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| **JURISDICTION** | **:** | CORONER'S COURT OF WESTERN AUSTRALIA |
| **ACT** | **:** | CORONERS ACT 1996 |
| **CORONER** | **:** | Michael Andrew Gliddon Jenkin, Coroner |
| **HEARD** | **:** | 9 MARCH 2020 |
| **DELIVERED** | **:** | 3 APRIL 2020 |
| **FILE NO/S** | **:** | CORC 1161 of 2016 |
| **DECEASED** | **:** | KELLY, VALERIE |

*Catchwords:*

Nil

*Legislation:*

Nil

**Counsel Appearing:**

| | | |
|---|---|---|
| Counsel | : | Alice Vivienne Barter |
| Counsel | : | Jessica Berry |
| Counsel | : | Aoife Nugent |
| Counsel Assisting | : | Sergeant Lyle HOUSIAUX |

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

Nil

*Coroners Act 1996*
(Section 26(1))

# RECORD OF INVESTIGATION INTO DEATH

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of* ***Valerie KELLY*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***9 March 2020*** *find that the identity of the deceased person was* ***Valerie KELLY*** *and that death occurred on* ***24 September 2016*** *at* ***Royal Perth Hospital****, from the* ***combined effects of bronchopneumonia and acute liver failure on a background of liver cirrhosis and hepatocellular carcinoma in a woman with atherosclerotic cardiovascular disease and recent fractured neck of femur treated palliatively*** *in the following circumstances:-*

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## INTRODUCTION[1]

**1.** Valerie Kelly (Ms Kelly) died at Royal Perth Hospital (RPH) on 24 September 2016. At the time of her death Ms Kelly was in the custody of the Chief Executive Officer of the Department of Corrective Services, as it then was.[2] She had been arrested on 25 June 2015 and after a medical assessment, she was remanded in custody to Bandyup Women's Prison (BWP) on 26 June 2015.[3]

**2.** Accordingly, immediately before her death, Ms Kelly was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and her death was a "*reportable death*".[4]

**3.** In such circumstances, a coronial inquest is mandatory.[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 whilst in that care.[6]

**4.** On 9 March 2020, I held an inquest into Ms Kelly's death, which members of her family attended.

**5.** The documentary evidence adduced at the inquest included independent reports concerning Ms Kelly's death prepared by the Western Australia Police Force[7] and the Department of Justice[8] (DOJ) respectively. Together, the Brief comprised three volumes.

**6.** The inquest focused on the on the quality of the supervision, treatment and care Ms Kelly received while she was in custody and the circumstances of her death.

**7.** The following DOJ employees gave oral evidence at the inquest:

a. Mr Richard Mudford, Senior Review Officer; and
b. Dr Joy Rowland, Director, Medical Services.

[1] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report
[2] Section 16, *Prisons Act 1981* (WA)
[3] Exhibit 1, Vol. 2, Tab A, Death in Custody Review
[4] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[5] Section 22(1)(a), *Coroners Act 1996* (WA)
[6] Section 25(3) *Coroners Act 1996* (WA)
[7] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report
[8] Exhibit 1, Vol. 2, Tab A, Death in Custody Review

## MS KELLY

### *Background*[9,10]

**8.** Ms Kelly was born in Bunbury in 1948 and was 67-years of age when she died at RPH on 24 September 2016.[11] She attended Harvey Primary School and Narrogin High School before moving to Perth. Ms Kelly had four children with her partner of some 50 years and lived in Fremantle. She was described by her daughter as "*very homely*" and was said to enjoy reading and gardening.[12]

### *Offending History*

**9.** During the period 1966 - 2011, Ms Kelly was convicted on 60 occasions for offences including: disorderly conduct, stealing and assault. Prison records show she was admitted to BWP in 1975, 1978, 1980 and 1988 and her criminal record records short periods of incarceration in 1970, 1973, and 1976.[13,14]

### *Overview of Medical Conditions*

**10.** During a bail assessment interview on 31 August 2015, Ms Kelly disclosed a long standing problem with alcoholism. She said the issue had been particularly problematic when she was younger but that as she got older and her health declined, she had reduced her alcohol intake.[15]

**11.** Ms Kelly's medical conditions included: ischaemic heart disease, type-2 diabetes, alcohol related liver disease, chronic subdural haematomas, high cholesterol, osteoarthritis, osteoporosis and low platelet levels (thrombocytopenia). Her surgical history included: removal of her gallbladder, a coronary artery bypass graft, a total knee replacement and a traumatic right sided subdural haematoma and empyema. Ms Kelly had also sustained several fractures.[16,17]

[9] Exhibit 1, Vol. 2, Tab A, Death in Custody Review, pp4-5 and ts 09.03.20 (Mudford), pp7-9
[10] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report, p2
[11] Exhibit 1, Vol. 1, Tab 6, Post Mortem Second Supplementary Report, p1
[12] Exhibit 1, Vol. 1, Tab 9, File Note of discussion with Ms C Corbett (22.03.17)
[13] Exhibit 1, Vol. 3, Tab 4, Deceased's criminal record and ts 09.03.20 (Mudford), p9
[14] Exhibit 1, Vol. 2, Tab A, Death in Custody Review, p5
[15] Exhibit 1, Vol. 3, Tab 3, Bail Assessment Report, p2
[16] Exhibit 1, Vol. 2, Tab A, Death in Custody Review, p4 and ts 09.03.20 (Rowland), p28 & p33
[17] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p3

