Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 06/19

I, Sarah Helen Linton, Coroner, having investigated the death of ***Aurelio Monterlegre CRUZ*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***8 February 2019*** *find that the identity of the deceased person was* ***Aurelio Monterlegre CRUZ*** *and that death occurred on* ***11 December 2016*** *at* ***Fiona Stanley Hospital*** *as a result of* ***bronchopneumonia complicating terminal palliative care in an elderly man with chronic renal failure, ischaemic heart disease and cerebral atrophy*** *in the following circumstances:*

Counsel Appearing:

Ms A Barter assisting the Coroner.
Ms Z Bush (State Solicitor's Office) appearing on behalf of the Department of Justice.
Mr P Ash appearing on behalf of the family of the deceased.

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INTRODUCTION

1. Aurelio Monterlegre Cruz died in hospital on 11 December 2016. He had been receiving terminal palliative medical care so his death was not unexpected.

2. At the time of his death Mr Cruz was a sentenced prisoner. He had been held at Casuarina Prison until his medical needs became too great to be managed outside a hospital setting, at which time he had been transferred to Fiona Stanley Hospital.

3. As Mr Cruz 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]

4. I held an inquest at the Perth Coroner's Court on 8 February 2019. Separate investigations into the death were conducted by the Western Australian Police Force and by the Department of Corrective Services (the Department) and reports were prepared.[2] The authors of both reports were also called as witnesses at the inquest.

5. The inquest focused primarily on the medical care provided to the deceased while a prisoner, both within the custodial environment and while admitted to hospital. A primary concern of Mr Cruz's family was why he was not released on the royal prerogative of mercy prior to his death, given his terminal illness, and this issue was also explored at the inquest.

A BRIEF BACKGROUND

6. Mr Cruz was born and raised in Gibraltar. He moved with his family to the United Kingdom during wartime and then returned to Gibraltar after the war. He left school at 15 years of age and did compulsory military service before working in various jobs, mainly in the boating industry. He married and had five children. He moved with his family to the United Kingdom and then a few years later migrated with his wife and children to Australia in 1972. He resided in Australia on a permanent residency visa. His last period of work was as a painter.[3]

7. Mr Cruz enjoyed good health for most of his working life but his health began to deteriorate as he grew older and he retired for health reasons onto an invalid pension when he was in his early sixties.[4] In 1996 he was diagnosed with bowel cancer, which resulted in partial colectomy and he required a colostomy bag.[5]

8. In December 2002 Mr Cruz was convicted after a trial before a jury of sexual offences committed against children who were related to him. He maintained

[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibit 1.
[3] Exhibit 1, Tab 9.
[4] Exhibit 1, Tab 2, p. 5 and Tab 16.
[5] Exhibit 2, Tab 1.

his denial of the offences after conviction. Mr Cruz had a number of significant medical conditions that were raised before the learned sentencing Judge. Mr Cruz was sentenced on 17 January 2003 to a term of 4 years' immediate imprisonment with eligibility for parole.[6]

9. While serving his first term of imprisonment Mr Cruz was seen at the prison medical centre predominantly for monitoring of his diabetes, blood pressure and asthma. Some of his testing suggested his diabetes was poorly controlled and his renal function was slightly impaired. He also underwent surgery in September 2003 for a disc extrusion in his neck.

10. Mr Cruz spent two years in prison before he was released on parole on 11 April 2004.

11. After his release, Mr Cruz attended the Dalyellup Family Medical Centre and then later the Rockingham Medical Centre. His renal function remained impaired and his diabetic control and blood pressure fluctuated. In January 2008 he also developed congestive heart failure.

12. Mr Cruz's wife of more than 50 years died in 2012. Mr Cruz's relationship with some other family members became distant in 2013 after he was charged with further sexual offences against another relative, although he continued to have the support of his son and his son's family.[7]

13. In June 2014 Mr Cruz was reviewed at the Rockingham Hospital Renal Clinic. The specialist advised that his renal failure would be best managed by avoiding nephrotoxic agents and ensuring his blood pressure and diabetes was well controlled. By the end of June 2014 Mr Cruz's renal function had deteriorated further.

14. In 2015 Mr Cruz was convicted after another trial before a jury of further sexual offences. The offences predated his first period of imprisonment but involved a different child to the other offences and were more recent in time than the other offences. As with the earlier convictions, Mr Cruz maintained a denial stance in relation to the offending after conviction.

15. At the time of sentencing on 2 April 2015, Mr Cruz was 79 years of age and his complex medical history included chronic renal failure, diabetes mellitus, ischaemic heart disease, asthma/chronic obstructive pulmonary disease, hypertension, neck injury, rectal cancer in 1996 with anterior resection and stoma formation, hernia, and anal fistulae. He was on a large number of medications to manage his medical conditions. He had been reviewed by a psychologist who assessed Mr Cruz as cognitively competent.[8]

16. The learned sentencing Judge acknowledged Mr Cruz's advanced age and reduced the total sentence he imposed on that basis. His Honour also accepted Mr Cruz suffered from medical issues, but noted that there was no

[6] Exhibit 1, Tab 16.
[7] Exhibit 1, Tab 2, p. 3 and Tab 9.
[8] Exhibit 1, Tab 17.

information to suggest his medical issues could not be properly managed in the prison setting.[9]

17. Mr Cruz was sentenced to a further sentence of 6 years 6 months' imprisonment. His earliest date to be considered for release on parole was 5 August 2019.[10]

ADMISSION TO HAKEA PRISON

18. Upon his return to custody on remand on 6 February 2015, after being charged with the new offences, Mr Cruz underwent a standard Adult Initial Health Screen. His admission blood tests showed low iron levels and confirmed renal failure.[11]

19. Mr Cruz initially said he would not eat or drink anything as he was protesting his innocence and would not back down until he was cleared. He said he would not harm himself in any other way but understood his health would be at risk from hunger and dehydration. It was noted that given his health conditions, any period of not hydrating could potentially cause him harm.[12] He was placed on the At Risk Management System (ARMS) and housed in the Crisis Care Unit. He was reviewed by the mental health team the following day. Mr Cruz eventually agreed to cease his hunger strike on 9 February 2015. He was eventually removed from ARMS on 16 February 2015 and transferred into the mainstream prison population.[13] He was given a medical certificate recommending a single cell to allow him appropriate discreet care of his stoma.[14]

20. Throughout his incarceration Mr Cruz received regular monitoring of his diabetes, kidney function and blood pressure. He was placed on a diabetic management plan, which was regularly reviewed and updated. He was immunised yearly against influenza.

21. On 2 April 2015, after becoming a sentenced prisoner again, Mr Cruz returned to Hakea Prison. He was also placed back on ARMS, as he again indicated he wished to die via starvation.[15] He maintained this position until 7 April 2015. He commenced eating again and he was removed from ARMS the same day.

22. Mr Cruz had a counselling session on 7 April 2015. He appeared settled but was intermittently teary when talking about his deceased wife. He indicated he had been greatly disappointed by his sentence, which had prompted his intention to initiate a hunger strike. Though he still protested his innocence, he indicated he had come to a greater acceptance of the outcome and was reassured by news that he would move to Casuarina Prison Infirmary due to his multiple health conditions. He gave assurances that he had no active

[9] Exhibit 1, Tab 17, pp. 6 - 8.
[10] Exhibit 1, Tab 2, p. 4.
[11] Exhibit 2, Tab 1, EcHO notes.
[12] Exhibit 1, Tab 29 and Tab 30.6.
[13] Exhibit 1, Tab 30, Mudford Report, p. 7.
[14] Exhibit 2, Tab 5.
[15] Exhibit 2, Tab 5.

suicidal plan or intent. It was recommended that he be removed from ARMS as the crisis had abated.[16]

23. Mr Cruz was moved to Casuarina Prison on 14 May 2015. At his request, and due to the nature of his offences, Mr Cruz was registered as a protection prisoner.[17]

24. On 25 May 2015 Mr Cruz wrote to the Honourable Attorney General to seek early release on parole on compassionate grounds due to his various medical conditions. He indicated he would live with his son and daughter and would not leave the premises and was willing to wear an ankle security device to ensure compliance. The Honourable Attorney General at that time wrote to Mr Cruz on 16 June 2016 and informed him that he could not be released on parole in the ordinary process under the provisions of the *Sentencing Act 1995 (WA)*. He also informed Mr Cruz of the relevant process for the exercise of the Royal Prerogative of Mercy, but indicated that he was not persuaded it should be initiated in Mr Cruz's case.[18] I will return to the Royal Prerogative of Mercy later in this finding.

