JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	24 AUGUST 2023
DELIVERED	**:**	30 AUGUST 2023
FILE NO/S	**:**	CORC 507 of 2022
DECEASED	**:**	HOWLETT, KEVIN GEORGE

Catchwords:

Nil

Legislation:

Prisons Act 1981 (WA)

Counsel Appearing:

Sergeant A. Becker assisted the coroner.

Ms A. Nowak (State Solicitor's Office) appeared for the Department of Justice and the South Metropolitan Heath Service.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Kevin George HOWLETT*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 24 August 2023, find that the identity of the deceased person was* ***Kevin George HOWLETT*** *and that death occurred on 24 February 2022 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch, from complications of ruptured abdominal aortic aneurysm (treated surgically) in the following circumstances:*

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INTRODUCTION

1. Kevin George Howlett (Mr Howlett) died on 24 February 2022 at Fiona Stanley Hospital from complications of a ruptured abdominal aortic aneurysm (treated surgically). At the time of his death, Mr Howlett was a sentenced prisoner at Casuarina Prison, and thereby in the custody of the Chief Executive Officer (CEO) of the Department of Justice (DOJ).[1,2,3,4,5,6,7,8,9,10,11]

2. Accordingly, immediately before his death Mr Howlett was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*". In such circumstances, a coronial inquest is mandatory. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[12]

3. I held an inquest into Mr Howlett's death at Perth on 24 August 2023. The documentary evidence adduced at the inquest comprised one volume and the following witnesses gave evidence:

a. Dr Rick Bond, (State Director of Vascular Surgery);

b. Dr Joy Rowland ACM, (Director Medical Services, DOJ); and

c. Ms Toni Palmer (Senior Review Officer, DOJ).

4. The inquest focused on the care, treatment and supervision provided to Mr Howlett while he was in custody, as well as the circumstances of his death.

[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (24.02.22)
[2] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. D Murphy (24.08.22)
[3] Exhibit 1, Vol. 1, Tab 3, Report - Sen. Const. E Lamperd (24.02.22)
[4] Exhibit 1, Vol. 1, Tab 4, Death in Hospital form (24.02.22)
[5] Exhibit 1, Vol. 1, Tab 5.1, P92 - Identification of Deceased: Other than by Visual Means (01.03.22)
[6] Exhibit 1, Vol. 1, Tab 5.2, Affidavit - Act. Sgt. R Vogels (01.03.22)
[7] Exhibit 1, Vol. 1, Tab 5.3, Affidavit - Act. Sgt. S Durka (01.03.22)
[8] Exhibit 1, Vol. 1, Tab 5.4, PathWest Coronial Identification Report (01.03.22)
[9] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (24.03.22)
[10] Exhibit 1, Vol. 1, Tab 11, FSH Discharge summary (24.02.22)
[11] Section 16, *Prisons Act 1981* (WA)
[12] Sections 3, 22(1)(a) & 25, *Coroners Act 1996* (WA)

MR HOWLETT

Background[13,14,15]

5. Mr Howlett was born on 19 February 1939, and was 83 years of age when he died. He was a qualified butcher, and according to one of his daughters he had seven children from his first wife, whom he divorced. The daughter also told police that in the late 1980's, Mr Howlett began a defacto relationship with a new partner, who he was with until 2011.

Offending history[16,17,18,19,20,21]

6. On 1 February 2013, in the District Court of Western Australia at Perth, Mr Howlett was convicted of multiple child sex offences and sentenced to 16 years' imprisonment. On 29 January 2014, following a successful appeal to the Western Australian Court of Criminal Appeal, Mr Howlett's sentence was reduced to 14 years' imprisonment. He was made eligible for parole and Mr Howlett's earliest eligibility date was calculated as 19 September 2023.

Medical history[22,23,24]

7. When Mr Howlett was about 19 years of age, he reportedly sustained head injuries after a serious motorcycle accident. His injuries rendered him unconscious for almost two weeks and unable to return to work for five months. He was also reportedly "*king hit*" at a hotel when he was 26 years of age. On being admitted into prison, it was noted that Mr Howlett had numerous significant health issues, which I have listed in the next paragraph. It was also noted that his mother had died from a heart attack and/or stroke, and that his father may have died from an abdominal aortic aneurysm.

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[13] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. D Murphy (24.08.22), pp2-3
[14] Exhibit 1, Vol. 1, Tab 8, Background information report
[15] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (10.05.23), p7
[16] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (10.05.23), pp7-8
[17] Exhibit 1, Vol. 1, Tab 9.1, Transcript of sentencing remarks - District Court of WA (01.02.13)
[18] Exhibit 1, Vol. 1, Tab 9.2, [2014] WASCA 19
[19] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (10.05.23), pp4 & 7-8
[20] Exhibit 1, Vol. 1, Tab 15.3, History for Court - Criminal and Traffic
[21] Exhibit 1, Vol. 1, Tab 15.4, Sentence Summary - Offender
[22] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. D Murphy (24.08.22), p5
[23] Exhibit 1, Vol. 1, Tab 9.2, [2014] WASCA 19 at p24, para 91 per Hall J
[24] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23)

8. After Mr Howlett's death, DOJ reviewed his medical care and produced a document entitled Health Services Summary into Death in Custody (Health Review). The Health Review notes Mr Howlett's medical history included:

- Chronic renal impairment (Stage 3);
- Ischaemic heart disease with angina;
- Myocardial infarction in 1991 and stent in 1999;
- High blood pressure;
- High cholesterol;
- Paget's disease of bone;
- Cervical spondylosis;
- Gastro-oesophageal reflux disease;
- Depression;
- Gout;
- Memory problems after vehicle accident in 1958, and seizures in 1979;
- Squamous cell carcinoma of the tonsils, treated in 1999;
- Melanoma removed from his back;
- Ischaemic colitis in 2004; and
- Meningioma identified in 2008.[25]

9. In August 2021, after an X-ray to investigate back pain, Mr Howlett was found to have an abdominal aortic aneurysm. However, confirmatory imaging (ultrasound and CT angiogram) were not performed until early February 2022, and the rupture of the abdominal aortic aneurysm caused Mr Howlett's death.[26]

Prison history[27,28,29,30,31]

10. Mr Howlett was received into custody at Hakea Prison (Hakea) on 19 September 2011, and given a maximum security rating in accordance with departmental policy. Mr Howlett was also interviewed by a reception officer who conducted a risk assessment to determine whether Mr Howlett should be managed under the At Risk Management System (ARMS).

