IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2007 3554

FINDING INTO DEATH WITH INQUEST[1]

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: ANDREW TIMOTHY DAVIES

Hearing Dates:	14 February 2011, 15 February 2011, 16 February 2011 and 21 March 2011
Appearances:	Mr R. Shepherd of Counsel on behalf of Pacific Shores Healthcare Mr D. Masel with Mr A. Mazzone of Counsel on behalf of Justice Health
Police Coronial Support Unit:	Leading Senior Constable G. McFarlane, Assisting the Coroner
Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	19 July 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, AUDREY JAMIESON, Coroner having investigated the death of ANDREW TIMOTHY DAVIES

AND having held an inquest in relation to this death on 14 February 2011, 15 February 2011, 16 February 2011 and 21 March 2011

at MELBOURNE
find that the identity of the deceased was ANDREW TIMOTHY DAVIES
born on 12 March 1968
and the death occurred on 7 September 2007
at St Vincent's Hospital, Victoria Parade, Fitzroy 3065

from:

1 (a) ACUTE MYOCARDIAL INFARCTION
1 (b) CORONARY ARTERY ATHEROSCLEROSIS

in the following summary of circumstances:

1. Mr Andrew Timothy Davies was a prisoner at Her Majesty's Prison (HMP), Ararat. He presented at the prison medical centre with chest pain approximately 16 days prior to his death. An electrocardiogram (ECG) was performed and showed changes consistent with an ischaemic event. No medical follow-up occurred. He subsequently suffered a fatal acute myocardial infarction (heart attack).

BACKGROUND CIRCUMSTANCES

2. Mr Andrew Timothy Davies was 39 years of age at the time of his death. He married Jasmin Davies in 1998. The couple had no children but Mr Davies had three children to previous partners. His medical history included depression for which he was treated with the anti-depressant medication, Efexor. He was also a heavy smoker of cigarettes and prior to incarceration was known to consume large quantities of alcohol particularly at the weekends. He had no known family history of cardiac disease/illness.

3. Mr Davies had a long criminal history. At the time of his death, Mr Davies was serving his third term of imprisonment. He entered into custody on 29 May 2001 and on 12 December 2002, was convicted of the offences of abduction and rape of two minors. He was sentenced to an indefinite period of imprisonment that was varied on appeal in 2005 to a finite period of 16 years imprisonment with a non-parole period of 12 years. At the time of his death, he had

served a period of 6 years and 4 months. His earliest release date was 3 May 2013. At the time of his death, Mr Davies was accommodated at Her Majesty's Prison (HMP), Ararat. He was located in the Hopkins Unit, Cell 18 which he shared with prisoners, Raymond Bonello and Keith King. He was employed in the screen printing works at the prison.

Pacific Shores Healthcare

4. The GEO Group Australia Pty Ltd trades as Pacific Shores Healthcare and provides primary and some limited secondary health services to HMP Ararat under a contractual arrangement with Justice Health.

SURROUNDING CIRCUMSTANCES

5. On Saturday 18 August 2007 at approximately 5.30am, cellmate Mr Raymond Bonello heard Mr Davies vomiting. Mr Davies also complained of chest pain but declined Mr Bonello's offer to "buzz up" for immediate attention and instead indicated that he would attend the medical clinic when the cells were routinely opened at 7.00am. According to his other cellmate, Mr Keith King, Mr Davies complained of pain in both arms.

6. At approximately 9.00am, Mr Davies attended at the prison medical clinic and was seen by Nurse Peter Skrabl, a Registered Nurse in Division 2 and Division 3[2] of the Register. Nurse Skrabl was the only healthcare professional on duty as was the norm for a weekend. Mr Davies presented with *pains to the chest, general aches and pains and some congestion and problems breathing*. Nurse Skrabl recorded Mr Davies' vital signs including heart rate, respirations, temperature, blood pressure and oxygen saturation level. An electrocardiogram (ECG) was performed and reported as: "Normal sinus rhythm. Normal ECG". Nurse Skrabl noted Mr Davies' presentation to be of *cold and flu symptoms* and he initiated the administration of Panadol x 2, TDS (three times daily). Mr Davies was provided with a "Rest in Cell" certificate and requested to attend for a review the following day.

