[2020] WACOR 7

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Michael Andrew Gliddon Jenkin, Coroner
HEARD	**:**	7 APRIL 2020
DELIVERED	**:**	17 APRIL 2020
FILE NO/S	**:**	CORC 905 of 2017
DECEASED	**:**	BECHARA, HASSAN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Counsel Assisting	:	Sergeant Lyle HOUSIAUX
Counsel	:	Robyn Hartley

Case(s) referred to in decision(s):

Nil

Coroners Act 1996

(Section 26(1))

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Hassan BECHARA*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 7 April 2020, find that the identity of the deceased person was* ***Hassan BECHARA*** *and that death occurred on 6 July 2017 at Fiona Stanley Hospital from ischaemic heat disease in the following circumstances:*

Table of Contents

INTRODUCTION

1. Hassan Bechara (Mr Bechara) died on 6 July 2017 at Fiona Stanley Hospital (FSH) from ischaemic heat disease. At the time of his death, Mr Bechara was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice.[1] Accordingly, immediately before his death, Mr Bechara was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[2]

2. In such circumstances, a coronial inquest is mandatory.[3] 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] Accordingly, I held an inquest into Mr Bechara's death on 7 April 2020.

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

4. The following DOJ employees gave oral evidence via telephone[7] at the inquest:

a. Dr Joy Rowland, Medical Director;[8] and

b. Mr Richard Mudford, Senior Review Officer (and the author of the Death in Custody Review);[9]

5. The inquest focused on the care provided to Mr Bechara while he was in custody, 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, Police Investigation Report
[6] Exhibit 1, Vol 2, Tab A, Death in Custody Review
[7] This was necessary because of the social distancing measures in place to combat the COVID-19 pandemic
[8] ts 07.04.20 (Rowland), p9
[9] ts 07.04.20 (Mudford), pp22-23

MR BECHARA

Background[10,11,12]

6. Mr Bechara was born in Lebanon[13] on 4 January 1965 and was 52 years of age when he died on 6 July 2017.[14,15] He had three siblings and in 1985, he came to Australia to join family members who had emigrated previously. On arrival in Australia, Mr Bechara undertook courses in English and mechanics. Initially he worked as a courier, but later he worked in businesses owned by his brother. He was married in 1990, but the relationship failed after about three years. On his release from prison in 2011, he cared for his elderly mother.

Offending History[16,17,18,19]

7. In 2004, Mr Bechara was placed on a 12-month good behaviour bond, following his conviction on two counts of inciting a person under 16 years of age to commit an indecent act. In 2010 and 2011, he was imprisoned in New South Wales following convictions for the possession of child pornography.

8. In August 2014, Mr Bechara was extradited from New South Wales to Western Australia, to face charges relating to six offences allegedly committed in 2008. The charges related to exposing children to indecent material and procuring children to engage in sexual activity.

9. On 19 March 2015, in the District Court of Western Australia at Perth, Mr Bechara was sentenced to a total of 4 years imprisonment with respect to those six charges.[20] On 12 May 2016, the Western Australian Court of Appeal upheld Mr Bechara's appeal against his sentence, and substituted a term of imprisonment of three years.[21,22]

---

[10] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p1
[11] Exhibit 1, Vol 2, Tab A, Death in Custody Review, p4
[12] Exhibit 1, Vol 2, Tab 3, Bechara v The State of Western Australia [2016] WASCA 77, p6
[13] Known officially as the Lebanese Republic
[14] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death
[15] Exhibit 1, Vol 1, Tab 5, Death in Hospital form - Fiona Stanley Hospital
[16] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p4
[17] Exhibit 1, Vol 2, Tab A, Death in Custody Review, p5
[18] Exhibit 1, Vol 2, Tab 1, Criminal history WA & NSW
[19] Exhibit 1, Vol 2, Tab 3, Bechara v The State of Western Australia [2016] WASCA 77, pp16-17
[20] See also: Exhibit 1, Vol 1, Tab 40, Warrant of Commitment (19.03.15)
[21] See also: Exhibit 1, Vol 1, Tab 40, Warrant of Commitment (12.05.16)
[22] See also: Exhibit 1, Vol 2, Tab 2, Sentence Summary - Offender