25. Mr Cruz was reviewed at Fiona Stanley Hospital Nephrology Clinic on 27 July 2015. At that time he had stage IV chronic kidney disease and worsening proteinuria (protein in urine), hypocalcaemia (low calcium levels), Vitamin D deficiency and secondary hyperparathyroidism. Changes to his medications were made and regular reviews scheduled.[19]

26. On 4 September 2015 Mr Cruz was commenced on insulin in an effort to better control his diabetes. On 16 September 2015 Mr Cruz was reviewed at Rockingham Hospital Diabetic Clinic and another antidiabetic medication was added to his treatment regime.

27. By this time a plan had been made to transfer Mr Cruz to Acacia Prison but he requested to be transferred to Albany Prison to be closer to his son and daughter-in-law.[20] This request was facilitated and he was transferred to Albany Prison on 5 October 2015 after his scheduled renal appointment in early October.[21] However, due to outstanding hospital appointments in Perth, Mr Cruz only remained in Albany for a week before he was transferred back to Perth and placed in Casuarina Prison on 13 October 2015. He was placed at Casuarina Prison because it has an infirmary.[22]

28. On 2 November 2015 Mr Cruz had a videolink consultation with a Nephrologist at Fiona Stanley Hospital and his possible need for dialysis in the future was recognised. It was recommended Mr Cruz see a renal education nurse to discuss dialysis.[23]

[16] Exhibit 1, Tab 29, Prison Counselling Session file note 7.4.2015.
[17] Exhibit 1, Tab 30, Mudford Report, p. 8.
[18] Exhibit 3.
[19] Exhibit 1, Tab 30.3.
[20] Exhibit 1, Tab 19.
[21] Exhibit 2, Tab 5.
[22] Exhibit 1, Tab 2, p. 4.
[23] Exhibit 2, Tab 5.

29. Throughout the end of 2015 and into early 2016, Mr Cruz's health deteriorated. On 11 January 2016 Mr Cruz visited the Nephrology Clinic at Fiona Stanley Hospital and investigations showed deteriorated in his renal function. Haemodialysis and peritoneal dialysis were discussed as options for treatment. Mr Cruz was not keen for haemodialysis but a meeting was arranged for him to discuss peritoneal dialysis with a specialist nurse.[24] It was explained that both forms of dialysis could be said to be equally invasive, but peritoneal dialysis can be conducted at home, or in this case in the prison, whereas haemodialysis requires attendance at a clinic with a haemodialysis machine three times per week and to be attached to the machine with a tube for a period of time.[25] There is also a limit to peritoneal dialysis, and eventually it will fail and a patient must move on to haemodialysis.[26]

30. By 12 February 2016 Mr Cruz had developed persistent anaemia and worsening renal function. Kidney dialysis became his only chance of long term survival.

31. On 18 February 2016 Mr Cruz was informed by specialists during a hospital visit that he required dialysis treatment. He initially declined renal dialysis, stating he was prepared to die. On his return to prison he was placed in the Crisis Care Unit and on ARMS. After speaking with the Crisis Care Unit staff and the prison counsellor he changed his position and presented as accepting of his situation.[27] He indicated that he had discussed his decision with his family and decided that his wife would not wish him to die in such a manner.[28]

32. Mr Cruz attended the Endocrine clinic at Rockingham Hospital in March 2016 for management of his diabetes. Mr Cruz was seen by the Stoma Care Services at Fremantle Hospital from April 2016 until November 2016 to assist him with care of his stoma.[29]

33. On 22 April 2016 Mr Cruz missed a step in his unit and fell. He sustained two small grazes to his knees and a small swelling over his right elbow.[30]

34. On 2 May 2016 Mr Cruz attended a Renal Clinic appointment. His dialysis options were reviewed and his preferred option, peritoneal dialysis, was considered to not be viable due to his previous abdominal surgery and colostomy. Mr Cruz still expressed reservations about haemodialysis.[31]

35. On 18 May 2016 Mr Cruz had a fall in prison, when he fell while folding washing and grazed his nose. He said it was just a loss of balance and he did not lose consciousness.[32]

[24] Exhibit 2, Tab 5.
[25] T 59 – 60.
[26] T 60.
[27] Exhibit 1, Tab 30, Mudford Report, p. 9.
[28] Exhibit 2, Tab 5.
[29] Exhibit 2, Tab 5.
[30] Exhibit 2, Tab 5.
[31] Exhibit 2, Tab 5.
[32] Exhibit 2, Tab 5.

36. On 27 May 2016 Mr Cruz had a GP review and at the end of the review it was suggested to the Director of Medical Services that Mr Cruz might be considered for Stage 1 of the Terminally Ill Prisoner list (meaning they have a terminal illness but are unlikely to die within the next 12 months).[33] On 29 May 2016 Mr Cruz was registered as a Stage 2 Terminally Ill Prisoner, which was defined as someone likely to die within the next 12 months, but unlikely to die within the next 3 months as their condition is relatively stable.[34]

37. On 2 June 2016 Mr Cruz was reviewed by vascular surgeons and the plan was to proceed to AV fistula formation and haemodialysis.

38. On 6 June 2016 Mr Cruz was transferred to Acacia Prison. Approximately two weeks later, on 20 June 2016, Mr Cruz indicated to prison counselling staff that he was not coping and was thinking about taking his life. Although he denied suicidal intent he was monitored on ARMS as a precautionary measure over the next few days. Supports and interventions were provided by unit, counselling and medical staff as well as peer support and chaplaincy services. After presenting as calm and settled, with improved mood, he was removed from ARMS on 23 June 2016.[35]

39. Around this time Mr Cruz also underwent a physiotherapy falls risk assessment. A recommendation was made that he be housed where there are no steps and to use a stick.[36]

40. On 28 June 2016 Mr Cruz attended Fremantle Hospital for formulation of a fistula but he was observed to have a productive cough, so he was transferred to Fiona Stanley Hospital and admitted to the renal team. He was diagnosed with pneumonia and underlying Chronic Obstructive Pulmonary Disease. He was treated with IV antibiotics to good effect and discharged back to Acacia Prison on 1 July 2016 with a further two week course of oral antibiotics.[37]

41. On 19 July 2016 a Code Blue (medical emergency) was called as Mr Cruz developed difficulties breathing. He was admitted to SJOG Midland with an exacerbation of congestive heart failure. He was discharged back to prison on 1 July 2016. He still had evidence of a chest infection on 8 July 2016 and on 14 July 2016 he fell out of bed.[38]

42. On 19 July 2016 a Code Blue was called due to Mr Cruz's respiratory distress and he was taken to the clinic in a wheelchair and then transferred to St John of God Hospital in Midland for treatment. He was diagnosed with exacerbation of his congestive cardiac failure and discharged back to prison on 21 July 2016. On 23 July 2016 he was checked by a nurse and his breathing was found to have improved.[39]

[33] Exhibit 1, Tab 30.4; Exhibit 2, Tab 5.
[34] T 61 – 62; Exhibit 1, Tab 30.4.
[35] Exhibit 1, Tab 30, Mudford Report, p. 9; Exhibit 2, Tab 5.
[36] Exhibit 2, Tab 5.
[37] Exhibit 2, Tab 5.
[38] Exhibit 2, Tab 5.
[39] Exhibit 2, Tab 5.

