IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2004 2347

FINDING INTO DEATH WITH INQUEST

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

(Amended pursuant to Section 76 of the ***Coroners Act 2008*** *on 26 June 2013)*

Inquest into the Death of: THOMAS BRIGHAM

Delivered On:	20 June 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	1, 2, 3 and 4 June 2010 24, 25 November 2011
Findings of:	IAIN TRELOAR WEST, DEPUTY STATE CORONER
Representation:	Ms E. James with Mr K. Wolahan appeared on behalf of the family of the deceased in June 2010 and Ms V. Nadj appeared on their behalf in November 2011. Mr D. Burnett appeared on behalf of Dr Boyd. Mr J. Goetz appeared on behalf of St Vincent's Hospital. Mr D. Masel appeared on behalf of Justice Health. Mr R.D. Shepherd appeared on behalf of Pacific Shores Healthcare.

Police Coronial Support Unit	Leading Senior Constable K. Ramsey was present to assist the Coroner.

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of THOMAS BRIGHAM

AND having held an inquest in relation to this death on 1, 2, 3, 4 June 2010 and 24, 25 November 2011

at MELBOURNE

find that the identity of the deceased was THOMAS JAMES BRIGHAM

born on 17 December 1965

and the death occurred on the 7 July 2004

at St Vincent's Hospital, 41 Victoria Parade, Fitzroy 3065

from:

1 (a) METASTATIC LUNG CARCINOMA

in the following circumstances:

1. Thomas Brigham was a 38-year-old single male at the time of his death and an inmate at Loddon Prison, Castlemaine, where he was serving a 28 month prison sentence for trafficking a commercial quantity of amphetamines. He had been held in police custody since 6 October 2003 and was initially held at the Melbourne Assessment Prison (MAP) before being transferred on the 22 October 2003 to Loddon Prison. Mr Brigham was eligible for parole on 7 January 2005. He was serving his third prison sentence at the time of his death and prior to his incarceration, had worked on a full time basis in the field of demolition and excavation.

2. During the eight months spent in Loddon Prison, Mr Brigham attended the medical centre on 35 occasions. Five medical officers saw him on 15 occasions, nursing staff saw him on 19 occasions and he had one consultation with a physiotherapist. During his first five months, he attended the medical centre on 14 occasions for minor aliments. Medical investigations undertaken during the period of attending included serum blood pathology, which indicated elevated cholesterol levels and no other abnormalities. On the 29 March 2004, Mr Brigham complained of lower back pain that started four days earlier. In the following three months, he attended the medical centre on 21 occasions and complained of recurrent severe shoulder, neck and back pain, along with a continuous cough. Two radiological investigations were undertaken during this time; a lumber spine X-ray indicated some minor spondylosis but no further abnormalities and a CT scan of the lumbar sacral spine, indicated no abnormalities. On 6 April 2004, Mr Brigham complained to the medical officer of low intermittent back pain

which he had for years (Mr Brigham had a past medical history that included a back injury whilst playing cricket, sustained 20 years previously) and added that the pain had recommenced approximately two weeks earlier. He was prescribed anti-inflammatory medication and in May 2004, he continued to complain of pain which at that time was in his neck and shoulder. The pain increased over the five consultations he had during May. He was regularly prescribed analgesic, however, when presenting to the medical officer on multiple occasions throughout June, he continued to complain of escalating pain. A lumber spine X-ray was ordered and reported on the 15 June, indicating minor spondylosis.

3. On 17 June it was noted that Mr Brigham had a poor appetite, with some weight loss and during review by the medical officer, he complained of a two-week history of dry cough, which increased at night, and of lower back pain, which radiated to his buttocks. He further stated that his anti inflammatory medication was no longer relieving the pain. Narcotic analgesic was prescribed, however, he returned to the medical centre on the 19 June, still complaining of ongoing back pain. Mr Brigham was given the results of his lumber spine X-ray and was encouraged to continue with warm showers and analgesia. Later in the day Mr Brigham's unit prison staff telephoned the Medical Centre informing the nursing staff that Mr Brigham was in a distressed state, due to severe back pain. An ambulance was called and Mr Brigham was taken to Bendigo Hospital where he was seen in the Emergency Department by Dr James Boyd, a medical registrar at that time. Mr Brigham was subsequently discharged from the hospital with Ibuprofen, anti-inflammatory medication.

