Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 18/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Garth Cyril HEAVEN*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***10 May 2019*** *find that the identity of the deceased person was* ***Garth Cyril HEAVEN*** *and that death occurred on* ***26 July 2016*** *at* ***Bethesda Hospital****, from* ***bronchopneumonia complicating a metastatic and locally advanced primary adenocarcinoma of the right lung in a man under palliative care*** *in the following circumstances:-*

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner

Ms A Davies (State Solicitor's Office) appeared on behalf of the Department of Justice

Table of Contents

INTRODUCTION 2
THE DECEASED 2
Background 3
Offending History 3
Application for Parole 4
Overview of Medical Conditions 5
PRISON HISTORY 5
Hakea Prison: 26 July 2013 - 03 February 2015 6
Casuarina Prison: 03 February 2015 - 5 November 2015 6
Acacia Prison: 5 November 2015 - 24 March 2016 6
Casuarina Prison: 24 March 2016 - 17 July 2016 7
DIAGNOSIS & SUBSEQUENT MANAGEMENT 8
CAUSE AND MANNER OF DEATH 10
QUALITY OF SUPERVISION, TREATMENT AND CARE 11

INTRODUCTION

1. Garth Cyril Heaven (the deceased) died on 26 July 2016 at Bethesda Hospital as a result of bronchopneumonia complicating a metastatic and locally advanced primary adenocarcinoma of the right lung.

2. At the time of his death the deceased was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Corrective Services, as it then was.[1]

3. Accordingly, immediately before his death, the deceased was a "person held in care" within the meaning of the *Coroners Act 1996* (WA) (Coroners Act) and his death was a "reportable death".[2]

4. In such circumstances, a coronial inquest is mandatory.[3]

5. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[4]

6. I held an inquest into the deceased's death on 10 May 2019.

7. The documentary evidence adduced at the inquest included two independent reports of the deceased's death prepared by the Western Australia Police[5] and by the Department of Justice[6] respectively, which together comprise two volumes.

8. Mr Richard Mudford, a senior review officer employed by the Department of Justice and the author of the Death in Custody review was called as a witness at the inquest.

9. The inquest focused on the care provided to the deceased while he was a prisoner, as well as on the circumstances of his death.

---

[1] Section 16, *Prisons Act 1981 (WA)*
[2] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[3] Section 22(1)(a), *Coroners Act 1996* (WA)
[4] Section 25(3) *Coroners Act 1996* (WA)
[5] Exhibit 1, Vol 1, Tab 2
[6] Exhibit 1, Vol 2

THE DECEASED

Background[7,8]

10. The deceased was born in Kadina in South Australia on 25 February 1959, and had three siblings. At the time of his death he was 57-years of age.

11. The deceased's father was reportedly a violent alcoholic and the deceased's mother is said to have left home with the deceased and his siblings in about 1971. The deceased completed year 10 at school and at 15-years of age, he left the family home and worked as a fruit-picker and on the railways.

12. It appears the deceased came to Western Australia in 1979 and began an apprenticeship as a boilermaker in Port Hedland.

13. The deceased had married twice with his second marriage producing two children. During his second marriage the deceased lived in New Zealand, undertook civil engineering studies and ran his own steel fabrication business.

14. In 1984 the deceased separated from his second wife and returned to Australia. The deceased was in a defacto relationship at the time he entered prison and was reported to be his defacto partner's full-time carer.

