JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	23 - 24 AUGUST 2021
DELIVERED	**:**	29 SEPTEMBER 2021
FILE NO/S	**:**	CORC 128 of 2018
DECEASED	**:**	CRAIG, ROBERT CHARLES

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Prisons Act 1981 (WA)

Counsel Appearing:

Mr W Stops appeared to assist the Coroner.

Ms G Mullins and Ms F Allen (State Solicitor's Office), appeared on behalf of the Department of Justice and the South Metropolitan Health Service.

Ms C Elphick (Dominion Legal), appeared on behalf of Dr E Ng.

Mr E Panetta (Panetta McGrath Lawyers), appeared on behalf of Dr M Jackson.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Robert Charles CRAIG*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, between 23 - 24 August 2021, find that the identity of the deceased person was* ***Robert Charles CRAIG*** *and that death occurred on 31 January 2018 at Bethesda Health Care from disseminated malignancy (advanced lung carcinoma and mouth carcinoma) in a man with co-morbidities including chronic obstructive pulmonary disease in the following circumstances:*

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INTRODUCTION

1. Robert Charles Craig (Mr Craig) died on 31 January 2018 at Bethesda Health Care (BHC) from advanced lung cancer and advanced mouth cancer. At the time of his death, Mr Craig was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (DOJ) and therefore a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA). As a result, Mr Craig's death was a "*reportable death*" and a coronial inquest is mandatory.[1,2,3,4,5,6]

2. 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 that the person received while in that care.[7] I held an inquest into Mr Craig's death on 23 - 24 August 2021. The Brief containing the documentary evidence adduced at the inquest comprised three volumes.

3. The inquest focused on the care provided to Mr Craig while he was in custody, and the circumstances of his death. The following witnesses gave evidence at the inquest:

a. Dr Arman Hasani, Independent Medical Oncologist (Dr Hasani);
b. Dr Evan Ng, Radiation Oncologist (Dr Ng);
c. Dr Magdalen Foo, Faciomaxillary Surgeon (Dr Foo);
d. Dr Matthew Salamonsen, Respiratory Physician Dr Salamonsen);
e. Dr Lokesh Yagnik, Respiratory Registrar (Dr Yagnik);
f. Dr Simon Troon, Medical Oncologist (Dr Troon);
g. Dr Melanie Jackson, Radiation Oncologist (Dr Jackson);
h. Dr Paul Cannell (Dr Cannell)[8];
i. Ms Toni Palmer, Performance Analyst, DOJ (Ms Palmer); and
j. Dr Joy Rowland, Director of Medical Services, DOJ (Dr Rowland).

[1] Exhibit 1, Vol 1, Tab 6A, Post Mortem Report (05.02.18)
[2] Exhibit 1, Vol 1, Tab 4, P92 Identification of deceased person (31.01.18)
[3] Exhibit 1, Vol 1, Tab 5, Death in Hospital form - Bethesda Health Care (31.01.18)
[4] Section 16, *Prisons Act 1981* (WA)
[5] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[6] Section 22(1)(a), *Coroners Act 1996* (WA)
[7] Section 25(3), *Coroners Act 1996* (WA)
[8] Dr Cannell is a Clinical Consultant Haematologist, and Head of Department, PathWest Haematology at FSH

MR CRAIG

Background[9,10,11,12,13]

4. Mr Craig was born in Sydney on 13 April 1944 and had four siblings. He completed his schooling in Sydney and according to departmental records, he described a difficult childhood during which he was routinely exposed to physical abuse by, and criticism from, both parents.

5. After finishing school, Mr Craig completed an apprenticeship as a painter, interior decorator and signwriter and worked on the Snowy River Hydro Scheme. When he was about 21-years of age, he enlisted in the Australian Army and served for nine-years, including a tour of duty in what was then South Vietnam.

6. After discharging from the Australian Army, Mr Craig worked as a signwriter for about 11-years in Sydney and then later, Western Australia. He then carried out maintenance work until his retirement in 2003, due to ill-health. Mr Craig had four children from various relationships and he attributed the failure of his three marriages to his heavy drinking.

7. Mr Craig was described as an artistic person who enjoyed sketching and painting. He also liked reading, especially about military aircraft, and watching movies and documentaries. Mr Craig was 73-years of age when he died on 31 January 2018.[14,15,16]

[9] Exhibit 1, Vol 1, Tab 8, Statement - Ms D West, paras 4-24
[10] Exhibit 1, Vol 1, Tab 2, Police Investigation Report (06.10.18), p3
[11] Exhibit 1, Vol 1, Tab 3, Report - FC Const. N Arnold (31.01.18), pp2-5
[12] Exhibit 1, Vol 2, Tab 46, Death in Custody Review (26.09.19), pp5-6
[13] Exhibit 1, Vol 2, Tab 48, Report, Mr R Craig (04.11.16), pp2-4
[14] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death
[15] Exhibit 1, Vol 1, Tab 4, P92 Identification of deceased person (31.01.18)
[16] Exhibit 1, Vol 1, Tab 5, Death in Hospital form - Bethesda Health Care (31.01.18)

Overview of Medical Conditions[17,18,19,20]

8. After Mr Craig's death, DOJ conducted a review of the health services provided to him during his incarceration. That review summarised his medical conditions in the following manner:

