Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 6/15

I, Sarah Helen Linton, Coroner, having investigated the death of ***Shane John ROBINSON*** *with an inquest held at the* ***Perth Coroner's Court, Court 52, CLC Building, 501 Hay Street, Perth****, on* ***10 February 2015****, find that the identity of the deceased person was* ***Shane John ROBINSON*** *and that death occurred on or about* ***10 June 2011*** *at* ***Casuarina Prison*** *as a result of* ***multiple drug toxicity*** *in the following circumstances:*

Counsel Appearing:

Ms I O'Brien assisting the Coroner
Mr N van Hattem (State Solicitor's Office) appearing on behalf of the Department of Corrective Services

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INTRODUCTION

1. Shane John Robinson died sometime between 1.40 am and 6.50 am on 10 June 2011 at Casuarina Prison (Casuarina). He was found in an unresponsive state in his cell shortly after an early morning cell check and could not be revived, despite cardiopulmonary resuscitation being attempted.

2. As the deceased was a sentenced 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 *Coroner's Act 1996* (WA).

3. Pursuant to section 22(1)(a) of the *Coroner's Act*, where a person was held in care immediately before his or her death in Western Australia, an inquest is required to be held. Accordingly, I held an inquest at the Perth Coroner's Court on 10 February 2015.

4. Under section 25(3) of the *Coroner's Act*, 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.

5. The inquest focussed primarily on the ongoing health issues of the deceased, his medical treatment while in prison, and how he may have been able to access the drugs that, in combination, caused his death. In addition, evidence was given about the steps taken by the Department of Corrective Services (the Department) to minimise the trade in drugs in the prison environment.

6. The documentary evidence tendered comprised a total of three volumes of materials,[1] as well as an additional medical report[2] and some additional documents

[1] Exhibits 1 - 3.
[2] Exhibit 4.

provided by the family of the deceased and the Department.[3]

7. Oral evidence was heard from: Dr Cherelle Fitzclarence and Dr Geoff Forbes, who were involved in the deceased's medical care while he was in prison; two prison officers who were involved in the discovery of the deceased in his cell on the day of his death; Mr Richard Mudford, who conducted a 'Death in Custody Review' from the perspective of the Department's professional standards; and Dr David Joyce, a toxicologist who provided expert evidence in relation to the drugs found in the deceased's system after his death.

BACKGROUND OF THE DECEASED

8. The deceased was born in 1982 in Sydney, New South Wales. He had a number of medical issues as a child, including a congenital heart disorder, asthma and bronchiolitis.

9. When he was approximately eight years old, he was diagnosed with Attention Deficit Hyperactive Disorder (ADHD) and he took Ritalin for this condition until he was a teenager.[4] From that time, his ADHD was managed by diet control.[5]

10. The deceased's parents separated when he was young. While still a child the deceased moved to Perth, Western Australia with his mother, who had remarried. His schooling was unsettled and he attended several different high schools after reportedly being expelled on more than one occasion.[6]

11. The deceased left school at 14 or 15 years of age and returned to the eastern states to live with his father. He worked as a labourer and also gained work experience

[3] Exhibits 5 - 10.
[4] Exhibit 2, Tab 2.7, 2 (1st report).
[5] Exhibit 1, Tab 2, 14; Exhibit 2, Tab 2.1, 3.
[6] Exhibit 2, Tab 2.7, 5 (2nd report).

in car detailing and as a mechanical apprentice with his father's business.[7]

12. At an early age, the deceased had begun to use cannabis and then moved on to smoking heroin, then injecting heroin daily.[8] As a result, he started getting into trouble with the law as a teenager. The deceased's father encouraged him to engage in drug rehabilitation and he appeared to have some success on the methadone program. However, when the deceased was 19 years old his father committed suicide. Following his father's death the deceased relapsed into heavy drug use and returned to Western Australia.[9] He primarily used heroin and cannabis, although he reported using amphetamine on occasions when heroin was not available.[10]

13. Upon returning to Perth, the deceased initially lived with his mother and stepfather before moving to live with his sister. He continued to use drugs heavily and was not working. His behaviour became erratic and volatile and he continued to commit criminal offences, including drug-related offences and property-related offences, some involving violence.

14. The deceased eventually served a number of prison terms in Western Australia between 2003 and 2006 for offences including burglary and armed robbery.[11]

15. After being released on parole in November 2006, the deceased committed further offences, including arson on 25 February 2007. His parole was suspended and he was taken back into custody on 3 March 2007. He was eventually sentenced to a further term of 3 years and 5 months' imprisonment, backdated to commence on 5 November 2008. The deceased was denied release on parole in June 2010 and remained in prison until

[7] Exhibit 2, Tab 2.7, 2 (1st report).
[8] Exhibit 2, Tab 2.7, 3 (1st report).
[9] Exhibit 1, Tab 2, 14; Exhibit 2, Tab 2.1, 3.
[10] Exhibit 2, Tab 2.1, 4.
[11] Exhibit 2, Tab 2, 7; Tab 2.2, Criminal History.

his death.[12] He had not been due for release until 4 April 2012.[13]

16. The deceased was initially received at Hakea Prison on 3 March 2007 and after some movement he eventually transferred to Casuarina Prison on 17 May 2007 as a protection prisoner.[14]

MEDICAL HISTORY

17. The deceased's medical records show that throughout his terms of incarceration he became increasingly unwell.

18. In summary, the deceased's medical history around the time of his death included the following:

- Active Crohn's disease, complicated by recurrent non-compliance with recommended treatment;
- Anaemia secondary to active Crohn's disease, warfarin therapy and probably a degree of malabsorption;
- Low albumin in the blood – a chronic inflammatory state *may* have contributed to this as it is a marker of malabsorption;[15]
- Pulmonary emboli (blood clots in the lungs) – noting the deceased was found to have a hereditary genetic condition that can lead to blood clots;[16]
- Previous deep vein thrombosis – linked to the pulmonary emboli;[17]
- Previous duodenal ulcer;
- Asthma;
- Polysubstance drug abuse including opiates, for which he was on the prison methadone programme;
- Previous Hepatitis C, which he had cleared;

[12] Exhibit 2, Tab 2, 7.
[13] Exhibit 2, Tab 2.8, 1.
[14] Exhibit 2, Tab 2, 3.
[15] T 8.
[16] T 8.
[17] T 8.