**12.** Ms Kelly attended the medical centre at BWP on numerous occasions. Her appointments related to various issues, including management of her diabetes, knee pain and investigations of rectal bleeding, for which she was referred to the gastrointestinal clinic at Fiona Stanley Hospital (FSH).[18,19,20]

### *Management during Ms Kelly's last admission*[21]

**13.** Ms Kelly was arrested on 25 June 2015 and charged with murder in relation to an incident involving her sister.[22,23] After a medical assessment, she remanded in custody at BWP on 26 June 2015. During her reception interview at BWP, Ms Kelly was visibly upset and it was noted that she was withdrawing from alcohol. As a result, she was housed in the Crisis Care Unit (CCU) and placed on the At Risk Management System (ARMS).[24]

**14.** ARMS is DOJ'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.[25]

**15.** Ms Kelly was assessed as being at moderate risk and she was monitored at 6-hourly intervals and reviewed regularly by the Prisoner Risk Assessment Group (PRAG). She also received support from the Prison Counselling Service, a peer support officer and workers from the Aboriginal Visitors Scheme.

**16.** In 2016, the ARMS observation levels were changed and are now: high (one-hourly), moderate (2-hourly) and low (4-hourly). Ms Kelly was adamant that she had no self-harm or suicidal ideation and she was removed from ARMS on 7 July 2015 and transferred to the DOJ's Support and Monitoring System (SAMS). SAMS is a secondary suicide prevention measure that targets prisoners deemed to be at a higher risk of suicide.[26]

[18] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, pp3-7 & 9
[19] See also: Exhibit 1, Vol. 1, Tab 46, Ms Kelly's BWP medical appointment records
[20] Exhibit 1, Vol. 1, Tab 46, Patient referral (16.03.15)
[21] Exhibit 1, Vol. 2, Tab A, Death in Custody Review, pp6-8 and ts 09.03.20 (Mudford), pp9-11
[22] Exhibit 1, Vol. 1, Tab 38, Remand warrant (26.06.15)
[23] Exhibit 1, Vol. 1, Tab 39, Statement of material facts relating to charge number MC FRE 150007116
[24] Exhibit 1, Vol. 3, Tab 6, ARMS Reception intake assessment, p5
[25] ARMS Manual (1998), pp1-6 and ts 09.03.20 (Mudford), pp13-15
[26] SAMS Manual (June 2009), p3 and ts 09.03.20 (Mudford), p14

**17.** SAMS is designed to provide support to prisoners who, whilst not deemed to be at acute risk of suicide or self-harm, nevertheless require additional support, intervention or monitoring.[27] During the time she was on SAMS, Ms Kelly was regularly monitored by PRAG and removed from SAMS on 11 September 2015, after being assessed as having no issues.

**18.** Ms Kelly's cell occupancy record shows that she remained in the CCU until 29 June 2015, when she was transferred to a shared cell with a niece who was in BWP at the time, who acted as her carer.

**19.** The DOJ prisoner management system[28] records numerous examples of Ms Kelly's challenging behaviour. During her last period of incarceration, she was the subject of numerous negative offender and case notes for belligerent behaviour and abusing prison staff.[29,30]

**20.** Ms Kelly was also convicted of two offences under section 69 of the *Prisons Act 1981* (insubordination/misconduct and disobeying a rule respectively) and was the subject of one breach of the code of conduct resulting in the loss of canteen privileges for three days.[31,32]

**21.** The Death in Custody Review completed by DOJ described Ms Kelly's conduct on the following terms:

> [O]ften belligerent she was recorded as using abusive language, threats and intimidation or attempted assaults on staff and other inmates.[33]

**22.** On 7 August 2015, Ms Kelly made an application to be transferred to the self-care unit at BWP but her application was not approved. A further application by Ms Kelly on 24 February 2016 was refused on the basis that she:

> [D]oes not display the right attitude that is required for self-care".[34]

[27] SAMS Manual (June 2009), p3 and ts 09.03.20 (Mudford), pp14-15
[28] Total Offender Management Solutions, abbreviated as TOMS
[29] Exhibit 1, Vol. 2, Tab A, Death in Custody Review, p7
[30] Exhibit 1, Vol. 1, Tab 32, Deceased's Charge History
[31] Exhibit 1, Vol. 2, Tab A, Death in Custody Review, p7
[32] Exhibit 1, Vol. 1, Tab 32, Deceased's Charge History
[33] Exhibit 1, Vol. 2, Tab A, Death in Custody Review, p7
[34] Exhibit 1, Vol. 1, Tab 25, Applications for living in self-care units (07.08.15 & 24.02.16)

**23.** On 30 January 2016, Ms Kelly made an application to attend the funeral of one of her sisters. The application was refused on 15 February 2016, because of security concerns and Ms Kelly's poor conduct since her incarceration.[35] Ms Kelly was subsequently granted permission to visit her sister's gravesite and did so on 24 February 2016.[36]

**24.** On 7 March 2016, Ms Kelly asked to be transferred from Unit 2 at BWP to Unit 6. She said she was struggling with "*the stairs, noise and young people*" in Unit 2 and she referred to the fact that with winter approaching, her health (including her arthritis and "bad" knee) would suffer. She gave an assurance that she would "…*maintain good behaviour and control [her] temper if given this chance*".[37] Ms Kelly's application was approved and cell occupancy records show that she moved into Unit 6 on 17 March 2016.[38]

