QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Steven Leslie Harrison**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2016/4726
DELIVERED ON:	5 December 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	5 December 2019
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes.

REPRESENTATION:

Counsel Assisting:	Ms Rhiannon Helsen
Queensland Corrective Services:	Ms Nikola Core

Contents

Introduction

1. Steven Harrison was 61 years of age when he died in the Wolston Correctional Centre (WCC) on the morning of 10 November 2016. He died as a result of a sudden heart attack due to severe coronary atherosclerosis.

The investigation

2. Detective Senior Constable Richard Fry from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) led the investigation into the circumstances leading to Mr Harrison's death.

3. Based on the information obtained by police in the form of witness statements, criminal histories, medical histories and the autopsy report, Detective Senior Constable Fry reached the following conclusions in relation to Mr Harrison's death:

    - Mr Harrison had been diagnosed with a number of medical issues including non-insulin dependent Diabetes, chronic back pain and was Hepatitis C positive. Mr Harrison was always afforded medical care for his illnesses during his time as an inmate at WCC.

    - Queensland Corrective Services (QCS) staff correctly followed death in custody protocols.

    - An autopsy was performed on Mr Harrison which confirmed the cause of death was Coronary Atherosclerosis.

    - No other circumstances contributed to Mr Harrison's death.

    - No suspicious circumstances exist in relation to this death.[1]

4. At the request of the Coroners Court, Dr Ian Home Hall from the Clinical Forensic Medicine Unit (CFMU) examined the medical records for Mr Harrison from the WCC and the Princess Alexandra Hospital (PAH) and reported on them.

The inquest

5. As Mr Harrison died while in custody an inquest was required by s 27 of the Coroners *Act 2003*. Ms Helsen appeared as counsel assisting. All the statements, records of interview, medical records, photographs and materials gathered during the investigations were tendered at the inquest.

[1] Exhibit A6 – Coronial Report, p 8.

The evidence

Criminal history

6. Mr Harrison had a lengthy Queensland criminal history, notwithstanding that he only came to the attention of the Queensland justice system when he was aged 44.

7. Initially, he appeared in court regularly for breaches of bail and charges of obstructing police. However, in 2001 he was given his first prison sentence of four months for convictions on multiple charges of fraud, stealing, obtaining property by false pretences and unlawful use of motor vehicles. In 2004, Mr Harrison was given a two-year suspended sentence for a number of indictable offences, the most serious of which was assault occasioning bodily harm while armed.

8. Mr Harrison regularly served short sentences of imprisonment for repeated summary offences until 2011, when he was sentenced to 15 months' imprisonment for a long list of offences which included petty property and fraud offences, as well as burglary and entering premises to commit an indictable offence.[2]

9. Between 2011 and 2015, Mr Harrison spent much of his time in prison, either on short sentences or remand awaiting sentencing. Mr Harrison was released on court ordered parole on 9 September 2015.[3]

Medical History

10. By 2015, Mr Harrison had a medical history of hepatitis C infection, Type 2 Diabetes, Parkinson's disease/restless leg syndrome and chronic lower back pain. He had advised doctors that he was a heavy smoker and used speed and heroin intravenously. He had been prescribed Metformin for his diabetes and had been having investigations for some years into the cause of his restless leg syndrome and lower back pain.

11. In October 2008, Mr Harrison had been referred to a pain specialist for his restless leg syndrome. The specialist found that he was quite agitated and difficult to take a full history from. The specialist noted that Mr Harrison appeared to be displaying some drug seeking behaviour. Mr Harrison did not re-attend the pain clinic.[4]

12. On 7 August 2013 and 22 September 2015, Mr Harrison had CT scans of his spine to investigate his lower back pain. Both radiologists' reports noted various degenerative changes to Mr Harrison's discs, and noted calcification of the abdominal aorta.

[2] All dealt with summarily.
[3] Exhibit C1- QLD Criminal History.
[4] Exhibit D2 - PAH records, pp 1 - 32.

