IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 0481

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Charles Bertram Squires
Delivered on:	30 March 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	19, 20 & 21 May 2021
Counsel assisting the Coroner:	S Wallace Instructed by G Horzitski
Counsel for Correct Care Australasia Pty Ltd:	E Gardner Instructed by Meridian Lawyers
Counsel for the Department of Justice and Community Safety	R Singleton Instructed by Victoria Government Solicitor's Office

CONTENTS

INTRODUCTION

1. Charles Bertram Squires was a 76-year-old man who was in custody at the Kareenga Annexe of the Marngoneet Corrections Centre at Lara at the time of his death. He had been serving a prison sentence since 2014.

2. On 26 January 2017 Mr Squires sought help for a headache after a fall with head strike.

3. He died in hospital on 29 January 2017 from an intracranial haemorrhage.

THE CORONIAL INVESTIGATION

4. Mr Squires' death was reported to the Coroner as it appeared to have been unexpected and to have resulted from an injury, and so fell within the definition of a reportable death pursuant to section 4 of the *Coroners Act 2008* (**the Act**).

5. As Mr Squires was a person in custody at the time of his death, his death was reportable and an inquest into his death mandatory pursuant to section 52(2)(b) of the Act. This requirement ensures the independent scrutiny of the circumstances surrounding the death of persons for whom the State has assumed responsibility.

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[1] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[2]

7. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the phrase "*circumstances in which death occurred*,"[3] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

[1] Section 89(4) *Coroners Act 2008* (Vic).
[2] Preamble and section 67 *Coroners Act 2008* (Vic).
[3] Section 67(1)(c) *Coroners Act 2008* (Vic).

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners.

10. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[5] or to determine disciplinary matters.

11. The coronial investigation in this case was undertaken on my behalf by a member of Victoria Police who was appointed as the coroner's investigator, Senior Constable Joseph Vallelonga. A coronial brief was prepared with witness statements taken from persons who witnessed the circumstances leading to Mr Squires' death, and the forensic pathologist's report, as well as a neuropathology report from Dr Linda Iles.

12. Expert opinions were prepared by Associate Professor John Laidlaw and Associate Professor Michael Murphy.

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[6] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[7]

BACKGROUND

14. Mr Squires had a medical history of atrial fibrillation (**AF**), coronary artery bypass grafting, abdominal aortic aneurism repair, hypertension, hypercholesterolaemia, and type 2 diabetes.

15. Mr Squires was taking Apixaban, a blood thinning agent, for the management of AF along with aspirin and other medications to treat his medical conditions.

SCOPE OF THE INQUEST

16. The scope of the inquest was formulated as follows:

    (a) was the traumatic component of Mr Squires' medical condition adequately assessed and investigated at Marngoneet Correctional Centre on 26 January 2017?

[4] *Keown v Khan* (1999) 1 VR 69.
[5] Section 69(1) *Coroners Act 2008* (Vic).
[6] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[7] (1938) 60 CLR 336.

(b) what were the applicable guidelines for the investigation of patients regarding assessment of blunt head trauma for nursing staff and escalation for medical review?

(c) were those guidelines appropriate?

(d) whether the intracranial haemorrhage was of traumatic origin.

17. The inquest heard evidence over three days from seven witnesses. Dr Linda Iles and Associate Professor John Laidlaw gave concurrent expert evidence regarding the cause of Mr Squires intracranial haemorrhage.

Other investigations

18. As Mr Squires was in custody at the time of his death, his death was reviewed by Justice Health and the Office of Correctional Services Review (**OCSR**).

19. Prisoners' deaths are reviewed by the Office of Correctional Services Review (which is now the Justice Assurance and Review Office) as OCSR reports to the Secretary of the Department, who is responsible for monitoring all correctional services to achieve the safe custody and welfare of prisoners. Justice Health has responsibility for the delivery of health services to Victoria's prisoners.

Justice Health Review

20. The Justice Health Offender Death Report found, based on a file review:

> *… there is nothing to suggest that the healthcare provided to Mr Squires was not in accordance with Justice Health Quality Framework 2011. As such Justice Health makes no recommendations for systemic improvements arising from the death of Mr Squires on 29 January 2017.*[8]

Review by the Office of Correctional Services Review

21. The OCSR review into the death of Mr Squires found the custodial management and response to his death met the required standards prescribed by Corrections Victoria, and there were no findings requiring systemic attention by Corrections Victoria.

