QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of David John Cooper**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
FILE NO(s):	2016/1402
DELIVERED ON:	11 September 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	13 July 2018, 15 to 16 August 2018
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, health care related death**,** pneumonia due to S. aureus, adequacy of health services to prisoners, communication between corrective services and health services

REPRESENTATION:

Counsel Assisting: Ms M Jarvis

Counsel for Cairns & Hinterland Hospital and Health Service: Ms S Gallagher i/b CHHHS

Counsel for Nurses K Pink and B Allen: Ms S Robb i/b Roberts & Kane

Counsel for Queensland Corrective Services: Ms S Williams i/b QCS

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Introduction

1. David John COOPER was a 54 year old man who was detained in the Lotus Glen Correctional Centre ("Lotus Glen") near Mareeba in Far North Queensland. He was accommodated in a single cell within one of the Residential Cell Blocks.

2. On 6 April 2016, during morning muster, Mr Cooper was found unresponsive in his bed in his cell, with no signs of life. Despite CPR efforts by Lotus Glen staff, Mr Cooper was unable to be revived. An autopsy later determined that Mr Cooper had died due to bacterial pneumonia, with the bacteria commonly known as "Golden Staph" found in his lungs and airways.

3. On Sunday 27 March 2016, eleven days prior to his death, Mr Cooper had completed a Health Services Request Form stating he was suffering from a sore throat, cough and headache, which he had for four days. He was seen by a nurse from the Lotus Glen Health Service (LGHS) during the medication round that day, and a telephone order was obtained from a doctor for pain relief medication.

4. Two days later on Tuesday 29 March 2016 Mr Cooper completed another Health Services Request Form stating he believed he was suffering from a virus that had been going around; that his symptoms were not improving; that he had lost weight and had been unable to eat for four days; and he was requesting antibiotics. A nurse who signed as having received that form cannot recall assessing Mr Cooper that day, and there is no record of him being seen by a doctor in the medical clinic either that day or in the days following.

5. On Saturday 2 April 2016 Mr Cooper completed another Health Services Request Form stating he had "flu symptoms" and was "shaking". A note made on the form indicates he was booked into the medical clinic.

6. At 2300hrs that same day, 2 April 2016, a "Code Blue" was called by Custodial Correctional Officers (CCOs) in relation to Mr Cooper, who was complaining of shortness of breath and chest pain, as well as "flu-like" symptoms. Mr Cooper was examined by nursing staff who found nothing of clinical significance. He was reassured and given a doona rolled up as a pillow to elevate his head in bed. Nursing staff confirmed that Mr Cooper was already on the list of prisoners to be reviewed at the nurses' medical clinic the next day, 3 April 2016.

7. The following day, Sunday 3 April 2016, there is evidence Mr Cooper presented to the nurses' medical clinic with left sided 'pleuritic' chest pain (that is, pain whilst breathing in and out), and with some shortness of breath. Nursing staff undertook some examinations of Mr Cooper's chest and lungs, with one of them noting "chest crackles" in the left lower lobe. Mr Cooper reported that Panadol was helping with his chest pain, but that it was worse lying down. A telephone order was obtained from a doctor for Panadeine forte, a stronger analgesia.

8. This was the last recorded clinical assessment of Mr Cooper, prior to him being found deceased, although he would have been seen briefly by nurses on medication rounds. He had not at any point seen a doctor in the Visiting Medical Officer's clinic. However, on 5 April 2016, CCOs had spoken to Mr Cooper about reports he was feeling unwell and offered him the opportunity to be assessed at the medical clinic, but he declined that offer. He was found deceased in his cell the next morning on 6 April 2016.

Issues for Inquest

9. As Mr Cooper died whilst in detention pursuant to the *Corrective Services Act 2006*, his death is a 'death in custody' under the *Coroners Act 2003*[1] and must be investigated by way of inquest.[2]

10. In listing this matter for inquest, it was proposed that the issues for the inquest be stated simply as those formal findings required by the s 45 92) of the *Coroners Act 2003*, namely the identity of the deceased, when, where and how he died and what caused his death.

11. It was noted that in the context of determining "how" he died, the investigation and inquest would also inquire into the adequacy of health services received by Mr Cooper in the eleven days prior to his death. C&HHHS had conducted a Root Cause Analysis (RCA) into the circumstances of the health care provided and the RCA report was provided to the coroner.

12. It was also relevant to consider, in this context, whether Custodial Correctional Officers (CCO) or other staff of the Lotus Glen Correctional Centre had any other information about Mr Cooper's health that, if communicated to Cairns & Hinterland Hospital and Health Services (C&HHHS) staff or acted upon in some other way, may have resulted in a different outcome for Mr Cooper.

Autopsy results

13. Dr Paul Botterill, Forensic Pathologist, conducted a post-mortem examination. He stated the post-mortem examination showed severe infection involving both lungs, some heart enlargement, some hardening and narrowing of the arteries of the heart and the rest of the body, kidney scarring and enlargement of the prostate and bladder. No significant injuries were identified.

14. Dr Botterill opined the cause of death was most probably sepsis complicating extensive bilateral pneumonia but the possible contribution of cardiac enlargement

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[1] s10

[2] s27(1)(a)(i)

and/or drug toxicity were difficult to completely exclude at the time of autopsy examination.

15. Further investigations were subsequently performed. Microbiology cultures isolated staphylococcus aureus from the lung. Microscopic examination confirmed the presence of a bacterial pneumonia with heart muscle scarring, some liver inflammation and early scarring.

16. Testing for drugs showed the presence of pain killers in the form of paracetamol, ibuprofen and codeine, all at drug levels below the reported individually potentially lethal ranges.

17. The cause of death was considered to be pneumonia due to staphylococcus aureus.

Staphylococcus aureus

18. Staphylococcus aureus (S. aureus, Golden staph) is a common bacteria that lives on the skin and in some peoples' noses. It can cause a range of mild to severe infections including to the lungs (pneumonia) and can be fatal. Drug-resistant strains of S. aureus have developed (Methicillin-resistant S. Aureus – MRSA).

19. Dr Margaret Purcell stated S. aureus is a less common cause of pneumonia and she had seen only three or four cases involving that bacteria in pneumonia. Dr Purcell was unable to say how quickly a person can deteriorate or when the overwhelming sepsis set in but it is not impossible that a person could be seen to be relatively well one day and dies the next day. If sepsis develops there is a change in temperature and blood pressure and these were not evident on any of the clinical reviews of Mr Cooper.

20. Dr Hall agreed S. aureus may cause a serious pneumonia and it could only take a short period of time to cause death. He noted the relative absence of abscess and pussy material at autopsy. Dr Hall stated it could be that Mr Cooper had been unwell with the flu and had some consequent reduced immunity and then developed a secondary infection with S. aureus with a rapid demise after that, particularly in the presence of an enlarged heart.

