IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013/1711

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of James William Steele

Delivered On:	1 December 2015
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	18, 19 and 20 November 2015
Findings of:	CORONER JACQUI HAWKINS
Representation:	Mr S. Cash appeared on behalf of Dr E. Lou Ms E. Gardner appeared on behalf of Correct Care Australasia Pty Ltd
Police Coronial Support Unit	Leading Senior Constable K. Taylor

I, JACQUI HAWKINS, Coroner having investigated the death of James William Steele

AND having held an inquest in relation to this death on 18, 19 and 20 November 2015
at Melbourne
find that the identity of the deceased was James William Steele
born on 15 February 1950
and the death occurred on 22 April 2013
at Her Majesty's Prison, Langi Kal Kal, Langi Kal Kal Road, Langi Kal Kal, Victoria, 3352
from:

1 (a) HYPOTENSIVE AND ATHEROSCLEROTIC HEART DISEASE
CONTRIBUTING FACTORS: OBESITY, DIABETES MELLITUS TYPE 2

in the following circumstances:

1. James William Steele was 63 years old when he died at Her Majesty's Prison, Langi Kal Kal (Langi Kal Kal prison) on 22 April 2013.

2. Mr Steele left school after form two, however later returned and completed Year 12 at Melbourne High School. Mr Steele completed three tertiary courses including a Bachelor of Social Work from Melbourne University which he completed in 1991.

3. After graduating from university Mr Steele worked in youth services, working for Brunswick Youth Welfare, St Vincent's Residential Care and Turana Youth Training Centre. He also worked as a Prison Officer at Beechworth Prison. In around 2001, Mr Steele moved to Corowa to care for his mother and started working as a truck driver.

4. Mr Steele never married and did not have any children.

5. On 15 April 2011, Mr Steele was sentenced to five years and three months imprisonment with a non-parole period of three years for an assortment of sexual offences. He would have been eligible for parole in April 2014.

6. Whilst in prison, Mr Steele had regular contact with family members, received regular visits and maintained regular telephone communication.

7. The prison records confirm that Mr Steele presented as friendly, compliant, polite and caused no issues with other prisoners or staff. Mr Steele routinely received good work reports.

8. On 13 March 2013, Mr Steele was transferred from the Hopkins Correctional Centre to Langi Kal Kal prison. Langi Kal Kal prison is four kilometres north of Trawalla. The prison

provides minimum-security accommodation for prisoners who require a level of protection. It has a working farm, with a focus on preparing offenders for reintegration to the community.

9. Mr Steele had a number of chronic medical health conditions including Type II diabetes mellitus, hypertension, high cholesterol and osteoarthritis in his right hip. According to his brother-in-law Richard Gorniakowski, Mr Steele had not smoked for approximately 10 years.

10. Whilst in custody, Mr Steele was managed in accordance with his chronic health care plan and was on medications for his diagnosed conditions.

Circumstances surrounding his death

11. At approximately 2.04pm on Sunday 21 April 2013, Mr Steele telephoned and spoke to Mr Gorniakowski and advised that he had missed a medical appointment on 16 April 2013 and had been rebooked for 23 April 2013. Mr Steele also complained of suffering from cramps in his legs.

12. On Monday 22 April 2013, Mr Steele was herding cattle along Langi Kal Kal Road with other prisoners, as part of the prisoner program, when Mr Steele collapsed without warning at approximately 9.25am, hitting his head as he fell. Prisoners ran to inform the prison officers who quickly attended the scene where Mr Steele had collapsed.

13. A 'code black' was called, which indicated a prisoner death or serious medical incident.

14. Cardiopulmonary resuscitation (CPR) was performed approximately three minutes after Mr Steele collapsed by prison officers and the prison nurse, Vanessa Smith. The cardiac defibrillator was used to perform two cycles of cardiac reversion however staff were unable to establish a return of spontaneous circulation.

15. Ambulance Victoria paramedics arrived at 9.54am on the commencement on the third cycle of cardiac reversion and continued CPR and intravenous resuscitation medication, with no return of spontaneous circulation. CPR continued until 10.28am where he was pronounced deceased.