4. On 22 June 2004, Mr Brigham was reviewed by the prison medical officer as his lower back pain had worsened, with the pain radiating to his buttocks and knees, such that he was unable to walk. Pain relief from the narcotic analgesic was only lasting one to one and a half hours, and the pain kept him awake at night. On examination, it was noted that the 'lumber disc three/sacral disc two' region was painful and, although there was no swelling or haematoma, there was significant limitation of movement in all directions. An urgent lumbar sacral region CT scan was ordered. The Medical Director at Port Phillip Prison was contacted and informed of Mr Brigham's condition and a request was made to transfer him to the Port Philip Prison. Mr Brigham was commenced on MS Contin and Panadeine Forte, both narcotic analgesics, and a transfer was organised for the 25 June. On the 23 June however, Mr Brigham continued to complain of severe back pain and demanded to be hospitalised. Despite regular analgesic being given he continued to complain of the pain. Mr Brigham was kept under observation in

the medical unit, with it being decided that he have a further medical review the following morning.

5. On 24 June when reviewed by a medical officer, Mr Brigham's back pain and cough was still present. The medical officer diagnosed bronchospasm and he was prescribed analgesia, bronchodilator and nasopharyngeal medication. Mr Brigham was transferred to the Port Phillip Prison and was admitted into St John's ward. His weight was noted at 81 kilograms and the medical officer prescribed anti-inflammatory and muscle relaxant medications and ordered serum bloods to be taken.

6. On 25 June Mr Brigham was examined by the medical officer, resulting in X-rays and CT scan of the lumber/sacral spine being ordered, however, they generated unremarkable reports. The medical officer transferred Mr Brigham to the St Vincent's Hospital for further investigation and follow up of the chronic back pain. Following admission to the St Augustine's Ward within St Vincent's Hospital, further investigations led to a diagnosis on 2 July of metastatic cancer. On 5 July, Mr Brigham was transferred to the Caritas Christi Hospice where he was examined by Professor Peter Martin, the clinical director of the palliative care unit. On examination he was found by Professor Martin to be bed bound and in a frail and de-conditioned state. Palliative care was initiated as Mr Brigham's condition continued to worsen and he died at approximately 5.35am on the 7 July 2004.

7. On 8 July 2004 a post mortem examination was conducted by Dr Noel Woodford, Senior Pathologist with the Victorian Institute of Forensic Medicine. Dr Woodford performed an external and internal examination of Mr Brigham at the mortuary, reviewed the circumstances of his death, the medical deposition and clinical notes, the post mortem CT scan and provided a written report of his findings. Histological examination of lung tissue found extensive infiltration by a malignant tumour, that further testing showed to be a metastatic undifferentiated large cell carcinoma. Dr Woodford reported that in all the circumstances a reasonable cause of death was a natural disease process with the cause of death being metastatic lung carcinoma.

8. The focus of the inquest was the appropriateness of the healthcare provided to Mr Brigham. Pacific Shores Healthcare (PSH) was responsible for providing medical care to him whilst an inmate at the prison. The family are critical of the health care provided by PSH and of Dr Boyd at Bendigo Hospital, alleging his examination of Mr Brigham was inadequate, with no

appropriate follow up. The family believe that there was an unacceptable delay in diagnosing the terminal condition and a failure to adequately manage obvious and very severe and undiagnosed pain. Medical management following the diagnosis of terminal cancer was not an issue at the inquest. Whilst the family acknowledged the delayed diagnosis did not affect the inevitable outcome of Mr Brigham's condition, they believe it may have contributed to him experiencing unnecessary pain by delaying his palliative care. It is their belief that Mr Brigham ought to have been transferred earlier into palliative care and, at the latest, on 19 June 2004.

9. The inquest had the benefit of hearing from Dr Angela Sungaila, a Forensic Physician with the Victorian Institute of Forensic Medicine. Dr Sungaila has had experience in conducting general medical practice sessions on a weekly basis in a Victorian Prison in the mid 2000's and was involved in a special project in prison medicine in 2006, as part of her Masters Degree in Forensic Medicine. In her report to the Coroner dated 22 January 2008, Dr Sungaila stated that Mr Brigham's diagnosis could have, and should have, been achieved at an earlier time. She stated that although it would not have extended his life, it may have allowed his last days to be palliated possibly in the comfort of his own home, once his prognosis was found to be terminal. She made the following points:

a) "Healthcare in a correctional setting should be the same as that in the community.

b) Statements from non-medical sources (fellow inmates) describe Mr Brigham's condition very differently than is recorded in the medical notes. From these sources the picture is painted of a man in great distress with a high level of incapacity. This is certainly not reflected in the medical notes. It is unclear if the doctors were given a description of Mr Brigham's distress, or were in contact with his relatives, as would have occurred in a non-custodial situation.