Western Australian prison history[23]

10. Mr Bechara was received at Hakea Prison on 19 March 2015. During his At Risk Management System (ARMS) reception interview, Mr Bechara denied any self-harm or suicidal ideation. However, he told the reception officer that he felt at risk in the prison because of the nature of his offences. He was initially allocated to the Crisis Care Unit and then, after assessment, he was placed into protective custody.[24]

11. Mr Bechara's educational and vocational needs were reviewed on 26 March 2016, and it was recommended that he attend numeracy and literacy courses. Mr Bechara was reportedly ambivalent about attending these courses, because he said he was planning to resume his role as a fulltime carer for his mother on his release from prison.

12. Prison staff described Mr Bechara as a respectful person who complied with prison rules. He caused no management issues and maintained his cell in a clean and tidy fashion. During his incarceration, Mr Bechara had the following prison placements:

a. ***Hakea Prison***
19 March 2015 - 16 April 2015 (28 days)

b. ***Casuarina Prison***
16 April 2015 - 2 February 2016 (292 days)
23 September 2016 - 5 October 2016 (12 days)

c. ***Acacia Prison***
2 February 2016 - 12 April 2016 (70 days)

d. ***Bunbury Regional Prison***
12 April 2016 - 6 September 2016 (142 days)

e. ***Karnet Prison Farm***
6 - 23 September 2016 (17 days)
5 October 2016 - 6 July 2017 (274 days)

[23] Exhibit 1, Vol 2, Tab A, Death in Custody Review, pp6-9
[24] Exhibit 1, Vol 2, Tab 4, ARMS - Reception intake and assessment (19.03.15)

13. Mr Bechara remained in protective custody until his security classification was reduced to minimum, and he was transferred to Karnet Prison Farm. As Mr Mudford pointed out, minimum-security prisons are not able to offer protective custody and a prisoner transferred to such a facility must sign a waiver acknowledging this before they are transferred.[25] Mr Bechara's prison placements largely related to changes in his security ratings and his various health issues. For example, in 2015, Mr Bechara's security rating was reduced to medium and he was transferred to Acacia Prison.[26]

14. In March 2016, Mr Bechara's security rating was reduced to minimum and it was planned to transfer him to Karnet Prison Farm.[27] In fact, due to muster pressures, he was transferred to Bunbury Regional Prison instead. Whilst at Bunbury Regional Prison, Mr Bechara was employed as a unit worker and then in the prison's market garden.

15. Mr Bechara was assessed as suitable to attend a prison program known as the medium intensity sexual offending treatment program (MSOTP). However, his poor health, hearing difficulties and English skills were identified as potential challenges for his completion of the program. Nevertheless, he was scheduled to undertake the MSOTP in the fourth quarter of 2016 at Karnet Prison Farm.[28]

16. Mr Bechara's earliest eligibility date for release on parole was 16 September 2016. On 31 August 2016, the Prisoners Review Board (PRB) refused Mr Bechara's application to be released on parole on the basis of his prior criminal history and his unmet treatment needs. The PRB advised Mr Bechara that he could reapply for release on parole once he had completed the MSOTP.[29,30]

17. Mr Bechara commenced the MSOTP program on 28 February 2017, but was withdrawn on 22 March 2017, because of his lack of comprehension, poor hearing and difficulty with English.

---

[25] ts 07.04.20 (Mudford), p26
[26] Exhibit 1, Vol 2, Tab 8, Individual Management Plan (14.04.15), p4
[27] Exhibit 1, Vol 2, Tab 10, Individual Management Plan (09.03.16), p4
[28] Exhibit 1, Vol 2, Tab 11, Individual Management Plan (10.03.17), p4
[29] Exhibit 1, Vol 1, Tab 42A, Letter - Prisoners Review Board to Mr Bechara (31.08.16)
[30] Exhibit 1, Vol 1, Tab 39, Parole Plan (06.06.16)

18. On 10 April 2017, Mr Bechara wrote to the PRB, requesting a review of its decision, of 31 August 2016, not to release him on parole. His request, which was made pursuant to section 115A of the *Sentence Administration Act 2003* (WA), stated that he had started the MSOTP, but had been withdrawn. In a letter dated 12 May 2017, the PRB refused Mr Bechara's application on the same grounds as its earlier decision.[31]

19. An application, which Mr Bechara had foreshadowed in March 2017, for release on inter-state parole in New South Wales after completion of the MSOTP, and an application in May 2017, to be transferred to Pardelup Prison Farm were not pursued.[32,33]

20. Mr Bechara maintained telephone contact with his family and friends in New South Wales using the Prisoner Telephone system. When his mother died in June 2015, he was offered support by the Prisoner Counselling Services, but he said he preferred to maintain telephone contact with his family instead.

