JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON
HEARD	**:**	29 OCTOBER 2020
DELIVERED	**:**	3 DECEMBER 2020
FILE NO/S	**:**	CORC 1216 of 2018
DECEASED	**:**	DINAH, MACKER JOSEPH

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sgt A Becker assisted the Coroner.
Mr B Nelson (SSO) appeared for the Department of Justice.
Ms E Langoulant with Ms H Barbarich (ALS) appeared for Mr Dinah's family.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Coroner, having investigated the death of ***Macker Joseph DINAH*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth*** *on 29 October 2020, find that the identity of the deceased person was* ***Macker Joseph DINAH*** *and that death occurred on 1 October 2018 at Casuarina Prison from atherosclerotic heart disease in a man with diabetes mellitus in the following circumstances:*

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INTRODUCTION

1. Macker Dinah was serving an indefinite term of imprisonment at Casuarina Prison when he died suddenly on 1 October 2018 in his cell.

2. Mr Dinah was known to have been suffering significant health issues, including poorly controlled diabetes and complex chronic heart disease. He was generally frail and unwell prior to his death, but at his request he had been moved from the prison infirmary to the mainstream prison population.

3. During the afternoon of 1 October 2018 Mr Dinah was found unresponsive in his cell by his cell mate, who raised the alarm. Prison officer and health staff attempted resuscitation but Mr Dinah could not be revived and his death was confirmed by a doctor. A post mortem examination was conducted and the cause of death was given as atherosclerotic heart disease in a man with diabetes mellitus.

4. Because he was a prisoner at the time of his death, Mr Dinah was a 'person held in care' for the purposes of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1] I held an inquest on 29 October 2020. At the inquest, extensive written material was tendered in relation to the investigations into Mr Dinah's death conducted by the WA Police and the Department of Justice,[2] and a number of witnesses were called to give evidence in person.

5. The main issue considered at the inquest was the question of Mr Dinah's medical care and supervision, touching upon his health issues and some reports that Mr Dinah had access to illicit drugs sometime prior to his death. Consideration was also given to why Mr Dinah was not released prior to his death, as his family had raised this as an area of concern to them. Mr Dinah had told them many times that he wanted to come home as his health deteriorated, and they had experienced great hurt and sadness at losing him so suddenly, without a chance to say goodbye.

BRIEF BACKGROUND

6. Mr Dinah was born in Wagin on 30 May 1961. He had five sisters and one brother. Mr Dinah and his family were victims of the Stolen Generation. Mr Dinah was taken from his parents by Federal agencies when he was young and placed at Wandering Mission with some of his siblings. He later went to

[1] Section 22(1)(a) *Coroners Act*.
[2] Exhibits 1 – 3.

Albany Christian Brothers College. Despite being taken away from his family when he was a child, he still retained close ties to his family for the rest of his life and his siblings remained a close support for him.[3] Mr Dinah's family knew him as someone who liked to tell jokes and play card tricks and make people smile.[4]

7. After leaving school in Year 10, Mr Dinah completed a TAFE course and then commenced work for the local Shire for a period. He was a talented artist in his spare time and also taught his younger relatives to paint.[5]

8. Mr Dinah married and had a son and daughter, although sadly his daughter was killed in 2009, almost a decade before his own death. At some stage Mr Dinah separated from his wife, and although they remained married, he formed a number of other relationships over time. He apparently had other children from these relationships and at the time of his death his current de facto partner was said to be pregnant with his child.[6]

9. Mr Dinah began drinking alcohol and smoking cannabis heavily in his twenties and continued these habits throughout his life.[7] His alcohol abuse led to criminal offending.[8] Mr Dinah was first imprisoned in 1984 and then served a number of prison terms in numerous prisons throughout Western Australia. A number of Mr Dinah's convictions were for serious violent sexual offences, which eventually led to Mr Dinah being declared a dangerous sexual offender under the *Dangerous Sexual Offenders Act 2006* (WA).[9] The first declaration was made in April 2009. A further order was made on 25 January 2012 after Mr Dinah was released in 2011 on a supervision order and breached the order on multiple occasions.[10]