[25] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p3
[26] Exhibit 1, Vol. 1, Tab 14, Report - Dr R Bond
[27] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (10.05.23), pp8-14 and ts 24.08.23 (Palmer), p47
[28] Exhibit 1, Vol. 1, Tab 15.2, Substance Use Tests Results - Prisoner copy
[29] Exhibit 1, Vol. 1, Tab 15.6, At Risk Management System - Reception Intake Assessment (19.09.11)
[30] Exhibit 1, Vol. 1, Tab 15.12, Cell Placement History - Offender
[31] Exhibit 1, Vol. 1, Tab 15.19, Regular Contact Reports (04.08.14 - 15.02.22)

11. ARMS is DOJ's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide. During his ARMS assessment, Mr Howlett was identified as a first time prisoner and his medical issues were noted. Mr Howlett denied any suicidal or self-harm ideation, but did say he felt "*at risk*" because of the nature of his offences. Mr Howlett was not considered to be at risk of self-harm or suicide and was therefore not managed on ARMS.[32,33]

12. After Mr Howlett had been sentenced, a management and placement checklist was completed and on the basis of his medical conditions, he was assessed as unsuitable for work, sport, or a top bunk. Mr Howlett's security level was reduced to "medium" and an individual management plan was prepared.[34,35,36]

13. Mr Howlett was deemed suitable for transfer to Acacia Prison (Acacia) and was sent there on 15 March 2013. He remained at Acacia until 12 July 2021, when his deteriorating medical condition saw him transferred to the infirmary at Casuarina Prison (Casuarina). Mr Howlett remained at Casuarina until his death.[37]

14. During his incarceration, Mr Howlett was described as a "*generally polite prisoner*" who "*maintained his cell hygiene to a high standard*". He had nine social visits during the time he was imprisoned, and maintained contact with his family and friends by means of letters and phone calls. Mr Howlett was employed for short periods as a general worker, and was the subject of 46 random drug and alcohol tests, all of which returned negative results.[38,39,40,41]

[32] ARMS Manual (2019), pp2-13 & 21-24
[33] Exhibit 1, Vol. 1, Tab 15.6, ARMS Reception Intake Assessment (19.09.11)
[34] Exhibit 1, Vol. 1, Tab 15.7, Management and Placement Checklist - Sentenced (11.02.13)
[35] Exhibit 1, Vol. 1, Tab 15.8, Individual Management Plan (14.03.13)
[36] Exhibit 1, Vol. 1, Tab 15.9, Classification Reviews (various dates)
[37] Exhibit 1, Vol. 1, Tab 15.11, Decision Slip - Temporary Transfer for Medical/Mental Health (09.07.21)
[38] Exhibit 1, Vol. 1, Tab 15.20, Visits History - Offender
[39] Exhibit 1, Vol. 1, Tab 15.21, Work History - Offender
[40] Exhibit 1, Vol. 1, Tab 15.23, Prisoner Mail - Offender
[41] Exhibit 1, Vol. 1, Tab 15.23, Recorded Call Report

MANAGEMENT OF HEALTH ISSUES[42,43]

15. Departmental records show that at Acacia, Mr Howlett regularly attended the medical centre for treatment for minor medical issues. He attended regular physiotherapy and podiatry appointments and was the subject of electrocardiograms (ECG). His chronic kidney disease and chronic obstructive airways disease were reviewed at regular intervals, and he had weekly blood pressure checks.

16. When biopsies of Mr Howlett's right shoulder and leg tested positive for Bowen's disease (a form of squamous cell carcinoma), he was referred to a plastic surgeon, and he had numerous squamous cell carcinomas removed. Mr Howlett also underwent reconstructive surgery of the nose, and he was given a walking frame due to his history of frequent falls.

17. After Mr Howlett was transferred to the infirmary at Casuarina on 12 July 2021, he was reviewed regularly by nursing staff and prison medical officers (PMO). He received treatment for minor medical issues and continued to attend regular physiotherapy and podiatry appointments. When he complained of chest pain he underwent an ECG and was given glyceryl trinitrate spray.

18. When Mr Howlett's condition deteriorated, he was started on a pureed diet. He continued to use a walking frame, and a falls risk assessment was completed. On 25 August 2021, Mr Howlett was taken to Fiona Stanley Hospital (FSH) after experiencing a fall and complaining of chest pains, but he was returned to Casuarina the same day.

Abdominal aortic aneurysm

19. On 26 August 2021, Mr Howlett had an X-ray at FSH to investigate his complaints of back pain. The X-ray found no acute compression fracture or bony lesion, but did identify lower lumbar degenerative disease and facet arthropathy.[44]

[42] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (10.05.23), pp8-18
[43] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23) and ts 24.08.23 (Rowland), pp21-45
[44] Exhibit 1, Vol. 1, Tab 13.1, FSH Medical Imaging Report - Lumbosacral Spine X-ray (27.08.21)

20. However, the X-ray incidentally found that Mr Howlett had an abdominal aortic aneurysm (AAA), with the X-ray report (X-ray Report) noting:

> *Finding:* There is diffuse calcified atheroma of the abdominal aorta and iliac arteries. Fusiform dilation of the abdominal aorta measures up to 8.7 cm on the oblique projection. This may be magnified by the projection.
>
> *Comment:* Calcification and fusiform dilation of the abdominal aorta, size not accurately measured. **This could be assessed by ultrasound or CT angiogram if clinically appropriate.**[45] [Emphasis added]

21. Although a PMO sent a request for an ultrasound to FSH on 1 September 2021, Mr Howlett did not have an ultrasound (or a CT angiogram) until 7 February 2022. I will have more to say about this delay later in the finding.

