FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

*Section 67 of the **Coroners Act 2008***

Court reference: 1758/09

Inquest into the Death of NOEL ROBERT ROGERSON

Delivered On:	17th August, 2011
Delivered At:	Melbourne
Hearing Dates:	8th November 2010 and 7th February 2011
Findings of:	CORONER HEATHER SPOONER
Representation:	
Place of death:	St Vincent's Hospital
PCSU:	
Counsel Assisting the Coroner:	

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 1758/09

In the Coroners Court of Victoria at Melbourne

I, HEATHER SPOONER, Coroner

having investigated the death of:

Details of deceased:

Surname: ROGERSON
First name: NOEL
Address: Port Phillip Prison, Laverton, Victoria 3028

AND having held an inquest in relation to this death on 8th November 2010 and 7th February 2011 at Melbourne

find that the identity of the deceased was NOEL ROBERT ROGERSON and death occurred on 28th March, 2009

at St Vincent's Hospital, Victoria Parade, Fitzroy, Victoria 3065

from
1a. CHRONIC LIVER DISEASE (ALCOHOL, HEPATITIS C)

In the following circumstances:

1. Mr Rogerson was aged 50 when he died. He was serving a sentence of imprisonment. He had previously resided with his partner in Shepparton. Mr Rogerson had a past medical history that included chronic liver disease, schizophrenia, alcohol abuse and sporadic drug use. He had a lengthy forensic history commencing when he was aged just twelve.

2. It was apparent that Mr Rogerson had died from natural causes being chronic liver disease whilst *'in custody'* so an inquest was required and mandated pursuant to s.52(2)(b) **Coroners Act 2008**:

> *"Subject to subsection (3), a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and-*
> *(b) the deceased was, immediately before death, a person placed in custody or care;"*

Inquest of 8 November 2010

3. The Office of Correctional Services Review (OCSR) and Justice Health, provided a movement/accommodation timeline that included the following:

> On 20 August 2008, Mr Rogerson was remanded in custody in Melbourne Assessment Prison (MAP);
> On 21 August 2008, he was transferred to St Augustine's Secure Ward, St Vincent's Hospital;
> On 26 August 2008, he returned to MAP;
> On 27 August 2007, a file note reveals 'Noel has been told that he may have only six months to live, is very distraught, psych contacted, koori officer contacted is being counselled. Psychiatrist does not recommend observations. Noel guarantees own safety ';
> On 21 October 2008, Mr Rogerson was sentenced to a period of imprisonment. On appeal the sentence was reduced to 18 months, with a non parole period of 10 months; He was due to be paroled on 16 June 2009;
> On 31 October 2008, he was transferred to Loddon Prison;
> On 2 December 2008, he was transferred from Loddon Prison to Bendigo Base Hospital Accident and Emergency ward;
> On 8 January 2009, seen by Doctor at Bendigo Hospital;
> On 2 March 2009 and 17 March 2009, he went to St Vincent's Hospital for treatment;
> On 26 March 2009, he was transferred from MAP to St Vincent's Hospital;
> On 28 March 2009, he passed away.

4. A police investigation was conducted into the circumstances surrounding the death and the inquest initially proceeded on 8 November 2010, by way of summary. Reports from OCSR and Justice Health were tendered. The OCSR report concluded:

> "The review found that Mr Rogerson's custodial management during his final period of imprisonment was appropriate and that the incident of his death was also managed appropriately.
>
> No opportunities for improvement were identified in relation to Mr Rogerson's death, and accordingly no recommendations have been made."

5. The Justice Health Report however highlighted some shortcomings regarding his medical condition:

Medical

Mr Rogerson's cause of death is documented as being hepatocellular carcinoma and cirrhosis secondary to chronic (decompensated) liver disease on a background of hepatitis C and excessive alcohol consumption.

Medical (M) Alerts

Having considered the Commissioner's Requirement 4/2006 for a medical alert, (any medical condition that requires immediate treatment or diagnosis, including known or suspected conditions that have not been confirmed), and the obligations in regard to establishing and recording medical risk information; the review found that the rating of M2 on the Prisoner Information Management System (PIMS) did not truly reflect the severity of the patients health status. This would have been more accurately reflected by a M1 rating, which identifies a serious medical condition.