43. On 28 July 2016 another Code Blue was called for shortness of breath. Mr Cruz improved after using a salbumatol inhaler.

44. Mr Cruz had another documented fall on 29 July 2016, this time from a chair. He had no apparent injury but complained of being unable to walk due to pain in his legs. He was taken to the clinic in a wheelchair and reviewed.[40] His failing health was noted, including congestive cardiac failure, COPD and renal failure. It was recommended he be admitted to Casuarina Prison Infirmary.

45. Due to his failing health and increased frequency of falls he was transferred back to Casuarina Prison on 4 August 2016 so that he could be cared for in the Infirmary.[41] It appears he remained in the Infirmary thereafter, other than for the periods when he was hospitalised.

46. He had a GP review and his various chronic diseases were noted on 5 August 2016. He was updated on the Terminally Ill prisoner list that day and remained as Stage 2, with the belief he was likely to still have greater than six months to live.[42]

47. On 8 August 2016 Mr Cruz was taken to Fiona Stanley Hospital with exacerbation of his COPD. He was diagnosed with fluid overload secondary to end stage renal function. He was discharged back to prison on 11 August 2016 after treatment.[43]

48. On 15 August 2016 Mr Cruz was having difficulties with his memory, reporting gradual short term loss of memory over the past few months. His Mini Mental State Examination scored 20/30, which is consistent with mild to moderate cognitive impairment,[44] and a possible diagnosis of dementia was made.[45]

49. On 5 September 2016 Mr Cruz attended the renal clinic and was said to be stable and plans were being made for him to undergo haemodialysis. Another falls risk assessment was completed three days later.[46] The nature of this assessment was detailed to include recommendations about how he could be assisted with toileting and encouraged to maintain hydration levels, and the need for daily care.[47]

50. On 9 September 2016 Mr Cruz appeared confused and was recommended to have a CT brain scan. A Mini Mental State Examination scored 14/30, a significant deterioration from his last MMSE score, indicating progressive dementia and quite severe impairment.[48]

[40] Exhibit 2, Tab 5.
[41] Exhibit 1, Tab 27.
[42] Exhibit 2, Tab 5.
[43] Exhibit 1, Tab 30, Mudford Report, p. 9.
[44] T 73.
[45] Exhibit 2, Tab 5.
[46] Exhibit 2, Tab 5.
[47] T 65 – 66.
[48] T 73; Exhibit 2, Tab 5.

51. A head CT scan later performed on 23 September 2016 revealed small vessel disease with age related atrophy but no established pattern of specific type of dementia visible.[49]

52. On 13 September 2016 Mr Cruz was placed on the Support and Monitoring System (SAMS) and reviewed by the Prisoner Risk Assessment Group (PRAG) via monthly case conference.[50]

53. On 15 September 2016 Mr Cruz was admitted to Fremantle Hospital as a day case to undergo fistula formation in preparation for the commencement of kidney dialysis.

54. Mr Cruz was felt to be suffering from progressive dementia by this stage and frequent welfare checks were required due to his health-related behavioural issues, which placed him at risk of self-injury.[51] His behaviour became increasingly difficult to manage, with periods of aggression and agitation in the evenings. On 28 October 2016 Mr Cruz refused to have his medications or insulin and expressed a desire to die.

55. On 9 November 2016 Mr Cruz was seen briefly by the palliative care team. It was noted the team was unsure what they could offer Mr Cruz and they were recorded as saying they believed dialysis would probably be futile and offered to speak with the Fiona Stanley Hospital dialysis team.[52]

56. On 11 November 2016 Mr Cruz was seen by a prison medical officer, Dr Princewell Chuka, after he refused to talk to anyone. Mr Cruz was recorded as saying he should be allowed to die peacefully and he did not want any form of care. He was clearly very distressed. Mr Cruz was referred for palliation consideration.[53]

57. A review at the Nephrology Clinic on 14 November 2016 found his kidney function had worsened and Mr Cruz stated he did not want to prolong his life with dialysis. On 16 November 2016 this situation was communicated by the specialists to Dr Joy Rowland at Casuarina Prison. It was noted that Mr Cruz was clinically appropriate to commence dialysis but he had refused. He was said to be aware that he would die earlier without dialysis. The specialist, Dr Abu Abraham, reportedly felt that Mr Cruz understood the reality of refusing dialysis and felt his reasoning was sound and reasonable. However, he was still uncertain as to whether Mr Cruz could be said to be competent to make such a decision as his dementia was so advanced. He requested advice in relation to a guardian or next of kin who could assist in relation to the decision making. Dr Rowland spoke to Dr Chuka who agreed that Mr Cruz was probably not competent to make this sort of decision. A plan was made to discuss the matter with the Assistant Superintendent of Offender Services.[54]

[49] Exhibit 2, Tab 5.
[50] Exhibit 1, Tab 30, Mudford Report, p. 10.
[51] Exhibit 1, Tab 30, Mudford Report, p. 10.
[52] Exhibit 2, Tab 1, EcHO notes, 9.11.2016, 2.12 pm and Tab 5.
[53] Exhibit 2, Tab 1, EcHO notes, 11.11.2016, 4.31 pm, Dr Chuka.
[54] Exhibit 2, Tab 1, EcHO notes, 16.11.2016, 11.51 am, Dr Rowland.

58. I note at this stage that attempts were made on 17 and 18 November 2016 to contact Mr Cruz's next of kin, without success. Messages were apparently left. Further unsuccessful attempts were made on 22 and 23 November 2016.[55] Interestingly, in between those dates, Mr Cruz's son and other family visited him on 20 November 2016, but the prison staff organising the visits appear to have been unaware of the attempts to contact the next of kin, so it wasn't used as an opportunity to speak to Mr Cruz's son about the medical issues his father was having.[56]

59. There was a sudden deterioration in Mr Cruz's state at the end of November 2016.[57] On 27 November 2016 Mr Cruz was said to be extremely confused. He was banging on the door and removing his colostomy bag. He was transferred to a safe cell for observations.[58] It was indicated by a doctor at the inquest that this behaviour was more consistent with the increasing uraemia than the dementia/cerebral atrophy, due to its sudden onset and the types of behaviour exhibited.[59]

60. On 29 November 2016 Dr Rowland made an entry in the EcHO medical records related to an advance health directive. Dr Rowland's entry refers to a telephone call received from Mr Cruz's daughter-in-law and son. They were recorded as having told Dr Rowland they were willing to be Mr Cruz's guardians and assist with decision-making about his health care and other affairs. Dr Rowland indicated she explained Mr Cruz's current health status and outlined Mr Cruz's decision to decline dialysis. Dr Rowland understood from the conversation that Mr Cruz's family were fully supportive of Mr Cruz's decision not to continue with dialysis and they also did not wish him to have dialysis due to his poor quality of life. They were said to have accepted that his life would be shortened by not having dialysis and that he might suffer a sudden event or else have a gradual deterioration in health. Mr and Mrs Cruz's main expressed concern was that he not die inside the prison walls and they indicated a willingness to care for him in their home. Dr Rowland explained Mr Cruz's high care needs and advised he would require constant supervision and care. It was noted that a referral had already been made for an ACAT assessment, although as mentioned this may not have been processed given the way in which it was done.[60]

61. On the same day Dr Rowland provided the next of kin information to Dr Abraham by email and advised approval had been given for Fiona Stanley Hospital staff to discuss Mr Cruz's care needs and decisions with the next of kin. It was explained they lived on a farm and were often difficult to contact in daylight hours but they would return calls if messages were left.[61]