21. Mr Mudford confirmed that Mr Bechara was never placed on ARMS or the Support and Management System (SAMS) during his incarceration. ARMS is the Department's primary suicide prevention strategy 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.[34]

22. SAMS is the Department's secondary suicide prevention measure that targets prisoners deemed to be at a higher risk of suicide. This includes first-time and/or younger prisoners, socially isolated or vulnerable prisoners and prisoners who have been identified as being at chronic risk of self-harm or suicide.[35]

23. During his incarceration, Mr Bechara received only one visit from his family, namely on both 19 and 20 September 2015, when his sister and brother-in-law saw him at Casuarina Prison.[36,37]

---

[31] Exhibit 1, Vol 1, Tab 42B, Letter - Prisoners Review Board to Mr Bechara (12.05.17)
[32] Exhibit 1, Vol 1, Tab 44, Application for Review (05.05.17)
[33] Exhibit 1, Vol 2, Tab 12, Individual Management Plan (10.05.17), p4
[34] ARMS Manual (1998), pp1-6
[35] SAMS Manual (June 2009), pp1-5
[36] Exhibit 1, Vol 2, Tab 9, Visits History
[37] Exhibit 1, Vol 2, Tab A, Death in Custody Review, p7

Overview of Medical Conditions[38,39]

24. After Mr Bechara's death, the Department conducted a review of the health services provided to him during his incarceration (the Review). The Review summarised Mr Bechara's medical conditions as follows:

> [H]e presented with a diagnosis of ischaemic dilated cardiomyopathy due to coronary heart disease, triple vessel disease, left bundle branch block, ventricular tachycardia and peripheral vascular disease and that he had a right femoral artery bypass in November 2006. Mr Bechara had been an insulin dependent diabetic since his mid-teens and was adept at monitoring his blood sugar levels and issuing his own insulin. During his time in prison he had refused blood tests and treatment on multiple occasions and signed several MR030 Release from Medical Responsibility forms. He was also non-compliant at times with his medications.[40]

Medical management during incarceration[41,42]

25. In accordance with departmental policy, when he was received into prison on 19 March 2015, Mr Bechara was assessed by a nurse and then, on 20 March 2015, by a doctor. Mr Bechara's self-reported medical history was noted, however, records from his doctors in New South Wales were not available at the time. Although he mentioned other medications, Mr Bechara did not tell the prison doctor that he had been taking the cholesterol lowering medication (atorvastatin) in the community.

26. The admission assessment noted that Mr Bechara was not always compliant with medication in the community and in the days after his admission, he declined his prescribed medications on the basis that they made him feel sick.

27. Several days after his admission to prison, notes from Mr Bechara's New South Wales GP arrived. The notes contained a letter from

[38] Exhibit 1, Vol 2, Tab A, Death in Custody Review, pp9-10
[39] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20)
[40] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), p3
[41] Exhibit 1, Vol 2, Tab A, Death in Custody Review, pp9-10
[42] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), pp3-12

Mr Bechara's cardiologist but the GP's progress notes were not comprehensive and did not refer to any cardiac concerns.

28. The fact that Mr Bechara had been prescribed cholesterol-lowering medication in the community was referred to in the GP's notes, but this medication was not immediately prescribed to Mr Bechara on his admission to prison, as it should have been.

29. On 22 March 2015, Mr Bechara was found to have fainted in his cell. He was taken to the prison medical centre in a wheelchair and treated for low blood sugar.[43] When reviewed by a prison doctor on 14 April 2015, Mr Bechara's oral diabetic medications were ceased and changes were made to his insulin regime.[44]

30. On 26 June 2015, Mr Bechara told a prison nurse that he usually took atorvastatin and he was concerned that this medication was not being given to him. Apparently, due to staff shortages this medication was not prescribed until 6 August 2015, following a review by a prison doctor.