> At his admission assessment by the Prison Medical Officer, completed on 22/06/2017, he gave a history of rectal cancer with surgery in 2001 and colostomy placement, Squamous Cell Carcinoma of the floor of his mouth with local spread (underwent jaw reconstruction 6 weeks prior to arrival in prison) and Squamous Cell Carcinoma of Lung (Left Lower Lobe), chronic obstructive pulmonary disease (had not taken medications for some years) and osteoarthritis. He was undergoing radiotherapy and chemotherapy at the time of his admission, with 4 weeks of treatment left to go.
>
> He disclosed a psychiatric history of post-traumatic stress disorder from military service in Vietnam, and paedophilia; he attempted suicide in 2016 unsuccessfully and facial injuries incurred during this attempt led to imaging that diagnosed his tumour. He spent 2 weeks in Bentley Hospital after this attempt, and he had been under the care of Mental Health in Rockingham prior to coming to prison. He was a heavy smoker at the time of admission, and disclosed a high-level, dependent intake of alcohol.[21]

9. According to his GP, Mr Craig's medical conditions included: ischaemic heart disease, osteoarthritis and post-traumatic stress disorder related to his military service. Mr Craig was prescribed medication for pain and to treat his anxiety, but declined all offers of psychological counselling.

10. In 2001, Mr Craig was diagnosed with colon cancer and subsequently had a colostomy bag fitted. Following his diagnosis, he reportedly reduced his alcohol intake but in about 2011, he started drinking vodka several times per week to help with sleep. Mr Craig denied any illicit drug use.

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[17] Exhibit 1, Vol 1, Tab 8, Statement - Ms D West, paras 25-36
[18] Exhibit 1, Vol 1, Tab 9, Report - Dr M Herath (26.02.18)
[19] Exhibit 1, Vol 2, Tab 48, Report, Mr R Craig (04.11.16), p3
[20] Exhibit 1, Vol 2, Tab 46, Death in Custody Review (26.09.19), pp5-6
[21] Exhibit 1, Vol 3, Tab 53, Health Services summary (August 2021), p3

11. Mr Craig's daughter said that her father had seen "*multiple psychologists*" but that he "*hated it*" and was a very proud person "*who kept to himself*". In 2016, Mr Craig was admitted to hospital following an overdose of medication in what was described as a "*failed suicide attempt*". He was started on an antidepressant, which he subsequently stopped taking, and declined offers of counselling.

12. Mr Craig presented to his GP in October 2016, with a history of persistent toothache and was advised to see a dentist. When seen again in December 2016, Mr Craig complained of right-jaw pain following a fall five-weeks previously. X-rays and scans were apparently normal, but after being referred to Fiona Stanley Hospital (FSH) by his dentist, Mr Craig was diagnosed with oral cancer and was also found to have lung cancer. He underwent surgery to remove the tumour from the floor of his mouth and received radiotherapy to treat his lung cancer.

13. Due to a breakdown in communication between clinics within FSH, Mr Craig did not receive the most appropriate form of chemotherapy to maximise radiotherapy for his lung cancer, nor did he receive radiotherapy and/or chemotherapy following the surgical removal of his oral cancer.

Offending History[22,23,24,25,26]

14. On 7 August 1990, in what was then the Court of Petty Sessions at Perth, Mr Craig was convicted of common assault and indecent dealing with a child under 14-years of age and was sentenced to six-months imprisonment.

15. On 4 May 2007, in the District Court of Western Australia (District Court), Mr Craig was sentenced to three-years and two-months imprisonment with respect to 11 counts of indecent dealing with a child under 13-years, and 13 counts of indecent dealing with a child over 13-years but under 16-years.

[22] Exhibit 1, Vol 2, Tab 46, Death in Custody Review (26.09.19), p6
[23] Exhibit 1, Vol 1, Tab 11, Criminal and traffic history
[24] Exhibit 1, Vol 2, Tab 48, Report, Mr R Craig (04.11.16), pp2-4
[25] Exhibit 1, Vol 2, Tab 48, District Court of WA - Sentencing remarks (02.06.17), p3-4
[26] Exhibit 1, Vol 1, Tab 22, Warrant of Commitment (02.06.17)

16. On 2 June 2017, in the District Court, Mr Craig was convicted of three counts of indecent dealing with a child under 13-years of age. He was sentenced to a term of two-years imprisonment, and his earliest release date was 1 June 2018.[27]

Prison History[28,29,30,31]

17. During his final period of incarceration, Mr Craig had the following placements:

a. *Hakea Prison:* 2 June 2017 - 19 September 2017 (109 days);
b. *Casuarina Prison:* 19 September 2017 - 26 January 2018 (129 days); and
c. *Bethesda Health Care:* 26 - 31 January 2018 (5 days).

18. During his intake assessment at Hakea Prison on 2 June 2017, Mr Craig was identified as requiring protection because of the nature of his offending. He told reception staff he was being treated for anxiety and depression and was "*full of cancer*". Mr Craig also disclosed a history of self-harm and his attempt to take his life in 2016, but denied any current self-harm or suicidal ideation. Although he was not placed on the At Risk Management System (ARMS) on his admission to prison,[32] Mr Craig was placed on ARMS on two subsequent occasions.