CORONIAL INVESTIGATION

The purpose of a coronial investigation

16. The Coroners Court of Victoria is an inquisitorial jurisdiction.[1] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the

[1] Section 89(4) *Coroners Act 2008* (Vic).

identity of the deceased person, the cause of death and the circumstances in which death occurred.[2] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances to the death, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[3]

17. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

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

19. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety and the administration of justice.[5]

20. This finding draws on the totality of the material produced as part of the coronial investigation into Mr Steele's death, including the coronial brief, statements, reports and testimony of witnesses who gave evidence at the inquest and any exhibits tendered through them. In writing this finding I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance.

21. In writing this finding I have considered the *Charter of Human Rights and Responsibilities Act* 2006 (Vic), particularly in the context of how it relates to investigations into the conduct of public authorities, especially when people die while in the care of public authorities, for example, deaths in custody.[6]

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2 Section 67(1) *Coroners Act 2008* (Vic).
3 *Harmsworth v The State Coroner* [1989] VR 989, *Clancy v West* (unreported 17/08/1994, Supreme Court of Victoria, Harper J).
4 *Keown v Kahn* (1999) 1 VR 69.
5 Section 72(1) and (2) *Coroners Act 2008* (Vic).
6 Section 9 and 22 of the *Charter of Human Rights and Responsibilities Act* 2006 (Vic)

22. Victoria Police attended Langi Kal Kal prison and commenced a coronial investigation. The Coroner's Investigator, Detective Senior Constable Anthony Euvard prepared a coronial brief of evidence which included a medical examiner's report, statements, photographs and documentation including Mr Steele's prisoner file and medical records.

Forensic medical investigation

23. On 26 April 2015, Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy on the body of Mr Steele. Dr Lee made the following autopsy findings and diagnosis:

- Hypotensive and atherosclerotic heart disease
- Left ventricular hypertrophy
- Coronary atherosclerosis
- Myocardial ischemia and microscopic infarctions
- Obesity
- Diabetes mellitus, type II
- Diverticulitis of colon
- Benign prostatic hyperplasia
- Rib fractures, attempted resuscitation with chest compressions
- Facial abrasions, perimortem.[7]

24. Toxicological analysis did not detect any ethanol. A small amount of paracetamol was detected in post-mortem blood. Further, Dr Lee reported "vitreous humour glucose was not indicative of hyperglycaemia and electrolytes were essentially within normal limits."[8]

25. Dr Lee reported that death was the result of cardiac arrhythmia.

> In the setting of coronary artherosclerosis causing a narrowing of the arteries supplying blood to the heart and increased demand of blood by the muscle of the heart, an arrhythmia is likely. The demand for blood by the heart muscle exceeded the ability of the arteries to supply the blood as needed. Increasing thickness of the heart caused by hypertension would further increase the likelihood of an arrhythmia. Diabetes mellitus and obesity are risk factors for coronary atherosclerosis.[9]

26. Dr Lee provided an opinion that the medical cause of death was due to natural causes from 1a) 1 HYPOTENSIVE AND ATHEROSCLEROTIC HEART DISEASE and contributing factors were OBESITY, DIABETES MELLITUS TYPE 2.[10]

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7 Exhibit 1 – Medical Examiner's Report dated 30 August 2013, p63
8 Exhibit 1 - Medical Examiner's Report dated 30 August 2013, p63
9 Exhibit 1- Medical Examiner's Report dated 30 August 2013, p64
10 Exhibit 1- Medical Examiner's Report dated 30 August 2013, Coronial brief, p64

Investigation into the circumstances of Mr Steele's healthcare whilst at Langi Kal Kal prison

Transfer to Langi Kal Kal

27. On 13 March 2013, Mr Steele was transferred to Langi Kal Kal prison and was given an induction which included a medical review by a registered nurse at reception. Each prisoner is allocated a case worker who prepares a local management plan which includes work programs, education, health needs, visits and religious needs.[11] This is dependent on the skill set of the prisoner and what they want to achieve whilst incarcerated. The local management plan is reviewed and documented monthly between the case manager and prisoner. At Langi Kal Kal prison, prisoners are not allocated work duties that put their health at risk.[12] In relation to Mr Steele, no specific needs were identified. There were no alerts or warnings to suggest anything other than that he was progressing well through his sentence plan.[13]