10. That continuing detention order was rescinded by his Honour Justice Fiannaca on 9 June 2017 and subsequently, on 30 June 2017, Mr Dinah was released on a supervision order with a large number of conditions. One week after his release Mr Dinah was charged with two contraventions of the supervision order. Mr Dinah was returned to custody on 13 July 2017 to await the outcome of proceedings in relation to those alleged contraventions.[11]

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[3] Exhibit 1, Tab 8.
[4] Letter to Court from Gwenda Dinah dated 9 November 2020.
[5] Letter to Court from Gwenda Dinah dated 9 November 2020.
[6] Exhibit 1, Tab 8; Exhibit 2, DIC Review Report, p. 4.
[7] Exhibit 1, Tab 8.
[8] Exhibit 1, Death in Custody Review Report, p. 4.
[9] Exhibit 2, Tab 1.
[10] *DPP (WA) v Dinah* [2017] WASC 158.
[11] Ibid; *DPP (WA) v Dinah* [2017] WASC 315.

11. Mr Dinah eventually pleaded guilty to both contraventions, which related to attending private residences without prior approval and using cannabis. In light of the admitted contraventions, the State sought a further continuing detention order. On 10 November 2017 her Honour Justice Archer rescinded the previous supervision order and made a further continuing detention order. This meant that from that time Mr Dinah was to be held in custody indefinitely, with annual reviews to consider whether he ought to be released again in the future.[12] Mr Dinah's next review in the Supreme Court was scheduled for 12 November 2018, but he died the month before.[13]

LAST ADMISSION TO CUSTODY – JULY 2017

12. After contravening the terms of his supervision order, Mr Dinah was placed first at Hakea Prison on 14 July 2017. During his reception intake assessment, Mr Dinah indicated his family and friends would provide him with support while incarcerated, both within and outside the prison. He appeared positive and indicated he had no reason to believe he required protection within the prison.

13. In August 2017 Mr Dinah refused to take his insulin a number of times, despite being counselled by prison doctors. A telehealth review with gastroenterology services at Fiona Stanley Hospital (FSH) was arranged on 19 September 2017 and after this review Mr Dinah agreed to start taking his insulin again. He was restarted on his insulin that day.[14]

14. While at Hakea Mr Dinah was found to have cannabis in his system following a urine test, and he was confined to a punishment cell for three days. It was not discovered where he sourced the illicit drug.[15]

15. Mr Dinah became progressively more unwell in November 2017 and after the court hearing in November 2017, when it was determined that Mr Dinah would remain in custody indefinitely, he was transferred to Casuarina Prison on 27 November 2017.[16]

16. Mr Dinah was admitted to FSH on 22 December 2017 and diagnosed with various serious medical issues including endocarditis, sepsis, respiratory failure, cerebrovascular accident (stroke) and diabetic ketoacidosis. He had also suffered a myocardial infarction (heart attack) and was found to have coronary

[12] *DPP (WA) v Dinah* [2017] WASC 315.
[13] Exhibit 2, DIC Review Report, p. 3.
[14] Exhibit 2, Tab 12.
[15] Exhibit 2, DIC Review Report, p. 6.
[16] Exhibit 2, Tab 12.

artery disease affecting his three main heart vessels. He was not suitable for heart valve surgery at that stage due to his poor condition. It was considered he might die at any time. However, his condition improved with treatment and by February 2018 it was apparent that his death was no longer imminent. He remained in hospital until 13 March 2018, and was then discharged back to the Infirmary at Casuarina. His long term prognosis depended on the possibility of surgery for mitral valve replacement, but his health needed to improve more before this could be considered.[17]

17. Mr Dinah continued to have ongoing issues relating to his conditions and poor compliance with taking his prescribed medication, particularly insulin for his diabetes. However, he was eventually managing well enough that his request to return to mainstream custodial care was able to be considered. The transition to mainstream began with a trial of capability within the Infirmary on 16 August 2018, to ensure that Mr Dinah was capable of self-caring to an appropriate level. He was able to demonstrate that he could walk with a Zimmer frame unassisted and shower and dress himself, although he often chose to ask other prisoners for help, which was his prerogative. Accordingly, on 28 August 2018 his request to return to the mainstream prison was granted. Arrangements were, however, made for him to keep using the showers in the Infirmary to ensure assistance was available if necessary.[18]

