JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON
HEARD	**:**	14 OCTOBER 2020
DELIVERED	**:**	2 DECEMBER 2020
FILE NO/S	**:**	CORC 869 of 2017
DECEASED	**:**	SHARPE, SIMON JOHN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms R Collins assisted the Coroner.
Ms E F Archer (SSO) appeared on behalf of the Department of Justice and the South Metropolitan Health Service.

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 ***Simon John SHARPE*** *with an inquest held at the* ***Perth Coroner's Court*** *on 14 October 2020, find that the identity of the deceased person was* ***Simon John SHARPE*** *and that death occurred on 30 June 2017 at Fiona Stanley Hospital from non-specific interstitial pneumonia in the following circumstances:*

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INTRODUCTION

1. Simon Sharpe was serving a prison term when he died at Fiona Stanley Hospital on 30 June 2017 after a period of declining health. By virtue of Mr Sharpe's status as a sentenced prisoner at the time of his death, Mr Sharpe 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 at the Perth Coroner's Court on 14 October 2020.

2. The circumstances of Mr Sharpe's death were relatively clear. He had been diagnosed with an incurable lung disease prior to commencing his term of imprisonment. Without a lung transplant, Mr Sharpe's long-term prognosis was poor, but he was not eligible to be placed on the transplant list for a number of reasons. Mr Sharpe was treated by specialists at Fiona Stanley Hospital, both before and throughout his term of imprisonment, but ultimately his disease progressed to its end stage and he died in hospital.

3. The primary focus of the inquest was on the medical treatment provided to Mr Sharpe while in custody, to ensure it was of an appropriate standard. Mr Sharpe and his family had raised a number of concerns prior to his death about the adequacy of his medical care, so particular attention was given to considering the nature of these concerns and whether they were addressed appropriately by the authorities at the time they were raised.

BACKGROUND

4. Mr Sharpe was born and raised in Western Australia. He worked in the transport industry, mainly as a truck driver, for over 25 years before he had to stop working due to illness. He had a deep love for trucks, cars and motorbikes and their mechanics and continued to tinker with them in his spare time. He had been in a number of de facto relationships and had two children, a daughter and a son. He was single and living with his son, who assisted with his care, and his doted on pet dog, prior to his imprisonment.[2]

5. Mr Sharpe was convicted after a trial before a jury of historical child sexual offences. On 27 January 2016 he was sentenced in the District Court of Western Australia to a term of two year's imprisonment, to commence from that day, with eligibility for parole.[3]

[1] Section 22(1)(a) *Coroners Act*.
[2] Exhibit 1, Tab 8; Exhibit 2, Death in Custody Report.
[3] Exhibit 2, Tab 3.

6. During the sentencing proceedings, it was noted that Mr Sharpe had a chronic, incurable lung condition, known as idiopathic nonspecific interstitial pneumonia, which reduced the capacity of his lungs and reduced his life expectancy. He had been suffering from the respiratory illness since 2012 and had been receiving a disability pension.[4]

7. Mr Sharpe took daily medications and required 24 hour oxygen therapy, to help the body overcome the deficiency in the lungs to maintain oxygen levels, and a CPAP machine at night.[5] It was noted at the time of sentencing that he had not been found to be a suitable candidate for a lung transplant at that time.[6] Mr Sharpe had multiple barriers to being placed on the transplant list, including obesity, intermittent cigarette smoking, and poor compliance with attending the gym and clinic, although he had indicated he was working on some of these factors so his position was to be reviewed on an ongoing basis.

8. Prior to his imprisonment, the Department of Corrective Services (the Department) had been contacted by Mr Sharpe's lawyers and the Director of Public Prosecutions with respect to the type of medical care that the Department could provide to Mr Sharpe. The lawyers were told that Mr Sharpe would be provided with care commensurate with community standards, including specialist medical care if clinically necessary, and he would be referred to tertiary care if required.[7]

9. Mr Sharpe's treating physician at Fiona Stanley Hospital (FSH), Dr Michael Musk, also provided a report to Mr Sharpe's lawyers setting out the treatment Mr Sharpe required for his chronic disease.[8] Dr Musk is a lung transplant physician and is currently the Head of Service of the whole of Respiratory Medicine at FSH and the Medical Director of their Lung Transplant Unit. In his letter, Dr Musk confirmed that Mr Sharpe was **not** currently on the lung transplant waitlist and he needed to take multiple medications on a daily basis and be in a position where he could access medical care in the setting of deterioration, as well as be able to attend regular medical and allied health appointments at FSH. This letter was made available to the learned sentencing Judge prior to sentencing.

10. The information available was that Mr Sharpe had been diagnosed with idiopathic non-specific interstitial pneumonitis/pneumonia, a type of interstitial lung disease. Interstitial lung diseases are a group of conditions

[4] Exhibit 2, Tab 3, pp. 4 - 7.
[5] Exhibit 2, Tab 3, pp. 4 - 7.
[6] Exhibit 2, Tab 3, p. 7.
[7] Exhibit 1, Tab 45.
[8] Exhibit 1, Tab 12B.

characterised by varying patterns of inflammation and fibrosis of the lung tissue. The result is damage to the lung interstitium, the connective tissue that forms the support structure for the alveoli of the lungs. Interstitial lung diseases with no apparent cause are referred to as idiopathic. Prognosis and treatment varies between the subtypes but low oxygen levels and respiratory failure can develop as the disease progresses. Dr Musk explained at the inquest "the lungs essentially shrink and they lose their elasticity."[9] As a result, the work that is required by the muscles to expand the lungs increases, and that is why people get breathless.[10]

11. Mr Sharpe's disease was incurable and his median survival, without transplantation, was estimated at about five years. There is some active treatment that can extend that median survival, but only by effectively stabilising the condition rather than improving it. The only way to actually improve the patient's condition is a lung transplant.[11]

12. The information also confirmed that Mr Sharpe was already in significant respiratory failure and required ambulatory and home oxygen. He was essentially independent in activities of daily living but became breathless with almost any exertion. He was not on the transplant waitlist, for the reasons listed above. Mr Sharpe required continuous oxygen therapy at 4-6 litres per minute at rest, but up to 6-8 litres per minute on exertion.