62. On 30 November 2016 Mr Cruz was reviewed by a palliative care team from Bethesda Hospital Aged Care, which is a specialist team that makes frequent visits to the prisons to help in determining how aged care patients are cared

[55] T 10 – 11, 23 – 25.
[56] T 26 – 27.
[57] T 79.
[58] Exhibit 2, Tab 5.
[59] T 77.
[60] Exhibit 2, Tab 1, EcHO notes, 29.11.2016, 12.00 pm, Dr Rowland.
[61] Exhibit 2, Tab 3, Email Dr Rowland to Dr Abraham.

for and managed.[62] Mr Cruz explained he was having a terrible time during the night when he was locked up in his cell. It was suggested that he needed assessment by a geriatrician.[63]

63. On 1 December 2016 Mr Cruz had a fall. The medical notes indicate the fall was unwitnessed but it appeared he was at the kitchenette when he fell backwards. He was found lying on his back, unconscious and unresponsive but still breathing. He had a laceration to the rear of his skull and a moderate amount of blood loss. He regained consciousness quickly and his head was bandaged and the bleeding stopped before the ambulance arrived. By the time the ambulance officers attended he was fully conscious and able to converse in full sentences.[64]

64. Mr Cruz was taken by ambulance to Fiona Stanley Hospital, where a CT scan confirmed there was no acute intracranial bleed or skull fracture. The laceration to his head was stapled and he was transferred back to prison. On the same day a prison psychiatrist reviewed his file and felt Mr Cruz was most likely suffering a delirium and recommended he be started on a low dose antipsychotic medication such as risperidone or haloperidol.[65] It was noted at the inquest that there was no suggestion from hospital staff at this stage that Mr Cruz required management in the hospital setting, given their willingness to discharge him back to prison.[66]

65. On 2 December 2016 Mr Cruz was reviewed by a doctor and found to be in good spirits and his wound was clean.[67]

66. Overnight on 2 to 3 December 2016 Mr Cruz flooded his cell. It was deemed unsafe for Mr Cruz to remain in his cell and so he was escorted into a safe cell for medical observation.[68]

67. Mr Cruz's behaviour continued to deteriorate and on 4 December 2016 he was found confused and distressed with his cell flooded, his stoma bag removed and faeces in the sink and on the floor.[69]

68. Mr Cruz's terminal status was escalated to Stage 4 (death considered to be imminent) on 6 December 2016 and it became clear he could no longer be managed in the prison setting. On a Terminally Ill Health Advice it was noted that the Department of Corrective Services were in the process of trying to find him a hospital bed where he could have nursing care without being locked in a cell, as he became very agitated and distraught when locked in. It appeared at times he didn't understand where he was or what was happening.[70]

[62] T 67.
[63] Exhibit 2, Tab 1, EcHO notes, 30.11.2016, 11.30 am.
[64] Exhibit 1, Tab 20; Exhibit 2, Tab 1, EcHO notes, 1.12.2016, 11.05 am.
[65] Exhibit 2, Tab 1, EcHO notes, 1.12.2016, 1.32 pm, Dr Bilyk; Exhibit 2, Tab 2.
[66] T 80.
[67] Exhibit 2, Tab 1, EcHO notes, 2.12.2016, Dr Fitzclarence.
[68] Exhibit 1, Tab 30.12.
[69] Exhibit 2, Tab 5.
[70] Exhibit 1, Tab 30.5.

69. In this regard, Dr Chuka, spoke to a Geriatric Registrar at Fiona Stanley Hospital about what could be arranged. The Registrar undertook to make enquiries.[71]

70. On 7 December 2016, the Geriatric Registrar at Fiona Stanley Hospital rang Dr Chuka and advised he had spoken to a Consultant about Mr Cruz and the hospital was not readily accepting a direct admission of Mr Cruz. It was suggested that Mr Cruz could be sent to the hospital's Emergency Department and he could then be reviewed by a geriatrician and admission could be considered.[72]

71. Mr Cruz was transferred to the Fiona Stanley Hospital Emergency Department that same day for geriatric and palliative care assessments. He was transported in handcuff restraints only and no leg irons were used due to his risk of falling.[73]

72. Unsuccessful attempts were made to notify Mr Cruz's son on 7 and 8 December 2016.[74] A note entered into the terminally ill module within TOMS by a staff member at Sentence Management noted that several attempts to telephone were made on 7 December 2016 and at least one call was made on 8 December 2016.[75]

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73. After presenting to the FSH Emergency Department, Mr Cruz was admitted under the care of the Nephrology Dialysis Department. Mr Cruz was diagnosed with end stage renal failure, uraemic encephalopathy, hypercalcaemia and urinary retention. It was noted he had an advanced directive in place (signed on 7 December 2016 after discussion with the Consultant)[76] and had refused dialysis "after having had extensive education in this regard."[77] The treatment aims were noted to be comfort measures following discussions between the treating team, palliative care, Mr Cruz and his family.[78]

74. A catheter was inserted to manage his urinary retention and he was trialled on IV pamidronate to reduce his high calcium levels in an effort to relieve some of his symptoms. Under the guidance of the palliative care team he was also prescribed diazepam, antipsychotics and a strong painkiller, fentanyl, to reduce his suffering and keep him as comfortable as possible.[79]

75. While being treated at Fiona Stanley Hospital Mr Cruz remained a sentenced prisoner and under the custody of the Department of Corrective Services.

[71] Exhibit 2, Tab 1, EcHO notes, 6.12.2016, 3.55 pm, Dr Chuka.
[72] Exhibit 2, Tab 1, EcHO notes, 7.12.2016, 12.00 pm, Dr Chuka.
[73] Exhibit 1, Tab 30, Mudford Report, p. 10.
[74] T 36.
[75] T 53 – 54.
[76] Exhibit 2, Tab 3, Not for CPR form.
[77] Exhibit 2, Tab 3, Discharge Summary 11.12.2016, p. 1.
[78] Exhibit 2, Tab 3, Discharge Summary 11.12.2016, p. 1.
[79] Exhibit 2, Tab 3, Discharge Summary 11.12.2016, p. 1.

He was guarded by Serco custody officers and physical restraints were used.[80] He was described as a frail and sick old man by that time.[81]

76. Mr Cruz was recorded as having had a fall while at the hospital on 8 December 2016. It did not occur in the presence of nursing or medical staff but they were advised of the fall by the guards and a falls protocol was commenced. His observations thereafter remained unremarkable.[82] The prison medical team were advised that he had the fall and no injuries had resulted.[83]

77. It was noted that Mr Cruz's next of kin, his son, was contacted on 9 December 2016 at 9.45 am and advised he had approval to visit his father in hospital.[84] One of Mr Cruz's granddaughters was also given permission to visit him, which took place at about 11.30 am on 9 December 2016, and a bit later that day the Serco guards received permission for Mr Cruz's treating doctors to speak to Mr Cruz's son on the telephone about his care. Arrangements were being made that evening for Mr Cruz's son and daughter-in-law to drive up to Perth to visit.[85]

78. A note was made on 9 December 2016 that if Mr Cruz could not be settled by an increase in his medications then consideration would be given to an admission to a hospice facility.[86]

79. On 10 December 2016, Dr Roanna Bornship, a Palliative Care Consultant at the hospital, telephoned and spoke to a nurse at the prison about Mr Cruz and advised of a deterioration in his medical condition and his delirious state. She asked that his restraints be released.[87] As this decision has security implications, it was referred up the chain to Dr Cherelle Fitzclarence and Dr Rowland and then on to the prison management team. The Superintendent of Casuarina, Mr Schilo, gave approval for reduction to a single leg restraint that day and this was communicated at 5.15 pm.[88]