7. On 19 August 2007, Nurse Skrabl reviewed Mr Davies in the medical clinic. The records reflect that Mr Davies *continues with cold and flu symptoms*. Observations are stated to be *NAD* although no actual observations are recorded in the file. Mr Davies was again advised to rest in his cell and given the authorising certificate and advised to return on 20 August for a further review.

[2] A Division 3 nurse is a psychiatric nurse.

JURISDICTION

11. At the time of Mr Davies' death, the *Coroners Act 1985* (the Old Act) applied. From 1 November 2009, the *Coroners Act 2008* (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[5]

12. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the new Act.[6]

13. Section 67 of the new Act describes the ambit of the coroner's findings in relation to a death investigation. A coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[7] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

14. A coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[8] A coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death, which the coroner has investigated including recommendations relating to public health and safety or the administration of justice.[9]

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[5] Section 119 and Schedule 1 – **Coroners Act 2008**

[6] See for example, sections 67(3) & 72 (1) & (2)

[7] Section 67(1)

[8] Section 67(3)

[9] Section 72(1) & (2)

8. There is no record of Mr Davies returning to the medical clinic or of any follow-up of him by the nursing or medical staff although Mr Davies returned daily to the clinic to receive his prescription medication. There is no documentation or notation of the signature[3] of the visiting medical officer Dr Michael Plunkett, which would indicate that he was given or saw the ECG to review or that the ECG was subject to the normal processes for the doctor to review that is, placed on his desk.[4]

9. On 4 September 2007, at approximately 5.30am, Mr Davies complained of chest pain, nausea and pain in both arms. At approximately 6.20am, prison staff responded to a duress call from Mr Davies' cell. He was seen by the prison Supervisor, Beverley Kaliszewski and Prison Officers, Barry Hewitt and Cameron White. An ambulance was requested and Mr Davies was transported to East Grampians Health Service. He was admitted to the hospital at approximately 7.10am and suspected of having suffered an acute myocardial infarction. An ECG showed evidence of an anterolateral myocardial infarction. He received thrombolysis, clopidogrel and enoxaparin. At approximately 8.15am Mr Davies suffered a ventricular tachycardia cardiac arrest. He was DC reverted but suffered a further arrest at approximately 8.46am. He was resuscitated again with DC reversion and the administration of antiarrhythmic medication. He was transferred by air ambulance to St Vincent's Hospital, Melbourne, arriving at approximately 4.50pm. Mr Davies underwent an emergency angiography in the cardiac catheterisation laboratory but went into cardiogenic shock necessitating intubation and the insertion of an aortic balloon pump. Angiography showed significant triple vessel coronary artery stenosis. A left anterior descending (LAD) stent was inserted and he was admitted to the Intensive Care Unit (ICU) for management however, despite maximal inotropic support Mr Davies' condition continued to deteriorate.

10. Mr Andrew Timothy Davies died at 11.15pm on 7 September 2007.

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[3] T @ p 354

[4] T @ p 353

INVESTIGATION

Identity

15. The identity of Andrew Timothy Davies was without dispute and required no additional investigation.

Medical investigation

16. Dr Noel Woodford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Mr Davies. Anatomical findings were of significant cardiovascular pathology including widespread coronary artery atheroma with associated acute and more remote infarction change, predominately involving the anteroseptal region of the left ventricle. Dr Woodford reported that the mechanism of death was likely to have been one of progressive cardiac failure (cardiogenic shock) in the setting of acute myocardial infarction (heart attack) and he ascribed the cause of death to natural causes being acute myocardial infarction arising from coronary artery atheroscelerosis.

Police investigation

17. The police investigation and preparation of the coronial brief of evidence was undertaken by senior Constable Ales Brgoc.