- Schizoaffective disorder with associated auditory hallucinations;
- Chronic depression with alleged previous self-harm;[18]
- Migraines/headaches; and
- Multiple skin naevi (moles) with some previous excisions.[19]

19. Arguably, the most significant of these medical conditions, in terms of its long-term effect on the deceased's health, was the Crohn's disease, which is a form of inflammatory bowel disease.[20]

20. Dr Geoff Forbes, a Consultant Gastroenterologist at Royal Perth Hospital was involved in the deceased's medical care in hospital for his Crohn's disease and he provided a report[21] and also gave oral evidence at the inquest. In June 2009, the deceased was diagnosed with Crohn's disease[22] following investigation for progressive anaemia.[23] He was treated with a variety of medications to try to bring the disease under control but they were not effective. This led to him undergoing a laparoscopic total colectomy (removal of the colon) and ileorectal anastomosis (joining of the end of the small bowel to the rectum) in August 2010.[24]

21. From that time the deceased was admitted to Royal Perth Hospital on a total of six occasions for acute exacerbation of Crohn's disease and complications related to this condition.[25]

22. Dr Forbes noted that, following the surgery in August 2010, investigations led to the determination that local pelvic sepsis related to the anastomotic sinus tract was the deceased's underlying problem. After medical therapy failed, completion proctectomy with

[18] T 8.
[19] Exhibit 4, Updated report from Dr Cherelle Fitzclarence, 26.1.2015.
[20] T 37.
[21] Exhibit 1, Tab 37.
[22] T 36; Exhibit 2, Tab 2.9.
[23] T 38; Exhibit 2, Tab 2.8, Report of Dr Moss.
[24] Exhibit 2, Tab 2.8, Report of Dr Moss.
[25] Exhibit 2, Tab 2.8, Report of Dr Moss.

end ileostomy was recommended.[26] It is a major surgery.

23. The deceased steadfastly refused the option of further surgery to manage his condition. It seems he was particularly resistant as he did not want to have an ileostomy bag, which was a likely consequence of the surgery.[27]

24. Given the deceased's refusal to undergo surgery, Dr Forbes and the other doctors then considered medical therapy options, but the decision was postponed until a further MR scan was undertake to exclude bony involvement.[28] However, the deceased also repeatedly refused to attend appointments, have recommended treatment and undergo further investigations, such as the MR scan, which was scheduled for 2 May 2011.[29] Dr Forbes acknowledged that it was fine for people not to follow medical advice, but noted that the deceased appeared to be more prone to doing this than other patients.[30] Dr Forbes described the deceased as struggling to cope with his disease and life in general, and noted that he deceased's underlying psychiatric and psychological issues may have contributed to this failure to cope with his illness and make the best decisions.[31]

25. The deceased was provided with supervised medication and daily clinical care in prison, overseen by the Gastroenterology specialists. He refused admission to the prison infirmary or assisted care unit, preferring to remain housed in Unit 6 (the protection unit).[32]

26. Due to the complexity of the deceased's medical conditions and his variable compliance with treatment, his medical management was under regular weekly review along with those prisoners on the terminally ill

[26] Exhibit 1, Tab 37, 1 – 2.
[27] Exhibit 2, 2.12, 3 – 4.
[28] Exhibit 1, Tab 37.
[29] Exhibit 2, Tab 2.11, Letter of Dr Geoff Forbes, 6.5.2011.
[30] T 42.
[31] T 41 – 42.
[32] T 19; Exhibit 2, Tab 2, 6.

list.[33] He saw nurses regularly and was often seen more than once a week by a doctor.[34] If he had been housed in the prison infirmary as recommended by the prison doctors he would have been reviewed every day and his medical condition monitored even more closely but, as noted above, he didn't want to be transferred to the infirmary.[35] Even though he was a prisoner, the deceased was entitled to make decisions about his health care, so his decision not to be housed in the infirmary was documented and respected.[36]

27. The medical staff managing his treatment had to try to facilitate his care, both within the prison and via tertiary care in hospital, in the context of the deceased frequently refusing to take recommended medications or attend for treatment. This refusal put him at increased risk on more than one occasion, as by the time he agreed to be transferred to hospital he was often critically ill. His refusal to be placed in the infirmary, where his care would have been more easily supervised, also made it more difficult to identify when his health was beginning to deteriorate.[37]

28. Nevertheless, the medical notes reveal the deceased's medical conditions were intensively managed by the prison medical staff.[38]

MONTHS LEADING UP TO THE DEATH

29. The deceased was reported to usually look pale and unwell. A nurse who saw him regularly noticed that over the last two or three months of his life the deceased was becoming significantly more ill and looked, as she described it, "quite ghastly."[39] It was accepted by his doctors that the deceased was increasingly unwell over

[33] Exhibit 2, Tab 2.8, Report of Dr Moss.
[34] T 19.
[35] T 19 - 20.
[36] T 20.
[37] T 19 – 21; Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 5.
[38] Exhibit 1, Tab 36.
[39] Exhibit 1, Tab 15 [16].

that time,[40] with an unusually high number of hospital admissions during this period.[41]

30. In the last month or so before his death there was no marked visual deterioration in the deceased's appearance,[42] but that was within the context of him always generally looking very unwell at that time.[43]

31. On 6 May 2011, the deceased refused a recommendation by a doctor to transfer to a hospital Emergency Department or to the prison infirmary. He stated "there's nothing wrong with me, this is normal for me." He then signed a release from medical authority confirming that he refused to go to the Emergency Department or the prison infirmary.[44]

32. That same day the deceased's treating gastroenterologist, Dr Forbes, wrote to the Doctor in charge of Casuarina Prison and indicated that the deceased had serious ongoing pathology and Dr Forbes was concerned that the deceased was going to "run into further major problems in the near future."[45] Dr Forbes asked for his view to be communicated to the deceased when he next attended the prison medical centre.[46]

33. On 7 May 2011, the deceased refused medication and a clinic review. This was despite him telling the nurse on this day that he was feeling unwell. Dr Cherelle Fitzclarence, the Deputy Director of Health Services for the Department, attempted to have a telephone conference with the deceased to discuss the matter, but he refused to participate in the telephone conference.[47]

34. In the early hours of 8 May 2011, the deceased complained of chest pain and, on this occasion, he agreed to be transferred to hospital. He was admitted to

[40] T 14, 41; Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 2.
[41] T 17.
[42] T 18.
[43] Exhibit 1, Tab 19 [8] and Tab 20 [15].
[44] Exhibit 2, Tab 2.11, Medical Release dated 6.5.2011; Exhibit 4.
[45] Exhibit 2, Tab 2.11, Letter of Dr Forbes 6.5.2011.
[46] Exhibit 2, Tab 2.11, Letter of Dr Forbes 6.5.2011.
[47] T 17; Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 2.

Royal Perth Hospital for investigation of the chest pain, which he described as central chest pain radiating to his left arm. While in hospital his pain improved and his vital signs remained stable. No cardiac cause could be determined and the likelihood that he had ischaemic heart disease was considered very small given the deceased's age and the fact that he was already on warfarin therapy.[48] He was kept in hospital for 12 hours to do further troponin tests, to help identify damaged heart muscle. After the testing came back negative, he was considered safe to discharge on 9 May 2011.[49] The deceased was told to return if he experienced a recurrence of symptoms.[50]

35. The deceased's last admission to Royal Perth Hospital was on 17 May 2011. He had complained of diarrhoea and was admitted to hospital due to an exacerbation of his Crohn's disease. The MR scan was ultimately performed during this admission, on 20 May 2011.[51] The scan excluded bony infection and led to the administration of a new treatment drug adalimumab or Humira.