Health Services provided to Lotus Glen

21. Cairns and Hinterland Hospital and Health Service's (C&HHHS) provide the health services for prisoners at Lotus Glen. The standard set for health services by Lotus Glen Health Service (LGHS) is one that is comparable to that of the general community.

22. The LGHS provides a primary health model of care that is nurses led. This includes some onsite point of care testing and scheduled visits from medical staff, pharmacist and other specialist outreach services. There is a two bed medical

ward to monitor prisoners with low risk health situations for short periods. More serious situations require transportation to Mareeba Hospital by ambulance or Queensland Corrective Services.

23. Visiting Medical Officers (VMOs), who are based at Mareeba Hospital, hold clinics twice a week on Monday and Friday at Lotus Glen, with a further clinic held on a Wednesday, which is mainly accessed by low risk prisoners in the farming facility.

24. Otherwise VMOs are available on the telephone for advice and to give medication orders. Since 2016 the availability of telephone VMO advice has been expanded to include access to extra medical officers from the Mareeba Hospital Emergency Department.

25. Prisoners or CCOs may initiate a medical emergency by calling a Code Blue at any time in acute situations. It is evident the threshold for calling Code Blues by CCOs is low, and some situations are minor in nature, but each Code Blue is attended to by nurses from LGHS. For non-acute health issues, prisoners can request an appointment seeking nursing or medical care via a Health Services Request Form. Health Service Request Forms are able to be handed to nursing staff during twice daily medication rounds and subsequently triaged and appointments made accordingly. Correctional staff do not have direct access to these forms on patient health confidentiality grounds.

26. In 2016 Health Service Request Forms were triaged by nurses during the night shift. Since Mr Cooper's death the forms are now discussed by nurses as a group "huddle" at 10 am each morning during the morning lock down. This reduces the chances of the forms not being triaged at all, as appears to have been the case at least once for Mr Cooper.

27. CCOs are able to provide information relevant to a prisoner's health status to LGHS staff but patient confidentiality prevents a liberal exchange of information back to Correctional staff. The exchange of information between DCS and health staff is a feature often ventilated in Death in Custody inquests. A Memorandum of Understanding exists between the two organisations, which is currently being reviewed.

28. Nursing care is guided by the use of the *Primary Clinical Care Manual, 9th edition 2016,* a comprehensive document that one witness says she uses daily as her Bible. The manual states it seeks to promote and support compliance of national standards and is based on the current evidence as applied to rural and isolated practice settings. It does state that all clinicians are expected to work within their scope of practice.

The Corrective Services Investigation Unit investigation

29. An investigation report was completed by Sergeant Stephen Carr of the Corrective Services Investigation Unit of Queensland Police Service.

30. Mr Cooper had been a prisoner since 9 April 2013 and was serving a sentence for the offence of manslaughter. He resided in cell 3 In Residential Cell Block 27 at Lotus Glen. Cell 3 is a single bed unit with ensuite. Mr Cooper had a key for his cell, which he was able to lock from the inside. The cell was neat and tidy when entered on the day of his death.

31. Mr Cooper was said to be generally in good health. Dr Margaret Purcell is a Senior Medical Officer at Mareeba Hospital and works two days per week at Lotus Glen. In relation to Mr Cooper she noted the medical history showed no chronic illness and no regular medications were being taken by him. Dr Purcell had reviewed Mr Cooper on six occasions since he came to the prison in 2013. On each occasion the examination revealed a skin rash.

32. The CSIU investigation revealed that on 3 April 2016 Mr Cooper reported to the Medical Centre asking for panadeine forte for pain in his ribs. A telephone order was approved by Dr Purcell. It was also noted that on 5 April 2016 Mr Cooper was spoken to by Correctional staff about reports he was not feeling well, but he refused to seek medical treatment from the prisoner hospital.

33. Mr Cooper was locked down in his cell from 18:30 hours on Tuesday, 5 April 2016. The Lotus Glen log books noted checks were conducted at 19:52 hours, 22:46 hours, 01:43 hours and 04:40 hours. Statements were taken from all officers who attended and no concerns with respect to his health and well-being were noted on these checks.

34. CCO officers Kaye Hodson and Mukul Hastir attended the cell during morning muster at 07:20 hours on 6 April 2016. Mr Cooper was found lying on his back in bed with a doona covering most of his body. He appeared to be in a normal sleeping position. There were signs of him having been ill in his cell toilet.

35. The cell was secured until police attended. Police were provided with his offender profile and medical records.

36. The CSIU investigation report noted Mr Cooper died of natural causes and Sergeant Carr came to the conclusion Mr Cooper had been provided with adequate medical care whilst a prisoner. In forming this conclusion the CSIU would not have been aware of or considered the history of the requests for medical attention as indicated in the Health Service Request Forms or the clinical issues identified in later reviews of health services that had been provided to Mr Cooper. This were identified in the investigation into health care carried out by my office.

The evidence on how Mr Cooper died

37. Clinical Nurse (CN) Bianca Allen took a completed Health Services Request Form from Mr Cooper on 29 March 2015. CN Allen says she has no recollection of this event but agrees she had signed and dated it. Her practice would have been to take the form to the night staff who had at the time the responsibility to triage the request and place it on the appropriate nurses' or VMO clinic list. CN Allen agreed that on the information contained in the request form this indicated a need for early review by a doctor but she was unable to say if as a result of a visual assessment of Mr Cooper she was less concerned.

38. There is no evidence Mr Cooper was placed on the list to see a doctor or nurse the next day. CN Allen stated it was possible he was and had not turned up but they did not keep records of this at the time. On balance I find it is more likely the form was missed and not triaged.

39. CN Ross Clarksmith and CN Bridgetta Makoti were the clinical nurses who attended a Code Blue called on 2 April 2015. CN Makoti took the lead role during the Code Blue. They were asked to attend by CCOs due to Mr Cooper stating he was experiencing shortness of breath.

40. The immediate impression of CN Clarksmith on seeing Mr Cooper was this was not an immediate presenting emergency. CN Clarksmith was not surprised this was the case as many Code Blues turn out not to be medical emergencies. When the two nurses attended the residential unit they could see Mr Cooper through the glass panel talking normally to CCO staff. They were told the presenting issue was shortness of breath but did not observe any heaving/gasping/shortness of breath. Mr Cooper said he was complaining of coughing up phlegm and was sore from coughing and feeling congested.

41. Although CN Makoti was the lead nurse and would ordinarily complete a record of the attendance in the progress notes back at the medical centre, it was CN Clarksmith who undertook this task. The reason for this was a bit unclear but the nurses stated they worked as a team and presumed it was a workload issue.

42. CN Makoti says she took a full set of vital observations but was unable to recall and did not record his blood pressure and his temperature was not recorded in the progress notes. She did not record the observations in the Queensland Adult Deterioration Detection System (Q-ADDS) chart but says she knew the observations would have scored 1 on the chart and would not have required a particular escalation. Mr Cooper was complaining of chest pain over a wide area indicating with his hands up and down between his waist and shoulders.

