ms Lagozzino's recollection of the detail and sequence of events may have faded somewhat.

98. In any case, Prisoner VJ said that the deceased's pulse was racing and that the deceased had said her chest was "*hurting*".[114] I note that there is no evidence that these observations were passed on to Nurse Owen either by the deceased herself, or by anyone else.

99. Ms Lagozzino said that before the deceased left the unit with Nurse Owen, the deceased stood up, hugged Ms Lagozzino and said "*I'll see you soon*". Ms Lagozzino says she and other prisoners were then "locked down" and that she did not see the deceased after that time.[115]

100. Ms Lagozzino says that on the following day, she was taken into the office of a senior custodial officer where Nurse Owen told her what had happened to the deceased. Ms Lagozzino says the senior officer asked her to: "*spread around the prison that they had a wheelchair outside of wing*" but that she had refused to do so because she had not seen a wheelchair.[116]

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[109] Exhibit 1, Vol. 1, Tab 32, Statement - Officer Yagmich, para 10 & ts 24.06.19 (Yagmich), pp68-69
[110] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, para 13 & ts 24.06.19 (Rodney), p55
[111] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, paras 10-11 & ts 24.06.19 (Rodney), p54
[112] Exhibit 1, Vol. 1, Tab 34, Statement - Officer Hall, para 6 & ts 24.06.19 (Hall), p115
[113] Exhibit 1, Vol. 1, Tab 28, Statement - Officer Rodney, paras 10-11 & ts 24.06.19 (Rodney), p54
[114] Unsworn statement Ms Lagozzino, (undated), para 22
[115] Unsworn statement Ms Lagozzino, (undated), paras 30-31
[116] Unsworn statement Ms Lagozzino, (undated), paras 33 & ts 01.08.19 (Lagozzino), p17-21

101. Nurse Owen said she had spoken to prisoners about the circumstances of the deceased's death but denied she had ever asked prisoners to spread rumours about the use of a wheelchair.[117]

102. On 12 December 2016, Nurse Owen had a conversation with the Department's then Director, Medical Services, during which she was asked why she made the deceased walk to the medical centre. Nurse Owen said she then realised that misinformation had been circulating and on 16 December 2016, she sent the Director an email to clarify the situation.[118,119]

103. In her email, Nurse Owen confirmed that she had left the wheelchair she brought from the medical centre in front of the Unit one control room. She said the deceased walked across the courtyard with "*nil concern*" and that she pushed the deceased to the medical centre without assistance.[120,121]

104. The Unit one plan (and the photographs that accompanied it) make it clear that prisoners in the courtyard would not have been able to see the deceased after she passed through the access gate next to the control room and headed off to the medical centre.[122,123]

105. There is therefore no inconsistency between the evidence of Nurse Owen and others who say that the deceased was taken to the medical centre in a wheelchair and the evidence of several prisoners who say they did not see a wheelchair.

106. Accordingly, I find that the deceased walked across the courtyard of Unit one to the control room and was taken from there to the medical centre in a wheelchair pushed by Nurse Owen.

107. With the benefit of hindsight, it would clearly have been preferable for the wheelchair to have been brought to where the deceased was sitting.

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[117] ts 24.06.19 (Owen), p26
[118] ts 24.06.19 (Owen), pp23-24
[119] Exhibit 1, Vol. 1, Tab 33, Attachment to Statement - Nurse Owen: Email (16.12.16)
[120] ts 24.06.19 (Owen), pp23-24
[121] Exhibit 1, Vol. 1, Tab 33, Attachment to Statement - Nurse Owen: Email (16.12.16)
[122] Exhibit 3, unit one plan and photographs
[123] See also: ts 24.06.19 (Owen), p45

108. Prisoners in the courtyard could have been moved out of the way by Officers Hall and Yagmich and/or the two recovery officers. Some or all of those officers could also have helped Nurse Owen push the deceased across the courtyard in the wheelchair, or she could have been pushed along the concrete path bordering the Unit one courtyard.

109. Nevertheless, Dr Rowland expressed the opinion that on the basis of the deceased's presentation when first reviewed by Nurse Owen, the decision to ask the deceased to walk to the control room was not unreasonable.[124] I accept Dr Rowland's opinion on this point.

