Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 11/19

I, Barry Paul King, Deputy State Coroner, having investigated the death of ***Troy Michael Conley*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***15 February 2019****, find that the identity of the deceased person was* ***Troy Michael Conley*** *and that death occurred on* ***21 January 2016*** *at* ***Sir Charles Gairdner Hospital*** *from* ***severe chronic obstructive pulmonary disease*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisted the Coroner

Ms R M Hartley (State Solicitor's Office) appeared for the Department of Justice

Table of Contents

INTRODUCTION

1. On 16 October 2012, Troy Michael Conley (the deceased) was sentenced to imprisonment for four years. While he was incarcerated, he was treated for smoking-related chronic obstructive pulmonary disease (COPD). On 7 January 2016, he was admitted to Bunbury Hospital after he fell at Bunbury Prison and, on 12 January 2016, he was transferred to Sir Charles Gairdner Hospital for treatment of infective exacerbation of chronic lung disease.

2. By 13 January 2016 the deceased had decided that he had had enough. He was provided with palliative care from 14 January 2016 until he died in the evening on 21 January 2016. He was 45 years old.

3. About six hours before the deceased died, he was released from custody by way of the exercise of the Royal Prerogative of Mercy by the Attorney-General, but he was too unwell to leave hospital.

4. The deceased's treating doctor completed a 'Death in Hospital' form, indicating that the death appeared to have resulted directly or indirectly from injury and that immediately before death the deceased had been 'a person held in care'; the latter term includes a sentenced prisoner. The doctor did not complete a 'Medical Certificate Cause of Death'.[1]

5. Under s19 *Coroners Act 1996*, a coroner has jurisdiction to investigate a death if it appears that the death is or may be a 'reportable death'. A 'reportable death' is defined to include one where the treating doctor did not certify the cause of death. It follows that the deceased's

[1] Exhibit 1, Volume 1, Tab 4

death was a reportable death and that I had jurisdiction to investigate the death.

6. Under s 22(2) of the Act, a coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable.

7. Members of the deceased's family alleged that, while in prison, the deceased received inadequate medical treatment and that he had been using drugs which may have contributed to his death. Given those allegations, it was desirable to hold an inquest to investigate the quality of the supervision, treatment and care of the deceased while imprisoned. This was especially so because he had been released on the Royal Prerogative of Mercy only a short time before his death.

8. On 15 February 2019, I held an inquest at the Perth Coroner's Court. The primary issues were the medical care provided to the deceased and the question of whether he had used illicit drugs while in prison.

9. The documentary evidence adduced at the inquest comprised a brief of evidence[2] which included a report completed on 30 November 2016 by First Class Constable (now Senior Constable) Dana Stewart of the Coronial Investigation Squad of the Western Australia Police[3] and a report by Richard Mudford, Senior Review Officer of the Department of Corrective Services.[4]

10. Dr Fraser Moss, a GP and a former principal medical officer with the Health Services Division of the Department of Corrective Services, provided a report on the medical care provided to the deceased while

[2] Exhibit 1, Volumes 1 and 2
[3] Exhibit 1, Volume 1, Tab 2
[4] Exhibit 1, Volume 2 before Tab 1

imprisoned.[5] Also obtained by the Court were the Department of Corrective Services EcHO Filing records for the deceased and the deceased's medical records from SCGH.

11. Oral evidence was provided by (in order of appearance):

    a. Senior Constable Stewart;[6] and

    b. Mr Mudford.[7]

THE DECEASED

12. The deceased was born in Geraldton on 12 August 1970 and grew up there with an older brother and a younger sister. He completed his schooling and went on to find employment as a gyprock worker.[8]

13. The deceased was somewhat of a rebel as he grew up. He had an extensive and varied criminal history, which included traffic offences, burglary and stealing, and drug offences.[9]

14. He had been smoking tobacco from the age of 10 and cannabis from the age of 15. In 1998 he was diagnosed with attention deficit hyper activity disorder, and two years later he began using amphetamine. He became addicted to intravenous amphetamine and heroin. In about 2010 he was using $1000 of heroin daily.[10]