31. On 20 September 2016, a nurse saw Mr Bechara at the prison medical centre. He was found to have a low pulse rate and he reported a two-month history of lethargy, shortness of breath on exertion and swelling of the ankles.[45] He was taken to Fiona Stanley Hospital (FSH) where he was diagnosed with community-acquired pneumonia and possibly heart failure.[46]

32. Mr Bechara was returned to Karnet Prison Farm on 21 September 2016, and although he initially declined to have investigative blood tests, he eventually agreed to do so.

33. On 23 September 2016, he reported feeling unwell and he was returned briefly to FSH for assessment.[47] He was diagnosed with congestive cardiac failure and discharged to the Infirmary at Casuarina Prison. He remained in the Infirmary until 5 October 2016, when he was transferred back to Karnet Prison Farm.

[43] Exhibit 1, Vol 2, Tab 14, Incident Description Report (22.03.15)
[44] EcHO Medical records (14.04.15)
[45] Exhibit 1, Vol 2, Tabs 15-17, Incident Description Reports (23.09.16)
[46] FSH Emergency Medicine Summary, L9452574 (20.09.16)
[47] FSH Emergency Medicine Summary, L9452574 (23.09.16)

34. On 27 October 2016, Mr Bechara was reviewed Dr Jamie Rankin, the Head of Cardiology at FSH. Dr Rankin considered it was likely that Mr Bechara had cardiomyopathy, which was probably ischaemic, and that Mr Bechara was clinically stable. Dr Rankin planned to see Mr Bechara in six to eight weeks, after he had undergone an echocardiogram and blood tests. Meanwhile, Dr Rankin wrote to Mr Bechara's New South Wales cardiologist to obtain some collateral history.[48]

35. A prion nurse saw Mr Bechara on 25 and 26 November 2016, after he reported feeling unwell. He said he felt "*bloated and full*" and complained of shortness of breath, difficulty sleeping and "*palpitations in his neck"* when walking. On examination, his pulse, blood pressure and blood sugar levels were within normal limits.[49] A prion doctor reviewed Mr Bechara on 7 December 2016, and his symptoms appeared to be improving when he was reviewed by a prison nurse on 12 December 2016.[50]

36. Dr Rankin reviewed Mr Bechara on 20 January 2017, by means of a tele-health appointment. Mr Bechara said he felt much better, was sleeping well and was able to walk without significant breathlessness. He denied any chest pain or oedema.

37. By this time, Dr Rankin had received reports from Mr Bechara's New South Wales specialists.[51,52,53] Those reports confirmed that Mr Bechara was known to have had dilated cardiomyopathy since at least 2005.

38. According to a report from a cardiologist in May 2013, Mr Bechara was to have undergone a coronary angiogram and have an implantable cardioverter defibrillator (ICD) inserted. However, Mr Bechara declined these procedures and neither was performed.[54]

[48] Exhibit 1, Vol 1, Tab 14, Letters - Dr Rankin (27.10.16) & (02.01.20)
[49] EcHO Health Record (25.11.16 & 26.11.16)
[50] EcHO Health Record (07.12.16 & 12.12.16)
[51] Exhibit 1, Vol 1, Tab 14, Letters - Dr P Kelleher (07.07.05) & (16.11.05)
[52] Exhibit 1, Vol 1, Tab 14, Letters - Dr F Nasser (22.12.06)
[53] Exhibit 1, Vol 1, Tab 14, Letter - Dr G Charbel (01.05.13)
[54] Exhibit 1, Vol 1, Tab 14, Letters - Dr Rankin (20.01.17) & (02.01.20)

39. Mr Bechara told Dr Rankin that he preferred to be followed-up by his cardiologist in New South Wales, after being released from prison.[55] Dr Rankin felt that Mr Bechara's cardiomyopathy and low ejection fraction made him a candidate for an ICD and revascularisation (i.e.: to address blockages in his coronary arteries). However, Dr Rankin noted that as Mr Bechara:

> [H]ad been clinically stable for some this does not appear urgent, so at this stage I will not press Hassan to have further investigations in Western Australia. If he does change his mind though, let me know and we can arrange a coronary angiogram and possibly an ICD at Fiona Stanley Hospital.[56]

40. Dr Rankin also suggested increasing Mr Bechara's cholesterol lowering medication, although Mr Bechara subsequently declined to accept this recommendation.[57]

41. When reviewed by a prison doctor on 10 May 2017, Mr Bechara looked well and reported no shortness of breath or oedema. His clinical observations were normal and there were no overt signs of congestive cardiac failure. The prison doctor discussed the contents of Dr Rankin's report with Mr Bechara at length and made the following entry about Mr Bechara in his EcHO health record:

> [A]gain declined to have angiogram and ICD - aware of risks of sudden death - adamant when he gets his freedom he will see his doctor in Sydney. Does not want atorvastatin double dose.[58]

[55] Exhibit 1, Vol 1, Tab 14, Letters - Dr Rankin (20.01.17) & (02.01.20)
[56] Exhibit 1, Vol 1, Tab 14, Letters - Dr Rankin (20.01.17) & (02.01.20)
[57] Exhibit 1, Vol 1, Tab 14, Letters - Dr Rankin (20.01.17) & (02.01.20)
[58] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20) and EcHO Health Record (10.05.17)

EVENTS LEADING TO DEATH

Presentation to prison medical centre[59]

42. On 23 June 2017, Mr Bechara presented to the prison medical centre. He was grey and sweaty and looked unwell. He said he had vomited after lunch and felt dizzy. His pulse rate was elevated and his blood sugar level was low. Prison staff called emergency services and Mr Bechara was taken to Armadale Kelmscott Memorial Hospital (AKMH) by ambulance.

Admission to Armadale Kelmscott Memorial Hospital[60]

43. On admission to the AKMH, Mr Bechara's pulse was very high and an ECG showed his heart was in an abnormal rhythm known as ventricular tachycardia (VT). Mr Bechara was given some medication to treat the VT, but he went into cardiac arrest. After he was successfully defibrillated, his pulse rate slowed and his heart resumed a normal rhythm.[61]

44. An ECG also showed signs of cardiac ischaemia and following discussions with the cardiology team at Royal Perth Hospital (RPH), Mr Bechara was transferred to RPH for urgent treatment.

Transfer to Royal Perth Hospital[62]

45. On arrival at RPH on 23 June 2017, Mr Bechara was gravely ill and in cardiogenic shock, a medical emergency resulting from inadequate blood flow due to the dysfunction of the ventricles of the heart. His presentation was assessed as being predominantly a VT arrhythmia associated with ischaemic heart failure. Mr Bechara underwent a coronary angiogram that showed severe disease in the three main coronary arteries, and a subsequent MRI scan showed widespread ischaemic damage with limited viability of the cardiac muscle.[63]

[59] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), p10
[60] Exhibit 1, Vol 1, Tab 10, AKMH Discharge Summary (23.06.16)
[61] See also: Exhibit 1, Vol 1, Tab 14, Letter - Dr Rankin (02.01.20)
[62] Exhibit 1, Vol 1, Tab 11, RPH Discharge Summary (02.07.17)
[63] See also: Exhibit 1, Vol 1, Tab 14, Letter - Dr Rankin (02.01.20)

46. Doctors at RPH discussed Mr Bechara's clinical situation with him, with the assistance of an interpreter and Mr Bechara's brother. Although Mr Bechara was reluctant to consider surgery, on 2 July 2017, he was transferred to FSH for consideration of coronary bypass grafting.[64]

Transfer to Fiona Stanley Hospital[65]

47. On admission to FSH, Mr Bechara was managed by the advanced heart failure team. As a result of his deteriorating condition, Mr Bechara was considered to be at high risk of cardiac arrest due to an arrhythmia. On 5 July 2017, with the help of an interpreter, Mr Bechara's treating team consulted with members of his family.