The risk rating and alert system is intended to alert Corrections Victoria officers and/or prison health staff, to an issue. It is unlikely that the lower risk rating of M2 would have had any significant impact on the prisoner's medical management or prognosis.

Findings

Mr Rogerson was diagnosed with chronic liver disease in 1993. Over time, his liver became decompensated; a diagnosis of hepatocellular carcinoma was made in December 2008. Chronic Health Care Plans are a required service delivery outcome for the contracted prison health services and this man met the criteria for a Chronic Health Care Plan for a number of reasons.

Given the chronicity of Mr Rogerson's condition, Justice Health would have expected that a Chronic Health Care Plan be implemented earlier than 2008. Whilst a chronic health care plan may have led to a more structured monitoring regime, it is unlikely that this would have prevented his death.

Recommendations

Justice Health to ensure and monitor the implementation of Chronic Health Care Plans, where indicated, by all Justice Health's contracted health care providers.

6. When the hearing concluded it was decided to further investigate and adjourn for evidence from OCSR and Justice Health, regarding the apparent failure within the OCSR report to reflect the concerns of Justice Health. Further statements were also obtained from Bendigo Hospital and St Vincent's Hospital outlining Mr Roberson's' treatment and medical management.

Adjourned Inquest of 7 February 2010

7. When the Inquest was reconvened Ms Gardner and Ms Croser gave evidence and a number of issues with OCSR and Justice Health were highlighted:

Justice Health

Oversighting issues regarding ensuring that appropriate medical alert ratings are provided to prisoners and regular assessments are undertaken to ensure that ratings are updated if appropriate;

The implementation of a palliative care plan similar to a Chronic Health Care Plan for prisoners with palliative care issues; and

The sharing of information between health professionals, such as staff at St Vincent's Hospital, and Justice Health in particular by establishing agreed protocols.

OCSR

The terms of reference for OCSR reports should refer to the inclusion of specific findings and recommendations made in Justice Health reports;

OCSR reports should highlight for coroners any deficiencies in medical management as identified in Justice Health reports (whether or not these are the subject of specific findings and recommendations in Justice Health reports); and

The sharing of medical information between health professionals and OCSR.

Response to Issues

8. Both OCSR and Justice Health[1] have comprehensively responded to those concerns:

Justice Health

Justice Health ensures that prisoners receive regular medical reviews by contracted health service providers in order that medical alert ratings can be reviewed periodically. There are several mechanisms by which such reviews occur, including:

- Review by health care staff at reception into the prison system;
- Medical review in response to prisoner request or requirements;
- An acute health event that triggers a review;
- Review by health care staff on inter-prison transfer; and
- Regular review and revision of Chronic Health Care Plans for prisoners with chronic health conditions by the contracted health service provider and Justice Health.

In addition, JH ensures that medical record audits, which include an assessment of medical alert ratings and whether these have been appropriately assigned at key points, are routinely conducted by contracted health service providers. JH undertakes opportunistic review of medical records as well as planned targeted audits of patient medical records (it being a term of the contract with service providers that a sample of medical records be routinely audited on a regular basis). Findings from this audit are, required to be submitted to JH on a quarterly basis.

Review of medical alert ratings by contracted health service providers is further prompted by the JH notifiable health incident/event template used by the providers following a notifiable incident. A notifiable health incident refers to any event or circumstance, which has actually or could potentially, lead to an adverse health outcome or consequence for a person in custody. JH routinely audits notifiable health incidents as reported by contracted health service providers 10 ensure that the medical management of the prisoner, including his/her medical alert rating, has been appropriately handled.

A copy of the Notifiable Incident/Event Report template and JH/St Vincent's Notifiable Incident Guidelines is attached at Attachment C. The template and guidelines are currently being amended in consultation with the contracted health service providers to include review of risk ratings, including medical status and outcome. JH expects that the amended template and guidelines will be completed in draft form within the next two weeks. A copy will be forwarded to Her Honour as soon as it becomes available.

[1] Submissions of the Office of Correctional Services Review and Justice Health, p2-6.

Palliative care plans

Currently contracted health service providers notify JH if a prisoner is diagnosed with a terminal illness, and/or if an end of life treatment plan is developed to ensure that all appropriate care, including palliative care, is provided.

