CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mr William Haines
File number:	2021/00118189
Inquest dates:	31 January 2023-2 February 2023
Place of inquest:	NSW Coroners Court sitting at Tamworth Local Court
Findings of:	**Deputy State Coroner Carmel Forbes**
Date of findings:	1 March 2023
Catchwords:	CORONIAL LAW-natural causes death in custody-cause of death-pulmonary thromboembolus-care and treatment by Hunter New England Local Health District and Justice Health
Representation:	Mr M Dalla-Pozza instructed by Ms T Bird, Crown Solicitor's Office Ms H Webb of the Aboriginal Legal Service instructed by Samuel Emery of the Aboriginal Legal Service representing Mr Haines' father Mr Roy Haines Ms G Mahony instructed by Ms A Heritage of the Department of Communities and Justice Legal representing Commissioner of Corrective Services New South Wales

	Mr J Harris instructed by Ms K Hinchcliffe, Makinson d'Apice Lawyers representing Justice Health & Forensic Mental Health Network & Hunter New England Local Health District
Findings:	***Identity*** The person who died was William Haines. ***Date of death*** Mr Haines died on 27 April 2021. ***Place of death*** Mr Haines died at Cessnock Correctional Centre, NSW. ***Cause of death*** Mr Haines died as a result of pulmonary thromboembolus due to a left leg deep vein thrombosis. ***Manner of death*** Mr Haines died of natural causes while he was in lawful custody.
Non-publication orders:	Orders for non-publication of certain evidence have been made in this inquest. The orders may be found on the Registry file.

INTRODUCTION

1. This is an inquest into the sad death of Mr William Haines.

2. Mr Haines was an Aboriginal man of the Bundjalung and Gomeroi nations. He died on 27 April 2021 of a pulmonary thromboembolus at Cessnock Correctional Centre. He was only 37 years old at the time of his death.

3. This inquest has been an open and public examination of the adequacy and appropriateness of the level of health care Mr Haines received whilst in custody.

4. As set out in section 81(1) of the *Coroners Act 2009* (NSW) (the Act), the role of a Coroner is to record findings as to the identity of the deceased, the date and place of the death, and the manner and cause of death. In addition, the coroner may make recommendations that are considered necessary or desirable in relation to any matter connected with the death.

5. Pursuant to section 37 of the Act, a summary of the details of this case will be reported to Parliament.

Mr William Haines

6. Mr Haines was born on 9 March 1984 in Newtown. His father is Mr Roy Haines, who has been very closely involved in this coronial investigation and inquest along with other family members and friends. His mother was Ms Leanne Roberts. She passed away when she was 34 years of age. She had been part of the stolen generation. Mr Haines was the middle of two brothers; Robert Haines and Roy Haines Jnr. Roy Haines Jnr died aged only four years of age and tragically, Robert Haines died just two weeks after Mr William Haines' funeral.

7. As a young man, Mr Haines went to school in Moree, where he was recognised by the principal as a talented and gifted student. The principal told family and friends that Mr Haines could well be the first Aboriginal astronaut.

8. When he was about 12 years of age, Mr Haines moved to Marrickville and lived with his grandmother. He soon developed a heroin dependency and became homeless. That was the start

of a cycle of incarceration, drug abuse, homelessness and unemployment that trapped Mr Haines for the entirety of his shortened life. According to his father, "there wasn't any violence involved with Bill. He was always a quiet boy. […] he just stole to get money for drugs".[1]

Mr Haines' medical history

9. Mr Haines' Justice Heath & Forensic Mental Health Network (Justice Health) records reveal that he received treatment for a variety of medical conditions while he was in custody; including asthma, for which he had a Ventolin inhaler and for dental issues.

