JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	23 MAY 2023
DELIVERED	**:**	23 NOVEMBER 2023
FILE NO/S	**:**	CORC 300 of 2022
DECEASED	**:**	STINSON, BRADLEY JAMES RAYMOND

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sergeant Alan Becker assisted the Coroner
Ms A Kildea (State Solicitor's Office) appeared on behalf of the Department of Justice

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

AMENDED RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Bradley James Raymond STINSON*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 23 May 2023, find that the identity of the deceased person was* ***Bradley James Raymond STINSON*** *and that death occurred on 2 February 2022 at St John of God Hospital, Midland, from cardiac arrhythmia in a man with arteriosclerotic cardiovascular disease, pulmonary thromboembolism and metastatic cancer of the pancreas in the following circumstances:*

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LIST OF ABBREVIATIONS

Abbreviation	Meaning
Acacia	Acacia Prison
Briginshaw principle	The accepted standard of proof the Court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
COPP 6.2	Commissioner's Operating Policy and Procedure 6.2: Prisoners with a Terminal Medical Condition
COPP 12.3	Commissioner's Operating Policy and Procedure 12.3: Conducting Escorts
CPR	cardiopulmonary resuscitation
CT scan	computerised tomography scan
the Department	the Department of Justice
EMRA	External Movement Risk Assessment
Hakea	Hakea Prison
the Minister	the Minister for Corrective Services
Serco	Serco Australia Pty Ltd
SJOGMH	St. John of God Midland Hospital
Stage 3	The third stage cited in the Department's terminally ill register which means the prisoner is expected to die within three months
Stage 4	The fourth stage cited in the Department's terminally ill register which means the prisoner's death is expected imminently

INTRODUCTION

Alcohol and tobacco seem to go together: Drinkers smoke and smokers drink. In addition, heavier drinkers tend to be heavier smokers.
- Saul Shiffman and Mark Balabanis

1 Bradley James Raymond Stinson (Mr Stinson) died on 2 February 2022 at St John of God Midland Hospital (SJOGMH). He died from cardiac arrhythmia in the presence of arteriosclerotic cardiovascular disease, pulmonary thromboembolism and metastatic cancer of the pancreas. Mr Stinson was 66 years old.

2 At the time of his death, Mr Stinson was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (the Department).[1]

3 Accordingly, immediately before his death, Mr Stinson was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[2] In such circumstances, a coronial inquest is mandatory.[3]

4 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.[4]

5 I held an inquest into Mr Stinson's death at Perth on 23 May 2023. Mr Thomas Perrin (Mr Perrin), an acting senior review officer with the Department, gave oral evidence at the inquest.

6 Documentary evidence at the inquest comprised of one volume of the brief, which was tendered as exhibit 1 at the commencement of the inquest.

7 After the inquest had concluded and at my direction, counsel assisting sought some additional information from the Department and Serco Australia Pty Ltd (Serco)[5] regarding the restraints used on Mr Stinson at the time of his last hospital admission. The Court received a letter dated 16 June 2023 from David Hughes, Acting Director, Operational Policy, Compliance and Contracts at the Department, and an email dated 10 July 2023 from legal counsel at Serco. I have considered the contents of those documents in my finding.

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[1] *Prisons Act 1981* (WA) s 16
[2] *Coroners Act 1996* (WA) s 3 and s 22(1)(a)
[3] *Coroners Act 1996* (WA) s 25(3)
[4] *Coroners Act 1996* (WA) s 25 (3)
[5] Serco privately operates Acacia Prison under an agreement with the Department and is responsible for the prison's operational and maintenance services.

8 The inquest focused on the medical care provided to Mr Stinson, with an emphasis on the care provided to him regarding his pancreatic cancer. It also examined the use of restraints on Mr Stinson when he was transferred to SJOGMH on 22 January 2022.

9 In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a matter adverse in nature has been proven on the probabilities (the ***Briginshaw*** principle).

10 I am also mindful not to assert hindsight bias into my assessment of the actions taken by Mr Stinson's prison carers in their treatment of him. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[6]

MR STINSON

Background [7]

11 Mr Stinson was born on 25 June 1955 in Sydney. He had an unsettled childhood with his mother leaving the family when he was a toddler. As his father was unable to adequately care for Mr Stinson and his siblings, they were placed in State care.

12 Mr Stinson was educated to year 10 at high school, after which he held short term positions in various manual labour jobs before injuring his back. He was unable to work for a considerable time and developed an alcohol dependency during this period which was to become long-lasting.

13 Mr Stinson had a son and a daughter with his first wife, and a daughter to his second wife who he married in 1989. He moved to Perth at the end of 2004 and obtained a security guard's license. Mr Stinson subsequently worked as a security guard for Perth Racing for eight years before his arrest for the offence that led to his imprisonment.