[8] Coronial Brief (**CB**) 96.

22. The report's findings regarding the circumstances of death references paramedics assessment that Mr Squires had likely suffered a stroke and the hospital CT scan confirmed a large brain haemorrhage.

23. Both the OCSR and Justice Health reviews were conducted in the context of Mr Squires' death being from a stroke, and neither review considered whether his fall, being the traumatic component of his condition, was adequately assessed and investigated.

IDENTITY OF THE DECEASED PURSUANT TO SECTION 67(1)(a) OF THE ACT

24. On 29 January 2017, Kath Dellar, Prison Officer, visually identified Charles Bertram Squires, born 15 December 1940.

25. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

26. On 31 January 2017, Dr Khamis Almazrooei, a Forensic Pathology Trainee practising at the Victorian Institute of Forensic Medicine (supervised by Dr Michael Burke, Senior Pathologist), conducted an examination and provided a written report, dated 2 June 2017. In that report, Dr Almazrooei concluded that a reasonable cause of death was '*Intracranial haemorrhage*'.

27. I accept Dr Almazrooei's opinion as to cause of death.

28. Toxicological analysis of ante-mortem specimens collected on 26 January 2017 identified the presence of amitriptyline[9] and nortriptyline, atenolol,[10] gliclazide,[11] metformin,[12] and paracetamol.

29. Dr Almazrooei explained that neuropathological examination of the brain showed left subdural haemorrhage, subarachnoid haemorrhage about the left temporal lobe, interhemispheric fissure and right convexity, left temporal lobe haemorrhage, and adjacent infarction associated with patchy areas of cerebritis and meningitis most marked at the base of the brain.

[9] Amitriptyline is used to treat depression.
[10] Atenolol is an anti-hypertensive drug.
[11] Gliclazide is an antidiabetic drug.
[12] Metformin is an antidiabetic drug used to treat maturity-onset diabetes.

30. Dr Linda Iles, Forensic Pathologist, completed a neuropathology report on 17 May 2017. In her opinion, the subdural haematoma was likely to be due to trauma, however the presence of meningitis in association with patchy cerebritis surrounding the left temporal lobe haemorrhage suggested that the most likely cause for the deceased's left temporal lobe haemorrhage was septic emboli.

31. Post-mortem examination showed evidence of blunt force trauma to the head in the form of two subgalea bruises which possibly occurred consequent to the fall. Other medical conditions identified were cardiomegaly (heart weighed 600 grams), severe coronary artery atherosclerosis, myocardial fibrosis, pulmonary oedema, and congested liver. There was no obvious macroscopic evidence of infection (as a source for septic emboli), and no evidence of infective endocarditis.

32. It was possible that Mr Squires had a primary intracranial bleed (secondary to septic emboli) which caused him to fall and sustain a traumatic injury (subdural and subarachnoid haemorrhage). However, the relative contributions of natural disease and bleeding due to trauma could not be ascertained with any certainty. The report noted elderly people who are anticoagulated (on blood thinner medication) are at increased risk of bleeding complications, especially intracranial haemorrhage, following trauma, such as a fall.

33. I shall return to this when I consider the expert evidence.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

34. On 26 January 2017, at approximately 2.10pm, Mr Squires pressed the duress alarm in his cell. Prison Officer Lovett attended. Mr Squires said he had fallen earlier at 9.00am and had hit his head. He had had a rest and some lunch but had woken up and the headache was worse so he activated the duress alarm. The prison officer noted he had a lump on his head and called a Code Black.

35. At 2.10pm Nurses Megan Treharne and Jennifer McPhee attended Mr Squires' cell. Mr Squires stated he did not feel pain or dizzy prior to falling and believed he had tripped.[13] He had a small bump to the left top part of his head. At 2.30pm he was transferred via wheelchair to the medical centre for monitoring.

[13] JCare records p 17.