10. He also had the following relevant admissions to hospital:

    a. On Boxing Day 2015, Mr Haines presented to the Emergency Department at Royal Prince Alfred Hospital with right-arm swelling and generalised lethargy and sweats. An ultrasound showed evidence of thrombosis and thrombophlebitis in the deep veins 3–5cm distal to the right cubital fossa. He was provided with analgesia and received doses of Flucloxacillin and Clexane before he was discharged.[2]

    b. On 15 July 2017, Mr Haines presented to the Emergency Department of Auburn Hospital where he underwent CT scanning with spiral angiography of an abscess on the back of his knee. Mr Haines was treated with Clexane.[3]

    c. In June 2019, Mr Haines was admitted to Prince of Wales Hospital. Justice Health records indicate that he was treated with Clexane and apixaban for deep vein thrombosis (DVT) for a period of three months while he was in custody.[4]

Mr Haines' last period of incarceration

11. On 6 April 2020, Mr Haines was arrested by Surry Hills Detectives. He was taken into custody and a Reception Screening Assessment listed, amongst other things, asthma, opioid dependence, atherosclerotic disease, acute bacterial endocarditis as his 'existing active health conditions'.[5]

[1] Exhibit 1 Vol 1 Tab 36 p 18

[2] Exhibit 1 Vol 3 Tab 63 pp 3-5

[3] Exhibit 1 Vol 3 Tab 63 p 23

[4] Exhibit 1 Vol 3 Tab 63 p 177

[5] Exhibit 1 Vol 3 Tab 63 p 248

12. On 11 May 2020, Mr Haines was transferred to Shortland Correctional Centre and, on 3 July 2020, was moved from Shortland Correctional Centre to Cessnock Correctional Centre. At the time of his death, Mr Haines remained at Cessnock Correctional Centre.

13. On 19 November 2020, Mr Haines was committed for trial at the Downing Centre District Court which was due to commence on 23 June 2021.

Mr Haines' admission to hospital 9 March - 20 March 2021

14. On 9 March 2021 it was Mr Haines' 37th birthday. Sadly, on that day he was so unwell he was taken by ambulance from Cessnock Correctional Centre to Cessnock Hospital.

15. The "Clinical Summary Transfer to External Hospital" recorded **"**acute bacterial endocarditis", "asthma", "opioid dependence" and "other atherosclerotic disease" as existing active health conditions.[6] A "Daily Update- Patient Transfer To An External Hospital" recorded that the clinical reasons for the transfer to hospital were:

> *"[P]atient seen at methadone window c/o nausea and lethargy for 3/7*
> *has been requesting to be locked in around lunch each day*
> *sleeping approx. 8 hours each night, nil spontaneous waking*
> *feeling lethargic all day, exacerbated when mobilising*
> *states SOB when attempting activities*
> *states has been experiencing hot and cold sweats*
> *states has been eating as usual, appetite robust*
> *hx endocarditis, "years ago" unable to give further info*
> *denies chest pain, denies numbness or tingling in arm or jaw"*[7]

That document also recorded the clinical reason for transfer to hospital as being for "endocarditis".

16. At Cessnock Hospital, Mr Haines' blood tests were normal, however an ECG showed abnormal changes and possible "endocarditis"/"pericarditis".[8]

[6] Exhibit 1 Vol 3 Tab 63 p 281

[7] Exhibit 1 Vol 3 Tab 63 pp 293, 295

[8] Exhibit 1 Vol 2 Tab 61 p 12

17. Mr Haines was transferred to Maitland Hospital on that same day for further monitoring. The Emergency Department Senior Resident Medical Officer formed the impression, based on the troponin rise in the context of lethargy and shortness of breath, that Mr Haines was suffering infective endocarditis with a differential diagnosis of non-ST segment elevation myocardial infarction (also known as "NSTEMI"). No embolic or septic complications were found, and there was no evidence of heart failure. He was treated with antibiotics, Clexane at 1mg/kg and clopidogrel (at 75mg/day) and aspirin (100mg/day). His methadone (80mg/day) was also continued.[9]

18. On 9 March 2021, a blood culture was taken from Mr Haines. On 10 March 2021, the on-call microbiologist provided urgent notification that a gram-positive coccus had grown from that blood culture. Mr Haines experienced a systolic murmur which radiated to his axilla and carotid arteries. An emergency ECG and blood-borne-disease screening were ordered. Mr Haines was given a single dose of Clexane for possible myocardial ischemia and to treat NSTEMI.[10]

19. On 11 March 2021, Mr Haines was transferred to John Hunter Hospital for ongoing management by cardiologist Dr Nicholas Jackson.