Events at the medical centre

110. On arrival at the medical centre, the deceased got out of the wheelchair unaided, walked inside and got onto the examination bed. Nurse Owen gave the deceased some Mylanta for her reported indigestion and Nurse Corcoran gave the deceased oxygen and aspirin.[125,126]

111. Nurse Owen took the deceased's blood pressure and oxygen saturations and Nurse Corcoran carried out an electrocardiogram (ECG).[127]

112. Nurse Corcoran did not recall the deceased complaining of chest pains, but was aware the deceased was at high risk of heart attack because of her Aboriginality, obesity, smoking and high blood pressure. As Nurse Corcoran was doing the ECG, she noticed the deceased become very clammy, cold and a bit grey.[128]

113. At about 6.35 pm, the deceased said she felt as if she was going to die and complained of a closed in feeling in her chest. Her pain score was 7/10 and her ECG was abnormal. Nurse Corcoran told Nurse Owen the deceased was having a heart attack and needed to go to hospital "*straight away*".[129]

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[124] ts 25.06.19 (Rowland), p144
[125] ts 24.06.19 (Owen), p19
[126] Exhibit 1, Vol. 1, Tab 40, Statement - Nurse Corcoran, para 12
[127] Exhibit 1, Vol. 1, Tab 40, Statement - Nurse Corcoran, para 13-15
[128] Exhibit 1, Vol. 1, Tab 40, Statement – Nurse Corcoran, para 13-15
[129] Exhibit 1, Vol. 1, Tab 40, Statement – Nurse Corcoran, para 17-18

114. At 6.36 pm, Nurse Owen rang the Officer in Charge (OIC) of the Prison to tell him the deceased needed to go to hospital by ambulance. She did this because the OIC had to make the necessary arrangements for the ambulance to get in and out of the Prison and for custodial officers to accompany the deceased. The OIC told Nurse Owen the Prison was short staffed and she called him several times to confirm that the necessary arrangements had been made.[130,131,132,133]

115. At 6.42 pm Nurse Owen sent an email to a prison doctor, (referred to as an e-consult), setting out her clinical observations concerning the deceased and stating: "*Appears to me she may be having an MI can I get an ambulance please*".[134] Nurse Owen said that her understanding of departmental policy was that she was had to seek permission from a doctor before sending a prisoner to hospital in an ambulance.[135]

116. In this case, there was no response to the e-consult and so the deceased went to hospital by ambulance anyway.[136]

117. The appropriateness of the requirement to alert the OIC of the Prison that an ambulance is required is obvious. Doing so enables the OIC to make the arrangements necessary to ensure that the ambulance enters and leaves the Prison in a timely and efficient manner.[137]

118. At the inquest hearing, I expressed concern that valuable time may be wasted if an experienced clinical nurse like Nurse Owen (who completed her training in 1980 and has worked with DOJ for over 25 years)[138] had to first seek the approval of a doctor before a prisoner could be sent to hospital by ambulance.

119. At my request, counsel for the Department provided a copy of Health Services Procedure: PM14 Patient Transfers (the Policy), by email dated 26 July 2019.

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[130] Exhibit 1, Vol. 1, Tab 33, Statement - Nurse Owen, paras 32 & 34
[131] Exhibit 1, Vol. 1, Tab 31, EcHO medical records (10.12.16), p2-3
[132] Exhibit 1, Vol. 1, Tab 30, Death in Custody Review, p11
[133] Exhibit 1, Vol. 1, Tab 33, Statement - Nurse Owen, paras 26-27 & Annexure to that statement
[134] Exhibit 1, Vol, 1, Tab 33, Statement - Nurse Owen, para 27
[135] ts 24.06.19 (Owen), p34
[136] ts 24.06.19 (Owen), p34
[137] ts 24.06.19 (Owen), p32 & p33
[138] Exhibit 1, Vol. 1, Tab 33, Statement - Nurse Owen, paras 1-5

120. The Policy was implemented in January 2015 and was current at the time of the deceased's death.[139] Paragraph 1.3.1 of the Policy relevantly provides that:

> ***Except in a medical emergency***, *any patient requiring transfer to an Emergency Department for unscheduled treatment or investigation is to be reviewed by a Medical Practitioner on duty or the Medical Practitioner on call by e-consult, prior to transfer arrangements being made.*[140] [emphasis added]

121. The Policy also requires the doctor or nurse coordinating the transfer to complete certain documentation on EcHO, the departmental medical record system, and send a copy of that documentation with the patient.[141]

122. Clearly, the intent of the Policy is that where, as in this case, the transfer arises out of an emergency situation, the prior review of the patient by a medical practitioner is unnecessary for the obvious reason that the situation is an emergency.

123. In this case, Nurse Owen's e-consult was not responded to and the deceased was transferred to hospital by ambulance without the prior review or approval of a prison doctor. It follows that Nurse Owen's misunderstanding of the policy relating to prisoner transfers to emergency departments was not significant.

