QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Garnett Allan Mickelo**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2012/4258
DELIVERED ON:	6 July 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	6 August 2015, 9 February 2016, 26-29 April 2016
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	CORONERS: Death in custody, health care related, coronary atherosclerosis, recent stent angiography, adequacy of medical treatment, adequacy of observations in prison

REPRESENTATION:

Counsel Assisting:	Ms Megan Jarvis
Woodford Correctional Centre:	Ms Kylie Hillard i/b QLD Corrective Services
Metro North HHS:	Mr John Allen QC i/b Metro North Legal Services
Metro South HHS:	Ms Patricia Feeney i/b Metro South Legal Services
The interests of Nurse Maynard:	Mr K Brandon i/b Slater & Gordon
The Mickelo family:	Mr C Martinovic i/b Howden Saggers Cridland Lawyers

Contents

Introduction

1. On 24 November 2012, Garnett Allan Mickelo, aged 48, was being housed in the Safety Unit at the Woodford Correctional Centre (WCC). He had recently returned to WCC after an admission to the Princess Alexandra Hospital (PAH) for cardiac treatment. He was checked on and observed to be settled. Some hours later, he was again checked but noted to have no movement. A Code Blue was eventually called but no resuscitation was attempted. Mr Mickelo was subsequently declared deceased.

2. As Mr Mickelo was in custody it is mandatory that an inquest is held. Mr Mickelo was also an indigenous man. As was acknowledged by the final report of the Royal Commission into Aboriginal Deaths in Custody, 'Deaths in custody are particularly distressing for families and friends, and engender suspicion and doubt in their minds and also in the minds of members *of* the public. The deceased person has been in the custody and care of the State, not accessible in the general sense, his or her life controlled and ordered by functionaries of the State, out of sight and of normal contact. Deaths in such circumstances breed anguish and suspicion equally. Time may heal some of the anguish, but the suspicion can be allayed only by the most open and thorough going over and laying of the facts on the table.'

3. It is also a recognised principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community.

4. With those principles in mind an inquest was originally listed for hearing on 7 October 2015. Shortly prior to that date one of the witnesses, Nurse Marcia Maynard was found deceased, in circumstances, which of its own required a further investigation. Her identity was initially the subject of a non-publication order, however Nurse Maynard's family have requested that order be lifted. At a pre-inquest hearing held on 6 August 2015 and subsequently on 9 February 2016 the issues for the inquest were determined as follows:

    - confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death
    - consider whether any third party contributed to his death
    - consider the adequacy of the cardiac care provided to the deceased during his admission to the PAH over 19-22 November 2012
    - consider the adequacy of the management of the deceased's medication upon his discharge from the PAH on 22 November 2012, and his subsequent re-admission to WCC
    - consider the adequacy of the health care provided to, and the observations of, the deceased in his cell at WCC over 22-24 November 2012.

The investigation

5. An investigation into the circumstances leading to the death of Mr Mickelo was conducted by Detective Sergeant Brad Hallett from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

6. Upon being notified of Mr Mickelo's death, the CSIU attended WCC whereby an investigation ensued. Photographs were taken of the scene. The investigation obtained Mr Mickelo's correctional records and his medical files from both WCC and the PAH. The investigation was informed by interviews with Mr Mickelo's fellow inmates at WCC, and statements from relevant custodial and medical officers at WCC, medical staff from the PAH including the treating cardiologist. These statements and interviews were tendered at the inquest.

7. A full internal autopsy examination was conducted by Dr Nathan Milne. This was peer-reviewed by Professor Tony Ansford. Further photographs were taken during this examination.

8. At the request of the Coroners Court of Queensland, the Clinical Forensic Medicine Unit (CFMU) provided an overall review of the medical care provided to Mr Mickelo whilst he was in custody. Further, I was assisted by expert reviews of the cardiac treatment at the PAH which was undertaken by Professor Darren Walters, Director of Cardiology at the Prince Charles Hospital and Dr Andrew Clarke, cardiac surgeon. During the course of the investigation a number of other medical opinions and statements were provided.

The inquest

9. An inquest was held in Brisbane over 26 to 29 April 2016. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

10. Oral evidence was heard from the following witnesses:
    i. Detective Sergeant Brad Hallett
    ii. Louise Drake
    iii. Lynette Addison
    iv. Paul Broanda
    v. Scott Collins
    vi. Mark Beswick
    vii. CN Vicki Adamson
    viii. RN Dean Izzard
    ix. Dr Lance Le Ray
    x. Dr Rajendra Prakash
    xi. Dr Darren Walters
    xii. Dr Nelle van Buuren
    xiii. Dr John Hill
    xiv. Dr Paul Garrahy
    xv. Dr Andrew Clarke
    xvi. Dr Kenneth Hossack
    xvii. Dr Stephen Cox
    xviii. Dr Nathan Milne
    xix. Professor Stephen Rashford

The evidence

Personal circumstances and correctional history

11. Mr Mickelo was born in Cherbourg in 1964. In October 1981, he was sentenced to life imprisonment for murder. Mr Mickelo was 17 years of age at the time. He

served the majority of this sentence at WCC, during which he worked as a kitchen hand, a cleaner, a tradesperson and a tutor. During his incarceration, he was convicted of multiple offences relating to violence and threats against correctional staff and damaging his cell.

12. Mr Mickelo's primary next-of-kin was Carmel Gyemore, and his sister Brenda Mickelo. Notwithstanding Mr Mickelo's lengthy period of incarceration, members of his family remained in contact with him and noted that he had provided a brotherly role to many prisoners over the years and was well regarded by them.

Medical history

13. Mr Mickelo had a complex and serious medical history, which included hepatitis B, type 2 diabetes mellitus on insulin, and dyslipidaemia. He had also been a heavy smoker for many years. More particularly, his history also included chronic ischaemic heart disease with previous heart attacks suffered in 1996 and 2009. The heart attack in 2009 resulted in the diagnosis of triple vessel coronary artery disease and stents were inserted.

14. Mr Mickelo was routinely seen by the prison medical service through Offender Health Services, and provided with the following medications:

    - Isosorbide mononitrate - used to widen blood vessels;
    - Atenolol - used to treat angina (chest pain) and hypertension (high blood pressure);
    - Lisinopril - used to treat hypertension and congestive heart failure;
    - Metformin - used to treat type 2 diabetes; and
    - Aspirin.

15. On 9 November 2012, a Code Blue was called after Mr Mickelo developed crushing central chest pain. He was transferred to the Caboolture Hospital Emergency Department where it was confirmed that he was suffering from acute myocardial infarction. He was appropriately administered with anticoagulation and antiplatelet therapy, and the chest pain resolved and the ECG improved.

16. Mr Mickelo was transferred to the PAH later that day for further treatment. He remained at the PAH until his discharge on 22 November 2012. During this final admission, Mr Mickelo underwent treatment with optimisation of medical therapy. On 13 November 2012, angiography was performed. On 14 November 2012, coronary stenting to two vessels was performed.

17. It was confirmed that Mr Mickelo was suffering from congestive cardiac failure, acute kidney injury and also may have suffered a transient ischaemic episode (mini stroke) resulting in a temporary loss of vision. It was noted that he continued to suffer shortness of breath and chest discomfort after the coronary stenting was performed.

18. The adequacy of the cardiac care provided to Mr Mickelo over this admission was investigated at the inquest, and I ultimately deal with this issue later on in these findings.