20. At John Hunter Hospital endocarditis was ruled out and Mr Haines' discharge plan suggested ceasing antibiotics and continuing to monitor him. The final primary diagnosis was of "atypical chest pain".[11]

21. During his admission to John Hunter Hospital, Mr Haines had been handcuffed to his bed.[12]

22. After his return to Cessnock Correctional Centre, on 20 March 2021, Mr Haines' condition was reviewed by a Justice Health Registered Nurse on 21 March 2021 and Dr Mary-Frances Foley on 24 March 2021. Dr Foley noted initial tachycardia from Mr Haines "not drinking enough water" and noted that he was "feeling well" and there was "no endocarditis" [13]. Mr Haines was then also seen by Dr John Kehoe on 25 March 2021 in relation to his opioid addiction and an ECG was done to check his heart in relation to his drug and alcohol treatment.

[9] Exhibit 1 Vol 2 Tab 61

[10] Exhibit 1 Vol 2 Tab 61 p 13

[11] Exhibit 1 Vol 2 Tab 60 pp 2-6

[12] For example, Exhibit 1 Vol 2 Tab 60, p 14

[13] Exhibit 1 Vol 3 p 383

The circumstances of Mr Haines' death on 27 April 2021

23. At approximately 8:21am on 27 April 2021 a head count was completed at the jail and Mr Haines waved his hand at the Corrections Officer.

24. At 8:38am milk and cereal were delivered to the front of his cell by an inmate, holding the designated role of sweeper.

25. At 9:11am the inmates were let out from their cells, at which time Mr Haines collected his breakfast.

26. At 9:16am, a fellow inmate entered the cell to give Mr Haines a newspaper and saw that he was still in bed with a blanket over him. Mr Haines said he would read the newspaper later.

27. At approximately 10:10am, a fellow inmate found Mr Haines unresponsive on the floor of his cell. He alerted another inmate, who was undertaking sweeper duties, who called for assistance.

28. The attending officers observed that Mr Haines' jaw was clenched, and he was making a fist with his right hand. They rolled him onto his back and checked for signs of life. One officer could not feel a radial pulse, another officer felt a faint carotid pulse. They then rolled Mr Haines onto his side to unclench his jaw and clear his airway, before rolling him onto his back again. Mr Haines did not appear to be breathing. CPR was commenced.

29. At around 10:14am, two nurses took over CPR and continued performing compressions for approximately 30 minutes. Several defibrillator analyses were conducted during this period.

30. The first ambulance arrived at 10:47am, with two further ambulances attending within the next 11 minutes. Paramedics took over CPR but, despite their efforts, Mr Haines was pronounced life extinct at 11:16am.

Results of the post-mortem investigations

31. At autopsy the cause of Mr Haines' death was determined as pulmonary thromboembolus with a left leg deep vein thrombosis being the antecedent cause.[14] The forensic pathologist also recorded obesity and coronary atheroslerosis as being other significant conditions contributing to the death but not relating to the disease or condition causing it. The forensic pathologist also noted that there was a saddle thrombosis within the pulmonary trunk and pulmonary arteries.

[14] Exhibit 1 Vol 1 Tab 6

Independent Medical Expert Evidence

32. Associate Professor Grabs, Vascular and General Surgeon, provided an independent review and independent expert opinion of the medical care and treatment Mr Haines received prior to his death.[15] He has worked in the capacity as a Vascular Consultant for the last 21 years at St Vincent's Hospital in the Department of Surgery and as a Staff Specialist undertaking procedures at St Vincent's Public and St Vincent's Private Hospital. He regularly treats patients who have preventable blood clots, DVT and Pulmonary Embolism (PE).