[6] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

[7] Exhibit 1, Tab 7, Coronial Investigation Squad Notes – Background Information; Exhibit 1, Tab 9, Transcript of sentencing proceedings dated 9 December 2013

Circumstances of imprisonment [8]

14 On 18 December 2012, Mr Stinson was arrested and subsequently charged with the murder of a woman who he knew. It was alleged that the murder had occurred within 24 hours of his arrest.

15 After pleading guilty to the murder, Mr Stinson was sentenced in the Supreme Court of Western Australia, sitting in Perth, on 9 December 2013. He was sentenced to life imprisonment with a minimum parole period of 17 years. The sentence was backdated to 18 December 2012 to reflect the time Mr Stinson had spent on remand in police custody and in prison. Consequently, his earliest eligible date for release to parole was 17 December 2029. This was the only occasion he had been imprisoned.

Prison history [9]

16 Mr Stinson had the following prison placements and transfers with respect to the 9 years and 2 months he was in prison:

(i) Hakea Prison: 20 December 2012 – 16 January 2014 (392 days)
(ii) Acacia Prison: 16 January 2014 – 2 February 2022 (2,939 days)

17 On 16 January 2014, Mr Stinson was transferred to Acacia Prison (Acacia) from Hakea Prison (Hakea) to facilitate visits. He therefore spent most of his incarceration at Acacia.

18 During his imprisonment at Acacia, Mr Stinson maintained regular contact with family and friends through visits, telephone calls and letters. He was also employed at Acacia, predominantly working in the carpentry workshop area.

19 Mr Stinson was subjected to 38 drug and alcohol tests, all of which returned negative results.

20 The material before me demonstrated that Mr Stinson was a well-behaved prisoner who was not a management issue.

[8] Exhibit 1, Tab 8, Transcript of sentencing proceedings dated 9 December 2013; Exhibit 1, Tab 12, Review of Death in Custody dated February 2023
[9] Exhibit 1, Tab 12, Review of Death in Custody dated February 2023

OVERVIEW OF MR STINSON'S MEDICAL TREATMENT AND CARE IN PRISON [10]

At Hakea

21 At his admission into Hakea on 20 December 2012, Mr Stinson was medically assessed by a prison nurse. He stated he had a previous history of hypercholesterolemia (high cholesterol in the bloodstream) for which he was prescribed cholesterol medication, which he had not taken. He also stated having chronic back pain, for which he had had previous surgery. In addition, Mr Stinson said he was a heavy smoker of cigarettes, consuming 50 cigarettes a day. He also reported a high alcohol dependency which involved consuming 24 cans of beer, four days a week.

22 The prison doctor at Hakea assessed Mr Stinson on 3 January 2013. Mr Stinson stated his brother had heart disease, and his father and mother were both smokers who had had lung cancer (his father) and throat cancer (his mother). Upon examination, the prison doctor noted that Mr Stinson had a large liver, reduced air entry to the left side of his chest and normal blood pressure. A chest x-ray was arranged, together with blood tests regarding Mr Stinson's cholesterol levels. Prescriptions were provided for his high cholesterol, pain relief and medication for constipation.

23 During his time at Hakea, Mr Stinson underwent regular physiotherapy sessions for his chronic lower back pain, received treatment for bronchitis and chest infections, spirometry tests (to measure the level and rate of air being inhaled and exhaled) and dental care.

At Acacia from 2014 to 2020

24 For the eight years he was imprisoned at Acacia, Mr Stinson underwent regular health assessments and blood tests. He was also offered annual immunisations against influenzas. During this period, he was treated for a number of additional medical conditions.

25 In 2015, Mr Stinson was diagnosed with epididymo-orchitis (testicle inflammation), left varicocele (enlarged veins in the scrotum) and hydrocoele (swelling in the scrotum).

26 In 2016, he was diagnosed with chronic obstructive pulmonary disease (COPD) for which he was treated with inhalers. It was also found that he had

[10] Exhibit 1, Tab 11.1, Acacia's Health Services Summary into the Death in Custody dated 24 March 2023; Exhibit 1, Tab 11.2, Department's Health Services Summary into the Death in Custody dated 6 May 2023; the Department's Electronic Health Online (EcHO) medical records for Mr Stinson

hypertension (high blood pressure), and he was prescribed the medication, ramipril.

27 In 2018, a gastroscopy diagnosed a bleeding duodenal ulcer which was treated with pantoprazole.

28 In November 2018, Mr Stinson was diagnosed with mild coronary artery disease and non-ST-elevation myocardial infarction (NSTEMI).[11] For these conditions, Mr Stinson was treated with aspirin and bisoprolol.

29 Further medical conditions were diagnosed in November 2018. These included haemorrhoids and colonic polyps that were found after a colonoscopy, a fatty liver that was diagnosed from an ultrasound and pulmonary nodules which remained stable after repeat imaging.