**25.** In a letter dated 7 March 2016, AC (who was a prisoner at BWP at the time), wrote a letter asking to move into Ms Kelly's cell to help care for her. It is not clear whether AC's request to assist M Kelly was approved.[39]

**26.** In passing, I note that two "contact restrictions" were raised with respect to Ms Kelly. The first related to Ms Kelly's niece, NG. Custodial records show that on 8 February 2016, Ms Kelly approached a prison officer to say that if NG was housed on the same unit, she (Ms Kelly) would kill her because Ms Kelly believed that NG was responsible for her (Ms Kelly's) incarceration.[40] Cell occupancy records show that Ms Kelly was housed in the same cell as NG but only for a period of 9 minutes on 4 January 2016, apparently without incident.[41]

**27.** The second contact restriction related to LG, another of Ms Kelly's nieces. On 2 May 2016, a security alert was raised to the effect that Ms Kelly was not to be housed in the same unit as LG.[42] Cell occupancy records show that in fact, Ms Kelly had been housed in the same cell as LG from about 2.00 pm on 1 January 2016 to about 5.00 pm on 2 January 2016, apparently without incident. Obviously that cell placement predates the security alert.

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[35] Exhibit 1, Vol. 3, Tab 7, Funeral application (30.01.16)
[36] Exhibit 1, Vol. 2, Tab A, Death in Custody Review, p7
[37] Exhibit 1, Vol. 1, Tab 24, Unit Interview Form, Request by Ms Kelly to move to Unit 6 (07.03.16)
[38] Cell occupancy history, Unit 6 (17-21.03.16), Unit 6, Cell 13
[39] Exhibit 1, Vol. 1, Tab 24, Unit Interview Form, Request by AC to care for Ms Kelly (07.03.16)
[40] Exhibit 1, Vol. 2, Tab 3A, Offender movement information form (02.06.16)
[41] Cell occupancy history, Unit 6 (17-21.03.16), Unit 1, Cell A19
[42] Exhibit 1, Vol. 2, Tab 3A, Offender movement information form (02.06.16)

**28.** Both LG and NG were released from prison in January 2016 and custodial records note that the previous alert issues were therefore resolved.[43]

***Medical issues during incarceration - HCC***

**29.** On 23 December 2015, Ms Kelly was referred to the hepatology clinic at FSH after blood tests showed she had a low blood count that was possibly related to liver disease.[44,45] The referral was made on a "*semi-urgent basis*" meaning an appointment was requested within 31 - 90 days and was received by FSH on 24 December 2015.[46]

**30.** Dr Rowland explained that all referrals made by prison medical officers to external agencies are assessed and prioritised by the Health Department's central referral agency. The central agency is not obliged to follow the priority attached to the referral by the prison medical officer and might, in some cases, assign a different priority.[47]

**31.** FSH records show that an appointment was made for Ms Kelly to see a liver specialist in the hepatology clinic on 10 February 2016. FSH records also show that notification of that appointment was posted to BWP on 12 January 2016.[48] However, a review of Ms Kelly's medical care conducted by DOJ's Health Services & Critical Incident Review Group (the Health Services review) found there was no record of the appointment notification ever having been received.[49]

**32.** When Ms Kelly did not attend the hepatology clinic appointment, she was discharged from the clinic. According to FSH policy, when a patient does not attend a clinic appointment and they are to be discharged, a letter (known as a DNA letter) should be sent to the patient, telling them that their name has been removed from the clinic list and that a new referral from their doctor is required. This did not occur in Ms Kelly's case and is obviously regrettable.[50]

[43] Exhibit 1, Vol. 3, Tab 7, Funeral Application (30.01.16)
[44] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, pp3 & 9
[45] Exhibit 1, Vol. 1, Tab 46, Patient Referral (23.12.15)
[46] Exhibit 1, Vol. 1, Tab 48, Letter FSH to SGT L Housiaux (15.02.19)
[47] ts 09.03.20 (Rowland), pp30-31
[48] Exhibit 1, Vol. 1, Tab 48, Letter FSH to SGT L Housiaux (15.02.19)
[49] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, pp3 & 9
[50] Exhibit 1, Vol. 1, Tab 47, Letter FSH to SGT L Housiaux (15.02.19), pp2-3 and Attachment 5

**33.** At the time of Ms Kelly's hepatology clinic appointment, DNA letters at FSH were generated manually. Clerical officers entered patient details into a DNA letter template and then posted it out. Since October 2017, DNA letters have been generated automatically and all appointment letters now warn of the consequences to patients of not attending scheduled clinic appointments.[51]

**34.** Despite the fact that the referral to the hepatology clinic at FSH had been made on a "semi-urgent basis", prison medical staff at BWP did not take any action to follow up on an appointment date. This lack of action is obviously regrettable.[52,53]

**35.** At the inquest, Dr Rowland said that where there had been no apparent response to a referral made by a prison medical officer, she would have expected that the referral would be followed up. In this case, given Ms Kelly's clinical picture, Dr Rowland said she expected that follow-up action would have been taken within three months of the referral having been made, that is, by around the end of March 2016.[54]

**36.** Dr Rowland speculated that Ms Kelly's referral to the hepatology clinic may have been overlooked because prison medical staff were attending to her other pressing medical issues, including her rectal bleeding. A referral had been made the Gastroenterology Clinic for Ms Kelly to have a colonoscopy to investigate her rectal bleeding and Dr Rowland said that she would have expected Ms Kelly's liver issues to have been investigated as part of that assessment.[55]