33. Associate Professor Grabs explained that Mr Haines' symptoms on 9 March 2021 were serious. He was a young man with lethargy and malaise and shortness of breath on exertion. He said that this history would suggest either a cardiac cause for his symptoms or a pulmonary cause. He emphasised that these symptoms needed to be fully investigated.

34. Associate Professor Grabs agreed that the initial diagnosis of bacterial endocarditis made at Cessnock Hospital was reasonable. Mr Haines had a previous history of suffering from that condition and some of the symptoms which Mr Haines had reported were consistent with this diagnosis.

35. Associate Professor Grabs also said that he would not have expected the clinicians at Cessnock Hospital to have immediately investigated Mr Haines as suffering from PE and says that this would only have become important after the indications of coccus on the blood test conducted on 9 March 2021 had been identified as a false positive.

36. Associate Professor Grabs is of the view that Mr Haines did have a PE. He is further of the opinion that the initial focus on endocarditis "pigeonholed" Mr Haines into a particular diagnostic pathway. In his report, Associate Professor Grabs expressed the following opinion:

> *"If the past history of major left DVT with bacteraemia had been identified, the possibility of pulmonary emboli may have been entertained".*

37. Associate Professor Grabs informed this court that, in any event, all inpatients in NSW hospitals require a DVT assessment which is formally called a VTE risk assessment. This identifies patients at moderate to high risk of DVT and defines appropriate prophylactic interventions to prevent

[15] Exhibit 1 Vol 8 tab 84

DVT and PE. He noted that none of the hospitals that Mr Haines attended undertook a VTE assessment and no pharmacological or mechanical prophylaxis was used as a result.

38. While Mr Haines was admitted to the hospitals he was handcuffed to his bed. Associate Professor Grabs explained that this would have reduced Mr Haines' ability to mobilise and increases a risk for the development of DVT and PE's.

39. Associate Professor Grabs is of the opinion that when Mr Haines presented to the nurse at Cessnock Correctional Centre feeling unwell he was appropriately transferred to Cessnock Hospital; however, the transfer documentation did not include the previous history of a DVT. He said that this was significant as the doctors at the hospital never investigated DVT as a cause of the symptoms. While Associate Professor Grabs is of the opinion that these investigations should have occurred in any event, he is also of the view that had the doctors been aware of this history that they would have gone on to make these further investigations.

40. Associate Professor Grabs is of the opinion that the treatment Mr Haines received at Cessnock Hospital was appropriate in circumstances where the history of his left leg DVT had not been provided to the hospital. The differential diagnosis at Cessnock Hospital was either an acute coronary syndrome, infective endocarditis, or pericarditis.

41. Associate Professor Grabs is also of the opinion that in the transfer to Maitland Hospital, Mr Haines was treated and managed appropriately for possible endocarditis and myocardial ischaemia.

42. Associate Professor Grabs states that, at John Hunter Hospital, appropriate investigations for endocarditis were undertaken. He said that Mr Haines received excellent treatment for possible endocarditis.

43. Associate Professor Grabs is of the opinion that once the infective endocarditis had been excluded there should have been further assessment of the symptoms. He states that at this point ischaemic chest pain was not formally excluded and nor were DVT or PE. He considers it possible that the history of endocarditis possibly blinkered other possible diagnoses. In particular, Associate Professor Grabs considers that the fact that no history of DVT had been provided by Cessnock Correctional Centre contributed to this not being considered as a possible diagnosis.

44. Associate Professor Grabs stated that if PE had been identified, therapeutic anticoagulation would have been administered and may have prevented Mr Haines' death.

ISSUES

45. An issues list was prepared prior to the inquest to provide structure to the hearing. I have considered all the submissions made by the parties and I am of the view that the following matters are the relevant issues that require comment.

Did Mr Haines have a PE in hospital?