13. In the 2015 report, the calcification was described as ‘severe’. It is unknown whether these findings were ever explained to Mr Harrison, or whether he was aware of them at all. It is clear from his medical records that he did not, at any time, report any history of cardiovascular disease. Mr Harrison’s PAH records show that Mr Harrison had been booked for a vascular ultrasound (of his leg) shortly after the CT scan in 2013, but he had refused to attend for this procedure.[5]

Recent incarceration

14. In July 2016, Mr Harrison was arrested and placed on remand for further offences. At the time of his admission to the Brisbane Correctional Centre (BCC) on 27 July 2016, Mr Harrison did not advise that he had any history of heart problems. He did advise that he was taking Metformin for diabetes, and that he had been prescribed Lyrica and Codapane for back pain, as well as a daily dose of Valium.

15. He advised that he was in withdrawal from heroin use, having injected it daily for the previous eight months. The medical records from his local medical centre showed that he had also been prescribed opioid medication in the form of Duragesic and Fentanyl patches, and Targin tablets, and was also taking a medication called Sifrol for his restless legs. The records contain a note warning that the clinic had suspicions that Mr Harrison was diverting the pain medication. Because of the discrepancies in his medication history and the warning, the BCC continued to provide Mr Harrison’s Metformin, and offered him Panadeine forte for his back pain. The BCC declined to provide any other medication until he could be examined by a doctor.[6]

16. On 1 August 2016, Mr Harrison made a telephone complaint to the Office of the Health Ombudsman and advised that he would stop taking his Metformin until he was given Lyrica and Sifrol. At medication rounds that afternoon he became irate and demanded Lyrica. Mr Harrison admitted to the nurse that he had abused Fentanyl in the past but was adamant that his need for Lyrica was legitimate. At medication rounds on 5 August 2016, Mr Harrison refused to take his Metformin, and on 7 August 2016 refused to attend the clinic to have his blood sugar levels checked.[7]

17. On 8 August 2016, Mr Harrison attended the Visiting Medical Officer (VMO) at the BCC and requested that he be given Lyrica and Sifrol. The VMO noted that Mr Harrison was clearly fully mobile and that this seemed inconsistent with his claim to be suffering debilitating back pain. Given these circumstances, and the fact that the BCC had received inconsistent information from Mr Harrison and his medical centre as to his medication, the doctor advised Mr Harrison that he could not prescribe the requested medication without “coherent evidence of need”.

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[5] Exhibit D2 - PAH records, pp 23, 27 - 28 and 92 - 93 and Exhibit D2.1 - PAH records, p 5 - 6.
[6] Exhibit D1 – Correctional medical records, pp 22 – 28.
[7] Exhibit D1 – Correctional medical records, pp 22 – 28 and 67 - 69.

18. Mr Harrison left the consultation "prior to its conclusion". Mr Harrison was re-prescribed Sifrol as a result of this appointment.[8]

19. On 16 August 2016, Mr Harrison was transferred to the WCC. During his orientation to WCC medical services with a nurse, he asked for pain medication for his back. The nurse explained that pain medication had not been prescribed at BCC, so Mr Harrison would need to see the VMO at WCC and have his medical records available for the VMO to see. The nurse provided Mr Harrison with request forms for his records and for the previous CT scans, but Mr Harrison refused to complete them and left.[9]

20. On 30 August 2016, Mr Harrison attended an appointment with the VMO at the WCC, Dr Neeraj Khanna. Dr Khanna examined Mr Harrison and reviewed his CT scan from 2015. Dr Khanna ordered a range of blood and urine tests to check blood count, liver function, electrolytes, Vitamin D and blood sugar, and ordered an x-ray of his lumbar spine. Dr Khanna discussed with Mr Harrison his diet and the importance of exercise for his back pain and prescribed him Panadeine Forte.[10]

21. On 8 September 2016, Mr Harrison had the x-ray that Dr Khanna had ordered. The report noted changes to his spine and various discs which was consistent with degenerative disc disease. Also, the x-ray revealed "[a]ge-advanced atherosclerotic calcifications of the abdominal aorta, for correlation with vascular risk factors".[11]

22. On 13 September 2016, Mr Harrison saw Dr Khanna for a review of his test results. The x-ray results had not yet been returned to WCC.[12] Dr Khanna advised Mr Harrison that the other test results had all been normal, apart from his blood sugar, which was low. Dr Khanna discussed Mr Harrison's Metformin dosage with him and explained that it was important that he not decide to reduce it by himself. Dr Khanna noted that Mr Harrison told him that the Panadiene Forte was adequately managing his pain. He made a follow-up appointment for 27 September 2016. However, on that day Mr Harrison refused to attend the clinic.[13]