43. CN Makoti then used a stethoscope and listened to his chest. Mr Cooper's chest was clear, there were no wheezes or crackles that would indicate an infection. CN Makoti stated auscultation was part of her training and she performs that task daily

and continues to receive top up yearly training in this task. CN Clarksmith stated auscultation is not a task he performs often but others do. It was noted one of the physical examinations recommended in the *Primary Clinical Care Manual* includes listening to the chest for air entry and added sounds.

44. A verbal handover was given at the end of the night shift about the Code Blue and it was noted Mr Cooper was placed on the nurses' clinic for the next day. CN Clarksmith said there was sufficient concern to place him on the nurses' clinic for the next day because Mr Cooper had indicated he was in pain.

45. The Root Cause Analysis (RCA) team noted that some of the issues relating to this event included progress notes documentation was not completed by the nurse who conducted the assessment. There was also incomplete documentation of the assessment including vital signs. The Q-ADDS chart was not used to record vital signs. As well the nursing clinical handover record contained minimal information.

46. It is apparent the RCA was set up relatively quickly after Mr Cooper's death and CN Makoti was able to provide further information to the RCA team based on her memory about his vital observations including that his temperature was 37 degrees and therefore in normal range.

47. CN Clarksmith and CN Makoti referred to a number of significant changes in practice since Mr Cooper's death, which they considered a positive step and is an improvement to the provision of health care. This included conducting a Q-ADDS chart assessment on admission of a prisoner to provide a baseline and continued use of that chart at all subsequent observations. They have also been trained in the SBAR model of communication, which is adopted in writing up their progress notes, for written handovers, and now for medication requests to VMOs. SBAR is an acronym for *Situation, Background, Assessment, Recommendation*, and is a technique used to facilitate prompt and appropriate communication.

48. On 3 April CN Allen is noted to have written up a telephone order for Mr Cooper for a prescription for panadeine forte for two days, Ibuprofen for seven days and paracetamol for seven days. CN Allen cannot remember if she physically saw Mr Cooper or if she in fact made the telephone order to the VMO.

49. Enrolled Nurse Advanced Practice (ENAP) Kerry Pink was at first unclear if she had spoken to the VMO given the progress notes for the medication order were written up by CN Allen. ENAP Pink is now more certain she spoke to the VMO during the telephone call to obtain the medication order, explaining the VMO would sometimes ask to speak to the nurse who assessed the patient, and this may have happened in this case. ENAP Pink noted Mr Cooper was a little short of breath when he attended the clinic but he settled down once he was seated. She took his vital observations, which were within normal limits. He was talking in full sentences, did not have a temperature and complained of pain from his cough. He did not look unwell.

50. ENAP Pink says she listened to his chest and thought she could hear some crackles in the left lobe and had CN Allen also listen, but CN Allencould not hear any crackles. ENAP Pink was asked about her training and experience in chest auscultation. She had worked in EDs for years and had attended annual MERC training, which included listening to chest and heart sounds and had performed this procedure on many occasions. ENAP Pink asked CN Allen to also listen as she was a more senior nurse. ENAP Pink reiterated she did not diagnose and her role was to record observations to assist others in making a diagnosis.

51. On 3 April 2016 Dr Purcell says she received a telephone call which she recalls was from ENAP Kerry Pink, who told her Mr Cooper had bony pain in his ribs and had asked for an order for panadeine forte. Dr Purcell says she asked if Mr Cooper had chest pain rather than rib pain and was told by the nurse he had sore ribs and his observations were normal. Dr Purcell therefore gave a telephone order for panadeine forte for three days. Dr Purcell did not consult with Mr Cooper and she had no further contact with him or any other clinician about him.

52. ENAP Pink gave evidence that she assumes she would have told Dr Purcell that she had initially heard crackles in Mr Cooper's chest but that her colleague, CN Allen, listened and did not hear those crackles. However, she does not have a clear recollection of this. It is therefore unclear on the evidence whether Dr Purcell was given information about one of the nurses hearing crackles and the other not.

53. When asked about this from a general clinical perspective, Dr Purcell stated those two observations are not clinically inconsistent as it is possible, with upper respiratory congestion, for crackle sounds to clear by way of coughing between the two examinations. As such, if Dr Purcell was told ENAP Pink heard crackles, however they were not heard by a second CN, this would not have necessarily caused Dr Purcell to be suspicious of a chest infection, particularly in the context of Mr Cooper's otherwise normal observations and ENAP Pink's impression that he did not look unwell, both of which were conveyed to Dr Purcell.

54. Dr Purcell stated she recalls being told his chest was clear, which means his pain was not due to a respiratory cause. Dr Purcell considered ENAP Pink an experienced nurse and she had confidence in her assessments. Dr Purcell said the prison health service is a nurse led model and if a nurse thinks a prisoner should go to hospital they make that decision. On the basis Dr Purcell was called she said she can assume the prisoner was not in a state where he needed to go to hospital.

55. On 5 April 2016 CCO Ryan Guilfoyle spoke with Mr Cooper as he had heard from another prisoner that Mr Cooper was feeling unwell. Mr Cooper was not a prisoner known to him. When Mr Guilfoyle approached Mr Cooper he thought Mr Cooper appeared normal and did not look pale or clammy. Mr Guilfoyle stated their training includes observing prisoners for any obvious health issues, within the limitations

of them not being clinically trained. Mr Guilfoyle asked Mr Cooper whether he felt he needed to attend the Medical Centre and Mr Cooper stated he just had a cold and did not want to attend the Medical Centre. Mr Cooper stated he just wanted to rest. Mr Guilfoyle told him if he changed his mind Mr Cooper should come and see him and he could also use the duress button.

56. Mr Guilfoyle stated that if he had considered Mr Cooper needed medical attention or Mr Cooper wanted to see the LGHS staff he could have called a Code Blue if it appeared an acute issue, or he would contact the medical centre and see if they could see him at an early clinic. He did not think Mr Cooper's presentation warranted either action.

57. Mr Guilfoyle was aware of the use of Health Service Request Forms, which CCOs will provide on request but for confidentiality reasons they are handed to the nurses on their medication rounds.

58. Mr Guilfoyle also noted that Mr Cooper had the opportunity to raise any concerns he had with registered nurses during their daily morning and afternoon medication rounds. The evidence is that the medication rounds are a very structured process for security reasons and there would be some but limited opportunity for nurses to assess a prisoner or speak to them. Mr Guilfoyle completed a note about his attendance on the IOMS computer system specifically to record there had been a refusal to attend the medical centre.