124. However, one consequence of there being no response to the e-consult sent to the on-call doctor by Nurse Owen was that she was unable to administer glyceryl trinitrate spray (GTN) to the deceased. GTN, which is used in the treatment of angina, can help relieve chest pain. GTN is a schedule 3 drug which prison nurses are currently not authorised to administer on their own initiative. Instead, the prior approval of a medical officer is required.[142]

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[139] Health Services Procedure: PM14 Patient Transfers
[140] Health Services Procedure: PM14 Patient Transfers, para 1.3.1
[141] Health Services Procedure: PM14 Patient Transfers, para 1.3.2
[142] Exhibit 1, Vol. 1, Tab 33, Statement - Nurse Owen, para 34

125. As will be seen, GTN was administered to the deceased by ambulance officers after they arrived at the Prison. However, the evidence of both Dr Spiro and Dr Rowland is that any delay in giving the deceased GTN was of no consequence.[143]

126. As Dr Spiro explained:

> *GTN is not going to restore blood flow to the heart muscle, and the STEMI pathway, which this type of heart attack was one of…GTN itself may help a little bit with pain, but...it's not going to influence the underlying process and either treat the heart attack…or reduce the patient's risk of dying.*[144]

127. At the inquest, Dr Rowland said she was confident that in the very near future, a departmental committee would approve a policy change which would allow prison nurses to administer GTN.[145,146]

128. Given that GTN can be administered to prisoners by ambulance officers, this seems a very sensible initiative.

Arrival of the ambulance

129. Nurse Owen says she called "*OOO*" at 6.44 pm.[147] However, the St John patient care record suggests the call was received at either 6.45 pm or 6.47 pm.[148]

130. On the basis of the available evidence, it therefore appears that an ambulance was called between 8 - 11 minutes after the decision had been made that the deceased needed to go to hospital. As Dr Rowland noted:

> *Ideally, as soon as ischaemic chest pain is identified the ambulance would have been arranged, Priority One, and this call would have been made by someone other than the nurse.*[149]

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[143] ts 24.06.19 (Rowland), p137
[144] ts 24.06.19 (Spiro), pp81-82
[145] ts 24.06.19 (Rowland), p137
[146] See also: Exhibit 1, Vol. 2, Tab 1.O, Minutes - Drug and therapeutic committee
[147] Exhibit 1, Vol. 1, Tab 33, Statement - Nurse Owen, paras 28 & Annex A to that statement
[148] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record
[149] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p13

131. The ambulance arrived at the Prison at 6.53 pm[150] and ambulance officers were at the medical centre by about 6.55 pm and left with the deceased at about 7.10 pm.[151] Ambulance officers received a handover from the prison nurses and made two unsuccessful attempts to insert a cannula into the deceased. They transferred her to a stretcher, placed her in the ambulance and headed to the front gate of the Prison, having obtained a 12-lead ECG and transmitted this to RPH.[152]

The STEMI treatment pathway

132. Western Australia has three strategically located cardiac catheter laboratories (cath labs) at RPH, Sir Charles Gairdner Hospital and Fiona Stanley Hospital. The cath labs treat patients who have ST-elevation myocardial infarction (STEMI), a very serious type of heart attack during which one of the heart's major arteries becomes blocked.[153]

133. The standard treatment for STEMI is an urgent primary angioplasty, which involves inflation of a balloon device in the blocked vessel. ST-segment elevation is an abnormality which can be picked up by way of a 12-lead ECG. Patients with STEMI:

> *are best treated by urgent primary angioplasty, performed by an interventional cardiologist in a cardiac catheter laboratory, also known as a cath lab. This process is called CODE STEMI.*[154]

134. The standard procedure for sending ECG traces from an ambulance to a cath lab is as follows. Ambulance officers send the ECG trace to the ambulance phone via Bluetooth and from there, it is sent to a server at St John headquarters. The server electronically converts the ECG into a fax and sends it to the relevant cath lab's fax machine. The fax is then printed off at cath lab and the printed trace is then reviewed by the on-duty cardiologist.[155]

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[150] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record, p1
[151] Exhibit 1, Vol. 1, Tab 33, Statement - Nurse Owen, paras 28 & 35
[152] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record. p2
[153] Exhibit 1, Vol. 1, Tab 26, Statement - A/Professor Bailey, p1 & ts 24.06.19 (Bailey), p85
[154] Exhibit 1, Vol. 1, Tab 26, Statement - A/Professor Bailey, p1 & ts 24.06.19 (Bailey), p85
[155] Exhibit 1, Vol. 1, Tab 26, Statement – A/Professor Bailey, pp1-2

135. After transmitting the ECG trace, ambulance officers call the hospital to confirm that the fax has arrived. If STEMI is identified, then ambulance officers are instructed to administer anticoagulant medication intravenously.[156]

136. As can be seen, the convoluted process of transmitting ECG traces from an ambulance to a cath lab[157] is subject to a number of points of potential failure.[158].