36. In the medical centre he was given Panadol and ibuprofen at 2.30pm and observations were taken at 2.30pm, 2.40pm and three further sets of observations at 15 minute intervals.[14]

37. At 3.45pm Mr Squires returned to his cell with the advice (according to the Justice Health report) to call for assistance if he had any further symptoms.

38. On 26 January 2017 at 7.16pm during a prison count, Mr Squires was noted to be absent and later found on the floor of his unit, incoherent and confused.

39. He was transported to University Hospital Geelong. On arrival in the Emergency Department a 'stroke call' was made. The doctor assessed him within eight minutes of arrival. A CT scan of the brain demonstrated subdural, subarachnoid, and intracerebral haemorrhages. The treating team sought a neurosurgical opinion which advised there was no surgical option to treat the haemorrhage.

40. Mr Squires was treated with medical and blood products to reverse the anticoagulant effects of the Apixaban and admitted to hospital under the neurology team.

41. Mr Squires' condition deteriorated, and he died at 3.25am on 29 January 2017.

Medical assessment and investigation in custody

Was the traumatic component of Mr Squires' medical condition adequately assessed and investigated at Marngoneet Correctional Centre on 26 January 2017?

42. At the commencement of the inquest, Ms Gardiner, Counsel appearing on behalf of Correct Care Australasia, noted that the health provider and the nurses who attended upon Mr Squires considered, that with the benefit of hindsight, a more appropriate course would have been for nursing staff to have requested an ambulance.[15]

43. The inquest heard evidence from the nurses who treated Mr Squires, Megan Treharne and Jennifer McPhee. Ms Treharne, a registered nurse was on the 7.00am to 3.00pm shift and Jennifer McPhee, a registered nurse was on the 11.00am to 7.00pm shift. Both nurses attended the Code Black at 2.10pm. Ms Treharne attended to Mr Squires for about 35 minutes until her shift ended and she left him in Ms McPhee's care.

[14] JCare records p 16-17.
[15] Transcript (**T**) 8.

44. Following the Code Black, Mr Squires was assessed in his prison cell and then reviewed in the medical centre by Ms Treharne and Ms McPhee. Nursing observations were performed which were normal, save for Mr Squires having a slightly elevated blood pressure. The nurses noted the bump on his head, but fellow prisoners had stated Mr Squires had not hit his head when he fell. In evidence, Ms Treharne confirmed when she attended the Code Black, she felt the lump on Mr Squires' head. Mr Squires complained of a headache and rated the pain as 9.5/10.

45. In their statements to the coronial investigation, Ms Treharne and Ms McPhee outlined their assessment and management of Mr Squires. They did not address questions such as whether they knew about Mr Squires' medical history and that he was taking apixaban, whether they had access to a record of his medications, whether they considered the need for a medical review or transfer to hospital, or whether there were any policies or guidelines to guide their decision making.

46. In her second statement, Ms Treharne stated the nurses had access to Mr Squires' medical records on a database on the computer. She stated:

> *While I was undertaking assessment of Mr Squires, RN Jenny McPhee went to the medication room to obtain medication for Mr Squires which would have required review of the drug chart. I cannot recall looking at the drug chart.*[16]

She did not know that Mr Squires was taking apixaban and that it was unlikely she referred to any guidelines or policies. As Mr Squires' condition was stable, she did not consider transfer to hospital.

47. In her evidence to the inquest, Ms Treharne stated prior to this incident, she knew of Mr Squires and recalled he would attend the medical clinic every afternoon to get his medications.[17]

48. Ms Treharne stated at the medical clinic she kept observing Mr Squires whilst Ms McPhee went into the medication room. Ms McPhee then gave Mr Squires panadol and ibuprofen. Ms Treharne conducted observations at 2.30pm and 2.40pm. Ms Treharne stated:

> … *he's pretty much stayed the same* …

[16] Exhibit 7 Statement by Megan Treharne dated 20 November 2019.
[17] Ms Treharne gave evidence with a certificate pursuant to section 57(5) of the *Coroners Act 2008.*

> *His blood pressure and that did get better, and his heart rate did decrease so they're two good things … and his pupils were still reactive and equal … he still had equal limb strength … that's pretty much all we would have handed over.*[18]

49. Ms Treharne was not concerned that Mr Squires headache rated 9.5/10 for pain as at 14.40pm, as '*… he'd only had the Panadol and Nurofen 10 minutes earlier …*'.[19]

50. Ms Treharne explained each prisoner had their own medication chart which was kept in the medication room. Ms Treharne presumed Ms McPhee looked at Mr Squires drug chart to give him Panadol and Nurofen.[20] She agreed that it was standard to check a person's drug chart before given them medication.