Events leading to death

19. Following his final admission to the PAH, Mr Mickelo was discharged back to WCC on 22 November 2012. His medications at this time had changed since he was last at WCC. His discharge medications were:

    - Metformin - used to treat type 2 diabetes;
    - Aspirin;
    - Amiodarone - antiarrhythmic medication used to treat ventricular tachycardia or ventricular fibrillation;
    - Atorvastatin – used to treat high cholesterol levels;
    - Digoxin - used to treat congestive heart failure;
    - Eplerenone – used in the management of chronic heart failure;
    - Frusemide - used to treat fluid build-up and swelling caused by congestive heart failure;
    - Lantus insulin - form of insulin used to treat type 2 diabetes;
    - Nicotine patch – to assist with nicotine addiction;
    - Omeprazole – used to treat gastroesophageal reflux disease;
    - Perindopril – used to treat high blood pressure;
    - Temazepam - used for treating anxiety and to assist sleep; and
    - Ticagrelor - antiplatelet agent used in the management of acute coronary syndrome.

20. Eplerenone and Ticagrelor were new medications. Lisinopril, Atenolol and Isosorbide mononitrate were no longer part of his medication regime.

21. The records from Offender Health Services (OHS) were tendered at the inquest. The nursing notes from 22 November 2012 sets out that they were informed there were 'no new meds ordered', but it is then noted that indeed there were new medications. Registered Nurse (RN) Adamson noticed this when reviewing the discharge summary and medications and comparing them to their own records. She rang the PAH. It was confirmed to RN Adamson these new medications would be sent from the PAH the next day. These were medications not routinely held at WCC. RN Adamson spoke to a nurse at PAH and she believes the nurse spoke to a doctor and confirmed that there was no urgency to commencing those new medications and a delay until the next day was fine. RN Adamson also had regard to the Discharge Summary from PAH, which noted there was no follow upon discharge (this was an error and there should have been a request for out-patient review in about 6 weeks) and Mr Mickelo was not on any medical observation schedule. RN Adamson appropriately noted Mr Mickelo required a medical review on Monday when the Visiting Medical Officer, Dr Prakash attended.

22. Despite some of his previous medications no longer being part of his medication regime, the OHS records confirm that Mr Mickelo was given Lisinopril and Isosorbide mononitrate on his return from PAH. Of the new medications two of them were missed. Ticagrelor was to be given twice daily. Mr Mickelo was given Ticagrelor on the morning prior to discharge at PAH and he then missed the doses on the afternoon of 22 November and morning of 23 November. Mr Mickelo received the first dose of Ticagrelor in the afternoon of 23 November. Eplerenone, was to be given in the morning, and was given on 22 November prior to discharge from PAH. He received his next dose at WCC in the afternoon of 23 November, in effect only 5 hours late. As will be noted in the opinion of the

experts, the missed doses, whilst regrettable, would have had either no impact clinically or at its highest may have had some impact.

23. Mr Mickelo was kept in the Safety Unit immediately after the return from PAH. RN Adamson seems to have made that decision on the basis of his late return that day from hospital and the fact the Safety Unit at WCC was next to the medical centre. Over the morning and afternoon of 23 November 2012, Mr Mickelo was noted not to have had any 'chest pain for "6/7" (six days)', and his medical observations were fine other than a little low blood pressure. It was therefore considered by nursing staff he could return to his residential unit. Mr Mickelo was also being regularly seen during the day by nursing staff to check his blood sugar levels. WCC management were advised that Mr Mickelo was no longer requiring 'medical observations'. RN Adamson said she had no health concerns for Mr Mickelo and did not observe any shortness of breath or that he was ashen in colour. She said if this was the case she would have taken further observations of Mr Mickelo and called the VMO.

24. However, it was arranged by Custodial Manager Lynette Addison that Mr Mickelo continue being housed in the Safety Unit. The Safety Unit is set up to manage inmates who are primarily at risk of suicide or self-harm, but is also utilised for those who have medical issues that require monitoring. Telephone calls in the Safety Unit are not monitored. Nurse Izzard stated it was not standard practice for the Safety Unit to be used for persons with medical conditions requiring nursing observations or care. Persons requiring acute medical or nursing care are not accommodated at WCC.

25. Ms Addison said she was concerned about the appearance of Mr Mickelo after his return from hospital. She spoke to the Medical Centre and in particular RN Adamson and was told there was no intention to place Mr Mickelo on any sort of medical observation regime. When Ms Addison was told that he had been cleared to go back to his usual unit she talked to the medical staff about her concerns because of the surgery he had and his presentation, and particularly in relation to his physical incapacity to walk even a moderate distance. Ms Addison did not consider the response from RN Adamson satisfactory.

26. Ms Addison then took the matter up with the Deputy General Manager of WCC, Paul Broanda. She expressed her concerns and her recommendation that Mr Mickelo be placed in the Safety Unit so that medical help was closer. Ms Addison considered Mr Mickelo was too far away from medical assistance if he was placed in his usual cell. She completed the formal request and noted the reasons being that he had recently undergone heart surgery and had been placed in the Safety Unit to be monitored, for health concerns. Ms Addison specifically did not write anything about the need for 'medical observations' as that is outside her area of responsibility. It is the protocol that medical observations are performed by the medical staff. Custodial officers would observe and report as part of normal duties. It is apparent Mr Mickelo was not listed for medical observations on a white board in the control room.

27. Ms Addison stated in evidence she was wanting to be risk averse and considered it was more convenient to have Mr Mickelo next to the medical centre. She said Mr Mickelo did appear to be short of breath and ashen in colour. She also made some reference to him being in a wheelchair although that recollection may be less clear. She also stated that Mr Mickelo said he was happy to stay in the Safety Unit. This is somewhat at odds with the evidence of RN Adamson who said Mr Mickelo was keen to go back to his residential unit. Given the extra

confines of the Safety Unit it is likely he would have preferred his residential unit, but perhaps was not strongly objecting to staying in the Safety Unit.

28. In any event, Paul Broanda agreed with the approach recommended by Ms Addison for a variety of reasons and signed the Safety Order. He intended to have the case medically reviewed after the weekend but Mr Mickelo died before that could occur.

29. By about 2000 hours on the night of 23 November, Mr Mickelo complained of chest heaviness following a walk. Nurse Maynard was the only nurse on duty over this shift in the Safety Unit. A medical assessment was conducted by Nurse Maynard by way of measuring blood pressure and oxygen saturations. She noted her observations in the nursing notes and recorded he had 'no cardiac issues'. Mr Mickelo was also having difficulty sleeping and she received an order for him to be given diazepam and paracetamol.

30. Two aspects of the above scenario were ventilated during the inquest. The first was the reference to there being 'no cardiac issues' and the second related to the giving of diazepam and not temazepam, as was prescribed for Mr Mickelo on discharge.

31. Nurse Maynard died before the inquest. In her statement, she confirmed upon commencing her shift that she received a handover from Clinical Nurse Vicki Adamson to the effect that:

- Mr Mickelo had been returned from the PAH on 22 November;
- He had not had chest pain for six days; and
- He was in the Safety Unit for operational reasons, not medical reasons.