59. It is also apparent that the designated supervisor for the residential prisoner accommodation block, Andrew Goodmanson, also spoke with Mr Cooper after he was approached by another prisoner who suggested Mr Cooper was unwell. He also questioned Mr Cooper as to whether he required medical attention and Mr Cooper stated he did not want to attend the Medical Centre. When Mr Goodmanson went to his cell Mr Cooper was lying down looking at the television. Mr Cooper jumped up from his bed and he looked well. Mr Goodmanson saw the top of his shirt was wet and Mr Cooper stated he had simply wet his beard. Mr Goodmanson told him the nurses were in the block and he could arrange for him to be seen, or he could arrange to go to the clinic. He informed him about the use of the duress button.

60. Mr Goodmanson thought Mr Copper's demeanour was consistent with normal observations and he did not appear distressed. He was standing and talking and there were no grounds to call a Code Blue.

61. Jason Rees attended with Mr Goodmanson. He recalls Mr Cooper may have been sweaty but he did not appear unwell. He was walking, talking and said he was ok and was in apparent good health. Mr Rees confirmed Mr Goodmanson discussed with Mr Cooper his options.

62. CCO Aaron Humphries performed a head count/cell check at 19:28 hours and 20:46 hours on 5 April 2016. This cell check is performed by shining a torch into each cell through the viewing glass. He did not notice anything out of the ordinary with the occupant of cell 3 who appeared fit and healthy.

63. CCO Walter Niehsner performed a cell check of cell 3 with CCO Andrew Gordon at 0:40 hours on 6 April 2016 and did not notice anything out of the ordinary.

64. CCO officers Kaye Hodson and Mukul Hastir attended the cell during morning muster at 07:20 hours and found Mr Cooper deceased.

Review of health services provided to Mr Cooper

Root Cause Analysis

65. Cairns and Hinterland Hospital and Health Service's (C&HHHS) conducted a Root Cause Analysis.

66. The RCA noted a Health Services Request Form had been completed on 27 March 2016, 11 days prior to his death. This stated Mr Cooper was suffering from a four-day history of sore throat, coughing and headaches and was requesting Panadol and Brufen. The registered nurse who reportedly received the form on the medication round noted the patient *"looked thin and was an older guy who looked like he had a hard life"* but he did not look obviously unwell. A telephone order was obtained from the VMO for oral paracetamol twice daily for six days.

67. The RCA team noted that an influenza outbreak had previously been declared in Lotus Glen in mid-March 2016, however swabbing for the responsible organism had reportedly ceased by the date of this presentation. The RCA noted it was unlikely the patient met the criteria for any specific influenza investigation and management. There was no complaint of fever and no high risk comorbidities.

68. The RCA team noted the Health Services Request Forms are completed by the patient and handed directly to nursing staff on twice daily medication rounds. The forms are prioritised by night staff to the appropriate clinic. The RCA team noted that in this instance the telephone order was not signed by the medical officer when next visited and therefore there was no additional prompt for patient review. The telephone order for ibuprofen was not completed. No vital signs observations were recorded. There was also no record apart from progress notes of the patient's attendance at the clinic.

69. On Tuesday, 29 March 2016 the patient completed a further request form. In this instance the form stated he had been suffering from the *"virus that was going" around since last Thursday and had a bad headache, sore throat and coughing up green phlegm."* The form stated he had been receiving *'Panadol and Brufen but cannot get rid of it and had lost 5 kg in weight'*. He requested antibiotics. The clinical nurse who signed to confirm she had received the form is said to have not

assessed the patient and had no recollection of the patient or the form. She could not confirm if any attempts were made to book him into a nurse or Doctor's clinic for the next day.

70. The RCA team noted that VMO attendances are twice weekly on Monday and Fridays. Medical attendance on Wednesdays is mainly restricted to the low security offenders at the farm complex. It was noted there was very limited time for nursing or medical clinics on Wednesday afternoons. The RCA team noted that if this patient had been seen by a medical officer there is no guarantee that further investigations such as chest x-rays or treatment with antibiotics would have been ordered. The VMO on interview stated she would rarely order the collection of sputum specimens. The RCA team stated that if the patient had been fully assessed and an appropriate follow up plan implemented, there may have been opportunities to better monitor his progress and identify potential deterioration.

71. The RCA team considered the issues identified included that he had not been seen by the medical officer nor had he been booked in to the next clinic on Friday, 1 April 2016. He was not assessed by nursing staff in the clinic. There was no documentation in the progress notes. There was no documentation on the Health Services Request Form regarding actions or outcome. Oral paracetamol had been given twice daily but there was no documentation of the effect.

72. On Saturday 2 April 2016 the patient completed a further request form stating he had "*flu symptoms/shaking'*. He was booked into a nurse's clinic. It was noted that the Health Services Request Form had not been signed by the patient. The form was not signed and dated by the nurse and only that "Nurses Clinic" was recorded.

73. On Saturday 2 April a CODE BLUE was called because the patient was reporting shortness of breath. He complained of flu-like symptoms and chest pain in areas stated as "*vaguely between waist and shoulders"*. In interview for the RCA, the clinical nurse was adamant the patient did not complain of chest pain specifically, but when asked where his pain was, moved his hand up and down his trunk from stomach to chest and vaguely around the stomach. The clinical nurse stated that if the patient had complained of chest pain per se they would have proceeded as per the *Chest Pain Management Procedure* with an ECG being recorded and faxed to the medical officer.

74. The clinical nurse is said to have auscultated his chest and was confident this was done thoroughly, and heard good, equal air entry without abnormal sounds. He was booked into the nurse's clinic for the next day.

75. The RCA team noted booking him into the clinic was an appropriate response. Staff reported there is an average of one CODE BLUE call per night shift and these are not always clinically warranted. The RCA team noted that staff report that prisoners are aware that by stating they have chest pain this will generate a CODE BLUE for immediate attention. Staff are aware that requests for medication, particularly pain relief, may be made in excess of clinical requirements and relate

to drug seeking behaviour. However, this was not likely in this case as the patient was reportedly offered further analgesia but declined it.

76. The RCA team noted that some of the issues relating to this event included progress notes documentation not completed by the nurse who conducted the assessment. There was incomplete documentation of the assessment including vital signs. The Q-ADDS chart was not used to record vital signs. As well the nursing clinical handover record contained minimal information.

77. The RCA noted in relation to the presentation on 3 April 2016 that his presentation was of increasing shortness of breath on exertion, coughing up white sputum and increasing pain in his ribs when lying down. His vital observations were recorded. The Enrolled Nurse Advanced Practice (ENAP) was asked if he had chest pain to which he replied no. An ECG was not recorded as the ENAP was confident the pain was in the ribs due to excessive coughing rather than a cardiac source. The ENAP completed a chest auscultation and reported equal air entry bilaterally but was sure she did hear crackles in the left lower lobe. The ENAP asked the clinical nurse to listen to the chest. The CN reported she did not hear crackles or other abnormal breath sounds but agreed with the overall assessment as probably a viral illness. According to the RCA report the VMO was telephoned and the ENAP reportedly explained she heard crackles in the chest but the clinical nurse did not hear abnormal signs. The VMO asked if the patient had chest pain to which she replied no. The ENAP states she asked the doctor if she wanted to order pain relief or antibiotics. Panadeine forte, brufen and Ventolin puffer was ordered but no antibiotics. The ENAP did not remember any specific monitoring or follow-up instructions and the medical officer could not recall specifically asking the nurse to conduct any particular follow-up for the patient including booking him into a nurses or Doctor's clinic.