30 In September 2020, Mr Stinson developed polymyalgia rheumatica which is an inflammatory disorder causing muscle pain and stiffness, particularly in the shoulders and hips. He was treated with steroids for this condition.

At Acacia from 2021

31 On 15 January 2021, Mr Stinson was reviewed for the purpose of updating his cardiac and respiratory care plans. At the time, he was noted to be doing reasonably well.

32 On 17 February 2021, he developed a chest infection and was prescribed antibiotics.

33 On 16 March 2021, Mr Stinson had a steroid injection for his ongoing left shoulder pain caused by polymyalgia rheumatica.

34 On 16 July 2021, Mr Stinson had a telehealth review with the urology team from Fiona Stanley Hospital regarding his ongoing testicular pain and hydrocoele. Arrangements were made for an ultrasound and elective surgery to treat the hydrocoele. This surgery was planned at Fremantle Hospital in approximately three months.

35 On 10 September 2021, Mr Stinson was prescribed a course of antibiotics for another chest infection.

36 On 9 November 2021, Mr Stinson complained to a prison nurse that he had been feeling bloated and was having difficulties opening his bowels. He was reviewed by a prison doctor the next day who noted that

[11] NSTEMI is a partial blockage of a coronary artery that causes reduced blood flow to the heart muscle.

Mr Stinson's abdominal examination was normal. He was diagnosed with constipation and prescribed enemas and laxatives.

37 On 25 November 2021, a prison nurse noted that Mr Stinson was still experiencing chronic constipation and abdominal discomfort.

38 On 1 December 2021, Mr Stinson had the previously arranged surgery for his hydrocoele at Fremantle Hospital. He was discharged from hospital the same day. When he returned to Acacia, Mr Stinson was placed in the medical centre. The following day, he was reported to be opening his bowels with the assistance of laxatives.

39 At 10.20 am on 5 December 2021, a Code Blue medical emergency was called after Mr Stinson developed severe abdominal pain, sweating and dry retching. His abdomen was tender, and the prison doctor recommended he be given enemas.

40 Mr Stinson was reviewed several hours later by the prison doctor and was still dry retching, panting, in pain and struggling to stand. He was administered injections of pain-relief and anti-nausea medications and appeared to be improving. He was monitored overnight.

41 However, by the following morning, Mr Stinson was still experiencing ongoing pain and the decision was made to transfer him to the emergency department at SJOGMH. He was subsequently admitted to a ward.

42 Mr Stinson's initial differential diagnoses were acute cholecystitis (inflammation of the gallbladder) or a perforated duodenal ulcer. However, the test results from blood taken on 6 December 2021 showed raised cancer markers and a CT scan was arranged for the next day. That scan showed a primary pancreatic cancer with metastases[12] in the liver and lungs. A subsequent liver biopsy confirmed adenocarcinoma of the pancreas.

43 Mr Stinson was commenced on tapentadol and paracetamol to manage his pain and he was discharged from SJOGMH on 9 December 2021. He was initially placed in the medical centre at Acacia; however, he requested a return to his cell in November Block and that was subsequently arranged.

44 On 15 December 2021, the prison doctor advised Mr Stinson of the severity of the cancer diagnosis and that he likely had less than a year to live.

45 Mr Stinson continued to be reviewed regularly to monitor his pain and nausea, and his medications were adjusted accordingly. Although there were records

[12] The development of secondary malignant growths at a distance from the cancer's primary site

regarding complaints from Mr Stinson as to the times that he received his medications, these issues appear to have been resolved in a timely manner.

46 On 12 January 2022, Mr Stinson attended an outpatient appointment with a consultant at SJOGMH. He was informed that he had an aggressive cancer of the pancreas that had already spread which was not amenable to surgical removal. He was given a prognosis of six to nine months, with the possibility of two or three years if he had chemotherapy.

47 On 19 January 2022, Mr Stinson had another outpatient appointment with an oncologist who discussed the option of chemotherapy to prolong his life.

48 On 20 January 2022, Mr Stinson decided he would not commence with chemotherapy. He had also developed difficulty swallowing and oral thrush, which were treated with antifungal medication.

EVENTS LEADING TO MR STINSON'S DEATH [13]

49 On 22 January 2022, a prison nurse completed a welfare check for Mr Stinson and noted that he was experiencing severe nausea and vomiting associated with generalised abdominal pain. He was given ondansetron and tramadol.

50 When his pain did not improve, Mr Stinson was taken to the medical centre at Acacia for further assessment. Given the amount of pain he was experiencing, the decision was made to take Mr Stinson by ambulance to hospital. An ambulance subsequently attended Acacia and at 11.10 am, it left the prison to take Mr Stinson to SJOGMH.