Offending History

15. The deceased had an extensive criminal record with numerous convictions for traffic and drug-related offences from 1979. In 1983, he was sentenced to a term of 4 years imprisonment for possessing heroin with intent to sell or supply.[9]

16. It appears that the deceased was convicted of offences in South Australia and Victoria in 1977 and the Northern Territory in 1995.[10]

[7] Exhibit 1, Vol 1, Police Investigation report, pp2-3
[8] Exhibit 1, Vol 2, Death in custody review, pp4-5
[9] Exhibit 1, Vol 2, Tab 1, Criminal History
[10] Exhibit 1, Vol 2, Death in custody review, p5

17. On 8 August 2000, the deceased was convicted of the offences of breaching a community based order, giving a false name and stealing. He was sentenced in the Perth Court of Petty Sessions (as it then was) a cumulative term of 1 year and 9 months imprisonment.[11]

18. On 1 April 2005, the deceased was sentenced in the District Court of Western Australia at Perth to a cumulative term of 5 years and 2 months imprisonment with respect to two counts of manufacturing amphetamines.[12]

19. The deceased was declared a drug trafficker on 29 November 2007 following his second conviction for possessing heroin with intent to sell or supply. He was sentenced to imprisonment for 2 years and 6 months.

20. In relation to his last incarceration, the deceased was convicted of the offences of aggravated burglary, grievous bodily harm and two counts of assault occasioning bodily harm, in the District Court of Western Australia at Perth on 3 July 2014.[13,14]

21. He was sentenced to a term of 4 years' imprisonment (backdated to 18 May 2013).[15] He was made eligible for parole and had an earliest eligibility date of 17 May 2015.[16]

Application for Parole

22. On 12 March 2015 and on 5 May 2016 respectively, the Prisoners Review Board of Western Australia (PRB) refused the deceased's applications for parole.

23. The PRB's refusal on 5 May 2016 was based on the deceased's previous poor response to community supervision, his unmet medical needs and the unviability of his parole plan.[17,18]

---

[11] Exhibit 1, Vol 2, Tab 1, Criminal History
[12] Exhibit 1, Vol 2, Tab 1, Criminal History
[13] Exhibit 1, Vol 1, Tab 19, Sentence Summary
[14] Exhibit 1, Vol 2, Tab 2, Transcript of Proceedings – District Court of Western Australia (03.07.14)
[15] Exhibit 1, Vol 1, Tab 18, Warrant of Commitment
[16] Exhibit 1, Vol 2, Death in Custody Review, p5
[17] Exhibit 1, Vol 2, Tab 10, Decision – Prisoner Review Board of Western Australia (05.05.16)
[18] Exhibit 1, Vol 2, Death in Custody Review, pp7-8

Overview of Medical Conditions[19]

24. At the time of his admission, the deceased was noted to have had his spleen removed in childhood following a motor vehicle accident, to have gallstones and be positive for hepatitis C.[20,21]

25. The deceased had been a smoker and had a history of illicit drug use, including heroin. He was on the methadone opiate replacement program at the time of his most recent incarceration and this was continued whilst he was in prison.

26. The deceased had smoked cigarettes since he was in his late teens and several efforts were made to address this during his incarcerations. It appears the deceased ceased smoking about 2½ years before his death.

27. During his last incarceration the deceased was managed for prostatism (an obstruction of the neck of the bladder), back and chest pain, dental issues and headaches.[22] Prison records show that he attended various prison medical centres on 98 occasions for treatment of these issues.[23]

PRISON HISTORY[24]

28. Whilst in prison, the deceased was noted to be quiet, polite and respectful. He had placements at Hakea Prison, Casuarina Prison and Acacia Prison.

29. The deceased was generally employed until his medical condition rendered him unfit for work. He was variously employed in prison metal shops and as a gardener. He was regarded as a reliable and efficient worker with a helpful and pleasant attitude. He was amendable to direction and required minimal supervision.[25]

---

[19] Exhibit 1, Vol 2, Death in Custody Review, pp8-9
[20] Exhibit 1, Vol 1, Tab 8, Microbiology Report
[21] Exhibit 1, Vol 1, Tab 12.B, Discharge Summary – Fiona Stanley Hospital (27.05.16)
[22] Exhibit 1, Vol 2, Tab 12, Report – Dr Fitzclarence
[23] Exhibit 1, Vol 2, Tab 16, Total Offender Management System – Schedule of events – Prisoner
[24] Exhibit 1, Vol 2, Death in Custody Review, pp6-8
[25] Exhibit 1, Vol 1, Police Investigation Report, pages 2-3

30. On 11 February 2014 the deceased was convicted of a prison charge after he tested positive for cannabis after a random drug screen. He was sentenced to 4 days confinement and one month loss of visits. With the exception of this charge, his prison record was exemplary.