**37.** Notwithstanding the fact that Ms Kelly had been referred to the FSH gastroenterology clinic, Dr Rowland agreed that her separate referral to the FSH hepatology clinic, should have been followed up.[56]

**38.** Dr Rowland noted that currently, individual medical officers are encouraged to follow up on referrals that they or their colleagues had made, in order to ensure that the referrals had been actioned and an appointment time had been scheduled. As in this case, that system is clearly subject to human error.[57]

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[51] Exhibit 1, Vol. 1, Tab 47, Letter FSH to SGT L Housiaux (15.02.19), p3 and Attachments 10 & 12
[52] Exhibit 1, Vol. 1, Tab 47, Letter FSH to SGT L Housiaux (15.02.19), p3 and Attachment 10 to that letter
[53] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, pp3 & 9
[54] ts 09.03.20 (Rowland), pp30-31
[55] ts 09.03.20 (Rowland), pp41-42
[56] ts 09.03.20 (Rowland), p42
[57] ts 09.03.20 (Rowland), pp37-38

**39.** Dr Rowland, with whom I agree, said she favoured a "hard fix" to EcHO, DOJ's electronic prison health management system, so that it generated automatic reminders whenever a referral had been made. Dr Rowland said that EcHO currently has this functionality, but that additional resources, in the form of data entry clerks, would be required to implement the automatic system.[58]

**40.** As I understood Dr Rowand's evidence, the data entry clerks would be necessary because information about whether a particular prisoner has attended a clinic appointment would need to be entered into EcHO, in order for the automatic alert to be deactivated. Dr Rowland advised that there are only two data entry clerks available in DOJ, and they are already working at full capacity on existing tasks.[59]

**41.** Notwithstanding this apparent difficulty, I would urge DOJ to investigate whether the EcHO system can be adapted to generate an automatic alert, without the need for additional data entry support.

**42.** From documentation in Ms Kelly's case, it appears that when a prisoner attends a clinic or specialist appointment, the relevant consultant (or someone acting on their behalf), sends the prison a letter summarising the consultant's assessment of the prisoner and the recommended treatment plan. It may be possible for EcHO to generate an automatic reminder about referrals, which could be cancelled by prison medical staff at a subsequent review of the prisoner, once a medical report from the clinic or consultant that the prisoner was referred to, had been sighted.

**43.** In this case, Ms Kelly was eventually diagnosed with Hepatocellular carcinoma (HCC) during her admission to RPH in June 2016. HCC is a common form of liver cancer than occurs most often in patients with chronic liver diseases, such was cirrhosis.[60,61] With respect to Ms Kelly's HCC, the Health Services review made the following observation:

> Ms Kelly's screening for hepatocellular carcinoma (HCC) had not occurred despite documentation of liver disease, possibly because cirrhosis as a diagnosis was not added to her active problem list.[62]

[58] ts 09.03.20 (Rowland), pp37-38
[59] ts 09.03.20 (Rowland), p37
[60] ts 09.03.20 (Rowland), p34
[61] See also: https://www.mayoclinic.org/diseases-conditions/hepatocellular-carcinoma/cdc-20354552
[62] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p9

**44.** The Health Services review noted that since Ms Kelly's death, all prison medical officers have received further education regarding cirrhosis, particularly diagnosis, management and the need to screen for HCC. Further, an electronic cirrhosis care plan template has been created. The template highlights risk factors relating to cirrhosis and sets out appropriate treatment options.[63]

**45.** Dr Andrew Kilmaitis (a consultant physician who reviewed Ms Kelly's medical care after her death), said that he did not believe that the fact that Ms Kelly's HCC was not identified earlier: "*[H]ad any meaningful impact on her medical admission or death*".[64]

**46.** It therefore seems that the respective failures by FSH and BWP with respect to Ms Kelly's hepatology clinic referral, did not contribute to her death. Nevertheless, as I have already observed, these respective failures are regrettable.

***Medical issues during incarceration - Falls Risk***

**47.** Departmental policy requires that within 24 hours of admission, all prisoners undergo a full health screen by a registered nurse.[65] The policy requires that a risk assessment for falls using the falls risk management tool is to be completed "*as appropriate*".[66,67]

**48.** Despite the fact that Ms Kelly had several risk factors for falls, no formal falls risk assessment was documented on her admission to BWP.[68] During her incarceration, Ms Kelly complained of gradually increasing knee pain, and asked for a knee brace on a number of occasions, despite being told that a knee brace had not been prescribed by either an orthopaedic surgeon or a physiotherapist.[69,70]

**49.** On 3 July 2015, Ms Kelly was reviewed by a prison medical officer and found to have a "*slow gait*". She was provided with a walking frame to assist her mobility, although it is not clear when she stopped using the walking frame, before a new one was issued to her on 18 April 2016.[71]

[63] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p9
[64] Exhibit 1, Vol. 1, Tab 48, Report - Dr A Klimaitis, p2
[65] Exhibit 1, Vol. 1, Tab 45, Health Services: PM01 Adult Admission and Risk Assessment, para 2.1.3
[66] Exhibit 1, Vol. 1, Tab 45, Health Services: PM01 Adult Admission and Risk Assessment, para 2.1.14
[67] Exhibit 1, Vol. 1, Tab 44, MR036: Falls Risk Management Tool
[68] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p9
[69] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report, p4
[70] Exhibit 1, Vol. 1, Tab 50, Letter - DOJ Corporate Services to SGT Housiaux (17.1218), p4
[71] Exhibit 1, Vol. 1, Tab 50, Letter - DOJ Corporate Services to SGT Housiaux (17.1218), p5