In the case of Mr Rogerson, documentation on the file confirms that although an end of life treatment plan was not prepared for him, all components of appropriate end of life care were undertaken, comprising:

- Privacy in single rooms;
- Pain management;
- Support visitation from family members; and
- Pastoral care.

Further, the St Augustine's ward of St Vincent's Hospital maintains a high standard of end of life care despite it not being a designated palliative care unit.

However JH, in consultation with St Vincent's Hospital and its other contracted health service providers, will now work towards developing a palliative care plan to be used with palliative care prisoners. The plan will be modelled on the best-practice palliative care pathways used at Caritas Christi Hospice (the St Vincent's Hospital palliative care facility), with expert input from palliative care clinical staff, and reference to relevant Australian Council on Healthcare Standards and Royal Australian College of General Practitioners standards.

It is envisaged that a template palliative care plan will be finalised and available for implementation by contracted health service providers by 4 April 2011. JH will oversight the implementation and review of palliative care plans on a case by case basis.

Sharing of medical information between health professionals/establishment of protocols

JH notes that her Honour was particularly concerned as to why the JH medical file pertaining to Mr Rogerson did not contain a copy of a letter from St Vincent's Hospital to "To whom it may concern" dated 5 March 2009 regarding a request that Mr Rogerson's sentence be reviewed in light of him having only months to live. JH can now confirm that the letter was in the original medical file held by JH pertaining to Mr Rogerson, however due to a photocopying error the letter was not included in the copy medical file provided to Ms Gardner for her review prior to the inquest.

With regard to petitions for plea for mercy. JH confirms that the process is for a petition to be made to the Governor of Victoria. The petition is then forwarded to the Attorney-General for consideration, with the Department of Justice Criminal Law Policy Unit providing advice on the issue, including contacting JH for confirmation of the applicant's health status.

In the case of Mr Rogerson, JH was not informed of any application by him for a plea for mercy. Enquiries made since the inquest have failed to identify any formal documentation regarding a plea for mercy by Mr Rogerson to the Governor of Victoria.

JH is currently conducting a review of the process to be followed when a contracted health service provider is contacted directly by a prisoner to provide documentation for the purpose of a plea for mercy. This review is expected to be finalised by 7 April 2011 and a formal protocol will then be provided to the contracted health service providers

Further, there are a range of mechanisms through which general health information is shared between JH and the contracted health service providers. These include:

- Monthly health service provider meetings with JH;
- The introduction of a 24 hour 'on call' phone for JH;
- Site visits by JH officers to prison locations;
- JH attendance at case management meetings for prisoners with complex
- health care needs; and
- The introduction of a daily patient bed list for inpatient's including St
- John's, Port Phillip Prison and St Augustine's, St Vincent's Hospital.

Office of Correctional Services Review

Amendment of terms of reference in OCSR reports

OCSR has amended the terms of reference to be included in all future reports into deaths in custody to clearly reflect that the OCSR inquiry itself does not address the medical management and care of the prisoner, however any key findings and recommendations arising from the JH review are identified together with the OCSR recommendations in the body of the OCSR report.

A copy of the amended terms of reference, including the paragraph regarding the review of health files and inquiry regarding the prisoner's medical management, to be included in all future OCSR reports is attached at Attachment C.

OCSR reports should highlight for coroners any deficiencies in medical management as identified in JH reports (whether or not these are the subject of specific findings and recommendations in JH reports)

OCSR will ensure that all future OCSR reports clearly identify in the body of the report any deficiencies in the medical management of a prisoner as identified in the JH report, whether or not the deficiency has been identified as a key finding or been the subject of a recommendation in the JH report

The sharing of medical information between health professionals and OCSR

OCSR is not required to interface with contracted health services providers as it is an investigatory and review body, which provides advice to the Secretary of DOJ on specific matters concerning the operation of the corrections system. OCSR does not play any role in the medical management of prisoners, only having an investigatory and review role after an incident such as a death in custody.

Post Mortem Examination

9. The Coroner granted an application objecting to autopsy and an inspection and external examination was performed by Dr Noel Woodford, Forensic Pathologist with the Victorian Institute of Forensic Medicine. In his report he made the following comments:

"A section 29 objection to autopsy has been raised by the next of kin in this case.