22. For the moment, I note that the "*Clinical History*" on the ultrasound report stated: "*Incidental finding of possible aneurysm on recent lumbar spinal X-ray*". The ultrasound report confirmed that Mr Howlett had a 7 cm "*fusiform abdominal aortic aneurysm*", and the CT angiogram report expressed the same opinion and recommended a review by a vascular surgeon.[46,47]

23. Following Mr Howlett's death, the Court sought an opinion from Dr Rick Bond, the State Director of Vascular Surgery. Dr Bond reviewed the diagnosis and treatment of Mr Howlett's AAA and gave evidence at the inquest. In his report to the Court (and at the inquest), Dr Bond explained that an AAA:

> [I]s a swelling (or bulge) of the main artery of the body (the aorta) as it passes from the chest to the legs via the abdomen. The normal diameter of the abdominal aorta in a fully grown male is approximately 2 cm. It is not known why aneurysms occur in some people, but they are more common in males, in smokers and run in families…

[45] Exhibit 1, Vol. 1, Tab 13.1, FSH Medical Imaging Report - Lumbosacral Spine X-ray (27.08.21)
[46] Exhibit 1, Vol. 1, Tab 13.2, FSH Medical Imaging Report - Ultrasound of Abdominal Aorta (09.02.22)
[47] Exhibit 1, Vol. 1, Tab 13.3, FSH Medical Imaging Report - CT Angiogram Abdomen (10.02.22)

> …Aneurysms form by slow, localised dilatation of the aorta over years. When they are "small" (less than 5cm), they pose little danger and rarely cause any symptoms. Generally, aneurysms grow at around 2 - 4 mm per year but sometimes they grow faster and sometimes they don't grow at all for many years.[48]

24. Dr Bond said that about 1% of men over the age of 60 years will have an AAA, and if the patient has a first degree relative with an AAA, the rate rises to about 5% as AAA "*do tend to run in families*". Most AAA are identified incidentally during routine tests such as X-rays or ultrasounds. The diameter of a "*normal*" aorta in an average size male is about 2 cm and for small aneurysms, the risk of rupture is usually very low. However, the risk of rupture is thought to be about 30% for AAA that are 7 cm in size, and about 50% when the aneurysm is 8 cm.[49]

25. Dr Bond explained that in the past a non-ruptured aneurysm was repaired surgically by replacing the damaged section of the aorta with a graft of synthetic material. These days, aneurysms are more commonly repaired by inserting a stent. The stenting procedure is less invasive and has a lower mortality risk, however where a patient survives either procedure, "*they will have a normal life expectancy after the surgery*".[50]

26. As Dr Bond explained, a ruptured AAA is a catastrophe and 50% of patients do not make it to hospital alive. Of those that do, 50% will die after surgery making the mortality rate for a ruptured AAA about 75%. In his report, Dr Bond also noted that a ruptured AAA:

> [P]resents suddenly with back/abdomen pain and shock due to internal bleeding. Many patients die within minutes, but some will survive long enough to reach hospital. Overall, it is associated with a close to 100% death rate if not treated by surgery and a 75% risk of death even if surgery is attempted. Consequently, most aneurysms would be repaired "routinely" once they are over 5 - 5.5 cm to avoid this potential disaster.[51]

[48] Exhibit 1, Vol. 1, Tab 14, Report - Dr R Bond, p1 and see also: ts 24.08.23 (Bond), pp7-8
[49] Exhibit 1, Vol. 1, Tab 14, Report - Dr R Bond, p1 and ts 24.08.23 (Bond), p7
[50] Exhibit 1, Vol. 1, Tab 14, Report - Dr R Bond, p1 and ts 24.08.23 (Bond), pp7 & 10-12
[51] Exhibit 1, Vol. 1, Tab 14, Report - Dr R Bond, p1 and see also ts 24.08.23 (Bond), pp7-8

Mr Howlett's death[52,53]

27. At about 7.10 am on 23 February 2022, Mr Howlett's cellmate made an emergency cell call and told prison officers Mr Howlett was unwell. Nursing staff and prison officers attended and Mr Howlett was pale and complained of "*spinal and generalised body pain*". He denied any chest pain or shortness of breath and was taken to the medical treatment room, where he complained of nausea. When Mr Howlett became unresponsive an ambulance was called and defibrillator pads were applied to his chest. An intravenous catheter was also inserted, and he was given supplemental oxygen.

28. An incident report completed by Senior Officer Jones states: "*CPR and compressions started at approximately 7.13 hrs*", and that at about 7.17 am Mr Howlett "*started to show movement whilst medical staff were treating him*". By about 7.25 am, Mr Howlett had become "*responsive to medical treatment*".[54]

29. Confusingly however, a document entitled "*Incident Report Minutes*" states: "*CPR was not required however defibrillator unit was placed on standby not used*".[55] The other staff incident reports say that Mr Howlett received "*medical treatment*" or "*medical attention*",[56,57] but in any event, he left Casuarina in an ambulance bound for FSH at 7.45 am.

30. Mr Howlett was diagnosed with a ruptured AAA and his family were advised. At about 9.05 am, Dr Bond and his team performed emergency surgery and found a large rupture of the AAA and significant internal bleeding. During the surgery, Mr Howlett experienced a cardiac arrest, but he was resuscitated and the rupture was repaired using a graft.[58]

31. At about 2.15 pm, Mr Howlett was transferred to the intensive care unit where he developed multi-organ failure, abdominal compartment syndrome[59] and low blood pressure.