18. Mr Dinah was placed in a double-up cell in Unit 14 with another prisoner, Mr Jonathon Leering, who knew Mr Dinah from many years before when they had been housed at Greenough Prison together and Mr Dinah coached the prison football team. Mr Leering had employment in the prison as a wheelchair pusher, so he was used to assisting other prisoners with some of their daily care. Mr Leering was able to assist Mr Dinah with daily activities, including helping him with obtaining his clothing from the laundry and getting him meals. He would also help him get into and out of his wheelchair. It was recorded that Mr Dinah was happy in the mainstream unit and with his cellmate.[19]

19. Mr Dinah continued to receive his medications daily at the medication review and appeared to be managing well. Mr Dinah was reviewed by a prison medical officer about a week before his death and no acute issues were identified.[20]

20. On 25 September 2018 Mr Dinah refused to provide a urine sample voluntarily. It was required to be done monthly as part of his DSO classification. He was

[17] Exhibit 2, Tab 11 and Tab 12.
[18] Exhibit 2, Tab 12.
[19] Exhibit 1, Tab 12; Exhibit 2, Tab 12.
[20] Exhibit 2, Tab 12.

charged and convicted with failing to provide the sample upon request. This was his second conviction, having refused to supply a similar sample on 9 July 2018. Loss of privileges for 60 days was imposed as the penalty, taking into account it was his second offence in 12 months.[21] He had only just come off an earlier penalty involving loss of privileges for the earlier offence.

21. It was explained at the inquest that prisoners often refuse to provide a sample if they know they have taken drugs and the sample will be 'dirty'. Mr Dinah had a history of using cannabis, and I note he had cannabis in his system at the time of his death (despite there being a zero tolerance approach to drugs in prison and searches being conducted regularly).[22] Mr Dinah also had a history of intravenous drug use, which was felt to be a direct cause of his hospital admission back on 22 December 2017 with infective endocarditis. He had a chronic Hepatitis C infection, which he apparently contracted while in prison from drug use, and had likely associated liver cirrhosis.

EVENTS LEADING TO DEATH

22. Witness statements indicate that there was nothing unusual about Mr Dinah's presentation on the day of his death, being 1 October 2018. There were no warning signs noted of an impending cardiac arrest.[23]

23. Mr Dinah's cell mate recalled they woke up around 7.30 – 8.00 am and he made Mr Dinah a cup of tea. Mr Dinah's grandson, who was a prisoner housed in the same unit block, got Mr Dinah some toast and baked beans for breakfast. After breakfast, Mr Leering pushed Mr Dinah in his wheelchair to the medication parade and Mr Dinah visited some other family members who were also prisoners at Casuarina.[24]

24. Mr Dinah spoke to a prison officer in his unit at around 11.00 am to ask how much money he had in gratuities. He seemed his usual self at that time.[25]

25. At lunchtime, Mr Leering got some pies and Mr Dinah and Mr Leering ate the pies in their cell during the lunchtime lock up period. Mr Dinah ate one pie and had a cup of tea and a cigarette. He was talking for a while and seemed in good spirits before he told Mr Leering he wanted to have a sleep. Mr Leering picked him up and put him into bed in the bottom bunk. Mr Leering then left the cell to

[21] Exhibit e, Tab 16.
[22] T 24.
[23] Exhibit 2, Tab 12.
[24] Exhibit 1, Tab 12.
[25] Exhibit 1, Tab 13.

make some phone calls and have a cigarette. He returned to wake Mr Dinah up for the afternoon muster at approximately 3.00 pm. He found Mr Dinah still lying in his bunk but he could not be roused.[26]

26. Mr Leering called out to other prisoners for help. His calls were heard by nearby prison officers. Prison officers attended the cell immediately and checked Mr Dinah for signs of life. They were unable to feel a pulse, he appeared to have been incontinent of urine and was not breathing. They placed him on the floor and commenced CPR, then moved him out into the corridor so they could have more space to provide first aid. At approximately 3.10 pm a Code Amber medical emergency was called, which was quickly upgraded to a Code Red. This notified health services staff that there was a medical incident. Nursing and medical staff immediately attended, arriving between 3.12 pm and 3.14 pm. They assisted with further resuscitation attempts.[27]