46. Dr Choi, Director of Medical Services, John Hunter Hospital, reviewed all of Mr Haines' medical records. He is of the opinion that Mr Haines was not suffering from a PE during his admissions to hospital. He says the reason he is of this opinion is because:

    a. a saddle embolism, is usually attended by massive clinical and subclinical features which were not evident during Mr Haines' admission to hospital; and

    b. the development of a saddle embolism is usually sudden, and 6 weeks elapsed between Mr Haines' discharge from hospital and the date of his death.

47. Associate Professor Grabs disagreed and pointed out that the autopsy report indicated there was the presence of other pulmonary emboli in the presence of the lungs. Dr Choi opined that these were likely the results of detachments from the saddle embolism. The forensic pathologist stated that the emboli in the vessels around the lungs were estimated, to be likely one week to numerous weeks in age. Even so, Dr Choi stated that this time differential was sufficiently broad as not to cause him to alter his opinion in this respect.

48. I note that the forensic pathologist was of the opinion that at autopsy it was not possible to determine whether the 'DVT and PTE' were present during the deceased's admission to hospital.

49. Associate Professor Grabs however had the benefit of Mr Haines' medical records as well as the autopsy report. He is of the opinion that the evidence from the autopsy together with Mr Haines' clinical symptoms warranted a diagnosis of PE (although he acknowledged that there was no evidence of saddle embolus during the period that Mr Haines was hospitalised). He says that Mr Haines displayed "classic" features of PE.

50. Associate Professor Grabs stated that when Mr Haines presented to hospital, he had symptoms and circumstances consistent with a diagnosis of PE or that represented a risk factor for its development. These included, most relevantly:

    a. his reported shortness of breath;

b. his tachycardia or elevated pulse rate. Mr Haines had a pulse of 134 at the time of his admission and clinical records at the John Hunter Hospital indicate that, during his admission at that hospital, he had experienced an episode of elevated pulse rate of up to 140 beats per minute whilst showering;

c. His weight (the autopsy report indicating that Mr Haines weighed 109 kilograms and was 173 centimetres, which represented a BMI of 36.4); and

d. Potentially, his history of endocarditis.

51. Dr Choi stated that there were other potential explanations for each of these conditions. He specifically noted:

a. That, whilst the 140 beats per minute heart rate was "significant" and "worthy of consideration", it would not result in a PE diagnosis because the episode of tachycardia was self-resolving;

b. There were other explanations for the shortness of breath, most notably, Mr Haines' history of suffering from asthma and potentially also pulmonary regurgitation; and

c. That, on its own, obesity would not trigger investigation into a PE.

52. Dr Choi remained of the view that even when these factors were considered cumulatively, it would not have triggered investigations into PE. He says that he would not personally have entertained PE, even as a differential diagnosis.

53. Associate Professor Grabs did not share Dr Choi's opinions. He noted that the symptoms Mr Haines was experiencing were "classic" features of PE. He noted, particularly, that asthma could be entirely excluded because the shortness of breath was not accompanied by any wheezing. He did not regard the self-resolving of the episode of tachycardia at John Hunter Hospital as being significant, noting that Mr Haines had earlier reported similar symptoms before his admission into hospital.

54. That there was no evidence of tenderness in the calves during Mr Haines' period of hospitalisation does not, in Associate Professor Grabs' view, indicate an absence of DVT; since Associate Professor Grabs notes that over 50% of DVTs are asymptomatic.

55. Associate Professor Grabs is an experienced specialist vascular surgeon. Dr Choi's experience is in the field of general medicine. Only infective endocarditis was ruled out as a cause of the

symptoms Mr Haines was suffering when he was taken to hospital. PE was never investigated. I accept Associate Professor Grabs' opinion that Mr Haines had the classic signs of PE. I accept that on the balance of probabilities Mr Haines had PE while he was in hospital, and this was the cause of his symptoms.