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[52] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (10.05.23), pp12-13
[53] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p8
[54] Exhibit 1, Vol. 1, Tab 15.15, Incident Description Report - Sen. Offr. T Jones (23.02.22)
[55] Exhibit 1, Vol. 1, Tab 15.15, Incident Report Minutes, p2, para 4
[56] Exhibit 1, Vol. 1, Tab 15.15, Incident Description Report - Offr. L Barnard (23.02.22)
[57] Exhibit 1, Vol. 1, Tab 15.15, Incident Description Report - Reg. Nurse E Blundell (23.02.22)
[58] ts 24.08.23 (Bond), pp11-12
[59] The term abdominal compartment syndrome refers to abnormally increased abdominal pressure.

32. At about 10.10 pm, Mr Howlett deteriorated and his treating team assessed his condition as "*critical*" and his next-of-kin were advised. Mr Howlett's condition continued to deteriorate, and he was declared deceased at 4.49 am on 24 February 2022.[60,61,62,63,64,65,66,67]

Management on the terminally ill register[68,69,70]

33. Prisoners with a terminal illness[71] are managed in accordance with a DOJ policy known as *COPP 6.2 Prisoners with a Terminal Medical Condition*. Once a prisoner is identified as having a terminal illness, a note is made in the terminally ill module of the Total Offender Management Solution (TOMS), the computer system DOJ uses for prisoner management. Prisoners are identified as Stage 1, 2, 3 or 4, on the basis of their expected lifespan. Stage 3 prisoners are expected to die within three months, whereas death is expected imminently for Stage 4 prisoners.

34. On 22 March 2021, Mr Howlett was identified as a Stage 1 terminally ill prisoner due to his chronic obstructive pulmonary disease and chronic kidney disease. He was escalated to Stage 4 on 23 February 2022, following his emergency admission to FSH.[72,73]

Delay in treating Mr Howlett's aneurysm

35. The Health Review identified several missed opportunities to have identified and/or treated Mr Howlett's AAA at an earlier stage. Whilst the Health Review notes that routine screening for AAA is not currently recommended in Australia, given Mr Howlett's smoking history, age, ischaemic heart disease, and his family history (i.e. that his father apparently died from a ruptured AAA):

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[60] Exhibit 1, Vol. 1, Tab 4, Death in Hospital form (24.02.22)
[61] Exhibit 1, Vol. 1, Tab 5.1, P92 - Identification of Deceased: Other than by Visual Means (01.03.22)
[62] Exhibit 1, Vol. 1, Tab 5.2, Affidavit - Act. Sgt. R Vogels (01.03.22)
[63] Exhibit 1, Vol. 1, Tab 5.3, Affidavit - Act. Sgt. S Durka (01.03.22)
[64] Exhibit 1, Vol. 1, Tab 5.4, PathWest Coronial Identification Report (01.03.22)
[65] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (24.03.22)
[66] Exhibit 1, Vol. 1, Tab 11, FSH Discharge summary (24.02.22)
[67] Section 16, *Prisons Act 1981* (WA)
[68] Exhibit 1, Vol. 1, Tab 15, Death in Custody Review (10.05.23), pp15 & 17
[69] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), pp5-6 & 13
[70] COPP 6.2 - Prisoners with a Terminal Medical Condition, pp4-6
[71] One or more conditions that on their own or as a group, significantly increase the likelihood of a prisoner's death
[72] Exhibit 1, Vol. 1, Tab 15.10, Terminally Ill Health Advice (22.03.21)
[73] Exhibit 1, Vol. 1, Tab 15.18, Terminally Ill Health Advice (23.02.22)

> (Mr Howlett) could have been considered for imaging to check for these years earlier, including in the community. However, there was no specific trigger and with his other issues requiring attention and despite the many comprehensive reviews documented by a range of doctors, this possibility was not noted.[74]

36. At the inquest, Dr Bond confirmed that routine screening for AAA does not occur in Australia. This is apparently because there is such ready access to imaging services that AAA tend to be picked up incidentally, as happened in Mr Howlett's case. Dr Bond said that even given Mr Howlett's co-morbidities and his family history, it was probably unlikely that he would have been routinely screened for an AAA if he had been in the community.[75]

37. In any case, the X-ray Report (that identified Mr Howlett's AAA) was dated 27 August 2021, and was entered into EcHO (the computer system DOJ uses to manage prisoner health) on 30 August 2021.[76] Although a PMO sent a request for an abdominal ultrasound to FSH on 1 September 2021, at no stage was the AAA added to Mr Howlett's "*Active Problem List*" in EcHO.

38. The failure to add Mr Howlett's AAA to his Active Problem List in EcHO was very unfortunate indeed. That is because Mr Howlett's AAA was not readily visible to health staff accessing his EcHO record, and because the AAA was not mentioned in emergency transfer letters or patient summary letters which were created using EcHO when Mr Howlett was sent to hospital.[77]

39. Further, although Mr Howlett's EcHO record was reviewed by PMO's on several occasions between August 2021 and February 2022, because the AAA was not listed in his Active Problem List, it would only have appeared "*as a comment in a result and was not prominent*".[78]

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[74] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p9
[75] ts 24.08.23 (Bond), p9
[76] Exhibit 1, Vol. 1, Tab 13.1, FSH Medical Imaging Report - Lumbosacral Spine X-ray (27.08.21)
[77] ts 24.08.23 (Rowland), p24-26
[78] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p9

40. The AAA identified in the X-ray Report was large, and as a result, confirmatory imaging and treatment should have been actioned promptly. As I have noted, although a request for an abdominal ultrasound was sent to FSH on 1 September 2021, the first appointment offered by FSH was 7 February 2022.