**50.** From August 2015, Ms Kelly's blood pressure was monitored after she complained of feeling dizzy. Ms Kelly's dizziness had an obvious impact on her mobility and clinical staff attempted to regularly monitor her blood pressure and she was prescribed medication for her blood pressure. Unfortunately, Ms Kelly was often non-compliant with her medication and on occasion, she refused to have her blood pressure and/or sugar levels checked.[72]

**51.** On 11 February 2016, Ms Kelly was seen by a physiotherapist because of right knee pain. At the request of the physiotherapist, the prison medical officer referred Ms Kelly for an ultrasound of her hip and right knee. Ms Kelly remained fixated on obtaining a knee brace and was resistant to other strategies regarding mobility assistance.[73]

**52.** On 6 April 2016, Ms Kelly reported she was still having difficulty walking. She was advised that a walking frame with a seat had been ordered for her, but she declined it, saying she would prefer a knee brace.[74] On 11 April 2016, she asked for permission to use a wheelchair to visit the prison canteen, saying she had fallen because of the distance she was required to walk to get there. Her request was approved on 12 April 2016.[75]

**53.** On 18 April 2016, Ms Kelly requested a walking frame be issued to her on account of her knee pain. She was issued with a four wheeled walker with a seat and also provided with knee support in the form of a tubigrip bandage. On 2 June 2016, Ms Kelly was referred back to the physiotherapist because nursing staff had concerns that she did not have the grip strength to operate the four wheel walker effectively. After a review, Ms Kelly was again told a knee brace was not required and she was issued with a two wheel walker and encouraged to use it instead.[76]

**54.** Unfortunately, as will be discussed, in the afternoon of 2 June 2016, Ms Kelly fell heavily in the doorway of her cell and was taken to RPH, where she was found to have fractured the neck of her left femur. The Health Services review noted that since Ms Kelly's death, education had been provided to nursing staff about falls risk assessment on how to correctly use the falls risk management tool in EcHO.[77]

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[72] Exhibit 1, Vol. 1, Tab 50, Letter - DOJ Corporate Services to SGT Housiaux (17.1218), pp2-5
[73] Exhibit 1, Vol. 1, Tab 50, Letter - DOJ Corporate Services to SGT Housiaux (17.1218), p3
[74] Exhibit 1, Vol. 1, Tab 2, Police Investigation Report, p2
[75] Exhibit 1, Vol. 1, Tab 24, Unit Interview Form (11.04.16)
[76] Exhibit 1, Vol. 1, Tab 50, Letter - DOJ Corporate Services to SGT Housiaux (17.1218), p3
[77] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p9

### *Medical issues during incarceration - Rectal bleeding*

**55.** On 21 April 2016, Ms Kelly was referred to the FSH gastroenterology clinic for a colonoscopy to investigate her reported rectal bleeding.[78] That referral was acted upon and a pre-admission "*telehealth interview*" was conducted at BWP on 2 June 2016.[79]

**56.** Ms Kelly was placed on the colonoscopy waitlist and the procedure was scheduled for 14 June 2016.[80] However, as a consequence of her admission to RPH on 2 June 2016 following a fall, her colonoscopy was cancelled.[81] This is particularly unfortunate given Ms Kelly's history of anaemia, low platelet count (thrombocytopenia), cirrhosis, constipation and reports of pain on defecation.[82]

### *Comments - medical issues during incarceration*

**57.** The Health Services review identified three areas for improvement, namely:[83]

a. no formal risk assessment was conducted despite the fact that she had several identified risk factors;

b. Ms Kelly and her cellmates reported rectal bleeding on several occasions and although she was examined and referred for a colonoscopy, this had not been undertaken prior to her death; and

c. Mr Kelly's was not screened for HCC despite her documented liver disease, possibly because cirrhosis had not been added to her "active problem list".

**58.** It is clearly regrettable that Ms Kelly's falls risk was not formally assessed on her admission to BWP. Although Ms Kelly had been resistant to using a walking frame and concerns had been expressed about whether she had the grip strength required to use a four-wheeled walker, an earlier formal risk assessment should have been carried out.

[78] Exhibit 1, Vol. 1, Tab 46, Patient Referral (16.03.15)
[79] Exhibit 1, Vol. 1, Tab 47, Letter FSH to SGT L Housiaux (15.02.19), p2 and Attachments 7 & 8
[80] Exhibit 1, Vol. 1, Tab 47, Letter FSH to SGT L Housiaux (15.02.19), p2 and Attachments 7 & 8
[81] Exhibit 1, Vol. 1, Tab 47, Letter FSH to SGT L Housiaux (15.02.19), p2 and Attachments 7 & 8
[82] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p9
[83] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p9

**59.** However, the documentation in the Brief of Evidence establishes that Ms Kelly was referred to an optometrist (to address her vision) and a physiotherapist (to address knee pain and walking issues) and that attempts were made to manage her blood pressure and resultant dizziness. In addition, Ms Kelly was provided with a walker and she given approval to use a wheelchair to access the BWP canteen. All of these measures were clearly aimed at mitigating Ms Kelly's fall risk.[84]

