CORONERS ACT, 2003

*SOUTH* *AUSTRALIA*

# FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 21st day of September 2010 and the 19th day of September 2011, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Vincent Norman Rigney.*

*The said Court finds that Vincent Norman Rigney aged 35 years, late of Port August Prison, Stirling North, South Australia died at the Port Augusta Hospital, Hospital Road, Port Augusta, South Australia on the 25th day of April 2009 as a result of ischaemic heart disease due to coronary atherosclerosis. The said Court finds that the circumstances of hsi death were as follows:*

## 1. Introduction and reason for Inquest

1.1. Vincent Norman Rigney was an aboriginal man aged 35 years at the time of his death on 25 April 2009. He was a prisoner at the Port Augusta Prison at the time of his death, serving a sentence of 3 years and 6 months following a conviction for robbery in 2007. Accordingly, his was a death in custody within the meaning of section 21(1)(a) of the Coroners Act 2003 and this Inquest was held as required by that section.

## 2. Cause of death

2.1. An autopsy was carried out by Dr John Gilbert, forensic pathologist, who provided a report[1] giving the cause of death as ischaemic heart disease due to coronary atherosclerosis and I so find.

[1] Exhibit C3a

## 3. Background and circumstances of Mr Rigney's death

3.1. Mr Rigney shared a cell with another prisoner and at approximately 6:20am on Saturday 25 April 2009 he contacted Department for Corrections (DCS) staff using the intercom in his cell and stated that he felt unwell. Three officers attended his cell and spoke with him. They provided slightly varied accounts of the nature of his symptoms as described at that time, ranging from a general stomach ache to pains in his chest and tingling in his left arm. He was given two tablets of Panadol and a Mylanta tablet and told to contact staff if he did not experience any relief.

3.2. At 6:50am his cellmate called for assistance and Mr Rigney was then taken to the prison medical centre for observation and was to await the arrival of medical staff who were due to commence work at 7am. At about 7:17am Mr Rigney collapsed on the floor. Two prison officers responded immediately by calling for assistance and initiating emergency procedures. The staff conducted cardiopulmonary resuscitation until the arrival of South Australian Ambulance Services at 7:28am. The ambulance officers continued resuscitation including the use of defibrillation without success. They transported Mr Rigney to the Port Augusta Hospital and, despite resuscitative efforts which were continuous, he was pronounced deceased at 8:40am.

3.3. At the time, and still today, there was no 24 hour medical service at Port Augusta Prison.

3.4. According to Dr Peter Frost, Clinical Director of the South Australian Prison Health Service, all South Australian prisons under the management of DCS have defibrillators within the prisons[2]. All nursing staff working within prison infirmaries are trained to use the defibrillators and, in particular, the nursing staff at Port Augusta Prison are so trained.

3.5. Correctional Officer Roehr gave evidence that he did not hold a senior first aid certificate at the time of Mr Rigney's death, although he has received first aid training since. He said that it is his view that Port Augusta Prison should have 24 hour medical staff on duty[3]. Correctional Officer Hayward gave evidence that he did hold a senior first aid certificate at the relevant time but he was also of the opinion that Port Augusta Prison should have a 24 hour on-site medical service and that it was his opinion that correctional officers are not properly qualified to make judgments

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[2] Exhibit C16b
[3] Exhibit C5a

regarding the health of prisoners[4]. Finally, the General Manager of Port Augusta Prison at the relevant time was Mr Derek Taylor. He expressed the opinion that all prisons should have nursing staff on duty at all times and pointed out that Port Augusta Prison was the second largest prison in the State, second only to Yatala at the relevant time[5].

3.6. Dr Frost gave evidence that on several occasions while in prison Mr Rigney was checked for high blood pressure, high cholesterol and diabetes and showed no signs of concern. He had a marginally high blood pressure on admission in 1998. According to Dr Frost the only apparent risk factors for heart disease in Mr Rigney were that he was of aboriginal descent and with a history of smoking. Dr Frost said that, given this background, it may have been prudent to repeat the tests annually. Dr Frost said that the Prison Health Service staff were not aware of any previous family history of heart disease in Mr Rigney's case but he acknowledged that after the event he had learnt that Mr Rigney did have such a family history[6].