36. He was commenced on the drug Humira on 24 May 2011, and was given the first induction dose over two days. It is used for treating several inflammatory conditions affecting the digestive system.[52]

37. The deceased was discharged and returned to prison on 26 May 2011.

38. The deceased was in the habit of asking for a prescription for Diazepam to help him sleep on his return from hospital, which he did on this occasion. A prescription for five days of Diazepam was given by Dr Wee on 26 May 2011.[53] On 3 June 2011, the

[48] Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 2; Exhibit 7.
[49] T 14; Exhibit 2, 2.12, 3; Exhibit 7.
[50] T 15 – 16; Exhibit 7.
[51] Exhibit 1, Tab 37.
[52] Exhibit 2, Tab 2, 6 and Tab 37.
[53] Exhibit 1, Tab 36, Entry 26/05/2011 12:52, Richard Wee MD.

deceased requested the Diazepam, as per Dr Wee's orders, although the prescription had finished so he was told he would have to see a doctor to get more.[54] He was later given a three day prescription by Dr Fitzclarence, taking him through to 8 June 2011.[55] Dr Wee then authorised a further three days of the medication. However, this had not been transmitted to the nursing staff immediately, so he was not dispensed a dose on 9 June 2011.[56]

39. The deceased attended Royal Perth Hospital as a day patient on 8 June 2011 for his scheduled second dose of Humira.[57] The registrar noted there were signs of ongoing disease activity and pain. The registrar wanted to initiate a plan for a repeat of blood tests and a follow-up for review in one month. However, the medical note also indicates the deceased was agitated on that day and did not want to attend follow-up at the hospital.[58] The reason for his agitation was not known, but a letter sent by a Gastroenterology intern on 26 May 2011 suggested the deceased had concerns about his safety in some parts of the hospital.[59]

40. As a result, it appears from the medical notes that the second dose was given to the deceased in prison on 8 June 2011 under the supervision of a clinical nurse and Dr Wee.[60]

41. According to Dr Fitzclarence, there was nothing in the deceased's medical notes to suggest that he was contemplating deliberate self-harm at the time of his death.[61] His behaviour was not at all atypical or out of the ordinary and there was nothing to suggest that he was experiencing deterioration in his mental state.[62] The reports of prisoners who were housed with the

[54] Exhibit 1, Tab 36, Entry 03/06/2011 15:06Hayley White CN.
[55] Exhibit 1, Tab 36, Entry 06/06/2011 09:27, Elizabeth Smith EN.
[56] T 13; Exhibit 1, Tab 36, Entry 08/06/2011 16:35, Richard Wee MD.
[57] T 45; Exhibit 10.
[58] Exhibit 10.
[59] Exhibit 3, RPH letter 26.5.2011 from Dr John Wong to Casuarina Prison.
[60] Exhibit 1, Tab 36, Entry 8/06/2011 14:09 and 16:35; Exhibit 2, 2.12, 3 – 4.
[61] Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 2.
[62] Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 5.

deceased are noted below, and they confirm that he appeared generally happy and at no stage mentioned having any suicidal thoughts.

THE DECEASED'S DRUG USE

42. Not surprisingly, given his many health conditions, the deceased was prescribed a number of medications while in prison.

43. As noted above, he was being dispensed daily methadone to assist with his opiate addiction. At the time of his death he was being dispensed a dose of 90 mg a day. The deceased had been progressively weaned down to that dose from a maximum dose of 120 mg a few months before after advice from the Royal Perth Hospital pain clinic.[63]

44. The deceased's other regular medications included:[64]

- Humira 40 mg fortnightly, to treat his Crohn's disease – he had been given a dose of 160 mg a fortnight before his death and 80 mg two days before his death, as per a plan to reach a 40 mg ongoing dose, which is standard;[65]
- Warfarin, a blood thinner – the dose was variable according to his INR levels, aiming to keep them between 2 – 3.5;
- Atorvastatin 20 mg, an anti-cholesterol agent given at a dose to control his dyslipidaemia;
- Mirtazapine 60 mg, an anti-depressant/anti-anxiety medication – a high dose, but not unusual;[66]
- Quetiapine 800 mg, an anti-psychotic – prescribed at the maximum recommended dose as the deceased had reported the lower doses had not stopped the voices he was hearing in his head;[67]

[63] Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 3 – 4.
[64] Exhibit 1, Tab 36.d
[65] T 12 - 13.
[66] T 11 - 12.
[67] T 10 – 11.

- Pregabalin 300 mg, an anti-convulsant used here to assist with pain relief – prescribed at the maximum dose as the deceased complained of uncontrolled pain at lower doses;
- Indomethacin 100 mg suppository, anti-inflammatory/analgesic – limited to one a day due to the possibility of interaction with his warfarin;
- Esomeprazole 40 mg, anti-acid medication – a standard dose for someone with severe ulceration;
- Loperamide, an over the counter drug for diarrhoea; and
- Protein and vitamin supplements.

45. Whenever the deceased went to hospital, he found it challenging to settle back into prison life. He regularly sought, and often obtained, a prescription for diazepam for three to five days, to assist him to sleep at those times.[68] As noted above, he was last dispensed Diazepam in the three days leading up to his death, but not on the day before his death.

46. In addition to his prescribed medications, it was not unknown for the deceased to access other drugs within the prison system.

47. From April 2004 to August 2008, 16 prison charges are recorded against the deceased. Many of the offences were drug related, including being found in possession of syringes, smoking implements and cannabis, as well as secreting medication that was issued to him.[69]

48. When the deceased spoke with a psychologist in November 2008, he expressed disinterest in abstaining from using illicit drugs. He did not perceive cannabis use as a problem and said he would always smoke it. He said he would be able to abstain from using other illicit substances 'when he was ready,' which he said was when he was released to the community.[70]

[68] T 13; Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 2.
[69] Exhibit 2, Tab 2, 8 and Tab 2.16.
[70] Exhibit 2, 2.7, 3 (1st report).

49. The deceased's history of polysubstance abuse and attitude towards drug-taking did make his medical management difficult within a prison environment. His Crohn's disease was serious and he had difficulty in dealing with this condition.[71] His reaction to the disease impacted on his need for antidepressant and antipsychotic medication and also for large doses of analgesia.[72] However, as Dr Fitzclarence observed, it is difficult for a clinician to determine real need versus drug-seeking behaviour in a situation such as this, where a patient has real, very serious medical conditions but who is at the same time a recognised drug seeker/addict.[73]

50. The hospital staff also struggled to manage the deceased's analgesia regime. He was regularly reviewed by Acute Pain Service staff in respect to how best to manage his analgesic requirements. However, he often declined to take on board the recommendations. In addition, Dr Forbes noted that the deceased was reported by nurses on 24 May 2011 to be putting his ketamine lozenges in his mouth then spitting them out and putting them in his bedside drawer.[74] This was despite him asking for them and reporting pain. The frequency of his ketamine administration was reduced from that time.[75]

51. It had also been noted on his medical chart from 21 May 2011 under his prescription for methadone that the deceased was to be supervised to ensure that the entire dose was consumed, although the exact method of the supervision is not known.[76] He was given his last dose of methadone in hospital on 26 May 2011 at a dose of 92.5 mg.[77] It was given in syrup form.[78]

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[71] T 20.
[72] T 20.
[73] T 20 – 21; Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 5.
[74] Exhibit 1, Tab 37, 2.
[75] Exhibit 1, Tab 37; Exhibit 8.
[76] Exhibit 1, Tab 37.
[77] Exhibit 1, Tab 38.
[78] Exhibit 9.