51. Ms Treharne was referred to the Correct Care Australasia Head Injury Assessment policy,[21] which she *presumed* she had seen previously. Ms Treharne did not notify a doctor or transfer Mr Squires to hospital by ambulance. She agreed a headache rated 9.5/10 would definitely have warranted a transfer by ambulance but noted Ms Squires had only taken the panadol and nurofen ten minutes prior to her leaving the shift. When asked why she did not consider calling an ambulance was necessary she stated:

> *… so based on my observations of Mr Squires, his … Glasgow Coma Scale did stay at 14 but his pupils were equal and reactive. He was still neurologically intact. As in, he was able to smile. There were no obvious deficits … or weakness to either side … his blood pressure had gone down and so had his heart rate … he was quite, he was okay when I left.*[22]

52. Ms Treharne told the inquest if she had known Mr Squires was on apixaban and aspirin she would have sent him straight to hospital.

53. As she was finishing her shift, Ms Treharne was only with Mrs Squires for about 35 minutes.

54. In her evidence Ms McPhee[23] advised prior to 26 January 2017 she knew Mr Squires by name and had previously administered him his daily medication.

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[18] T 110.
[19] T 111.
[20] T 113.
[21] CB 157-8. The Guidelines dated 2013 were applicable at the time.
[22] T 123.
[23] Ms McPhee gave evidence with a certificate pursuant to section 57(5) of the *Coroners Act 2008.*

55. In her second statement Ms McPhee agreed she had access to Mr Squires medical records and medication list. She believed Correct Care had relevant policies for treating head injury but did not recall looking at them. She did not believe a transfer to hospital was required as Mr Squires' observations were within normal limits, '*pupils were reactive – positive and negative and he had no slurred speech.*'[24]

56. When she attended the Code Black, Ms Treharne took the history whilst she took notes. Ms McPhee described both she and Ms Treharne were in equal consultation with each other about Mr Squires medical treatment.[25]

57. When they returned with Mr Squires to the medical centre, they did the first set of observations together and when he complained of a headache, '*I went and got some Panadol and nurofen,*' and administered the medication. '*I didn't have regard to a drug chart at that time*.' [26] She agreed this was not standard practice and had no reason for not reviewing the drug chart. It was not until her final assessment of Mr Squires at 3.45pm she looked at the drug chart. This was because Mr Squires had requested his usual night medication.

58. Ms McPhee then administered his apixaban and aspirin medication without considering she was administering an anticoagulant medication when Mr Squires had complained of a head injury and a severe headache rated 9.5/10.

59. Ms McPhee was referred to the Correct Care Australasia Head Injury Assessment policy. When asked if she would have taken different steps if she had looked at it, she stated, '*Possibly. But these are a guide and with how Mr Squires was presenting in front of me … I … can't say for certain that I would have*.'[27] Ms McPhee only did 45 minutes of observations because Mr Squires asked to return to his room to rest, and she was happy with his last set of observations which she took manually. Ms McPhee gave Mr Squires his medication to take with him.

Conclusions

60. In responding to the Code Black it was good practice from Ms Treharne and Ms McPhee to take Mr Squires back to the medical centre for observation. As Mr Squires was photo sensitive it was good practice for them to turn the lights off. During his observations, Mr Squires' blood pressure improved.

[24] Exhibit 10 Statement Jennifer McPhee 10 October 2019.
[25] T 133.
[26] T 135.
[27] T 142.

61. Neither Ms Treharne nor Ms McPhee checked Mr Squires' medication chart. Ms McPhee agreed it was not in accordance with standard practice for her not to look at his medication chart. Neither of them referred to Correct Care Australasia Guidelines regarding the treatment for Head Injury. At 3.45pm following her final set of observations Ms McPhee improperly administered apixaban and aspirin to Mr Squires, even though they were anti-coagulant medications, and he had sustained a head injury. Ms Treharne sated if she had known Mr Squires was on apixaban and aspirin she would have sent him straight to hospital.