19. ARMS is DOJ's primary suicide prevention strategy and aims to provide clear guidelines to assist staff to identify and manage prisoners at risk of self-harm and/or suicide. As happened in Mr Craig's case, when a prisoner is first received at a prison, an experienced prison officer conducts an "*intake assessment*" designed to identify any risk factors. Once a prisoner is placed on ARMS, an interim management plan is prepared and the prisoner's mental state is monitored at regular intervals, referred to as "high", "moderate" or "low". Since mid-2016, the ARMS observation intervals have been: high (one-hourly), moderate (two-hourly) and low (four-hourly).[33,34]

[27] Exhibit 1, Vol 1, Tab 26A, Sentence summary
[28] Exhibit 1, Vol 1, Tab 27, Temporary Placement History - Offender
[29] Exhibit 1, Vol 2, Tab 46, Death in Custody Review (26.09.19), pp7-9 and ts 24.08.21 (Palmer), pp137-145
[30] Exhibit 1, Vol 1, Tab 24, Offender summary, p2
[31] Exhibit 1, Vol 1, Tab 37, Running sheet (January 2018)
[32] Exhibit 1, Vol 1, Tab 23, ARMS Reception intake assessment (02.06.17)
[33] Exhibit 1, Vol 2, Tab 46, Death in Custody Review (26.09.19), pp7-8
[34] ts 24.08.21 (Palmer), pp139-140 & 144-145

20. Within 24-hours of a prisoner being placed on ARMS, the Prisoner Risk Assessment Group (PRAG) meets to determine the appropriate level of support and monitoring required to manage the prisoner's identified risks. After removal from ARMS, prisoners are sometimes placed on the Support and Monitoring System (SAMS), which is designed to provide ongoing support.[35,36]

21. Mr Craig was first placed on ARMS on 11 September 2017. He had been admitted to FSH on 8 September 2017 and on his way back to Hakea Prison, Mr Craig told officers he intended to: "*top himself and find a way to do it without anyone knowing*". As a result, he was placed on high-ARMS and allocated a "safe cell" in the Crisis Care Unit.[37,38]

22. When interviewed by a staff member from the Prison Counselling Service (PCS), Mr Craig said his remarks had been misunderstood. On 15 September 2017, the PRAG recommended Mr Craig be removed from ARMS, because he was: "*doing well within his general housing unit*" and "*is positive in his thoughts with nil self-harm or suicidal ideations*".[39,40,41]

23. Mr Craig was also placed on ARMS on 2 December 2017, after returning to prison following an appointment at FSH. Mr Craig reportedly told escorting officers he: "*needed to find a way to end his life*". He was placed on low-ARMS and when interviewed by PCS, Mr Craig said he had made the statement out of frustration and anger and had no intention of taking his life. On 4 December 2017, the PRAG recommended Mr Craig be removed from ARMS and he was placed on SAMS.[42,43,44,45]

[35] Exhibit 1, Vol 2, Tab 46, Death in Custody Review (26.09.19), pp7-8
[36] ts 24.08.21 (Palmer), pp140 & 144-145
[37] Exhibit 4.1, ARMS Interim Management Plan (12.09.17) and ts 24.08.21 (Palmer), pp140-141
[38] Exhibit 4.6, ARMS Offender Supervision Log (11-15.09.17 & 02-04.12.17)
[39] Exhibit 4.1, ARMS Interim Management Plan (12.09.17)
[40] Exhibit 1, Vol 1, Tab 13, Prisoner Counselling Services file note (14.09.17)
[41] Exhibit 4.2, PRAG Minutes (12.09.17) and Exhibit 4.3, PRAG Minutes (15.09.17)
[42] Exhibit 4.4, PRAG Minutes (04.12.17)
[43] Exhibit 4.5, ARMS Interim Management Plan (04.12.17)
[44] Exhibit 4.6, ARMS Offender Supervision Log (11-15.09.17 & 02-04.12.17)
[45] Exhibit 1, Vol 1, Tab 17, Support and Monitoring System record (26-31.01.18)

24. Ongoing health issues prevented Mr Craig from undertaking employment whilst he was in custody and from completing a sex offender treatment program. He wrote letters and received regular visits and phone calls from family members and Mr Craig's conduct in prison was described as exemplary.[46,47,48,49,50]

25. On 25 January 2018, Mr Craig's condition deteriorated and he was transferred to BHC for end-of-life care on 26 January 2018. Whilst at BHC, Mr Craig was subject to SAMS and was monitored daily.[51,52,53]

26. At that time, Mr Craig was a medium security prisoner and he was therefore required to wear leg irons and be shackled to a prison officer during his transfer to BHC. Handcuffs were removed once Mr Craig arrived at BHC and he was secured to his hospital bed.[54,55]

27. On 27 January 2018, BHC staff requested a variation to Mr Craig's restraints because of swelling in his legs and feet. Approval was granted, and Mr Craig was secured to his hospital bed by means of a "*flexicuff*" fitted to his ankle and subsequently, the removal of all restraints was approved.[56,57]

28. Visits were permitted at BHC and Mr Craig died in the presence of family members at about 9.55 am on 31 January 2018.[58,59,60,61,62,63]