c) There is sufficient reason for Mr Brigham to have very severe pain throughout the last few weeks/months of his life. Had diagnosis of bony metastases occurred earlier, treatment for pain would have consisted of adequate analgesia and possible radiotherapy. The treatment given would have done little to alleviate Mr Brigham's pain.

d) A plain chest X-ray would have diagnosed his lung tumour at a much earlier date. In general, a young person with undiagnosed pain should be investigated extensively. A plain X-ray of the spine or CAT scan is not adequate to identify cancerous change in the

bony spine. Appropriate investigations were not conducted until Mr Brigham was transferred to St Vincent's Hospital.

e) An enlarged liver was detected on admission to St Vincent's Hospital. This finding would have been detectable for some time.

f) It is highly likely that Mr Brigham did not look well in the last month of his life and was losing weight. It is unclear if any of the medical staff noted any change in his condition.

g) Pathology done at St Vincent's Hospital indicated abnormalities which would have been present for some time before. Despite numerous presentations to the Prison Medical Centre, repeat pathology was not carried out despite Mr Brigham's escalating symptoms and presentation".

10. Dr Sungaila concluded that it was likely Mr Brigham would have had symptoms relating to his chest for several weeks or longer and she gave three reasons as to why, in her opinion, the symptoms had not been investigated adequately. They are:

a) The reasons for consultation were related predominantly to Mr Brigham's pain in his back which would have been severe and would have diminished the importance of chest symptoms in his mind;

b) Investigation examinations by medical personnel were focussed on his back pain and, as well, diminished the importance of his chest symptoms; and

c) The examinations and investigations were inadequate. She stated that with the wisdom of hindsight, a chest X-ray should have been performed on the first or second consultation which featured chest symptoms. She made the point that Mr Brigham did not have asthma recorded as a general complaint and he was a non-smoker. In this situation, a wease and other chest symptoms, together with weight loss and poor appetite, should have suggested adequate investigation, rather than assumption.

11. In her evidence to the inquest Dr Sungaila was of the opinion that as of 19 June 2004, Mr Brigham would have had terminal cancer and she agreed that even if an investigation for cancer had been initiated, such investigation would almost certainly not have altered the outcome of him dying from the disease.

Adverse findings of fact

12. In reviewing the evidence in this case and the role of the parties involved in Mr Brigham's medical management, I am mindful of the test that is to be applied in relation to serious findings concerning professional persons, including health care providers. It was stated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336 that a Court should not make an adverse finding unless persuaded to a reasonable degree of satisfaction having regard to the gravity of the matters alleged.

Pacific Shores Healthcare

13. I accept the submission on behalf of PSH that it cannot be concluded from the findings of Dr Martin made on 5 July, it was more likely than not, that Mr Brigham was in a frail and de-conditioned state on 19 June 2004. The history is that Mr Brigham presented as a well person who suffered from intermittent back pain. The MAP assessment on 6 October 2003 and the Pacific Shores Screening Form dated 22 October 2003, did not record a history of cancer or chronic illness. In addition, MAP considered him fit for transfer to HMP Loddon. There is evidence of a good level of fitness prior to June. Whilst Mr Brigham had an underlying morbid condition and complained of unspecified intermittent back pain, it appears from the medical records on 12 February 2004 that he was advised by a medical officer to stop weight lifting and later, as at 20 May 2004, he had returned to lifting weights and was advised by nursing staff to decrease. This activity could be seen as causative of acute pain of a musculoskeletal nature and could also present an explanation for his complaint of neck and shoulder pain.

14. Prior to the 19 June, I am satisfied the focus of Mr Brigham's attendances on medical staff was for back pain and I am not satisfied that his symptoms were such as to alert doctors to suspect underlying pathology. It is not entirely clear as to whether Mr Brigham chose to describe his symptoms in a full and frank manner, or in a limited way. There is evidence, however, of non compliance with anti inflammatory medication, potentially confusing the diagnostic picture. In this setting, I am satisfied the analgesia prescribed for pain management was appropriate from PSH's perspective, up until 19 June 2004. On that date, following a suspicion of underlying pathology, the medical officer acted appropriately by referring Mr Brigham to Bendigo Hospital and by providing a referral letter and X-ray. Following his examination by Dr Boyd, I am satisfied it was reasonable for PSH to rely on the findings of

Dr Boyd and to following his management plan, which was done by dispensing the prescribed medication.