78. The RCA team noted the ENAP and clinical nurse were experienced. The RCA team noted the medical officer is only on call by telephone. If prisoners are needed to be seen by medical officers outside of clinical hours they are usually transported to Mareeba Hospital ED. The RCA noted that even if the patient had attended hospital, there is no guarantee that further investigation such as chest x-rays or antibiotics would have been ordered.

79. The RCA team also noted that if antibiotics had been ordered at this stage it would most likely have been amoxicillin. As staphylococcus aureus was identified on autopsy and this was resistant to penicillins, the routine antibiotic for mild community-acquired pneumonia would not have been effective. The RCA team noted there may have been further opportunity to identify the patient was not improving despite antibiotic therapy, which potentially may have prompted further review.

80. The RCA was given access to a note made in the Lotus Glen case file that on 5 April 2016 Mr Cooper seemed ill and was seen by Residential Sierra. The prisoner admitted he felt ill but refused to go down to the Medical Centre, saying he just wanted to rest. The RCA noted the Corrective Services report, while indicating

some level of concern, was somewhat contradictory, as the report ended with a statement to the effect there were *"no issues"*. The RCA team noted it appears officers have relied on the prisoner's reported refusal to attend the health centre.

81. The RCA noted there was a potential clinical deterioration that had not been communicated to Lotus Glen Health Centre staff as per protocol. It was considered this may have been a missed opportunity to potentially provide nursing and medical assessment, further investigation and potentially treatment.

82. The RCA team had no concerns regarding the nursing staff response to the CODE BLUE. It was appropriate for CPR to be discontinued considering no signs of life were evident and early signs of rigor mortis were present. The RCA team noted that although Corrective Services staff conduct regular checks throughout the night, these are only torch checks and would not usually be able to observe whether or not the prisoner was breathing.

83. The RCA team noted that Staphylococcus aureus having been cultured in post-mortem specimens is the likely causal organism of the patient's pneumonia complicating a viral respiratory illness. Staphylococcus aureus is an infrequent pulmonary pathogen, however it is associated with severe disease and is usually resistant to standard antibiotics. The RCA team speculated the patient may have deteriorated rapidly on the evening of 5 April 2016. If deterioration had been recognised and suspected pneumonia identified that this would have provided an opportunity to transfer him to hospital.

84. The RCA found it was difficult to determine exactly whether any other specific interventions through the course of his illness would have altered the adverse outcome. The RCA team however, identified that opportunities for patient review and follow-up were not maximised and therefore proposed various corrective actions for system improvements.

85. With respect to contributing factors identified the RCA noted that as systems for handover, follow up and monitoring of patients at risk of deterioration were either not adequate or was not adequately followed in this case, the patient's most recent nursing assessment did not trigger a clinical review increasing the likelihood he received sub-optimal clinical follow-up and monitoring. This together with sub optimal communication between QH and QCS staff regarding patients at risk of deterioration and over-reliance on self-referral, leading to clinical staff not being notified of his potential deterioration, may have contributed to clinical deterioration not being identified in order to provide an opportunity to consider appropriate treatment. This in turn may have increased the likelihood of the patient dying unexpectedly in custody from pneumonia.

86. The RCA recommended that systems for follow-up of monitoring of Lotus Glen Health Service patients at risk of deterioration are reviewed and formalised.

87. The RCA team also identified that the Q-ADDS chart was not being routinely utilised within the Lotus Glen Health Service centre unless patients were identified

as acutely unwell. It was recommended that the health service comply with state-wide implementation of the Q-ADDS tool. As well it was recommended that the Medication Telephone order be reviewed and further revised to comply with relevant medication, clinical documentation and handover procedures.

88. A total of six recommendations were made. Ms Vickye Coffey, Director of Nursing for Mareeba Hospital and LGHS provided a detailed statement setting out how those recommendations were being implemented.

Clinical Forensic Medicine Unit Review

89. A Forensic Medical Officer with the Clinical Forensic Medicine Unit within Queensland Health, Dr Gary Hall was asked to comment on the circumstances of Mr Cooper's death from a clinical perspective. Having reviewed Mr Cooper's medical file as well as the autopsy report, Dr Hall expressed a number of concerns regarding the health care Mr Cooper received.

90. Whilst acknowledging that Mr Cooper's presentation initially was quite 'generic' with mild non-focal symptoms and no fever, Dr Hall noted Mr Cooper had progressive shortness of breath, pleuritic chest pain and audible noises on his chest with raised pulse and respiratory rate by the time of his examination on 3 April 2016. Dr Hall expressed a view this ought to have caused nursing staff to refer Mr Cooper to the doctor for review and potentially referral for chest x-ray. Dr Hall acknowledged an x-ray may not have revealed classical signs of the bacterial pneumonia, which was found in Mr Cooper's lungs at autopsy, but it is likely some evidence of chest infection or pleural reaction would have been discernible, providing a reasonable opportunity for a chest infection to have been diagnosed and antibiotics commenced prior to Mr Cooper's death.

91. Dr Hall went on to acknowledge he was unable to state whether those antibiotics would have been effective against the particular strain of bacteria present in Mr Cooper's lungs, and therefore it is unknown whether such treatment would have made any difference to the outcome in Mr Cooper's case.

92. Dr Hall expressed a particular concern that the examination of Mr Cooper on 3 April 2016 was performed by an enrolled nurse, who would not normally be qualified to auscultate (or listen to breath sounds in) a person's chest as the nurse purported to do that day. He also noted it appeared the enrolled nurse then formed an opinion to prescribe Panadeine forte and requested this of the doctor, rather than this being initiated by the doctor, and without any referral of Mr Cooper to the doctor for further medical assessment.

93. Based on these concerns, Dr Hall recommended that the level of medical supervision and staffing at the Lotus Glen Health Service Centre be reviewed to ensure that prisoners are examined appropriately by qualified medical practitioners and within acceptable timeframes.

94. Subsequent to this initial review, Dr Hall was provided a copy of the C&HHHS RCA review of the health services provided to Mr Cooper by staff working within the medical centre at Lotus Glen. Dr Hall was asked to comment on whether the information contained in that review changed his opinion in any way.

95. Dr Hall pointed to a number of findings consistent with his own, including inadequacy of documentation, lack of review of Mr Cooper by a doctor, and a missed opportunity to arrange a more urgent medical review and possibly further clinical investigations when Mr Cooper presented to the clinic and was assessed on 3 April 2016.