15. Around 1990, the deceased met and married Lisa Conley in Mandurah. They stayed together for about 20 years

[5] Exhibit 2
[6] ts 5 – 12 per Stewart, D A
[7] ts 12 – 18 per Mudford, R P
[8] Exhibit 1, Volume 1, Tab 7
[9] Exhibit 1, Volume 1, Tab 59
[10] Exhibit 1, Volume 1, Tab 2

and had three daughters together. In August 2011, they separated due to the deceased's drug use and criminal activity. He had previously concealed much of his drug addiction from Ms Conley.[11]

16. On 16 October 2012, the deceased was sentenced to four years imprisonment for stealing, aggravated burglary and breach of a suspended sentence. The sentence was back-dated to 25 April 2012.[12] On 27 November 2012 he was moved from Hakea Prison, where he had been kept on remand, to Bunbury Prison. Apart from temporary transfers to Casuarina Prison to facilitate medical appointments, he remained at Bunbury Prison from then until his death.[13]

17. Upon the deceased's initial entry to prison on remand, he indicated his desire to commence a methadone program. On 19 June 2012, he was placed on the program, and he stayed on it throughout his custody.[14]

TREATMENT IN PRISON

18. On 15 June 2012, the deceased saw a medical officer in Hakea Prison, complaining of a cough and wheeze. He was advised that he did not have asthma but was at risk of chronic obstructive pulmonary disease (COPD) due to his history of smoking. He was commenced on salbutamol and advised to quit smoking. Six months later, he was diagnosed with COPD and started on steroids and long-acting b2 agonists. He was again advised to cease smoking.[15]

[11] Exhibit 1, Volume 1, Tab 2
[12] Exhibit 1, Volume 1, Tab 59
[13] Exhibit 1, Volume 2, report before Tab 1
[14] Exhibit 1, Volume 2, report before Tab 1
[15] EcHO Filing records

19. For the next 18 months, the deceased did not appear to be troubled by respiratory complaints but, when he was reviewed by a prison doctor on 20 June 2014, he reported that he used his salbutamol three times a day and that he had a gradual increase of shortness of breath on exertion. He had coughed up blood and had not responded to the b2 agonist. On 23 July 2014 spirometry showed severe obstruction and a chest x-Ray indicated possible pneumonia. The doctor ordered a CT scan of his chest.[16]

20. On 17 October 2014, the prison doctor reviewed the deceased and noted that the CT scan results showed an inflammatory process in the lungs. The deceased claimed to have cut back on his smoking, but he refused to go to a respiratory specialist for review.[17]

21. On 27 November 2014, a general physician reviewed the deceased at the South West Health Campus and considered that he had progressive upper lung fibrosis and scarring, most likely from occupational exposure to dust and contaminants from intravenous drug use. The physician advised that the deceased should quit smoking and that he should undergo a battery of tests.[18]

22. On 29 January 2015, the deceased returned to the general physician, who noted that test results showed significant pulmonary hypertension and very significant obstructive lung disease with gas trapping. The physician believed that the deceased had significant emphysema related to smoking, and 'progressive massive fibrosis … related to significant occupational exposure' and '… potentially related to fibrosing venulitis related to his significant intravenous drug use'. The physician referred

[16] EcHO Filing records
[17] EcHO Filing records
[18] EcHO Filing records under Correspondence Tab

the deceased to Professor Fiona Lake, a respiratory specialist at Sir Charles Gairdner Hospital.[19]

23. On 8 June 2015, the deceased saw Professor Lake after being transferred to Casuarina Prison. The delay in his attendance was due to delays at the hospital clinic and the deceased's reluctance to transfer to a Perth prison so that he could attend the clinic. Professor Lake advised further investigations, including a bronchoscopy and a right heart catheter.[20]

24. On 4 August 2015, Professor Lake spoke to the prison doctor and advised that the deceased should have a PET scan to look for active inflammation of the lung, repeat lung function tests, repeat ECHO and right heart catheter and, depending on the findings, a bronchoscopy and biopsy.[21]

25. On 27 August 2015, the deceased was transferred to Bunbury Hospital with shortness of breath. He was treated with antibiotics and oral steroids and was discharged back to Bunbury Prison after two days.