51 Mr Stinson was admitted to SJOGMH and a CT scan showed significant progression of the intra-abdominal cancer and ascites (fluid in the abdomen). Blood tests showed a raised C-reactive protein (CRP) consist with an infection. Mr Stinson was prescribed intravenous antibiotics and a Goals of Patient Care form was completed stating he was not for CPR.

52 On 24 January 2022, a drain was inserted into Mr Stinson's abdomen to remove the ascitic fluid and he was given albumin infusions. Due to ongoing difficulties swallowing, he declined oral medications. Following a review by the palliative care team, Mr Stinson was commenced on steroids, anti-nausea medications and oxycodone, a strong pain-relief medication.

[13] Exhibit 1, Tab 11.1, Acacia's Health Services Summary into the Death in Custody dated 24 March 2023; St John Of God Midland Hospital medical records

53 Although there were plans to have Mr Stinson discharged to the infirmary at Casuarina Prison,[14] he remained at SJOGMH due to no bed availability at the infirmary.

54 On 27 January 2022, a plan was made to discharge Mr Stinson to Acacia. However, on 28 January 2022, his condition deteriorated rapidly as he began developing increasingly severe pain requiring continuous subcutaneous morphine.

55 Mr Stinson remained at SJOGMH on palliative care medications which include hydromorphone, midazolam and haloperidol.

56 On 1 February 2022, Mr Stinson was visited by his wife and daughter. By this stage his physical deterioration was significant, and he was extremely weak.

57 At 3.00 am on 2 February 2022, Mr Stinson was certified by a doctor as having died.[15]

CAUSE AND MANNER OF DEATH [16]

58 On 15 February 2022, Dr Clive Cooke (Dr Cooke), a forensic pathologist, conducted a post mortem examination of Mr Stinson's body.

59 The post mortem examination found that there was cancer at the end of the pancreas, with metastases in the liver, lungs and abdominal cavity. There was increased fluid in the chest and abdomen. Mr Stinson's heart was enlarged, with arteriosclerotic hardening of the arteries. There was congestion of the lungs, with possible blood clots in the lower parts of both lungs.

60 Subsequent microscopic examination confirmed the above changes, including the presence of small thromboemboli in the lower parts of the lungs. A specialist neuropathology examination of Mr Stinson's brain found no significant abnormalities. Microbiology testing of lung tissues showed mixed bacteria but did not identify a specific infection.

61 A toxicology analysis detected the presence of medications consistent with Mr Stinson's palliative care at SJOGMH.

62 At the conclusion of the post mortem examination, Dr Cooke expressed the opinion that the cause of Mr Stinson's death was: "*Cardiac arrhythmia*

[14] Casuarina Prison was the only prison housing male inmates that had an infirmary.
[15] Exhibit 1, Tab 4, Death in Hospital Form dated 2 February 2022
[16] Exhibit 1, Tabs 5.1-5.3, Supplementary Post Mortem Report, Full Post Mortem Report and Interim Post Mortem Report dated 15 February 2022; Exhibit 1, Tab 6, Toxicology Report dated 14 April 2022

in a man with arteriosclerotic cardiovascular disease, pulmonary thromboembolism and metastatic cancer of the pancreas."

63 I accept and adopt that conclusion expressed by Dr Cooke. Accordingly, I find that Mr Stinson's death occurred by way of natural causes.

ISSUES RAISED BY THE EVIDENCE

Mr Stinson's management on the terminally ill register

64 Prisoners with a terminal illness[17] are managed in accordance with the Department's policy titled, "*Commissioner's Operating Policy and Procedure 6.2: Prisoners with a Terminal Medical Condition*" (COPP 6.2). Once a prisoner is identified as having a terminal illness they are placed on a register and a note is made in the terminally ill module of the Department's Total Offender Management Solution (TOMS).[18]

65 A prisoner with a terminal illness is identified as Stage 1, 2, 3 or 4 depending on their expected lifespan. On 8 December 2021, following his cancer diagnosis, Mr Stinson was identified as a Stage 2 terminally ill prisoner.[19] On 6 January 2022, following the further progression of his cancer, Mr Stinson was elevated to Stage 3.[20] Prisoners at Stage 3 are expected to die within three months. After it was determined that Mr Stinson would remain in hospital with palliative care, he was escalated to Stage 4 on the terminally ill register. This took place on 28 January 2022.[21] For prisoners at Stage 4, death is expected imminently.

66 An outcome of a classification at either Stage 3 or Stage 4 is that a prisoner can be considered for release on compassionate grounds by the Governor before the expiration of the term of their imprisonment (i.e. the grant of a pardon in the exercise of the Royal Prerogative of Mercy).