Hakea Prison: 26 July 2013 - 03 February 2015

31. During his reception intake assessment at Hakea Prison on 26 July 2013, the deceased denied any self-harm or suicidal ideation but said he was concerned about arranging a carer for his defacto partner.[26]

32. The deceased was assessed as suitable for a mainstream cell. His security classification was amended from maximum to moderate on 31 July 2013.

33. After being in the District Court of Western Australia on 3 July 2014, the deceased remained at Hakea Prison. He was employed during most of his time there and received compliments from custodial staff regarding his work habits. The deceased completed an eight-week drug and alcohol program on 15 January 2015.

34. The deceased remained at Hakea Prison until 3 February 2015 when he was transferred to Casuarina Prison.

Casuarina Prison: 03 February 2015 - 5 November 2015

35. The deceased was received at Casuarina Prison on 3 February 2015. He completed several training and was employed as a gardener from 18 May 2015 onwards. The deceased remained at Casuarina Prison until he was transferred to Acacia Prison on 5 November 2015.

Acacia Prison: 5 November 2015 - 24 March 2016

36. The deceased was received at Acacia Prison on 5 November 2015. He completed a food handling program and was employed in the metal shop and later as a gardener.

[26] Exhibit 1, Vol 2, Tab 3, At Risk Management System Reception intake assessment

37. On 22 March 2016, the deceased told staff he was in acute pain, especially at night and was not sleeping. He had been unable to work and when interviewed, he was tearful and he seemed tired and "beaten". In light of his deteriorating medical condition, arrangements were made to transfer him to the infirmary at Casuarina Prison.[27]

38. The deceased declined to be transferred to the Crisis Care Unit pending his transfer, preferring to remain in his cell because of the support he was receiving from fellow prisoners. As a result of his presentation (thoughts of hopelessness about his prognosis), the deceased was placed on the At Risk Management System (ARMS) and subject to moderate frequency observations (i.e.: 3-hourly).[28,29]

39. ARMS is the Department's primary suicide prevention framework and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide. Depending on the perceived level of risk, prisoners on ARMS are observed at either high (one-hourly), moderate (three-hourly) or low (six-hourly) intervals. Prisoners on ARMS are managed by the Prisoner Risk Assessment Group (PRAG), which meets in each prison regularly.[30]

40. By 24 March 2016, the deceased's demeanour had improved and so the frequency of his ARMS observations was changed to low (12-hourly). The deceased remained concerned about his prognosis but was focused on his application for parole, which he hoped would be approved.[31]

Casuarina Prison: 24 March 2016 - 17 July 2016

41. The deceased was transferred to the infirmary at Casuarina Prison on 24 March 2016. He was removed from ARMS on 19 May 2016 and placed on the Support and Monitoring System (SAMS) on 19 May 2016. [32]

---

[27] Exhibit 1, Vol 1, Tab 22, Acacia Prison Offender Movement Information
[28] Exhibit 1, Vol 1, Tab 22, Acacia Prison Offender Movement Information
[29] Exhibit 2, ARMS Offender Supervision Log (22.03.16)
[30] ts 10.05.19 (Mudford), pp6-7
[31] Exhibit 2, PRAG Minutes (24 Mar 16)
[32] Exhibit 2, ARMS notes (19 May 16)

42. SAMS is the Department's secondary prevention measure that assists prisoners who, whilst not considered to be at immediate risk of self-harm or suicide, nevertheless require additional support. This can include prisoners like the deceased who have significant health issues. As for ARMS, prisoners on SAMS are managed by the PRAG. Prisoners on SAMS are reviewed regularly using a case conference model.[33]

43. The deceased was reviewed at SAMS case conferences on 2 June 2016 and 30 June 2016 respectively. On each occasion, it was decided to maintain the deceased on SAMS.[34]

44. During his incarceration at Casuarina Prison, the deceased had regular contact with his friend through social visits and phone calls.[35]

45. The deceased remained at Casuarina Prison until he was transferred to Fiona Stanley Hospital on 17 July 2016. On 25 July 2016, he was transferred to Bethesda Hospital.