28. According to Mr John Parsons, Operations Manager at Langi Kal Kal prison, all programs are developed to rehabilitate the prisoner and prepare them for reintegration back into society as per acceptable community standards. The programs are designed for prisoners to take responsibility and the onus is on themselves to manage their own affairs.[14]

29. Mr Steele was allocated to work on the farm. This included general farm hand duties, herding cattle, moving sheep, cutting wood and repairing fences.[15] Work commenced at approximately 8.15am and finished at 3.45pm each day, with a 45 minute lunch break. While working on the farm, prisoners would not always be supervised. An assessment would be made by the prisoner officer in charge as to the specific task allocated and whether they required supervision during this task.[16]

Prison medical and health care services

30. Correct Care Australasia Pty Ltd (CCA) are contracted by the Department of Justice to provide primary health services at Hopkins Correction Centre and Langi Kal Kal prison. CCA contracted the medical care at both prisons to the Ararat Medical Centre.

31. At the time of Mr Steele's death, CCA were contracted to operate the Langi Kal Kal prison medical centre between the hours of 7am and 3pm, Monday to Friday. A General Practitioner

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[11] Exhibit 6 – Statement of John Parsons undated, Coronial brief, p27
[12] Exhibit 6 – Statement of John Parsons undated, Coronial brief, p27
[13] Exhibit 6 – Statement of John Parsons undated, Coronial brief, p27
[14] Exhibit 6 – Statement of John Parsons undated, Coronial brief, p28
[15] Exhibit 6 – Statement of John Parsons undated, Coronial brief, p27
[16] Exhibit 6 – Statement of John Parsons undated, Coronial brief, p27

was on site for a total of five hours per week. A registered nurse was on duty each weekday from 7am to 3pm. The nurse's main role was to dispense prescribed medication to the individual prisoner and to respond to any urgent medical needs.

32. In 2013, prisoners could access the medical centre by submitting a medical request which was then reviewed and triaged on a daily basis by nursing staff who scheduled appointments.[17] On the day of the appointment, the prisoner was notified via the public address system (PA system) or informed by his prison officer.

Medical care and management of Mr Steele whilst in custody

33. Justice Health records indicate that Mr Steele was managed in accordance with his chronic health care plan which was completed on 22 March 2013, by Nurse Vanessa Smith. Mr Steele's relevant clinical history was noted to be Type II diabetes mellitus, hypertension and osteoarthritis.

34. Dr Derek Pope, Medical Officer reported Mr Steele had a past medical history of obesity, hypertension, non-insulin dependent diabetes and osteoarthritis in his right hip.[18] Dr Edgardo Lou, Medical Officer reported Mr Steele checked his blood sugar levels morning and afternoon and he was reviewed by a medical officer every two to three months. Blood tests were ordered every three months.[19] According to Dr Lou, Mr Steele was advised to lose weight, exercise regularly by walking 30 minutes a day and choose the best food options for his meals.[20]

35. The medications Mr Steele was prescribed for his hypertension included Lercanidipine 20mg, Ramipril 10mg, Natrilix SR 1.5mg and Asprin 100mg daily. For cholesterol control he was prescribed Trovas 20mg daily. His regular diabetes medication was Metformin 500mg.

36. Mr Steele last saw a diabetes educator on 17 September 2012, at the Hopkins Correctional Centre. Dr Lou reported there was no referral to a cardiologist, however he had a renal Doppler ultrasound done on 16 April 2012, to try to establish the cause for his hypertension.[21]

37. Mr Steele's last recorded medical appointment was on 12 February 2013, at the Hopkins Correctional Centre with Dr Lou who reviewed his blood tests and fasting glucose levels.