48. It was explained that Mr Bechara had electrical issues in his heart leading to abnormal cardiac arrhythmias and he required an ICD. Mr Bechara's family were told that he also had heart failure (due to ischaemic and non-ischaemic cardiomyopathy) and severe triple vessel disease. Management options were discussed and it was decided to proceed with an angiogram on 7 July 2017 with a view to possible stenting to treat the blockages in his coronary arteries.[66]

49. At about 8.45 pm on 6 July 2017, Mr Bechara suffered a cardiac arrest. Prolonged CPR resulted in a spontaneous return of circulation, and he underwent an emergency angiogram. Cardiologists reviewed the angiogram and considered that coronary stenting would not improve his prognosis, given the results of the previous myocardial viability study and Mr Bechara's long-standing cardiomyopathy.[67]

50. As Mr Bechara was being returned to the coronary care unit after the angiogram, he had a further cardiac arrest. Despite concerted resuscitation efforts by clinical staff, Mr Bechara could not be revived and he was declared deceased at 11.35 pm on 6 July 2017.[68]

[64] See also: Exhibit 1, Vol 1, Tab 14, Letter - Dr Rankin (02.01.20)
[65] Exhibit 1, Vol 1, Tabs 15 & 15A, FSH In-Patient Notes and FSH Discharge Summary (06.07.17)
[66] See also: Exhibit 1, Vol 1, Tab 14, Letter - Dr Rankin (02.01.20)
[67] Exhibit 1, Vol 2, Tab 18, Incident Description Reports (07.07.17)
[68] Exhibit 1, Vol 1, Tab 5, FSH Death in Hospital Form

ISSUES IDENTIFIED BY THE REVIEW

51. The Review[69] identified several areas for improvement regarding Mr Bechara's health care whilst he was in custody. In summary, those issues were:[70]

a. Mr Bechara's need for specialist cardiac care was not identified on his admission to prison or during subsequent medical reviews;

b. On his admission to prison, Mr Bechara's community medical history was not available. When the records did arrive, they were voluminous and the limited references to Mr Bechara's cardiac condition was not picked up, apparently as a result of time pressures;

c. Mr Bechara was not started on cholesterol lowering medication, which he had been taking in prison, until four months after his admission; and

d. Mr Bechara was not added to the terminally ill prisoner list.

Failure to identify need for specialist cardiac care[71]

52. When Mr Bechara was admitted to prison on 19 Mach 2019, he did not report any cardiac symptoms and his cardiac examination was normal. Although Mr Bechara was seen by a number of prison medical officers during his time in prison, he consistently presented as clinically stable and did not complain of symptoms suggestive of heart failure until September 2016. Further, several comprehensive reviews and cardiac examinations, including one in June 2016, did not identify signs of cardiac failure.

53. When seen by a cardiologist (Dr Rankin) in January 2017, information from specialists in New South Wales had been received. A report from a cardiologist in May 2013, confirmed that Mr Bechara had been offered an angiogram and an IDC. As noted, he subsequently declined both procedures.

[69] The review of Mr Bechara's health care whilst he was in custody, conducted after his death
[70] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), pp10-11
[71] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), p11

54. Although Dr Rankin thought that Mr Bechara was a candidate for an IDC, Mr Bechara's decision not to have the procedure was respected on the basis that, as he was clinically stable, the procedure was not urgent.

Mr Bechara was not placed on to the Terminally Ill list[72]

55. Because of his medical conditions, Mr Bechara satisfied the criteria for admission to the Terminally Ill list at Stage 3 (List) when he was admitted to prison in March 2015.[73]

56. Had Mr Bechara been added to List at that time, his medical condition would have been the subject of periodic review by the Director of Medical Services. As Dr Rowland properly conceded, had Mr Bechara been placed on the List, it is probable that his need for a referral to a cardiologist would have been identified at an early stage.[74]

57. Had Mr Bechara been referred to a cardiologist at an earlier stage, it seems likely that he would have been advised to undergo an angiogram and have an ICD fitted, as happened when he was reviewed by cardiologists in the past.[75]

58. It is impossible to know whether Mr Bechara's clinical management would have been different had this occurred. Given that Mr Bechara had declined to have an ICD in May 2013 and again in October 2016, it seems likely that he would have done so had this been offered to him at an earlier stage during his incarceration.