56. I note that Associate Professor Grabs explained that there is a clear causal link between PE and saddle embolism. I accept his opinion that had the PE been detected, Mr Haines could have been treated with appropriate anticoagulants and his death may have been prevented.

Why was the history of Mr Haines' previous DVT not provided to Cessnock Hospital by Justice Health?

57. Mr Haines had a history of left leg DVT. The most recent episode occurred in June 2019 while he was in custody. At Prince of Wales Hospital, an ultrasound revealed occlusive above and below knee DVT extending superiorly to the proximal left femoral vein. Mr Haines was treated with Clexane and then apixaban for that condition for a period of 3 months while he was in custody.

58. The history of this left leg DVT was not provided in the transfer papers provided by Justice Health to Cessnock Hospital.

59. Associate Professor Grabs said that if this previous major DVT in the left leg had been included in the referral, this would have likely increased the differential diagnosis to include PE's and triggered an investigation into this diagnosis.

60. In his first statement, Dr Choi stated that if the history of left leg DVT had been provided it would have caused the possibility of PE to be considered, although he resiled somewhat from that position in his oral evidence. In his oral evidence, he stated that that history would not have triggered a diagnosis of PE absent other signs. He said, however, that provision of that history should and would have triggered more assertive DVT risk assessment as an absolute minimum.

61. Dr Gary Nicholls, Clinical Director of Primary Care, Justice Health,[16] states that the Clinical Summary Transfer To An External Hospital, dated 9 March 2021, set out a history of:

    a. Acute bacterial endocarditis;
    b. Asthma;
    c. Opioid dependence;
    d. Other atherosclerotic disease;

[16] Exhibit 1 Vol 8 Tab 88A & 88B

e. A 3-day history of nausea and lethargy; and

f. Shortness of breath when Mr Haines was attempting activities.

Dr Nicholls also notes that the transfer indicated that Mr Haines was experiencing hot and cold sweats.

62. Dr Nicholls acknowledges that a specific history of left leg DVT was not provided to Cessnock Hospital on 9 March 2021. Dr Nicholls asserts, however, that the history that was provided, particularly the history of endocarditis, cardiac disease, and the symptoms of shortness of breath, would have provided a sufficient basis for Cessnock Hospital to conduct a VTE risk assessment.

63. Dr Nicholls accepted that Mr Haines' DVT history was however relevant to a risk of him developing PE or DVT in the future.

64. Dr Nicholls identified several barriers to Justice Health providing this information to Cessnock Hospital. He particularly noted that at the time,

    a. the records of Justice Health were partially paper based;

    b. the records were kept in different places; and

    c. the clinicians involved in preparing the referral were focussed on getting an acutely unwell patient to a place of safety.

65. Dr Nicholls has explained to the court that improvements have been put in place that will reduce the likelihood of information of a similar nature to the history of Mr Haines' left leg DVT not being included in the transfer to an external hospital. He noted that a history of this nature would now be included as an alert and would "auto-populate", or automatically appear in, relevant clinical documentation, including any hospital transfer.

66. Dr Nicholls explained that the relevant policy as of June 2019, provided that an alert would be entered only "if required". The present version of the policy, is in more mandatory terms, using the word "must".

67. Clearly, the failure to include Mr Haines' DVT history was significant, and I accept Associate Professors Grab's opinion that if the treating team knew about the previous DVT that it would have heightened concern regarding PE.

Venous Thromboembolism (VTE) risk assessment

68. The relevant VTE risk assessment policy compliance procedure for Hunter New England Local Health District (HNELHD) in March 2021[17] was closely based on the NSW Health Policy Directive which provides that all adult patients admitted to a NSW public hospital or health service should undergo a VTE risk assessment within 24 hours of admission and if appropriate be prescribed prophylaxis.

69. Dr Choi acknowledged that a VTE was not and should have been performed on Mr Haines within 24 hours of his admission to hospital and that Mr Haines should have been reassessed every seven days while he was an inpatient or in response to any clinical change.