32. Nurse Maynard's statement said that at approximately 1940 hours she was informed by the Safety Unit officer that Mr Mickelo had said he had a heavy sensation in his chest. She immediately requested access to the Safety Unit via the Supervisor, Alan Preston. Nurse Maynard explained in her statement, consistent with other witnesses, that protocol required three correctional officers to be present if a cell in the Safety Unit needed to be entered. In this instance, Nurse Maynard was given access to Mr Mickelo's cell within five minutes.

33. Nurse Maynard confirmed that when she saw Mr Mickelo, there were no obvious signs of distress and he was alert and orientated. She asked him if he was having any chest pains, any pain in his arm, jaw or neck or any trouble breathing. Mr Mickelo said no. Nurse Maynard also asked him if he was experiencing pain similar to what led to his recent admission to the PAH. Once again, Mr Mickelo said no.

34. Nurse Maynard recalled asking Mr Mickelo for more detail about why he had reported feeling heavy in his chest. He said that since walking up to the 'MCR2' earlier that day, he had experienced soreness but said there had been no change since. Nurse Maynard stated that 'MCR2' was about 400 metres from the Safety Unit, and involved pushing or pulling some 26 doors. Drs Garrahy and Clarke agreed in their evidence that Nurse Maynard was looking for the right things and asked the right questions.

35. For the remainder of her shift, Nurse Maynard continued to monitor and observe Mr Mickelo. She provided details of her communications and observations to Dr Prakash, the VMO.

36. Dr Prakash prescribed Valium (diazepam) to help Mr Mickelo sleep. On this issue I find that very little turns on the prescribing of diazepam as opposed to temazepam. Temazepam was not routinely available at the WCC medical centre. Temazepam is short acting and is commonly used to assist sleeping. Diazepam is in the same family of drugs and is longer lasting. It is commonly used for anxiety and as a muscle relaxant. In this instance it was given on one occasion as ordered by the VMO to assist in sleeping. Although counsel for the family valiantly endeavoured to obtain an answer from various medical witnesses that the use of diazepam was adverse or contra-indicated in a heart patient, he was not successful. The prescribing of diazepam had no impact on the outcome and was appropriate.

37. Nurse Maynard noted that Mr Mickelo remained settled throughout the night and she communicated the events of the shift to the morning staff at handover. This was her last involvement with Mr Mickelo.

38. There are no nursing entries in the OHS records for the day shift of 24 November 2012.

39. Louise Drake spoke to Mr Mickelo on a regular basis by telephone. Mr Mickelo had met her brother in prison. She spoke to him on 24 November 2012. She recalls that he was full of praise for the attention he received in hospital. He seemed fine and happy and back to his old self. He did not complain of any heart problems or pain in his chest.

40. The nursing entries for 24 November 2012 commence at 1930 hours. Nurse Izzard commenced his shift on 24 November 2012 at 1800 hours. He was not provided any handover for Mr Mickelo and to his knowledge Mr Mickelo did not require any medical care or nursing intervention overnight. At approximately 1930 hours he noted Mr Mickelo was present in the Safety Unit; was noted as being settled; he was given access to the toilet; and he was talking to others. Nurse Izzard documented this briefly in the chart.

41. The Safety Unit officer on shift for this period was Grant Stevens. He finished his shift at 2200 hours, at which point Mark Beswick took over.

42. Mr Beswick's written statement notes that at 2210 hours he started checking on prisoners. He checked on Mr Mickelo through the window of his cell door and became concerned that he could not see Mr Mickelo's chest moving. Mr Beswick said he thought he saw a finger move, but was not sure. He called the supervisor Ryan McGregor and the nurse at 2215 hours. The nurse, Dean Izzard, looked through the cell door window and Mr Beswick asked Mr Mickelo (via the cell intercom) to move his arm. There was no response.

43. At 2218 hours Mr McGregor says he looked at Mr Mickelo through the cell door window and called a Code Blue. Two minutes later at 2220 hours, four other correctional officers attended at the Safety Unit, namely Rodney Townsend, Robert Van-Leeuwen, Graham Carter and John Quarman. After a briefing and putting on of gloves, they all entered the cell, by which time it was close to 2223 hours.

44. It is evident from the timeline above that the period between Mr Beswick commencing his welfare checks (during which period he observed that Mr Mickelo may not be breathing), to the time officers opened the cell door and

attended Mr Mickelo, was around 15 minutes. General Manager Scott Collins states the time period could be closer to 7-8 minutes as WCC records indicate CSO Beswick noted his first observation at around 2215 hours. The CCTV records uninterrupted focus on Mr Mickelo's cell commenced at 22:14:04. This suggests Mr Beswick noticed Mr Mickelo not moving through the cell window some time shortly before 2214 and he then went back to the office and fixed the CCTV to focus on his cell. Mr Collins stated a 7-8 minute response was reasonable on the basis of the distance officers had to travel and the number of locked doors they had to traverse. The time delay in reality was probably greater than 8 minutes and not as long as 15 minutes.

45. Nurse Izzard then entered the cell and conducted an examination of Mr Mickelo. Life extinct was declared at 2225 hours. Nurse Izzard says he checked for signs of life by touching him with his foot and then picking up his hand to see if there was a pulse. He says he also examined his pupils, which were fixed and dilated and open. There were no respiratory noises or sounds or evidence of breathing. Rigor mortis had not yet set in fully. This examination was recorded on CCTV.

46. Professor Rashford has viewed the CCTV and was of the view it shows a much shorter and very cursory examination. The CCTV footage certainly supports that opinion.

47. It is evident that nursing staff cannot enter a cell until it has been declared secure by a corrections officer. However, for future cases an issue raised was about the procedures applicable for entry of cells. This is provided in a Standard Operating Procedure (SOP) 'Night Shift'. This stated 'The officer in charge must be present when an unplanned cell opening occurs during a night shift except when a custodial correction officer reasonably suspects a medical emergency exists'.

48. General Manager Collins stated that when a medical emergency is thought to exist by night shift officers, a CODE BLUE must be called immediately. Officers may request that a cell door be opened immediately to initiate a medical response as required but a minimum of two officers must be in attendance.

49. Mr Collins also noted that Mr Mickelo's institutional history was poor and included significant episodes of criminal and violent behaviour and general non-compliance and was identified with a number of security risk factors. Mr Collins stated that in his view the officers adhered to procedures. He stated the current *Custodial Operations Practice Directive* essentially reflects the previous SOP.

50. Peter Anthony Shaddock, the General Manager, Operational Service Delivery, provided a statement after the inquest hearing looking at three issues. The first of those issues concerned the use of duress alarms by prisoners. The second referred to the use of a CODE BLUE and the third related to unscheduled night time entry to a cell.

51. Mr Shaddock stated Personal Duress devices are issued to individual stake holders and staff members.

52. There are also Static Duress alarms that are fixed button/switches placed in areas such as a desk top or wall to an office. There are no cord/lead operated duress systems in place provided to persons within the correctional environment. It is considered to be an unacceptable compromise to use such devices that incorporate a cord/lead given the need to reduce ligature points and ligature opportunity in general.

53. Mr Shaddock said alternatives have been considered such as voice-activated duress systems to be utilised within high risk prisoner areas. On the market systems had not been identified at this time. Mr Shaddock considered there will also be complicating factors in their use given that the unit such as a Safety Unit would be subject to constant noise and the system must be capable of discerning between that general noise and that of a distressed individual. Any duress system would quickly lose any effectiveness if it is constantly activated.