137. At the inquest hearing, I was told that some States use a less complicated process of electronic transmission, where an ECG trace is able to be viewed by a cardiologist in real time.[159]

138. Nevertheless, given the leading edge service provide by the cath labs, I found it surprising that in 2019, a critical aspect of that service relies on a multi-step transmission process and the analysis of the patient's ECG trace in paper form.

139. Presumably at some point, St John will revisit the issue of whether the present system is fit for purpose, notwithstanding the fact that on the evidence before me, it apparently rarely fails.[160]

140. In this case, in accordance with standard procedure, ambulance officers called RPH to confirm that their transmission of the deceased's ECG trace had been successful and they were told it had not been received.[161]

141. Given the process currently used to transmit ECG traces, it is not possible to determine why the first attempt to send the deceased's trace was unsuccessful.[162]

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[156] Exhibit 1, Vol. 1, Tab 26, Statement – A/Professor Bailey, pp1-2
[157] Namely: Royal Perth Hospital, Sir Charles Gairdner Hospital & Fiona Stanley Hospital
[158] Exhibit 1, Vol. 1, Tab 26, Statement - A/Professor Bailey, p2
[159] ts 24.06.19 (Bailey), pp88-89
[160] ts 24.06.19 (Bailey), pp88-89
[161] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record, p2
[162] Exhibit 1, Vol. 1, Tab 26, Statement – A/Professor Bailey, p2

142. The importance of the ECG trace being reviewed in a timely manner was explained by Dr Spiro in these terms:

> *the heart attack pathway activation is only done when the ECG is confirmed as showing this type of heart attack by Royal Perth emergency department. So with that first fax not going through, that would have potentially introduced some delay in that activation happening.*[163]

143. Officers re-sent the deceased's ECG trace and this time, the fax was successfully received by RPH. The patient care record completed by ambulance officers shows that the second (successful) fax was sent at 7.04 pm, apparently successfully.[164] It follows that any delay in re-sending the deceased's ECG was likely to have been in the order of a few minutes.

Why was there a delay in the sally port?

144. After leaving the medical centre, the ambulance proceeded to the "sally port" prior to leaving the Prison. The sally port facilitates entry and exit of vehicles to the Prison. The outer gate is not opened until the inner gate is closed and the sally port has been checked.[165]

145. As the ambulance was in the sally port, officers gave the deceased GTN. A short time later, she had a "*witnessed VF arrest*". Officers lowered the deceased's stretcher, started CPR and applied defibrillator pads. As a result of their efforts, the deceased was revived.[166]

146. The officers received a phone call to say that RPH had reviewed the ECG and in accordance with the cath lab protocol, they were instructed to administer warfarin. A cannula was inserted into the deceased's right jugular vein at 7.22 pm and the anti-coagulant, heparin sodium was administered at 7.35 pm.[167]

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[163] ts 24.06.19 (Spiro), p78
[164] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record, p3
[165] ts 24.06.19 (Mudford), p108
[166] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record, pp2-3
[167] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record, pp2-3

147. Prison records show the ambulance was in the sally port at 7.20 pm and left the Prison at 7.30 pm.[168] However, St John records show that the ambulance departed the Prison at 7.25 pm and arrived at RPH at 7.48 pm.[169].

148. I am satisfied that the deceased's evacuation to RPH, which was complicated by her cardiac arrest in the Prison's sally port, was handled professionally and efficiently.

The deceased's care at Royal Perth Hospital

149. An understandable concern expressed by the deceased's family was why the deceased was taken to RPH instead of St John of God Midland Public Hospital (SJOGMH), which is about 20 minutes closer by road to the Prison. However, there is a very cogent reason why the deceased was taken direct to RPH.

150. As it happens, RPH was the closest hospital that had the specialist heart care facilities that a critically unwell person such as the deceased urgently required. As Dr Spiro explained:

> *when patients suffer this type of heart attack, there's an artery that's blocked and the patient needs to be taken as quickly as possible to a hospital facility that are able to unblock that artery, and Midland does not have that facility…*
>
> *Therefore, there's a well-established pathway that patients in the east metro region if pre-hospital are diagnosed with this type of heart attack, they bypass institutions that can't provide lifesaving care.*[170]

151. It follows that had the deceased been taken to SJOGMH first, she would have been assessed and her condition would have necessitated her transfer to RPH. For that reason, going to SJOGMH would have actually delayed her appropriate management.