13. The learned sentencing Judge took into account Mr Sharpe's ill health and acknowledged he would suffer a great burden while imprisoned due to his respiratory condition, but did not consider it had been established Mr Sharpe could not receive appropriate medical care while incarcerated.[12]

ADMISSION TO PRISON

14. Mr Sharpe was admitted to Casuarina Prison, which has an infirmary, on the day he was sentenced. He was reviewed by prison medical officer Dr Richard Wee the day after he was admitted to prison.[13]

15. He also required a CPAP machine at night, which he had access to at his home. Dr Wee spoke to a doctor at the Fiona Stanley Hospital (FSH) Advanced Lung Unit and confirmed Mr Sharpe's current medications and the

[9] T 7.
[10] T 7.
[11] T 6 - 7; Exhibit 1, Tab 12A
[12] Exhibit 2, Tab 3, p. 8.
[13] Exhibit 1, Tab 49.

need to organise a respiratory consultation for Mr Sharpe, which was confirmed by email. Mr Sharpe was receiving immunosuppression so his usual immunosuppressant medications were prescribed. A mental health review was also scheduled as Mr Sharpe reported a history of bipolar affective disorder and indicated he had been prescribed antipsychotics in the past.[14]

16. Mr Sharpe was initially housed in the infirmary and was reviewed daily by nursing staff. There were some initial issues with his equipment and he was then given permission to bring in some of his own equipment from home. An oxygen concentrator was installed in his cell for use, with a medium sized oxygen cylinder left in his cell in case the concentrator failed overnight, and small oxygen cylinders were available for use when mobilising. Nursing records during the first week of Mr Sharpe's incarceration on 30 January 2016 noted that Mr Sharpe should be 'conservative' with his oxygen use while resting, as they were awaiting delivery of more oxygen, although there was also a note that he should not underuse.[15]

17. On 3 February 2016 Mr Sharpe was reviewed by a mental health nurse and no risk issues were identified.[16]

18. On 5 February 2016 Mr Sharpe saw Dr Wee for his first review appointment and he complained that the prison oxygen concentrator was inadequate as it was unable to supply 8L/min oxygen when required. Mr Sharpe's oxygen saturations were, however, normal at 97% during the review.[17]

19. On 8 February 2016 Mr Sharpe was registered as a terminally ill prisoner Stage 1, which simply noted he could potentially die in custody.

20. From this time there were occasional concerns raised by Mr Sharpe about the oxygen concentrator and its ability to supply the level of oxygen he needed. First, he complained about the heat it generated in his cell, so he was transferred to an air-conditioned cell, which appeared to resolve that issue and help him be more comfortable.[18] On 15 February 2016 Mr Sharpe's CPAP machine arrived and he indicated to a nurse at that time he was happy with the oxygen concentrator.

21. Mr Sharpe had a review at FSH with a Respiratory Consultant on 26 February 2016 and he was noted to be clinically stable, with no changes made to his

[14] Exhibit 1, Tab 49.
[15] T 33; Exhibit 1, Tab 49.
[16] Exhibit 1, Tab 49.
[17] Exhibit 1, Tab 49.
[18] Exhibit 1, Tab 49.

therapy, and no issues were raised with his oxygen delivery at that time. He reported he had stopped smoking one month ago. I note he had previously told Dr Musk he had stopped smoking in June 2015, which is perhaps an indicator of the difficulty he had permanently giving up smoking, despite his lung disease. The next clinic review was not due for another six months.[19]

22. On 1 March 2016 Mr Sharpe reported during a care plan review with a nurse that the hospital were not happy with his oxygen use and its fluctuations, although I note this is not mentioned in the report from the FSH Consultant, Dr Wrobel. An urgent appointment with a prison medical officer was scheduled to consider this issue and also Mr Sharpe's request to alter his medications. Mr Sharpe saw Dr Princewill Chuka for this review on 8 March 2016 and again raised his concerns about the oxygen levels he was receiving, which he believed were lower than what he was prescribed. Mr Sharpe suggested to Dr Princewill that he believed the learned sentencing judge had indicated he should be released from prison if the prison could not meet his health requirements, although this is not supported by the sentencing remarks and is inconsistent with the way a prison sentence is managed once it is imposed.[20]

23. Following these complaints, on 17 March 2016 Mr Sharpe was given a new oxygen concentrator. Mr Sharpe indicated it was less noisy and no other complaints are recorded. However, Mr Sharpe did continue to raise concerns that he was not permitted full access to his required oxygen, although he was self-administering his oxygen. Various administrators, doctors and nursing staff were involved in trying to resolve these issues, both within the prison medical team and from Fiona Stanley Hospital.[21]

24. On 8 April 2016 Mr Sharpe complained of left sided chest pain and increased shortness of breath. He was given increased steroids and pain management but on 11 April 2016 he had not improved, so he was sent to FSH. Mr Sharpe underwent a number of investigations, including a CT pulmonary angiogram to exclude pulmonary embolism. In the end, it was thought the pain was secondary to his underlying lung disease and he was returned to prison.[22]

25. On 14 April 2016 Mr Sharpe's lawyer wrote to the Department to raise concerns communicated to him by Mr Sharpe's family that his medical care within the prison was inadequate and did not comply with the assurances that

[19] Exhibit 1, Tab 12C.
[20] Exhibit 1, Tab 49.
[21] Exhibit 1, Tab 49.
[22] Exhibit 1, Tab 9A.

were given to the Court at the time of sentencing. Mr Sharpe's lawyer sought some reassurance that essential precautions, such as bottled oxygen, would be available to the same extent as they would be if Mr Sharpe were in the general community and that he would be properly quarantined from infectious patients given his immunosuppressed condition.[23]

26. Dr Cherelle Fitzclarence, who at the time was the Deputy Director of Health Services at the Department and had also worked as a prison medical officer,[24] responded to Mr Sharpe's lawyer on 26 April 2016. Dr Fitzclarence advised that Mr Sharpe had been housed in the infirmary at Casuarina and had been provided with continuous oxygen from the time of his admission to prison. Contrary to Mr Sharpe's claims, he was able to have 4-6L/min of oxygen and was able to self-regulate the flow in accordance with his needs. After a delay of a couple of weeks, he had also had his CPAP machine available at night since 15 February 2016. Dr Fitzclarence also confirmed he had been provided with all his prescribed medication since arriving in prison. In terms of exposure to other prisoners, he had his own room in the west wing infirmary. Dr Fitzclarence reiterated that, as was the case prior to his sentencing, Mr Sharpe was still "NOT currently on the lung transplant waiting list."[25]

27. Mr Sharpe was returned to FSH on 18 April 2016 after he reported worsening chest pain. It was noted that Mr Sharpe expressed concern to the FSH medical staff that his oxygen script of 6L/min was not being administered appropriately by prison health staff. Following assessment and discussion with the Advanced Lung Disease Unit Registrar, the impression was that the cause of Mr Sharpe's ongoing breathlessness and chest pain was due to progression of his disease. A note was sent back to the prison infirmary staff on the discharge summary, in capitals, as follows,[26]

> PLEASE ENSURE THAT SIMON RECEIVES ACCESS TO HIS FULL OXYGEN PRESCRIPTION AS PRESCRIBED BY HIS ADVANCED LUNG SPECIALISTS-AT A RATE OF 6 LITRES. THIS IS PARAMOUNT FOR MANAGEMENT OF SIMONS UNDERLYING LUNG CONDITION AND FAILURE TO COMPLY WITH THIS PUTS HIS HEALTH AT RISK.