80. Mr Cruz was visited by his son and daughter-in-law on the evening of 10 December 2016. They reportedly were abusive towards Serco staff because they were upset that he was in restraints. They were instructed to leave the room and stop shouting, which they did. The couple returned approximately half an hour later in a calmer state and were permitted to continue their visit.[89]

81. Mr Cruz died in the early hours of 11 December 2016. His death was confirmed by a doctor just after 3.00 am.[90] Initially, a doctor also purported to issue a medical certificate with the direct cause of death identified as uraemia on a background of hypercalcaemia, delirium and acute on chronic

[80] Exhibit 1, Tab 2, p. 5.
[81] Exhibit 1, Tab 2, p. 5.
[82] Exhibit 2, Tab 4C.
[83] Exhibit 2, Tab 1, EcHO notes, 8.12.2016, 1.20 pm.
[84] Exhibit 1, Tab 28.
[85] Exhibit 1, Tab 26.
[86] Exhibit 2, Tab 1, EcHO Notes 9.12.2016.
[87] Exhibit 2, Tab 1, EcHO Notes 10.12.2016 and 11.12.2016.
[88] T 21; Exhibit 1, Tab 30, Mudford Report, p. 10.
[89] Exhibit 1, Tab 30, Mudford Report, p. 10 and Tab 30.12.
[90] Exhibit 1, Tab 2, p. 1.

renal failure.[91] However, the WA Police were then notified of the death given Mr Cruz was a sentenced prisoner and hence his death came under the Coroner's jurisdiction. The medical certificate was therefore not accepted.

82. Two police officers from the Coronial Investigation Squad attended Fiona Stanley Hospital later that morning and commenced a coronial investigation into the death and Mr Cruz's body was taken to the State Mortuary for a post mortem examination to be conducted.[92] Mr Cruz's body was identified by his son at the State Mortuary.[93]

CAUSE AND MANNER OF DEATH

83. A post mortem examination was performed by a Forensic Pathologist, Dr Clive Cooke, on 14 December 2016.[94]

84. Dr Cooke found evidence of recent medical care, ischaemic heart disease, calcified coronary and aortic arteriosclerosis, granular atrophy of the kidneys (consistent with arteriosclerotic and diabetic nephroscloerosis), some enlargement of the prostate gland, with tiny calculi, and pulmonary congestions and oedema, with possible early bronchopneumonia. The early bronchopneumonia in the lungs was confirmed by microscopic examination.[95]

85. Neuropathology examination of the brain showed some areas of shrinkage (atrophy). Biochemical testing showed very high levels of urea and creatinine, consistent with chronic renal failure.[96]

86. Toxicology analysis showed the presence of several medications consistent with terminal medical care.[97]

87. At the conclusion of all investigations Dr Cooke formed the opinion that the cause of death was bronchopneumonia complicating terminal palliative medical care in an elderly man with chronic renal failure, ischaemic heart disease and cerebral atrophy. I accept and adopt the conclusion of Dr Cooke as to the cause of death.[98]

88. There is no evidence to suggest that Mr Cruz's fall on 1 December 2016 was the cause of Mr Cruz's final deterioration and death. Dr Cooke was asked about a possible head injury and confirmed there were no post mortem findings to suggest any internal brain injury and in his opinion the fall had no bearing on the cause of death.[99]

[91] Exhibit 1, Tab 6.
[92] Exhibit 1, Tab 2.
[93] Exhibit 1, Tab 5.
[94] Exhibit 1, Tab 7.
[95] Exhibit 1, Tab 7.
[96] Exhibit 1, Tab 7.
[97] Exhibit 1, Tab 7 and Tab 8.
[98] Exhibit 1, Tab 7.
[99] Exhibit 2, Tab 4.

89. There were some scabs on Mr Cruz's body when police viewed him at the hospital. They were noted by Dr Cooke in his post mortem examination.[100] It was felt by Dr Cooke they were most likely related to self-scratching.[101] This was supported by medical notes, which recorded that Mr Cruz had scratched his arms and was bleeding on 29 November 2016 after having a very disrupted night.[102]

90. There was also a bruise described on the right side of his abdomen. Dr Cooke responded to queries from Counsel Assisting about concerns raised by Mr Cruz's family in relation to the bruise. Dr Cooke noted the bruise on the right side of the abdomen appeared to between one and five or six days old and was most likely related to medical intervention or his documented fall on 8 December 2016.[103]

91. Following the cause of death given by Dr Cooke, and having excluded any contribution from the fall, I find that the manner of death was by way of natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

92. Under s 25(3) of the *Coroners Act 1996* (WA), 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.

93. The police investigation found the death was non-suspicious and there was no evidence to suggest Mr Cruz's incarceration contributed to his death, although it was noted that Mr Cruz's son was critical of the justice system and the way it had dealt with his father.[104]

94. The Department of Justice undertook its own review and found that there was policy and procedural compliance during Mr Cruz's prison term and that the deaths in custody procedures were followed. No business improvement recommendations were made.[105] Mr Richard Mudford, a Senior Performance Analyst in the Performance Assurance and Risk Division, conducted the review and prepared a report outlining the results of the review. He also gave evidence at the inquest.

95. In addition, Dr Fraser Moss, a Specialist General Practitioner, reviewed Mr Cruz's medical records at the request of the Acting Director of Health Services of the Department, and prepared a report of Mr Cruz's medical care whilst imprisoned leading up to his death.[106] Dr Moss ordinarily holds the position of Principal Prison Medical Officer with the Health Services Division of the Department, although he was on extended leave at the time he prepared the report.[107] Dr Moss had treated Mr Cruz on one occasion, on

[100] Exhibit 1, Tab 3 and Tab 7.
[101] Exhibit 2, Tab 4.
[102] Exhibit 2, Tab 1, EcHO notes, 29.11.2016.
[103] Exhibit 1, Tab 7, p. 2.
[104] Exhibit 1, Tab 2.
[105] Exhibit 1, Tab 30, Letter dated 19 April 2018.
[106] Exhibit 2, Tab 5.
[107] Exhibit 2, Tab 5.

19 October 2015, in relation to his stoma, but was not otherwise involved in his medical care.[108]

96. Dr Moss noted that Mr Cruz had many clinical problems, which required ongoing care and were a challenge to the clinical teams in the prisons. However, he concluded that Mr Cruz was provided with comprehensive professional clinical care during his imprisonment, which was consistent with his needs and in accordance with best medical practice.[109]

97. It was put to Dr Moss by counsel appearing on behalf of the family that consideration should have been given to subjecting Mr Cruz to dialysis against his wishes where the family had not been contacted and there were questions about Mr Cruz's competence to make that decision. Dr Moss disagreed and indicated that it was his belief it would have been an assault, but in any event it would have been impossible to do against his will unless he was sedated.[110] Once it was decided that Mr Cruz was not having dialysis and he became uraemic, Dr Moss indicated it was appropriate for Mr Cruz to commence palliative care as his progression was inevitable.[111]

98. From the information available it appears to me that every effort was made by the prison medical team and hospital staff to manage Mr Cruz's condition as well as possible, within the restrictions of him being a sentenced prisoner. He received appropriate medical care and allied health support such as podiatry and optometry visits. He attended regular outpatient clinics for dialysis, diabetic monitoring and for his other health needs, and his health was closely monitored.[112]

99. Mr Cruz was permitted to have visits from family members, other than children, and was able to maintain contact with family and friends by telephone.[113] His request to be transferred to Albany to be closer to his son was facilitated temporarily but unfortunately was unable to continue for long due to his increasing health needs.[114]

100. Prior to being housed in the infirmary there is evidence his frailty and limited mobility were noted by prison officers and he was exempted from working, given a single person cell and regularly monitored by prison staff.[115]

101. In the last few weeks of Mr Cruz's life his condition had significantly deteriorated and it was clear that without dialysis he would die. However, even if he had agreed to dialysis, doubt was expressed that it would achieve significant results.[116]

102. Mr Cruz died of natural causes as a result of his chronic medical conditions. His death was not unexpected and there was nothing to suggest the care he

[108] Exhibit 2, Tab 5.
[109] Exhibit 2, Tab 5.
[110] T 81.
[111] T 86.
[112] Exhibit 1, Tab 23 and Tab 30.3.
[113] Exhibit 1, Tab 23.
[114] Exhibit 1, Tab 23.
[115] Exhibit 1, Tab 29.
[116] Exhibit 2, Tab 1, EcHO notes, 9.11.2016, 2.12 pm.

received was any less than what he would have expected to receive in the community.

