Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 41/14

I, Sarah Helen Linton, Coroner, having investigated the death of ***Robert JAMES (aka Phillip Kevin LUCKIE and Robert John COUGHLIN)*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***31 October 2014*** *find that the identity of the deceased person was* ***Robert JAMES*** *and that death occurred on* ***1 February 2013*** *at* ***Royal Perth Hospital*** *the cause of death being* ***early bronchopneumonia in a man receiving palliative medical care for liver failure due to cirrhosis*** *in the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner
Ms G Bailey (State Solicitor's Office) appearing on behalf of Department of Corrective Services

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INTRODUCTION

1. Robert James (the deceased) died on 1 February 2013 at Royal Perth Hospital after he became terminally ill while a sentenced prisoner at Casuarina Prison.

2. As the deceased was a prisoner under the *Prisons Act 1981* (WA) at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1]

3. I held an inquest at the Perth Coroner's Court on 31 October 2014.

4. The documentary evidence included two comprehensive reports of the death prepared independently by the Western Australia Police and by the Department of Corrective Services (the Department), together comprising three volumes.[2] The authors of both reports were also called as witnesses at the inquest.

5. The inquest focused primarily on the care provided to the deceased while a prisoner, both within the custodial environment and while admitted at hospital.

THE DECEASED

6. The deceased was born on 31 October 1968 in Perth, Western Australia.[3] He was named Robert John Coughlin at birth. During the course of his life he legally changed his name on several occasions. His last name change was to Robert James on 27 November 2009[4] and that is the name under which he was last sentenced.[5] However, it seems he was known in prison as Phillip Kevin Luckie, his previous

[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibits 1 – 3.
[3] Exhibit 1, Tab 1.
[4] Exhibit 1, Tab 5; Exhibit 3, Tab 1, Change of Name Certificated dated 27 November 2009.
[5] Exhibit 1, Tab 14.

legally registered name, and that is the name used for him while being treated as a patient before his death.[6]

7. The deceased was the second youngest of six children and was raised by his mother on her own. Together with his siblings, the deceased was placed into care for two periods during his childhood when his mother could not care for him.[7]

8. Due to his unstable childhood, the deceased experienced behavioural problems as a child. He became involved in petty offending and drug use at an early age, which eventually led to more serious offending resulting in periods of juvenile detention.[8]

9. After completing Year 10, the deceased left school with no formal qualifications, skills or training.[9] He had a minimal work history after leaving school.

10. The deceased remained single throughout his life and did not have children.[10] He was described by one of his siblings as a person with a kind heart and love for people but an inability to show it properly, which was attributed to the damage caused by his broken childhood.[11] His personal relationships suffered as a result.

11. Having started using marijuana at the age of 12 years, the deceased had an entrenched illicit drug habit by the time he was 16 years old.[12] He initially used a variety of drugs, including heroin and LSD, but eventually settled upon marijuana and amphetamines. By the time he came to be incarcerated in 2010 the deceased's amphetamine addiction was costing him up to $1000 per day, which he funded by committing property related offences.[13] He was also a heavy smoker of both

[6] Exhibit 1, Tab 2, 2.
[7] Exhibit 1, Tab 12.
[8] Exhibit 1, Tab 12 & Tab 20.
[9] Exhibit 1, Tab 2, 2.
[10] Exhibit 1, Tab 2, 2.
[11] Exhibit 1, Tab 12.
[12] Exhibit 1, Tab 12; Exhibit 2, Tab 4.2, PSR 3.9.2010, 1.
[13] Exhibit 2, Tab 4.2, PSR 3.9.2010, 2 - 3.

cigarettes and marijuana, and regularly binged on alcohol.[14]

12. Due to his entrenched drug addiction and resultant criminal offending, the deceased spent much of his adult life in prison.[15]

13. At the time of his death the deceased was serving a total sentence of seven years and six months' imprisonment that was backdated to commence on 21 October 2010.[16] He was, therefore, not eligible to be released on parole until 20 April 2016.[17]

THE DECEASED'S MEDICAL HISTORY

14. As noted above, the deceased was a long-term intravenous drug user. He was diagnosed with hepatitis C in his twenties, contracted from contaminated needle use, and it proved resistant to treatment.[18] He underwent treatment in 2005 but could not complete it as he developed thrombocytopenia (a blood disorder).[19]

15. As a result of the hepatitis C infection, the deceased developed cirrhosis of the liver and was suffering from that condition at the time he was imprisoned in 2010.[20]

16. Medical progress notes record a general deterioration in the deceased's health during this prison term. During the last period of incarceration prior to his death, he was transferred to hospital on 51 separate occasions for appointments, emergencies and planned admissions.[21]

[14] Exhibit 3, Tab 3 [5].
[15] Exhibit 1, Tab 20.
[16] Exhibit 1, Tab 14.
[17] Exhibit 2, Tab 4.
[18] Exhibit 1, Tab 2, 2; Exhibit 2, Tab 4, 3.
[19] Exhibit 3, Tab 3 [3], [7].
[20] Exhibit 1, Tab 2, 2; Exhibit 2, Tab 4, 3.
[21] Exhibit 2, Tab 4, 7.