28. The note was acknowledged in a nursing note on 19 April 2016, together with a note that Mr Sharpe has been advised multiple times that if he is having

[23] Exhibit 1, Tab 45D.
[24] Exhibit 1, Tab 45.
[25] Exhibit 1, Tab 45E.
[26] Exhibit 1, Tab 9B.

6L/min he must administer the oxygen via a mask, but he remained non-compliant with this advice and continued to use nasal prongs. A medical review was booked and he was reviewed by Dr Wee the following day, during which time his medications were adjusted.[27]

29. On 21 April 2016 Mr Sharpe was moved out of the infirmary in order to accommodate other prisoners returning from hospital. A couple of days later he complained to a nurse about passive smoking by other prisoners, that might lead to nicotine in his system, which would preclude him from going on the transplant list.[28]

30. On 24 April 2016 Mr Sharpe had another care plan review with a nurse and he was asked about his recent complaints regarding his standard of care. He told the nurse that when he was sentenced, he was told by the learned sentencing judge that he would have the same equipment he had at home, but claimed he had only a 5L concentrator, as compared to two 8L concentrators at home, and limited access to a doctor. The nurse indicated she would speak to the Clinical Nurse Manager regarding the concentrators and would ensure he had a regular monthly appointment with a medical officer.

31. Mr Sharpe saw Dr Wee a few days later, on 29 April 2016, and maintained his complaint that he was not receiving the proper amount of oxygen and stated that if he tried to use more than 2-3L/min the nurses would "growl at him." Mr Sharpe told Dr Wee he believed he should be released from prison as the system was not able to cater to his medical needs. Dr Wee communicated with the nursing staff, who denied any such restriction was in place. Dr Wee then asked the nursing staff to remind Mr Sharpe that he can access the oxygen as per his specialists' recommendation.

32. A clinical nurse spoke to Mr Sharpe later that day and advised him that he is to use the amount of oxygen he requires and that is prescribed by his specialist. He was also advised that nasal prongs can only take a limited amount of oxygen, so if he required more oxygen he will need to use a mask. Mr Sharpe acknowledged that he understood the limitations of nasal prongs. The nurse reassured Mr Sharpe that he is, and always has been, in control of the amount of oxygen that he is using and that will continue to be the case. If any staff member tried to tell him otherwise, he was to ignore that advice and continue to use what he requires to remain comfortable.[29]

[27] Exhibit 1, Tab 49.
[28] Exhibit 1, Tab 49.
[29] Exhibit 1, Tab 49

33. From that time, Dr Fitzclarence, instructed nursing staff to record Mr Sharpe's oxygen use to get a better understanding of his needs. Later in the day, Mr Sharpe requested contact details to make a health complaint and was given the relevant information.[30]

34. Monitoring through May 2016 indicated Mr Sharpe was generally utilising oxygen at 4L/min and as low as 3L/min, and he was reminded he was prescribed 4-6L/min by his specialist, but he indicated 4L/min was all he needed and he continued to self-administer at this flow rate through June, July and August 2016. He was reminded to try to use a mask rather than nasal prongs for better oxygen delivery but notes were made that he continued to be non-compliant, with nasal prongs being used with high-flow oxygen.[31]

35. Mr Sharpe made a complaint to the Health and Disability Services Complaints Office (HaDSCO) on 11 May 2016 in relation to his oxygen supply, the outcome of which I refer to later in this finding.[32]

36. Mr Sharpe had a psychiatric review during this time on 26 May 2016 and he described his anger at how he was treated in prison regarding his lung issues but otherwise raised no complaints and showed no symptoms of his reported diagnosis of bipolar affective disorder. Nevertheless, as he had been on the same treatment for more than 10 years, it was decided to continue with his medication regime.[33]

37. On 22 August 2016 Mr Sharpe had an appointment with respiratory medicine at FSH. Mr Sharpe complained of increasing breathlessness with minimal exertion and sharp left-sided chest pain over the previous six months. His oxygen delivery during the consultation was 4L/min. It was noted he had gained weight and his respiratory function as measured with spirometry had declined. It was arranged for Mr Sharpe to undergo cardiac testing for his chest pain and comprehensive lung function tests and he was to return for review in 6 weeks. The tests were arranged and face to face appointments were booked with respiratory and cardiac specialists.[34]

38. In the meantime, Mr Sharpe suffered an acute deterioration on 26 September 2016 and was admitted to FSH under the respiratory team. Imaging and lung function tests showed scarring and reduced function consistent with progression of his lung disease. A rituximab infusion was given, which

[30] Exhibit 1, Tab 49
[31] Exhibit 1, Tab 49
[32] Exhibit 1, Tab 44.
[33] Exhibit 1, Tab 49.
[34] Exhibit 1, Tab 12D

decreases some cells in the immune system. He was discharged on 2 October 2016 with a plan to follow up in the clinic in six weeks' time with spirometry and a recommendation that he use oxygen at a flow rate of 4-5L/min at rest and 6-8L/min on exertion.[35]

39. On 4 October 2016 Mr Sharpe requested an appointment with the Department's medical director to discuss increased oxygen cylinder requirements, reporting he needed an extra 20 oxygen bottles per week. He was informed that the nursing manager could approve the oxygen cylinder supply and it was noted that he had been receiving adequate supply. The nurse arranged for a medical officer review so Mr Sharpe could discuss his oxygen requirements further.[36]

40. Dr Fitzclarence made an administrative entry just after 11.00 am on 5 October 2016 that Mr Sharpe had rung ACCESS (the Department's complaints service) stating that he was finding it hard to breathe and feeling very ill.[37] Dr Fitzclarence asked nursing staff to urgently assess him. A nurse spoke to Mr Sharpe at 11.55 am and appears to have suggested to him that he hadn't looked unwell during the morning and should have approached the nursing staff first, as they were available. After this exchange, he told the nurse to "forget it" and walked back to his cell, declining any further assessment by the nurse.[38]