52. As noted above, the deceased had his second injection of Humira on 8 June 2011.

53. The deceased was dispensed his last dose of methadone at the 7.00 am methadone parade, for protection prisoners, infirmary prisoners and prisoners who are on punishment on 9 June 2011.[79]

54. The process for receiving methadone at Casuarina Prison requires all prisoners not receiving doses to be locked down. The prisoners attending for methadone are then escorted to the clinic. They line up and are individually searched and their identification is checked against their photograph. An individual prisoner is then allowed through the locked gate before his identification is checked again and his name is ticked off the list. The prisoner then attends a window with a grille where the treating nurse again checks his identification before the prisoner is shown a pre-pack of methadone with his name on the front and his dose of methadone in it. The nurse then breaks the seal and pours the liquid methadone into about 100 mls of water. The prisoner signs for and is given the dose, and is required to drink it and an additional glass of water. The prisoner is then required to stand and wait for about 5 minutes before his mouth is checked by a prison officer. He is then permitted to leave the area and return to his unit.[80]

55. According to Dr Fitzclarence, it would be impossible for a prisoner not to consume their entire dose if the protocol is properly followed.[81]

56. According to that process, the deceased should have taken his dose on 9 June 2011 sometime between 7.00 am and 7.20 am.[82]

[79] T 9 – 10, 22 - 23; Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 3.
[80] T 23; Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 3.
[81] T 24.
[82] Exhibit 4, Updated report from Dr Fitzclarence, 26.1.2015, 3.

EVENTS ON 9 – 10 JUNE 2011

57. The deceased, together with the other prisoners in Unit 6, was unlocked from his cell at 7.00 am on 9 June 2011.[83]

58. As noted above, he went to the early morning methadone parade and received his daily dose of methadone by 7.20 am.

59. The deceased did not work, so he spent the day in his unit, mainly in his cell.

60. Prisoners housed in the unit were interviewed by police and they gave some account of what he did, and how he appeared, that day.

61. The prisoners spoke generally of the deceased looking pale and unwell during the day and that night at evening muster, but most thought he was not unusually so.[84] He didn't eat much that day and seemed tired.[85]

62. The prisoner housed in Cell 4, next door to the deceased's cell, spoke to the deceased for the last time at about 6.00 pm, just before lock- up. The deceased was sitting in a chair in his cell at that time. The prisoner described the deceased as looking "drugged and out of it," to a much greater extent than usual. The deceased didn't complain of any pain at that time, although he had on a previous occasion. The deceased had never mentioned suicide and had not given the prisoner the impression he would ever hurt himself.[86]

63. Another prisoner also saw the deceased just before muster and thought he seemed drugged up on medication.[87] They normally watched television

[83] Exhibit 2, Tab 18.
[84] Exhibit 1, Tab 22 and Tab 28 and Tab 29.
[85] Exhibit 1, Tab 28.
[86] Exhibit 1, Tab 19 [9] – [32].
[87] Exhibit 1, Tab 27 [16].

together but didn't that night as the deceased wasn't feeling well.[88]

64. Because it is a protection unit, Unit 6 is manned overnight, as the prisoners are deemed either vulnerable, disturbed or at risk. The night shift officer is responsible for conducting four random cell checks of all prisoners in the unit, two prior to midnight and two between midnight and 6.00 am.[89] The officer is not required to seek a response from the prisoner during those checks, to avoid unnecessarily disturbing their sleep.[90]

65. Officer Harrison, a very experienced prison officer, commenced duty at Unit 6 for the night shift at 6.30 pm. There were no issues raised at the handover.[91]

66. That night the deceased was locked in Cell 5 of Unit 6, from about the time Officer Harrison commenced his shift.[92]

67. Officer Harrison conducted his first cell check at 8.15 pm. All appeared correct at that time.[93]

68. At 10.40 pm, the night shift Recovery Team and a medic attended for the night time medical round. Medications were dispensed and the team departed at 10.45 pm.[94] A cell check was conducted by Officer Harrison five minutes later and everything again appeared correct.[95]

69. The third cell check occurred at 1.40 am. Officer Harrison recalls a prisoner was awake and walking around his cell during that check. Officer Harrison thought it was possible that prisoner

[88] Exhibit 1, Tab 27 [13] – [15].
[89] Exhibit 1, Tab 2, 7 and Tab 5 [2] – [5].
[90] T 33.
[91] Exhibit 1, Tab 2, 7.
[92] T 33; Exhibit 1, Tab 2, 7.
[93] T 33.
[94] Exhibit 1, Tab 2, 8.
[95] T 33; Exhibit 1, Tab 2, 8.

was the deceased, although he could not be 100% sure.[96]

70. Officer Harrison conducted the last overnight cell check at 4.15 am. He recalls he observed a prisoner asleep sitting in a chair with his hands on his knees and his head tilted to the left.[97] It was apparently not unusual to find a prisoner asleep in a chair and it did not concern Officer Harrison.[98]

71. Officer Harrison departed Unit 6 sometime between 5.30 and 5.45 am. He switched the cell call system to remote so the "Emergency Response Group" could respond to any calls.[99] No call was recorded from Cell 5 at any time, either while Officer Harrison was in the unit or after he left the unit.[100]

72. None of the prisoners housed on the wing reported hearing anything unusual in the wing that night after lockdown until they heard the officers in the morning.

73. Five prison officers were rostered to work the day shift at Unit 6 on Friday, 10 June 2011.

74. One of those officers, Officer Thompson, commenced a muster check of Unit 6, D Wing at 6.53 am. The check was to make sure that every prisoner was 'accounted for' before they unlocked the cell doors.[101] Cell 5 was checked and the deceased was observed sitting in his chair facing towards the shelving unit with his hands in his lap and his head tilted towards his right shoulder.[102] Officer Thompson knew the deceased and had seen him quite often in the mornings sitting in the same chair, so he was not concerned.[103]

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[96] T 33; Exhibit 1, Tab 2, 8.
[97] T 34; Exhibit 1, Tab 5 [22].
[98] T 34.
[99] Exhibit 1, Tab 2, 8.
[100] Exhibit 1, Tab 2, 12 and Tab 35 and Tab 5 [26].
[101] T 52.
[102] T 51 – 53; Exhibit 1, Tab 2, 8.
[103] T 53.