17. By the end of 2011, the deceased had been diagnosed with the following conditions:[22]

- Hepatitis C virus infection;
- End-stage hepatitis C related cirrhosis;
- Chronic liver failure secondary to liver cirrhosis;
- Cholelithiasis (gallstones);
- Colonic Tubular adenoma;
- Hypothyroidism;
- Back injury (L5/S1 degenerative changes and T12/L1 disc herniation).

18. He was housed in the prison infirmary from November 2011 and his medical care continued to be provided by prison doctors and infirmary nursing staff in consultation with hospital specialists.[23]

19. On 6 December 2011, the deceased was registered as a *Phase 1* (high probability of death) prisoner on the Total Offender Management Systems' (TOMS) terminally ill prisoner module. His condition was regarded as chronic and progressive and he was given an estimated life expectancy of less than 12 months.[24]

20. The deceased was evaluated for the possibility of liver transplant at the Liver Transplant Clinic at Sir Charles Gairdner Hospital (SCGH) in 2012.[25] However, his prolonged history of intravenous drugs and cannabis use, with no period of abstinence external to prison, was a barrier to the deceased undergoing the liver transplant.[26] He was ultimately concluded to be unsuitable for liver transplantation due to his poor social circumstances.[27]

21. On 20 March 2012, the deceased was escalated to *Phase 2* (death imminent) when his condition

[22] Exhibit 3, Tab 3.
[23] Exhibit 2, Tab 4, 11 & 14.
[24] Exhibit 2, Tab 4, 3.
[25] Exhibit 3, Tab 3.
[26] Exhibit 3, Tab 3.
[27] Exhibit 1, Tab 13; Exhibit 2, Tab 4, 7; Exhibit 3, Tab 2, Inpatient Case Notes 24.1.13.

deteriorated, and taking into his account his recurrent non-compliance with medical therapy.[28]

22. After complaining of worsening abdominal pain over a five day period and demanding to be sent to hospital, the deceased was transferred via ambulance to Royal Perth Hospital (RPH) for an overnight stay on 10 April 2012. He was diagnosed with cholelithiasis (gallbladder disease) but was treated conservatively as the doctors noted there was a significant risk of decompensating liver cirrhosis if surgery (a cholecystectomy) was to be performed.[29] The deceased was discharged on 11 April 2012 with tests scheduled to monitor his bilirubin levels and an outpatient gastroenterology appointment was scheduled for two months' time.[30]

23. The following day the, deceased told a prison officer that he was frustrated with not receiving what he considered to be adequate medical attention and that he felt vulnerable and at risk of hurting himself. He was placed into a safe cell as a precautionary measure and put on the At Risk Management System (ARMS) with 12 hourly observations.[31] The following day he was reviewed by the Prisoner Risk Assessment Group and removed from ARMS but his mental health was monitored on an ongoing basis.[32]

24. He was readmitted on two further occasions in May and June 2012 for abdominal pain associated with his gallstone disease.[33]

25. Department of Corrective Services staff investigated the possibility of the deceased's release by way of Royal Prerogative of Mercy provisions, but a ministerial briefing to the Honourable Attorney-General submitted in May 2012 did not recommend his release in view of

[28] Exhibit 2, Tab 4, 3 & 8.
[29] Exhibit 3, Tab 2, RPH Discharge Summary 11.3.2012.
[30] Exhibit 3, Tab 2, RPH Discharge Summary 11.3.2012.
[31] Exhibit 2, Tab 4, 8.
[32] Exhibit 2, Tab 4, 8.
[33] Exhibit 2, Tab 4, 9; Exhibit 3, Tab 2 – Discharge Summaries.

his lack of community supports and the deceased's own disinterest in early release. The Attorney General later accepted that recommendation.[34]

26. As a result of his chronic liver failure the deceased was immunocompromised. This meant that the deceased had lost the ability to fight infection effectively and would deteriorate rapidly with minor infections.[35]

27. The deceased was admitted as an inpatient in hospital multiple times from late 2011 until just before his death with the diagnosis of Hepatic Encephalopathy.[36] It is a condition secondary to constipation caused by liver dysfunction and leads to toxins in the blood that can affect brain function.[37] It was a sign that the deceased's liver disease was progressing.

28. On 4 January 2013, he was admitted to SCGH following another bout of hepatic encephalopathy with increasing confusion. A CT scan was performed but no intracranial pathology was detected. He was discharged on 8 January 2013.[38]

29. The deceased was readmitted two days later following increased confusion and two falls, one resulting in loss of consciousness. They were believed to be related to his recurrent hepatic encephalopathy. He had a further fall while in hospital and another CT scan was performed, but again it detected no intracranial pathology. He was discharged from hospital on 13 January 2013.[39]