23. On 7 October 2016, Mr Harrison was convicted in the Beenleigh Magistrates Court for the offences for which he was on remand, three counts of fraud. He was sentenced to 2 years and 6 months imprisonment and returned to WCC.[14]

[8] Exhibit D1 – Correctional medical records, pp 32 - 33.
[9] Exhibit D1 – Correctional medical records, pp 33 - 34.
[10] Statement of Dr Khanna, paras 14 – 20.
[11] Exhibit D2.1 - PAH records, p 3.
[12] They did not arrive until 24 September 2016 – see Exhibit D1 – Correctional medical records, p 37.
[13] Statement of Dr Khanna, paras 21 – 24 and Exhibit D1 – Correctional medical records, p 38.
[14] Exhibit C1- QLD Criminal History.

24. On 9 October 2016, Mr Harrison sent a letter to the person in charge of the medical clinic, saying that he wanted to see a doctor other than Dr Khanna, because "*we seemed to have a personality clash and I am not happy with his attitude towards supplying S8 medications for inmates*". On 23 October 2016, he sent a second letter addressed to the Queensland Health Services, asking about various matters, including when a doctor would be seeing him about his recent back x-ray and his CT scan. [15]

25. On 26 October 2016, Mr Harrison saw a different doctor, Dr Rasborsek,[16] who decided to recommence Mr Harrison's Lyrica and order another CT scan of his back. Mr Harrison requested that he be investigated for dementia, and the doctor ordered some pathology in relation to this. The doctor also referred Mr Harrison to the physiotherapist. The doctor recorded that Mr Harrison was happy with this plan. Mr Harrison saw Dr Rasborsek again on 2 November 2016 and advised him that his back pain had improved on the Lyrica.[17]

Events leading up to the death.

26. By 10 November 2016, Mr Harrison was housed in WCC's secure unit 7 (S7). His usual medications were issued to him in S7 by nursing staff who attended medication rounds. If Mr Harrison had a specific medical issue, he would attend the WCC Health Centre.[18]

27. At 8:52am on 10 November 2016, Mr Harrison buzzed corrective services staff from his cell on the emergency intercom and asked where the nurses were. He was advised that they were coming for the medication round. Mr Harrison was asked if he needed the nurse and he said "Yeah, I can't breathe properly".

28. A Code Blue was called, and nurses who were on the medication round responded almost immediately. RN Shaw was on shift as Team Leader of the HC, and when she saw the code blue, she left the HC and took the resuscitation trolley to go to S7. On arrival in S7 she saw Mr Harrison being assisted down the stairs by Registered Nurse (RN) Callum Baker and Endorsed Enrolled Nurse (EEN) Daniel Lio. The three nurses assisted Mr Harrison onto the trolley and took him back to the health centre. Mr Harrison was pale, sweating heavily, and was saying "I can't breathe".[19]

29. On arrival at the Health Centre, Mr Harrison was moved onto a bed. He was very distressed but, when asked, said he did not have any chest pain. RN Shaw examined him and gave him oxygen. She attempted to obtain an ECG reading, but Mr Harrison was too sweaty for the leads to stick and could not be kept still enough for a reading to be taken. RN Shaw was able to determine that Mr Harrison's heart-rate was 108bpm and he appeared to be

[15] Exhibit D1 – Correctional medical records, pp 51 and 59 - 60.
[16] The doctor's full name is unknown – no statement has been provided.
[17] Exhibit D1 – Correctional medical records, pp 39 - 41.
[18] Exhibit B3 – Statement of RN Shaw, paras 10 - 11.
[19] Exhibit E1 – Audio of Harrison's emergency intercom call and Exhibit B3 – Statement of RN Shaw, paras 12 - 16.

in atrial fibrillation (heartbeat irregular and rapid). At 9:08am, RN Shaw directed RN Peti Toomalatai to call the Queensland Ambulance Service (QAS).[20]

30. RN Shaw tried to insert an IV line but was unsuccessful due to the poor state of Mr Harrison's veins from his history of intravenous drug use. RN Shaw increased his oxygen supply which appeared to bring him some relief.[21]

31. QAS officers arrived at 9:20am, and also unsuccessfully tried to insert an IV line. At 9:25am, Mr Harrison's heart stopped beating and he became unresponsive. The QAS officers commenced CPR with a Laryngeal Mask Airway Device (LMA) and attempted to use a defibrillator, but no shockable rhythm was detected.[22]