75. However, as he walked away Officer Thompson had a feeling that something wasn't right so he went back to the deceased's cell about a minute later to check on him again. Officer Harrison attempted to get a response from the deceased by calling out his name and kicking the cell door.[104]

76. When the deceased did not respond, Officer Thompson immediately called for assistance from his senior officer and three other prison officers came to Cell 5. They then unlocked the cell and Officer Thompson and Officer Garbutt entered the cell while Officers Galant and McCallum waited outside.[105]

77. Officer Thompson observed that the deceased was very pale, unresponsive and not breathing. He checked the deceased and could not locate a pulse.[106] Officer Galant then called a 'Code Red' emergency, recorded as being made at 6.55 am, whilst Officer Garbutt retrieved the resuscitation equipment.[107]

78. The deceased was lifted from the chair and lowered onto the cell floor, after which cardiopulmonary resuscitation was commenced by Officers Thompson and Garbutt using the CPR equipment. They continued to perform CPR until medical staff arrived at 6.57 am and took over.[108]

79. Nurse Ayres-Smith checked the deceased and found no signs of obvious trauma or bleeding.[109] He also noted the deceased had been incontinent of bowel and urine, his pupils were fixed and dilated, his extremities were cold and his skin was pale in colour, but there were no signs of rigor mortis.[110] The defibrillator machine continually recorded 'nil shock advised', which is

T 53; [104] Exhibit 1, Tab 2, 9.
[105] Exhibit 1, Tab 2, 9 and Tab 6 [8].
[106] Exhibit 1, Tab 2, 9.
[107] Exhibit 1, Tab 2, 9.
[108] Exhibit 1, Tab 2, 9.
[109] Exhibit 1, Tab 13 [5].
[110] Exhibit 1, Tab 2, 9 and Tab 13 [9].

common if no rhythm is detected[111] and indicated they should continue CPR, which they did.[112]'

80. The medical staff continued to perform CPR for approximately 10 minutes before another nurse attended with a second defibrillator, to ensure that the first result was a true result of cardiac rhythm. The new machine showed the CPR was being performed and was giving a tracing showing a normal sinus rhythm. However, there was no pulse palpable at the carotid, femoral or radial sites, the deceased was not breathing and his pupils remained fixed and dilated.[113]

81. At 7.08 am, one of the nurses contacted the on-call medical officer, Dr Hames, and gave him an appraisal of the situation and explained that the deceased had been receiving CPR for approximately 20 minutes by this time, without any response.[114] After some discussion, Dr Hames instructed the medical staff to cease performing CPR, which they did at 7.13 am.

82. A St John Ambulance paramedic and ambulance officer arrived two minutes later and were advised resuscitation had been ceased on the doctor's instructions. The paramedic placed the three leads of the cardiac monitor onto the deceased's chests and confirmed he was asystole (showing no cardiac electrical activity) and had died.[115] The paramedic conducted some other brief checks that confirmed there were no signs of trauma or injury and also there was no lividity or rigor mortis, indicating that the death had not occurred that long before.[116]

83. At 7.19 am, all parties exited Cell 5 and the cell was videoed and sealed to await the arrival of police, who were notified and attended shortly afterwards.[117]

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[111] Exhibit 1, Tab 14 [10].
[112] Exhibit 1, Tab 2, 9 and Tab 13 [10].
[113] Exhibit 1, Tab 2, 10 and Tab 13 [13] and Tab 14 [13].
[114] Exhibit 1, Tab 15 [36] – [37].
[115] Exhibit 1, Tab 2, 10 and Tab 17 [15] – [17].
[116] Exhibit 1, Tab 17 [20] – [22].
[117] Exhibit 1, Tab 2, 10 – 11.

CAUSE OF DEATH

Post Mortem Reports

84. A forensic pathologist, Dr Judith McCreath, conducted a post mortem examination of the deceased on Tuesday, 14 June 2011. Dr McCreath found changes in the bowel consistent with evidence of Crohn's disease and 80% narrowing of one of the vessels supplying blood to the heart. However, neither of these findings pointed to an obvious cause of death. Following this examination, the cause of death was designated undetermined, pending histology, microbiology, toxicology, neuropathology and biochemistry.[118]

85. On 2 April 2012, Dr McCreath produced a supplementary report. Dr McCreath noted in the report that microscopic examination showed fatty change in the liver and atherosclerosis in one of the vessels supplying blood to the heart. The degree of coronary disease was noted as severe for someone of such a young age. Neuropathological examination of the brain showed a probable gyral abnormality and serology showed the presence of Hepatitis C antibody. Cultures did not locate an infection.

86. The most significant findings in relation to determining a cause of death came from the toxicological analysis. Analysis of blood samples taken from the deceased found the presence of:

- Methadone;
- Quetiapine;
- Mirtazapine;
- Olanzapine (not prescribed to the deceased);
- Irbesartan (not prescribed to the deceased); and
- Indomethacin.[119]

[118] Exhibit 1, Tab 41, Post Mortem Report 14.6.2011.
[119] Exhibit 1, Tab 41.

87. Benzodiazepines were also detected in the blood by immunoassay, which appeared to relate to the Diazepam he had previously been prescribed.[120]

88. Analysis of urine showed an alcohol level of 0.026%, as well as the presence of methadone, quetiapine, mirtazapine and olanzapine and the first of those three drugs were also found in the liver.[121]

89. The levels of olanzapine and irbesartan were consistent with therapeutic levels. The methadone, quetiapine and, most particularly, the mirtazapine levels, on the other hand, were all notably high.[122]

90. Based upon the information obtained from the additional investigations, Dr McCreath formed the opinion that the cause of death was multiple drug toxicity.[123]

Professor Joyce

91. Dr David Joyce, a Physician and Professor of Clinical Pharmacology and Toxicology, reviewed the relevant materials relating to the deceased and provided a report and an addendum report to this Court, expressing his expert opinion as to the contribution of drugs to the death of the deceased.[124] Professor Joyce also gave oral evidence at the inquest.

92. Professor Joyce was asked his opinion about what role, if any, was played by the different drugs found in the deceased's system in contributing to his death. He was also asked his opinion as to whether the drugs were consistent with the deceased's medication history.