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[168] Exhibit 1, Vol. 1, Tab 20, Record and Occurrences (10.12.16)
[169] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record, p1
[170] ts 25.06.19 (Spiro), p76-77

152. On arrival at RPH, the deceased was conscious and alert and she was brought to the holding bay in the cardiac care unit.[171,172] The deceased had a further VF cardiac arrest which did not respond to defibrillation and the initial resuscitation efforts of the treating team. As resuscitation efforts continued, a brief return of spontaneous circulation was achieved, but the deceased then suffered a further VF cardiac arrest and was intubated and ventilated.[173]

153. Because of her presentation (recurrent cardiac arrest secondary to acute myocardial ischaemia), Dr Spiro requested a LUCAS machine from St John and it arrived at RPH at 8.20 pm.[174,175]

154. A LUCAS machine is a device that performs automated CPR. It was required in this case because the deceased needed continuous CPR and was about to undergo potentially lifesaving stenting surgery. That surgery is performed with the guidance of x-rays and it is obviously not possible to have a human conducting CPR because of the risk of exposing them to x-rays.[176]

155. I find it surprising, that each of the cath labs[177] is not already equipped with at least one LUCAS machine, given the vital and important service they provide. Valuable time could potentially be saved if each of the cath labs had its own LUCAS machine and did not have to rely on St John to provide one when required.

156. Dr Spiro was asked whether having in-house access to a LUCAS machine would be beneficial and his response was:

> *I personally think that there is a benefit and I think that it could be shared potentially between the emergency department and cardiology. There are situations where the emergency department would perform prolonged resuscitation, so hypothermic patients and others, and, yes, I personally think it's a useful device to have access to.*[178]

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[171] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record, p1
[172] Exhibit 1, Vol. 1, Tab 9, Letter - Dr Spiro (12.12.06), p1
[173] Exhibit 1, Vol. 1, Tab 9, Letter - Dr Spiro (12.12.06), p1
[174] Exhibit 1, Vol. 1, Tab 11, St John Ambulance - Patient Care Record, p1
[175] Exhibit 1, Vol. 1, Tab 9, Letter - Dr Spiro (12.12.06), p1
[176] ts 25.06.19 (Spiro), p79
[177] Located at: Royal Perth Hospital, Sir Charles Gairdner Hospital & Fiona Stanley Hospital
[178] ts 24.06.19 (Spiro), p82

157. The total cost of three LUCAS machines (one for each of the cath labs) would be relatively modest (perhaps $60,000).[179] Although there is no evidence that the lack of immediate access to a LUCAS machine impacted on the deceased's death, I would urge the relevant Health Services to consider purchasing LUCAS machines for their respective cath labs, for the reasons so eloquently expressed by Dr Spiro.

158. The deceased was taken to the cath lab with automated CPR being performed by the LUCAS machine. Dr Spiro confirmed that the deceased had a blockage of her mid-left anterior descending coronary artery ("LAD"),[180] which is probably the most important of the coronary arteries.[181]

159. The deceased underwent a procedure (thrombus aspiration) to address the blockage in her LAD. However, this was unsuccessful and so Dr Spiro used a balloon device and managed to achieve some blood flow.[182]

160. He then inserted several stents to address other areas of blockage that were discovered. Despite further attempts to improve blood flow, the deceased's heart rhythm degenerated into an "agonal rhythm".[183]

161. Aggressive CPR was continued but the deceased did not respond and she was declared dead at 9.18 pm on 10 December 2016.[184,185]

162. Dr Spiro said that the outcome in this case would not have been different if the deceased had suffered her heart attack in hospital as opposed to the Prison. He said that heart attacks are extremely serious and that about 1/3 of patients with the deceased's condition die before an ambulance can be called.[186]

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[179] https://www.starkmed.com.au/products/physio-control-lucas-3-chest-compression-system
[180] Exhibit 1, Vol. 1, Tab 9, Letter - Dr Spiro (12.12.06), p1
[181] ts 25.06.19 (Spiro), p85
[182] Exhibit 1, Vol. 1, Tab 9, Letter - Dr Spiro (12.12.06), p2
[183] Exhibit 1, Vol. 1, Tab 9, Letter - Dr Spiro (12.12.06), p2
[184] Exhibit 1, Vol. 1, Tab 9, Letter - Dr Spiro (12.12.06), p2
[185] Exhibit 1, Vol. 1, Tab 5, Death in hospital form (RPH)
[186] ts 24.06.19 (Spiro), pp78-79