96. Regarding the assessment on 3 April 2016, Dr Hall noted further information that, apart from the enrolled nurse (identified in the RCA as an "advanced practice enrolled nurse" or "ENAP") who performed the initial chest auscultation, a second nurse at the level of Clinical Nurse also apparently examined Mr Cooper's chest and formed an opinion there were no crackle sounds. This information was then passed on to the doctor during the phone call to request Panadeine forte. Dr Hall noted this consultation with the Clinical Nurse and communication with the doctor was poorly documented or not documented at all within Mr Cooper's clinical notes. He also maintained his concern that the skill of chest auscultation and diagnosis would not be within the scope of practice of either of the nurses who assessed Mr Cooper that day. Dr Hall went on to state that the fact Mr Cooper's condition was such that it prompted those nurses to listen to his chest, should have resulted in Mr Cooper's case being escalated for medical review, if not that day then at least in the clinic the following day.

97. Dr Hall noted the recommendations made by the RCA team including improvements to monitoring of prisoners' health and improved policies and documentation regarding deteriorating patients and clinical handover. He also noted an increase in resources available to nursing staff, with the Visiting Medical Officer no longer being the sole medical officer on call and with out-of-hours advice also now available from the Mareeba Hospital Emergency Department. Dr Hall agreed the RCA's recommendations and subsequent improvements implemented by C&HHHS were reasonable. Dr Hall offered one further suggestion, namely that C&HHHS review the scope of practice of the ENAPs employed within their service areas, including within Correctional Services, to ensure they are not practicing outside of their scope and hence exposing themselves to professional harm.

98. Dr Hall maintained his concerns regarding the issues of nurses performing chest auscultation as potentially being out of their scope of practice. He considered there was a missed opportunity to have Mr Cooper examined by a doctor but because of the infection being S. aureus this may not have changed the outcome.

Other evidence

99. Michael McFarlane is the general manager of Lotus Glen. He provided a statement on behalf of Queensland Corrective Services (QCS) relating to the

recommendations in the RCA report. He noted that QCS communicate with Queensland Health staff via email or telephone if there are concerns regarding a prisoner health status. QCS does provide oversight for prisoners within accommodation units as per routine operational requirements including visual inspections within the cells. They do not rely on medical care plans until a medical assessment has been made. Although prisoners have the right, like those in the community, to refuse medical treatment, a CCO officer would report a sick patient to a nurse without the prisoner's permission or consent by calling a CODE BLUE emergency if the prisoner appears to be having a health crisis or is in distress.

100. In respect to the review of the Health Service Request Form Mr McFarlane believes this has been completed. He can confirm that an email was sent by the nursing unit manager requesting QCS officers have access to the revised Health Service Request Form. These were subsequently updated on the QCS system for easy access.

101. Mr McFarlane stated QCS conducts regular contingency testing for medical emergencies for CODE BLUES. This is conducted as a joint exercise between QCS and Queensland Health to assess where improvement could be made in the process.

102. Director of Nursing (DON) Vickey Coffey also provided a detailed response to a request for further information about the implementation of the recommendations from the RCA.

103. DON Coffey also advised that the model of the LGHS is nurse led primary health care. The nurses are guided by the *Primary Clinical Care Manual, 9th edition 2016.* This is a comprehensive manual applying to many conditions. The nurses use the manual to guide their clinical observation taking to then make calls to medical officers for advice and orders. DON Coffey stated that chest auscultation is one of the techniques used by nurses to conduct their investigations and now forms part of their training and is within their scope of practice. DON Coffey stated nurses receive training in how to perform chest auscultations as part of their mandatory annual training with CHHHS.

104. The guidelines that inform their clinical practice at the Centre, namely the *Primary Clinical Care Manual,* include an expectation that listening to the chest for air entry and added sounds (crackles or wheezes) will form part of their clinical assessment of a patient presenting with symptoms suggestive of an upper respiratory tract infection.

105. As well the Bachelor of Nursing Degree now includes chest auscultation (along with many other examinations and procedures that were historically only performed by doctors) as part of nurse training.

106. I accept that, based on her evidence as well as the nurses who gave evidence, chest auscultation is within the scope of practice of nurses providing health care at LGHS.

Conclusions on the Issues

107. In reaching my conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

108. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw*[3] sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

109. With respect to the *Briginshaw* sliding scale it has been held that it does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not.

110. In matters involving health care, when determining the significance and interpretation of the evidence the impact of hindsight bias and affected bias must also be considered, that is where after an event has occurred, particularly where the outcome is serious, there is an inclination to see the event as predictable, despite there being few objective facts to support its prediction.

How he died

111. The cause of death found at autopsy was considered to be pneumonia due to staphylococcus aureus. This appears to have rapidly developed as Mr Cooper was probably unwell but not critically unwell on 5 April 2016.

112. Given the evidence of Dr Purcell and Dr Hall regarding the speed in which he could have deteriorated with S. aureus, I consider it likely Mr Cooper deteriorated rapidly due to a process involving S. aureus in the context of a person being unwell with the flu with some consequent reduced immunity who then developed a secondary fulminant infection with S. aureus with a rapid demise after that, particularly in the presence of an enlarged heart.

Exchange of Health Information by correctional staff to health staff

113. One of the issues explored at the inquest was whether CCOs or other staff of Lotus Glen had any other information about Mr Cooper's health that, if communicated to LGHS staff or acted upon in some other way, may have resulted

[3] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361

in a different outcome for Mr Cooper. This was a matter that was critically raised in the RCA.

114. Having now heard from both LGHS and QCS staff, including the three individual QCS officers who interacted with Mr Cooper on 5 April 2016, it is my view the QCS officers that day acted professionally and appropriately. Immediately upon being notified of information that Mr Cooper was unwell, the officers took appropriate action to check on Mr Cooper's wellbeing. Mr Cooper was offered the opportunity to attend the medical clinic, which he declined. Each of those officers gave evidence that Mr Cooper was otherwise in "apparent good health", that is, there were no indicators that he might otherwise need urgent medical attention via the calling of a Code Blue.

115. The officers also gave evidence that they had the option to contact LGHS staff via telephone or email if they had concerns about a prisoner's wellbeing that was not at the level of a Code Blue. QCS officers and LGHS staff gave evidence this was a regular and well-working practice between staff of the two agencies but there was nothing about Mr Cooper that caused them to be concerned for his wellbeing at that time.

116. The QCS officers say they reminded Mr Cooper of his options if he did need help, which included speaking with QCS officers to arrange to go the medical clinic, speaking with the nurses on the medication rounds, and using the intercom in his cell to call for help.