93. Professor Joyce noted that the very small amounts of diazepam were consistent with the deceased having a couple of doses some days before and his body having

[120] Exhibit 1, Tab 40, 1st Report.
[121] Exhibit 1, Tab 41.
[122] Exhibit 1, Tab 42.
[123] Exhibit 1, Tab 41, Supplementary Post Mortem Report 30.3.2012.
[124] Exhibit 1, Tab 40, 1st Report dated 1.3.2013 and Addendum Report dated 3.5.2013.

had time to get rid of most of it.[125] That is consistent with the history of the deceased's diazepam prescription having ended a day or two before his death and the new dose not being given the evening before his death. The levels found posed no risk to the deceased's health and made no contribution to his death.[126]

94. Professor Joyce noted the olanzapine, an antipsychotic confirmed by mass spectrometry, was unexpected, as the deceased had not been prescribed this drug for a number of years.[127] The fact that the drug was found in the stomach contents meant that the deceased had ingested an oral dose of the drug, likely within 24 hours before his death.[128] Professor Joyce gave evidence that the sedating effect of the drug can make it attractive for recreational use, although it does not have the addictive properties of other drugs.[129] In terms of its effect upon the deceased on this occasion, Professor Joyce noted that the low levels detected indicate the olanzapine would not have played a role in the deceased's death.[130]

95. Similarly, the presence of the anti-hypertensive drug irbesartan, confirmed by mass spectrometry, was a surprise.[131] It is only available as an oral drug but it was not found in the stomach contents.[132] There is no explanation as to why the deceased might have chosen to ingest the drug, as it is not known to be attractive for recreational use. In any event, the very small amount detected played no role in the deceased's death.[133]

96. Professor Joyce also noted that the presence of alcohol in the urine implied alcohol ingestion. Given he was a prisoner, the only opportunity for the deceased to have ingested alcohol was illicitly. However, in terms of its role in the deceased's death, Professor Joyce noted that

[125] T 61 – 62.
[126] T 62.
[127] T 62; Exhibit 1, Tab 40, 1st report, 6.
[128] T 62 - 63
[129] T 62.
[130] T 62 – 63.
[131] T 63; Exhibit 1, Tab 40, 1st report, 6.
[132] T 63.
[133] T 64.

its absence from the blood meant that it did not contribute to the death.[134]

97. In relation to the methadone, Professor Joyce noted that skin sites were sampled and tested for methadone, which did not suggest that there had been an injection site for methadone. These tests are not foolproof, but they nevertheless suggest the deceased ingested the methadone.[135] This was confirmed by the high concentration of methadone in the deceased's gastric contents, which indicated ingestion by mouth.[136]

98. This would be consistent with the deceased having ingested the methadone from his prescribed dose the previous morning, except that the concentration found in the mortuary admission blood was very high and substantially exceeded the concentrations expected for a person taking a daily dose of 90 mg.[137] In Professor Joyce's expert opinion, "it points fairly strongly towards a more recent oral dose,"[138] because methadone is generally completely absorbed in around four hours. Even allowing for the deceased's gastrointestinal disorders and the effect of methadone on absorption, in Professor Joyce's opinion, it was unlikely the ingestion occurred more than 12 hours previously, strongly suggesting that the deceased had another dose of methadone after his 7.15 am prison-administered dose.[139]

99. The concentration was in the range that has been associated with death through drug intoxication, although it does depend upon the individual's sensitivity to methadone.[140] Nevertheless, even though the deceased may have been highly tolerant to methadone, in Professor Joyce's opinion, the

[134] T 64; Exhibit 1, Tab 40, 1st report, 6.
[135] T 64; Exhibit 1, Tab 40, 1st report, 6.
[136] T 67.
[137] T 66; Exhibit 1, Tab 40, 1st report, 6.
[138] T 67.
[139] T 67 – 68.
[140] T 66.

concentration was consistent with the methadone having contributed to his death.[141]

100. As to the quetiapine, the fact that it was found in the gastric contents indicated that there has been ingestion of quetiapine by mouth.[142] It is possible that some of the quetiapine in the stomach contents was possibly from his administered dose.[143] However, the blood concentration found exceeded the concentration expected for the dose that had been administered to the deceased (even though that was at the upper end of the recommended dosage range), although not markedly.[144] As noted below, a prisoner later gave information to the police that the deceased had been purchasing a drug from other prisoners that might have been Seroquel, which is a trade name for quetiapine.[145] This might explain why the deceased had a higher than expected amount of quetiapine in his system at the time of his death.[146]

101. However, even though high, the levels of quetiapine found in the deceased's blood and urine were comfortably survivable, if it was the only drug present.[147] Quetiapine may cause death through cardiorespiratory depression or through cardiac rhythm disturbance, a likelihood that is increased when taken in combination with other similar acting drugs, such as methadone.[148]

102. Finally, the levels of mirtazapine detected in the deceased's samples were also much higher than expected for a man taking 60 mg daily, a dose at the upper end of the recommended dosage range.[149] Professor Joyce explained that mirtazapine has a fairly wide margin of safety, so, although the concentrations

[141] T 67.
[142] T 68.
[143] T 68.
[144] T 68.
[145] T 69.
[146] T 69.
[147] T 68.
[148] T 69; Exhibit 1, Tab 40, 1st report, 8.
[149] T 69.

found in the deceased's blood and liver were in the range associated with overdose, they were still lower than concentrations that have previously been associated with death.[150]

103. In Professor Joyce's opinion, the elevated levels of the three drugs points to a single explanation, which could explain the high concentrations of all three drugs. He did not consider post-mortem redistribution as a sufficient explanation, nor an explanation based on the deceased's liver's impaired elimination ability. Professor Joyce considered that drug interaction could possibly offer an explanation, but thought it would have become apparent before the deceased's death.[151]

104. In summary, Professor Joyce was able to say with relative confidence that the olanzapine and methadone were taken recently and not consistently with any prescribed dose administered in prison and therefore, it follows, obtained illicitly. On the other hand, the other drugs detected may have been from prescribed doses.

105. Following discussion during the inquest, Professor Joyce agreed that the most probable explanation was that the deceased took his prescribed medication doses on 9 June 2011, and then took some additional prescription medication illicitly.[152]

106. Methadone is a potent respiratory depressant, and its capacity to depress breathing is enhanced by other drugs that have a sedative quality, which in this case would particularly apply to the quetiapine detected in the deceased's blood samples. When people take excessive doses of such medication by mouth, their breathing is suppressed and the oxygen levels in their blood fall, with a consequent rise in carbon dioxide levels. The metabolic consequence of this is tissue

[150] T 70; Exhibit 1, Tab 40, 1st report, 8.
[151] T 70 – 71.
[152] T 72.

damage and breathing is progressively less likely to return spontaneously.[153]

107. Professor Joyce explained that death in such circumstances can typically take place over hours, rather than immediately. It is also not unusual for a person to die in seated positions, such as in a chair, as the upright position creates an additional jeopardy of airway obstruction as the head lolls about.[154] Cardiac rhythm disturbance may also have been a contributor, as a result of the drug toxicity, unrelated to the deceased's coronary atherosclerosis.[155]

108. In conclusion, Professor Joyce agreed that the most probable explanation for the deceased's death was because of an acute drug overdose, mediated by either respiratory depression or cardiac rhythm disturbance.[156]

Dr Forbes

109. Dr Forbes gave evidence that he was initially surprised to hear of the deceased's death, as it is uncommon for a patient with Crohn's disease to die suddenly.[157] However, he acknowledged that the deceased's history of pulmonary embolism had occurred to him as a possible explanation, and he later became aware of the post-mortem results. He accepted that the forensic pathologist's opinion as to the cause of death was a reasonable explanation for the deceased's sudden death.[158]

Conclusion in relation to Cause of Death

[153] T 73.
[154] T 74.
[155] T 74.
[156] T 75; Exhibit 1, Tab 40, Addendum report, 4.
[157] T 48; Exhibit 1, Tab 40, 1st report, 8.
[158] T 48.