41. In this case, the request for Mr Howlett's abdominal ultrasound (Ultrasound Request) gave no indication of any urgency, and did not mention the apparent size of the aortic dilation (i.e.: 8.7 cm) which was referred to in the X-ray Report.[79] Instead, the clinical details stated in the DOJ Request merely stated:

> Incidental findings of a calcified and dilated fusiform appearance of the abdominal aorta on a recent lumbar X ray for further diagnostic clarity. History of chronic lower back pain.[80]

42. It is certainly true that the X-ray Report did not state that the AAA which was incidentally identified should be the subject of confirmatory imaging urgently. The X-ray Report did not even say that an ultrasound was necessary. Nevertheless, the X-Ray report did mention that the possible size of the AAA was 8.7 cm and did state: "*This could be assessed by ultrasound or CT angiogram if clinically appropriate*".[81]

43. With the benefit of hindsight, it would obviously have been preferable if the X-ray Report had indicated some level of urgency in obtaining a confirmatory abdominal ultrasound. Had this been suggested in the body of the X-ray Report, it may have prompted the PMO to have marked the abdominal ultrasound request as "*urgent*".[82]

44. I accept that when Mr Howlett was seen after his lumbosacral X-ray, the PMO was also dealing with changes to Mr Howlett's medication, and clinical checks to ensure he was recovering from a chest infection. I also accept that PMO's have limited time with each prisoner, and that patient lists in prisons are long.[83]

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[79] Exhibit 1, Vol. 1, Tab 13.1, FSH Medical Imaging Report - Lumbosacral Spine X-ray (27.08.21)
[80] Exhibit 1, Vol. 1, Tab 17.1, DOJ Imaging request (31.08.21)
[81] Exhibit 1, Vol. 1, Tab 13.1, FSH Medical Imaging Report - Lumbosacral Spine X-ray (27.08.21)
[82] ts 24.08.23 (Rowland), pp29-30
[83] ts 24.08.23 (Rowland), pp23-25

45. These issues have featured in other death in custody inquests I have presided over, and the situation is not helped by difficulties in recruiting appropriately experienced PMO's and retaining them in the longer term.

46. Nevertheless, as the Health Review makes clear it would appear that the PMO requesting the abdominal ultrasound had either "*not identified that the original estimate of the size of the AAA was indicative of a very high-risk lesion*" or, had not anticipated that there would be such a lengthy delay before the imaging would be performed.[84,85]

47. Had the high-risk nature of Mr Howlett's AAA been appreciated, the PMO could have pursued other management options, which according to the Health Review, included:

> [T]elephoning the radiology department to arrange urgent imaging, referring to vascular surgeons at the same time as requesting the imaging, or phoning a vascular surgeon to discuss the management plan.[86]

48. In terms of why there was such a lengthy delay in FSH offering an ultrasound appointment in what appeared (on its face) to be a routine request, the Health Review noted that it is FSH "*who triage and prioritise the requests, and who had the previous result on file*", and it was possible that: "*the impact of COVID, including border closures and staffing shortages across health systems, contributed to this delay*".[87]

49. In a detailed report (FSH Report), FSH explained how imaging requests it receives from DOJ are managed. Such requests are emailed to a dedicated email address and then reviewed by a senior medical imaging technologist (SMIT), or a radiologist "*for evaluation if required*". The SMIT reads the request and consider factors such as the degree of urgency identified by the requesting PMO, and the prisoner's age, gender and co-morbidities.[88]

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[84] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p10 and ts 24.08.23 (Rowland), pp22-24, 26-28 & 35-36
[85] See also: ts 24.08.23 (Bond), pp19-21
[86] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p10
[87] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p10 and ts 24.08.23 (Rowland), pp33-35
[88] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), pp2-3

50. As the FSH Report notes:

> Imaging timeframes are not arbitrary and having given due consideration to information on the form and taking into account current workload and capacity, an appropriate scheduling timeframe… is determined and noted on the request.[89]

51. At the inquest, Dr Rowland noted that in triaging the request, FSH would also have had access to the X-ray Report, meaning that the request could have been accorded a greater level of urgency, even though this had not been requested. However, as I have explained, the request for Mr Howlett's abdominal ultrasound (Ultrasound Request) gave no indication of urgency and did not mention the size of the aortic dilation (i.e.: 8.7 cm) which was clearly referred to in the X-ray Report.[90]

52. The FSH Report notes that where an imaging referral is considered "*urgent*", a booking is made immediately. For non-urgent bookings (as Mr Howlett's imaging request was taken to be), the FSH Report states:

> Non urgent requests will be scheduled immediately if clerical resources allow, but in times of high activity and/or limited resources, it is not uncommon for these to be set aside to be booked at a future date closer to the triaged timeframe. This is likely what occurred with the ultrasound request for Mr Howlett, received on 1st September 2021, entered onto the (Radiology Information System) on 3rd September 2021, and then scheduled (for 7th Feb 2022) on 31st December 2021 at which time the DOJ were informed.[91]

53. In explaining why imaging requests are triaged by a senior imaging technologist, the FSH Report notes that the "*sheer volume*" of imaging requests received internally and externally means it is: "*[N]ot practically feasible for a Consultant Radiologist or Registrar to review every request*". Whilst complex imaging requests, and those requiring "*guided interventional radiology or procedural examinations*" are all reviewed by a radiologist (or a registrar), it would appear that the vast majority of imaging requests are reviewed by a senior imaging technologist.

[89] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), p2
[90] Exhibit 1, Vol. 1, Tab 13.1, FSH Medical Imaging Report - Lumbosacral Spine X-ray (27.08.21)
[91] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), p2

54. The number of imaging examinations performed at FSH is mind boggling. According to the FSH Report, there were 211,145 imaging examinations in the 2021 calendar year, and the current figure is 240,000 examinations annually. This is reportedly 60,000 more examinations than the next busiest tertiary facility.[92]

55. Whilst the FSH triage system is understandable given the volume of imaging examinations it performs, in my view, it clearly underscores the importance of PMO's being alive to the need to indicate a degree of urgency in appropriate imaging requests. To be clear, it would not be appropriate for DOJ to assume that any error made by a PMO in terms of categorising the urgency of an imaging request will necessarily be picked up when the request is triaged at FSH.[93]