62. I find that if Ms Treharne and Ms McPhee were aware of the Correct Care Australasia Guidelines applicable for head injury, they would have called an ambulance for Mr Squires. They now concede that this should have occurred. There is no evidence that they notified a doctor in accordance with the 2013 Guidelines. Mr Squires should have been closely monitored for four hours, not one hour and 35 minutes, and given he had a severe headache, an ambulance should have been called. When Mr Squires was discharged from the medical centre and returned to his cell, no follow up appointment was made for him.

63. I note in the Introduction to the 2013 Correct Care Emergency Guidelines states: '*It is important that all nursing staff familiarise themselves with the guidelines to ensure they are prepared to manage emergencies when they occur.*'[28] There is no point in Correct Care Australasia having Guidelines regarding appropriate care if nursing staff are not familiar with them or how to access them. I intend to recommend that familiarity with the Correct Care Australasia Guidelines should be an essential part of the nurses' induction program.

Applicable Correct Care Australasia Guidelines

What were the applicable guidelines for the investigation of patients regarding assessment of blunt head trauma for nursing staff and escalation for medical review and were those guidelines appropriate?

64. Mr Scott Swanwick, Director of Health Services and Clinical Governance at Justice Health, gave evidence at the inquest.

65. The 2013 Correct Care Australasia Emergency Guidelines were applicable at the time of Mr Squires' death.

66. The 2013 Correct Care Australasia Emergency Guidelines did not comply with the Australasian College of Emergency Medicine (**ACEM**), 'Guidelines on diagnostic imaging'

[28] CB 132.

recommending that anyone with high-risk features has a CT scan. High risk features include being aged 65 years or over and being on oral anticoagulants.

67. Under the ACEM Guidelines, Mr Squires had two high risk features, namely, he was aged over 65 years and on oral anticoagulants.

68. Mr Swanwick noted the Justice Health Clinical Governance mechanism looks to what can be improved and stated, '*I suppose we need to look at what we can do to improve that process within Justice Health.*'[29]

69. The Correct Care Australasia Emergency Guidelines 2013 which applied at the time of Mr Squires' death have now been reviewed and replaced and updated in 2017 by Dr Gino Toncich, Emergency Physician.[30]

70. As well as being easier for a clinician to read, they now include a checklist to '*Consider high risk clinical factors in anyone presenting with a head injury*.' Presenting with a head injury and being aged 65 and over now requires the mandatory calling of an ambulance. The 2017 Guidelines incorporate specific instructions regarding the assessment and management of head injury and include the use of the Canadian CT head Rule and include specific reference to patients on anticoagulation medication. These are prompts in red mandating the call for an ambulance and transfer to an emergency department.

71. Correct Care Australasia has also developed a Medical and Nursing Response Record which prompts the inclusion of neurological observations along with other vital signs. Further education for all staff has been implemented.

72. The 2017 Guidelines are now superseded, and the 2021 Guidelines are currently in operation.

73. I find the 2013 Correct Care Emergency Guidelines were inadequate as they did not comply with the ACEM 'Guidelines on diagnostic imaging' recommending that anyone with high-risk features has a CT scan. High risk features include being aged 65 years or over and being on oral anticoagulants. There is no reference to a patient's age or the dangers of anti-coagulants in the 2013 Correct Care Emergency Guidelines.

74. The updated 2017 Correct Care Australasia Emergency Guidelines, and the now in operation 2021 Guidelines, with a mandatory call for an ambulance and preparation for transfer to an emergency department is a significant step towards prevention as it removes the need for

[29] T 98.
[30] CB 202.

discretion or judgement by nursing staff. The mandating of further assessment in any circumstance that would prompt a CT scan in a clinical setting is a meaningful change in the Guidelines.

Justice Health report

75. With respect to the Justice Health report, Mr Swanwick acknowledged that the review did not have the benefit of Associate Professor Laidlaw's report, but that on '*reflection we possibly could have made a recommendation in regard to the fact he [Mr Squires] should have been taken to an emergency department for further review*.'[31]

76. The Justice Health report is dated 20 April 2017. Although the Justice Health review does not specify, I understand from Mr Swanwick's evidence it was a 'desktop' review, prepared with reference to Mr Squires' medical records and JCare records, which are electronic prison medical records.