54. A CODE BLUE describes a medical emergency situation and is one of twelve contingency codes utilised within QCS to describe a type of incident within the correctional environment. During correctional officers' initial ten week training, individuals received training and instruction relevant to radio procedures, first officer response and At Risk of Procedures such as suicide prevention.

55. To complete their Certificate 3 in Correctional Practice, officers must be assessed on responding to medical emergencies and all corrective services officers must complete the certificate.

56. Suicide Prevention and first aid courses are formally conducted every three years. CPR, blood-borne viruses and suicide prevention practical skills are refreshed every twelve month period. Competencies are regularly and formally assessed. Staff are encouraged to err on the side of caution and not to hesitate to call a code of any description if there is any indication of this presenting circumstance. The evidence of medical staff at WCC confirmed that corrective officers had a low threshold to call a CODE BLUE, hence there were many and sometimes for minor issues, but medical staff always responded. Dr Le Ray stated that Code Blues are overused at WCC but this was understandable given officers would not have clinical experience and it has been determined that they would not try to change the current practices.

57. Mr Shaddock also commented on the current custodial practice directive concerning the opening of accommodation units and cell doors. He stated that staff have the capacity to conduct an unplanned cell opening if, they assess the situation warrants such action balanced against the level of assessed compromise to self and others. Consideration of a single officer having the capacity to open a cell containing a single or two prisoners is not considered a safe practice and could easily compromise the safety of the staff member and others as well as the security of the site.

Autopsy results

58. A full internal examination was conducted by forensic pathologist Dr Nathan Milne on 28 November 2012. Dr Milne's results at autopsy were peer reviewed by Professor Tony Ansford.

59. Internal examination showed severe extensive heart disease. The heart was enlarged. There were areas of old myocardial infarction and extensive recent infarction with large areas of death of the heart muscle. The coronary arteries showed widespread severe coronary atherosclerosis. The stents that were present showed no evidence of blockage or complication. Dr Milne described this was one of the worst hearts he had seen in his extensive experience.

60. Histology testing confirmed widespread myocardial infarction of variable age. The most recent areas appeared 1-3 days old (from the date of death), and older

areas appeared to be 10-14 days old. Dr Milne stated that it was not possible to be more exact to the day but the most recent myocardial infarction was over four hours old as you cannot see the microscopic healing changes inside that time. The lungs also showed evidence of emphysema.

61. Dr Milne stated it is possible the most recent infarct occurred prior to discharge from PAH. However he said that at autopsy there was 1 litre of fluid in the chest cavity, which was not evident on a chest x-ray taken on 21 November. That level of fluid can also be routinely picked up on stethoscope, an event likely to have been conducted prior to discharge.

62. Dr Milne stated that the observation of Mr Mickelo being cold and stiff at 2223 was inconsistent with him being alive at 2215 (as possibly suggested by the observation of Mr Beswick that he may have seen a finger move), as rigor mortis sets in commonly after an hour.

63. Dr Milne confirmed the cause of death as being myocardial infarction resulting from coronary atherosclerosis. The myocardial infarction was severe and extensive. There was also evidence of heart failure. The likely precipitating event was an arrhythmia and probably it was spontaneous.

Medical Issues for investigation

Medical reviews

64. The inquest heard from a number of health clinicians considering the medical issues referred to, both from those treating Mr Mickelo as well as independent expert reviews.

Dr Nelle van Buuren

65. Dr Nelle van Buuren is a Forensic Medical Officer with the Clinical Forensic Medicine Unit. She was provided with the entirety of the investigation material and asked to provide an opinion as to the adequacy and appropriateness of the medical care afforded to Mr Mickelo whilst he was in custody. Dr van Buuren's report was tendered at the inquest and I also heard oral evidence from her.

66. Dr van Buuren confirmed Mr Mickelo had a number of risk factors for ischaemic heart disease including the fact he was an indigenous person, a prisoner, a smoker, he had diabetes and also had high cholesterol. She opined that at the time of his last admission to hospital on 9 November 2012, Mr Mickelo was managed appropriately by staff at WCC and also by staff at Caboolture Hospital.

67. It was recognised by Dr van Buuren that Mr Mickelo's recovery from the infarct suffered on 9 November (being his third heart attack since the age of 32), was complicated by the following co-morbidities:
    - Heart failure
    - Acute kidney injury
    - Atrial fibrillation (rapid, irregular and dysfunctional contractions of the heart)
    - Possible transient ischaemic attack (stroke).

68. Dr van Buuren opined that Mr Mickelo's health was investigated appropriately during his admission to the PAH. The restriction of blood supply to his heart muscle was reviewed with a view to whether the flow of blood could be improved.

Prior to his undergoing the angioplasty and stenting on 12 November 2012, doctors discussed with him the serious nature of his illness. Throughout his admission to the PAH he was seen by various medical professionals for the variety of health issues he was facing including his heart problems, high cholesterol, diabetes and temporary vision loss.

69. Dr van Buuren raised a number of issues for further investigation. She stated the chest heaviness reported by Mr Mickelo on 23 November 2012 should have raised a high index of suspicion it was cardiac in origin, with or without the history of ischaemic heart disease. Dr van Buuren explained in her evidence that the possibility the chest heaviness was of cardiac origin was confirmed by the autopsy findings identifying areas of scarring, which appeared to be only 1-3 days old. Dr van Buuren raised the question of whether there was a chest pain protocol in existence at WCC, and whether it was followed in this instance.

70. Dr van Buuren's report also dealt with Mr Mickelo's medication regime when he was discharged back to WCC on 22 November 2012. In her evidence to the inquest, Dr van Buuren could not be certain as to whether giving Mr Mickelo doses of Lisinopril, Atenolol and Isosorbide mononitrate, in addition to the medication he had received at the PAH, might have contributed to his subsequent myocardial infarct. Dr van Buuren was also uncertain as to whether the two missed doses of Ticagrelor might have contributed to his demise.

71. With respect to the circumstances and timing of Mr Mickelo being found deceased in his cell, Dr van Buuren was unable to say whether the delay in gaining access to his cell contributed to his death.

Professor Darren Walters

72. So as to further investigate the concerns raised by Dr van Buuren regarding Mr Mickelo's medication regime, a further medical review was requested to be conducted by Professor Darren Walters. Professor Walters is an Interventional Cardiologist and is the Director of Cardiology at the Prince Charles Hospital. His report was tendered to the inquest and I also heard oral evidence from him.

73. Professor Walters gave evidence that Mr Mickelo suffered from ongoing coronary ischaemia and decompensated congestive cardiac failure. His underlying condition, even with optimal therapy, carried with it a poor prognosis.

74. With respect to the medication regime, Professor Walters gave evidence that the communication of the discharge medication, and the subsequent incorrect administration of the medication regime may have had a minor contribution to the overall outcome. He explained that the additional Atenolol may have had an acute impact to slow the heart rate further and worsen cardiac failure in the short term. The omission of Ticagrelor was significant, though the period of omission was short. The primary role of the Ticagrelor was to prevent coronary thrombosis. Professor Walters noted that, at autopsy, there was no evidence of coronary thrombosis in the stents.

75. The eplerenone was a diuretic prescribed to treat heart failure. Its omission may have contributed to Mr Mickelo's clinical state.

76. Professor Walters gave evidence, which was somewhat critical of the overall coronary care provided to Mr Mickelo whilst at the PAH. He opined that the overall treatment strategy in managing Mr Mickelo may well have contributed to his outcome. Whilst Mr Mickelo had severe underlying pathology that was not

assisted by his ongoing cigarette abuse, the management of his coronary disease did not seem optimal when compared with current recommendations.