15. There is evidence to suggest that Mr Brigham was a poor historian and that he was suffering more pain and symptoms than he revealed to his PSH care providers on and before 19 June and to Dr Boyd that same day. Possible reasons for lack of frankness were canvassed during the course of the inquest. The issue of whether Mr Brigham was forthright during his medical presentations impacts upon opinion evidence given during the course of the inquest. The hearing heard from Ms Michele Gardner, Director of Justice Health, who was critical of the medical service provided by PSH, stating "that the prison failed to recognise the severity or potential severity of Mr Brigham's medical condition in a timely manner" and that this "fell short of the health care expected by Justice Health". This opinion however, was based on the evidence of lay witnesses and she conceded that she did not take into consideration, that had Mr Brigham been a poor historian, it might have affected the ability of the medical officers to recognise the severity, or potential severity of his condition, in a timely manner. Whilst the evidence remains unclear as to whether Mr Brigham gave a full and frank description of his symptoms to health care providers, it would not be appropriate to make an adverse finding against them.

16. Ms Gardner further stated that "the contracted health provider at HMP Loddon treated Mr Brigham's health concerns in an unsympathetic and dismissive manner". Again, this conclusion was based on the statements of lay witnesses and not on the medical records, which give some evidence of contradiction as, for example, the entry of the 3 June "wants X-ray" and an X-ray was subsequently performed. In addition, further evidence that tends to question the validity of this conclusion, is found in the findings of the Department of Human Services Healthcare Unit review of August 2004. The author (Mr David Greene) concluded that "Whilst there is no doubt that Mr Brigham's condition deteriorated over a very short period of time, there is little on the file to suggest that the patient had been neglected by the health service." This report was not only made in a timely way in relation to the medical system that then existed, but the author had the benefit of having interviewed Mr Brigham. As Mr Brigham's sister told the hearing, her brother had said to her "...that he told David Greene everything that had happened, and that he'd gone through all steps about what had happened up at Loddon."

17. Dr Sungaila was critical of PSH's failure to adequately investigate Mr Brigham's chest symptoms, which she believed would have been present for several weeks, or longer. This conclusion is not supported, however, by the evidence of Dr Boyd in respect to his consultation of the 19 June, nor by the entry in the medical centre records of the 7 June, where it was recorded his chest was negative to examination. There is support in the entry of the 10 June, when Mr Brigham was treated with prednisolone and found to have inhaling and exhaling rhochi. When asked for an explanation as to Mr Brigham's shortness of breath, Dr Sungaila conceded that it may have been due to his primary lung cancer, or it could have been associated with a chest infection. Dr Tuck (Director of Medical Services of St Vincent's Correctional Health Service at Port Phillip Prison) was of the view that the 10 June presentation may well have been consistent with a patient presenting with an acute respiratory track infection, which would not necessarily indicate a chest X-ray being performed. Rather than having chest symptoms for several weeks, the possibility remains that Mr Brigham's symptoms varied from inactive to active and on 19 June, were inactive, with Dr Sungailia agreeing that the chest symptoms could wax and wane when treated with prednisolone. In these circumstances it would be inappropriate to make an adverse finding on the failure to perform a chest X-ray on the first or second consultation, which featured chest symptoms.

18. There is little doubt that the difficulties facing health providers generally are exacerbated when the patient is a poor historian and/or is non-compliant with prescribed medication. If the history is not forthcoming, there must be greater reliance on the presentation of the medical signs. In Mr Brigham's case the signs were potentially confusing as the X-ray investigations showed mild spondylosis and he had a history of weight lifting. In all the circumstances, I am satisfied that PHS managed Mr Brigham's medical conditions as at 19 June, to the standard required for a primary health care provider, including blood testing and obtaining a plain X-ray of the spine.

Dr James Boyd

19. On presentation to the Emergency Department at Bendigo Hospital on 19 June, Mr Brigham was seen by the triage nurse at 4.30pm, and triaged as category 4, meaning not urgent. A history was taken of "5 out of 52 weeks of back pain, lumber, back legs, anti-inflammatory ceased three out of seven days ago". Dr Boyd told the inquest that Mr Brigham did not present with, nor did he complain of, symptoms of the cancer from which he died. He stated that he did not complain of chest pain, nor a cough and that he did not cough during the consultation,

nor did he appear short of breath. Dr Sungaila, in her evidence, agreed that respiratory symptoms in patients with this type of cancer could wax and wane. She agreed that Mr Brigham's respiratory rate of 18 was within the normal range and she further agreed that had Mr Brigham taken his prescribed medication for his asthma shortly prior to the consultation, it may have improved his respiratory situation by the time he presented to the Accident and Emergency Department. Dr Boyd further stated that Mr Brigham did not describe any shoulder, or neck pain, nor did he complain of lethargy. He presented as a quite well muscled 38-year-old man whose weight was approximately 75 to 80 kilograms (BMI of 27.4 at autopsy) and he did not look malnourished, or frail. Whilst Mr Brigham had lost weight in the months leading up to the consultation on 19 June, Dr Boyd stated that he was not told this by Mr Brigham. As Dr Boyd had only seen Mr Brigham on the one occasion, he did not have the opportunity to compare his physical presentation to earlier times.