56. As noted, the reason why Mr Howlett had an X-ray in August 2021 in the first place was because he had complained of back pain following a fall. After that point, although Mr Howlett saw PMO's on several occasions, he never complained of abdominal pain, and did not complain of back pain again until shortly before his death. When Mr Howlett collapsed in his cell on 23 February 2022, he complained of "*spinal and generalised body pain*" and was taken to FSH immediately. As the Health Review notes, this meant that:

> [T]he AAA had previously been asymptomatic, and it also meant that although he saw doctors several times between August 2021 and February 2022, including two specialists at FSH and an admission, that there was no trigger to re-examine him or to phone and arrange more urgent imaging. There was also no trigger for Mr Howlett to himself enquire about the ultrasound he was waiting for.[94]

57. Mr Howlett was reviewed by a geriatrician and a nephrologist at FSH, and was admitted there briefly on 9 September 2021 after a fall. The Health Review further notes that although all of these clinicians had access to the X-ray Report, the AAA is not "*noted to have been seen by any of them*".[95]

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[92] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), pp2-3
[93] ts 24.08.23 (Rowland), pp27-30
[94] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p10
[95] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p10 and ts 24.08.23 (Rowland), pp33-35

58. It is certainly unfortunate that none of these health professionals had appreciated the fact that Mr Howlett's AAA remained untreated. These interactions with Mr Howlett at FSH presented other possible opportunities when the urgency of reviewing his large AAA could have been identified.

59. Nevertheless, as section 7(1) of the *Prisons Act 1981* (WA) (the Prisons Act) relevantly provides:

> Subject to this Act and to the control of the Minister, the chief executive officer is responsible for the management, control, and security of all prisons and **the welfare and safe custody of all prisoners**. [Emphasis added]

60. When interpreting section 7 of the Prisons Act, the term "*welfare*" takes its ordinary English meaning, namely: "*the health, happiness, and fortunes of a person or group*".[96] It follows that because Mr Howlett was a sentenced prisoner the responsibility for managing Mr Howlett's health vested (and always remained with) the CEO. Whilst there was the potential for FSH to have identified that Mr Howlett's AAA should be investigated more urgently, the primary error was the PMO's failure to identify that urgency at the time of the Ultrasound Request.[97]

61. The Health Review also notes that a further unfortunate delay occurred after the ultrasound and CT angiogram had been performed. The imaging was carried out on 7 February 2022, and although the ultrasound and the CT were reported on 9 and 10 February 2022 respectively, the reports were not sent to Casuarina by FSH until 18 February 2022. Further, the results of the ultrasound and the CT were not uploaded to EcHO until 21 February 2022, which was two days before Mr Howlett's collapse.[98]

62. At the inquest Dr Bond said that if the ultrasound and CT angiogram reports had been sent to Casuarina sooner, it is possible that a referral to a vascular surgeon might have been made.[99]

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[96] Compact Oxford English Dictionary (3rd Ed, 2005), p1179
[97] See also: ts 24.08.23 (Rowland), p45
[98] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p11
[99] ts 24.08.23 (Bond), pp16-18

63. However, even if this had occurred, it might still have been one month before Mr Howlett underwent any corrective procedure to treat his AAA. As Dr Bond also noted at the inquest, had the Ultrasound Request been identified as urgent, then it is possible that Mr Howlett could have undergone corrective stenting by October or November 2021.[100]

Other issues referred to in the FSH Report

64. The FSH Report notes that for "*security and comfort*" prisoners do not "*mix or wait*" for imaging in the same areas as inpatients and outpatients. Instead, the prisoner is brought from FSH's secure unit to a vacant examination room for the imaging, and then returned to the secure unit before being returned to prison. The FSH Report refers to this process as "*inherently inefficient*" and notes that in practice, it means that imaging rooms are left vacant "*for extended periods*" whilst prisoners are being moved back and forth from the secure unit.[101]

65. As to the delay in providing an appointment for Mr Howlett's abdominal ultrasound, the FSH Report states:

> In this specific case, (the AAA) was an entirely incidental finding, in what appears to be an asymptomatic patient with no clinical urgency indicated on the imaging request. Under ideal circumstances it would have been protocolled at 1-3 months, but with operational issues as outlined separately, a delay out to 6 months would not seem unreasonable. If the provided clinical details had included clinical findings of a large palpable mass and/or regional symptoms and/or indicated that it was urgent and/or discussed telephonically regarding clinical urgency, then the examination booking would have been expedited.[102]

66. Although I would challenge whether a delay of six months could ever be justified in a case like Mr Howlett's, I accept that had the Ultrasound Request indicated the probable size of the AAA and/or indicated any degree of urgency, it is at least possible that an earlier appointment might have been offered to Mr Howlett.

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[100] ts 24.08.23 (Bond), pp16-18
[101] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), p4
[102] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), p4

67. The FSH Report also notes that unlike patients in the community who are referred for imaging by a GP, prisoners are unable to access "*corporate radiology entities*". This means that FSH staff are presented with an "*uncomfortable ethical and clinical problem*" when trying to service imaging requests from prisoners as well as those from FSH inpatients, outpatients and patients from the emergency department.[103]

68. The FSH Report makes the following sensible suggestions which are worthy of further detailed consideration, namely:

a. Capacity could be improved by sharing the prisoner imaging workload across Health Service Providers (HSP's) with all tertiary facilities "*providing imaging to patients residing in prisons that fall within their respective HSP catchment area*";

b. Dedicated equipment and resources could be provided to better support the prison system and "*ensure a more efficient and sustainable imaging service for patients who deserve and are entitled to the same quality service as the general community*"; and

c. The WA Health (Service Improvement Unit) is conducting a study into the feasibility of providing a mobile imaging service, with the "*Correctional Facilities cohort*" being considered. This would reduce the need to transport prisoners to and from hospital but the study "*remains in the early stages and a pilot is funding dependent*".[104,105]