77. Christine Fuller, Chief Nursing Officer for Correct Care Australasia, gave evidence that there is no requirement for nurses to make statements after an incident, and that the JCare record was a sufficient record for the incident or clinical review.

78. It was submitted that Justice Health now does conduct interviews with Correct Care staff involved in an incident as part of the review process in more complex cases. It was initially thought that Mr Squires had died from natural causes, namely a stroke, which illustrates the limitations of only conducting interviews with staff in seemingly 'more complex cases.'

79. The Justice Care report states:

> *Although not noted in JCare, Justice Health have (sic) been assured that at the time CCA staff informed Mr Squires to buzz control and request medical assistance if he had any of the following symptoms: dizziness, nausea, vomiting or blurred vision. CCA also report that they advised Mr Squires that if these symptoms occur, he may need to be sent to Accident and Emergency for further assessment, as these are classic signs and symptoms of head injury*.[32]

80. I note there is no reference in either the JCare records or in the statements prepared by nurses Ms Treharne or Ms McPhee regarding what Mr Squires was told following his discharge from

[31] T 96.
[32] CB 95.

the medical centre by them or other Correct Care Australasia staff. It is unclear how Justice Health received this information from Correct Care Australasia for the report.

81. I note the Justice Health report refers to the provisional diagnosis of Mr Squires' cause of death as intracranial haemorrhage. However, the Justice Health report does not refer to the forensic pathologist's report which referred to the neuropathological examination finding that the subdural haematoma was likely due to trauma. The Justice Health review would have benefitted from considering the relationship between Mr Squires' fall at 9am on 26 January 2017, his medical treatment, the applicable Correct Care Australasia Emergency Guidelines, and his cause of death.

82. Similarly, the OCSR review dated 23 May 2017[33] refers to paramedic's assessment that Mr Squires had likely suffered a stroke and repeats this in its conclusion.

83. The Justice Health report did not reference the 2013 Correct Care Head Injury guidelines when detailing the chronology of Mr Squires' medical treatment however Mr Swanwick agreed in evidence that as part of the review by Justice Health the policies in place at the time of the incident are reviewed.[34] Mr Swanwick noted '*that's possibly just that we've not articulated that properly in the report … and we certainly should have done that at the time*.'[35] He described the review process as:

> *It's looking at the medical record – is what we're reviewing, principal and the JCare medical record and comparing that to both the quality framework and also any Correct Care policies that are relevant to that particular incidence*.[36]

84. I find the Justice Health report to be deficient on a number of levels. Firstly, it does not reference the material relied on for its compilation. I only know from Mr Swanwick's evidence that the review considers the medical records, and the JCare records. Secondly, the review has clearly had regard to material beyond the medical records and JCare records which is not referenced as it refers to information received from Correct Care Australasia regarding follow up with Mr Squires following his discharge. Thirdly, there is no evidence in the Justice Health report that the review referenced the relevant 2013 Correct Care Australasia Emergency Guidelines or assessed them against the care provided to Mr Squires by nursing staff. Fourthly, the Justice Health review has had regard to the forensic pathologist's report to

[33] CB 97.
[34] T 85.
[35] T 97.
[36] T 86.

clarify the cause of death and consider the significance of the fact that Mr Squires' intracranial haemorrhage was potentially of traumatic origin.

85. I intend to make a recommendation regarding the content and preparation of the Justice Health report.

What was the origin of Mr Squires' intracranial haemorrhage?

86. The inquest heard concurrent evidence from Dr Linda Iles and Associate Professor John Laidlaw about the aitiology of Mr Squires' brain haemorrhage. Dr Iles is a forensic pathologist at the Victoria Institute of Forensic Medicine and Associate Professor Laidlaw is a neurosurgeon at the Royal Melbourne Hospital and an independent expert commissioned by the Coroner to prepare a report. Dr Iles prepared a neuropathology report dated 17 May 2017 and email dated 18 August 2020, and Associate Professor Laidlaw prepared a report dated 11 May 2020 and a subsequent report dated 26 September 2020.