DIAGNOSIS & SUBSEQUENT MANAGEMENT[36,37]

46. Following blood tests in December 2015 (which showed he had anaemia), the deceased was referred for a colonoscopy to check for gastro-intestinal bleeding.

47. The deceased declined to undergo the procedure, however, a chest x-ray in January 2016 identified a lesion in his right lung and he was referred for further tests and it was noted that he had lost considerable weight.

48. In February 2016, the deceased was diagnosed with metastatic lung cancer (adenocarcinoma) and he received radiotherapy. On 23 March 2016, the deceased was registered as Stage III terminally ill under the departmental policy dealing with prisoners with terminal illnesses, meaning death is expected within 3 months or one or more medical conditions means the potential for sudden death.[38]

---

[33] ts 10.05.19 (Mudford), p7-8
[34] Exhibit 2, SAMS Case Conferences Minutes (02 Jun 16) & (30 Jun 16)
[35] Exhibit 1, Vol 1, Tab 16, Telephone & Visitor Records
[36] Exhibit 1, Vol 2, Death in Custody Review, pp9-10
[37] Exhibit 1, Vol 2, Tab 12, Report – Dr Fitzclarence
[38] Policy Directive 8 - Prisoner with a terminal illness

49. In a report to the PRB in April 2016, Dr Fitzclarence (Deputy Director, Health Services) confirmed that the deceased had stage 4 lung cancer. There was no cure and the deceased was said to have a prognosis of 9-18 months.

50. It was noted that the deceased had declined palliative chemotherapy,[39] and on 9 May 2016, he was registered as "*Stage IV terminally ill*" in accordance with departmental policy, meaning that his death was regarded as imminent.[40]

51. In accordance with departmental policy, terminally ill prisoners can be considered for early release pursuant to the grant of a pardon in the exercise of the Royal Prerogative of Mercy.[41]

52. Although consideration was given to an application to release the deceased from custody pursuant to the Royal Prerogative of Mercy, this was not pursued because the deceased had limited community support and his medical needs were being addressed whilst he was in custody.[42]

53. On 27 May 2016, the deceased was transferred to Fiona Stanley Hospital by ambulance complaining of back pain. He was noted to have bony metastases which had been seen during a PET scan on 11 February 2016.

54. After treatment pain by the palliative team, the deceased was discharged to the infirmary at Casuarina Prison for further management.[43]

55. On 17 July 2016, the deceased was taken back to Fiona Stanley Hospital by ambulance following a deterioration in his condition. It was thought that he may have an infection but the deceased declined active intervention and instead opted for palliative care.

56. The deceased remained at Fiona Stanley Hospital until 25 July 2016, when he was transferred to Bethesda Hospital for end-of-life care.[44]

---

[39] Exhibit 1, Vol 2, Tab 12, Report – Dr Mitra, Fiona Stanley Hospital
[40] Exhibit 1, Vol 2, Tab 14, Terminally Ill Case file
[41] ts 10.05.19 (Mudford), p8
[42] Exhibit 1, Vol 2, Tab 14, Terminally Ill Case file (13.06.16) & ts 10.05.19 (Mudford), p9
[43] Exhibit 1, Vol 1, Tab 12.B, Discharge Summary – Fiona Stanley Hospital (27.05.16)
[44] Exhibit 1, Vol 1, Tab 12.A, Discharge Summary – Fiona Stanley Hospital (25.07.16)

57. Due to the deceased's condition, he was not restrained during his admission at Bethesda Hospital.[45]

58. Bandyup Women's Prison, where the deceased's defacto partner was an in-mate, was kept informed of the deceased's medical condition.