70. Dr Choi explained that since Mr Haines' death, compliance by clinical staff in relation to VTE has been a priority area for improvement. He said that the following have been put in place to improve compliance:

    - A multidisciplinary HNELHD VTE expert advisory group has been convened under the leadership of a haematologist, to increase awareness and improve clinical practice in the area of VTE risk assessment;
    - Training and education in VTE risk assessment and prophylaxis is specifically provided to new medical staff at orientation;
    - Ongoing VTE training and education is provided to medical staff through the doctors' professional hub;
    - HNELHD has initiated a VTE prevention champion programme; and
    - There is regular auditing of VTE risk assessment and review and discussion with clinical staff to provide data for improvement.

71. Dr Choi informs this court that in October 2022 compliance with VTE risk assessment policy was audited as 75%. He says that the changes that they have introduced, are greatly improving compliance. In previous years, compliance was at 40%.

72. Furthermore, Dr Choi informed the court that there are changes being made to the electronic prescribing software system used by the Local Health District called 'MedChart'. He said that the VTE forcing function on this system requires a risk assessment to be performed before any medication can be prescribed to a patient. He said that this system has been rolled out at

[17] Exhibit 1 Vol 8 Tab 87B p 5

Cessnock and Maitland Hospitals and will be going live at John Hunter Hospital in March or April 2023.

73. Dr Choi said that if a VTE risk assessment had been conducted on Mr Haines that 40mg of Enoxaparin daily should have been continued until Mr Haines' discharge on 20 March 2021. Associate Professor Grabs agrees and is of the opinion that this dosage could have prevented the development of PE.

The significance of Mr Haines being handcuffed to the hospital bed

74. Mr Haines was handcuffed to his hospital bed during his admission. Whilst the evidence is clear that a lack of mobility increases the risk of DVT, both Associate Professor Grabs and Dr Choi agreed that there are considerable difficulties relating to security and safety for the prisoner and hospital staff, for a proposal to have locked wards.

75. I agree, and on the available evidence it would be premature to make any recommendations in this regard. However, I am pleased to note that there is an established secure Annex gazetted as a Correctional Centre located on the site of the Prince of Wales Hospital in Sydney. This is for inmates requiring hospital care and treatment rather than them being handcuffed to a hospital bed in a ward in the general public hospital.

Whether the ultimate diagnosis at John Hunter Hospital of atypical chest pain was satisfactory?

76. The final diagnosis from John Hunter Hospital was of atypical chest pain.

77. Associate Professor Grabs regarded this as an incorrect diagnosis; primarily because it was unclear or in his words, was a "throw away" diagnosis. He said that such a diagnosis "tells nothing" to explain the symptoms for which Mr Haines was admitted.

78. Unsurprisingly, this diagnosis led to Mr Haines receiving a different level of care at Justice Health to what he would have received had PE been diagnosed.

79. Associate Professor Grabs noted that a person suffering from atypical chest pain would be managed by further observations whilst a person suffering from PE would be treated by appropriate prophylaxis.

80. Similarly, Dr Nicholls, on behalf of Justice Health, said that the discharge plan for a patient suffering from atypical chest pain would not involve any further investigations unless specifically recommended by the discharging hospital. In Mr Haines' specific case, Dr Nicholls was of the impression that the atypical chest pain had resolved.

81. The diagnosis of atypical chest pain did not give those at Justice Health sufficient insight into the true nature of Mr Haines' condition.

82. Associate Professor Grabs notes that a pulmonary angiogram or coronary angiogram was not performed before he was discharged by John Hunter Hospital. I accept his opinion that, if Mr Haines had a PE, this would have been clear on a pulmonary angiogram. He describes such an angiogram as "the investigation of choice for patients with undifferentiated symptoms".

83. Associate Professor Grabs did not share Dr Choi's reluctance to administer a D-Dimer test (a test used for the identification of clotting disorders) and says that, in his hospital, one would probably have been ordered.