20. Dr Boyd noted Mr Brigham's vital signs were all within the normal range when taken by the triage nurse in the Emergency Department shortly prior to the consultation. His vital signs were temperature 37 degrees, pulse 84 bpm, respiratory rate 18 bpm and oxygen saturation 97%.

21. Dr Boyd told the inquest that he believed he was treating Mr Brigham for lower back pain which was his primary complaint and, on viewing his X-ray report dated 15 June 2004, he noted minor spondylosis of the spine. He was told that Mr Brigham had stopped taking anti-inflammatory medication a few days before 19 June and concluded, following a basic standard physical examination of his back, that his musculoskeletal pain was due to inflammation. Accordingly, his treatment plan was for Mr Brigham to go back on the anti-inflammatory medication and to be reviewed at the prison medical centre in the following week. He stated that these oral instructions were given to Mr Brigham and the prison guard who accompanied him to the hospital. Dr Boyd concedes that he did not issue a discharge summary, or write a letter to the prison, or telephone the prison.

22. Dr Boyd had no recollection of being provided with Mr Brigham's medical file from the prison and the evidence indicates that it was not standard procedure for a medical file to accompany a prisoner to an external hospital, for various reasons. He also stated that he was not provided at the time of the consultation with a printed form known as a "transfer form, or medical report for Doctor, or Hospital". Whilst the evidence indicates that the referral letter was on the Bendigo Hospital file, the evidence is that Dr Boyd, for whatever reason, was not

shown it on the 19 June 2004. Whilst the letter is brief, it did refer to a suspicion or possibility of more underlying pathology, although there was no reference made to a suspicion of cancer.

23. It was submitted on behalf of Dr Boyd that with the wisdom of hindsight, it can be said that further investigations could have been ordered by him on 19 June in respect to a differential diagnosis for his back pain, but that hindsight is not the test to be applied of what was reasonable at the time. Support for this submission was found from Dr Sungaila, who agreed that there is an almost irresistible urge in these type of cases to rely on the wisdom of hindsight to assess a health professional's performance, after the patient's eventual medical outcome is known.

24. On the evidence before me, I accept Dr Boyd's evidence as to Mr Brigham's presentation and the history he gave regarding his symptoms. It is by no means clear that Mr Brigham was an accurate historian, nor that his presentation should have alerted Dr Boyd to a more sinister underlying condition. Dr Sungaila stated that given the information Dr Boyd had in his possession, his failure to suspect cancer was understandable, given the circumstances and his level of experience. In addition, Professor Martin told the inquest that Mr Brigham's deterioration had been "dramatic". He stated that his condition deteriorated significantly "day by day" in the final days before he died and agreed that it was therefore possible, that on 19 June 2004, he did not look malnourished, or frail. Professor Martin stated that it was possible that Mr Brigham could have been walking normally in mid June 2004, notwithstanding that he was bed bound by July 2004. I accept the submission made on behalf of Dr Boyd that it is unreasonable to have expected him to address any underlying pathology, given the circumstances of the presentation and a paucity of patient history.

25. It is clear on the evidence before me, that delayed diagnosis did contribute to Mr Brigham experiencing further pain, by delaying his palliative care. However, I am not persuaded 'to a reasonable degree of satisfaction' that the delayed diagnosis was due to medical neglect, or mismanagement. Adverse findings should not be made unless there is clear and cogent evidence to support them and should not be based on evidence formulated "with the wisdom of hindsight". Whilst there are identifiable shortcomings (e.g. Doctor Boyd not having the 'transfer form or medical report to doctor/hospital' available to him and he not providing a written discharge summary at completion of the consultation), the evidence does not establish treatment or management outside the parameters of reasonable health care practice.