117. The RCA team did acknowledge it had been reported to them that *"Health Service staff are regularly contacted by Corrective Services staff if concerns arise regarding prisoners' health and wellbeing"*, and that policies were in place to encourage this communication. The evidence of LGHS and QCS staff at the inquest was consistent with this description, with all witnesses speaking well of those communication practices and processes, from both a health and a custodial perspective.

118. In this case there is no evidence of any systemic communication issues between LGHS and QCS staff at Lotus Glen that impacted on the quality of care Mr Cooper received on 5 April 2016 when he was reported to QCS officers as being unwell.

119. Only Mr Cooper knew how unwell he felt on 5 April 2016. It cannot now be known why he refused medical treatment that day, when on several occasions previously he had actively sought treatment by way of Health Service Request Forms and the Code Blue call for shortness of breath. It is possible Mr Cooper held a belief that, due to the outcome of his earlier interactions with LGHS staff who found nothing of clinical significance, there was "nothing to be worried about". If processes had been such that Mr Cooper had been spoken to by a clinician in relation to his refusal to seek treatment that day, it is possible he may have made a different decision. It is equally possible that Mr Cooper simply did not feel that unwell, even on 5 April 2016.

120. The Refusal of Treatment Form allows LGHS staff the opportunity to speak with the prisoner to encourage them to accept treatment, and to advise them of the risks if they do not do so, so that the prisoner can make an informed decision. It is unclear if this would have made a difference in this case, in that Mr Cooper did not fall within the circumstances envisaged by that form, namely refusal to attend a pre-booked clinic appointment or other medical treatment previously arranged. In Mr Cooper's case, he was refusing an offer from QCS staff to arrange for his attendance at the clinic, based on fresh concerns that had arisen about his wellbeing rather than a pre-arranged appointment. This would not have triggered the Refusal of Treatment process.

121. Both QCS and Health Service staff gave evidence that, in those circumstances and consistent with current communication practices between QCS and the LGHS, it is likely QCS officers would still document the refusal (e.g. as a case note in IOMS) and, where they remain concerned about a prisoner's wellbeing, would raise this with LGHS staff by telephone or email or in person during medication rounds. LGHS staff gave evidence that, if they received such contact, they would have a discussion with QCS staff to essentially triage the concerns and determine whether further action is required, which may include actioning via a Code Blue, requesting QCS staff to encourage the prisoner to attend the clinic, or asking a nurse on a medication round to check on the prisoner.

122. The potential benefit in Mr Cooper's case of QCS alerting staff to his refusal of treatment, is that this may have caused LGHS staff to speak with Mr Cooper, as they would with anyone who had refused treatment, to let him know of the risks of not seeking treatment so at least he was making an informed decision. The question then arises whether this informal process may warrant some level of formalisation by way of written policy or procedure regarding communication between QH and QCS when a prisoner is refusing treatment that has not been pre-arranged.

123. Counsel Assisting suggested that rather than make a prescriptive recommendation in this regard, I should consider making a broad recommendation that the review currently underway by a working group of QH and QCS examining the existing MOU and Operating Guidelines and referred to in two recent inquests also include consideration of the circumstances of Mr Cooper's death and relevant coronial findings.[4]

[4] Referred to in the *Findings of the inquest into the death of Franky Houdini*, delivered 16 May 2018 and *Inquest into the death of Zachary James Holstein*, delivered 20 June 2018

Adequacy of health services received by Mr Cooper in the eleven days prior to his death

124. The RCA was clearly critical of a number of documentation issues in the records that made it more difficult to assess by those conducting later reviews, what action was taken by nurses at particular moments and how appropriate these actions were. Having heard the evidence at the inquest I am in a better position to make that assessment.

125. With regards to the attendance of CN Clarksmith and CN Makoti at the Code Blue in the evening of 2 April 2016 in response to the Code Blue, apart from the documentation issues noted by the RCA team, the actions taken by the nurses to respond to Mr Cooper's concern about being short of breath were appropriate. CN Makoti identified the possibility of a chest infection and made appropriate examinations of Mr Cooper, including taking his observations and listening to his chest. CN Makoti stated that Mr Cooper showed no clinical signs of a chest infection that evening and it was therefore appropriate to offer pain relief and help him relieve his discomfort by arranging extra bedding to prop his head up. The two CNs also ensured Mr Cooper was on the list to be seen in the clinic the following day, which in fact occurred.

126. The clinic was conducted by ENAP Pink and CN Allen on 3 April 2016. I have dealt with the issue of whether chest auscultation was in the scope of practice of the Enrolled Nurse (Advanced Practice Enrolled Nurse or ENAP) to perform such an examination and found that it was.

127. Dr Purcell recalls speaking with ENAP Pink that day in relation to Mr Cooper and being told, amongst other things, that Mr Cooper's "chest was clear" and that he was not unwell. Dr Purcell felt very confident in ENAP Pink's assessment of Mr Cooper. Although it is unclear if Dr Purcell was told by ENAP Pink that she had initially head crackles in Mr Cooper's chest but that her colleague, CN Allen did not hear those crackles, Dr Purcell stated that having that information would not have necessarily caused her to be suspicious of a chest infection, particularly in the context of Mr Cooper's otherwise normal observations and ENAP Pink's impression that he did not look unwell.

128. In those circumstances I find the assessments and actions taken following those assessments by the two nurses and VMO were reasonable.

129. As to whether further or better follow up should have been implemented, ENAP Pink gave evidence that consistent with her normal practice, she would have advised Mr Cooper to seek further medical attention if he continued to feel unwell or got worse.

130. The RCA team suggested that if additional steps were taken, such as advising custodial officers or booking Mr Cooper into the clinic the next day, this would have provided further and better opportunities for his health to be monitored and condition reviewed. With hindsight, it is understandable to point to those as possible missed opportunities. However, on the information LGHS staff had about Mr Cooper on 3 April 2016, it was reasonable for staff to allow Mr Cooper to return

to the centre and to rely on him to self-report any issues. It is clear from the evidence heard at inquest that LGHS staff would also be reassured that custodial officers would also alert them to any concerns they had about Mr Cooper's wellbeing, as was clearly the practice at that time and now.

131. Whilst the RCA team made reasonable suggestions as to ways to provide more opportunities for patients such as Mr Cooper to be monitored and any deterioration detected, in my view the health services provided to Mr Cooper on 3 April 2016 including both the assessments and actions taken were appropriate.

Preventative recommendations

132. It was explored with various witnesses whether a potential improvement might be to allow LGHS staff to share confidential health information about a prisoner with QCS staff, for the purpose of enabling QCS staff to assist in monitoring that prisoner's wellbeing out in the centre. The existing Memorandum of Understanding (MOU) allows QH staff to share confidential health information with QCS staff where there are "Significant health risks", with the examples given of:

- "When a prisoner's health condition requires specialised management or self-monitoring equipment"
- "When a prisoner is at risk of serious health consequences including death (eg. Terminally ill prisoners)"

133. At inquest, both LGHS and QCS staff described that, whilst confidential information about a prisoner's health is generally not shared with QCS (which is consistent with legislative restrictions on the sharing of such information and reflected in the existing MOU), LGHS staff can and do communicate with QCS staff to ensure that if a prisoner has particular needs related to a health condition, those needs can be met within the custodial environment without unnecessarily disclosing a prisoner's confidential health information. This is both through the formal "care plan" or "management plan" referred to by Mr McFarlane in his evidence as well as informally at interagency staff meetings and ad hoc by telephone and email.