103. Dr Moss' evidence was that Mr Cruz did show evidence of progressive dementia, but in addition his symptoms of being relatively stable and amenable during the day, with exacerbation of confusion, delirium and behaviour changes at night, was consistent with uraemia (raised levels of urea in the blood), which was consistent with his deteriorating kidney function.[117] Some of his other symptoms, such as skin irritation and restless legs syndrome, were also consistent with uraemia. The only treatment for uraemia is renal dialysis, which Mr Cruz had refused.[118]

104. An issue does arise on the evidence in relation to Mr Cruz's capacity to make decisions about his care, in particular to refuse dialysis towards the end of his life. However, as I have detailed in the chronology of events above, Mr Cruz took a generally consistent stance against dialysis from as early as January 2016, although he did appear to waver for a time in around February 2016 when he discussed his decision with his family and considered how his late wife might feel about his decision not to proceed with the treatment and he believed peritoneal dialysis was available to him. By May 2016, he was back to expressing reservations about haemodialysis, which was the only form of dialysis available to him. When he ultimately refused dialysis in November 2016, his renal specialist considered his decision was a sound and reasonable one in his circumstances, but had reservations about his capacity to make that decision. When Mr Cruz's family were finally consulted, they accepted and supported his decision.

105. While I accept that the Department might, and probably should, have done more to have Mr Cruz's mental capacity assessed to make such a decision at an earlier stage when it became apparent he was going to refuse dialysis and may begin to have issues of capacity, I am satisfied that the decision was consistent with the wishes he had expressed before his cognitive function was reduced, and was a reasonable decision to choose not to prolong his life for a limited period in circumstances where he had a number of co-morbidities and was almost inevitably going to die in prison in any event from one of his medical conditions.

106. Where a patient is identified as a Terminally Ill Prisoner, the only reference to liaison with the family in Policy Directive 8 seems to be at 3.3, which directs the reader to Policy Directive 82 – Prisoner Movements. This policy then directs, at Section 24, that the superintendent shall, subject to security considerations, arrange for the prisoner's next of kin to be advised if a prisoner is taken to hospital or another place for assessment/treatment as a result of serious injury or illness. It goes on further to provide in Section 24.6 for notification of next of kin where there is serious or imminent threat to life.

107. In my view, aspects of how and when the family should be contacted in relation to a patient with a terminal illness might be better placed within

[117] Exhibit 2, Tab 5.
[118] Exhibit 2, Tab 5.

Policy Directive 8, with more thought given to the types of decisions that are likely to arise with a prisoner suffering from a terminal illness. Medical staff within the prison might also take more initiative in assisting with identifying the prisoner's wishes and facilitating the completion of forms, such as 'do not resuscitate' type forms or other health directives. These could then, with the consent of the prisoner, be communicated by health staff to the prisoner's nominated next of kin. This might avoid a situation, such as arose in this case, where the family felt they were receiving limited information on which to base decisions.

Contact with Family

108. Mr Cruz had regular visits from family in 2015 and 2016, as well as visits from lawyers from time to time.[119] He was also able to speak to family and friends by telephone.[120]

109. There is a record in the Total Offender Management Solution (TOMS) records suggesting that there were problems with notifying Mr Cruz's next of kin on 17 and 18 November 2016 and 22 and 23 November 2016. Contact was then recorded as having been made with Mr Cruz's next of kin on 28 November 2016, before there were difficulties again on 7 and 8 December 2016. The document does not elaborate on how contact was attempted,[121] but other documents, identified as Terminally Ill Next of Kin/Family Notifications, do provide that information.

110. There are some issues about accuracy of information in the documentation, as one record made by a doctor as part of the terminally ill health advice on 5 August 2016 recorded Mr Cruz as having a supportive wife, although she had died some years before. This error was repeated in the next terminally ill health advice completed by the same doctor on 6 October 2016. It was corrected on the following terminally ill health advice completed by a different doctor on 4 November 2016. It was noted at that time that Mr Cruz's wife had died some years before although Mr Cruz did not always remember this.[122] The fact that he had a supportive son and daughter-in-law was then properly recorded.[123] It is possible the incorrect information arose due to Mr Cruz's confusion. It is very unfortunate that it was not immediately verified, but I note it was corrected prior to his death and correct information about his wife's death was recorded earlier on other prison records.[124]

111. The next of kin notification forms indicated that Mr Cruz's son and daughter-in-law were correctly recorded as the next of kin and attempts were made to contact them by telephone without success, so a message was left. It appears two calls were made on 17 November 2016 and one more on 18 November 2016.[125] On 18 November 2016 an ACAT assessment was

[119] Exhibit 1, Tab 30.9.
[120] Exhibit 1, Tab 30.9.
[121] Exhibit 1, Tab 30.5.
[122] Exhibit 1, Tab 30.5.
[123] Exhibit 1, Tab 30.5.
[124] Exhibit 1, Tab 30.6.
[125] Exhibit 1, Tab 30.5.

recorded as having been requested to consider Mr Cruz's suitability for placement in a non-custodial setting, as Mr Cruz would require an environment offering intensive support.[126] It was also noted at that time that, given the failure to make contact with the next of kin, a form had been completed for the purposes of applying for a guardian for Mr Cruz if his family were not willing or able to assist with health decisions.[127]

112. Later evidence indicated the ACAT referral may not have gone through in its ordinary form, as the GP instead wrote a referral to the geriatric services at Fiona Stanley Hospital, and in a subscript wrote that it was a referral to the ACAT team. It seems there may have been some confusion about which document governed the process.[128] A doctor gave evidence that an ACAT assessment would have been unlikely to have contributed more or changed Mr Cruz's ongoing management, in any event, as Mr Cruz was already being provided with all assistance necessary to maintain his daily living activities in the infirmary.[129] This doesn't really address the question of what assistance he would require outside of a prison setting, which an ACAT assessment could have informed, but I note that no recommendation was made for Mr Cruz to be released in any event, so it is perhaps of less significance.

113. After further attempts to call Mr Cruz's son or daughter-in-law on 22 and 23 November 2016, Mr Cruz's son was eventually successfully contacted on 28 November 2016. The notification form records that he was briefed regarding his father's situation and requested to contact Dr Rowland to discuss guardianship.[130]

114. Mr Cruz's son contacted Dr Rowland the following day. Dr Rowland's note was that after some discussion Mr Cruz's daughter-in-law and son indicated they were willing to be Mr Cruz's guardians and assist with decision-making about his health care and other affairs. They were supportive of Mr Cruz's decision not to continue with dialysis and their main expressed concern was that he not die inside the prison walls. Mr Cruz's son and family were willing to care for him in their home if this could be arranged.[131]

115. At the inquest, information was provided of the family's position. They indicated when they spoke to Dr Rowland, they were under the assumption that "he was entering his final stage of life, not near the end."[132]. In discussing dialysis care, Mr Cruz's daughter in law did not believe anyone discussed with them the pros and cons in detail so they could have perhaps spoken to Mr Cruz and tried to convince him to have dialysis. Mrs Cruz emphasised that she and her family experienced a great deal of stress, heartbreak and anger about how his treatment affected his mental wellbeing, and felt if he had been hospitalised earlier, and they had been notified, they

[126] Exhibit 1, Tab 30.5.
[127] Exhibit 1, Tab 30.5.
[128] Exhibit 2, Tab 5.
[129] T 69; Exhibit 2, Tab 5.
[130] Exhibit 1, Tab 30.5.
[131] Exhibit 2, Tab 1, EcHO notes, 29.11.2016, 12.00 pm, Dr Rowland.
[132] T 48.

could have had an opportunity to spend more time with him and they believe he would have been more settled with his family by his side.[133]

116. Mr Cruz's family has indicated in submissions filed on their behalf that they did not receive any messages on 17, 18, 22 and 23 November 2016.[134] I am not in a position to establish why not.