26. On 18 September 2015, the deceased underwent a PET scan at SCGH, which showed non-specific but likely active inflammatory process.[22]

27. On 25 September 2015, the deceased refused to transfer to SCGH for a respiratory appointment. About a month later, he refused to attend a cardiac procedure at SCGH.[23]

28. On 23 November 2015, the deceased saw a prison doctor. His exercise tolerance was 100 metres and he coughed at

[19] EcHO Filing records under Correspondence Tab
[20] Sir Charles Gairdner Hospital medical record
[21] Sir Charles Gairdner Hospital medical record
[22] EcHO Filing records
[23] EcHO Filing records

night. He continued to smoke despite advice to quit. He refused further follow-up in Perth.[24]

29. On 7 December 2015, the deceased performed a walk test at the prison clinic. He sat for 53 seconds after the four minute mark, and his oxygen levels fell to 83% after six minutes.[25]

30. On 21 December 2015, the deceased had a long tele-health consultation with Professor Lake. He reported that he continued to smoke despite struggling with shortness of breath and very poor exercise tolerance. Among other things, Professor Lake diagnosed severe airflow obstruction with emphysema from smoking, and pulmonary fibrosis possibly from industrial exposure to gyprock and from talcosis from previous drug use. Professor Lake advised treatment for COPD, a Brimica inhaler, and further investigations. [26]

31. On 29 December 2015, the deceased was taken to the emergency department at Bunbury Hospital after he collapsed and regained consciousness on the floor. He was diagnosed with cough syncope and was discharged back to prison with antibiotics and oral steroids.[27]

32. On 4 January 2016, the deceased saw a prison nurse and reported that he was aware that his lungs were badly damaged and that there was little chance of recovery at that stage. He was happy to attend his appointment with Professor Lake on the next week, but he saw no point in quitting smoking and he said that he felt worse when he did not smoke.[28]

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[24] EcHO Filing records
[25] EcHO Filing records
[26] Sir Charles Gairdner Hospital medical records
[27] EcHO Filing records
[28] EcHO Filing records

33. On 6 January 2016, the deceased went to the prison clinic for spirometry, but he was unable to continue due to coughing up phlegm. The prison doctor arranged for him to be transferred to the emergency department at Bunbury Hospital.[29]

EVENTS LEADING UP TO DEATH

34. On 7 January 2016, the deceased was admitted to the emergency department at Bunbury Hospital and was treated with intravenous antibiotics and steroids for infective exacerbation of chronic lung disease.[30]

35. On 11 January 2016, the deceased was moved to a ward, and on the next day he was transferred to SCGH under the care of Professor Lake, who diagnosed likely foreign body granulomatosis (talcosis) secondary to intravenous drug use causing progressive upper lobe fibrosis, likely upper lobe emphysema, central progressive massive fibrosis and pulmonary hypertension. The deceased was treated with high dose steroids. He was told that lung transplantation would be particularly onerous and that the only other treatment option was palliation.[31]

36. On 13 January 2016, the deceased told Professor Lake that his lungs were finished and that he wanted the palliation route. Professor Lake referred him to the palliative team and also took steps to have him pardoned so that he was not shackled to his bed and so that his family could be with him.[32]

37. The deceased's care was discussed at numerous multidisciplinary meetings at SCGH. His condition

[29] EcHO Filing records
[30] Sir Charles Gairdner Hospital medical records
[31] Sir Charles Gairdner Hospital medical records
[32] Exhibit 1, Volume 1, Tab 9

deteriorated to episodic severe breathlessness at rest and chest pain that was likely ischaemic and related to pulmonary hypertension, underlying cardiac disease and hypoxia. He was on continuous morphine and sedatives as well as his ongoing methadone.[33]

38. At about 2.00 pm on 21 January 2016, the deceased was released from prison under the royal prerogative of mercy.[34] At about 8.00 pm that evening, he died with his family present.[35]

CAUSE OF DEATH

39. On 1 February 2016, forensic pathologist Dr G A Cadden performed a post mortem examination of the deceased and found severe chronic pulmonary disease in keeping with pulmonary fibrosis, pulmonary congestion with small pleural effusions and mild atherosclerosis.[36]