3.7. It is particularly significant that Dr Frost acknowledged in a statement made on 30 June 2009 that:

> 'Earlier medical intervention, for example defibrillation, may have prevented his death.' [7]

3.8. Mr Charles, who appeared for Ms Kropinyeri, the partner of Mr Rigney, obtained a report from cardiologist, Dr Heddle[8]. In that report Dr Heddle affirmed that it is widely recognised in the Australian medical profession that aboriginal Australians have a disproportionately high morbidity and mortality from cardiac disease and that coronary disease in Australian aboriginals presents at a younger age than in non-aboriginal people. Dr Heddle, in his own practice, assumes that an Aboriginal person over the age of 25 years (male or female) has coronary artery disease until he has established that they do not.

3.9. Dr Heddle stated in his report that the treatment provided to Mr Rigney upon his collapse by the prison officers was appropriate.

3.10. Dr Heddle noted that, what he described as a 'monitor defibrillator', was available at the time in the infirmary of Port Augusta Prison. He pointed out that a study in

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[4] Exhibit C7a
[5] Exhibit C15a
[6] Exhibit C16a
[7] Exhibit C16a, page 5
[8] Exhibit C33

Chicago has shown that in the O'Hare Airport the presence of an automatic external defibrillator resulted in the best out of hospital survival (close to 50%) of victims of sudden cardiac arrest document in the western world and this was because the automatic external defibrillators could be used by anyone who recognised that a patient had a cardiac arrest. Dr Heddle commented that if such a defibrillator (an automatic external defibrillator) had been present and utilised immediately by the prison officers, there was a reasonable possibility that Mr Rigney would have been successfully resuscitated and taken to hospital. It will be recalled that Dr Frost had acknowledged in his statement that defibrillation may well have saved Mr Rigney's life.

3.11. It seems to me that if appropriately trained nursing staff are not available on a 24 hour per day basis then Port Augusta Prison, and any other prison which does not have such a facility, should be equipped with automatic external defibrillators which could be deployed by correctional officers with minimal or no training. This opinion is supported by guideline 10.1.3 of the Australian Resuscitation Council relating to public access defibrillation[9].

3.12. Dr Heddle referred to screening of high risk prisoners as follows:

> 'I cannot understand why prisoners who by age, sex, smoking and especially aboriginal background are not given regular medical examinations including resting ECG, exercise ECG, tests for diabetes mellitus, blood pressure check and fasting serum lipid assessment. By such regular assessment the cardiac disease of a prisoner would probably be detected and treated before he/she suffers a fatal heart attack.' [10]

That is clearly a highly desirable approach. According to Dr Frost there have been improvements made in recent times relating to the screening of health risk factors for prisoners including cardiac risk factors. This screening process now applies to all prison inmates. In addition to this there have been developments in health promotion programs that are available within prisons. However, Dr Frost acknowledged that he was aware that in the case of the death of Mr Rigney 'better screening should have taken place'[11] and that he was:

> '… aware that the Prison Health Service hadn't asked about or check(ed) his family history for this type of health risk.' [12]

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[9] See Exhibit C30
[10] Exhibit C33
[11] Exhibit C16b, page 4
[12] Exhibit C16b, page 4

## 4. Conclusions

4.1. I conclude that the treatment of Mr Rigney by prison officers and ambulance staff was appropriate in the circumstances.

## 5. Recommendations

5.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

5.2. I recommend that the Department for Correctional Services institute a 24 hour nursing service at Port Augusta Prison and investigate the institution of such a service at all other prisons within the State.

5.3. I recommend that the Department for Correctional Services provide public access defibrillators or automated external defibrillators to any prison in the State that does not have 24 hour nursing facilities.

5.4. I recommend that the Department for Correctional Services and the South Australian Prison Health Service investigate the provision of enhanced cardiac screening for prisoners as suggested by Dr Heddle.

*Key Words: Death in Custody; Prison Medical Service*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 19th day of September, 2011.*

*State Coroner*

Inquest Number 26/2010 (0695/2009)