117. On behalf of the family it was put that there was a system failure in relation to contacting them. Mr Mudford was asked this in questioning, and although he did not concede there was a problem with the system, he accepted there could have been more done in the individual circumstances of this case to try to make successful contact with the family.[135]

118. It was submitted, that more could and should have been done to contact the family, given the seriousness of Mr Cruz's health conditions and the relative simplicity with which other steps could have been attempted, such as placing a flag on visits to the deceased and/or requesting local police attend to notify the family.[136]

119. Submissions filed on behalf of the Department acknowledged the unfortunate delay between the Department first attempting to contact Mr Cruz's family (17 November 2016) and contact being successfully made (28 November 2016). However, the Department submits all reasonable attempts were made to contact the family, in the sense that the successful contact was eventually made on a telephone number that was used in a number of the earlier unsuccessful attempts.[137]

120. I agree with the submission that more could and should have been done to contact Mr Cruz's family, given it was apparent that his health had dramatically declined, as supported by the change in his status from Stage 2 directly to Stage 4 on the Terminally Ill register.

121. It will depend upon each individual case what steps are taken in such circumstances, but I consider it is incumbent on the Department to consider alternative options where simply leaving a message is not achieving the aim of making contact with the family and it is apparent the prisoner may die at any time.

122. It was clear in this case that Mr Cruz's son and his family were still actively involved in his life and it would have been a relatively simple task to check the visitor register and see if further visits were scheduled, as was indeed the case on 20 November 2016. The evidence suggests it would not have altered the decision for Mr Cruz to not receive dialysis, but it would have perhaps given Mr Cruz's family a better opportunity to process the information, and indeed to speak to him during the visit and make their own assessment of his understanding and reasons for his decision.

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[133] T 48.
[134] Brief Outline of Submissions on behalf of the Family of the Deceased, filed 1 March 2019.
[135] T 44.
[136] Brief Outline of Submissions on behalf of the Family of the Deceased, filed 1 March 2019.
[137] Written Submissions on behalf of the Department of Justice, filed 8 March 2019.

123. Mr Cruz's family's submissions conclude with the phrase that they were "effectively robbed of the chance to say goodbye."[138] Whilst it might not have been ideal, and was less than they wished, I note that Mr Cruz and his wife, and another relative, were notified prior to Mr Cruz's death of his imminent death and they were able to attend the hospital and visit him before he died. It cannot, in those circumstances, be said that they had no opportunity to say goodbye.

124. It is difficult to see how best to frame a recommendation in these circumstances, so I will leave it more as a comment, but I reiterate my conclusion that more could have been done in this case to alert Mr Cruz's family to his imminent death and I would expect the Department in another case to think a little bit more laterally, and consider other alternative means of contact if a similar situation arises.

Royal Prerogative of Mercy

125. I noted earlier that there is a process, known as the Royal Prerogative of Mercy, which can allow early release of a prisoner. It is a discretionary power, invested in the Governor of Western Australia as the Queen's representative, and Part 19 of the *Sentencing Act 1995* (WA) also creates a statutory scheme, which provides scope for the Attorney General to exercise the Royal Prerogative of Mercy by referring a petition to the Court of Appeal for the whole case to be reviewed as if it were an appeal. Alternatively, the Governor may exercise the Prerogative of Mercy in relation to an offender. It is a decision that is made by the Governor under advisement of the Executive Council.

126. When Mr Cruz wrote to the Honourable Attorney General on 26 May 2016, he was not yet registered as a terminally ill prisoner by the Department, although that occurred only days later. The Honourable Attorney General's response to Mr Cruz at the time was that his medical conditions were a matter for management by the Department and he was not persuaded he should interfere with his sentence by advising the Governor to make a parole order. He did however, forward Mr Cruz's correspondence to the Prisoners Review Board and the Minister for Corrective Services for future reference.[139]

127. Once Mr Cruz was registered as a terminally ill prisoner, it brought into play a policy and set of procedures for dealing with prisoners with a terminal medical condition, Policy Directive 8. This includes provision for the Department to provide information that might prompt the exercise of the Royal Prerogative of Mercy for prisoners whose death is imminent. The Department's internal review determined Policy Directive 8 had been complied with in relation to Mr Cruz.[140]

128. There are a number of factors to be taken into consideration before someone is eligible for release under Policy Directive 8, prior to any recommendation being contemplated.[141] One of the procedures requires that where a prisoner

[138] Brief Outline of Submissions on behalf of the Family of the Deceased, filed 1 March 2019.
[139] Exhibit 3.
[140] Exhibit 1, Tab 30, Mudford Report and Tab.30.4.
[141] T 8.

has been classified as a Stage 3 or Stage 4 terminally ill prisoner, a briefing must be prepared to the relevant authority providing details of:

- their criminal history and sentence,
- other relevant details such as estimated life expectancy and community supports,
- information about how they have served their sentence, such as whether they have attended programs within the prison and treated their offending behaviour,
- together with a recommendation as to whether the prisoner is suitable for release into the community.[142]

129. For State prisoners, the briefing is prepared by Sentence Management and it is passed up the chain of command through the Commissioner and Director-General and ultimately given to the Minister. If a recommendation is made for release, it is also forwarded to the Attorney General for consideration and finally must go before the Executive Committee to then make a recommendation to the Governor.[143] It is apparent from the policy that it is a lengthy process, and the ultimate decision does not rest within the Department of Corrective Services.[144] As Mr Mudford explained, a person can unfortunately die before the process is finalised.[145]

130. The trigger for the consideration of release under the Royal Prerogative of Mercy provisions is when the prisoner is classed as Stage 3 or Stage 4. Mr Cruz remained classed as Stage 2 on the Terminally Ill prisoner list until approximately one week before his death.[146]

131. Mr Mudford also explained that the factors to be considered are not just the health status of the prisoner and whether there is a place outside the prison that can accommodate them and their health needs. Mr Mudford said that often there are difficulties finding an appropriate community placement.[147]

132. In the case of Mr Cruz, it was relevant that he remained a strong denier of his offending behaviour. Therefore, by default, he was considered a risk to the community and this appeared to be a major factor in any recommendation made.[148]

133. It was put to Mr Mudford that, given Mr Cruz's poor health, that risk would be small.[149] However, I note that Mr Cruz was convicted of intrafamilial offences against more than one relative and was not permitted visits with children while in prison as he was a registered child sex offender.[150] The briefing note prepared from around 6 December 2016 and finalised on 9 December 2016, emphasised that at that stage he was not bedridden,

[142] T 8 – 9.
[143] T 9.
[144] Exhibit 1, Tab 30.4.
[145] T 9.
[146] T 53, 56.
[147] T 9.
[148] T 10.
[149] T 42.
[150] Exhibit 1, Tab 30.7.

albeit he had mobility issues.[151] I am informed the briefing did not reach the stage of final endorsement by senior staff as Mr Cruz died before it could be finalised.