Review of the ECG performed on 18 August 2007

18. Cardiologist, Associate Professor (A/Professor) Harry Mond, reviewed the unreported ECG performed at HMP Ararat by Nurse Skarbl. On 28 April 2008, A/Professor Mond reported that the electrocardiogram did show sinus rhythm as had been reported by the ECG machine but that there were:

> *..Q waves present in leads 2, 3 and AVF associated with minor ST elevation and T wave inversion in 3 and AVF. There was minor ST depression from leads V3 to V5. The findings are consistent with an inferior infarct, although the timing is not clear...In summary the electrocardiograph shows sinus rhythm with an inferior infarct, which may well be recent although not necessary acute.*[10]

19. Cardiologist, Dr Peter Habersberger also reviewed the ECG performed on 18 August 2007 and reported:

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[10] Exhibit 6 – report of A/Professor Harry Mond dated 28 April 2008.

"I believe Mr Davies suffered an inferior myocardial infarction on the 18th August, but this was not diagnosed at the time, as Mr Skrabl, the division 2 registered nurse, was misled by the printed report which said "normal sinus rhythm. Normal ECG".[11]

Justice Health Review

20. Justice Health undertook a review of the death of Mr Davies and prepared a report that was endorsed by the Director, Ms Michele Gardner on 20 April 2010. The report was prepared for the Office of Correctional Service Review (OCSR) with its' focus on the provision of health care to Mr Davies as a prisoner. The Justice Health review made a number of findings from which three recommendations for change to the delivery of health services to prisoners were made. All were pertinent to the coronial investigation.

21. Recommendation 1 arose from an acknowledgment that the results of the ECG undertaken by Nurse Skrabl were not referred to a health professional qualified to interpret ECG readings:

All diagnostic tests, including ECG's are interpreted and reported on by an appropriately accredited/qualified professional in a timely manner.

22. According to the report, implementation of this recommendation had already occurred:

...systems have since been put into place by the Health Service Provider to forward all ECG readings to a secondary/tertiary facility ASAP. This nominated facility will interpret and provide clinical advice dependent upon the result of the ECG and clinical presentation of the patient.[12]

23. Recommendation 2 arose from an analysis of the Victorian Nurses Board Scope of Practice Guidelines for nurses registered in Division 2 and Division 3 of the Register and the apparent failure of the Health Service Provider to implement, in particular, those guidelines that refer to the supervision of a Division 2 nurse. Registered nurses within Division 2 are required to work under the direct or indirect supervision of a Division 1 nurse but as Nurse Skrabl was working alone on 18 and 19 August 2007 he was practicing outside his scope of practice when:

(a) He was *(sic) rostered on duty as the sole nurse, with the expectation that he(sic) would be assessing general medical complaints*

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[11] Exhibit 15 – report of Dr Peter Habersberger dated 24 September 2009

[12] Exhibit 8

(b) *when he(sic) assessed Mr Davies for complaints of chest pain*

(c) *when he (sic) nurse initiated panadol as treatment.*

Consistent with the Victorian Nurses Board requirements for registration and scope of practice, it is the expectation of Justice Health that the contracted health service provider undertakes annual credentialing and periodic review of their employees to ensure they are working within their scope of practice. Evidence of this clinical governance activity is required to be submitted to Justice Health on an annual basis.

24. The recommendation being:

That Division 2 Registered Nurses are not rostered on duty unless a Division 1 Registered Nurse is also rostered on site.

25. Recommendation 3 arose from the fact that Nurse Skrabl had reviewed Mr Davies on 19 August 2007 and had made a note in the medical record that he be *reviewed tomorrow.* No such review occurred:

That processes are in place to ensure follow up appointments are booked at the time of review to ensure requests for follow up by the doctor or nurse are not overlooked.

26. According to the report, Justice Health were in the process of implementing an electronic health record system (EHRS) that amongst a number of objectives, aims to improve *standardisation of processes and provide accurate and timely information to inform service planning activities.*[13]

[13] Exhibit 8

INQUEST

27. An inquest was held in accordance with section 17(1)(b)[14] of the Old Act as immediately before death, Mr Davies was *a person held in care* as it was defined in section 3[15] being a person in the legal custody of the Secretary to the Department of Justice.