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[17] Exhibit 11 - Remainder of coronial brief, p52.1
[18] Exhibit 11 - Remainder of coronial brief, p31
[19] Exhibit 9 - Letter from Dr Edgardo Lou dated 4 August 2014, p30
[20] Exhibit 10 - Letter from Dr Edgardo Lou dated 10 October 2015, p30.1
[21] Exhibit 9 - Letter from Dr Edgardo Lou dated 4 August 2014, p30

38. At the time he was inducted at Langi Kal Kal prison, an appointment was made for him to attend the doctor for his next scheduled review on 16 April 2013.

Missed appointment on 16 April 2013

39. Mr Steele was scheduled for a review appointment with the general practitioner on 16 April 2013. At the time of Mr Steele's appointment a call was made over the PA system for him to attend, however Mr Steele did not hear the call as he was too far away. Mr Steele attended the medical centre later that day and an appointment was re-scheduled for 23 April 2013. Nurse Smith reported Mr Steele did not complain of any medical concerns at this time.[22]

22 April 2013

40. On 22 April 2013, between 7 and 8am, Mr Steele attended the medical centre and received his weekly prescribed medications. At no time during this visit did Mr Steele alert medical staff to any health complaints or concerns. According to Nurse Smith, Mr Steele's only interaction with nursing staff was for the purpose of receiving his daily medication, which was issued once per week.

Expert Opinion provided by Justice Health

41. As part of their investigation into Mr Steele's death, the Victorian Department of Justice and Regulation, Justice Health commissioned an independent medical review into Mr Steele's healthcare whilst in custody. Dr Robert Lefkovits, Consultant Physician was requested to provide an expert opinion as to whether Mr Steele received reasonable medical care and treatment necessary for the preservation of his health.

42. After reviewing the medical records, Dr Lefkovits acknowledged that Mr Steele had severe risk factors for underlying asymptomatic coronary artery disease, particularly his uncontrolled hypertension, type II diabetes mellitus and being a male in his 60s. Although Mr Steele was on appropriate treatment for both his diabetes and hypertension, according to Dr Lefkovits neither were well controlled. Nevertheless attempts were made to improve both parameters with ongoing surveillance and an increase in medication for his blood sugar levels.

43. Dr Lefkovits noted that on 15 January and 12 February 2013, when Mr Steele was reviewed by a doctor, no blood pressure readings or comments regarding his blood pressure control were documented.

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[22] Transcript of evidence, p83

44. Dr Lefkovits provided an opinion that the treatment of Mr Steele's blood pressure and diabetes "was not consistent with the care that would be expected to be available and delivered in the public sector."[23]

Supplementary Report

45. Dr Lefkovits provided a supplementary report to expand further on his comment above. Dr Lefkovits was critical of the medical treatment and management of Mr Steele whilst in prison, in relation to his uncontrolled hypertension and poorly controlled diabetes.[24]

46. Dr Lefkovits noted that the medical records revealed that Mr Steele had documented hypertension and blood pressure readings which were well above the acceptable range, for example Mr Steele's blood pressure regularly ranged between 180 to 200 systolic. He explained that clinicians aim to keep blood pressure at 140 systolic /90 diastolic. Further:

> these parameters are based on longstanding epidemiological studies which have shown that prognosis significantly worsens with regards to stroke, cardiovascular events, and all cause mortality in those hypertensives whose blood pressures are consistently above these recommended levels.[25]

47. Dr Lefkovits further noted that there seems to be no significant adjustment made to the medications despite frequent high blood pressure readings.

48. Dr Lefkovits stated:

> I felt that the documentation I received suggested that the medical attention in the months preceding the deceased's death, was therefore not up to the expected standard of treatment of patients with such high risk for cardiovascular complications including sudden death. If a more vigorous approach to control his risk factors would have been undertaken on a consistent basis, it is possible the outcome would have been different.[26]

49. Despite this, Dr Lefkovits acknowledged that Mr Steele did have significant risk factors for premature death.

CORONIAL INQUEST

50. Mr Steele was in the custody of Langi Kal Kal prison at the time of his death. Mr Steele's death originally required a mandatory inquest, however due to amendments made to the Coroners Act 2008 (Coroners Act),[27] an inquest is not required where there is a death in custody and the cause of death is due to natural causes. Due to the comments made by Dr