163. Dr Spiro said that what makes a difference to survival rates is time to defibrillation, noting:

> *So the paramedics, as I mentioned earlier, are extremely well-trained in this. This is their bread and butter, and they will have defibrillated and resuscitated Judy to the best of their abilities and, to be honest, as a frontline crew…they wouldn't have done anything differently initially than…a hospital team would have done.*[187]

164. I am satisfied that the deceased received high quality and care at RPH, especially within the cath lab. The deceased was critically unwell when she arrived at RPH and despite the considerable efforts of medical and nursing staff, tragically, the deceased could not be revived.

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[187] ts 24.06.19 (Spiro), pp78-79

AREAS FOR IMPROVEMENT

The state of the Prison's medical centre

165. The Prison was established in 1971 and by 2015, it was the metropolitan maximum security female prison and received remand prisoners from around the State.[188]

166. In 2016, the Prison experienced significant overcrowding. Its design capacity in 2014 was said to be 209, but in July 2016, the Prison's muster was 400. This meant that most prisoners were "*doubled up*" where two prisoners share a cell designed for one prisoner.[189][190]

167. As Nurse Owen noted, the situation at the Prison's medical centre at this time was difficult:

> *At the time of the incident, the work environment at Bandyup was difficult. The muster was very high and included a lot of remand prisoners, who always present with high needs. Prisoners were generally doubled up in cells. I note that the incident occurred approximately two weeks before the opening of Melaleuca Remand and Reintegration Facility for Women. There were a lot of staff shortages within the medical centre at that time, with a number of staff members on workers compensation leave and agency staff employed to cover the shortfall in staff.*[191]

168. When it opened in late December 2016, the Melaleuca Remand and Reintegration Facility became the primary receival prison for women in Western Australia. This had the effect of significantly reducing the number of women sent directly to the Prison.[192]

169. The 2017 report of the inspection of the Prison by the Inspector of Custodial Services (Report) found that the Prison's medical centre was "*not fit for purpose*".[193]

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[188] Exhibit 1, Vol. 2, Tab 1, Statement - Dr Rowland, para 13
[189] Exhibit 1, Vol. 2, Tab 1, Statement - Dr Rowland, paras 13-15
[190] ts 24.06.19 (Owen), p11
[191] Exhibit 1, Vol. 1, Tab 33, Statement - Nurse Owen, para 18 & ts 24.06.19 (Owen), p11
[192] Exhibit 1, Vol. 2, Tab 1, Statement - Dr Rowland, para 16
[193] Exhibit 1, Vol. 2, Tab 1.B, Report by Office of the Inspector of Custodial Services, p54

170. The Report noted that the medical centre was:

> *barely adequate to service a prisoner population of 230, yet in 2016 it serviced over 400 high-needs prisoners. The health centre footprint is too small, and has not been extended despite our repeated concerns.*[194]

171. The main concerns expressed by health care staff were: narrow corridors preventing two-way passage if a gurney is used; small offices; the lack of safe egress areas; and an insufficient number of treatment rooms. Staff also expressed concern about delays in filling critical vacancies and the inability to backfill positions when staff were away on extended leave.[195]

172. Nurse Owen said that in her view, the medical centre at the Prison was "*falling apart*" and had undergone little refurbishment since 2000 / 2001. She was also concerned about the standard of some of its equipment and that there were not enough rooms for nurses to work in.[196]

173. The question of whether the sub-optimal facilities at the Prison's medical centre had any bearing on the deceased's death is clearly relevant.

174. Dr Rowland agreed with the findings of the Report with respect to the cramped nature of the facilities at the medical centre and confirmed that there had been no upgrades to the centre since the deceased's death.[197]

175. However, Dr Rowland expressed the view that the Prison's medical centre:

> *provides a comprehensive range of adult, primary and allied health care services in a manner commensurate with general community standards.*[198]

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[194] Exhibit 1, Vol. 2, Tab 1.B, Report by Office of the Inspector of Custodial Services, p54
[195] Exhibit 1, Vol. 2, Tab 1.B, Report by Office of the Inspector of Custodial Services, p55
[196] ts 24.06.19 (Owen), p29
[197] ts 25.06.19 (Rowland), p146
[198] Exhibit 1, Vol. 2, Tab 1, Statement - Dr Rowland, para 9

176. Dr Rowland noted that the quality of the clinical care provided by health staff was not dependent on the quality of the facility they operated from, although she conceded that providing quality care in a sub-optimal environment was more challenging.[199]

177. Despite the fact that, at the relevant time, the medical centre was cramped and lacked appropriate facilities, in my view, the deceased was treated appropriately and in accordance with established clinical protocols. Her blood pressure and oxygen saturations were assessed and she underwent an ECG. She was given aspirin and oxygen and evacuated to the closest hospital with a cath lab in a reasonably efficient manner.