28. At the outset of the inquest, Leading Senior Constable McFarlane, assisting the Coroner, indicated that the issues identified in the course of the investigation that warranted further exploration included:

- The quality of health care at Ararat Prison;
- The policy and procedures related to the management of prisoners presenting with chest pain;
- The training of staff in the use of a 12-lead ECG machine and the appropriateness of relying on the self-reporting function of the machine;
- The supervision of nursing staff and the appropriateness of a Division 2 nurse working unsupervised.

29. *Viva voce* evidence was obtained from the following witnesses:

- Mr Keith King - shared prison cell with Mr Davies and Mr Bonello
- Mr Raymond Bonello – shared prison cell with Mr Davies and Mr King
- Mr Peter Skrabl – Registered Nurse – Division 2 and Division 3
- Ms Jennifer Blosfelds – Clinical Operations Manager, Pacific Shores Healthcare
- Professor Harry Mond, Cardiologist, Expert witness

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[14] s17(1) A coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and—

(a) the coroner suspects homicide; or

(b) the deceased was immediately before death a person held in care; or....

[15] **"person held in care"** means—

(a) a person under the control, care or custody of the Secretary to the Department of Human Services; or

(ab) a person—

(i) in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or.....

- Ms Michelle Gardner – Director, Justice Health, Department of Justice
- Dr Peter Habersberger, Cardiologist, Expert witness
- Mr Mark Bulger, Health Services Manager, HMP Ararat
- Dr Michael Plunkett – Visiting Medical Officer, HMP Ararat

FINDINGS & COMMENTS

The ECG performed on 18 August 2007

30. I find that the ECG taken by Nurse Skrabl on 18 August 2007, *showed a cardiac event*[16] but more specifically according to Dr Peter Habersberger[17] it demonstrated an acute inferior myocardial infarction. Dr Habersberger stated:

> *...the thing I've felt looking at the ECG that there was something happening right at the time that the electrocardiogram was being undertaken and that that thing that (sic) was happening was an acute inferior myocardial infarction. The fact that there were Q waves suggest that maybe that was a few hours old or could have been....older but the thing was that it was that it had the ST segment elevation which goes with the acute episode.*[18]

31. Cardiologist, Professor Harry Mond, was initially less equivocal about the age of the myocardial infarction but in evidence said that he would agree with Dr Habersberger *that it could well have been acute*[19] and that the history of chest pain suggests it was acute.[20]

32. I agree with Professor Mond when he says that he suspected that Nurse Skrabl *must have had an inkling, he must have had a thought that there may well be a condition that required an ECG*[21] although Nurse Skrabl was not himself so candid. Regardless, I find that it was appropriate for Nurse Skrabl to perform an ECG in response to Mr Davies presentation on 18

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[16] as described by Dr Plunkett - T @ p 375

[17] T @ p 220

[18] T @ p 226

[19] T @ p115

[20] T @ p116

[21] T @ p 121

August 2008 with complaints of chest pain on deep inspiration which was also described in evidence as "atypical"[22] chest pain.

Scope of Practice

33. In his statement dated 22 December 2008, Nurse Skrabl stated that he was *employed at HMP Ararat as a Registered Nurse Grade 2 year* 8.[23] However, according to Sandra Keppich-Arnold, Associate Director of Nursing and Operations, Psychiatry, Alfred Health, Nurse Skrabl had signed a position description for a Division 3 nurse and was thus employed in that capacity. His Division 2 registration was not a condition of his employment.[24] Nevertheless, I accept that at the time Nurse Skrabl interacted with Mr Davies on 18 August 2007, he was a Registered Nurse within Division 2 and Division 3 of the Register as it existed under the *Nurses Act 1993* and as it was maintained when superseded by the *Heath Professions Regulation Act* on 1 July 2007.[25] The scope of practice for a Division 2 and Division 3 nurse working in the prison system remained equivocal during the course of the inquest, however, it was clear that there is a clear delineation between the wider scope of practice afforded to Division 1 nurses and that of the Division 2 and Division 3 nurses. According to Justice Health, Division 3 nurses can practice unsupervised provided they are working in the area of mental health. Pacific Shores Healthcare submitted that a Division 3 nurse *must decide what their scope of work is and whether they are competent to perform work within the scope.*[26]