87. Associate Professor Michael Murphy, a neurosurgeon at St Vincent's Private Hospital and former Director of Neurosurgery at St Vincent's Hospital, prepared an expert report dated 22 April 2021 commissioned by Correct Care Australasia and gave evidence at the Inquest.

88. The Dr Iles and Associate Professor Laidlaw considered the possible origin of Mr Squires' brain haemorrhage and the significance and origin of the presence of meningitis and Associate Professors Laidlaw and Murphy also considered whether his death was preventable together with the role of anti-coagulation medication.

89. In her report, Dr Iles noted the evidence of head strike, stating it was not possible to be certain of the origin of the subdural haemorrhage. She stated the presence of meningitis in association with patchy cerebritis surrounding the left temporal lobe haemorrhage suggested the most likely cause of the left temporal haemorrhage was sceptic emboli. She noted whilst the source of the infection was not clear, in her opinion the findings of meningeal inflammation and the histological pattern clearly indicated an infective cause.

90. Dr Iles stated that meningitis can be caused by infection, chemicals, or an inflammatory reaction to dead brain tissue, however in this case, the presence of neutrophils (pus) was the basis of her opinion it was an infective meningitis.

91. Associate Professor Laidlaw considered the possibilities of stroke or primary meningitis as the cause of Mr Squires' intracerebral haemorrhage. On consideration of the clinical evidence

of Mr Squires' presentation, in his opinion the clinical scenario was entirely consistent with a primary head injury.

92. Associate Professor Laidlaw agreed with Dr Iles regarding the presence of infective meningitis, even in the absence of the origin of an infective cause. However, he questioned how to correlate this with Mr Squires' clinical presentation and subsequent deterioration as '*it usually presents in a totally different way*.'[37] He stated Mr Squires had symptoms of severe headache and photophobia which is associated with an inflammation of the meninges, whether from bacterial, chemical, or subarachnoid haemorrhage:

> *… so he did have some of those features which is consistent with trauma and subarachnoid haemorrhage but an infective cause. He didn't have any of the other features we would usually associate with an infective cause*.[38]

93. Associate Professor Laidlaw confirmed that a headache and photophobia were symptoms equally consistent with head injury or meningitis as both symptoms indicate the lining of the head is irritated. In his view there was no clinical suggestion of an infective meningitis. Although Dr Iles' finding of neutrophils looked infective, '*But … we haven't been able to tie that with his clinical situation*.'[39]

94. Associate Professor Laidlaw postulated a possibility that Mr Squires may have had an undiagnosed skull base fracture and dural fistula which can cause infective meningitis in people after head injury, even years later. These are subtle and difficult to detect.

95. Dr Iles also offered a potential explanation, that Mr Squires may have had a low grade meningitis, fallen over and had a traumatic intracranial haemorrhage. Dr Laidlaw agreed but noted Mr Squires' clinical presentation was not really consistent with a case of primary meningitis.[40]

96. Associate Professor Laidlaw was of the view that there was definitive evidence of trauma on the scalp that the cause of death was haemorrhage of the brain. The trauma, timing, and his deterioration fitted with this. With respect to the infective meningitis, in his view it was inflammation due to dead brain tissue however Dr Iles' opinion was that it was more in keeping with an infective pattern. Dr Laidlaw was not of the opinion the infective meningitis

[37] T 20.
[38] T 23.
[39] T 66.
[40] T 37.

could be the primary cause of death given the clinical scenario, and that the haematoma was the cause of death.

97. Dr Iles stated:

> *… I think we're in agreement that the trauma is a significant component here … and there is unequivocal evidence of trauma and we've got a man who is vulnerable to haemorrhage from trauma because of the … anti-coagulation therapy… It's just how the meningitis fits into that picture both pathologically but also important clinically, that's a little bit unclear*.[41]

98. Ultimately, I accept Associate Professor Laidlaw's opinion that Mr Squires had a traumatic intracranial haemorrhage. The evidence supports this sequence, namely Mr Squires tripped, fell and hit his head, and a lump on his head was identified by nurses attending the Code Black in his cell. The evidence was unresolved regarding the origin of the meningitis, namely whether it was infective or a reaction to dead tissue, and its effect.