67 COPP 6.2 requires that certain tasks must be undertaken by the Department once a prisoner is classified at Stage 3 or Stage 4. One of those tasks is that a briefing note is prepared for the Minister for Corrective Services (the Minister) which is to notify the Minister of the prisoner's medical condition and life expectancy, the likelihood of the prisoner dying in custody, and any other relevant information. For prisoners classified at Stage 3, this briefing

[17] A terminal illness is defined as one or more conditions that on their own, or as a group, significantly increases the likelihood of a prisoner's death.
[18] TOMS is the computer system that the Department uses for prisoner management.
[19] Exhibit 1, Tab 11.1, Acacia's Health Services Summary into the Death in Custody dated 24 March 2023, p.40
[20] Exhibit 1, Tab 11.1, Acacia's Health Services Summary into the Death in Custody dated 24 March 2023, p.46; Exhibit 1, Tab 12.12, Terminally Ill Health Advice dated 6 January 2022
[21] Exhibit 1, Tab 11.1, Acacia's Health Services Summary into the Death in Custody dated 24 March 2023, p.53; Exhibit 1, Tab 12.17, Terminally Ill Health Advice dated 28 January 2022

note is to also contain a recommendation as to whether the grant of a pardon should be exercised. This briefing note is to be prepared by the Department's Director, Sentence Management, within seven working days of the classification.

68 That briefing note was prepared with a recommendation that the grant of a pardon through a Royal Prerogative of Mercy is not exercised.[22]

69 A prisoner who is classified at Stage 4 is to have a briefing note prepared within three working days of the classification. Although a briefing note had been completed for Mr Stinson regarding his Stage 4 classification, it had not been forwarded to the Minister prior to his death. Once again, the briefing note did not recommend that there be an exercise of the Royal Prerogative of Mercy.[23]

The use of restraints on Mr Stinson for his final hospital admission.

70 If a prisoner is transferred to a hospital, the provisions of *Commissioner's Operating Policy and Procedure 12.3: Conducting Escorts* (COPP 12.3) are to apply. [24]

71 Whenever a prisoner is being taken to an external appointment (including a hospital), a risk assessment document known as an "*External Movement Risk Assessment*" (EMRA) is completed.

72 Section 5.3 of COPP 12.3 is titled: "*Reasons prohibiting the use of restraints*". Relevant to Mr Stinson's transfer to SJOGMH on 22 January 2022, this section reads:[25]

> 5.3.1
> Prisoners with significant medical and/or mobility issues shall not be placed in restraints unless there is a requirement following the completion of an EMRA … by prison staff and approval by the Superintendent/OIC …
>
> Particular consideration shall be given, but not limited, to the following cohorts:
> …
> (b) prisoners who are terminally ill
> (c) prisoners who are elderly and frail
> (d) prisoners with significant mobility issues
> …
> 5.3.2
> Where relevant, risk assessments shall be conducted in consultation with medical staff.

[22] Exhibit 1, Tab 12.14, Email from the Prisoner Review Board dated 15 February 2022
[23] Exhibit 1, Tab 12.14, Email from the Prisoner Review Board dated 15 February 2022
[24] Exhibit 1, Tab 15, COPP 12.3 - Conducting Escorts version 3.0
[25] Exhibit 1, Tab 15, COPP 12.3 - Conducting Escorts version 3.0, p.8

73 It is therefore abundantly clear that the Department's restraints policy[26] specified that no restraints were to be applied to Mr Stinson unless there was an adverse EMRA stipulating restraints were necessary.

74 In my view, the evidence clearly demonstrated that Mr Stinson did not have to be restrained, either during his transfer to SJOGMH or during his subsequent admission there. That is because he had already been classified as a Stage 3 terminally ill prisoner, he was frail and 66 years old, and, given his severe abdominal pain, he clearly had significant mobility issues. On the morning of 22 January 2022, the gravity of his abdominal pain necessitated the use of Acacia's internal ambulance to convey him to the medical centre.[27]

75 An EMRA requires a number of questions to be answered. Under the heading "*Medical Movement Assessment*", the following questions appear:[28]

> 3.4
> Are there any other known medical objections to the use of restraints? (e.g. psychiatric/cognitive/unconscious/terminally ill/elderly/frail/significant mobility issues/significant injury/experiencing childbirth or termination, etc.).
> 3.5
> Have Health Services be consulted?

76 It is bewildering that in Mr Stinson's EMRA, question 3.4 was answered, "*No*" when it would seem very obvious that the answer should have been, "*Yes*". Furthermore, although section 5.3.2 of the COPP 12.3 specifies that, if relevant, risk assessments should be conducted in consultation with prison medical staff, question 3.5 was also answered, "*No*."[29]

77 There is no other information in Mr Stinson's EMRA that would warrant the use of restraints. Under the heading "*Security Movement Assessment*", it is recorded that, "*No records exist*" regarding any escape history by Mr Stinson. The question, "*Are there any known issues which may indicate a significant desire to escape?*" is answered, "*No*".[30] In addition, the answer is also "*No*" to the question, "*Is the prisoner a risk to staff?*".[31]