34. In correspondence received after the completion of the inquest[27], the Australian Health Practitioner Regulation Authority (AHPRA) stated that the manner in which an employer used a Division 2 nurse would be dictated by the job description for that nurse and:

> *...the scope of practice under which the nurse was allowed to practise. It is notable that it is the nurse's responsibility to practice within his or her scope of practice and if the nurse had the relevant training to apply ECG leads, then that would be appropriate.*

35. I am satisfied that Nurse Skrabl had received some training on how to apply the electrodes and operate the 12-lead ECG machine and, as such, had the requisite qualification/scope of

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[22] T @ p 222

[23] Exhibit 3 – Statement of Peter Skrabl dated 22 December 2008

[24] See statement/report of Sandra Keppich-Arnold, Associate Director of Nursing and Operations, Psychiatry, Alfred Health, dated 18 October 2010

[25] See section 6 and section 170(2) *Heath Professions Regulation Act*, T @ pp 397-399

[26] T @ p 427

[27] Letter addressed to Leading Senior Constable Greig McFarlane dated 20 April 2011

practice to perform the investigative procedure. In addition and in response to clarification sought from Mr Shepherd, I also accept that Nurse Skrabl competently read the interpretative print out / auto reporting function from the ECG machine and that the printout informed him that the ECG was normal sinus rhythm, normal ECG. I also accept that Nurse Skrabl did not have the training nor did he attempt to interpret the ECG *per se*. Nevertheless, he effectively relied upon the self-reporting function because he was unaware that it could be incorrect.

36. Dr Plunkett, Professor Mond and Dr Habersberger all gave evidence that reliance on a machine's interpretation of an ECG to determine the health care response to chest pain is, and was, fraught. According to Professor Mond, at least one in three ECG's that he sees in the approximate 200-500 per week are incorrectly reported as being abnormal when they are in fact normal and although less frequently, reported as normal when they are in fact abnormal as in Mr Davies' case.[28] Dr Habersberger concurred that it was very good that Nurse Skrabl in fact made the decision to do the ECG but that there should be a review of the ECG by someone with some expertise as soon as possible thereafter because the machines make so many mistakes in their interpretations.[29] Nurse Skrabl's reliance on the machine's interpretation and his failure to ensure that an appropriately trained person read the ECG effectively ameliorated his *prima facie* thorough response to Mr Davies' complaints of chest pain.

37. In the context of addressing whether the ECG machine had any value, Mr Shepherd, for Pacific Shore Health Counsel said in closing submissions:

> ... *what Mr Skrabl did was to take a step that, ultimately, could have assisted in Mr Davies receiving treatment had the procedure, that the ECG be read by Dr Plunkett, resulted actually in Dr Plunkett reading that ECG. In that respect there is value....in having the ECG machines being used..*[30]

38. The source of Nurse Skrabl's lack of knowledge about the perils of relying on a machine to interpret an ECG was that the procedures in place under the control of Pacific Shores Healthcare that enabled, permitted and encouraged Nurse Skrabl to perform functions unsupported by a policy and procedures that ensured adequate follow-up. In closing

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[28] T @ p 117

[29] T @ p 222

[30] T @ p 412

submissions, Counsel for Justice Health Mr Masel described how shortcomings in the response to Mr Davies occurred:

> *Nurse Skrabl, and the evidence was, he's a responsible person, he's an experienced person; he's a caring person. What he doesn't have is the degree of experience in general nursing because his specialisation has been as a psychiatric nurse or as an assistant. He has lacked the leadership and guidance in day to day performance of his duties. The guidance to which he was entitled from his employer on matters such as the taking of histories in relation to chest pain. The assumption that he could do it is not a substitute for the fact that he hasn't been trained to do it, and that if he has been doing it without supervision because it's wrongly assumed that he's entitled to, then his deficiencies in taking histories, being attuned to the nuances of what has occurred, knowing what's important to prompt, knowing that all patients are unreliable. We have the dichotomy in this case, was there a history of vomiting or wasn't there. Was there pain sufficient to cause the patient to awake at 5.30 all of which were highly relevant in the hands of an appropriately skilled nurse and it's not a personal criticism of Nurse Skrabl to say that he was let down by his employer who wrongly assumed that he had a scope of duties that was wider than his training and experience and in fact the Act permitted.*[31]

39. I find that Nurse Skrabl incorrectly relied on the ECG machine automatic reporting function because his employer, Pacific Shores Healthcare, failed to provide him with proper training. His albeit limited training and endorsement to perform these duties empowered Nurse Skrabl to have the confidence to perform an ECG in appropriate circumstances but he had no training on how to read an ECG and insufficient training on how to implement a review of the ECG by appropriately trained personnel. Instead, Nurse Skrabl relied upon the 'intelligence' of the machine to dictate his response to Mr Davies' presentation and relied upon a 'procedure' for review of the ECG by the visiting medical officer, Dr Plunkett that somehow failed to eventuate. Nurse Skrabl's training in this regard may have improved his technical skills to operate a machine but fell well short of enhancing his overall professional skills as a nurse. In addition, Nurse Skrabl's reason(s) for not following an existing policy setting out a thorough examination/interrogation of complaints of chest pain[32] because he *"didn't treat him for chest*

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[31] T @ pp 401- 402

[32] Annexure "JB-1" to Exhibit 5 – Statement of Jennifer Blosfelds dated 8 October 2008

pain" but *treated him for cold and flu"* symptoms[33] is difficult to reconcile with the fact that he performed an ECG on Mr Davies. Similarly, Nurse Skrabl knew that the procedures for the follow-up of investigations were that all test results were to be logged and placed on the doctor's appointment diary file yet no explanation could be given as to why the ECG performed on 18 August 2007, was not reviewed by the doctor but instead 'filed'.

40. Dr Plunkett attended at the prison on Wednesdays and Thursdays which involved a total of 13 hours of consultations.[34] If this system had been adhered to, Dr Plunkett should have reviewed the ECG on the Wednesday following Mr Davies' presentation, that is, four days later on 22 August 2007.

Supervision

41. Pacific Shores Healthcare provided *direct supervision*[35] of its Division 2 and 3 nurses working in the clinic during the week by employing a Division 1 nurse but such *direct supervision* was not provided at the weekends.

42. The supervision of Nurse Skrabl's work by Pacific Shores Healthcare was also raised within the context of whether he was acting within his scope of practice at the time he saw Mr Davies in the medical clinic on 18 August 2007. Nurse Skrabl was working alone in the clinic as was the norm for the weekends at that time. Justice Health had indicated in their review that "direct" supervision of Division 2 nurses was required however, it was the evidence of Mr Bulger, the Health Services Manager at HMP Ararat at the time and himself a Registered Nurse in Divisions 1 and 3 of the Register, that there was no requirement for supervision to be on-site. I accept his evidence in this regard and accept that Mr Skrabl could contact Mr Bulger over the weekend if he deemed it necessary to do so. On this occasion Nurse Skrabl did not deem it necessary to report to or seek guidance from Mr Bulger.

43. Nurse Skrabl did not escalate/report to his supervisor that he had performed an ECG on a prisoner patient and there is no entry in the nursing progress notes that the ECG has been referred for review by the VMO.