[46] Exhibit 1, Vol 1, Tab 8, Statement - Ms D West, paras 37-38
[47] Exhibit 1, Vol 2, Tab 46.8, Education and Vocational Training Checklist (08.06.17)
[48] Exhibit 1, Vol 1, Tab 29, Offender visits history
[49] Exhibit 1, Vol 1, Tab 30, Incidents and Occurrences printout
[50] Exhibit 1, Vol 1, Tab 31, Prisoner mail printout and Exhibit 1, Vol 1, Tab 32, Prisoner telephone report
[51] Exhibit 1, Vol 1, Tab 34, Reports and Occurrences (26.01.18)
[52] Exhibit 1, Vol 1, Tab 14, Bethesda Health Care Patient Admission Assessment (26.01.18)
[53] Exhibit 1, Vol 1, Tab 20, Broadspectrum Prisoner in Custody records (26-31.01.18)
[54] Exhibit 1, Vol 1, Tab 35, Reports and Occurrences (26.01.18)
[55] Exhibit 1, Vol 1, Tab 26C, Hospital Admittance Advice - Prisoner
[56] Exhibit 1, Vol 1, Tab 26B, Letter - Dr A Krishnan to Casuarina Prison (27.01.17)
[57] Exhibit 1, Vol 1, Tab 19, Email - Mr G Carlson, Principal Officer, Casuarina Prison to Broadspectrum (27.01.18)
[58] Exhibit 1, Vol 1, Tab 15, Bethesda Health Care Discharge Summary (31.01.18)
[59] Exhibit 1, Vol 2, Tab 46.1, Faxes, Senior Officer Security Visit to Broadspectrum (29.01.18)
[60] Exhibit 1, Vol 1, Tab 8, Statement - Ms D West, paras 57-63
[61] Exhibit 1, Vol 1, Tab 18, Email Casuarina Prison approving visitors at Bethesda Health Care (27.01.18)
[62] Exhibit 1, Vol 1, Tab 38, Discharge to death form (31.01.18)
[63] Exhibit 1, Vol 1, Tab 5, Death in Hospital form - Bethesda Health Care (31.01.18)

Terminally ill prisoner status

29. Prisoners with terminal medical conditions are managed within the "*terminally ill module*" of the Total Offender Management Solution (TOMS), the computer system used by DOJ for prisoner management. A terminally ill prisoner can be entered into the module at one of four "stages" depending on their expected prognosis. For example, at Stage 1 death is not expected within 12-months, whereas at Stage 4, death is regarded as imminent.[64]

30. Mr Craig was listed as a Stage 1 terminally ill prisoner on 23 June 2017, and although his case was reviewed in December 2017, his status was not elevated. However, by that time, Mr Craig's clinical condition clearly warranted elevation to Stage 4, which eventually occurred on 25 January 2018.

31. Although Mr Craig's status should have been escalated at an earlier stage, Dr Rowland pointed out that the terminally ill module in TOMS is an administrative tool and that the stage allocated to a terminally ill prisoner does not impact on their clinical care.[65] However, there is a benefit to a prisoner's status being elevated where appropriate, as Dr Rowland explained at the inquest:

> The potential value to clinical care is the review of the file. That [is] because patients on the terminally ill list require a file review by myself or a senior physician under my delegation, that [is] someone who stops, spends time, looks through the file, checks the current status, makes a summary.
>
> That additional overview of the file can be very beneficial for some patients where we detect potential gaps early, and we address them by virtue of that senior overview. But in…this particular case there was no adjustment to his management required by…result of that review.[66]

[64] Exhibit 1, Vol 2, Tab 46.14, Policy Directive 8: Prisoners with a Terminal Medical Condition, pp2-5
[65] Exhibit 1, Vol 2, Tab 46, Death in Custody Review (26.09.19), p10
[66] ts 24.08.21 (Rowland), pp149-150

MANAGEMENT OF MEDICAL ISSUES

Overview of oncology services at FSH[67,68,69]

32. Oncology services at FSH are provided by the Medical Oncology department (which provides chemotherapy) and the Radiation Oncology department (which provides radiotherapy). Although the two departments are collocated in the FSH Cancer Centre, only medical oncology staff are directly employed by FSH. Radiation oncology services have been contracted to a private provider, namely Genesis Cancer Care (Genesis).

33. Genesis uses a computer system called MOSAIQ. This system operates the machines which deliver radiotherapy and Genesis staff use its database capability to record patient interactions. Medical oncology staff at FSH use a computer system called BossNet which is incompatible with MOSAIQ. Whilst Genesis staff have full access to BossNet, FSH staff have "*read only*" access to MOSAIQ.[70,71]

34. Patients with cancer may require surgery, radiotherapy and/or chemotherapy. Mr Craig required all three. Dr Cannell explained that radiation treatment is generally booked first because access to radiotherapy will dictate the timing of any concurrent chemotherapy.

35. Where a patient requires radiotherapy, Genesis staff are alerted by means of an "*eReferral*", generated by the FSH referral system. Genesis then advises FSH staff of the planned treatment dates, and radiosensitising chemotherapy (which enhances the effects of the planned radiotherapy) is then scheduled. The incompatibility of BossNet and MOSAIQ results in reliance on scanned documents, not all of which may be uploaded to either system.