32. At 9:55am a QAS Critical Care Paramedic (CCP), Aaron Smee, arrived as backup to the QAS officers already on scene. Mr Smee intubated Mr Harrison so ventilation could be performed more effectively than with the LMA, and CPR continued for the next 40 minutes. At that point, Mr Smee made the decision to discontinue first aid, as Mr Harrison was not responsive. Mr Harrison was declared to have died at 10:10am.[23]

Autopsy

33. On 14 November 2016, Dr Andrzej Kedziora conducted an autopsy consisting of an external and full internal examination of the body, blood tests, tissue samples, and a whole body CT scan. The internal examination revealed that Mr Harrison had severe narrowing or atherosclerosis of his coronary arteries and extensive areas of scarring or fibrosis in his heart. Dr Kedziora concluded:

> *The extent and distribution of the scar tissue in the myocardium correlate with the severity of triple vessel coronary atherosclerosis. Death in such circumstance may occur suddenly due to arrhythmia, usually ventricular fibrillation, or acute heart failure, like in this case.*[24]

34. The cause of death was given as coronary atherosclerosis.[25] The toxicology results were negative for alcohol or illicit drugs and showed only traces of opiates.[26]

[20] Exhibit B3 – Statement of RN Shaw, paras 17 – 20.
[21] Exhibit B3 – Statement of RN Shaw, paras 21 - 22.
[22] Exhibit B2 – Statement of RN Shaw, paras 23 – 28 and Exhibit B3 – Statement of CCP Smee, paras 3 - 10.
[23] Exhibit B2 – Statement of CCP Smee, paras 11 – 20.
[24] Exhibit A5 – Autopsy Report, pp 8 - 9.
[25] Exhibit A5 – Autopsy Report, p 10.
[26] Exhibit A4 – Toxicology Certificate, pp 1 - 2.

Clinical Forensic Medicine Unit Review

35. The Coroners Court requested that a review of Mr Harrison's death be conducted by the CFMU. Dr Ian Home of the CFMU was asked to comment on the healthcare provided to Mr Harrison at the WCC.[27]

36. Dr Home agreed with the cause of death given at autopsy, and gave the following opinion in relation to the care provided to Mr Harrison:

> *…On review, I see no reason to be critical of the care provided to Mr Harrison on the day of his death. I do however consider this man should have been assessed and offered medication to reduce his risk of cardiovascular complications earlier during his incarceration*.
>
> *Although he had no documented past medical history of symptomatic cardiovascular disease, given his age and risk factors, particularly poorly controlled diabetes, it could be presupposed that Mr Harrison had cardiovascular disease that likely exceeded the level normally seen in individuals of his age. This was evidenced by reports of heavy calcification of the abdominal aorta on imaging going back as far as 07/08/2013.*[28]

37. Dr Home noted that, in his statement, Dr Khanna said of Mr Harrison's x-ray report "[i]f I had been aware of this report I would have arranged Mr Harrison to undergo cardiovascular testing, including CT angiogram and calcium score".

38. It seems likely that Dr Khanna did have access to the 2015 CT scan, as he said earlier in his statement that at the appointment on 30 August 2016 "I reviewed [Mr Harrison's] medical file and noted that he had degenerative disc disease of the lumbar sacral spine, and that the CT scan of 2015 had confirmed this diagnosis". If this was the case, then Dr Khanna would have had notice of the severe "calcification of the abdominal aorta" noted on the 2015 CT at the time of his first appointment with Mr Harrison.[29]

39. Whether or not he had notice of any calcification, Dr Khanna said in his statement:

> *I am aware that diabetes can carry risk factors affecting the cardiovascular system. However, at the time of my reviews of Mr Harrison and during his period at WCC since his return no concerns were raised about any cardiac vascular issues. He did not complain of any chest pain or shortness of breath. Mr Harrison had multiple comorbidities for which I commenced investigations with the view of having a definitive diagnosis. On both occasions, Mr Harrison did not complain of any chest pain*

[27] Exhibit B5 – Home – CFMU Review, p 1.
[28] Exhibit B5 – Home – CFMU Review, p 3.
[29] Exhibit B5 – Home – CFMU Review, p 3 and Statement of Dr Khanna, paras 14 and 28.