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[23] Exhibit 2 – Statement of Dr Robert Lefkovits dated 18 June 2013, p72
[24] Exhibit 3 – Supplementary statement of Dr Robert Lefkovits dated 25 September 2015, p72.4
[25] Exhibit 3 – Supplementary statement of Dr Robert Lefkovits dated 25 September 2015, p72.2
[26] Exhibit 3 – Supplementary statement of Dr Robert Lefkovits dated 25 September 2015, p72.4
[27] Section 52(3A) and (3B) of the *Coroners Act* 2008 (Vic)

Lefkovits, I determined to use my discretion[28] and conduct an inquest to assess whether Mr Steele's medical care and management was appropriate, particularly as it related to the treatment of his Type II diabetes and hypertension.

51. A directions hearing was held on 15 September 2015, which set the scope of the inquest and the inquest was held on Wednesday 18 to Friday 20 November 2015.

Witnesses

52. The following witnesses were called to give *viva voce* evidence at inquest:

- Dr Jacqueline Lee, Forensic Pathologist, VIFM
- Dr Robert Lefkovits, Consultant Physician
- Richard Gorniakowski, brother-in-law
- John Parsons, Operations Manager, Langi Kal Kal prison
- Ms Vanessa Smith, Registered Nurse, Langi Kal Kal prison
- Dr Edguardo Lou, Medical Officer of Hopkins Correctional Centre
- Associate Professor Morton Rawlin.

Issues investigated at inquest

53. The following issues were investigated at inquest:

- Treatment and management of Mr Steele's Type II diabetes;
- Treatment and management of Mr Steele's hypertension; and
- Lack of documentation.

Treatment and management of Mr Steele's Type II diabetes

54. The evidence of Dr Lou is that he and a number of other general practitioners treated Mr Steele while he was in custody at the Hopkins Correctional Centre. Dr Lou stated that Mr Steele was receiving Metformin as part of his treatment and management of his Type II diabetes. Mr Steele was also required to take his blood sugar readings twice daily in the morning and afternoon, and have three monthly blood tests.

55. As part of the management of Mr Steele's diabetes, Dr Lou reported that Mr Steele was advised about the importance of losing weight, walking daily and choosing healthy food

[28] Pursuant to section 52(1) of the *Coroners Act* 2008 (Vic)

options for his meals.[29] To assist with this, Mr Steele saw a diabetes educator in September 2012, whilst he was at Hopkins Correctional Centre.

56. After reviewing the medical records, Dr Lefkovits stated that Mr Steele's diabetes was almost certainly linked to his obesity. He noted Mr Steele's "sugars were unacceptably high on all readings and HbA1c was 8.1 which is equivalent of fair to poor control."[30]

57. Dr Lefkovits felt Mr Steele's Metformin medication was an appropriate first line drug for Type II diabetes, however he believed that Dr Lou could have been more aggressive in controlling Mr Steele's diabetes and treatment of his high blood sugar levels.[31] Dr Lefkovits explained that more aggressive did not mean treating him with insulin but trying a combination of medications. Dr Lefkovits clarified that instead of aggressive, he probably meant that a more proactive approach would have been more appropriate.[32]

58. The evidence was that Dr Lou had adjusted Mr Steele's diabetes medications over the time he treated him. In evidence, Dr Lefkovits agreed that the increase in Mr Steele's Metformin dosage was a significant adjustment.[33] Dr Lefkovits also agreed that when you are changing diabetic medication, the patient ought to be closely monitored in case there are any adverse consequences.[34] However, he conceded there were difficulties associated with doing this in a prison setting, due to the fact that a prisoner was not allowed to access to a Glucometer unless it was at certain specified times throughout the day when the prisoner had to go to the medical centre and check their blood sugars.