134. Towards the end, there were also some issues contacting the family, which made it difficult to gauge his level of community support.[152]

135. It is apparent from the documentation on the brief that there were some attempts to have Mr Cruz's ability to be accommodated in the community assessed, with an ACAT assessment requested, although as I noted above, there were some issues with how this was undertaken. There is also a record that attempts were made to contact Mr Cruz's son again after the health advice was provided on 6 December 2016, to ascertain his willingness to be a full time carer for Mr Cruz should he be released on a Royal Prerogative of Mercy, but Mr Cruz's son was unable to be contacted despite several attempts to call him on 7 and 8 December 2016.[153]

136. The briefing to the Minister was finalised by the Sentence Management Unit on 9 December 2016 and no recommendation was made for release of Mr Cruz under the Royal Prerogative of Mercy at that stage. It was noted the ACAT assessment and another assessment had been requested and it was anticipated a further briefing might be required once those assessments had been completed.[154]

137. The Director General of the Department of Justice advised this Court that early release under the Royal Prerogative of Mercy provisions had been considered for Mr Cruz but was not recommended due to limited community support and perceived risk to the community due to his continued mobility, in particular to any young females.[155] It was noted that Mr Cruz continued to deny his offending and remained untreated, so his risk of reoffending was felt to be high. Mr Mudford confirmed that no recommendation was intended to be made that he be released.[156]

138. In terms of the viability of Mr Cruz being cared for at home, if he had been recommended for release, Dr Moss expressed the opinion that his needs by that time could not have been met without "very, very significant modifications and the availability of a full-time carer."[157] There is, however, the possibility that he may have still remained in hospital, but at least would not have required a leg restraint and guards to be present.

139. Ultimately, the decision whether to exercise the Royal Prerogative of Mercy is one for the Governor and/or the Government, and the process is entirely discretionary. There is already a process within the Department for providing advice and recommendations to the relevant decision-makers and I do not consider it necessary or appropriate to make any recommendation in that regard.

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[151] Exhibit 5.
[152] T 9 - 11.
[153] Exhibit 1, Tab 30.5.
[154] Exhibit 1, Tab 30.5.
[155] T 43; Exhibit 1, Tab 30, Letter dated 19 April 2018.
[156] T 42.
[157] T 74.

Restraints

140. The Serco operational instruction for hospital inpatient guarding was included in the brief of evidence. The policy indicates that all hospital sits will be carried out "in a manner that provides for the security, safety, privacy and dignity of the Person in Custody."[158] There is a presumption that the person will be restrained throughout, as the policy directs that officers must not allow any person in custody to be unrestrained unless it is authorised by a member of the Senior Management Team following a risk assessment, or it is ordered by a medical practitioner due to a medical emergency.[159]

141. The policy also requires that the officers are to "maintain continuous and direct visual observation of the Person in Custody at all times including when the Person in Custody is attending the bathroom or toilet."[160]

142. The occurrence log book kept by the Serco officers shows that the restraints were removed when Mr Cruz had to attend the bathroom and that medical checks were able to be performed when he was restrained. There was a note made at 10.20 pm on 8 December 2016 that additional restraints were added due to his frantic behaviour for his safety. This is further elaborated upon in a note at 1.30 am the following morning, where Mr Cruz is noted to be yelling and kicking and behaving erratically, and his behaviour continued to be very unsettled for the rest of the night.

143. The Department of Corrective Service's Prison Order relating to restraints on external escorts indicates that generally prisoners admitted to hospital are required to have two points of restraint, which means the prisoner is restrained by way of chain link ankle to ankle and another chain link from the ankle to the bed.[161] During the afternoon of 10 December 2016 Mr Cruz's security was reviewed in regard to the application of restraints at the request of his attending doctors. Serco made enquiries with the Department of Corrective Services and ultimately Superintendent Schilo gave approval to reduce the application of restraints to one single point, being Mr Cruz's leg. Mr Cruz's family were also advised that his condition was critical.[162]

144. There is a note that Mr Cruz's next of kin visited him in hospital late in the afternoon on 10 December 2016 and they became upset upon seeing Mr Cruz restrained to his hospital bed. Mr Cruz's son was reported to have been shouting abuse at Serco officers so Mr Cruz's son and daughter-in-law were asked to stop shouting and leave the room. Hospital security staff attended and removed them from the hospital. After Mr and Mrs Cruz had calmed down, they were allowed to re-enter and continue their visit with Mr Cruz.[163]

[158] Exhibit 1, Tab 30.10.
[159] Exhibit 1, Tab 30.10 [1.7].
[160] Exhibit 1, Tab 30.10 [4.1].
[161] DCS Prisons Order – No 01/2017 External Escorts Restraints [8.1.4], [9.1.7].
[162] Exhibit 1, Tab 30.11; Exhibit 2, Tab 1, EcHO note 11.12.2016, 8.48 am Dr Fitzclarence.
[163] Exhibit 1, Tab 30.12.

145. I can understand why Mr Cruz's family would be upset to see him restrained when he was clearly very ill and near death. However, there are security aspects that come into play, and the decision to permit a single restraint was made by the superintendent of the prison, so a person of great seniority with significant experience in making security-related decisions with regard to prisoners. It was made following medical advice that it was appropriate for restraints to be removed. My role is to consider Mr Cruz's treatment, care and supervision, and I do apply my mind to the use of a single leg restraint in that regard.

146. Dr Bornship apparently made her recommendation for removal of the restraints as per the National Guidelines for Management of Delirious Patients. I have viewed that document and note that there is an emphasis in the document on the avoidance of physical restraints as it has been shown to contribute to delirium.[164] I am not aware in this case of what information was provided to the superintendent to explain why Dr Bornship was making the recommendation, so I can't really take it further, although it does appear from the medical note that prison medical staff were informed, who I would assume would be aware of these guidelines. For future cases, where a doctor is making the recommendation for a prisoner who is known to have delirium, that information should be provided to the relevant decision-maker, so that they can have a full understanding when balancing issues of security with the wellbeing of the prisoner.

CONCLUSION

147. Mr Cruz was an elderly man with complex medical conditions and in failing health when he was released into the community after serving his first prison sentence. When he returned to prison his health deteriorated further and he appeared to lose hope. He was facing early death from a number of medical conditions and decided he did not want to prolong his life by receiving dialysis. Although he was a prisoner, he was entitled to make that choice, like any adult in the community who is mentally able to understand the consequences of their choice. While there is some issue with his ability to understand those consequences towards the end of his life, when he had full capacity he still made that choice and doctors understood it was a reasonable decision given the circumstances he was facing.

148. While terminally ill, Mr Cruz remained relatively stable for quite a long time and was cared for appropriately within the prison system. When his health issues became too great, he was moved to a hospital, where a greater level of medical care could be provided. He was given palliative care, which was the only reasonable option following his decision to refuse dialysis, and kept as comfortable as possible until his death.

149. There was an issue in this case in relation to contacting Mr Cruz's family when he took a significant turn for the worse and his death became imminent. I have concluded that the Department could and should have

[164] *Clinical Practice Guidelines for the Management of Delirium in Older People*, Published by the Victorian Government Department of Human Services, Melbourne, Victoria, Australia on behalf of AHMAC, October 2006.

done more to contact them at an early stage and keep them better informed about Mr Cruz's medical care and his imminent death. Fortunately, they were able to be contacted, and to visit Mr Cruz, in the hours before his death. Although I understand that they wished for more time with him, and a more comfortable environment within which to care for him, his repeated criminal offending had made that subject to the decision-making of the authorities, and no decision to exercise a discretion to release him on the grounds of mercy was made prior to his death. That is not a decision I am entitled to second guess within my role.

150. My role is to consider whether Mr Cruz's treatment, supervision and care were of an appropriate standard, and I have found that they were.

S H Linton
Coroner
31 May 2019