110. I accept and adopt the opinion of Dr McCreath, which was supported by the evidence of Professor Joyce, that the cause of death was multiple drug toxicity.[159]

MANNER OF DEATH

111. Apart from one threat to self-harm recorded on a police lock-up form in November 2003, no subsequent prison reception checklists record any other threats to self-harm and there is no record of any suicide attempts.[160]

112. However, the deceased self-reported three previous suicide attempts in 2002, 2004 and 2006 to a psychologist who was preparing a court-ordered report in relation to the arson sentencing proceedings.[161] At the time he spoke with the psychologist in November 2008, the deceased denied having any suicidal ideation and cited his life goals as protective factors.[162]

113. A prisoner housed in Unit 6 who befriended the deceased a couple of weeks before his death noted that the deceased appeared "very sick"[163] but was still a "reasonably happy guy"[164] who did not appear to have disputes with any other prisoners or prison staff. The prisoner did not think the deceased would deliberately take his own life.[165]

114. Other prisoners gave similar accounts. In summary, the prisoners who had contact with the deceased leading up to his death described him as a nice, polite and happy person, despite his obvious serious health issues. He didn't have issues with any other prisoners. He had never given any of them reason to think he might be suicidal. However, they were aware that his health was declining and he was noticeably more tired and pale and eating less.

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[159] Exhibit 1, Tab 41, Supplementary Post Mortem Report 30.3.2012.
[160] Exhibit 2, Tab 2, 5.
[161] Exhibit 2, 2.7 2 (1st report).
[162] Exhibit 2, 2.7 2 (1st report).
[163] Exhibit 1, Tab 21 [16].
[164] Exhibit 1, Tab 21 [30]
[165] Exhibit 1, Tab 21 [35].

115. One prisoner from Unit 6, who had known the deceased for many years, did provide police with information that the deceased had bought medications from other prisoners in the unit in the past.[166] The medication mentioned by the prisoner as being purchased by the deceased was possibly the same as one of the drugs found at a high level in the deceased after his death, as noted above.[167] However, the prisoner also mentioned the supply of methadone to other prisoners.[168] This prisoner was not surprised to hear that the deceased had overdosed on medication, given what he knew about the deceased's practice of purchasing medications from others.[169]

116. At the conclusion of the inquest, both counsel who appeared submitted that the evidence was consistent with the deceased intentionally ingesting the drugs, without intending death as a consequence.[170]

117. Taking into account all of the circumstances, I accept that the deceased did not intend to take his life when he ingested the various drugs, and his death was an unintended consequence of the combined effect of those drugs. Accordingly, I find that death occurred by way of accident.

QUALITY OF SUPERVISION, TREATMENT AND CARE

118. Received as an exhibit during the inquest was a letter written on behalf of the deceased's mother to this court, raising some concerns about the quality of the supervision, treatment and care provided to the deceased prior to his death.[171]

[166] Exhibit 1, Tab 2, 13 and Tab 33 and Tab 34.
[167] Exhibit 1, Tab 33 [12] – [14].
[168] Exhibit 1, Tab 33 [19].
[169] Exhibit 1, Tab 33 [22].
[170] T 81 – 82.
[171] Exhibit 5.

119. Through her lawyer, the deceased's mother raised some concerns about the fact that the deceased was able to access prescription drugs from other prisoners, despite the drugs apparently being administered in a controlled environment. She wanted to know what percentage of deaths in custody in Western Australia are from overdoses of prescription drugs, presumably to satisfy herself that this is not an ongoing problem within the Western Australian prison system.[172] The deceased's mother also expressed concern that an ambulance was not called for her son on 9 June 2011, despite reports he looked very ill. She also queried why the deceased's coronary artery blockages were not detected during his earlier admission to Royal Perth Hospital.[173]

120. These issues, and others, were addressed as part of the inquiry required for me to make relevant comments pursuant to s 25(3) of the Act.

Prescription Drug Diversion

121. Medication diversion is taken very seriously by the Department and, if detected, is subject to prison charges and may also result in loss of privileges.[174] It is targeted as part of the prison's searching strategy.[175] The aim of the strategy is to detect contraband, identify those individuals involved and to deter those contemplating the use, or secretion, of contraband.[176]

122. There is also a drug management strategy, aimed at minimising the harm caused by drug use by reducing the supply and demand for drugs in prison.[177]

123. The dispensing of prescription drugs is controlled by the prison pharmacist and pharmacy staff in conjunction with Health Services staff. All medication is secured in locked cupboards with limited access to keys, and

[172] Exhibit 5.
[173] Exhibit 5.
[174] Exhibit 6, 1.
[175] Exhibit 6.
[176] Exhibit 6.
[177] Exhibit 1, Tab 44.

secured when being taken around the prison in lockable medication trolleys.[178]

124. I have outlined the Casuarina prison methadone dispensing procedure above and it is set out in more detail in documents provided to this Court.[179] Information provided by the Department indicates that all other medication distribution at Casuarina is also supervised and at each medication parade, an officer checks the mouths of all prisoners in all units and at the infirmary.[180] Prisoners may also be subject to a search at any time[181] and urine drug testing.[182]

125. In addition, measures implemented to identify medication diversion include cell/area searches across the prison, occasionally with the assistance of drug detection dogs. The searches can be random or targeted. All prison officers are also continually looking for items and information to identify and prevent trafficking in prescription drugs.[183]

126. There are also drug containment safe cells for managing and monitoring the health of prisoners suspected of having ingested unauthorised drugs.[184]

127. The prison officers who gave evidence at the inquest were asked about their understanding and first-hand experience of the prison's drug management strategy.

128. Both Officers Harrison and Thompson have participated in searches and, in their experience, finding prescription medications is not common, but does happen occasionally.[185] Both prison officers also acknowledged they had heard of exchange or sale of prescription medications occurring between prisoners,

[178] Exhibit 1, Tab 44.
[179] Exhibit 1, Tab 44.
[180] Exhibit 6, 1.
[181] Exhibit 6.
[182] Exhibit 1, Tab 44.
[183] Exhibit 6, 1 – 2.
[184] Exhibit 1, Tab 44.
[185] T 31, 51.

but neither had ever personally witnessed it.[186] In the opinion of Officer Harrison, who has been a prison officer for 25 years, everything that can be done to prevent prisoners hoarding or diverting medications is being done.[187] Officer Thompson agreed with him.[188]

129. Mr van Hattem, who appeared on behalf of the Department, submitted that I should accept that the Department is doing everything it can to control the distribution of prescription and illicit drugs within the prison. He submitted that the difficulties faced by the prison in eliminating the problem arise from:

- the fact that the prison population, as a group, is better at evading detection of illegal activities than the general population;
- the fact that prison is a stressful environment, which can enhance the desire for people within prison to have recourse to illicit substances; and
- the need to balance security with consideration of the wellbeing and quality of life of the prisoners, who already undergo regular invasive procedures as part of the management strategy.[189]