**60.** As Dr Rowland pointed out, the importance of using the falls risk management tool in EcHO is that doing so highlights risk, especially where, in a particular case, that risk is more subtle. In Ms Kelly's case, her numerous medical issues and frailty meant that her falls risk was so obvious and steps were taken to address her mobility issues, notwithstanding the fact that a formal risk assessment had not been undertaken. Nevertheless, as Dr Rowland properly conceded, a formal falls risk assessment should have been completed in Ms Kelly's case.[85]

**61.** Ms Kelly's rectal bleeding was being monitored and she had been referred for a colonoscopy. Unfortunately, events overtook this procedure and it had not been conducted by the time of her admission to RPH. By that stage, Ms Kelly was too unwell and the procedure could not be carried out.[86]

**62.** Dr Rowland noted that Ms Kelly's medical conditions and her prescribed medications made her more vulnerable to bruising and bleeding. However, it does not appear that Ms Kelly's rectal bleeding was related to her HCC. Rather it was thought she may have had an internal haemorrhoid.[87]

**63.** It is also regrettable that because of an apparent breakdown in communication, Ms Kelly did not attend the hepatology clinic appointment which had been booked for her at FSH. Had Ms Kelly attended this appointment, it is possible that her HCC may have been identified at an earlier stage. However, as Dr Kilmaitis noted, the delayed diagnosis had no meaningful impact on Ms Kelly's medical admission or death.

[84] Exhibit 1, Vol. 1, Tab 47, Letter FSH to SGT L Housiaux (15.02.19)
[85] ts 09.03.20 (Rowland), pp25-26
[86] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, pp3-7
[87] ts 09.03.20 (Rowland), pp4-46

**64.** The Health Services review identified three improvements to the delivery of health services that have been made since Ms Kelly's death, namely:

a. prison medical officers have received education about the diagnosis and management of cirrhosis, and the need to consider whether the prisoner required screening for HCC;

b. a cirrhosis care plan template[88] has been introduced into EcHO which highlights risk factors and provides a checklist of appropriate treatment actions; and

c. prison nursing staff have received education regarding the importance of the importance of falls risk assessment and the falls risk management tool.[89,90]

**65.** The Health Services review concluded that:

> [A]ll care provided to Ms Kelly during her incarceration was appropriate and although areas for improvement in documentation have been identified, none of these issues impacted on the care provided to Ms Kelly or contributed to her death.[91]

**66.** On the basis of the evidence of Dr Rowland and Dr Klimaitis, I am satisfied that the issues identified in the Health Services review did not contribute to Ms Kelly's death. I am further satisfied that, when viewed in a global way, Ms Kelly's overall medical management whilst she was in custody was adequate.[92]

[88] See: Exhibit 2, EcHO cirrhosis care plan template
[89] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p9
[90] See also: ts 09.03.20 (Rowland), pp46-47
[91] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p10
[92] ts 09.03.20 (Rowland), p27

## ADMISSION TO RPH - 2 JUNE 2016

**67.** At about 3.55 pm on 2 June 2016, prison staff on Ms Kelly's unit were alerted to the fact that she had fallen near the door of her cell. A medical emergency call was made and nursing staff arrived at the unit at 3.57 pm. Staff called emergency services at 4.16 pm and an ambulance arrived at BWP at 4.28 pm.[93]

**68.** Ms Kelly told ambulance officers she had tripped on a step in the doorway of her cell and landed on her left side. She complained of pain and her left leg showed obvious shortening and rotation, but denied striking her head or losing consciousness.[94] Ms Kelly was taken to RPH by ambulance where she was found to have fractured the neck of her left femur. Her fractured hip was surgically repaired on 4 June 2016.[95]

**69.** During her admission at RPH, Ms Kelly was treated for a decline in brain function caused by severe liver disease (hepatic encephalopathy). Her hepatic encephalopathy caused her to become delirious and agitated and made her management in hospital very challenging. The condition also predisposed her to pneumonia.[96]

**70.** In Ms Kelly's case, her hepatic encephalopathy was due to cirrhosis of her liver, which in turn was the result of her previous excessive alcohol intake. Ms Kelly was also found to have hepatocellular carcinoma (HCC), a form of liver cancer often associated with cirrhosis of the liver. Unfortunately, because of her medical condition, it was determined that no treatment could be offered.[97]

**71.** On 7 June 2016, prison officers attending Ms Kelly noted a deterioration in her mood and she was making statements such as "*I am ready to die, dear lord take me now*".[98] RPH nursing notes at this time record the fact that Ms Kelly was non-compliant with medication and that her food and fluid intake was limited.[99] As a result of her mental state, Ms Kelly was placed on ARMS with 6-hourly monitoring. She was subsequently removed from ARMS on 14 July 2016.[100]

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[93] Exhibit 1, Vol. 3, Tab 9, Incident description report (02.06.16, Prison Officer R Lamb)
[94] Exhibit 1, Vol. 1, Tab 23, St John Ambulance patient care record (02.06.16), p3
[95] Exhibit 1, Vol. 1, Tab 41, RPH discharge summary (24.09.16), pp1-2
[96] Exhibit 1, Vol. 1, Tab 48, Report - Dr A Klimaitis, p1
[97] Exhibit 1, Vol. 1, Tab 48, Report - Dr A Klimaitis, pp1-2
[98] Exhibit 1, Vol. 2, Tab 6B, Manager's risk assessment and Exhibit 1, Vol. 2, Tab A, Death in Custody Review, p8
[99] RPH inpatient notes, (EO112952), (07.06.16)
[100] Exhibit 1, Vol. 1, Tab 20, ARMS - Interim Management Plan (08.06.16)