[67] Exhibit 1, Vol 1, Tab 42A, Statement - Dr P Cannell, paras 27 and 33-45
[68] Exhibit 1, Vol 1, Tab 44A, Statement - Dr E Ng, paras 10-13
[69] Exhibit 1, Vol 1, Tab 41A, Statement - Dr S Troon, paras 9-11
[70] Exhibit 1, Vol 1, Tab 41A, Statement - Dr S Troon, para 11
[71] ts 23.08.21 (Ng), pp43-44 and ts 24.08.21 (Cannell), p126

Multidisciplinary team meetings

36. The purpose of multidisciplinary team meetings (MDT) is to bring together clinicians involved in a patient's care (or their representatives), to enable diagnosis and staging of the patient's cancer, as well as the formulation of the most appropriate treatment plan. MDT meetings, which are typically held weekly, were recognised by the WA Cancer Plan 2020 – 2025, as an important feature of modern cancer treatment.[72]

37. According to Dr Hasani, a Medical Oncologist engaged by the Court to review Mr Craig's medical care, the "*gold standard*" for communicating MDT outcomes is: "*that MDT discussions and recommendations are documented and copies provided for hospital notes, MDT attendees, the patient and the patient's general practitioner*".[73]

38. The evidence before me is that at FSH, it was not uncommon for the most junior clinician at some MDTs to be tasked with taking notes and circulating a summary of the MDT discussions and outcomes, including the patient's treatment plan.[74]

39. Whilst there may be some training benefits from having junior staff take notes at an MDT, as Dr Ng observed, MDT notes are only as good as whoever has written them. Dr Ng said that notes for the MDTs he attends are usually taken by registrars and this results in a more accurate and comprehensive summary of the MDT.[75]

40. Whilst I accept that recording and transcribing MDTs is neither feasible nor necessary, it does seem sensible for MDT notes to be taken by a clinician or health practitioner with sufficient experience. Where this is not possible then, before circulation, it would be appropriate for the MDT notes to be checked and endorsed by an experienced clinician.[76]

[72] Exhibit 1, Vol 1, Tab 39C, WA Cancer Plan 2020-2025
[73] Exhibit 1, Vol 1, Tab 39B, Report - Dr A Hasani, p2 and ts 23.08.21 (Hasani), p14
[74] ts 23.08.21 (Ng), pp52-54 and ts 23.08.21 (Foo), pp64-65
[75] ts 23.08.21 (Ng), pp52-53
[76] ts 23.08.21 (Ng), p54

eReferrals[77,78]

41. In the medical context, a referral is a request by one clinician for another clinician to see a patient with a view to providing an opinion and/or further care. Referrals can be made verbally, in writing or by electronic means. At FSH, referrals are generally made using the eReferral system, a computer program that allows referrals to be electronically triaged (i.e.: assessed) before being directed to the most appropriate team.

42. I accept that the purpose of an eReferral is not to communicate a patient's "*entire medical history or needs*" and that the clinician to whom a patient is referred will necessarily need to review the patient's relevant medical records before deciding what treatment to offer.[79]

43. Nevertheless, I agree with Dr Salamonsen's suggestion that a "*reason for referral*" box should be added to the eReferral forms used at FSH. This would ensure that on their face, eReferrals would display the reason for the referral and, at least in general terms, the treatment being requested. At the inquest, Dr Cannell, Dr Troon and Dr Yagnik all agreed that this was a sensible suggestion, which Dr Cannell said could be achieved by a relatively simple system change.[80,81]

Overview of Mr Craig's treatment at FSH

44. Dr Hasani noted that Mr Craig's case was very complex because he was diagnosed with two unrelated locally advanced cancers in his mouth and lungs. Dr Hasani said that the chances of a cure for Mr Craig's oral cancer were greater than for his lung cancer and his optimal treatment plan should have been:[82]

a. Surgical removal of the mouth cancer;
b. Chemotherapy and radiotherapy to treat the lung cancer; and
c. Radiotherapy and possibly chemotherapy for the mouth cancer.

[77] Exhibit 1, Vol 3, Tab 52A, Statement - Dr L Yagnik, paras 54-69 and ts 23.08.21 (Yagnik), pp83-86
[78] Exhibit 1, Vol 1, Tab 41A, Statement - Dr S Troon, paras 23-28
[79] Exhibit 1, Vol 3, Tab 52A, Statement - Dr L Yagnik, para 64
[80] Exhibit 1, Vol 1, Tab 43A, Statement - Dr M Salamonsen, paras 52-54 and ts 23.08.21 (Salamonsen)
[81] ts 24.08.21 (Cannell), p132; ts 24.08.21 (Troon), p104; and ts 23.08.21 (Yagnik), pp87-88
[82] ts 23.08.21 (Hasani), p7 and ts 24.08.21 (Cannell), pp122-123

45. As Dr Cannell pointed out, Mr Craig required three treatment modalities (surgery, chemotherapy and radiotherapy) and "*coordinating multimodality treatment pathways is complex for staff and challenging for patients*".[83] In Mr Craig's case, because his treatment plan was not effectively communicated within FSH, he did not receive the most appropriate chemotherapy to augment radiotherapy for his lung cancer, nor did he receive radiotherapy or chemotherapy following the surgical removal of his oral cancer.[84]

46. Dr Cannell said the main contributors to the treatment errors in Mr Craig's case were "*process errors*" including: poor quality communication following MDTs; poorly integrated digital workflows; and a lack of process regarding communication of Mr Craig's treatment plan. Dr Cannell also identified patient factors including Mr Craig's incarceration and his limited health literacy.[85]

47. Dr Hasani said that the treatment errors in Mr Craig's cancers "*had no significant effect on the eventual outcome*" and at the inquest, he expressed the point in these terms:

> So with the benefit of hindsight we know that Mr Craig's cancer did metastasise and recur very quickly after radiation treatment. We also know that despite chemotherapy his cancer progressed, so the chemotherapy seemed to have no benefit. So knowing those two things, that would lead me to believe that even if he had received chemotherapy with radiation as appropriate for the lung cancer, that it wouldn't have made any difference to his cancer's recurrence and eventual progression, and that his lung cancer would not have been able to be cured even if he did receive the correct chemotherapy with the radiation.[86]

48. At the inquest, Ms Gemma Mullins (counsel for DOJ and SMHS) tendered a flowchart setting out key aspects of Mr Craig's treatment journey (the Chronology). I have reproduced the Chronology in this finding because it sets out relevant dates so clearly.[87]

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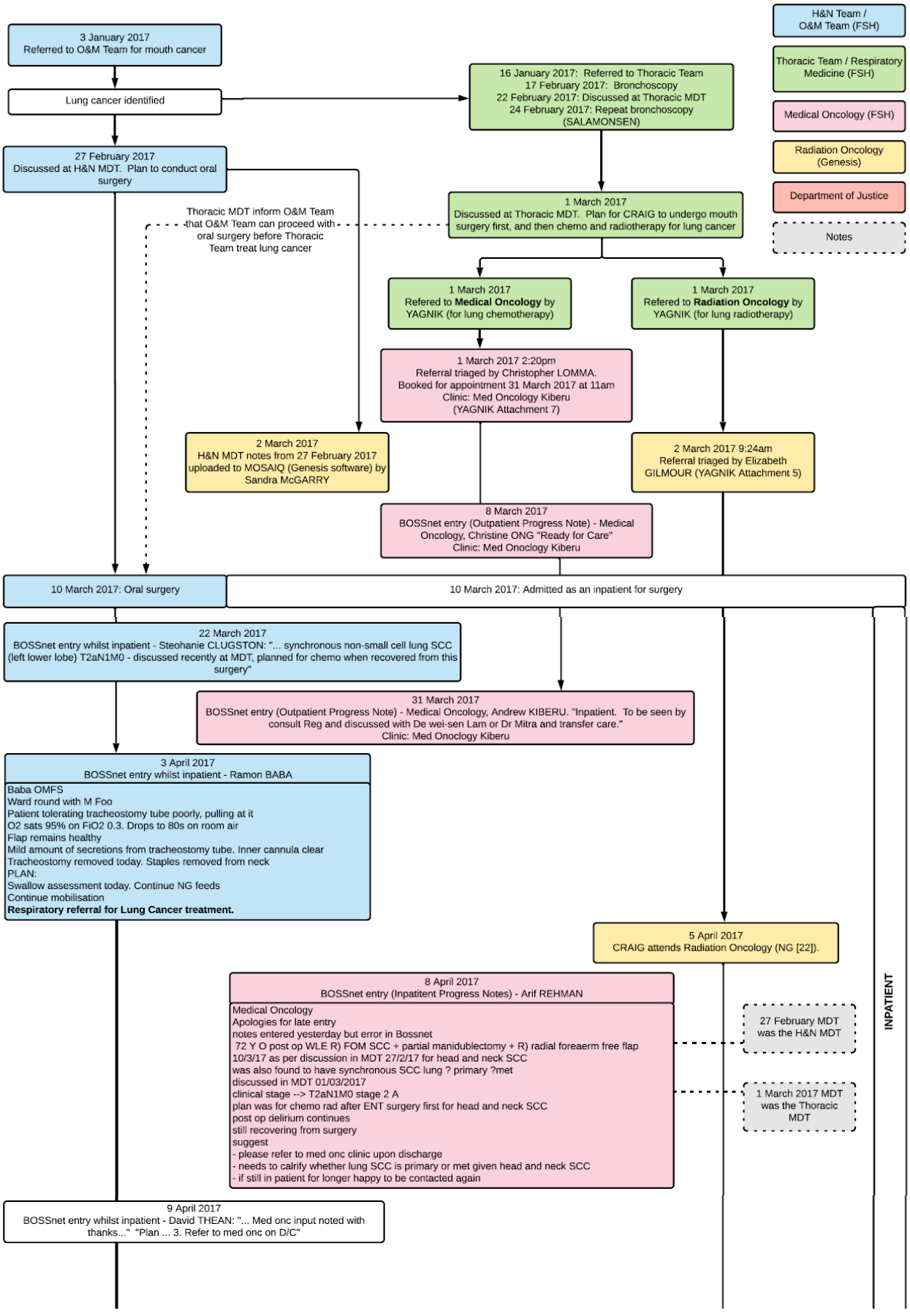
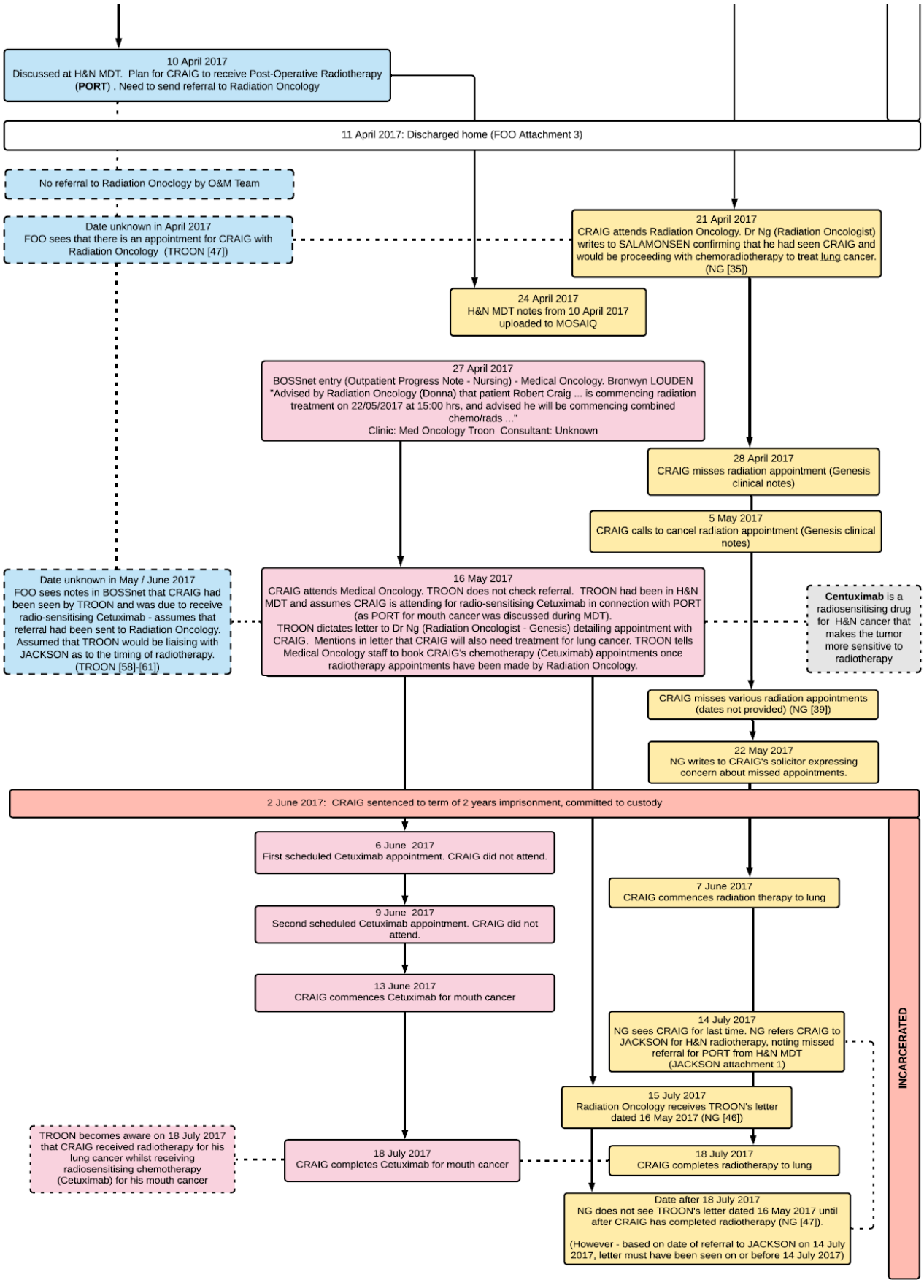
[83] Exhibit 1, Vol 1, Tab 42A, Statement Dr P Cannell, paras 46-48 and ts 24.08.21 (Cannell), p121
[84] ts 23.08.21 (Hasani), p14
[85] Exhibit 1, Vol 1, Tab 42A, Statement Dr P Cannell, paras 50-52
[86] Exhibit 1, Vol 1, Tab 39B, Report - Dr A Hasani, pp4-5 and ts 23.08.21 (Hasani), p14
[87] Exhibit 3, Chronology of Mr Craig's treatment prepared by Ms G Mullins