59. On this issue, the Health Services review, with which Dr Rowland agreed, concluded that:

> The delay in a referral to cardiology was unlikely to have affected the progression of his illness as he was stable on medical management and not showing any symptoms until September 2016.[76,77]

[72] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), p11
[73] ts 07.04.20 (Rowland), p16
[74] ts 07.04.20 (Rowland), p11 & pp16-17
[75] See: ts 07.04.20 (Rowland), p15-16 & p22
[76] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), p11
[77] ts 07.04.20 (Rowland), pp14-15 & p22

Cholesterol medication was not commenced on admission[78]

60. When Mr Bechara was admitted to prison, he mentioned several of his prescribed medications, but not atorvastatin. Notes received from his GP in New South Wales referred to the fact that Mr Bechara had been prescribed atorvastatin, but due to an apparent oversight, when Mr Bechara was admitted to prison, this medication was not prescribed straight away.

61. In June 2015, Mr Bechara told a prison nurse that he was concerned that he was not receiving atorvastatin. Although a doctor's appointment was subsequently requested so that the medication could be prescribed, the appointment did not occur until August 2015. The Review put the delay down to "*staff shortages*" and I will say more about this issue shortly.

Information obtained from community GP[79]

62. When prisoners are admitted to prison, they are asked about their medical conditions and medications. However, as Dr Rowland pointed out, prisoners are often poor historians for a variety of reasons. For that reason, concerted efforts are made to obtain information about the prisoner's medical management in the community.[80]

63. Dr Rowland identified a problem with requesting information from a prisoner's community doctors and/or specialists. At times, such requests result in the provision of a vast amount of information, including voluminous medical notes, much of which is irrelevant. Alternatively, on other occasions, the summaries of medical information that are provided are so brief, as to be of limited value.[81]

64. In Mr Bechara's case, information was received from his doctors in New South Wales. However, when that information was reviewed after Mr Bechara's death, it was determined that the quality of the notes was not of a high standard and important information was often sandwiched between less important information.

[78] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), p11
[79] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), p11
[80] ts 07.04.20 (Rowland), pp10-11
[81] ts 07.04.20 (Rowland), pp17-18

65. As the Review noted:

> Hakea Prison processes many new arrivals, and the…[release of information requests]…replies create a large volume of paperwork and the quality of information received is often challenging. Due to limited Prison Medical Officer numbers, this administrative work has tended to backlog significantly and the work is often done in haste due to time pressures.[82]

66. As can be seen, the lack of time to review information from a prisoner's community doctors, is another unfortunate consequence of the fact that the number of prison medical officers (PMOs) employed by the Department is limited.

IMPROVEMENTS MADE SINCE DEATH

67. The Review identifies several improvements to health service delivery that have been made since Mr Bechara's death, namely:

a. the doctor admission template has been updated and now includes specific questions about the involvement of community specialists in the prisoner's medical care;

b. a newly introduced release of information form includes specific questions for specialists seen by the prisoner to ensure that information is received directly from those specialists;

c. improvements have been made to the release of information process including MyHealthRecord links for Prison Health Services and in addition, medical summaries will be requested in an attempt to reduce the amount of material received from community doctors and specialists and to speed the uploading of relevant information into a prisoner's electronic health record; and

d. education has provided to the Prison Medical Officers on the prevention, recognition, investigation and management of cardiac failure, including advice on when to refer a prisoner to specialist care.

[82] Exhibit 1, Vol 2, Tab 20, Health Services Summary (02.04.20), p11

68. As Dr Rowland freely acknowledged in her evidence, and as the Review points out, the number of PMOs employed by the Department has not increased since Mr Bechara's death and therefore, the heavy workload that confronts PMOs remains unresolved.[83]

69. In order to justify employing additional PMOs, Dr Rowland must prepare a business case. Part of the difficulty she confronts is that there is no agreed standard as to the appropriate number of PMOs per 1,000 prisoners. Figures for GP's per 1,000 for the general community are inappropriate because, as a group, prisoners exhibit higher rates of chronic and age-related diseases, mental health and polysubstance issues.[84]

70. The current establishment for PMOs in Western Australia is 25.9 FTE[85] positions, although the actual number of PMO's currently employed is 16.2 (an occupancy of 62.5%). At the time of Mr Bechara's death, the establishment for PMOs was 21.5 FTE, and of those positions, 18.2 were occupied (an occupancy of 84.6%).[86]