77. Professor Walters stated he was unable to find the option of bypass grafting being formally entertained during Mr Mickelo's admission to the PAH. He opined that this would be a preferred revascularisation strategy in a patient with Mr Mickelo's co-morbidities. Dr Walters noted there was no evidence of a consultation with a cardiac surgeon or a multidisciplinary discussion.

78. Further, given Mr Mickelo's significant ischaemic cardiomyopathy and poor left ventricular function well prior to his final heart attack, Professor Walters questioned whether an implantable defibrillator was considered.

79. Dr Walters also opined that continuation of beta blockage may have been preferable in a patient where control of atrial fibrillation was being achieved with amiodarone and digoxin. Dr Walters noted he had come in with beta blockers but not discharged with them. He stated that digoxin is not shown to improve prognosis and may worsen prognosis in such patients.

80. With respect to the chest heaviness experienced by Mr Mickelo on 23 November 2012, Professor Walters said that this might have prompted referral back to the PAH. He concluded that these were symptoms of ongoing clinical instability. Professor Walters thought it suboptimal to discharge a patient of Mr Mickelo's condition with no arrangements made for cardiac follow up.

81. Overall, Professor Walters acknowledged that Mr Mickelo had severe underlying disease with a poor prognosis, who continued to contribute to his own demise by continuing to smoke. However, the incorrect medication being administered, together with the ongoing symptoms of instability not being acted upon are factors which may have contributed in some way to the death.

Dr John Hill, Dr Paul Garrahy, Dr Steven Cox

82. Given the criticisms raised by Professor Walters about the coronary care provided to Mr Mickelo during his final admission to the PAH, it was requested that an appropriate person from the PAH respond to those criticisms. A number of responses were received from the PAH. Dr John Hill, a Senior Staff Consultant Cardiologist who treated Mr Mickelo during his final admission until the morning of 12 November 2012 provided a statement. Dr Paul Garrahy, Director of Cardiology at the PAH who took over Mr Mickelo's treatment from Dr Hill from 12 November 2012 until his discharge also provided a statement. Dr Steven Cox, Visiting Cardiologist to the PAH, performed the stenting on 14 November 2012 and also provided a statement.

83. I heard evidence from Drs Hill, Garrahy and Cox at the inquest.

84. Dr Hill confirmed that he began treating Mr Mickelo once he was admitted to the coronary care unit at the PAH on the afternoon of 9 November 2012. Dr Hill was not involved in subsequent discussions held on 13 November 2012 regarding the most appropriate means of coronary revascularisation. Dr Hill confirmed that, upon Mr Mickelo's discharge on 22 November 2012, arrangements were not made for cardiological follow up. This was conceded to be an oversight.

85. Dr Garrahy had performed the previous stenting on Mr Mickelo in 2009 and was involved in the discussions surrounding the most appropriate means of coronary revascularisation on 13 November 2012.

86. Dr Garrahy gave evidence that, following an angiogram being performed by Dr Andrew McCann on 13 November 2012, the options were coronary by-pass graft surgery or insertion of stents. Dr McCann's report (of which I received an explanation from Dr Cox), recommended that consideration be given of all revascularisation options.

87. Dr Garrahy considered that stents would be less dangerous and more immediately effective for Mr Mickelo. He explained in his evidence that, since 2009 Mr Mickelo had suffered further significant cardiac damage. He was in heart failure with low blood pressure and experiencing episodes of atrial fibrillation. He was proving difficult to stabilise. Dr Garrahy was concerned that if Mr Mickelo was subjected to by-pass surgery, he would not survive the procedure or the immediate post-operative period.

88. Dr Garrahy recalled discussing the options with Dr Cox along with the images relating to the diagnostic angiogram. It was decided that the safest immediate option for Mr Mickelo was to proceed with stenting of the circumflex and re-stenting of the left anterior ascending coronary artery.

89. In his evidence to the inquest, Dr Garrahy responded directly to the criticisms put forward by Professor Walters. With respect to the most appropriate method of revascularisation, Dr Garrahy disagreed that it was coronary bypass surgery in this case. He pointed out that scientific studies and clinical guidelines are valuable in the assistance they provide to the clinical decision making process. However, they are not a substitute for clinical judgement on the part of treating practitioners.

90. Dr Garrahy gave evidence of a number of additional circumstances which must be accounted for when deciding the method of revascularisation. These were:
    - The specific clinical condition of the patient
    - The history of the patient's disease
    - The number of blockages in the coronary arteries
    - Where the blockages are situated
    - The quality of cardiac muscle tissue and the amount of residual viable tissue
    - The general physical and mental state of the patient.

91. Overall, Dr Garrahy maintained his opinion that given Mr Mickelo's clinical situation, it was considered the risks of cardiac surgery, balanced against the potential benefits were not justified. The risk/benefit ratio for stent angiography was considered by Dr Garrahy and other cardiac physicians as more appropriate. Dr Garrahy maintained that he and Dr Cox did not need a cardiac surgeon to tell them there was a high risk of Mr Mickelo dying from bypass surgery.

92. With respect to Professor Walters' evidence that a defibrillator might have been considered to be inserted, Dr Garrahy provided evidence that this measure is only to be considered in patients at least 40 days post myocardial infarction.

93. Dr Garrahy agreed that beta blockers are appropriate to use in patients with advanced heart failure who have stable fluid balance. However, Mr Mickelo was not in that category as his fluid balance remained difficult to manage throughout his admission. He stated that beta blockers would likely have precipitated an

overt pulmonary oedema. Moreover, prior to the insertion of the stents, Mr Mickelo's blood pressure was low and beta blockers would have reduced it further, creating an acutely dangerous situation. He stated that it is apparent from the clinical notes that beta blockers were to be considered once stable fluid balance had been achieved. Dr Garrahy also stated that amiodarone does have some beta blocker in it. Atenolol, which was not part of his discharge medication but had previously been prescribed, was given when he came back to WCC and also has some beta blocker. Dr Garrahy stated it is possible this impacted.

94. An issue was raised during the inquest by counsel for the family as to the clinical interpretation of creatinine kinase studies taken on 9, 10 and 14 November 2012 and whether further or more specific creatinine kinase or troponin studies would be clinically indicated after 14 September, before discharge and if not why. Dr Cox was requested to provide a report on that issue and this was received after the inquest hearing.

95. The two CK readings on 9 November 2012 were consistent with acute myocardial infarction probably involving substantial cardiac ischaemia.

96. On 10 November 2012, a third CK was performed which represented a plateauing of his CK.

97. At Dr Cox's request a CK was performed on 14 November the day after cardiac catheterisation. The CK is two times the upper limit of normal and therefore unlikely to represent a significant complication following the angioplasty. It was probably best explained by a progressive fall from the CK following his myocardial infarction and therefore not related to the angioplasty procedure on 14 November 2012. It would have been his usual practice not to repeat the CK or troponin levels if the twelve hour CK was not greater than two times the upper limit of normal. Dr Cox stated that the only reason to repeat those measurements would be if there was a new episode of significant chest pain or ECG changes. Dr Cox also stated in general terms because the troponin falls much more slowly than the CK, it would not be his usual practice to check the troponin more than once or twice after the initial myocardial infarction being diagnosed.