> *or shortness of breath, nor did he show any obvious signs of cardiovascular disease...*[30]

40. However, Dr Home suggested that Mr Harrison should have been investigated for signs of cardiovascular complications even without the results of the radiology reports, or complaint by Mr Harrison himself of chest pains, as:

> *Given diabetics are at increased risk of cardiovascular disease, which can often be asymptomatic (no warning signs felt), even in the absence of [the x-ray report], as a minimum it would have been prudent to check Mr Harrison's blood pressure and lipid (cholesterol and triglyceride) profile as well as perform a baseline ECG. Along with better control of blood sugar levels, cardiovascular morbidity can be significantly reduced with pharmacological interventions including aspirin to reduce the risk of blood clots, a statin to lower cholesterol and a blood pressure lowering agent, such as an angiotensin converting enzyme (ACE) inhibitor.*[31]

41. It appears that Dr Raborsek, who saw Mr Harrison at WCC after Dr Khanna, did not make any of the investigations of the type recommended by Dr Home, despite having access to at least the 2015 CT scan and the 2016 x-ray, if not the 2013 CT scan. Nor, it seems, did any of his treating doctors at the PAH or at local practices commence investigations after his diagnosis with diabetes (as early as 2001) onwards.

42. In respect of the Prison Health Service's (PHS) management of prisoners with diabetes, Gayle Williams, Clinical Director of PHS advised of work that PHS "is undertaking around the management of prisoners with diabetes". Ms Williams advised of two initiatives, both of which commenced after Mr Harrison died:

    a. The development and implementation of a standardised way of prescribing insulin across the service using a short stay-based insulin form specifically adapted for use in prisons; and

    b. the appointment of a Nurse Practitioner (NP) 'Nurse Navigator for Chronic Disease Management': the NP's works with patients with other chronic disease, but much of her work has been with diabetic patients, and involves developing care plans, diabetic medication management, ensuring they have relevant checks for complications of diabetes and implementing the insulin order form.

43. On 3 April 2019, clarification was sought from Dr Home as to the following matters:

[30] Statement of Dr Khanna, para 29.
[31] Exhibit B5 – Home – CFMU Review, p 3.

a. Whether, if practitioners had taken the steps Dr Home advised it would have been prudent for them to take, Mr Harrison's death could have been prevented;

b. Whether the NP/Nurse Navigator initiative, if it had been in place before Mr Harrison's death, would have been likely to have addressed the gaps that Dr Home has identified in Mr Harrison's care; and

c. Whether there were any other recommendations Dr Home could suggest which could prevent similar deaths in the future

44. On 9 April 2019, Dr Home provided an addendum report in which he advised that:

a. in respect of question A:

Given Mr Harrison's cardiovascular risk factors, I stated it would have been appropriate to perform a baseline assessment for cardiovascular disease as well as discuss pharmacological interventions to reduce the risk of cardiovascular complications, such as myocardial infarction. Whilst the use of pharmacological agents can significantly reduce morbidity and mortality, it is difficult to speculate if Mr Harrison's death could have been prevented by the introduction of medication alone given the extent of the coronary artery disease evident at autopsy. To maximise his chance of survival, Mr Harrison may well have required some form of revascularisation procedure, either using balloon angioplasty and stenting or more probably, coronary artery bypass grafting.

…

Whilst earlier investigation and management may have increased Mr Harrison's chances of survival, it is questionable whether any efforts made during the seven-week window between the report of 'age-advanced atherosclerosis. Calcification of the abdominal aorta, for correlation with vascular risk factors on a lumbar spine x-ray and Mr Harrison's death would have altered the outcome.[32]

b. in respect of question B:

The benefit of the Nurse Practitioner/Nurse Navigator in altering the outcome in this case would depend very much on their role description and clinical knowledge. In theory, such a role should assist in ensuring detainees' health needs are better met, including 'flagging' any abnormal investigation results and querying the need for further investigations or possible modifications to their existing medication regime.

[32] CFMU addendum report, pp 1 - 2.