59. Associate Professor Rawlin's evidence was that the medication was acceptable and the change in dose to Metformin and the follow up was very appropriate.[35]

Consideration of a referral to an endocrinologist

60. Dr Lou's evidence is that he did not want to adjust Mr Steele's diabetes medications without input from a specialist and he would want the specialist to adjust the medication regime.[36] Dr Lou testified that he discussed a referral to an endocrinologist with Mr Steele, but he was resistant to this. Dr Lou did not document this conversation in the medical records.[37]

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29 Exhibit 9 - Letter from Dr Edgardo Lou dated 4 August 2014, p30
30 Exhibit 3 – Supplementary statement of Dr Robert Lefkovits dated 25 September 2015, p72.4
31 Exhibit 3 – Supplementary statement of Dr Robert Lefkovits dated 25 September 2015, p72.4
32 Transcript of evidence, p36
33 Transcript of evidence, p40
34 Transcript of evidence, p43
35 Transcript of evidence, p145
36 Transcript of evidence, p125
37 See paragraphs 72-73

61. Associate Professor Rawlin and Dr Lefkovits both agree that they felt that they could have managed Mr Steele's diabetes without referral to an endocrinologist[38] but it does depend on the individual GP's experience and comfort levels.[39]

Best approach to diabetes management is self-management

62. Dr Lou's evidence was that he educates patients each time he sees them, in terms of compliance with medication, good diet and a healthy lifestyle.

63. Dr Lefkovits agreed the best way to control diabetes is through lifestyle and diet and agreed that it was difficult in a prison setting to maintain a healthy lifestyle. The evidence of Mr Parsons was that there were opportunities for prisoners to maintain a healthy lifestyle whilst in prison. He stated there are recreational activities offered after work, as well as an ability to choose a low calorie meal plan, however this was very much reliant on the individual's commitment to their own health.

64. Mr Gorniakovski gave evidence that when he spoke to Mr Steele, he was excited because he could now walk up a hill that he could not previously. Further, Mr Steele told Mr Gorniakovski that he was losing weight and feeling good.

65. It appears Mr Steele was able to manage his diabetes, it did not seem to cause him any issues despite regular high blood sugar readings. The evidence was that Mr Steele was interested in improving his health, he had committed to losing weight and was capable of managing a healthy lifestyle. The evidence also demonstrates that Mr Steele regularly attended the medical centre to check is blood sugar levels and he also attended weekly to collect his weekly medication. There was no evidence before me to suggest that Mr Steele was non-compliant with his medication.

Treatment and management of Mr Steele's hypertension.

66. The evidence is that Mr Steele's hypertension presented as asymptomatic. Dr Lefkovits testified that hypertension produces no symptoms in an otherwise perfectly healthy person.[40] Dr Lou confirmed that Mr Steele never had any specific concerns about his blood pressure.[41]

67. Dr Lefkovits commented that the main purpose of controlling hypertension is to try and minimise the risk of the development of coronary artery disease due to high forces brought on

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[38] Transcript of evidence, p150
[39] Transcript of evidence, p162
[40] Transcript of evidence, p29
[41] Transcript of evidence, p111

by high levels of blood pressure, and also to prevent left ventricular hypertrophy which increases the risk of ischaemia and arrhythmia. Dr Lefkovits stated that Mr Steele's uncontrolled hypertension was a significant contributor to his premature sudden death.[42]

68. Mr Steele was on three sets of medications for his hypertension including Lercanidipine 20mg, Ramipril 10mg and Natrilix SR 1.5mg daily. Dr Lefkovits stated that the anti-hypertensive medication regime was perfectly acceptable.[43] However, he stated "if the blood pressure management would have been more aggressive, I do believe that the risk of sudden death would have been less." Dr Lefkovits explained that more aggressive treatment meant increasing Mr Steele's medications in a pyramidal way. By way of explanation, he said he would have started one drug and got it to a tolerable dose, then added another drug and taken that to a tolerable dose and would have added up to four medications before considering an alternative method, for example a referral to a tertiary institute where they deal with refractory hypertension.[44]

69. The evidence reveals that Dr Lou did adjust Mr Steele's anti-hypertensive medication and Dr Lefkovits acknowledged that this was a significant adjustment and clarified in evidence that he meant to say there was no *effective* adjustment to his anti-hypertensive medication.[45]

70. In relation to the management of hypertension, Dr Lefkovits testified that a more proactive approach by Dr Lou would have been appropriate, in that he would have increased his anti-hypertensive medication, however he acknowledged that it may or may not have had any effect on the outcome.[46]

Should Mr Steele been referred to a cardiologist?