78 Despite the absence of any recorded evidence justifying an adverse EMRA for Mr Stinson, under the section headed "*Final Assessment*", question 4.1 asks, "*Restraints required?"* and is answered, "*Yes*". No explanation is given for this response. The restraints that were to be used on Mr Stinson for his

[26] Although Mr Stinson was imprisoned at Acacia, the policy and procedures for the Department apply: ts 23.5.23 (Mr Perrin), p.6
[27] Exhibit 1, Tab 12.15, Acacia Prison Incident Report Minutes, p.1
[28] Exhibit 1, Tab 15.3, External Movement Risk Assessment dated 22 January 2022, p.2
[29] Exhibit 1, Tab 15.3, External Movement Risk Assessment dated 22 January 2022, p.2
[30] Exhibit 1, Tab 15.3, External Movement Risk Assessment dated 22 January 2022, p.1
[31] Exhibit 1, Tab 15.3, External Movement Risk Assessment dated 22 January 2022, p.2

transfer to SJOGMH were listed as "*Mechanical restrains. Leg chain. Flexi cuff*."[32] It defies not only the restraints policy but also logic and humanity that a terminally ill, 66-year-old frail man with significant mobility issues and no history of any attempts of escaping or being a risk to staff should be restrained in this manner.

79 Once Mr Stinson had been admitted to SJOGMH, his supervision became the responsibility of Ventia, the company that is used for what is called "hospital sits" of prisoners admitted to hospital. Unfortunately, the incorrect application of the Department's restraints policy for Mr Stinson continued once he was placed in the care of Ventia officers. The document titled "*Hospital Admittance Advice – Prisoner*" that had been finalised by the designated superintendent/officer in charge at Acacia stated that handcuffs and security chain link were to be used to restrain Mr Stinson during his hospital admission.[33] This meant he was subjected to "*the standard restraint regime.*"[34]

80 Ventia records dated 28 January 2022 indicated treating doctors had advised the "hospital sit" officers that end-of-life palliative care for Mr Stinson was to commence as he was not expected to survive. At 5.22 pm that day, doctors at SJOGMH requested the removal of Mr Stinson's restraints. At 6.10 pm, approval was received from Acacia for Mr Stinson's restraints to be removed.[35]

81 The use of restraints on Mr Stinson caused me some considerable disquiet following the inquest. It was the reason why I sought further information through counsel assisting from the Department and Serco. Amongst the questions asked of Serco was: "*Why the EMRA specified, at point 4, that Mr Stinson was to be restrained in the standard manner even though he was classified as Stage 3 terminally ill*?"

82 The following answer was provided:[36]

> The Operations Manager does not have access to the terminally ill register therefore would not know whether prisoner Stinson was on this list therefore would default to the standard application of restraints. Although terminal illness is a consideration in the application of the restraints, it is not an automatic exclusion.

[32] Exhibit 1, Tab 16.3, External Risk Movement Assessment dated 22 January 2022, p.3
[33] Exhibit 1, Tab 16.2, Hospital Admittance Advice – Prisoner, p.2
[34] Exhibit 1, Tab 12, Review of Death in Custody dated February 2023, p.17
[35] Exhibit 1, Tab 12, Review of Death in Custody dated February 2023, p.18
[36] Email from Serco's legal counsel to counsel assisting dated 10 July 2023

83 This answer only elevated my unease about this sorry state of affairs for two reasons. First, I find it extraordinary that the Operations Manager responsible for completing the EMRA does not know if a prisoner requiring a transfer to a hospital has been classified as terminally ill. How then would an Operations Manager know whether section 5.3.1 of COPP 12.3 applies? That section makes it abundantly clear that the use of restraints are prohibited for prisoners who are terminally ill with significant medical issues, unless there has been an adverse risk assessment completed.

84 It is therefore incumbent upon the Operations Manager to find out the status of a seriously ill prisoner who is being taken to hospital. Should that person not have access to the terminally ill module on TOMS (which, I must say, makes no sense), it would be very easy for that person to find out by contacting a prison health service provider. As a matter of fact, the question at 3.5 of the EMRA ought to remind the Operations Manager to undertake precisely that task.

85 The second reason for my unease concerns the complete misunderstanding of the requirements of COPP 12.3 that is evident from this part of Serco's answer: "*Although terminal illness is a consideration in the application of restraints, it is not an automatic exclusion*".

86 At the risk of repeating myself and/or stating the obvious, section 5.3.1 of COPP 12.3 makes it abundantly clear that a Stage 3 or Stage 4 terminal illness classification prohibits (in the absence of an adverse EMRA) the application of restraints as, by definition, a prisoner with either of these classifications must have a "*significant medical issue*". That is because there is an expectation the prisoner will either die from their existing terminal illness within three months (Stage 3) or imminently (Stage 4). It would be a rare case for a prisoner to get a more significant medical issue than either of those prognoses.