A detailed review of a detainees' medical chart and assessment of their current level of function with a view to optimising their health would be particularly useful for those individuals that are in and out of incarceration, such as Mr Harrison. Had the heavy calcification of the abdominal aorta reported in 2013 been identified and actioned around that time then it is highly conceivable that Mr Harrison would have been offered medication and/or some form of cardiac intervention procedure that could well have prolonged his life.[33]

Response by West Moreton Health

45. Following receipt of Dr Home's opinion, a response was sought from West Moreton Health as to the issues raised, particularly the missed opportunities to recognize Mr Harrison's risk of cardiovascular complications in 2013 and 2015 following CT scans, and an x-ray in 2016, which identified calcification of the abdominal aorta.

46. On 17 June 2019, a response was provided by Executive Director Medical Services, Dr Eleri Carrahar and Executive Director, Nursing and Midwifery, Dr Robyn Henderson. In addition to answering the concerns raised by Dr Home, further information was provided as to how Mr Harrison's identified atherosclerosis would currently be managed.

47. With respect to Mr Harrison's medical conditions and the subsequent treatment he received, the following was noted:

- Mr Harrison had a history of diabetes and other comorbidities for which he was largely non-compliant with treatment recommendations, failing to turn up to appointments or leaving before the completion of the medical review.

- Shortly prior to his death, Mr Harrison refused to engage further with the VMO.

- Most of the health care provided to Mr Harrison related to his diabetes, dental issues and complaints of back pain, for which he underwent CT scans in 2013 and 2015. These showed degenerative disc disease of his lumbar spine, with atherosclerosis an incidental finding.

- An x-ray in 2016 confirmed the status of Mr Harrison's back pain and reported *'aged advanced atherosclerosis.* It was noted that this was an incidental finding, which would not normally be reported by the radiologist.

- Consistent with how a GP would have managed Mr Harrison, treatment was provided based on his clinical symptoms and presentation at the time of review. Despite the findings of the CT

[33] CFMU addendum report, p 2.

scan and X-ray, Mr Harrison did not show or report any signs of symptoms of cardiovascular disease warranting further treatment. He did not complain of or report any chest pain or shortness of breath. No abnormalities were identified during his intake to the BCC or WCC. It was acknowledged that a base line ECG was not undertaken, which would now be carried out with the results catalysed into some form of therapeutic intervention.

- Mr Harrison's BP was regularly monitored (including most recent incarceration 2016) and was found to be within normal limits (except for two readings in 2011 and 2013).

- In response to Dr Home's comment that Mr Harrison should have been commenced on a statin, it was noted that his lipid profile levels were checked in 2013, and the results were below the risk range. Previous results in 2009 and 2011 were also consistently low. As such, he was not commenced on a statin. It was noted that there are side effects of starting someone on a statin when it is not necessary, which can include muscular and bone pain. This was relevant given Mr Harrison's significant back pain due to degenerative disc disease.

- It was acknowledged that the cholesterol and triglyceride levels should have been taken in 2016 at the time Mr Harrison was incarcerated in BCC/WCC. A specific explanation as to why this was not done was unable to be provided, although possible issues with the movement of consumers or refusal by consumers, was proffered.

48. It was noted that Mr Harrison would have been managed more vigorously today considering the following changes implemented since his death, namely:

I. *Appointment of the Nurse Practitioner/Nurse Navigator model for Chronic Disease Management*

Implemented in March 2018, with the aim being to identify patients with chronic health conditions and assist them throughout their health care journey by both monitoring their health condition and escalating it when required. Whilst much of this work has been with diabetic patients, patients with chronic disease (such as atherosclerosis) and other comorbidities are also engaged. This role also regularly reviews investigation results, monitors BP, arranges blood tests identifying any abnormal results, determination of further investigations and/or medications required or altered. Base line ECG's are conducted when deemed appropriate and necessary.

VMO's and NP/NN also undertake cardiovascular risk assessment at the time of the initial assessment, as well as when consumers

are asymptomatic, as set out by the RACGP Guideline for CVD risk assessments.

II. *A new reception and Medical Request Triage system*

This process ensures that prisoners with identified medical issues, such as atherosclerosis, are reviewed by an appropriate clinician to be seen within a defined timeframe.

III. *Updated rebooking system*

The new rebooking system allows for consumers to be reviewed in a timelier manner and to identify those prisoners who miss their appointments to ensure they are followed up and rebooked to be reviewed as soon as practicable to ensure their health care needs are met.

49. The current management of inmates with atherosclerosis was described as follows:

- In accordance with the Guidelines for the Management of Absolute Cardiovascular Risk consumers undergo a full risk assessment, including blood pressure and lipid testing every two years for those people over the age of 45 years, or over the age of 35 for indigenous people, with statins commenced if deemed appropriate.