27. A defibrillator was used and it advised one shock, which was delivered. SJA had been notified at 3.15 pm and the first ambulance officers arrived on scene at 3.23 pm. A second ambulance crew arrived shortly after. After approximately 20 minutes of rotational CPR by custodial and medical staff, a decision was made for all resuscitation efforts to be ceased. Mr Dinah's death was declared by a prison medical officer at 3.34 pm.[28]

CAUSE AND MANNER OF DEATH

28. On 8 October 2018 a forensic pathologist, Dr White, conducted a post mortem examination on Mr Dinah. The examination showed an enlarged heart with coronary artery disease and severe congestion of the lungs with features of pneumonia, although an acute lung infection was not confirmed on microscopic examination. The liver showed early cirrhosis and the kidneys were scarred. Mr Dinah's extensive medical records were also reviewed by Dr White, which detailed a history of longstanding, poorly controlled type II diabetes, high cholesterol, heart failure in association with complex chronic heart disease, previous stroke and hepatitis C. Post mortem biochemistry confirmed poor sugar control.[29]

29. Toxicology analysis showed prescription-type medication and tetrahydrocannabinol, consistent with the recent use of cannabis.[30]

[26] Exhibit 1, Tab 12.
[27] Exhibit 2, DIC Review Report; Exhibit 3, Tab 15.
[28] Exhibit 2, DIC Review Report.
[29] Exhibit 1, Tab 6.
[30] Exhibit 1, Tab 6 and Tab 7.

30. At the conclusion of all investigations, Dr White formed the opinion the cause of death was atherosclerotic heart disease in a man with diabetes mellitus.[31] There was nothing to suggest the cannabis contributed to his death.

31. I accept and adopt Dr White's opinion in relation to the cause of death. It follows that the manner of death was by way of natural causes.

COMMENTS ON TREATMENT, SUPERVISION & CARE

32. I am required under the Act to comment on Mr Dinah's treatment, supervision and care while in custody, prior to his death. That can encompass many things and varies depending upon the circumstances of the death. In Mr Dinah's case, given his longstanding chronic health issues, attention must be directed to the medical care he received. The attempts to resuscitate Mr Dinah after he was discovered unresponsive are also relevant in the context of the care he received. Finally, there is the issue arising in relation to his ability to access illicit drugs while in custody, although given his cause of death this is perhaps less significant.

33. I have given consideration to all of the evidence before me as to Mr Dinah's supervision, treatment and care while he was a prisoner. I have concluded that his medical treatment and care was of a high standard. Dr Joy Rowland, the Director of Medical Services with the Department, gave evidence at the inquest that Mr Dinah was known to suffer several conditions that might lead to sudden death, in particular his heart disease. Dr Rowland explained that his cardiac issues were severe, but he had not been found suitable for surgical intervention as he might not have survived the surgery. He was still being reviewed by his cardiologists at FSH, although he had refused to attend his most recent appointment shortly before his death. Mr Dinah's health conditions were otherwise generally stable at the time of his death and he was steadily improving in terms of his independence and mobility.[32]

34. I note some concerns were raised about how much assistance Mr Dinah received, given his frail state of health and the fact he was generally wheelchair bound. His cellmate suggested in his statement that perhaps Mr Dinah could have received more help, as he often had to assist him of his own volition.[33] Dr Rowland noted that Mr Dinah had been assessed before he was permitted to move out of the Infirmary, and he had demonstrated that he could generally care

[31] Exhibit 1, Tab 6.
[32] T 33 – 35, 45.
[33] Exhibit 1, Tab 12.

for himself. It had been noted in the past, however, that he liked being pushed in the wheelchair and preferred that to walking in his walking frame, and to have help from friends and family when he could arrange it. Mr Leering described how respected Mr Dinah was within the prison, as an elder, and Dr Rowland agreed that it was not uncommon in such circumstances for younger prisoners to undertake small tasks as a sign of respect.[34] Given it was Mr Dinah's preference to be housed in the unit, and his ongoing monitoring by custodial and health services staff suggested he was managing well, I am satisfied that he was being cared for appropriately.

35. Mr Dinah was described as having been institutionalised, first in the mission and then in the criminal justice system, and sadly this seems to have been the case. Nevertheless, he managed to make lifelong friends in prison and became a mentor for many of his fellow prisoners, teaching them how to paint and gaining their respect.[35] I accept that younger prisoners, including younger family members, would have voluntarily helped Mr Dinah as a mark of respect to him.