178. After careful consideration of the evidence, I am not satisfied that the current state of the Prison medical centre contributed to the deceased's death.

179. However, on the basis that the Department's Director, Medical Services, one of its senior nurses and the Inspector of Custodial Services all agree that the Prison's medical centre is 'not fit for purpose', there is a clear and pressing need for the Chief Executive Officer of the Department (CEO) to remedy the situation as quickly as possible.

180. Section 95A of the *Prisons Act 1981* (WA) provides: "*The chief executive officer is to ensure that medical care and treatment is provided to the prisoners in each prison*". Further, the patient charter attached to Dr Rowland's statement relevantly states: "*Prisoners have the right to safe, high quality health care and to the provision of the information they need to participate in decisions about their care*".[200]

181. The standard of medical care provided to Western Australian prisoners is said to be: "*commensurate with general community standards*".[201] However, it seems to be widely accepted that the Prison's medical centre is currently not 'fit for purpose'. In my view, given the CEO's statutory responsibilities in this area, the CEO should take urgent action to remediate the medical centre's many shortcomings.

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[199] ts 25.06.19 (Rowland), p149
[200] Exhibit 1, Vol. 2, Tab 1, Attachment D, CG13 Adult Health Services Charter, p2
[201] Exhibit 1, Vol. 2, Tab 1, Attachment D, PM100 Adult Patient Healthcare Management, p3

Education and improvements to EcHO

182. Nurse Owen said that education about cardiac risk factors, weight management and diet was given to prisoners (including the deceased) during routine visits to the medical centre.[202] However, it is not clear whether the deceased was given advice about self-management of her hypertension (reducing salt intake, exercise etc.).[203,204]

183. As Nurse Owen pointed out, the very high muster at around the time of deceased's death, coupled with staff shortages in the medical centre meant that health promotion interactions were necessarily more limited than they might otherwise have been.[205]

184. An additional issue is the fact that the deceased had a patchy history of attending appointments,[206] although as noted, she did seek advice on weight management on at least two occasions.[207]

185. Dr Rowland indicated that since the deceased's death, EcHO, the Department's electronic medical record system has been improved by the addition of "service codes".[208]

186. The service codes make it much easier for health staff to record the fact that they have given a prisoner education and advice on such matters as quitting smoking, weight management, diet and exercise. As Dr Rowland noted, these "*health literacy*" services are often provided, but poorly documented.[209]

187. Other improvements to EcHO since the deceased's death include the addition of:[210]

a. Cardiovascular risk calculators: which enable a risk score to be calculated and automatically placed into the prisoner's medical summary;[211]

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[202] ts 24.06.19 (Owen), pp44-45
[203] ts 24.06.19 (Owen), pp44-45
[204] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p12
[205] ts 24.06.19 (Owen), pp44-45
[206] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), pp8-10
[207] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), pp8-9
[208] Exhibit 1, Vol. 2, Tab 1.N, EcHO Service codes
[209] Exhibit 1, Vol. 2, Tab 1, Statement - Dr Rowland, para 30(f)
[210] Exhibit 1, Vol. 2, Tab 1, Statement - Dr Rowland, paras 30(c)-(e) & ts 25.06.19 (Rowland), pp135-136
[211] Exhibit 1, Vol. 2, Tab 1.I, Cardiovascular risk calculators

b. Care plans: templates for conditions such as cardiovascular disease, diabetes and cirrhosis are now built into EcHO and promote self-management;[212] and

c. Annual health assessment template: has now been aligned with the relevant Medicare item for assessment of Aboriginal and Torres Strait Islander People.[213]

188. At the time of her death, the deceased was not the subject of a cardiac care plan. Even if she had been, at that time, plans were paper based and stored separately from the prisoner's medical notes.[214]

189. The benefit of care plans being embedded into EcHO is that the prisoner's status is more obvious when the prisoner is seen by a health care worker who then accesses the prisoner's EcHO record.