41. Later that afternoon, Dr Geoff Masters reviewed Mr Sharpe in response to his complaint to ACCESS. It was noted Mr Sharpe believed he only had a further 16 weeks to spend in prison (as it appears he was anticipating being released on parole). Following his review, Dr Masters formed a plan to issue a letter advising that Mr Sharpe be permitted to have a spare portable oxygen bottle in his room, as well as the large bottle, and to be given two rebreathing oxygen masks as they will be more efficient in delivering bottle oxygen to him. Mr Sharpe was seen at the medication parade that night not wearing the mask, as recommended by Dr Masters, and seemed to be in good spirits.[39]

42. Mr Sharpe was personally reviewed by Dr Fitzclarence on 13 October 2016. He reiterated his complaints about his access to appropriate oxygen flow and also alleged that his equipment has not been functioning properly. He indicated he had been told at the hospital that he could still not go on the transplant list as he was putting on too much weight and he complained that he

[35] Exhibit 1, Tab 9C and Tab 10A and Tab 49.
[36] Exhibit 1, Tab 49.
[37] Exhibit 1, Tab 49.
[38] Exhibit 1, Tab 49.
[39] Exhibit 1, Tab 49.

was unable to exercise in the prison as they were unable to keep up with his oxygen requirements. He felt that he was not being taken seriously by prison health staff when he said his lung disease was worsening and blamed the prison environment for his worsening condition. Overall, Dr Fitzclarence noted that Mr Sharpe's biggest complaint was that he felt he wasn't able to access enough oxygen. Dr Fitzclarence had a 'gentle' discussion with him about making sure he keeps the appropriate litres flowing (noted in capitals that he was never to have less than 4L/min and she would discuss his concerns with the clinical nurse manager.[40]

43. Dr Fitzclarence noted afterwards that Dr Wee had consistently supported Mr Sharpe being given oxygen as per the specialist recommendations from the time he was admitted to prison and the notation of nursing staff also supported the position that Mr Sharpe was generally encouraged to use appropriate oxygen levels. She did acknowledge there was some passive smoking issues in his cell and she spoke to the custodial staff about ensuring prisoners did not smoke nearby. She also spoke to health staff about Mr Sharpe's anxiety issues and his need for reassurance from staff.[41]

44. On 31 October 2016 Mr Sharpe had another review at the Respiratory Medicine clinic at FSH. It was noted that recent cardiac investigations were unremarkable and the pain he was reporting was thought to be muscular. Lung function testing showed significant progressive decline. It was noted again that Mr Sharpe was not an ideal candidate for lung transplantation due to morbid obesity, poor compliance and ongoing intermittent smoking. He reported lessening benefits from his CPAP machine and it was thought this might be a reflection of his progressive severe disease. The plan was to give him another rituximab infusion, which he had tolerated well previously, repeat lung function tests in 4 months and refer him to a sleep clinic to ensure adequate CPAP therapy. However, Mr Sharpe later indicated he did not find the rituximab efficacious so it was not repeated.[42]

45. On 15 December 2016 Mr Sharpe was seen at the sleep clinic but he had not brought his CPAP machine so it could not be checked. He was put on a new therapy with a plan to review in a couple of months and, if necessary, reprogramme his CPAP machine.[43]

[40] Exhibit 1, Tab 49.
[41] Exhibit 1, Tab 49.
[42] Exhibit 1, Tab 12E.
[43] Exhibit 1, Tab 12F.

46. Although Mr Sharpe had clearly expected he would be released on parole in January 2017, this did not occur. His release was apparently denied by the Prisoners Review Board as it was determined that Mr Sharpe had unsuitable accommodation and insufficient protective strategies in place.[44]

47. He experienced increasing shortness of breath in February 2017 and was admitted to FSH. Following investigations, it was determined that the cause was the progression of Mr Sharpe's underlying lung disease. He was given a median survival of 50% over the next 12 months and symptomatic management only was considered to be the best option as he was not deemed to be suitable for transplantation.

48. On 23 February 2017 Mr Sharpe's status on the Terminally Ill Prisoner Register was escalated to Stage 3 (death likely within 3 months or one or more medical conditions with the potential for sudden death). It was downgraded for a brief period to Stage 2 in June 2017 before returning to Stage 3.

49. Mr Sharpe's early release via the Royal Prerogative of Mercy was considered but not recommended.

50. Mr Sharpe expressed concern that he was not on the transplant list, and could not receive proper respiratory treatment, because he was a prisoner, although there is no evidence to suggest this was the case.

51. Mr Sharpe was reviewed again at the Respiratory Medicine Outpatient Clinic at FSH on 10 April 2017. It was noted he had progressive interstitial lung disease with severe respiratory failure and very limited further treatment options. He had deteriorated significantly since his last review. Mr Sharpe told the doctors he was worried he would collapse or even die suddenly, which was felt to be quite fair concerns given his degree of hypoxia. He was still not a suitable candidate for lung transplantation and it was noted he was aware of this. The main aim moving forward was to alleviate his symptoms and provide palliative care support as need. It was noted this would be harder in a prison setting, so it was proposed to write a letter in support of Mr Sharpe being granted parole. Steps were also to be taken towards discussing end of life care options with Mr Sharpe and his family. Mr Sharpe had indicated his CPAP machine mask was broken, so the doctors also indicated in the plan that this needed to urgently be replaced (although there is no note of any problem with the CPAP machine in the prison EcHO notes).

[44] Exhibit 1, Tab 32D

52. The Advanced Lung Disease Registrar at Fiona Stanley Hospital wrote a letter supporting Mr Sharpe's parole application that day, noting he might soon be restricted to a bed or wheelchair and he required supportive and palliative care.[45] He was not, in fact, released, but he was commenced on palliative care.

53. The FSH Advanced Lung Disease Registrar rang a nurse at Casuarina infirmary on 20 April 2017 and advised there was nothing more that could be done for Mr Sharpe treatment wise. She gave a life expectancy of less than a year and a palliative care referral was recommended. The referral was completed by Dr Wee and a palliative care review was undertaken by Dr Sarah Pickstock on 24 April 2017. Dr Pickstock advised changing his current tramadol medication to tapentadol but advised against use of opioids at that time.