71. As these figures show, there are fewer PMOs employed today than there were in 2017, in circumstances where the adult prisoner muster has risen from an average of 6,283 in 2016, to 6,881 in 2019, the latest publicly available figure.[87,88]

72. Dr Rowland acknowledged that it was difficult to recruit suitable doctors to fill available PMO positions because the work was not necessarily seen as attractive. Further, the level of remuneration offered by the Department is below that which what a doctor in general practice might reasonably expect to earn.[89]

[83] ts 07.04.20 (Rowland), pp19-20
[84] ts 07.04.20 (Rowland), pp19-20
[85] FTE stands for "*full time equivalent*" and relates to the hours worked by one full-time employee
[86] Email from Ms R Hartley to SGT L Housiaux (17.04.20)
[87] Quarterly Statistics - (Custodial Adult Prisoner), 2019, Quarter 3, figures as at 30 September each year
[88] See: https://www.correctiveservices.wa.gov.au/_files/about-us/statistics-publications/statistics/2019/2019-quarter3-adult-custodial.pdf
[89] ts 07.04.20 (Rowland), pp19-20

73. Dr Rowland said that if it were possible to recruit suitable doctors to fill the 25.9 PMO positions currently available, then health service delivery within the prison system would improve.[90]

74. Although it cannot be said that the shortfall of PMOs led directly to Mr Bechara's death, the present situation is clearly unacceptable and should be urgently addressed.

75. Staff shortages were cited as reasons why Mr Bechara was not referred to a cardiologist at an earlier stage and why there was a four-month delay in prescribing his cholesterol lowering medication.

76. Therefore, I strongly urge the Department to make every effort to urgently recruit more prison medical officers, and thereby improve health service delivery within the prison system.

CAUSE AND MANNER OF DEATH[91]

77. A forensic pathologist (Dr Moss) reviewed Mr Bechara's hospital medical notes and conducted an external post mortem examination on 10 July 2017. Toxicological analysis found a number of medications in Mr Bechara's system that were consistent with his hospital care and alcohol and common drugs were not detected. At the conclusion of the post mortem examination, Dr Moss concluded that the cause of Mr Bechara's death was ischaemic heart disease.[92]

78. I accept and adopt that conclusion and find that death occurred by way of Natural Causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

79. On the basis of the evidence before me, I am satisfied that Mr Bechara was appropriately managed whilst he was incarcerated. However, several issues relating to his medical care were identified.

[90] ts 07.04.20 (Rowland), pp21-22
[91] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report
[92] Exhibit 1, Vol 1, Tab 7, ChemCentre Report

80. Perhaps most importantly, the fact that Mr Bechara may have benefitted from being referred to a cardiologist was not identified when he was admitted to prison on 19 March 2015. However, at that time, Mr Bechara was not demonstrating signs of cardiac failure and medical notes from his doctors in New South Wales were not available.

81. When notes from Mr Bechara's doctors in New South Wales were received, it appears that the extent of Mr Bechara's cardiac history may not have been properly appreciated because of staff shortages and the resultant backlog, relating to reviewing community medical information received about prisoners.

82. Nevertheless, during his incarceration, Mr Bechara was the subject of diabetic and cardiac plans and when he demonstrated signs of cardiac failure in September 2016, he was appropriately referred to a cardiologist.

83. A feature of Mr Bechara's medical management was that he was sometimes non-compliant with prescribed medication and that he often declined blood tests, investigations and recommended procedures. Notably, when Mr Bechara was reviewed by cardiologists in May 2013 and again in 2016, he declined recommended procedures. In October 2016, Mr Bechara's decision was respected, on the basis that his condition was stable at that time.

84. Dr Rowland agreed with the conclusion expressed in the Review, namely that the delay in referring Mr Bechara to a cardiologist was unlikely to have affected the progress of his illness.[93]

85. After carefully considering the available evidence, I am satisfied that the standard of supervision, treatment and care that Mr Bechara received whilst he was in custody was adequate.

[93] ts 07.04.20 (Rowland), pp14-15 & p22

I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

CORONER M Jenkin

23 APRIL 2020