98. Professor Walters was provided with the statements from Dr Garrahy and Dr Cox. At the inquest he maintained his opinions.

Reports of Dr Andrew Clarke and Dr Kenneth Hossack

99. Dr Andrew Clarke is a cardiothoracic surgeon. He was requested by my office to provide an opinion on the suitability for coronary artery bypass surgery on Mr Mickelo. Dr Clarke noted the past history of previous acute myocardial infarction and stenting. He also noted a number of cardiovascular risk factors including diabetes, being a current smoker, hypercholesterolaemia, hypertension and his aboriginal heritage. Mr Mickelo had known moderate to severe left ventricular dysfunction secondary to ischaemic cardiomyopathy.

100. Dr Clarke also noted the findings at autopsy of old scar consistent with previous myocardial ischaemic injury. There was also evidence of new extensive near full-thickness myocardial infarction being 10–14 days old, consistent with his initial presentation with a STEMI on 9 November 2012. He also noted evidence of acute myocardial infarction that was felt to be 1–3 days old consistent with the likely myocardial infarction/chest heaviness that occurred on the evening of 23 November 2012.

101. Dr Clarke opined that Mr Mickelo was clearly a high risk case. He had evidence of ischaemic cardiomyopathy with a baseline poor left ventricle due to previous myocardial infarction and scarring. He presented with new extensive full-thickness myocardial infarction and significantly worse left ventricular function.

102. Dr Clarke reviewed the coronary angiogram and stated it revealed a potentially surgically graftable left anterior descending coronary artery. His circumflex coronary artery looked to be a poor distal target, and although potentially surgically graftable, it would likely not remain patent in the medium to long-term. His right coronary artery was likely to be surgically ungraftable.

103. Dr Clarke opined that Mr Mickelo almost certainly died from a cardiac arrhythmia in the setting of extensive myocardial full-thickness infarction. There was no evidence to suggest thrombosis of his stents at autopsy.

104. Dr Clarke stated that in retrospect it would have been reasonable to seek a cardiac surgical opinion after his initial angiogram. At the inquest he stated this was largely in the context of the current medico-legal environment. He opined that otherwise what was done at PAH was a reasonable clinical decision. He believes Mr Mickelo would have been extremely high risk for surgical intervention (calculation of mortality of 22.2% he based on EuroScore 1[1]). Furthermore a question mark remains over how much viable myocardium was actually left, given the findings at autopsy of widespread full-thickness infarction. An MRI viability scan after the initial coronary angiogram would have been helpful to determine the likely benefit of stenting or surgery over simple medical non-interventional cardiac failure management alone.

105. Given the history and post-mortem findings, Dr Clarke thought the management of Mr Mickelo at PAH in 2012 was reasonable (that is stenting rather than coronary artery bypass grafting). He did not think coronary artery bypass surgery would have given a superior result and would have been extremely high risk given the clinical picture. Implantation of an internal defibrillator was not indicated acutely, and would generally not have been performed for a period of 1–3 months after the acute myocardial event. There could have been a case for implantation of an AICD after the 2009 events, but as pointed out by Dr Garrahy, the patient refused to return for review and therefore this did not occur.

106. Dr Clarke stated the ultimate outcome was predictable given Mr Mickelo's extensive myocardial injury. Even if Mr Mickelo had made a successful recovery from the acute cardiac events, his short to medium prognosis from his disease would be regarded as poor.

107. Dr Kenneth Hossack, cardiologist, also provided a report. Dr Hossack stated that in his opinion the medications provided to Mr Mickelo during his period as an inpatient at PAH were appropriate. The initial medications were used to treat an acute coronary syndrome. Diuretics were used to treat pulmonary oedema. The combination of digoxin and amiodarone were appropriate to treat the recurrent episodes of atrial fibrillation. The use of aspirin and Ticagrelor was appropriate

[1] EuroScore is a method of calculating predicted operative mortality for patients undergoing cardiac surgery. Dr Walters was critical of the use of EuroScore 1 as he says it overstates the risk. EuroScore 2 has been in place since 2011 and he says it is more widely validated. Dr Clarke agrees EuroScore overestimates the risk but he gave a reason for using EuroScore 1. I do not need to determine this as an issue as in either event I accept the view of Dr Clarke that most surgeons would say he was high risk, whatever the score.

following stent implantation. The use of lipid lowering treatment, oral hypo-glycaemic agents and insulin were all appropriate treatments for Mr Mickelo.

108. Dr Hossack considered that coronary bypass graft surgery was not an appropriate treatment for Mr Mickelo. This was based on his review of the angiogram and the clinical features of Mr Mickelo who had a significant operative risk.

109. Dr Hossack also stated it was appropriate for the cardiology team to decide that Mr Mickelo was not a candidate for coronary artery bypass surgery.

110. Dr Hossack was also of the opinion the insertion of stents was appropriate treatment for Mr Mickelo. The use of bare metal stent was also appropriate. In Mr Mickelo's case there was a potentially advantageous reason for using bare metal stent. This was due to Mr Mickelo's documented difficulties with compliance issues regarding long-term dual antiplatelet therapy.

111. Dr Hossack was also of the opinion the guidelines for implantation of a defibrillator indicate that maximal medical management should be undertaken for at least six weeks before implantation.

112. Dr Hossack was further of the opinion that Mr Mickelo received appropriate care at the PAH. He disagrees with Dr Walters' opinion regarding prevention of sudden death and was of the opinion that deferring defibrillator insertion was in accordance with guidelines.

Conclusions on the adequacy of the cardiac care provided

113. I am satisfied that Mr Mickelo was given appropriate medical care by staff at the PAH. The medical opinions on the issue of stents versus CABG, type of stents and medications did vary. As Dr Clarke stated reasonable minds on some of these issues will differ and 10 doctors may all give different opinions. The majority of the evidence supported the view that reasonable decisions not outside of an appropriate standard of medical practice were made.

Conclusions on the adequacy of the management of the deceased's medication upon his discharge

114. The evidence heard on this issue was not entirely clear in terms of causation to the death.

115. Dr van Buuren could not be certain as to whether giving Mr Mickelo doses of Lisinopril, Atenolol and Isosorbide mononitrate, in addition to the medication he had received at the PAH, might have contributed to his subsequent myocardial infarct. Dr van Buuren was also uncertain as to whether the two missed doses of Ticagrelor might have contributed to his demise.

116. Professor Walters gave evidence that the incorrect administration of the medication regime may have had a minor contribution to the overall outcome. He explained that the additional Atenolol may have had an acute impact to slow the heart rate further and worsen cardiac failure in the short term. The omission of Ticagrelor was significant, though the period of omission was short. The primary role of the Ticagrelor was to prevent coronary thrombosis. Professor Walters noted that, at autopsy, there was no evidence of coronary thrombosis in the stents. In that regard therefore, I find the omission of one dose was not contributory.

117. The eplerenone was a diuretic prescribed to treat heart failure. Its omission may have contributed to Mr Mickelo's clinical state.

118. It was also put to most of the medical witnesses that the use of amiodarone (3 doses x 200mgr daily) was contra–indicated. The medical witnesses were largely in agreement that its use at that level initially was appropriate until further review some weeks or more down the track.

119. Based on the medical evidence I have heard, I am satisfied that it can be placed no higher than the administration of an incorrect medication regime by giving atenolol and omitting briefly eplerenone, may have contributed in some way to Mr Mickelo's death.