69. At the inquest, Dr Rowland confirmed she was aware of the mobile service feasibility study, and that in her view it had the potential to assist in dealing with routine imaging requests. Dr Rowland also noted that although Casuarina (and Hakea) have X-ray machines, they are not currently being used, apparently because of legal and policy issues. In my view grappling with these issues would be beneficial. The X-ray machines at Casuarina and Hakea could possibly deal with routine imaging.[106]

[103] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), p5
[104] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), pp5-6
[105] See also: ts 24.08.23 (Bond), p15-16 and ts 24.08.23 (Rowland), pp30-32 & 36-38
[106] ts 24.08.23 (Rowland), pp38-42

Changes since Mr Howlett's death

70. The Health Review notes that there have been several improvements in processes since Mr Howlett's death. These changes are aimed at improving the quality of EcHO records in relation to a prisoner's Active Problem List, and at mitigating risks associated with imaging requests not being appropriately categorised. These changes include:[107]

a. *Education*:
PMO's are provided with ongoing education regarding the importance of updating the Active Problem List is ongoing, and this issue is included in clinician "self-audits". Multiple prompts are also included in templates used for admissions and care plan visits;

b. *Reporting*:
Imaging reports from FSH are now received via HealthLink electronically, with the aim of reducing any delay in the receival of reports; and

c. *Urgent results and notifications*:
This issue has been discussed with FSH, and an email contact has now been provided. A new template has also been developed for rapidly adding contact details of the requesting Doctor to any imaging requests to ensure that urgent results can be provided immediately, either by phone to the relevant prison health centre, and/or by email to the requesting doctor or to DOJ's Director of Medical Services.

71. The Health Review notes in August 2021, EcHO did provide clinicians with links to "*current and evidence-based clinical resources to guide decision-making in medical imaging or investigation and management of conditions*". This includes when to seek immediate consultation from tertiary services, but in Mr Howlett's case, it was highly likely that the PMO who requested the ultrasound had: *[F]ollowed the advice on the imaging report (i.e.: the X-ray Report) which was to consider an ultrasound or CT angiogram, without considering this advice could be inadequate*.[108]

[107] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p12
[108] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p12 and ts 24.08.23 (Rowland), pp32-33

72. Whilst the delay in confirming and treating Mr Howlett's AAA was unacceptable, as I have outlined, DOJ have made changes to mitigate the risk of this error being repeated. For that reason, I have concluded that it is not necessary for me to make any recommendations in this case.

73. However, I would **strongly** urge DOJ to carefully consider the suggestions in the FSH Report about potential improvements to imaging services offered to prisoners,[109] and to actively explore the possibilities that these suggested options may offer.

CAUSE AND MANNER OF DEATH[110,111]

74. A forensic pathologist (Dr V Kueppers) conducted an external post mortem examination of Mr Howlett's body on 8 March 2022 and reviewed CT scans. Dr Kueppers noted that Mr Howlett had been diagnosed with a rupture of his AAA, which she described as "*an acute life-threatening emergency*".

75. Dr Kueppers also noted that Mr Howlett had undergone emergency surgery "*in an attempt to repair/perform damage control*". The AAA rupture site had been identified and there was "*associated retroperitoneal bleeding*". Mr Howlett's prognosis had been assessed as "*very poor*" because he was "*coagulopathic[112] and in multi-organ failure*", and as noted, he also had abdominal compartment syndrome and low blood pressure.

76. Toxicological examination found multiple medications in Mr Howlett's system that were consistent with his medical care,[113] and Dr Kueppers stated:

> No suspicious features were noted in the context of this being a death in custody. External examination and post mortem CT imaging were in keeping with the clinical findings.[114]

[109] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), pp5-6
[110] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (24.03.22)
[111] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (08.03.22)
[112] A condition where the blood's ability to coagulate (form clots) is impaired. This can cause prolonged/excessive bleeding.
[113] Exhibit 1, Vol. 1, Tab 7, Toxicology Report (22.03.22)
[114] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (24.03.22)

77. At the conclusion of her external post mortem examination, Dr Kueppers expressed the opinion that the cause of Mr Howlett's death was "*complications of ruptured abdominal aortic aneurysm (treated surgically)*", and that in her opinion, Mr Howlett's death was due to "*natural causes*".

78. I respectfully accept and adopt Dr Kueppers' conclusion as my finding in relation to the cause of Mr Howlett's death and further, I find that Mr Howlett's death occurred by way of natural causes.

Allegation of assault[115]

79. Following Mr Howlett's death, one of his daughters viewed his body at the State Mortuary. In the police questionnaire she completed which provided some background information about Mr Howlett, she reportedly stated:

> I saw him at the mortuary. He was obviously suffering a lot of bruising and major swelling to the face and side of his head, which the mortuary officer acknowledged. Although I did not see the rest of him, he looked to have major head injuries. It appears he was beaten to death, as he was due for parole this year, because he was a paedophile.[116]

80. As I have outlined, on the basis of the unequivocal evidence of Dr Kueppers, I have found that the cause of Mr Howlett's death was complications of ruptured abdominal aortic aneurysm.

81. Mr Howlett's AAA was comprehensively diagnosed by ultrasound and CT angiogram and further in her post mortem report, Dr Kueppers noted "*no suspicious features*" in respect of Mr Howlett's body and that her:

> *[E]xternal examination and post mortem CT imaging were in keeping with the clinical findings*".[117]

[115] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. D Murphy (24.08.22), p3
[116] Exhibit 1, Vol. 1, Tab 8, Background information report
[117] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (24.03.22)

82. For the sake of completeness, I note that Dr Kueppers observed "*lividity staining*" to various parts of Mr Howlett's body including the back of his face, scalp, back of his head and neck, backs of his elbows, legs, and torso, and to his buttocks. Lividity is caused by the gravitational settling of blood in the vessels after circulation has ceased, and the bluish-purple (or reddish-purple) staining of the skin which results can give the appearance of bruising to the untrained eye.[118]

83. Dr Kueppers also noted evidence of medical intervention to Mr Howlett's face, and an area of reddening and slight abrasion just below the outer aspect of his right eye. However, she made no other findings which were suggestive of Mr Howlett having been "*beaten to death*".[119]

84. Before his body was taken to the State Mortuary, police took a series of photographs of Mr Howlett in his hospital room. I have examined these images and in my view, they do not show any evidence of "*major swelling to the face and side of his head*".[120,121]

85. It is obviously the case that most people do not routinely see the bodies of deceased people, and are therefore unfamiliar with the appearance of post mortem changes. Quite understandably, it appears that the changes Mr Howlett's daughter noticed to her father's body were due to normal post mortem changes, rather than being evidence of an assault.