71. Dr Lou considers that Mr Steele was on three separate medications for his hypertension however he was not comfortable adding another agent or changing his medication because he believes it would have been better for him to see a specialist.[47] Dr Lou said he did make a recommendation for Mr Steele to see a cardiologist but Mr Steele declined because he did not want to be sent to St Vincent's Hospital in Melbourne.[48]

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42 Exhibit 3 – Supplementary statement of Dr Robert Lefkovits dated 25 September 2015, p72.3
43 Exhibit 3 – Supplementary statement of Dr Robert Lefkovits dated 25 September 2015, p72.3
44 Transcript of evidence, p29-30
45 Transcript of evidence, p39
46 Transcript of evidence, p32
47 Transcript of evidence, p106
48 Transcript of evidence, p105

72. Dr Lou explained there are difficulties associated with referring a prisoner to a specialist in Melbourne because it requires them to leave Langi Kal Kal prison and go to Port Phillip Prison which is a maximum security prison for an uncertain amount of time until they can be transported back to Langi Kal Kal prison. Dr Lou commented that the "majority of the patients would decline to go to St Vincent's because they don't want to go to Port Philip Prison."[49]

73. Dr Lou testified that because Mr Steele was being transferred from Hopkins Correctional Centre to Langi Kal Kal prison Mr Steele declined to be sent to St Vincent's Hospital.[50] Dr Lou did not make a note of this conversation in Mr Steele's medical notes because Mr Steele asked him not to the reason was that Mr Steele thought it would have a negative impact on his status as a prisoner.[51]

74. Associate Professor Rawlin commented that even if Mr Steele had been referred to a cardiologist it still may not have revealed any problem.

Lack of documentation

75. Dr Lefkovits said the only area he was really concerned about with Dr Lou was the lack of documentation of the blood pressure on a couple of occasions.[52] Dr Lefkovits noted that no blood pressure was recorded in the February 2013 consultation with Mr Steele, stating it is unclear if it was ever taken.[53]

76. Dr Lou provided an additional statement to the Coroners Court on 15 October 2015 and reported that blood pressure measurements were taken at the appointments on 15 January 2013 and 12 February 2013. Dr Lou conceded that at both these appointments he did not record the blood pressure measurements in his medical notes.[54]

77. Associate Professor Rawlin considered that when you have a patient with high blood pressure you should take their blood pressure each time you see them and document this.[55] In relation to whether Dr Lou should have recorded his suggestion for a referral to a cardiologist,

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49 Transcript of evidence, p102
50 Transcript of evidence, p105
51 Transcript of evidence, p107
52 Transcript of evidence, p34
53 Exhibit 3 – Supplementary statement of Dr Robert Lefkovits dated 25 September 2015, p72.3
54 Transcript of evidence, p106
55 Transcript of evidence, p161

Associate Professor Rawlin considered that despite Mr Steele's request, Dr Lou should have recorded the discussions around referral.[56]

Submissions of interested parties

78. At the conclusion of the inquest, I invited interested parties to provide me with oral submissions.

Dr Lou

79. Counsel for Dr Lou made the following final submissions in relation to Dr Lou:

- Dr Lou was not able to take a more aggressive approach to manage Mr Steele's hypertension and diabetes given constraints posed by various factors peculiar to a custodial setting.
- The anti-hypertensive medication regime was appropriate, that is – it was perfectly acceptable and a usually successful regime. Dr Lefkovits conceded that Dr Lou did make a significant adjustment to his medications.
- That Dr Lou's evidence that he suggested referral to a specialist and his reasons were truthful and should be accepted. Dr Lou conceded that he should have recorded that this discussion took place in the medical notes.
- Mr Steele was asymptomatic and was not outwardly troubled by his high blood pressure or diabetes.
- Associate Professor Rawlin considered that Dr Lou's management of Mr Steele was consistent with what one would expect of a reasonably competent GP, particularly given the constraints of the custodial setting.
- Dr Lou was attempting to manage Mr Steele as best he could.