54. On 24 May 2017 Mr Sharpe was reviewed by Dr Chuka and he was noted to have increasing respiratory symptoms and was coughing up phlegm. He was prescribed antibiotics and steroids. He appears to have improved on these medications and on 25 June 2017 he was reviewed by a nurse in regards to his care plan and was noted to be stable although he spent most of his day in bed.[46]

LAST ADMISSION TO FIONA STANLEY HOSPITAL

55. On 27 June 2017 prison nursing staff responded to a cell call and found Mr Sharpe in respiratory distress in his cell with very low oxygen levels despite being on 8L/min oxygen. He was transferred to FSH by ambulance and admitted under the care of Dr Musk. The impression was that he was suffering an infective exacerbation of his interstitial lung disease and he was commenced on active management with antibiotics and steroids. Medical staff were given permission to notify Mr Sharpe's family.[47]

56. Mr Sharpe's condition continued to deteriorate. His resuscitation status was clarified and it was noted that in the event of sudden deterioration, he was not for resuscitation.

57. Approval was granted by the Assistant Commissioner of Custodial Operations for Mr Sharpe's family members to visit, given his poor prognosis.[48]

[45] Exhibit 1, Tab 12G.
[46] Exhibit 1, Tab 45 and Tab 49.
[47] Exhibit 1, Tab 11 and Tab 49.
[48] Exhibit 1, Tab 2.

58. During the consultant ward round on 30 June 2017, Dr Musk decided observations should be ceased and the aim would be to keep Mr Sharpe comfortable. Palliative care doctors gave advice about what medication should be provided to achieve this aim.

59. Later on 30 June 2017 Mr Sharpe was visited by a priest as his death was considered imminent, and his daughter and daughter-in-law remained by his side. Two Custody Care Officers were stationed outside Mr Sharpe's room to ensure he remained secure. They conducted a welfare check at 6.40 pm and found he was not breathing, so they notified nursing staff who attended and confirmed he had died during the early evening of 30 June 2017.[49] The custody officers secured the room and police were notified so that they could commence a coronial investigation.[50]

CAUSE AND MANNER OF DEATH

60. On 4 July 2017, a Forensic Pathologist, Dr Daniel Moss, performed a post mortem examination on Mr Sharpe. Microscopic examination of the lungs confirmed the presence of end-stage fibrotic lung disease in keeping with the clinical history of non-specific interstitial pneumonia (NSIP). There was no evidence of acute infection.[51]

61. Dr Moss formed the opinion the cause of death was non-specific interstitial pneumonia (or alternatively, pneumonitis). Dr Moss confirmed there was no evidence of infective (eg. bacterial or viral) pneumonia and it appeared that the lung disease itself caused the death.[52] Toxicology analysis showed medications in keeping with the medical care provided.[53]

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

TREATMENT, SUPERVISION AND CARE

63. While in prison, Mr Sharpe made complaints to the Department's Complaints and Administration branch (ACCESS), the Prison Superintendent, the Department's Commissioner and to the Health and Disability Services Complaints Office (HaDSCO). Mr Sharpe's family also raised concerns with

[49] Exhibit 1, Tab 2.
[50] Exhibit 1, Tab 2 and Tab 3 and Tab 8.
[51] Exhibit 1, Tab 6.
[52] Exhibit 1, Tab 6.
[53] Exhibit 1, Tab 6 and Tab 7.

his lawyer, who acted on the complaints by raising concerns with the Deputy Director of Health Services, and others.

64. The ongoing themes for concern were Mr Sharpe's access to unlimited oxygen supply at an appropriate flow rate, as well as access to specialist care. There appeared to be a subtext that he could not be cared for properly in custody and should, therefore, be released.

65. In the HaDSCO complaint, Mr Sharpe alleged that he was under supplied with oxygen during the first three months of his incarceration at Casuarina. He sought compensation and early release from prison to manage his medical needs in the community. A review of documents information spanning 27 January to 8 July 2016 disclosed that Mr Sharpe was prescribed continuous oxygen, which was self-regulating and able to be delivered by either nasal prongs or a mask, and continuous CPAP (at night). The complaint was deemed to not warrant further action on the basis that it could not be demonstrated that Mr Sharpe was restricted in his use of oxygen. He was advised of the outcome by HaDSCO on 20 October 2016.[54]

66. The ACCESS complaint also revolved around Mr Sharpe's access to oxygen and Mr Sharpe's belief he was not seeing the specialists when he felt he should. He also alleged his specialist had decreed that he couldn't be cared for in jail and, therefore, should be released. The Department was reactive to the complaints and steps were taken to make sure that health staff were doing their best to provide the care that he required, but in terms of Mr Sharpe being released, that was obviously beyond the scope of the prison healthcare services.[55]

67. At the inquest, the concerns about the adequacy of Mr Sharpe's medical treatment while incarcerated were canvassed with Dr Musk, in terms of his overall treatment for his chronic disease, as well as Dr Fitzclarence more specifically in relation to his care within the prison system.

Dr Musk

68. Dr Musk explained at the inquest that the cause of Mr Sharpe's breathlessness was not due to low oxygen levels. Rather, the reason for Mr Sharpe's breathlessness was due to the need for his muscles to work harder to expand the chest to breathe as his disease progressed and his lungs became stiffer. The stiffness of the lungs themselves caused all of the extra energy requirements,

[54] Exhibit 1, Tab 44.
[55] T 40.

as more energy is required to get the air in and out of the lungs. Dr Musk confirmed that it was expected that Mr Sharpe's health would deteriorate, as the stiffening became more severe. As a result, Mr Sharpe's oxygen requirements would increase.[56]

69. However, it is important to note that Mr Sharpe's oxygen therapy was not intended as a cure for his breathlessness, but rather to overcome the deficiency of the lungs to maintain oxygen levels and correct that issue. Dr Musk explained the oxygen therapy is "solely trying to maintain oxygen levels to reduce the complications that low oxygen levels in the blood … can create."[57] These include arrhythmias and even cardiac arrest. Dr Musk indicated that "it's not a great treatment for breathlessness in these patients"[58] because it doesn't stop the stiffness of the lungs and consequential loss of elasticity. With that stiffness still occurring, the patient would still be breathless, irrespective of whether their oxygen levels are 100 per cent.[59]

70. Dr Musk explained that this ongoing symptom of breathlessness was often why doctors would have to introduce medications in more palliative ways, in order to reduce patients' anxiety and make them feel more comfortable, completely separate to their oxygen levels. Dr Musk indicated that feelings of anxiety over being breathless and not having enough oxygen is "universal … in this condition"[60] and he specifically recalled speaking to Mr Sharpe about it.