St Vincent's Hospital Melbourne (SVHM) and St Vincent's Correctional Health Service (SVCHS)

26. On the evidence before me I am satisfied that the treatment and management of Mr Brigham whilst in the care of SVHM and SVCHS, was within the parameters of reasonable health care practice. This includes the advice given by Dr Tuck on the 22 and 23 June; the investigations undertaken and medications prescribed following Mr Brigham's transfer to Port Phillip Prison on the 24 June and his palliative care at the Caritas Christi ward.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. Following an unrelated review of deaths in Victorian correctional facilities, the Coroner's Prevention Unit (CPU) identified several cases in which prisoners died from metastatic cancers. These were cancers that were only detected after they had spread beyond the primary or original site, to other parts of the body. Fifteen deaths unambiguously linked to cancer were identified in the period from 1 January 2000 to 31 March 2010. Of these deaths, the available evidence suggests that in 10 cases (66%), the cases were only detected after it had metastasized. The concentration of cases featuring late detection of cancer raises potential concerns about the quality of medical care prisoners may be receiving.

2. Health care providers within the prison system need to remain alert to international research suggesting that there is a greater incidence of cancer among prisoners, than the general population, and that they suffer a higher rate of lethal malignancies. Risk factors occur in much higher levels in prison populations, with viral infections, histories of drug and alcohol abuse, smoking, chronic illness and social and economic disadvantage, being recognized risk factors for cancer.

3. A change in medical management practice has occurred since Mr Brigham's death. In July 2010, Justice Health issued a directive to health service providers prescribing a "notifiable incident" [1] in the following terms: "When a prisoner experiences a period of persistent pain

[1] A notifiable health incident refers to any event or circumstance which has actually or could potentially lead to an adverse outcome or consequence for a person in custody, the health service provider or the Department of Justice. All

that has failed to respond to a planned medical approach for a period of greater than 14 days", Justice Health will receive an incident notification on day 15. The obligation is on the health service provider to report and provide updates, including the development of a care plan for patients with undiagnosed pain.

4. Following review of this case, Justice Health suggested a number of recommendations be adopted in order to improve the quality of medical care within the prison system:

   i. That processes be in place to ensure follow up appointments are booked at the time of review, to ensure requests for follow up by the doctor are not overlooked and that all prisoners attending an Emergency Department are reviewed by the nursing staff member upon return from hospital, but not later than 24 hours post return.

      Changes have been implemented and I note the response to this recommendation given by Ms Christine Fuller, Chief Nursing Officer, PHS: "*The process that is now in place is that the booking process at Loddon is managed by St Vincent's Hospital. Referrals for secondary and tertiary appointments are written by the attending General Practitioner and are faxed to St Vincent's Hospital. This is entered into the computer database and a waiting list is at the hospital. The hospital then notifies PSH nursing staff at Loddon once a week of all appointments for the coming month. The nursing staff then check that the referral is still current and confirmation is then provided. If there is no time for a planned admission, then the process is that the prisoner would be sent to the nearest emergency department by ambulance if this is indicated.*"

   ii. That all results of pathology, radiology or investigative procedures be disclosed to the patient by a general practitioner, or suitably qualified health professional. Ms Fuller's response: "*Current practice is that the General Practitioner reviews all pathology, radiology or investigative procedures and discusses with a patient the results of any tests. Nursing staff are generally not permitted to disclose any results of tests to a patient unless the doctor advises the nurse that the results are normal and that the patient should be advised of this in a nurse clinic or it is necessary for the nurse's immediate management of the patient. Save for these situations I believe it is not the role of a nurse to disclose such matters to a patient*".

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incidents must be identified, managed and reported in accordance with relevant legislation, standards, policies and Department of Justice protocols.

iii. That all occasions of service are clearly documented within the medical record. These occasions should include, but not be limited to: doctor's clinic, nurse clinic, nurse triage, physiotherapy review etc. Ms Fuller's response: *"Entries into the medical records are clearly documented with the designation of the person entering the progress note and signed. Stamps are used to further ensure legibility in some cases to identify the type of clinic. It is anticipated that the implementation of an electronic health record system by Justice Health will further enhance processes."*

iv. All patients with complaints of pain of an unknown origin or cause, who show no signs of improvement over a two week period from initial complaint, should:

a) undergo further diagnostic testing;

b) be commenced on a care program for pain management;

c) be referred to a tertiary care facility if symptoms persist or worsen over a 4 week period from the time of complaint and the cause.