Correct Care Australasia

80. Counsel for CCA made the following final submissions:

- The nuances associated with the delivery of healthcare in the correctional setting are relevant matters for me to consider.

[56] Transcript of evidence, p161

- Mr Steele's healthcare records reveal that he was reviewed regularly, by many GPs during his period of imprisonment both at Hopkins Correctional Centre and Langi Kal Kal prison.
- There was good continuity of medical care in that Mr Steele saw Dr Lou and Dr Pope and that there is evidence that they regularly reviewed pathology and conducted blood pressure checks.
- It is also clear from the medical records that Mr Steele was seen by allied health professionals, including an optometrist, podiatrist and a diabetes educator. Further he attended the medical centre daily to check his blood sugar levels and would collect his medications on a weekly basis and he was subject to a chronic health care plan.
- There is no evidence of any act or omission on any part of any organisation or individual involved in the care of Mr Steele that caused or failed to prevent his death. Accordingly, no adverse finding should be made in this matter.
- CCA have implemented some important and systemic improvements since Mr Steele's death including:
  - Changed the notification and reminder system in relation to prisoner medical appointments.
  - Introduced mandatory recording of baseline observations on the clinical documentation completed upon the reception of a prisoner.
  - Computerisation of the nurses clinical records which prompt entry of baseline observation.
  - Increased the hours of operation of the medical centre at Langi Kal Kal prison.

Family considerations

81. Counsel Assisting read a closing statement on behalf of the family to the Court at the conclusion of the inquest which stated:

> it was our hope that things would change in the prison system so that prisoners could get medical attention when needed, also to be monitored more closely for serious ailments. We know that this will be hard in the prison system, but we have noted in the brief that Langi Kal Kal has changed the method of calling prisoners. Hopefully, this will make sure where they are on the farm, they know to go to the doctor for ongoing conditions such as hypertension and diabetes.[57]

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[57] Transcript of evidence, p178

FINDINGS

82. I find that James William Steele died on 22 April 2013 from 1a) 1 HYPOTENSIVE AND ATHEROSCLEROTIC HEART DISEASE and contributing factors were OBESITY, DIABETES MELLITUS TYPE 2.

83. I acknowledge that Mr Steele had a number of risk factors associated with artherosclerotic heart disease, including hypotension, obesity, Type II diabetes mellitus and being a male over 60 years of age. The evidence is clear that Mr Steele's artherosclerosis presented as asymptomatic.

84. I find the clinical treatment and management provided to Mr Steele for his diabetes and hypertension by Dr Edgardo Lou whilst in custody was acceptable. I note that Dr Lou acknowledged that he should have recorded and documented Mr Steele's blood pressure in the medical notes on each occasion he saw him and also recorded details of when he discussed referrals to other specialists, including that Mr Steele did not wish to pursue this line of medical investigation. I find that even if Mr Steele accepted Dr Lou's suggested referral to an endocrinologist or cardiologist, there is evidence that this may not have changed the outcome.

85. I acknowledge whilst Dr Lou is an experienced clinician, his vast experience was in the Philippines and that his experience of the Australian health care setting was only two years at the time of Mr Steele's death.

86. I find that Correct Care Australasia have proactively implemented some systemic changes at Langi Kal Kal prison since Mr Steele's death in relation to the notification of prisoners' medical appointments and also increased the hours that medical officers and nurses are in attendance and available.

87. I acknowledge that providing health care in a prison setting does have some constraints, as outlined in this finding, however prisoners should be entitled to the same standard and level of care as that available in the community.

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

- Mrs Dorothy and Mr Richard Gorniakowski, Senior Next of Kin
- Justice Health
- Correct Care Australasia Pty Ltd
- Office of Correctional Services Review
- SC Tony Euvrard, Coroner's Investigator

Signature:

JACQUI HAWKINS
CORONER
Date: 1 December 2015