71. The other issue was Mr Sharpe's preference for using nasal prongs to deliver his oxygen therapy. Dr Musk explained that using nasal prongs limits the flow of oxygen to, in effect, a maximum of five litres (per minute) and increasing the flow volume does not fix this issue. In comparison, use of a mask increases the air intake as the oxygen can be taken in both through the nasal passages and through the mouth as well, so it is a much more effective mechanism for oxygen administration. Therefore, Dr Musk said he clearly advises patients that once they are using above five litres, to get better benefit of the oxygen flow they should use a mask, as it can allow oxygen delivery up to 15 litres, which is the most that can be achieved in the community. In hospital, they can provide more effective oxygen delivery using other means, and this was done for Mr Sharpe at the end.[61] Dr Musk acknowledged that patients have different preferences, and in Mr Sharpe's case he clearly preferred using nasal prongs. This would have had a direct effect on his oxygen delivery, but ultimately it is

[56] T 7 - 9.
[57] T 11.
[58] T 11.
[59] T 11.
[60] T 12.
[61] T 10, 14.

up to the patient to decide. Dr Musk did not recall any question ever being raised about Mr Sharpe's capacity to make informed decisions, so his right to make that choice was respected.[62]

72. Further, Mr Sharpe's description of left-sided chest pain was said to be very consistent with the progression of his disease, as with the shrinking of the lungs the person will experience significant changes in the structure of the chest wall and musculoskeletal stressors. This would also be a reason for the administration of analgesia for pain management.[63]

73. Dr Musk confirmed that FSH medical staff were in communications with prison medical staff about his general care, and if Mr Sharpe had been out of prison the exact same conversations would have occurred with his GP or Silver Chain or palliative nurses as Mr Sharpe would generally have been looked after in the community, "because coming into hospital actually doesn't provide any other benefit other than support."[64] Dr Musk indicated that in the community, a patient like Mr Sharpe might even choose to die at home, but in Mr Sharpe's case he came to hospital as the community services weren't available, and the FSH staff were happy to look after him at the hospital in those circumstances.[65]

74. Dr Musk was also asked about the reasons why Mr Sharpe was not on the transplant waiting list at any time, and whether it had anything to do with Mr Sharpe's status as a prisoner. Dr Musk confirmed that the fact he was a prisoner was not a reason that precluded him from being on the transplant waiting list. Dr Musk explained that there are numerous guidelines that govern the listing for transplantation and they are solely based around whether they are likely to get a successful outcome from a transplant. Dr Musk indicated that Mr Sharpe did not fulfil a number of the guidelines, including the fact he was a smoker, he was obese and they were never able to get him to compliantly attend pulmonary rehabilitation classes. All of these issues interfered with the possibility of a successful transplant outcome. From the early stages of his diagnosis, well before he was incarcerated, transplantation was a consideration and his status was reviewed regularly, but at no stage was he found suitable to be placed on the waiting list.[66]

75. Although Dr Musk accepted that Mr Sharpe may have stopped smoking at some point around the time of his incarceration, he advised it is usual to have a

[62] T 14 - 15.
[63] T 11 – 12.
[64] T 13.
[65] T 13.
[66] T 19- 20.

period between cessation of smoking and being placed on the transplant list due to the high relapse risk, although this rule is not always strictly applied. In any case, Mr Sharpe remained obese, which was known to significantly limit a good outcome. Dr Musk gave evidence that Mr Sharpe was a youngish patient and they would have been very keen to try and get him to transplantation, but unfortunately Mr Sharpe never managed to resolve the issues that prevented him from being considered for transplantation.[67]

76. Mr Sharpe complained that he was prevented from exercising appropriately in prison, which limited his ability to lose weight, but I note he was obese before he went into custody and Dr Musk confirmed that there were always going to be limitations for Mr Sharpe to lose weight through exercise given his severe lung disease. Instead, diet would have been a far more potent way for him to lose weight, as is the case for most people. Interestingly, Dr Musk noted that Mr Sharpe's excess weight was an unusual feature of his case, as the usual weight related issues faced by such patients was being too underweight, because of the additional energy requirements of breathing with the condition.[68]

77. Another doctor did explain that people often put on weight in prison because the food is not generally what they might eat at home and they also comfort eat, but it was also possible to choose healthier foods as those options were always available in the prison.[69]

78. Dr Musk commented that "it's a very tricky disease because of the rate of deterioration and because it's so difficult providing effective relief of symptoms."[70] The fact that Mr Sharpe required hospital admission a number of times was not unusual, as people often struggle to stay on top of their symptoms. Mr Sharpe's treatment moved to a more palliative approach at the end, in around April 2017, in order to alleviate his symptoms as he was at the end stage of his disease and there were no longer any treatment options available by that stage.[71] When Mr Sharpe was admitted under the FSH Respiratory Medicine Team in June 2017, he was provided with predominantly comfort measures as well as treatment for an infective exacerbation of his disease. He continued to decline and died a few days after he was admitted to hospital. Dr Sharpe confirmed that despite the possibility of an acute infection, he agreed with the forensic pathologist that Mr Sharpe

[67] T 21 - 22; Exhibit 1, Tab 47.
[68] T 22.
[69] T 50 – 51.
[70] T 24.
[71] T 25.

died from a progression of his long term interstitial pneumonia, which was a non-infective disease.[72]

79. Dr Musk also confirmed that the progression of Mr Sharpe's disease was typical for a patient with his condition and his death in that time period was consistent with the median survival rate for the disease.[73]

Dr Wee

80. Dr Richard Wee, who saw Mr Sharpe very early upon his admission to prison, and also after he made complaints about his medical treatment in prison, was contacted to ask about his recollection of these events when he was caring for Mr Sharpe within the prison. Dr Wee recalled that Mr Sharpe's allegations of inadequate access to oxygen therapy were not accurate and indicated that Mr Sharpe's specialist provided instructions concerning the concentration of oxygen necessary for his condition and Mr Sharpe was able to freely regulate the amount of oxygen he required throughout the day to comply with these instructions.[74]

Dr Fitzclarence

81. Dr Fitzclarence had been involved in supervising Mr Sharpe's care, in her role as the Deputy Director of Health Services and she was later asked by the Director of Health Services for the Department to review Mr Sharpe's medical records and provide an overall report with respect to his medical management in prison. At the time of providing the report, Dr Fitzclarence was no longer employed by the Department and had taken on a new role with the West Australian Country Health Service.[75]