120. WCC was requested to provide any information in response to the issue of the medication difficulties. This was provided by Dr Lance Le Ray, the Director of Medical Services at Caboolture and Kilcoy Hospitals. Dr Le Ray's role extends to the clinical governance and patient safety at the medical centre at WCC. I also heard evidence from Dr Le Ray at the inquest.

121. In his evidence to the inquest, Dr Le Ray accepted the conclusions of Dr van Buuren regarding the medication processes. He conceded that improvement was required with respect to the process for reconciliation of the medication history on admission/readmission to WCC.

122. Dr Le Ray gave evidence of an overall review of medication management processes that had taken place at WCC. He confirmed that the current position is the PAH now fax through the discharge report directly to WCC once the prisoner has been discharged. This then provides the opportunity for the discharge summary to be reconciled prior to the prisoner's physical return to WCC.

123. The issue of some prescribed medications not being in stock at WCC remains somewhat of a problem, as it is not always the case that prisoners are sent back to WCC with a supply of the new medication. It presents the problem, which occurred in Mr Mickelo's case, whereby a prisoner gets discharged without a supply of new medication, arrival back at the prison occurs in the late afternoon and as such the new medication cannot be obtained until the following day.

124. De Le Ray confirmed in his evidence that OHS is now in the practice of requesting that the PAH and Caboolture Hospital supply a prisoner with five days' supply of discharge medications. He also gave evidence of a new initiative, in place since July 2015, whereby on-site pharmaceutical support is available to OHS.

125. I am satisfied that a more proactive approach is now undertaken by OHS with respect to discharge medications for prisoners. The faxing of the discharge summary and the request for a number of days' supply of discharge medications to be provided to a prisoner upon return to the prison are reasonable and appropriate steps.

Conclusions on the adequacy of the health care provided to, and the observations of, the deceased in his cell

126. With respect to the health care provided to Mr Mickelo over 22-24 November 2012, I am satisfied that the issues are contained to:

- the management of the report of chest heaviness by Mr Mickelo on 23 November 2012; and
- the delay in finding Mr Mickelo deceased and the sufficiency of the attempts to resuscitate.

Dr Lance Le Ray

127. Dr Le Ray provided to the inquest the procedures which were in place at the time, relating to the management of chest pain. These documents were entitled *'Chest Pain/Angina/Heart Attack Flowchart'* and '*Standing Treatment Order Chest Pain'.* In his evidence Dr Le Ray conceded that the guideline for nursing assessment in this regard was very subjective and relied heavily on the judgement of the nurse at the time.

128. Dr Le Ray was taken to the OHS records entry at 2200hrs on 23 November 2012, citing 'no cardiac issues'. His opinion was that this conclusion was incomprehensible in the context of Mr Mickelo's circumstances. He agreed in his evidence that, given the benefit of hindsight, the chest pain protocol should have been applied to Mr Mickelo and an effective review process should have triggered some further action. This evidence was in line with that given on this issue by Professor Walters.

129. Dr Le Ray gave evidence that there was a lack of awareness, or lack of compliance with the guideline that was in place. He agreed that future recurrences would be prevented by better orientation and training of staff. Dr Le Ray gave evidence of this having occurred since Mr Mickelo's death, by way of the relevant procedures now being incorporated into the orientation training for new staff. This training, named *'Basic Life Support'* training, is to be undertaken annually. Further, Dr Le Ray confirmed that a number of nursing staff have attended the Corrections Emergency Nurses Training Workshop, which is specifically designed around the medical issues in a correctional setting. This will progressively be offered to all nursing staff.

130. From the evidence I heard at the inquest, it seems that an overarching key issue at the time of Mr Mickelo's death was that, although management of the WCC medical centre was moved under the umbrella of the Caboolture Hospital in July 2012, it had not been effectively integrated into Caboolture Hospital's clinical governance processes.

131. Dr Le Ray gave evidence as to how this integration was now more effective. He confirmed that they are currently in the process of undertaking an accreditation process with the Australasian Council for Health Care Standards to identify gaps in clinical governance. All OHS policies have now been updated and are available to staff at WCC electronically, via the staff intranet.

Dr Stephen Rashford

132. During the course of the police investigation, the CCTV footage of Mr Mickelo's cell was obtained. From viewing that footage, the actions of Nurse Izzard in examining Mr Mickelo could be seen. Despite Mr Mickelo displaying no obvious

signs of life, it appeared clear from that footage that Nurse Izzard did not use a defibrillator, and did not check for vital signs of life.

133. Nurse Izzard was re-interviewed by police investigators on this issue. He told police that he did not check for a carotid pulse, but that Mr Mickelo's eyes were open and there was no pupil dilation or rise and fall of the chest. He checked for an arterial pulse, but not a carotid pulse. The defibrillator was available, but was not necessary. Nurse Izzard said that he was 100% satisfied that Mr Mickelo was deceased, and there was no necessity for the ambulance as the body was cold to touch.

134. Given the actions of Nurse Izzard, investigating police arranged for a medical review of the CCTV footage. This review was conducted by Dr Stephen Rashford who, at the relevant time, was the Medical Director of the Queensland Ambulance Service. That review was tendered at the inquest.

135. Dr Rashford viewed the footage and confirmed that for approximately nine minutes prior to the entrance of the guards and Nurse Izzard, Mr Mickelo did not make any obvious spontaneous movements. From this, Dr Rashford assumed that the cardiac arrest occurred before this point. Dr Rashford confirmed, from his viewing of the footage, that the assessment conducted by Nurse Izzard consisted of an initial tap of the body and then feeling for a pulse for a very short period of time.

136. Dr Rashford provided opinion that a thorough examination should have included examination of the cardiorespiratory system, looking for evidence of central and distal pulses and also attaching a defibrillator to ensure no cardiac rhythm compatible with defibrillation was present.

137. However, Dr Rashford accepted from viewing the footage that the cardiac event had at least occurred minutes prior to Mr Mickelo being found, such that it was highly unlikely that Mr Mickelo had a cardiac rhythm compatible with defibrillation. The limited examination conducted by Nurse Izzard made no difference to the ultimate outcome.

138. Nurse Izzard had been provided with a copy of Dr Rashford's opinion and has also reviewed the video footage. He acknowledges that his actions as depicted on the footage may not appear particularly comprehensive or concerned but believed that his actions and demeanour were not accurately depicted in this footage.

139. From the time he was contacted he observed Mr Mickelo constantly through the window and via the monitor and did everything he could to attempt to rouse him. This was for a period of approximately 9 minutes. He believes that COO Beswick had not seen any movement from Mr Mickelo, including any chest movement, for some time.

140. Due to Mr Mickelo's physical condition and the position in which he was located, he believes that any chest movement or other visual signs of life would have been visible to him had Mr Mickelo been breathing during this time.

141. RN Izzard believed there were clear indications that he could not be resuscitated. He believes he complied with the Offender Health Services Death in Custody Procedure.

142. He however has taken the opportunity to reflect upon his assessment and with the benefit of hindsight he acknowledges he would respond to similar circumstances differently in the future. This would include examination of the cardiorespiratory system and looking for any evidence for central and distal pulses even in the event he was of the view there was a clear indication that the person is deceased and cannot be resuscitated.

143. I accept Dr Rashford's opinion. Nurse Izzard's examination was cursory but I accept this was in the context where he had been observing Mr Mickelo for at least 9 minutes and was certain Mr Mickelo had been deceased for some time and CPR would have been futile.