- In Mr Harrison's case, regardless of the results of the 2016 x-ray, he would now have undergone a full risk assessment and cardiovascular work up (as he was aged over 60 with diabetes), including BP at each visit, lipid profile levels at intake and every five years thereafter, stress test ECG and echocardiogram as base line clinical assessments and calcium score blood tests. Depending on the results of these tests and assessments, consideration would be given to whether an angiogram, stenting or other surgical cardiac intervention was necessary (managed by way of referral to the PAH). The need to commence Statin or blood pressure medication would also be considered.

- Consumers are also advised and educated about the risk factors of cardiovascular disease and prevention of complications of diabetes and atherosclerosis, which includes advice to cease smoking and lifestyle guidance.

50. It was recognised by West Moreton Health that with the changes made since Mr Harrison's death, a prisoner in his position now, with identified/known atherosclerosis, would be managed in a more thorough way, which would identify risk factors in a timelier manner, enabling the provision of appropriate and necessary treatment in order to prevent complications from arising.

51. At present, correctional facilities do not operate using an electronic record system. It was acknowledged that this would assist with information sharing of consumers health issues across all prison health services, prison mental health service, GP and other health service providers. Currently, there is no definite date for the implementation of the Corrections electronic Medical Record system.

Conclusions

52. The standard of health care expected within a corrective services facility is a primary health care standard commensurate with that available in a community setting.

53. Mr Harrison had a history of diabetes, coronary atherosclerosis and other comorbidities. Despite those comorbidities, there was evidence that Mr Harrison was often non-compliant with treatment recommendations and failed to turn up for appointments or left before medical reviews had been completed.

54. Mr Harrison was also living the community at various times after the 2013 CT scan identified abdominal atherosclerosis, including from September 2015 to 27 July 2016, when he was returned to custody. There was no capacity for WCC to manage his health care during those periods.

55. I accept that in terms of the primary health care model that was in place at WCC prior to Mr Harrison's death, he had not complained of any symptoms relating to cardiovascular disease, despite the CT findings.

56. Mr Harrison's main concern appeared to be to have access to strong pain relief for his back pain. His blood pressure and other vital signs were within normal ranges. Although West Moreton Health acknowledged that lipid levels should have been checked on return to prison in 2016, his lipid profile levels from 2009 to 2013 were below risk range and he was not commenced on a statin.

57. While I note the concerns raised by Dr Home about the lack of assessment and provision of medication to reduce the risk of cardiovascular complications earlier in Mr Harrison's incarceration, I also agree with his conclusion that it was difficult to speculate that Mr Harrisons' death might have been prevented by the introduction of a statin alone, and that surgical intervention such as coronary artery bypass grafting may have been required. This is particularly so having regard to the severe coronary atherosclerosis of all coronary arteries identified at autopsy, with more than 90% stenosis.

58. I am also satisfied that the measures implemented by West Moreton Heath since his death, including the more thorough management of prisoners with chronic diseases, sufficiently address such concerns.

59. I am satisfied there is no evidence to indicate that Mr Harrison died from anything other than natural causes and that there were no suspicious circumstances surrounding the death.

Findings Required by s. 45

60. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all the evidence I am able to make the following findings:

Identity of the deceased – Steven Leslie Harrison

How he died - Mr Harrison had a long history of intravenous drug use, diabetes and chronic back pain. He served 11 periods in custody in New South Wales and Queensland between 2009 and 2016. In 2013 and 2015, CT scans for back pain revealed calcification of the abdominal aorta. However, this was not identified and actioned at that time. On 7 October 2016, he was sentenced to 2 years and 6 months imprisonment for fraud offences. On 10 November 2016, he complained of sudden chest pain and collapsed. Resuscitation attempts were made by prison and ambulance officers but were unsuccessful.

Place of death – Wolston Correctional Centre, Wacol in the State of Queensland.

Date of death – 10 November 2016.

Cause of death – Coronary atherosclerosis.

61. The circumstances of Mr Harrison's death do not call for any comment relating to issues of public health and safety or the administration of justice or ways to prevent deaths from happening in similar circumstances.

62. I close the inquest, and extend my condolences to Mr Harrison's family.

Terry Ryan
State Coroner
5 December 2019