82. In her report, Dr Fitzclarence provided a very detailed summary of Mr Sharpe's medical care from the time he came into custody on 27 January 2016. Dr Fitzclarence acknowledged that during his time of incarceration Mr Sharpe made multiple allegations of receiving poor care. Dr Fitzclarence commented that there was a discrepancy between what Mr Sharpe was feeling and how staff were managing him.[76] Dr Fitzclarence expressed the opinion, based upon her own involvement and her review of the medical notes, that Mr Sharpe's allegations of poor medical care appeared to be without foundation and to have been driven by his distress at his incarceration and his distress over his terminal diagnosis. Dr Fitzclarence speculated that Mr Sharpe

[72] T 27 - 28.
[73] T 29 – 30.
[74] Exhibit 1, Tab 48.
[75] Exhibit 1, Tab 45A.
[76] T 35.

appeared to harbour "hopes that his medical condition would gain him his freedom if it could be proven that he was not being cared for in the prison setting."[77]

83. This is supported by information in the HaDSCO complaint. Mr Sharpe made it clear he maintained his innocence and felt unjustly incarcerated. It is also clear he thought he would be released on parole, and that would have made his ongoing incarceration even more difficult to accept after that did not occur in January 2017. Dr Fitzclarence concluded Mr Sharpe's anger in respect to his situation and his distress at his terminal diagnosis appears to have been directed towards the prison health staff, despite their efforts to care for him appropriately within custodial constraints.[78]

84. Dr Fitzclarence was specifically questioned at the inquest about the complaints made by Mr Sharpe in relation to his medical care, and the steps taken by the Department to address them. Dr Fitzclarence noted that she judged her responses against the mandate of prison health services "to provide care to the best of their ability within community standards, and to seek help … when that's not possible within the prison setting."[79] She found in her review that "at every point in time Mr Sharpe was entirely in control of the oxygen flow rate and the amount of oxygen that he received"[80] and there was no difference in his ability to access oxygen in prison as compared to the community.[81]

85. Dr Fitzclarence noted there were times Mr Sharpe was found to have adjusted his flow rate below the rate suggested by the FSH Respiratory Team and this was believed to be partly due to his preference for using nasal prongs over a mask, as it could be quite irritating using dry oxygen at a higher flow rate with nasal prongs. He was encouraged to use a mask instead, but he was resistant to follow that advice, and he was considered competent to decline therapy. Even using the lower flow rate, his saturations were generally found to be within an acceptable range, so Dr Fitzclarence felt it was not a major concern.[82]

86. Dr Fitzclarence had been personally involved in investigating many of these complaints at the time and monitoring his situation, and she had a one on one meeting with Mr Sharpe on one occasion to hear his claims and make sure that he was not being disadvantaged, but she found nothing to substantiate his

[77] Exhibit 1, Tab 45A, p. 14.
[78] Exhibit 1, Tab 45A.
[79] T 33.
[80] T 36.
[81] T 37.
[82] T 38 – 39.

claims.[83] Dr Fitzclarence commented that she had "a gentle discussion regarding making sure he keeps the appropriate litres flowing"[84] as there was a common issue that he didn't always use the appropriate amount, and she organised to get some longer tubing to allow him to move further away from the oxygen bottle and raised his concerns with custodial staff about ensuring that people did not smoke near him. Dr Fitzclarence had inspected Mr Sharpe's cell herself to ensure he had the proper equipment and that everything was in order.[85]

87. Dr Fitzclarence gave evidence it was clear to her that he was a relatively young man with a terminal illness who was very anxious about his diagnosis and she felt a lot of his complaints "grew out of that anxiety and concern and fear."[86] She spoke to the prison health staff about managing Mr Sharpe's anxiety and his physical journey with his disease in a sensitive way. Dr Fitzclarence believed the staff did their best to approach him in an understanding way.[87]

88. Mr Sharpe openly stated to Dr Fitzclarence during their conversation that he believed if he could raise enough concerns about the medical care he was receiving, it might lead to his early released, but that was outside the scope of her role. As Mr Sharpe's condition deteriorated and his FSH treating team reached a view that he had 12 or less months to live, Dr Fitzclarence did take steps to make sentence management aware of the need to consider the question of whether a recommendation should be made about Mr Sharpe's potential release under the royal prerogative of mercy, but that was her only role in this process.[88]

Parole

89. If an offender sentenced to an immediate term of imprisonment is made eligible for release on parole as part of their sentence they can be considered for release on parole once they reach their parole eligibility date. The decision whether to release an offender on parole is considered by the Prisoners Review Board, taking into account factors affecting the offender, victims of crime and, most importantly, the safety of the community.[89] The Board is independent of

[83] T 39, 43 – 45.
[84] T 45.
[85] T 45.
[86] T 40.
[87] T 45.
[88] T 46 – 49.
[89] https://www.prisonersreviewboard.wa.gov.au, accessed 10.11.2020.

the Department, although the Department provides relevant information to the Board to assist them in making that decision.[90]

90. It is clear from the evidence that Mr Sharpe had an expectation that he would be released on parole when he reached his parole eligibility date on 25 January 2017. Prior to that date, information was provided to the Board by the Department in relation to Mr Sharpe, which indicated amongst other things the nature of his offences, his conduct while in prison, his level of support in the community and his medical issues. It also set out the details of his proposed release plan and any recommended special conditions on his parole, should he be released.[91]

91. The Prisoners Review Board considered Mr Sharpe's case on 16 January 2017 and notified him on that date that the Board had decided to deny his release on parole at that time. In making this decision the Board noted it gave paramount consideration to the safety of the community and had determined that his release would present an unacceptable risk to the safety of the community due to his release plan not including any confirmed suitable accommodation nor sufficient protective strategies to reduce his risk of reoffending.[92]

92. Mr Sharpe immediately wrote to the Board on 19 January 2017 in relation to this decision, although it was unclear in his letter what action he was requesting. He was given some information about how he could request a review or submit a re-application request.[93]

93. Mr Sharpe wrote to the Board again on 17 February 2017, requesting an opportunity to re-apply for parole and provided a proposed new parole address, although he provided limited detail about the address and what supports would be available. The Deputy Chairperson of the Board wrote to Mr Sharpe in March 2017 and indicated that he was not satisfied he had offered significant changes in his circumstances for a further application for parole to be considered at that time and his re-application for parole was denied.[94]

94. Mr Sharpe wrote a third time to the Board on 15 March 2017 requesting again to re-apply for parole on the basis of having new accommodation and also referring to his failing health. Upon receipt of this letter the Board requested an accommodation assessment. The new address was found to be suitable but