44. These omissions to follow through on or consolidate, his initial correct decision or "inkling" to perform the ECG, are difficult to reconcile with Nurse Skrabl's experience as a nurse and

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[33] T @ p 48

[34] Exhibit 20 – Statement of Dr Michael Plunkett dated 15 February 2011

[35] T @ p 428

the level of responsibility assigned to him by Pacific Shores Healthcare. The imbalance of the provision of direct supervision has not been specifically addressed by Pacific Shores Healthcare however, there have been some changes to staffing levels and times at the weekends which has the potential to lessen the burden on the nurse holding the clinic. According to Mr Skrabl there are now two nurses rostered on in the morning on the weekends and a change from an eight to a nine hour shift which permits additional doubling up of staff for a period in the PM or afternoon shift.

Delivery of health services

45. Pacific Shores was engaged by Justice Health to provide professional medical services to the prison. Dr Plunkett is sub-contracted to Pacific Shores as the only visiting medical officer to HMP Ararat. Pacific Shores had promulgated a series of guidelines for its health care professionals to assist them in the delivery of health services at HMP Ararat. Service delivery by Pacific Shores came into question in this matter in part because Dr Plunkett had not seen the guidelines.

46. I find that the healthcare procedures in place HMP Ararat under the control of Pacific Shores Healthcare lacked rigor and resulted in a failure to have the ECG reviewed by the visiting medical officer in a timely manner. This in turn denied Mr Davies an opportunity to receive appropriate medical assessment, monitoring and treatment. According to Dr Habersberger:

> *...acute myocardial infarction is a serious medical issue and time is of the essence of the management of the condition.*[36]

47. Dr Habersberger also stated that if the ECG had been read by a doctor that had appreciated the need for hospitalisation, the prognosis for Mr Davies would have been different. He said:

> *In a young man with an acute myocardial infarct...what we would do is to undertake coronary angiography and that artery would probably have been unblocked at the time of the angiography and we would use a balloon, do balloon angioplasty and stent (sic) it and then, if he had subsequently blocked the other artery then he would not have two arteries blocked.*[37]

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[36] T @ p 228

[37] T @ p 221

I think if the problem had been recognised on the 18th August he would have – and he'd received the appropriate investigations he would have done extremely well.[38]

48. The evidence of Dr Habersberger indicates that because Mr Davis' compromised cardiac function was left untreated, his heart had a diminished capacity to respond to the subsequent insult to his heart on 4 September 2007.[39]

49. I accept the opinion of Dr Habersberger and I find that the outcome for Mr Davies *would have been very different*[40] if he had been availed of the opportunity to receive appropriate medical intervention contemporaneous to his presentation on 18 August 2007. A significant and defining opportunity was lost to implement treatment that Dr Habersberger maintained would have significantly improved Mr Davies' chance of survival from the myocardial infarction he suffered on 4 September 2007. The logical conclusion to be drawn from Dr Habersberger's evidence is that the ultimate fatal consequences of the insult that occurred on 4 September 2007 could have been prevented if Mr Davies had received treatment for the infarction he suffered on or about 18 August 2007. However, given the knowledge obtained through the post mortem examination and, in particular, having regard to the level of coronary artery disease identified, it is not possible to definitively find that Mr Davies' death from coronary artery disease could have been prevented.

50. Mr Masel of Counsel informed me that Justice Health and Pacific Shores Healthcare have been working collaboratively *in remedying the* situation and *on a collaborative basis to improve* which I interpret to mean, improve on the delivery of medical services at HMP Ararat. Pacific Shores Healthcare has implemented a new practice since the death of Mr Davies for the management of prisoners presenting with chest pain being that whenever a prisoner presents with any type of chest pain they will be referred to hospital if a doctor is not on site and otherwise if a doctor is on site, that the doctor will make decisions on the management of the prisoner's complaints.[41] I was informed by Mr Shepherd of Counsel that it was the intention of Pacific Shores to design a policy to reflect this practice.[42]

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[38] T @ p 233

[39] T @ 231, 232, 246, 250, 251-252

[40] T @ pp 251-252

[41] T @ p 433

[42] *Op cit*

CONCLUDING FINDINGS

51. I accept and adopt the cause of death as identified by Dr Woodford and I find that Andrew Timothy Davies died from natural causes being acute myocardial infarction arising from coronary artery atherosclerosis.