190. Since the deceased's death, an emergency chest pain pathway tool has also been introduced to provide consistent guidelines to health staff when responding to prisoners with chest pain. Importantly, this tool:

> *prompts the early recognition of cardiac chest pain and prioritises the calling of an ambulance.*[215]

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[212] Exhibit 1, Vol. 2, Tab 1.J, Care plans
[213] Exhibit 1, Vol. 2, Tabs 1.K, 1.L & 1.M
[214] ts 24.06.19 (Owen), p43
[215] Exhibit 1, Vol. 2, Tab 1.P, Emergency chest pain pathway tool

CAUSE AND MANNER OF DEATH

191. Dr Cadden, a forensic pathologist, conducted a post mortem examination of the deceased's body on 21 December 2016. Dr Cadden noted that the deceased had coronary artery disease (coronary atherosclerosis) and that a metal stent was present.[216]

192. Dr Cadden also found pooling of fluid in the deceased's lungs which although non-specific, is consistent with acute cardiac failure.[217]

193. The deceased's weight was recorded as 106 kilograms, giving her a body mass index of 38.9[218] and placing her in the 'obese' category.[219]

194. Toxicological analysis found metoprolol, amiodarone and midazolam in the deceased's system. Amiodarone and midazolam were administered to the deceased in hospital and metoprolol was her regular blood pressure medication.[220,221,222]

195. A low therapeutic level of salicylic acid was also found, and this is consistent with the aspirin given to the deceased in the Prison medical centre before the ambulance arrived. Alcohol and common drugs were not detected and as noted, a therapeutic level of quetiapine was found.[223,224]

196. Dr Cadden expressed the opinion that the cause of death was acute myocardial infarction due to a coronary thrombosis.[225]

197. I accept and adopt that conclusion.

198. I find the deceased's death occurred by way of natural causes.

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[216] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report
[217] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report
[218] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report
[219] http://healthyweight.health.gov.au/wps/portal/Home/helping-hand/bmi
[220] Exhibit 1, Vol. 1, Tab 12, RPH emergency department medical notes
[221] Exhibit 1, Vol. 1, Tab 31, EcHO medical records
[222] Exhibit 1, Vol. 1, Tab 8, ChemCentre Toxicology Report
[223] Exhibit 1, Vol. 1, Tab 8, ChemCentre Toxicology Report
[224] ts 24.06.19 (Owen), p22
[225] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report

QUALITY OF SUPERVISION, TREATMENT AND CARE

199. In general terms, I am satisfied that the supervision, treatment and care provided to the deceased during her incarceration was appropriate.

200. However, in my view, the deceased's heightened risk of cardiovascular disease should have been recognised at a much earlier stage and she should have been the subject of a cardiac care plan.

201. Even though the deceased's high lipid levels were not detected until almost 4 months after her last admission, she had a number of obvious risk factors. The deceased was a 44-year old Aboriginal woman with a history of high blood pressure who was obese and who smoked heavily. She was also known to use amphetamines and cannabis and be non-compliant with her blood pressure medication when not in custody.

202. Had the deceased's risk of cardiovascular disease been recognised earlier, it is almost certain that, as Dr Rowland pointed out, the deceased would have been managed "*more aggressively*".[226] Presumably, this would have included regular monitoring of the deceased's blood pressure over an extended period.

203. In addition, had there not been staff shortages and a very high muster of vulnerable prisoners at the relevant time, it is possible that health staff may have been able to adopt a more proactive approach to health promotion with respect to the prison muster generally and with respect to the deceased in particular.

204. In this case, there are so many imponderables that it is impossible to say whether, had any of these things occurred, the outcome in this tragic case would have been different.

205. In particular, it may not have been possible to successfully counteract the deceased's lifetime of accumulated risks (including adverse childhood events), given her relatively brief stay in prison.

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[226] Exhibit 1, Vol. 2, Tab 1.G, Report - Dr Rowland (11.06.19), p11

CONCLUSION

206. The deceased was a much loved daughter, sister, mother, grandmother and friend, whose tragic death is no doubt keenly felt by her loved ones.

207. The deceased was only 44 years of age when she died and as her eldest child, Mr Cheyne Bolton eloquently observed:

> *Mum had a life waiting for her. Mum had plans for what she would do when she got out of Bandyup Women's Prison. I was looking forward to Mum being free and being part of our daily lives again. Mum was meant to be here and I really miss her.*[227]

208. I can only hope that the changes made to health service delivery by the Department, as well the changes that are about to be made, will provide the deceased's loved ones with some level of comfort as they continue to deal with their terrible loss.

MAG Jenkin
Coroner
20 August 2019

[227] Statement - Mr Bolton (02.07.19), paras 14-15