87 The intent of section 5.3.1 of COPP 12.3 is clear: the use of restraints on prisoners with significant medical and/or mobility issues will not take place unless an EMRA deems otherwise. However, if an EMRA concludes that restraints are required, there must be cogent reasons for that decision. It is entirely unsatisfactory for an EMRA to state restraints are required without recording the justification for that decision. Sadly, as demonstrated below, that is precisely what happened in Mr Stinson's case.

88 After the inquest, Serco was also asked by counsel assisting: "*If a risk assessment was conducted and concluded that restraints were required, is*

that decision/rationale for that decision recorded anywhere and if not, why not?".

89 The answer provided by Serco was:[37]

> No - There is no requirement, aside from the EMRA, to record restraint rationale for the application of restraints. Rationale/commentary would only be recorded if the application of restraints were not required.

90 Once again, this answer demonstrates a significant misunderstanding of what is required when completing an EMRA for a prisoner who falls within section 5.3.1 of COPP 12.3. I feel it is almost trite to again state the obvious; however, I will.

91 If the general or usual practice (in this case, the prohibition of restraints on prisoners with significant medical issues) is not to be applied, then the rationale for that decision must be explained in the interests of transparency and fairness. That is because there is now an exception to what the usual practice requires. There is no need for an EMRA that is following the usual practice to set out the reasons why it is following that usual practice.

92 Applying the ***Briginshaw*** principle and having carefully considered all the relevant material and Serco's submissions, I am satisfied that the use of restraints upon Mr Stinson during his transfer to, and admission at, SJOGMH from 22 - 28 January 2022 was completely inappropriate and failed to comply with the relevant restraint policies and procedures. Because of Acacia's error in having Mr Stinson restrained when he was handed over into the care of Ventia on 22 January 2022, I am satisfied that Serco must also be held responsible for the continued inappropriate use of restraints after Mr Stinson had been admitted to SJOGMH on that date.

93 The incorrect application of the Department's restraints policy with respect to terminally ill prisoners being admitted to and then dying in hospital has featured in a number of deaths in custody inquests held this year. The prisons that have featured at those inquests, including Acacia, have been the subject of adverse comments from the presiding coroners.

94 I was the coroner in two of these inquests. The first was the *Inquest into the death of* ***Edward Ivan Africh*** [2023] WACOR 14 (delivered 17 April 2023) and the second was the *Inquest into the death of* ***Errol Warren Bartlett-Torr*** [2023] WACOR 11 (delivered 22 May 2023). Since those two inquests, Coroner Jenkin has handed down his findings in the *Inquest into the death of* ***Frank Kenneth Major*** [2023] WACOR 23 (delivered 25 July 2023) and the

[37] Email from Serco's legal counsel to counsel assisting dated 10 July 2023

Inquest into the death of ***John Henry Waterfall*** [2023] WACOR 32 (delivered 21 September 2023). The deaths of these four prisoners occurred between February 2019 and December 2021.

95 The Department and Serco should now be fully aware of the Court's insistence that COPP 12.3 is complied with regarding prisoners who are admitted to hospital because of their terminal illness and who subsequently die in hospital after receiving palliative care. In those situations, it would be rare for such prisoners to be restrained.

96 As a result of the feedback received following the findings from these four inquests, I am satisfied of the efforts made by the Department to increase the awareness amongst custodial staff of section 5.3 of COPP 12.3 when terminally ill prisoners are being transferred and then admitted to hospital. I have also taken some comfort from the following passages in the letter dated 16 June 2023 provided to the Court from the Department's David Hughes:[38]

> The Department is currently considering opportunities to enhance the risk assessment to ensure that:
>
> - officers consider whether a prisoner has a significant medical condition/mobility issue such that they should not be restrained unless otherwise determined.
> - where it is determined that restraints are required, a justification/rationale for the use of such restraints is documented within the risk assessment.
> - The inclusion of "Palliative Care" in the drop-down list as a reason for the transfer.
> - The inclusion of a checkbox asking if the prisoner is expected to return to the prison.
>
> The Department has also directed Ventia (the Contractor) to review their Standard Operating Procedures and associated risk assessments form to provide for specific consideration of whether each prisoner has a significant medical condition/mobility issue within the meaning of 5.3.1 in COPP 12.3 and, if so, to provide details of any decision to apply restraints within their prospective risk assessment.

97 In those circumstances, I have determined it is not necessary to make any further recommendations beyond those that have already been made in the inquests I have cited above.