**72.** On 16 June 2016, Ms Kelly was referred to the RPH palliative care team and reviewed the next day, after her agitation had subsided. At that time, her prognosis was uncertain, but it was felt that her condition would deteriorate over the following few weeks. She was assessed as unsuitable for hospice care because of her variable mental state.[101]

**73.** I note that during the period 21 July 2016 to 16 August 2016, custodial officers supervising Ms Kelly at RPH recorded frequent instances of physically and verbally aggressive behaviours by Ms Kelly which included screaming and yelling and attempts to assault hospital and escort staff.[102] Dr Rowland noted a number of terminally ill prisoners have (and are) cared for at Bethesda Hospice, which offers a more appropriate environment for end-of-life care. It is unfortunate that in Ms Kelly's case, her medical conditions prevented her being transferred there.[103]

**74.** On 7 July 2016, Ms Kelly's status on TOMS was escalated to Phase IV on the terminally ill module, meaning that death was thought to be imminent.[104,105,106] The palliative care team continued to regularly review Ms Kelly, and on 13 July 2016, all unnecessary medications were ceased.[107]

**75.** In accordance with standard departmental procedure, when she was admitted to RPH, Ms Kelly was wearing ankle restraints.[108] On 13 June 2016, following representations by her clinical team, approval was given for Ms Kelly to use a one-point restraint.[109] Following further representations by her clinical team, Ms Kelly's restraints were removed altogether on 13 July 2016.[110]

**76.** A psychiatric review by Dr Arenson on 2 August 2016, concluded that Ms Kelly's cognitive function had deteriorated since a previous assessment on 23 June 2016. After his assessment, Dr Arenson concluded that Ms Kelly did not have the capacity to make treatment decisions.[111]

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[101] RPH inpatient notes, (EO112952), (16-17.06.16 & 13.07.16)
[102] Exhibit 1, Vol. 2, Tab A, Death in Custody Review, p8
[103] ts 09.03.20 (Rowland), p36
[104] Exhibit 1, Vol. 3, Tab 11, Terminally ill health advice (07.07.16)
[105] Exhibit 1, Vol. 2, Tab A-1, Health Services Review, p8
[106] Exhibit 1, Vol. 3, Tab 10, PD8: Prisoners with a terminal medical condition - procedures, para 4.4.1
[107] RPH inpatient notes, (EO112952), (16-17.06.16 & 13.07.16)
[108] Exhibit 1, Vol. 2, Tab 7A, Letter, Dr G Carr (12.06.16)
[109] Exhibit 1, Vol. 2, Tab 7B, Email, Prin. Off. K Laidler (12.06.16)
[110] Exhibit 1, Vol. 2, Tab 7E, External risk assessment form (13.07.16)
[111] Exhibit 1, Vol. 1, Tab 42, RPH inpatient notes (02.08.16)

**77.** Dr Arenson noted that Ms Kelly's "*cognitive reserve*" had been diminished by her previous alcohol intake, neurovascular disease (secondary to poorly controlled type-2 diabetes), head injury and HCC.[112]

**78.** An application was made to the State Administrative Tribunal (on Ms Kelly's behalf) for the appointment of a guardian. The application was due to be heard on 30 September 2016, but Ms Kelly died before the scheduled hearing.[113]

**79.** Ms Kelly received palliative care and remained largely unconscious over the next few weeks. Her condition continued to deteriorate and she was certified deceased at 1.10 am on 24 September 2016.[114,115]

### *Comment on Ms Kelly's medical care at FSH*

**80.** According to Dr Kilmaitis (the consultant physician who reviewed Ms Kelly's medical care), at no stage during her admission to RPH was she well enough to undergo treatment of her HCC.[116] With respect to Ms Kelly's medical care whilst at RPH, Dr Kilmaitis said:

> I cannot fault the medical management. This was a difficult situation where her encephalopathy resulted in significant agitation and delirium. Medication was required to settle her down. As doctors we can find ourselves between two extremes, i.e.: if she is too agitated then she could harm herself (or others), whereas if she is too sedated then medical complications such as aspiration pneumonia can occur. It does not appear that the encephalopathy cleared for a sufficient time to allow her sedation to be weaned.[117]

**81.** On the basis of the evidence of Dr Kilmaitis, I am satisfied that Ms Kelly received appropriate medical care during her admission to RPH.