134. I consider it is not the role of, nor should it be expected of, QCS officers to monitor someone's wellbeing (above and beyond what is already provided for the general prison population). If there are individuals who require a higher level of monitoring, they should be brought in to the clinic or admitted to a hospital.

Contribution of QCS staff to RCA

135. It is evident that the RCA team did not interview Lotus Glen QCS staff. It was apparent an offer may have been made to Lotus Glen staff but this was not taken up. The RCA team's comments regarding the interaction between Health Services and QCS, suggested there may have been some failure by QCS officers to pass information on to LGHS regarding Mr Cooper's wellbeing on 5 April 2016. QCS were not asked to comment on this potentially adverse finding.

136. RCA reports are confidential and are not normally released in a public manner, except to a coroner if a copy is requested[5]. Given a Death in Custody inquest is mandatory, it is inevitable any relevant RCA report will be released to QCS if they attend the inquest and become an exhibit.

137. I made a comment in a recent Death in Custody inquest[6] in respect to an Office of Chief Inspector investigation, where investigators from the Chief Inspector's office made criticisms of Health Services staff without interviewing those staff or otherwise seeking any information from that agency. I made a recommendation that the Office of Chief Inspector, Queensland Health and all Hospital and Health Services who provide health services to prisoners jointly consider ways for ensuring that, where a prisoner dies and health services provided to that prisoner are relevant to the Office of Chief Inspector's investigation into that death, there is a mechanism for gathering relevant Queensland Health and Hospital and Health Services information to inform that investigation, including through interviews with Queensland Health and Hospital and Health Service staff.

138. In a similar vein I intend to make a recommendation that where a Hospital and Health Service conducts a RCA in relation to the death of a prisoner who was receiving a health service, and concerns/opportunities for improvement are identified in relation to QCS policies and practices, the health service (for instance in this case CHHHS) liaises with QCS to jointly review and take appropriate action (which may involve further investigation and/or development of recommendations) and ensure there is a mechanism for gathering relevant QCS information to inform that investigation, including through interviews with QCS staff.

Changes since Mr Cooper's death

139. I heard from a number of LGHS staff who all agreed that the changes that have been made were significant improvements and it has to be said CHHHS has taken the issues identified seriously and have assiduously implemented the recommendations of the RCA. I commented at the conclusion of the inquest that I was impressed with the level of staff knowledge about the RCA recommendations and how they have taken them on board. I do not intend to list out all of the recommendations and how they have been implemented but will highlight a few.

140. It was noted that if prisoners require medical attention at night in non- Code Blue situations, they will be now brought to the clinic rather than Health Services staff attend to them in their cell. Staff spoke very positively about this improvement which allows nursing staff to conduct assessments in a more appropriate environment with everything at hand including not just medical equipment but also a prisoner's health records including progress notes.

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[5] s 113 *Hospital and Health Boards Act 2011*

[6] *Inquest into the death of Zachary James Holstein*, delivered 20 June 2018

141. It is evident the use of the Q-ADDS chart tool has been adopted for all new prisoners and compliance with its use for all subsequent vital observations has been adhered to.

142. LGHS staff gave clear and consistent evidence about implementation of the SBAR tool for clinical handovers and telephone medication orders with a new form now in place. Audits have identified very high level compliance with the new medication order format and Clinical Handover reports.

143. The Health Service Request Form has been revised. The forms collected on the morning medication round are now triaged at a nurse huddle at 10 am. The forms collected in the afternoon medication round are reviewed and triaged to the appropriate clinic by the night nurse. Audits have again noted high compliance levels with the completion of the form and triaging processes.

144. In addition a Clinical Nurse Consultant and CN Consultant Opioid Substituted Treatment have been appointed.

Findings required by s. 45

Identity of the deceased – David John Cooper

How he died – David John Cooper had been suffering from flu like symptoms for a period of 11 days. He had been seen on two occasions by nursing staff at Lotus Glen Correctional Centre and prescribed at various times pain relief and antibiotics. He had not been seen by a Doctor in that time. The day before his death he was asked by Custodial Corrections staff if he wanted to attend the medical clinic as there had been reports he was unwell. Mr Cooper declined this offer. Corrections staff observed him to not be in any distress or sufficiently unwell to call a Code Blue or make arrangements for medical staff to see him. It is likely that Mr Cooper deteriorated rapidly due to a process involving S. aureus, which is resistant to antibiotics that are usually prescribed for a suspected bacterial infection of unknown origin. This was in the context of a person being unwell with the flu with some consequent reduced immunity who then developed a secondary fulminant infection with S. aureus with a rapid demise after that, particularly in the presence of an enlarged heart.

Reviews of health care provided noted inadequacy of documentation, lack of review of

Mr Cooper by a doctor, and a missed opportunity to arrange a more urgent medical review and possibly further clinical investigations when Mr Cooper presented to the clinic and was assessed on 3 April 2016. This may have provided a reasonable opportunity for a chest infection to have been diagnosed and antibiotics commenced prior to Mr Cooper's death. However, the antibiotics would have likely been ineffective against the particular strain of bacteria present in Mr Cooper's lungs, and therefore such treatment may not have made any difference to the outcome in Mr Cooper's case.

A RCA hospital review made recommendations including improvements to monitoring of prisoners' health and improved policies and documentation regarding deteriorating patients and clinical handover, which have been implemented.

Place of death – Lotus Glen Correctional Centre MAREEBA QLD 4880 AUSTRALIA

Date of death– Between 05 April 2016 and 06 April 2016

Cause of death – 1(a) Pneumonia (Staphylococcus aureus)

Comments and recommendations

1. It is recommended that the review currently underway by a working group of QH and QCS examining the existing MOU and Operating Guidelines and referred to in two recent inquests also include consideration of the circumstances of Mr Cooper's death and relevant coronial findings.
2. It is recommended that where a Hospital and Health Service conducts a RCA in relation to the death of a prisoner who was receiving a health service, and concerns/opportunities for improvement are identified in relation to QCS policies and practices, the health service (for instance in this case CHHHS) liaises with QCS to jointly review and take appropriate action (which may involve further investigation and/or development of recommendations) and ensure there is a mechanism for gathering relevant QCS information to inform that investigation, including through interviews with QCS staff.

I close the inquest.

John Lock

Deputy State Coroner

BRISBANE

11 September 2018