Conclusions

144. None of the other inmates at WCC provided information to the investigating officer suggesting foul play or that there was any deficiency or inappropriateness in the treatment received by Mr Mickelo while in custody.

145. The examination of Mr Mickelo's body and his room at WCC revealed no signs of violence.

146. The CSIU investigation into Mr Mickelo's death did not lead to any suspicion that his death was anything but natural.

147. It is clear that there were two options available to the clinicians at the PAH, namely stent angiography or by-pass surgery. Both options were considered by the treating clinicians. I am satisfied, having heard the range of medical opinion, that the option of stent angiography adopted by the PAH was well within the appropriate options for a patient of Mr Mickelo's status. I am satisfied that the care provided to Mr Mickelo throughout his final admission at the PAH was adequate and appropriate.

148. I note that Dr Le Ray was also critical in his evidence of how Mr Mickelo's death was reviewed by WCC. He confirmed that the review took place too long after the death occurred, and did not include a review of the events immediately surrounding the death. Dr Le Ray gave evidence of a new process now in place to ensure death reviews are conducted quicker, and with regard to the entirety of the circumstances surrounding the death.

149. I heard evidence that clinical incidents are now reviewed at in-house quality and safety meetings, and tracked through the Caboolture Hospital's PRIME clinical incident management system. Dr Le Ray expanded on this in his evidence to confirm that, in the second half of 2015, these reviews will also include all Code Blue calls made by corrective services staff.

150. I am satisfied that, whilst there were inadequacies in the care provided to Mr Mickelo in terms of medication management and chest pain management, that these have been addressed.

151. I make no adverse comment about the actions of Nurse Maynard, as it is clear that the subsequent medical opinion has been provided with the benefit of hindsight. Nurse Maynard conducted a thorough assessment of Mr Mickelo in response to his report of chest heaviness, and this included having a conversation with him to try and gain a better understanding of the complaint. She continued to monitor him closely over the remainder of her shift.

152. Although Dr Walters and Dr Le Ray were critical of the term *no cardiac issues* in the notes, it is my view open to find that Nurse Maynard was not discounting the fact that Mr Mickelo had serious heart disease, but simply recording that, at that point of time, in her assessment, he was not experiencing symptoms of an acute cardiac issue. With the benefit of hindsight, the chest protocol could have been considered and a further medical review considered, although it is evident form Dr Le Ray's statement that Nurse Maynard may not have received training on its use. Dr Le Ray said the guideline for nursing assessment in this regard was very subjective and relied heavily on the judgement of the nurse at the time. Dr Le Ray noted a lack of awareness, or lack of compliance with the guideline that was in place and there has now been put in place better orientation and training over this and other issues. As well, heaviness in the chest can be non-specific as a symptom and there may be other reasons, for instance fluid overload, as suggested by Dr Garrahy.

153. The examination by Nurse Izzard was very brief although I accept there were no obvious signs of life present, and Mr Mickelo did not move from when the CCTV focused on him at 2214 hours. I am satisfied he died sometime earlier in the evening and by the time he was attended to at 2223 hours, resuscitation would not have been successful even if commenced immediately. This is because the coldness and stiffness in his body indicated rigor mortis was setting in and indicated Mr Mickelo had been dead for some time.

154. I conclude that Mr Mickelo died from natural causes. I find that none of the corrective service officers or inmates at WCC caused or contributed to his death. It is important to be clear that Mr Mickelo's prognosis, when viewed holistically, was very poor. This was his third heart attack and second round of stenting.

155. It is a well-recognised principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. The evidence tendered at the inquest established the adequacy of the medical care provided to Mr Mickelo when measured against this benchmark.

156. I am satisfied that Mr Mickelo was given appropriate medical care by staff at the PAH. The medical opinions on the issue of stents versus CABG, type of stents and medications did vary. As Dr Clarke stated reasonable minds on some of these issues will differ and 10 doctors may all give different opinions. The majority of the evidence supported the view that reasonable decisions not outside of an appropriate standard of medical practice were made.

157. The omission of a request for out-patient review in 6 weeks was a mistake on the part of the discharge writer and not optimal, but clearly was not contributory to the death. RN Adamson had requested review by Dr Prakash. Dr Garrahy stated he was satisfied the prison medical officer would have picked this up and clarified and Mr Mickelo would have been seen. I accept that was the likely outcome.

158. As well, the difficulties in discharge medication not being immediately available was also not optimal but these difficulties have been adequately dealt with by Dr Le Ray and his hospital. If there was any contribution to or impact on Mr Mickelo's death because of the medication difficulties this cannot be quantified.

159. I am satisfied that, where there were deficiencies in the care provided to Mr Mickelo whilst at WCC, that these have been dealt with adequately.

Findings required by s. 45

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. As a result of considering all of the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Garnett Allan Mickelo

How he died - Mr Mickelo died in the Safety Unit at Woodford Correctional Centre from natural causes following a lengthy admission to the Princess Alexandra Hospital relating to worsening coronary atherosclerosis.

Place of death – He died at Woodford Correctional Centre, Woodford in Queensland.

Date of death – He died on 24 November 2012.

Cause of death – Mr Mickelo's medical cause of death is:

1(a) myocardial infarction due to or as a consequence of
1(b) coronary atherosclerosis (medically treated)

Comments and recommendations

160. Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

161. I note the family's counsel suggested there be a review by Australian Commission on Safety and Quality in Health Care of the discharge summary utilised in Queensland hospitals and there be a comprehensive system of cross checking of the discharge summary amongst other suggestions. I am not of the view that the example of this one case where there was an error in not setting a requirement for a future follow up should mean the whole document and process needs to be changed. In any event the cross checking set out would require multiple medical practitioners reviewing discharge summaries for hundreds and perhaps thousands of patients discharged each day in hospitals throughout Queensland. This would be resource intensive and unworkable.

162. There were also submissions regarding improvements concerning the availability of medications on discharge. I accept the submission of counsel assisting that the systemic improvements made at WCC Offender Health Services and Caboolture Hospital since Mr Mickelo's death, including the faxing of the discharge summary and the request for a number of days' supply of discharge medications to be provided to a prisoner upon return to the prison are reasonable and appropriate steps and largely deal with the issues raised by the family.

163. There were also submissions made with respect to the QCS unplanned cell entry policy and access by prisoners with health issues to personal duress alarms. It is likely access to a duress alarm would not have assisted Mr Mickelo as a cardiac arrhythmia with the state of his heart would likely to have immediately incapacitated him. I note the statement of Mr Shaddock and accept there are

various difficulties that some of these devices pose in a prison environment and do not intend to make any further comment.

164. Certainly I had some concerns about the delay in accessing the cell in this instance. The delay did not change the outcome as Mr Mickelo had been deceased for some time and resuscitation was futile at that point. However, an early capability to respond may make a difference in other cases. On considering the evidence of Mr Shaddock and submissions from QCS I am of the view a change to the policy to access cells outside of normal hours is not appropriate or required.

165. There was a submission that WCC should be upgraded to include a medical convalescence unit for discharged prisoners from hospital requiring ongoing medical observation treatment and care. In my view, if a prisoner requires continued observations and treatment that should take place in hospital not in prison. I note the clear evidence from corrective services and medical staff that the threshold for requesting QAS attendance for admission to hospital is a low one and that should remain the case.

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
6 July 2016