40. Toxicological analysis detected potentially significant levels of methadone as well as morphine, amitriptyline and midazolam.[37] The patient dispensing records at SCGH show no changes to the deceased's methadone dose until 18 January 2016, after which methadone does not appear in the records.[38] Professor Lake said that she was unable to say whether the methadone had been increased, but it was possible because methadone would have been appropriate for palliation.[39]

[33] Exhibit 1, Volume 1, Tab 9
[34] Exhibit 1, Volume 2, report before Tab 1; Sir Charles Gairdner Hospital medical record
[35] Sir Charles Gairdner Hospital medical record
[36] Exhibit 1, Volume 1, Tab 5
[37] Exhibit 1, Volume 1, Tab 6
[38] Sir Charles Gairdner Hospital medical record
[39] Exhibit 1, Volume 1, Tab 9

41. Dr Cadden formed the opinion, which I adopt as my finding, that the cause of death was severe chronic obstructive pulmonary disease.[40]

HOW DEATH OCCURRED

42. The evidence makes clear that, following long-term exposure to gyprock dust, intravenous drug use and smoking, the deceased developed chronic obstructive pulmonary disease, which caused his death.

43. I find that death occurred by way of natural causes.

COMMENTS ON SUPERVISION, TREATMENT AND CARE

Drug use in prison

44. The deceased was subjected to ongoing random bulk substance testing while in prison. He tested positive to opiates on 17 February 2014. He was also found with tramadol on 11 June 2014 and a synthetic cannabis on 29 June 2014 and 24 December 2014. Paracetamol tablets were found in his cell on 2 July 2014. Urinalysis detected cannabis on 23 December 2014 and 30 December 2014. In April 2015, random urinalysis again detected cannabis, for which the deceased was charged and subjected to five days confinement in a punishment cell. All other bulk testing showed negative returns.[41]

45. There is no evidence to indicate that the deceased continued to use illicit drugs in prison apart from the isolated incidents mentioned, and there is no causative

[40] Exhibit 1, Volume 1, Tab 5
[41] Exhibit 1, Volume 1, Tab 54; Exhibit 1, Volume 2, Report before Tab 1

connection between those incidents and the deceased's death.

46. There is no evidence to suggest that the supervision of the deceased with respect to drug use while in prison was anything other than appropriate.

Treatment and care

47. Professor Lake provided a report in which she said that the deceased's management in prison appeared adequate.[42]

48. Professor Lake said that the deceased had an atypical condition that was difficult to diagnose and that the diagnosis was delayed because he was in Bunbury Prison and did not have access to all of the tertiary hospital investigations. Some delay was caused by the SCGH Respiratory Medicine department in not arranging and coordinating investigation in a timely manner, and some delay was due to the deceased's reluctance to go to a Perth prison.[43]

49. Professor Lake said that the deceased's episodic symptoms may have led to an underestimation of the severity of his condition, but this did not change the outcome because there was no effective treatment available.[44]

50. Dr Moss reviewed the chronology of the medical care provided to the deceased while in prison and concluded that he received comprehensive professional clinical care for his respiratory disease and that the care was timely,

[42] Exhibit 1, Volume 1, Tab 9
[43] Exhibit 1, Volume 1, Tab 9
[44] Exhibit 1, Volume 1, Tab 9

consistent with his needs, and in accordance with best medical practice.[45]

51. The evidence provided by Professor Lake and Dr Moss and that found in the EcHO Filing records makes clear that prison health staff provided the deceased with regular and frequent ongoing care and arranged for him to attend hospital and to see external specialists as required. The management by prison staff was hindered by the deceased's inability to stop smoking and to attend some medical appointments.

52. I am satisfied that the treatment and care of the deceased while incarcerated was reasonable and appropriate.

CONCLUSION

53. The deceased died at a relatively young age from a dreadful disease. While his death occurred through his own actions and despite appropriate advice and care and treatment, it is impossible not to feel profound sympathy for him and his surviving family.

B P King
Deputy State Coroner
9 July 2019

[45] Exhibit 2