99. In the circumstances I am of the view the cause of death should remain as formulated by Dr Almazrooei as '*Intracranial haemorrhage*'.

Was Mr Squires' death preventable?

100. Associate Professor Laidlaw was asked to consider whether earlier intervention would have changed the outcome.

101. There was the delay in transporting Mr Squires to hospital, Associate Professor Laidlaw's evidence was that if he had been taken to hospital at 2.10pm he would have been kept under observation. If he had been taken to Geelong Hospital, he would probably have been transferred to a tertiary hospital where there was neuro-surgery capacity. Having a headache and being on apixaban he stated:

> *I think we would have looked and said this is a big real worry, this may get worse but if we're going to operate on him now …we're going to have trouble controlling the bleeding so let's just hope it doesn't.*[42]

102. In Associate Professor Laidlaw's opinion:

[41] T40.
[42] T 60.

Emergency surgery … was the only therapeutic intervention that might have improved Mr Squires' outcome. The use of apixaban and aspirin, which at that time did not have a reversing agent would dramatically increase the risk of surgery and make haemostasis very high risk. …

In a man of Mr Squires' age with his comorbidities, the clinical signs of herniation at the time of the scan (unequal pupils), the large size and extent of the haemorrhages, and the minimum of one hour (but probably 2-4 hours) delay for delay for emergency transfer from Geelong Hospital would all suggest a very low chance of surgical survival and a[n] much lower chance of a good neurological recovery. These factors, and apixaban and aspirin, would make most Australasian neurosurgeons recommend against intervention. I consider the decision to use palliative care was appropriate and compassionate.[43]

103. Associate Professor Murphy agreed with Associate Professor Laidlaw that given Mr Squires' age, the extent of the cranial haemorrhage, coupled with him being on apixaban and aspirin and having co-morbidities, the time delay with transfer from Geelong Hospital and existing evidence of brain herniation, surgery was unrealistic.

104. Associate Professor Murphy's opinion was Mr Squires would have died irrespective of whether he had been transported to hospital at 2.10pm. Whilst he acknowledged that with a CT scan, a diagnosis could have been made several hours earlier:

… the situation would be similar in that the patient had a large intracerebral haemorrhage, most likely a bleed into an infarct, as well as a subdural haematoma and subarachnoid [bleed]. He still would have had both apixaban and aspirin [in] his blood system and as there is no agent in Australia to reverse apixaban, operating would have had the same problems if he had been operated on a few hours later.[44]

105. Associate Professor Dr Murphy's view if Mr Squires had been operated on and survived the immediate post operative period, he would have suffered irreversible brain injury and been on a ventilator in intensive care, and highly unlikely to survive.

106. I accept the expert medical opinions from Associate Professors Laidlaw and Murphy that Mr Squires' death was not preventable: even if he had been taken to hospital at 2.10pm, given

[43] CB 68-9.
[44] CB 340.

the extent of his brain injury, his comorbidities and use of apixaban and aspirin, he had a very low chance of survival.

FINDINGS AND CONCLUSION

107. Having investigated the death, and held an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Charles Bertram Squires, born 15 December 1940, died on 29 January 2017 at Geelong Hospital, 272-322 Ryrie Street, Geelong, Victoria, from intracranial haemorrhage in the circumstances described above.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. To the Secretary, Department of Justice and Community Safety:

   That Justice Health reports into prisoners' deaths detail the materials relied on, and specifically reference any applicable Guidelines relevant to medical care and compliance or otherwise. As all deaths in custody are reportable to the coroner, Justice Health should conduct interviews with staff involved and consider the forensic pathologist's report, so the Justice Health review has accurate details regarding the prisoner's cause of death.

2. To Correct Care Australasia:

   That Correct Care Australasia ensures the Induction Program for nursing staff employed in Victorian correctional facilities includes education and advice about the relevant and applicable Guidelines including Emergency Guidelines.

I convey my sincere condolences to Mr Squires' family.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Phyllis Squires, senior next of kin
Correct Care Australasia (care of Meridian Lawyers)
Rebecca Falkingham, Secretary, Department of Justice and Community Safety (care of Victoria Government Solicitor's Office)
Barwon Health

Senior Constable Joseph Vallelonga, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 30 March 2022