Chronology of Mr Craig's treatment - page 1



Chronology of Mr Craig's treatment - page 2



eReferral to Radiation Oncology - 1 March 2017[88,89,90]

49. Mr Craig's oral and lung cancers were diagnosed by means of scans and biopsies, and his case was discussed at the Thoracic MDT held on 1 March 2017. The Thoracic MDT decided that Mr Craig could proceed with surgery to address his oral cancer and then receive chemotherapy and radiotherapy for his lung cancer. Dr Yagnik was tasked with communicating Mr Craig's treatment plan to clinicians.[91]

50. After the Thoracic MDT on 1 March 2017, Dr Yagnik telephoned the Oral and Maxillofacial registrar to advise that surgery to remove Mr Craig's oral cancer could proceed, and would be followed by radiotherapy and chemotherapy to treat his lung cancer. Dr Yagnik then sent eReferrals to the Medical Oncology and Radiation Oncology departments to schedule treatment for Mr Craig's lung cancer.

51. Dr Yagnik's eReferral to Radiation Oncology was in these terms:

> As per MDT today, thank you for seeing this man for further treatment. He has floor of the mouth SCC and suspected synchronous lung SCC in the LLL with then 11L hilar LN which was also positive. Other nodes are negative. He shall have a wide local excision + flap on the 10th of March for his mouth cancer. I have referred him to the Medical Oncologists as well. Thank you. Lokesh.[92]

52. As can be seen, although the eReferral refers to both of Mr Craig's cancers, it does not specifically request radiotherapy for lung cancer. Instead, the referral states: "*As per MDT today*" and proceeds on the assumption that the person receiving the referral is aware of the treatment plan discussed at the Thoracic MDT. However, as Dr Hasani observed, it would have been preferable for the referral to have specifically requested radiotherapy for lung cancer. Nevertheless, FSH records show that on 2 March 2017, Dr Yagnik's Radiation Oncology eReferral was appropriately triaged.[93,94,95]