[112] Exhibit 1, Vol. 1, Tab 42, RPH inpatient notes (02.08.16)
[113] Exhibit 1, Vol. 2, Tab 8, State Administrative Tribunal Interim Orders (08.08.16)
[114] Exhibit 1, Vol. 1, Tab 42, RPH inpatient notes (16-24.09.16)
[115] Exhibit 1, Vol. 1, Tab 5, RPH death in hospital form (24.09.16)
[116] Exhibit 1, Vol. 1, Tab 48, Report - Dr A Klimaitis, p2
[117] Exhibit 1, Vol. 1, Tab 48, Report - Dr A Klimaitis, p1

## CAUSE AND MANNER OF DEATH

**82.** A forensic pathologist (Dr J McCreath), conducted a post mortem examination of Ms Kelly's body on 4 October 2016. Dr McCreath found Ms Kelly had atherosclerotic cardiovascular disease with the left anterior descending artery and the left circuflex and right coronary arteries almost completely blocked.[118]

**83.** Microscopic examination of tissues showed scarring within Ms Kelly's heart, pneumonia in her lungs and marked chronic kidney disease. There was cirrhosis in Ms Kelly's liver as well as HCC (liver cancer).[119]

**84.** Neuropathological examination of Ms Kelly's brain showed an old traumatic brain injury and an old stroke. There were thin organising subdural haematomas (blood clots) on both sides of her brain and multifocal arteriosclerosis (hardening of the arteries) was present.[120]

**85.** Toxicological analysis found olanzapine, haloperidol, midazolam (along with a midazolam metabolite) and hydromorphone in Ms Kelly's system. These medications were prescribed during her hospital admission.[121,122]

**86.** At the conclusion of her examination, Dr McCreath expressed the opinion that the cause of Ms Kelly's death was combined effects of bronchopneumonia and acute liver failure on a background of liver cirrhosis and hepatocellular carcinoma in a woman with atherosclerotic cardiovascular disease and recent fractured neck of femur treated palliatively.[123]

**87.** I accept and adopt that conclusion and I find Ms Kelly's death occurred by way of Natural Causes.

[118] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report, p5
[119] Exhibit 1, Vol. 1, Tab 6, Post Mortem Second Supplementary Report, p1
[120] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report
[121] Exhibit 1, Vol. 1, Tab 8, ChemCentre Toxicology Report
[122] Ms Kelly's RPH Medication chart (14-23.09.16), In-patient notes (EO112952)
[123] Exhibit 1, Vol. 1, Tab 6, Post Mortem Second Supplementary Report, p1

## RECOMMENDATIONS

**88.** In light of the observations I have made, I make the following recommendation:

***Recommendation***

> In order to ensure that referrals of prisoners to external agencies, made by prison clinical staff, are appropriately actioned, the Department should consider using its health records system (EcHO) to generate automatic reminders to clinical staff. These reminders would prompt clinical staff to check whether an appointment had been received from the external agency for the prisoner and/or whether the appointment had been attended by the relevant prisoner.

**89.** I note that at my request, Sergeant Housiaux forwarded a draft of the above recommendation to Ms Berry on 17 March 2020 and invited comment from the Department.[124]

**90.** On 2 April 2020, Ms Berry sent an email to Sergeant Housiaux, indicating that the Department's comment on the draft recommendation was as follows:

> The EcHO system has the capability to flag prisoner referrals to external appointments as an alert to prison staff, however further system changes are required to enable this functionality. In addition, significant data uploads, system testing, development of procedures and training resources for doctors, medical booking clerks, receptionists and nurses will need to be undertaken.[125]

**91.** It is pleasing that the EcHO system already has the functionality to generate automatic alerts with respect to external appointments. Given the importance of prisoners actually attending those appointments, it is my view that the recommendation I have made is appropriate. As I have already said, I urge DOJ to investigate whether the automatic alert system can be introduced without the foreshadowed data entry burden.

[124] Email to Ms J Berry (State Solicitor's Office) from Sgt. L Housiaux (17.03.20)
[125] Email from Ms J Berry (State Solicitor's Office) to Sgt. L Housiaux (02.04.20)

## QUALITY OF SUPERVISION, TREATMENT AND CARE

**92.** During her incarceration, Ms Kelly was seen regularly at the medical centre at the BWP. She was referred to allied health professionals and specialist medical and significant attempts were made to manage her blood pressure and other medical issues. At times, the efforts of clinical staff were hampered by Ms Kelly's non-compliance with medication and her refusal to undergo tests and assessments.

**93.** The Health Services Review identified several areas for improvement in Ms Kelly's care whilst she was in custody. She should have been the subject of a formal falls risk assessment and there should have been a more comprehensive assessment of her liver issues and rectal bleeding. However, on the basis of the evidence to which I have referred, I am satisfied that none of these issues contributed to Ms Kelly's death.

**94.** Having carefully reviewed the documentary and oral evidence in this case, I am satisfied that the supervision, treatment and care that Ms Kelly received whilst she was in custody at BWP was adequate. Further, in my view, Ms Kelly was effectively managed on ARMS and subsequently, SAMS at various times and her often challenging behaviour was managed appropriately.

**95.** When Ms Kelly fell on 2 June 2016 and fractured the neck of her left femur, she was transferred to RPH in a timely and efficient manner. Her fracture was successfully repaired but unfortunately, she developed hepatic encephalopathy related to her liver disease and her condition deteriorated.

**96.** Ms Kelly was provided with palliative care at RPH and kept comfortable, until her death. After considering all of the evidence in this matter, I have concluded that Ms Kelly's clinical care at RPH was of a high standard.

## CONCLUSION

**97.** Since Ms Kelly's death, the DOJ have implemented several changes aimed at improving health outcomes for prisoners in the care of the Chief Executive Officer. I have recommended a further change which, in my view, would help to ensure appointments to external agencies are not overlooked.

**98.** I can only hope that the changes DOJ have made to health service delivery, as well as the further change I have recommended, will provide Ms Kelly's loved ones with some level of comfort.

MAG Jenkin
**Coroner**
2 April 2020
I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

CORONER M Jenkin

2 APRIL 2020