59. Meanwhile, prison authorities had contacted the deceased's estranged wife and children in New Zealand and alerted them to the deceased's prognosis. They travelled to Western Australia and were with the deceased when he died at Bethesda Hospital.

60. The deceased was declared dead at 11.42 am on 26 July 2019.[46]

CAUSE AND MANNER OF DEATH[47]

61. Dr White (forensic pathologist) conducted a post mortem of the deceased's body on 2 August 2016 and found a large right-sided lung mass with extensive local spread and metastases. The deceased's heart was enlarged, his kidneys showed granular changes and his liver was congested.

62. Histological analysis confirmed these findings and identified the lung mass as an advanced primary lung adenocarcinoma. There was evident metastatic spread to the inner wall of his chest, throughout his right lung and to the outer surface of his heart. He was also found to have acute bronchopneumonia. The histological analysis also found that his liver had features of chronic active hepatitis with early cirrhosis and there was focal scarring of his liver and kidneys.

63. Toxicological analysis found medications in the deceased's system, consistent with his medical treatment.[48] A high level of methadone was noted which can be seen in cases of palliation with underlying multi-organ failure in the terminal phase of death.[49]

[45] Exhibit 1, Vol 1, Tab 11, SERCO Reports & ts 10.05.19 (Mudford), p6
[46] Exhibit 1, Vol 2, Tab 14, Terminally Ill Case file
[47] Exhibit 1, Vol 1, Tab 6, Post Mortem Report
[48] Exhibit 1, Vol 1, Tab 7, Toxicology Report
[49] Exhibit 1, Vol 1, Tab 6, Post Mortem Report

64. Dr White expressed the opinion that the cause of death was bronchopneumonia complicating a metastatic and locally advanced primary adenocarcinoma of the right lung in a man under palliative care.

65. I accept and adopt that conclusion.

66. I find the deceased's death occurred by way of natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

67. During his incarceration, the deceased was seen by prison medical staff on approximately 98 occasions with respect to various medical issues.[50,51]

68. Following blood tests and a PET scan, the deceased was diagnosed with metastatic lung cancer. He received palliative radiotherapy but declined chemotherapy. When his pain management could no longer be maintained at Acacia Prison, he transferred to the infirmary at Casuarina Prison.

69. The deceased was appropriately transferred to Fiona Stanley Hospital with respect to his cancer related back pain on 27 May 2016 and following treatment returned to the infirmary at Casuarina Prison.

70. When his medical condition deteriorated, the deceased was quite properly transferred to Fiona Stanley Hospital on 17 July 2016. The deceased's transfer to Bethesda Hospital on 25 July 2016 for hospice care was also appropriate.

71. During his incarceration the deceased completed a number of training and therapeutic courses and was gainfully employed. It appears he particularly enjoyed being employed as a gardener, a job that was described as "*his passion*".[52]

---

[50] Exhibit 1, Vol 2, Death in Custody Review, p8
[51] Exhibit 1, Vol 2, Tab 16, TOMS records – Schedule of Events
[52] Exhibit 1, Vol 1, Tab 22, Acacia Prison Offender Movement Information

72. When the deceased's condition deteriorated, prison authorities contacted the deceased's family in New Zealand and co-ordinated the arrival in Perth of his estranged wife and two children. They were able to visit the deceased at Bethesda Hospital and were at his bedside when he died.

73. The deceased's defacto was incarcerated at the time of his death and staff at Bandyup Women's Prison (where she was housed) were made aware of the deceased's situation.

74. Appropriate regard was had to the release of the deceased pursuant to a grant of the Royal Prerogative of Mercy. The decision not to proceed with that application seems justified on the basis of the evidence.

75. Having regard to all of the circumstances of the deceased's incarceration, I am satisfied that the supervision, treatment and care provided to the deceased was reasonable and appropriate.

M A G Jenkin
Coroner
22 May 2019