36. However, despite the fact that he had managed well in prison for most of his life, Mr Dinah's sister Gwenda Dinah has eloquently expressed in a letter to the Court how, as her brother became older and sickness started to creep in to his life, he lost his joviality and ability to cope with prison and wanted to go home to his family. Mr Dinah's family raised at the inquest a question as to why his release had not occurred, given his failing health.

37. It was explained at the inquest by Mr Brian Ellis, the Director of Sentence Management at Corrective Services, that consideration was given as to whether Mr Dinah should be recommended for release on the Royal Prerogative of Mercy on 27 December 2017 when he was listed as being Stage Four (Death is imminent) on the Department's Total Offender Management Solutions system. A Sentence Management Briefing was urgently prepared and completed on 29 December 2017. The assessing officer recorded that Mr Dinah was not recommended for early release on merciful grounds due to the historical nature of his offending, his placement at that time on the Dangerous Sexual Offending Continuing Detention Order and his recent period in the community on a DSO release order, during which he contravened the order twice in a 15 day period. The briefing was forwarded to the Minister for Corrective Services.[36]

[34] T 42.
[35] Letter to Court from Gwenda Dinah dated 9 November 2020.
[36] T 11; Exhibit 2, Tab 17.

38. Mr Dinah's health status actually improved after that date, and he was de-escalated to Stage Three (Death Likely within three months or one or more medical conditions with the potential for sudden death). If his health had deteriorated again to the extent that his death was considered imminent, then a further briefing note would have been prepared, with further consideration given to whether he should be released on the Royal Prerogative of Mercy. However, this did not occur.[37]

39. Mr Ellis explained in his evidence that even if a recommendation was made for Mr Dinah to be considered for early release, the Minister for Corrective Services could reject that recommendation. If the Minister agreed, it would be required to go to the Attorney General for his or her consideration, and the Attorney General can dismiss the recommendation out of hand or ask the State Solicitor's Office to review the matter or accept the recommendation. All in all, it can be a long process and there is no guarantee a prisoner will be released prior to their death, even if ultimately all of the relevant Ministers approve.[38]

40. In Mr Dinah's case, it was noted that he was due to appear in the Supreme Court on 12 November 2018 for the annual review of his continuing detention order. His release could have been granted by a Supreme Court Judge at that time, but unfortunately he died suddenly only a few weeks before this could be considered.[39]

CONCLUSION

41. Mr Dinah had known complex health issues when he returned to prison for the last time in July 2017. His health care was often challenging due to his lack of compliance with instructions and medications. He had a serious decline in health in December 2017, and at that time it was thought he might not survive, but after spending some months in hospital he improved enough to eventually return to Casuarina Prison and then move from the Infirmary into the mainstream population at his request.

42. Unfortunately, due to his severe heart disease, Mr Dinah remained at risk of a sudden cardiac event at any time and that is what occurred on 1 October 2018.

43. It was apparent that Mr Dinah was very loved by his family and he had a close relationship with his relatives even though he had spent much of his life forcibly separated from them. Mr Dinah's family's grief at his death was

[37] T 12 – 13; Exhibit 2, Tab 17.
[38] T 11 – 12; Exhibit 2, Tab 17.
[39] T 13.

compounded by the fact that he died in prison rather than at home surrounded by his loved ones. Although he was able to maintain contact with some relatives who were in prison with him, he had been unable to have social visits due to loss of privileges for prison offences. I acknowledge the hurt they have experienced at being unable to say goodbye, but as I explained at the conclusion of the inquest, the processes involved in his early release were complicated and even if he had shown signs of a deterioration in the weeks prior to his death, it is unlikely that would have led to his release on the Royal Prerogative of Mercy. It is very unfortunate that he died so soon before his annual review in the Supreme Court, as that perhaps may have had a more positive outcome for Mr Dinah and his family.

44. I understand that as a result of the inquest Mr Dinah's family, and in particular his sister Gwenda, have at least gained some better understanding of what occurred in the lead up to his death, and are able to reach some closure in Mr Dinah's life journey. I express my condolences to his family, acknowledging the early trauma all of his family suffered, which clearly had an ongoing effect on Mr Dinah throughout his life.

S H Linton
Coroner
3 December 2020