FINAL ADMISSION TO ROYAL PERTH HOSPITAL

30. In the last one and a half weeks before his death, it became apparent that the deceased's condition was

[34] Exhibit 2, Tab 4, 3 & 9.
[35] Exhibit 3, Tab 3 [4].
[36] Exhibit 1, Tab 13; Exhibit 3, Tab 3 [10].
[37] Exhibit 3, Tab 3 [11].
[38] Exhibit 1, Tab 13; Exhibit 2, Tab 4, 9.
[39] Exhibit 1, Tab 13; Exhibit 2, Tab 4, 9.

deteriorating further. He was becoming increasingly jaundiced and putting on weight.[40]

31. On 24 January 2013, the deceased was admitted to RPH with a serious infection that had tipped him into renal failure.[41] He remained in hospital until his death.[42]

32. The deceased was informed his prognosis was poor.[43] He requested that he be classified as "Not for Resuscitation" and, at the deceased's request, contact was made with his brother to notify his family. Eventually visit approvals were granted for his mother, stepfather and brothers.[44]

33. By 31 January 2013, the deceased's kidneys were failing and it was not expected that he would survive for more than a week.[45] He was commenced on palliative care.[46]

34. At his doctor's request, the deceased's restraints were removed on 1 February 2013.[47] His condition continued to deteriorate and he died that evening.[48]

CAUSE AND MANNER OF DEATH

35. On 5 February 2013, the Chief Forensic Pathologist, Dr C T Cooke, carried out a post mortem examination of the deceased. He noted signs of recent medical treatment and cirrhosis of the liver with features of liver failure. Congestion of the lungs was also noted, with possible early pneumonia.[49] At the conclusion of the initial examination, Dr Cooke was unable to determine a

[40] Exhibit 3, Tab 3 [11].
[41] Exhibit 2, Tab 4, 3 & 9.
[42] Exhibit 3, Tab 3 [14].
[43] Exhibit 3, Tab 2, Inpatient Case Notes 25.1.13.
[44] Exhibit 1, Tabs 6 & 25; Exhibit 2, Tab 4, 13; Exhibit 3, Tab 2, Inpatient Case Notes 30.1.13, Social Work.
[45] Exhibit 1, Tab 25.
[46] Exhibit 3, Tab 2, Inpatient Case Notes 31.1.13.
[47] Exhibit 1, Tab 25; Exhibit 2; Tab 4, 14.
[48] Exhibit 1, Tab 17; Exhibit 3, Tab 2, Inpatient Case Notes 1.2.13.
[49] Exhibit 1, Tab 8, Report to the Coroner

cause of death as he was awaiting the results of pending investigations.

36. After receiving the results of the investigations, including microscopic examination of the major body tissues, on 22 May 2013 Dr Cooke formed the opinion that the cause of death was early bronchopneumonia in a man receiving palliative medical care for liver failure due to cirrhosis.[50]

37. I accept and adopt Dr Cooke's conclusion as to the cause of death.

38. I find that the manner of death was natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

39. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

40. No issues arose in the evidence relevant to the quality of the *supervision* of the deceased from a security management perspective. In other words, it appears to me that no criticism can be made of the way in which the deceased's general imprisonment was managed.

41. The deceased suffered from hepatitis C, which had been present for many years. It appears he acquired the illness through the use of needles for the administration of illicit drugs. As time went by he developed a complication of hepatitis C, namely liver cirrhosis. This cirrhosis slowly progressed, leading ultimately to liver failure.

[50] Exhibit 1, Tab 8, Supplementary Report to the Coroner.

42. As the deceased's liver disease progressed and his condition deteriorated, he was placed on the Terminally Ill Offenders List and upgraded as his medical status changed. Some consideration was given to whether he might be suitable to be released early and it seems properly to have been concluded that he was not.

43. The deceased's medical management was coordinated by prison medical staff. As noted above, he saw numerous specialists and had numerous admissions to hospital while serving his sentence. He was assessed or the possibility of liver transplant but was not considered suitable. Without a transplant, it was inevitable that the deceased would die a premature death from his liver disease.

44. The deceased at times expressed some frustration about his medical treatment and showed some signs of experiencing psychological distress. This is not surprising given the recurrent pain he was experiencing and the limitations on what medical treatment could be provided to him for his various co-morbidities, as well as the knowledge that he was likely to die from his liver condition. However, there is no evidence that there was any failure on the part of the Department to provide medical treatment to the deceased when it was required.

45. I note the deceased's mother expressly indicated that she has no concerns in relation to his treatment while he was in prison or the health care provided to him.[51] Counsel assisting confirmed during the inquest that no other family member has raised any concern, nor has any independent witness.[52]

46. Therefore, as to the quality of *treatment and care* of the deceased, I find the treatment and care of the deceased was appropriate and of a high standard.

[51] Exhibit 1, Tab 11 [4].
[52] Transcript 11.

47. In these circumstances, I am satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death.

CONCLUSION

48. The deceased was a man with a longstanding history of hepatitis C and related cirrhosis of the liver when he commenced serving his final prison sentence.

49. Despite medical treatment, while serving his sentence his condition deteriorated, ultimately resulting in liver failure and complications that led to his death.

50. The deceased was in the custody and care of the Department immediately before he died. In my view the Department could not have prevented his death.

S H Linton
Coroner
21 November 2014