98 Instead, I will simply remind Serco, the Department and Ventia of two sentences that appear in COPP 12.3. The first of these sentences are the provisions in section 3.1.12 of the "*Guiding Principles for Corrections in*

[38] Letter from David Hughes, Acting Director, Operational Policy, Compliance and Contracts, pp.1-2

Australia, 2018" that is proudly quoted on the front page of COPP 12.3: "*Transport of persons in custody is conducted in a safe and humane manner, taking into account the dignity of the person being transported*."[39] The second sentence appears under the heading "*Policy*" within COPP 12.3: "*Prisoners are transported in a safe, humane and efficient manner that meets their individual needs, ensures self-respect and privacy as required …*".[40]

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF MR STINSON

99 Mr Stinson was already 57 years old when he commenced his term of imprisonment. He had a very long history of heavy tobacco smoking and alcohol dependency. There is every prospect one or both of these choices contributed to his pancreatic cancer.[41]

100 Not unexpectedly, Mr Stinson's health continued to deteriorate when he was in prison, as would be expected for a person of his age and history.[42]

101 I am satisfied that during the lengthy time Mr Stinson was imprisoned he received comprehensive and appropriately coordinated multi-disciplinary care. This included the management and monitoring of his existing and new health conditions as they developed.

102 As to the timeframe from the first likely symptoms of his pancreatic cancer to its diagnosis, I accept it may have been possible to make the diagnosis several weeks earlier. Nevertheless, I agree with the Department's assessment that, "*even had this occurred, the outcome is unlikely to have changed, given the stage of his disease and the limited treatment options.*"[43] Although earlier options for more aggressive symptom management may have improved Mr Stinson's well-being before his death,[44] there was every likelihood he would not have availed himself of these options.

103 Accordingly, I am satisfied that the standard of the medical supervision, treatment and care that Mr Stinson received whilst he was in custody, including the care and treatment he received as a hospital inpatient and outpatient, was appropriate.

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[39] Exhibit 1, Tab 15, COPP 12.3 - Conducting Escorts version 3.0, p.1
[40] Exhibit 1, Tab 15, COPP 12.3 - Conducting Escorts version 3.0, p.4
[41] Cancer of the pancreas is one of 16 cancers that smokers are at risk of getting: cancercouncil.com.au/news/there-are-16-cancers-that-can-be-caused-by-smoking/. There have been recent studies showing that alcohol consumption is associated with increased risk of pancreatic cancers: http://www.cancer.gov/about-cancer/causes-prevention/risk/alcohol/alcohol-fact-sheet
[42] Exhibit 1, Tab 11.2, Department's Health Services Summary into the Death in Custody dated 6 May 2023, p.8
[43] Exhibit 1, Tab 11.2, Department's Health Services Summary into the Death in Custody dated 6 May 2023, p.8
[44] Exhibit 1, Tab 11.2, Department's Health Services Summary into the Death in Custody dated 6 May 2023, p.8

104 However, as I have already outlined above, I am satisfied that the use of restraints upon Mr Stinson during his transfer to, and final admission at, SJOGMH was inappropriate and failed to comply with the relevant restraint policies and procedures.

CONCLUSION

105 Mr Stinson had been in custody since December 2012 and his earliest eligible date for release on parole was not until 17 December 2029. He was at Acacia for nearly 90% of the time he was imprisoned.

106 In addition to his pre-existing health conditions, Mr Stinson acquired a number of additional conditions that required management and various medications from prison health service providers.

107 In December 2021, Mr Stinson was diagnosed with an aggressive form of pancreatic cancer after a relatively short history of abdominal pain. Unfortunately, at the time of diagnosis, the cancer had already spread to Mr Stinson's liver and lungs and there was no treatment available to provide a cure.

108 The symptoms of pancreatic cancer are often specific, and it tends to be one of the most aggressive and least treatable cancers. It therefore usually has a very poor prognosis. Mr Stinson was offered chemotherapy as an option to potentially prolong his life; however, he chose to be managed palliatively. That palliative care was provided to Mr Stinson when he was in hospital and his wife and daughter were able to visit him shortly before he died.

109 As outlined above, I was satisfied with the standard of medical care provided to Mr Stinson by his health service providers in prison and at the hospitals he attended.

110 However, I was not satisfied with the restraining of Mr Stinson when he was transferred to SJOGMH from Acacia on 22 January 2022, and with the ongoing use of restraints when he was an inpatient at SJOGMH until 28 January 2022. I have found this use of restraints was entirely inappropriate and contrary to the Department's policies and procedures.

111 The unjustified use of restraints on terminally ill prisoners in the final days of their lives has already been the subject of four inquest findings in 2023 prior to this one. The Department, Serco and Ventia should now be very much aware of the Court's strident views regarding this inhumane practice. The Court has been assured that measures are now in place to ensure these mistakes are not repeated. I therefore expect that the misuse of restraints upon

terminally ill prisoners receiving treatment and/or end-of-life palliative care in a hospital setting will not happen again.

I extend my condolences to the family and loved ones of Mr Stinson.

P J Urquhart
Coroner
23 November 2023