In response Mr Fuller states: *"Nursing staff receive and assess a complaint of pain and directly refer to the General Practitioner as required. There are specific protocols which relate to chest pain presentations. The General Practitioner currently writes up all assessments of any complaints of pain and makes further appointments for follow-up. If appropriate the General Practitioner will make referrals which could also include referral to a Pain Management Specialist and the implementation of a chronic health care plan."*

5. I believe the measures outlined by Ms Fuller, appropriately address the recommendations of Justice Health.

6. In addition to recommendations put forward on behalf of Justice Health, the family have submitted 15 recommendations. A lot of thought has gone into these recommendations and, as some relate to prisoner medical care in general, it is appropriate to set them out in full, together with Ms Fuller's response.

i. Processes should be put in place to ensure follow up appointments are booked at a time of patient review in order to ensure a request for follow up by the doctor is not inadvertently overlooked. Ms Fuller's response: *"At present the process for booking appointments with the General Practitioner is that when the prisoner patient is seen by the doctor and requires a follow up appointment, this will be diarised by the*

nurse who reviews the doctor's notes at the end of the clinic. As part of the process of assisting the doctor to run the medical clinic the nurse reviews the notes. The appointments are booked at the time of the patient consultation. A prisoner at any time can attend a sick parade and request to see a doctor and an appointment can then be made."

ii. All prisoners attending an Accident and Emergency Department should be reviewed on their return from that hospital, not later than 24 hours after their return. That there is written communication between accident and emergency department and the primary health provider as to the outcome of the assessment and any follow up treatment plan. Ms Fuller's response: "*I agree that where a prisoner patient attends the accident and emergency department of a hospital, there should be written communication back such as a discharge summary or letter from the hospital to the prison / PHS, which is recorded in the patient's medical file. The prison General Practitioner should have access to that information and should review that information before the next consultation with the patient. I do not agree with the general recommendation that all returning prisoners should be reviewed within 24 hours. Whether a further review is indicated will depend on a number of factors including:*

   a. *the prisoner's conditions and symptoms upon return*
   b. *the prisoner's complaints (if any)*
   c. *the orders of the treating doctor at the hospital*
   d. *the availability of doctors or nursing staff at the prison*
   e. *the contents of the discharge summary or letter including recommended treatment*

iii. That the full medical file of the Loddon Medical Health Centre be sent to the Accident and Emergency Department for the doctor to review. Ms Fuller's response: "*I disagree with this recommendation. It is not feasible, practical or safe for the maintenance of health records that the entire patient file accompany a prisoner patient to a hospital appointment on every such occurrence. However, a written summary should accompany the patient, with any relevant investigative findings as occurred in this case. The written summary I accept should contain sufficient*

information to facilitate a proper handover. There is currently a form used for transfer of information when a prisoner is transferred to hospital."

iv. Where possible the doctor reviewing a patient at an Accident and Emergency Department have a telephone discussion with nursing or medical staff at the prison, as part of the assessment of the patient and before confirming or finalising any treatment plan. Ms Fuller's response: *"I believe this is a matter of clinical judgement for the hospital doctor who reviews a prisoner patient as to whether that doctor needs to contact medical staff at the prison. Further, such recommendation would not necessarily be possible because the prison is not permanently manned by medical staff. The best practice is for the written summary to accompany the prisoner patient or to be faxed from the hospital to the prison following the hospital consultation."*

v. Where a prisoner is sent to an external hospital by ambulance, the registered nurse or medical practitioner themselves initiate contact with the hospital. Ms Fuller's response: *"I disagree with this as a general recommendation. It is a matter of clinical judgement for the referring practitioner whether he or she needs to contact the receiving external hospital and the time that it is done, if at all. In some cases it will be appropriate, in some it will not. Further, if a referral takes place after-hours then that referral will be made by prison staff and not by medical staff."*

vi. That all results of pathology and/or radiology be disclosed to the patient by the general practitioner or other suitable accredited health professional. Ms Fuller's response: *"As stated, nursing staff are generally not permitted to disclose any results of tests to a patient unless the doctor advises the nurse that the results are normal and that the patient should be advised of this in a nurse clinic, or it is necessary for the nurse's immediate management of the patient. Save for these situations I believe that it is not the role of a nurse to disclose such matters to a patient. This is a matter for the General Practitioner."*

vii. Patients should be told they are going to be transferred to hospital for further testing or treatment (with any necessary modifications having regard to security concerns on a case by case basis). Ms Fuller's response: *"For the purposes of obtaining informed consent and discussing treatment, and for that purpose only, I agree that patients should be told what further treatment they may be required to undergo. But for*

security reasons, it should not be the case that a prisoner patient knows, when or how that treatment will occur, or whether he will be leaving the prison premises for the treatment."