In a letter of objection from the deceased's son, he requested that medical records be referred to and noted the diagnosis of cancer of the liver. No other reasons were provided.

The deceased was a 50 year old male with a past history of alcoholic cirrhosis, hepatocellular carcinoma (diagnosed in August, 2008) hepatitis C, intravenous drug use, depression, schizophrenia and asthma. He was a prisoner. He was admitted to St Vincent's Hospital for drainage of tense ascites. This had been drained approximately 3 weeks previously but had rapidly re-accumulated. A diagnosis of decompensated liver disease was made and he was treated palliatively. He died on the 28th March, 2009.

According to a medical deposition, an opinion as to the cause of death was 'chronic liver disease - decompensated (cirrhosis and hepatocellular carcinoma)'. There were no issues to be addressed at autopsy on the deposition.

I have been provided with a photocopy of a medical certificate of cause of death. On this certificate, the cause of death is given as follows 1a) hepatocellular carcinoma, 1b) cirrhosis of the liver.

Examination of a post-mortem CT scan shows ascites, bilateral lung opacities and cirrhosis.

In addition to the above external examination, I have reviewed the police summary of circumstances, a medical deposition, death certificate and hospital notes and a post-mortem CT scan. On the basis of this information and, given the family's request that no autopsy be performed, I am of the opinion that a reasonable cause of death in the circumstances might be formulated as follows:- 1a) chronic liver disease (alcohol, hepatitis C)."

HMIT Review

10. The death of Mr Rogerson was also reviewed by the Health and Medical Investigation Team (HMIT)[2]. In particular they were requested to examine the last month of Mr Rogerson's life and the care and treatment he received for his inoperable liver cancer. The medical records and the statements that were obtained were reviewed.

11. It was apparent that on 2 March 2009, Mr Rogerson was transferred to St Vincent's with abdominal pain. It was thought he had a urinary tract infection and he was admitted under Gastroenterology for three days. He was transferred back to prison on 5 March. The poor prognosis ('months to live') was explained at that stage, with no further treatment available for the liver cancer. On 17 March, Mr Rogerson was seen at St Vincent's Hospital with difficulty passing urine. It was felt that was prostatism and Mr Rogerson was returned to prison with a plan to trial voiding in three weeks and an outpatient review. On 26 March, Mr Rogerson was admitted to St Vincent's Hospital and on this occasion he received terminal care prior to his death on 28 March 2009.

12. The HMIT review concluded that during these attendances and admissions Mr Rogerson was managed appropriately and in accordance with the way anyone with these presentations would have been managed.

2 The role of the Health and Medical Investigation Team (HMIT) is to assist the Coroner's investigation into the nature and extent of deaths, which occurred during the provision of healthcare and identify potential system factors in healthcare related deaths. HMIT personnel comprise of practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experiences, skills and knowledge, to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.

Finding

I find that both OCSR and Justice Health have responded sensibly to the concerns raised during the course of this inquest.

The circumstances surrounding Mr Rogerson's death did highlight some shortcomings particularly around his medical management however I find it unlikely they impacted upon his unfortunate demise from chronic liver disease.

Recommendations

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations connected with the death:

1. Both the OCSR and Justice Health should ensure the smooth implementation of the proposals contained in their submissions in accordance with best practice principles and including:

Justice Health proposals to:

- amend the Notifiable Incident/Event Report template and guidelines including review of medical alert rating, risk rating, medical status and outcome;
- develop a template palliative care plan to be used with palliative care prisoners; and
- review the process to be followed for the purpose of a plea for mercy, so that a formal protocol is provided to contracted health service providers.

2. The Office of Correctional Services Review proposal to amend the terms of reference and content of their reports and identify any deficiencies to better inform.

Signature:

Heather Spooner
Coroner

17th August, 2011

Distribution List

I also direct that this finding be distributed to the following for their information:

Office of Correctional Services Review
Liana Buchanan
Director
Level 38, 80 Collins Street
Melbourne, VIC, 3000

Justice Health
Michele Gardner
Director
Justice Health
Level 38, 80 Collins Street
Melbourne, VIC, 3000