130. Certainly, the evidence of Dr Fitzclarence supports the conclusion that prisoners will go to extreme measures to subvert the medication dispensing procedures. For example, Dr Fitzclarence referred to anecdotal accounts of prisoners vomiting their methadone up to achieve this, but she was not aware of the specifics of how they did it.[190]

131. The fact that alcohol, which was found in the deceased's system, is commonly the product of manufacture within the prison by prisoners using fermentation products stolen and diverted from within the prison, also highlights the ingenuity of prisoners to achieve their aims. The alcohol is known to be hidden in many

[186] T 32, 51.
[187] T 32.
[188] T 52.
[189] T 82 – 83.
[190] T 25.

places and is searched for regularly as part of the prison's searching strategy, but nevertheless it is obviously able to be consumed on occasion, such as in the case of the deceased shortly before he died.[191]

132. Nevertheless, the evidence suggests that, on the whole, the distribution of prescription drugs, at least, is largely contained within the prison. Both prison officers reported finding them rarely. Dr Fitzclarence, who has been working for the Department for many years, has not had any direct experience of another prisoner dying as a result of a fatal overdose of prescription medication while in prison. However, she had experience of non-fatal overdoses, suggestive of lesser quantities of prescription drugs being involved, which, in her experience, can occur at a variable rate.[192]

133. Finally, in response to the query raised by the deceased's mother, after the inquest the Department provided statistics in relation to deaths in custody attributed to prescription drug overdose. After reviewing deaths in custody from 1 January 1990 to 21 November 2014, the Department identified only two deaths in custody, other than those still under investigation, which may have involved prescription drug overdose.[193] This supports the conclusion that the incidence of fatal prescription drug overdoses in prison is rare in Western Australia.

134. I am satisfied that the Department has in place a comprehensive system to attempt to manage the administration of prescription medication within Casuarina prison, while limiting hoarding or diversion of such medications. Unfortunately, where the will to circumvent those systems exist, people will, from time to time, manage to come up with ways to do so. The need to extend some privacy to prisoners makes this more likely, but is not a reason for reducing even further the rights of prisoners.

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[191] T 31; Exhibit 6, 2.
[192] T 28.
[193] Letter from Mr van Hattem to Counsel Assisting dated 18.6.2015.

Medical Care

135. The deceased's medical notes are comprehensive and detailed.[194] They show that he was reviewed regularly by medical officers. In particular, looking at the last few days of his life, I note he was seen nearly every day.

136. It is the case that his coronary disease was not identified before his death, despite the deceased being admitted to hospital expeditiously and appropriate investigations having been carried out. It was thought at the time by the hospital doctors that the likelihood of ischaemic heart disease was very small for a patient of his age, and certainly it was noted by the forensic pathologist that the extent of the disease was unusual for someone of such a young age, suggesting possible genetic factors.[195]

137. Dr Fitzclarence acknowledged that it was unusual for a 29 year old to have that degree of coronary atherosclerosis and it was clearly more accelerated than you would expect in a young man. However, she also noted that 50% of heart attacks present with sudden death, so there are a lot of people who are unaware they have coronary atherosclerosis.[196] In the case of the deceased, Dr Fitzclarence had never observed any signs of atherosclerosis when treating him.[197]

138. What is also important is that the doctors at Royal Perth Hospital noted at the time he was admitted for cardiac investigations that, given he was already on warfarin therapy, his medical management would not have changed, even if his coronary disease had been identified.[198] Further, there is no evidence to suggest he died as a result of his coronary disease.

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[194] Exhibit 1, Tab 36; Exhibit 3.
[195] Exhibit 1, Tab 41.
[196] T 17.
[197] T 17.
[198] T 16; Exhibit 3, RPH Discharge Summary 9.5.2011.

139. As for his other medical issues, it is true that the deceased did appear to be increasingly unwell towards the last days of his life. However, as noted above, he was often resistant to seeking treatment even when seriously ill, and had declined to be housed in the infirmary, contrary to medical advice. It was important that his rights as a patient to refuse medical treatment were respected, despite the fact he was a prisoner.

140. The prisoner housed in the cell opposite the deceased confirmed the deceased often fell asleep slouched in the chair in his cell and rarely left his cell, other than for muster and to collect his medications.[199] He had known the deceased for a few years and had noticed the dramatic decline in his health and appearance in recent times. In particular, he thought the deceased had declined even further after he returned from hospital for the last time, approximately two weeks before. He last saw the deceased at the evening muster on 9 June 2011 and observed the deceased did not look well, although they did not speak. He did not hear anything from the deceased's cell until the morning. The prisoner expressed sadness about the deceased's death. Interestingly, this prisoner also offered the observation that he believed the deceased was given another six months alive because he was in prison and got the medical attention that he needed.[200]

141. Dr Max Kamien, an Emeritus professor of medicine who was asked to review the deceased's medical care by the Department, expressed the opinion that the medical care provided was of a good standard and was "probably much better than he would have accessed had he been living (out of prison) in the community."[201] As I noted above, even a fellow prisoner of the deceased shared that view.

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[199] Exhibit 1, Tab 23 [12] – [13] - Other prisoners also talked of seeing the deceased sleeping in his chair in his cell more recently, including on the day before he died - Exhibit 1, Tab 20 [17] and [21] and Tab 25 and Tab 30 [17].
[200] Exhibit 1, Tab 23 [32].
[201] Exhibit 2, 2.12, 4.

142. I understand why the deceased's mother has expressed some concern about the deceased's care and supervision prior to his death. It must be very difficult to watch a family member struggle with a serious illness while in prison and watch his or her health gradually decline without the ability to be there to help care for them. The unusual circumstances of the deceased's death would naturally exacerbate his mother's feelings of helplessness and raise questions about whether his death could have been prevented.

143. However, having explored the issues raised by the evidence, and taken into account the opinions of the medical experts, I am satisfied that the deceased received a high standard of medical care, at a minimum as good as what he would have expected to receive if he was not incarcerated.

144. I am also satisfied that there was nothing during the night and morning of 9 to 10 June 2011 that should have alerted the prison officers to the fact that the deceased had taken an overdose of prescription medication and required urgent medical care. By the time he was found, it was too late to resuscitate him, despite the prison officers' best efforts to do so.

CONCLUSION

145. The deceased had a large number of serious medical problems, which would be hard for anyone to cope with in the best circumstances. The management of his chronic illnesses was made more difficult by his mental disorders and drug addictions, which led him to make poor choices in relation to his medical care and general health. However, even in the context of the deceased refusing recommended medical care at times, his medical management was of a high standard.

146. Unfortunately, because of the chronic health conditions that caused him pain which was often difficult to manage, compounded by his long standing drug

addictions, his desire for relief led him to seek out additional medications to what was prescribed to him. It seems this was not the first time he had done so, and so the deceased did not anticipate that the effect of taking those drugs, in combination with what was already prescribed to him and the changing effect of his illness on his body's ability to clear the drugs, would lead to his death.

147. The deceased was in the custody and care of the Department immediately before he died. I am satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death.

S H Linton
Coroner
22 June 2015