[90] T 54.
[91] Exhibit 2, Tab 9.
[92] Exhibit 2, Tab 10.
[93] Exhibit 2, Tab 10.
[94] Exhibit 2, Tab 10.

the Deputy Chairperson of the Board found that he had not addressed what protective strategies could be put into place to reduce his risk of reoffending and address his offending behaviour and his re-application for parole was denied. Mr Sharpe was advised that until he addressed these concerns his case could not be referred to the Board for reconsideration. He was given some suggestions for organisations he might approach to assist him with addressing this issue. This response was provided in late May 2017 and it does not appear Mr Sharpe wrote to the Board again, which is not surprising given his rapidly declining health around that time.[95]

Royal Prerogative of Mercy

95. The question of why a terminally ill prisoner was not released on the royal prerogative of mercy is a common issue raised by the family of the deceased in inquests, and it is understandable why the family feel distressed that their loved one was unable to have the choice to die at home with family. However, it is my understanding that it is a prerogative rarely exercised as the process takes some time, there are a large number of issues to be taken into account that go well beyond the best interests of the prisoner and ultimately (if the matter progresses that far) the final decision rests entirely at the discretion of the Attorney-General.[96]

96. Mr Sharpe was eligible to be considered for release on compassionate grounds when he was recorded at Stage 3 on the Department's Terminally Ill Offender Management System (death likely within three months or on or more medical conditions with the potential for sudden death) on 23 February 2017, following a hospital admission. Mr Sharpe's treating specialists advised he had a 50% chance of survival over the next 12 month period. The Department's health services team notified the Department's Sentence Management staff, and the process was commenced. Ministerial briefings were prepared in respect to Mr Sharpe's possible early release.

97. Ultimately, a recommendation was not made that Mr Sharpe be considered for release on the royal prerogative of mercy. His needs were considered to be adequately met within the prison environment and his nominated place of residence was assessed as unsuitable due to a risk of reoffending.[97]

98. In Mr Sharpe's case, it was also relevant that he had already been refused release on parole three times in recent months. This made it less likely that a

[95] Exhibit 2, Tab 10.
[96] T 55 – 57.
[97] T 57; Exhibit 2, Death in Custody Review Report.

recommendation would be made that he be released via the royal prerogative of mercy.[98]

Comments

99. I indicated at the conclusion of the inquest that I was satisfied Mr Sharpe received medical care commensurate to what he would have received in the community and I would not be making any adverse comments of findings against any individual or agency in this matter. While the evidence showed Mr Sharpe made many complaints to various people and bodies throughout his incarceration, which demonstrates his great unhappiness while he was there, there was no evidence before me to substantiate his complaints of inadequate medical care. All investigations into his complaints during his life, including an independent investigation by HaDSCO, found his allegations were inaccurate and unsubstantiated.

100. That is not to say that Mr Sharpe was not actually experiencing distressing symptoms. Dr Musk gave evidence Mr Sharpe would have been experiencing breathlessness due to the disease, and no amount of oxygen therapy would have entirely alleviated that symptom. Dr Musk also indicated Mr Sharpe's symptoms of left-sided chest pain were entirely consistent with progression of his disease.

101. There was also evidence before me that Mr Sharpe was very distressed by his terminal diagnosis and felt he was unjustly incarcerated. He exhibited ongoing significant anxiety around his disease, its symptoms and its prognosis, which continued despite Mr Sharpe being continued on medications, which had an anti-anxiety effect. Dr Fitzclarence gave evidence that the prison health staff, including herself personally, attempted to provide Mr Sharpe with reassurance and emotional support, but he still struggled to cope.

102. It also appears Mr Sharpe mistakenly believed that if he could demonstrate that he was not receiving appropriate medical care in prison, he would be released earlier into the community, but this was not the case. The only options for Mr Sharpe being released from prison earlier than at the conclusion of his full prison term, were if he successfully appealed his conviction/sentence, he was released on parole or he was released on the Royal Prerogative of Mercy. Both these options were considered prior to his death, but neither were recommended due to a concern that he remained a risk to the community.

[98] T 56.

103. It is apparent that Mr Sharpe's distress was communicated to his family, and they were, quite rightly, very concerned to ensure that he received proper medical treatment and that his medical care was properly considered after his untimely death. Some of Mr Sharpe's family were able to attend the inquest and hear the evidence of the various witnesses, and I hope that this helped to alleviate their concerns and reassure them that he was given proper medical care, commensurate with what he would have received in the community. While it was understandably the preference of Mr Sharpe and his family that he be given the opportunity to die at home with his family, some of his next of kin were able to be with him by his bedside when he died in hospital.[99]

CONCLUSION

104. Prior to his admission to prison Mr Sharpe was already in significant respiratory failure and required continuous oxygen therapy. While incarcerated, Mr Sharpe continued to receive the same specialist treatment from the Advanced Lung Failure Unit at FSH with regular outpatient reviews and in-hospital admissions when required. His lung condition continued to progress and he became increasingly breathless, with limited exercise tolerance and increasing oxygen requirements.

105. In April 2017 Mr Sharpe's treating doctors indicated there were no more treatment options available and his prognosis was poor. He was referred to palliative care services and was kept comfortable until his death at the end of June 2017.

106. It is clear from the evidence that Mr Sharpe continually raised concerns about his care while in prison, particularly in relation to his oxygen therapy. However, the evidence does not support a finding that Mr Sharpe was denied an appropriate level of medical care while incarcerated. Mr Sharpe also raised concerns about the impact his prison care might have on his placement on the transplant list, but it was noted well before his incarceration that he had a number of factors that made him unsuitable for transplantation, and these did not apparently alter once he was in prison, other than his decision to cease smoking.

107. I appreciate that, for many reasons, Mr Sharpe felt that he should not have been in prison. The relevant ways in which he might have been released prior to his death, namely on parole or on the royal prerogative of mercy, were explored and ultimate early release was denied to him. This was a source of

[99] Exhibit 2, Death in Custody Review Report and Tab 11.

great distress to Mr Sharpe and his family, and I appreciate that it made his early death from a terminal disease that much harder for them to bear.

108. However, having considered the available evidence before me in relation to my role, which is to comment on Mr Sharpe's treatment, supervision and care while in custody, I find I am satisfied that Mr Sharpe received an appropriate standard of supervision, treatment and care while in prison. His death was due to the progression of his known respiratory condition and was not preventable.

S H Linton
Coroner
2 December 2020