84. I accept Associate Professor Grabs' opinion that once the diagnosis of infective endocarditis was excluded the hospital should have further investigated the reasons for Mr Haines' symptoms upon admission. Dr Choi stated that once the serious concern of infective endocarditis had been excluded, and the symptoms had resolved, it was appropriate to leave further investigation for follow-up. However, there was nothing in the discharge summary advising further investigation and whilst I acknowledge that different clinicians have different views I am persuaded and accept Associate Professor Grabs' opinion that ruling out PE or pericarditis should have occurred prior to discharge.

85. Once he was back in Cessnock Correctional Centre, Mr Haines had no family to look after him and there is no day-to-day medical care of inmates. While he was seen by a registered nurse on 21 March and Dr Foley on 24 March and Dr Kehoe on 25 March, Mr Haines did not receive medical attention close to the time he died on 27 April 2021. It appears clear that Mr Haines was not feeling well on the morning before he died. While it is evident from his Justice Health medical records that he had sought medical attention when he required it in the past, he may well have thought that three hospitals had recently investigated his ill health to no avail. This further highlights the possible significance of the diagnosis he was discharged with from John Hunter Hospital.

CONCLUSION

86. There were shortcomings in the health care provided to Mr Haines. I am satisfied on balance that he had a PE whilst he was in hospital, and this was not diagnosed. If it had been, the treatment would have in all probability prevented his untimely death.

87. The evidence that has been presented at this inquest is that various measures have been taken to prevent a similar death in the future.

88. In relation to the potential for improvement in the processes regarding the provision of relevant medical histories from Justice Health to an external hospital, there have been changes in the policy regarding the circumstances in which an alert of relevant medical information would occur. Dr Nicholls says that it is his expectation and understanding of the present policy that it would require a history like Mr Haines' history of left leg DVT to be included as an alert (and, consequently, automatically included on the relevant transfer papers).

89. Dr Nicholls' evidence suggests that, at present, the systems are adequate to prevent this failure from occurring again in the future.

90. Furthermore, Dr Choi explained that there is a scheme already in train allowing all NSW Health agencies to view a person's complete medical records. Such a scheme would have accorded an opportunity for those at Cessnock Hospital initially (and, later, the other hospitals) to have seen the history of Mr Haines' left leg DVT. Dr Choi expressed a hope that the scheme would be implemented within a month.

91. Another area identified as a potential area for recommendations was in relation to the failure of the hospitals to implement a DVT risk assessment. Dr Choi's evidence is that there is a scheme in place to address this failing; namely, the VTE forcing function on the 'MedChart' system which would require a risk assessment to be performed before any medication could be prescribed to a patient. Dr Choi explains that this system has been rolled out at Cessnock and Maitland Hospitals and will go live at John Hunter Hospital in March or April of this year.

92. The appropriateness of handcuffing custodial patients to a bed was also considered. Whilst the evidence clearly suggests that it is not an ideal practice, in that the enforced immobility increases the risk of DVT, the evidence also discloses no clear solution to this difficulty. Dr Choi and Associate Professor Grabs agreed that there were considerable difficulties with a proposal to have locked wards as an alternate. This issue remains a consideration for Justice Health, Corrective Services NSW, and the external hospitals.

93. I offer my heartfelt condolences and sympathy to Mr Haines' family and thank them for participating in this inquest when it has been so difficult and sad for them. Their daily attendance at the inquest is a testament to their love of Mr Haines and the ongoing grief they suffer.

Findings pursuant to s 81 (1) *Coroners Act 2009*

Identity

The person who died was William Haines.

Date of death

Mr Haines died on 27 April 2021.

Place of death

Mr Haines died at Cessnock Correctional Centre, NSW.

Cause of death

Mr Haines died as a result of a pulmonary thromboembolus due to a left leg deep vein thrombosis.

Manner of death

Mr Haines died of natural causes while he was in lawful custody.

Magistrate Carmel Forbes

Deputy State Coroner

1 March 2023

NSW Coroners Court