viii. Procedures should be set in place for referrals for ongoing and undiagnosed pain, which are the subject of repeated requests for medical assistance. Even where there is a confident diagnosis that the pain relates to musculoskeletal injury, the observation that the pain is not resolved would itself be a trigger. Ms Fuller's response: *"I believe that is a matter for clinical judgement of the General Practitioner to decide when apparently unresolved pain should result in a referral for further investigation. If the pain falls within the Justice Health's 'notifiable incident' directive (not in place at the time of this incident) then it will be followed by PHS "*

ix. All patients with complaints of pain from an unknown origin or cause, who show no sign of improvement over a two week period, should undergo further diagnostic testing. Ms Fuller's response: "*I disagree with this recommendation. I believe that it is a matter of clinical judgement what, if any, further diagnostic testing is indicated for a patient. Further, the concern which is contemplated by this recommendation will be addressed by implementation of Justice Health's 'notifiable incident' directive."*

x. A patient in a custodial setting should have the opportunity to make a written request to seek a second opinion from a practitioner, outside of the prison setting if need be. This may be able to be facilitated by a practitioner coming into the prison if there were security concerns. Ms Fuller's response: *"Patients in a custodial setting already have the right to request medical review from a doctor outside of the prison setting. Provided the cost of treatment is privately paid for and the doctor consents and Justice Health authorises the request, there is nothing preventing a prisoner patient from being allowed a professional visit from his/her preferred doctor."*

xi. That professional visits be allowed from a prisoner's preferred general practitioner, if their general practitioner was willing to do so. Ms Fuller addresses this recommendation in response to recommendation Roman 10.

xii. Where there exists signed consent from the patient, family members should be permitted to discuss their concerns about the prisoner's health treatment with a

treating doctor or nurse at the prison, rather than being referred to an external telephone service. Ms Fuller's response: *"There are protocols and security procedures in place which govern how family members can access a prisoner patient's medical information or his treating team. There are also consent issues. In general I accept that the more relevant medical information that is obtained in respect of a prisoner patient the better their health may be promoted. I believe it is a matter for the general practitioner to decide whether to seek further information from family members and how this should be approached. Furthermore it is also a matter for the general practitioner to decide whether to take any steps in relation to information received that a family member desires to communicate. I believe that the security protocols and procedures are matters for Justice Health and Corrections Victoria and the relevant doctor. One issue which comes to mind is how would a nurse be expected to verify the identity of a telephone caller who is purporting to be a family member of a prisoner? Further, I would have concerns about family members calling nurses directly and for nurses being expected to triage those calls and to allocate them based on severity, in addition to their professional nursing role. If that occurred, then it would come at a cost to the nurse's primary function of providing nursing services."*

xiii. Family members should be permitted to contact the treating physician or nurse/s directly. It is suggested that nurses answer calls initially and triage the matters as to severity in order to ensure medical professionals are not inundated with calls from concerned relatives. Ms Fuller addresses this recommendation in response to recommendation Roman 12.

xiv. That the primary healthcare provider has an ongoing duty to conduct their own medical assessments and to make their own treatment plan and not rely solely on comments of external doctors at Accident and Emergency Departments. Ms Fuller's response: *"Primary healthcare providers have a duty of care to their patients which is enshrined in law."*

xv. That a prisoner not be discharged from an Accident and Emergency presentation back to prison unless that decision is endorsed by a consultant medical practitioner of the relevant hospital. Ms Fuller's response: *"I believe that at present the expectation is that a prisoner patient would not be discharged from an Accident and Emergency hospital without a proper treatment decision being made. I do not*

believe that the discharge process should be restricted by the proposed recommendation."

7. I believe the measures outlined by Ms Fuller, appropriately address the recommendations of the family.

RECOMMENDATIONS

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

1. That the Department of Justice initiate and maintain appropriate performance audits of its health service providers, to ensure that all diagnostic services that are available to the general population, are available to the prison population.

2. That the Department of Justice ensures its health service providers implement appropriate cancer screening programs, aimed to make sure cancer detection and treatment among prisoners is not unduly delayed.

3. That the Department of Justice ensure health service providers have procedures set in place for delivery of written communications between the primary health care provider (transfer form, or medical report for doctor, or hospital) and a tertiary health care provider (discharge summary/management plan) and protocols to ensure acknowledgement of receipt and contents. Such communication would be enhanced by the introduction of a planned electronic record system by Justice Health. It is recommended its introduction be prioritized.

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

Family of Thomas Brigham
St Vincent's Hospital
Dr James Boyd
Department of Justice; Justice Health

Signature:

Coroners Court of Victoria

IAIN WEST
DEPUTY STATE CORONER
Date: 20 June 2013