86. At the inquest, both Dr Rowland and Ms Palmer confirmed that DOJ had identified no evidence that Mr Howlett had ever been assaulted. Dr Rowland also made the valid point that Mr Howlett was housed in the infirmary at Casuarina, where there is a 24-hour custodial presence and constant monitoring by nursing staff. Further, as Dr Rowland put it at the inquest, the infirmary at Casuarina "*would be a very difficult place to assault someone without it being known*".[122]

[118] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (08.03.22), pp3-4
[119] Exhibit 1, Vol. 1, Tab 8, Background information report
[120] Exhibit 1, Vol. 1, Tab 8, Background information report
[121] Photographs of Mr Howlett taken after his death at FSH by police
[122] ts 24.08.23 (Rowland), pp42-44 and ts 24.08.23 (Palmer), pp47-48

87. I also note that in his report, the police investigator stated:

> Throughout the investigation, there has been no evidence presented to suggest that (Mr Howlett) was assaulted whilst in custody prior to his death.[123]

88. Therefore, on the basis of the clear and unequivocal evidence of Dr Kueppers, and in the absence of any evidence to the contrary, I have concluded that Mr Howlett was not the victim of an assault prior to his death.

QUALITY OF SUPERVISION, TREATMENT AND CARE

89. In relation to the general medical care and treatment Mr Howlett received whilst he was in custody, the Health Review made the following observation, with which I agree:

> Mr Howlett received comprehensive and high-quality care during 10 years in custody for a range of chronic conditions and multiple acute presentations, including preventative care and regular health checks.
>
> Although his pneumococcal immunisation schedule was only partially completed, he received annual influenza immunisations and he also received a herpes zoster immunisation, [and] a course of Hepatitis B vaccination.
>
> In 2021, he also completed a primary course of COVID-19 immunisations. There is therefore evidence of good overall care over his period of incarceration.[124]

90. Having carefully reviewed the available evidence, I have concluded that the management of Mr Howlett's general health was of a good standard. However, in my view, the management of Mr Howlett's AAA was sub-optimal. In his report to the Court, Dr Bond was critical of the delay between the X-ray which first identified Mr Howlett's AAA, and the CT angiogram and ultrasound which confirmed it.[125]

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[123] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. D Murphy (24.08.22), p3
[124] Exhibit 1, Vol. 1, Tab 16, Health Services Review (15.08.23), p12
[125] Exhibit 1, Vol. 1, Tab 14, Report - Dr R Bond, p2

91. Dr Bond said that if Mr Howlett had been in persistent pain, he should have been admitted to hospital immediately for surgery or stenting. If he was not in pain, the AAA should have been repaired within one month of having been identified.[126]

92. Whilst I accept that Mr Howlett's overall medical condition was poor, as Dr Bond stated in his report:

> Mr Howlett's aneurysm was amenable to repair using a stent. It is highly likely that he would have survived an elective (non-ruptured) repair (1-2% mortality risk) and been discharged within 2-3 days. Once repaired, his aneurysm should not then have been a future threat to his life.[127]

93. The evidence before me establishes that for various reasons there was an unacceptable delay between the X-ray which identified Mr Howlett's AAA, and the ultrasound and CT angiogram which confirmed it. Further, on the basis of Dr Bond's evidence, I have concluded that Mr Howlett should have undergone these confirmatory tests within a few weeks of the X-ray he had on 26 August 2021, and had his AAA repaired (most likely by stenting) within a few months thereafter.

94. Whilst there is no necessary guarantee that Mr Howlett would have survived a stenting procedure to repair his AAA, Dr Bond's view was that this was "*highly likely*". It follows that because the AAA was not further explored in an expeditious manner once it had been identified, Mr Howlett was denied the opportunity for a timely repair.[128]

95. Although Mr Howlett's medical history was complex and he had numerous serious co-morbidities, the subsequent rupture of his AAA meant that he died earlier than he otherwise might. For these reasons, whilst it is my view that the management of Mr Howlett's general medical conditions was a very good standard, when viewed holistically, the quality of Mr Howlett's supervision, treatment and care was unacceptable.[129]

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[126] Exhibit 1, Vol. 1, Tab 14, Report - Dr R Bond, p2
[127] Exhibit 1, Vol. 1, Tab 14, Report - Dr R Bond, p2 and ts 24.08.23 (Bond), pp12-15
[128] See also: ts 24.08.23 (Rowland), p35
[129] See also: ts 24.08.23 (Rowland), p45

CONCLUSION

96. Mr Howlett was 83 years of age when he died following the rupture of his AAA. Although the AAA had been identified five months earlier, it was not managed in a timely manner.

97. This is clearly unacceptable, and since Mr Howlett's death DOJ have made some changes in an attempt to mitigate the risk of this occurring again. For that reason, I have decided it is not necessary for me to make recommendations in this case, but as I noted earlier:

> I would **strongly** urge DOJ to carefully consider the suggestions in the FSH Report about potential improvements to imaging services offered to prisoners,[130] and to actively explore the possibilities that these suggested options may offer.

98. As I did at the conclusion of the inquest, I wish to again convey to Mr Howlett's family, on behalf of the Court, my sincere condolences for their loss.[131]

MAG Jenkin
Coroner
30 August 2023

[130] Exhibit 1, Vol. 1, Tab 17, FSH Report (21.08.23), pp5-6
[131] ts 24.08.23, p50