52. AND I further find that had the ECG taken on 18 August 2007 been reviewed in a timely manner by the Visiting Medical Officer or other appropriately qualified medical practitioner, and medical treatment for the inferior myocardial infarction implemented, the death of Andrew Timothy Davies following the further myocardial infarction on 4 September 2007, could have been prevented.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That Pacific Shores Healthcare formalises the implementation of its policy to reflect its practice since the death of Mr Davies for the management of prisoner patients presenting with chest pain.[43] The policy should reflect that whenever a prisoner patient presents with chest pain of a type as described in the Emergency Guidelines[44] or of any other type such as on deep inspiration, and the visiting medical officer is not present on site, that the prisoner patient will be transferred by ambulance to a secondary/tertiary hospital and that otherwise, if a visiting medical officer is on site, it remains the discretion of the visiting medical officer to make decisions about the management of the prisoner patient's complaints of chest pain.

2. That Pacific Shores Healthcare incorporates into its policy regarding the management of prisoners presenting with chest pain that all ECG readings undertaken by a registered nurse at a correctional health facility in the absence of an appropriately accredited/qualified health professional/visiting medical officer, be forwarded with the prisoner to a secondary/tertiary health facility for interpretation, reporting and advice. And that such a service arrangement in respect of the interpretation, reporting and advice on electrocardiograms with an external provider also be formalised and available to the visiting medical officer to utilise from the

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[43] T @ p 376

[44] Exhibit 16

correctional health facility to assist the visiting medical officer with medical management decisions about that prisoner patient.

3. That Pacific Shores Healthcare implements a system specific for the purposes of following up the review of investigations/test results by the visiting medical practitioner and that it be designed with the aim of preventing the recurrence of the circumstances highlighted in Mr Davies' case. Such a system should be the responsibility of the nurse-in-charge on each shift and be aimed at insuring the communication of investigations/test results to the visiting medical officer in a timely manner and in order to ensure it is an effective communication tool it should incorporate details of the date the investigation was performed, by whom, when the results were received and by whom and date and time they were communicated to the visiting medical practitioner.

4. That Pacific Shores Healthcare implements a communication system specific for the purposes of follow up reviews of prisoner patients who have previously been seen in the medical clinic and assessed as appropriate for a review at a later date and that it be designed with the aim of preventing the recurrence of the circumstances highlighted in Mr Davies' case. Such a system should be the responsibility of the nurse-in-charge on each shift and be aimed at insuring effective communication to other members of the nursing staff in subsequent shifts. In order to ensure that this system is an effective communication tool it should incorporate details of the date the prisoner patient was seen, by whom, the reason(s) it was deemed necessary to review the prisoner patient and details of the review and by whom and what was the outcome of the review.

5. That Pacific Shores Healthcare formulates and implements an induction program for all medical and nursing employees and independent contractors/subcontractors and that such a program encompasses orientation and familiarisation with Pacific Shores' protocols, policies and procedures relevant to the delivery of health services within the correctional health environment that are comparable to primary health services received by the general public in the state of Victoria.

6. That Pacific Shores Healthcare provide periodic ongoing professional development to its medical and nursing employees and independent contractors/subcontractors with the aim of maintaining familiarity with its protocols, policies and procedures and maintaining knowledge and competency standards of its' medical and nursing employees and independent contractors /subcontractors.

7. That Justice Health incorporates the above recommendations into its service agreement with Pacific Shores Healthcare or any subsequent provider of health services to HMP Ararat, with the aim of ensuring the delivery of health services within the correctional health environment are at a standard comparable to primary health services received by the general public in Victoria.

Pursuant to section 73 of the **Coroners Act 2008**, this Finding will be published on the internet.

I direct that a copy of this finding be provided to the following:

- Mrs Jasmin Davies
- Director of Medical Services – Pacific Shores Healthcare
- Director, Justice Health

Signature:

AUDREY JAMIESON
CORONER
Date: 19 July 2013