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[88] Exhibit 3, Chronology of Mr Craig's treatment prepared by Ms G Mullins
[89] Exhibit 1, Vol 3, Tab 52A, Statement - Dr L Yagnik, paras 11-38 and ts 23.08.21 (Hasani), p14
[90] Exhibit 1, Vol 3, Tab 52C, Thoracic Tumour MDT Management Plan (01.03.17)
[91] Exhibit 1, Vol 1, Tab 43A, Statement - Dr M Salamonsen, paras 12-42
[92] Exhibit 1, Vol 3, Tab 52E, eReferral for radiation oncology (01.03.17)
[93] Exhibit 1, Vol 1, Tab 39B, Report - Dr A Hasani, pp2-3 and ts 23.08.21 (Hasani), pp11-12 & 19-22
[94] Exhibit 1, Vol 3, Tab 52I, Letter - Dr E Ng to Dr M Salamonsen (21.04.17)

eReferral to Medical Oncology - 1 March 2017[96,97]

53. On 1 March 2017, Dr Yagnik also sent an eReferral to the Medical Oncology department in similar terms to the eReferral he sent to the Radiation Oncology department. FSH records indicate that the Medical Oncology referral was correctly triaged on 1 March 2017.

Oral surgery - 10 March 2017[98]

54. On 10 March 2017, Mr Craig underwent surgery at FSH to remove his oral tumour. Following surgery, he was admitted to the intensive care unit (ICU) where he remained until 18 March 2017. Mr Craig expressed some suicidal ideation on 21 March 2017 and was seen by the mental health team.[99]

55. Mr Craig was transferred back to the ICU on 23 March 2017 following an elevated temperature and respiratory distress. He was thought to have aspiration pneumonia and an exacerbation of his chronic obstructive pulmonary disease and was returned to a general ward on 4 April 2017, before being discharged home on 11 April 2017.

Head and Neck MDT - 10 April 2017[100,101]

56. At the Head and Neck MDT on 10 April 2017, it was decided that Mr Craig required post-operative radiotherapy (PORT) for his oral cancer. Although the FSH discharge summary documented that Mr Craig had been advised to attend follow up appointments with the Oral and Maxillofacial Surgery team, there is no evidence that any such appointments were ever made.

57. Further, although Dr Foo (Mr Craig's Oral and Maxillofacial surgeon) assumed that a referral had been made for PORT, no such referral was ever made. As a result, Mr Craig did not receive PORT for his oral cancer.

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[95] See also: ts 24.08.21 (Troon), p102
[96] Exhibit 3, Chronology of Mr Craig's treatment prepared by Ms G Mullins
[97] Exhibit 1, Vol 3, Tab 52A, Statement - Dr L Yagnik, paras 39-46 and ts 23.08.21 (Yagnik), pp82-86
[98] Exhibit 1, Vol 1, Tab 40A, Statement - Dr M Foo, paras 32-40 & 42 and ts 23.08.21 (Foo), pp57-59
[99] Exhibit 1, Vol 3, Tab 50, Mental health referral report (22.03.17)
[100] Exhibit 1, Vol 1, Tab 40A, Statement - Dr M Foo, paras 42 & 56-57 and ts 23.08.21 (Foo), pp60-65
[101] Exhibit 1, Vol 1, Tab 40D, FSH Discharge Summary (11.04.17)

Review by Dr Ng - 5 April 2017[102]

58. Mr Craig saw Dr Ng on 5 April 2017, having been referred by the Respiratory Medicine team for radiotherapy for his lung cancer. Dr Ng was aware that following the Thoracic MDT, Mr Craig's treatment plan was for surgical excision of his oral cancer followed by radiotherapy and chemotherapy for his lung cancer. However, Dr Ng was not aware that at the Head and Neck MDT, it had been decided that Mr Craig would be referred for PORT for his oral cancer and he (Mr Craig) did not mention it during the consultation.

59. Mr Craig told Dr Ng he was reluctant to start treatment for his lung cancer and was "*considering not having it*". He also told Dr Ng he was due to appear in court in July 2017 and expected he would be sent to jail. Dr Ng scheduled a further outpatient appointment for Mr Craig and said he hoped that Mr Craig would bring his family to the next consultation.

Review by Dr Ng - 21 April 2017[103]

60. When Dr Ng reviewed him on 21 April 2017, Mr Craig said that his court appearance had been postponed. It was agreed that Dr Ng would contact Mr Craig's lawyer about radiotherapy treatment "*if required*" and Mr Craig was advised that his treatment could continue even after he was incarcerated. Dr Ng explained the risks and benefits of radiotherapy and Mr Craig provided his written consent for 30-sessions of radiotherapy to be delivered five-days per week for six-weeks.

61. After his consultation with Mr Craig, Dr Ng dictated a letter to the referring clinician, Dr Salamonsen, which stated, in part:

> Mr Craig understands the issues with combined chemoradiotherapy and is happy to go ahead. I have organised for him to have radiotherapy at Fiona Stanley Hospital and we will start radiotherapy as soon as we have slots available. I understand he has already seen the Medical Oncologists on the ward while he was an inpatient and I will liaise with them with regard to his dates.[104]

[102] Exhibit 1, Vol 1, Tab 44A, Statement - Dr E Ng, paras 22-34 and ts 23.08.21 (Ng), p32
[103] Exhibit 1, Vol 1, Tab 44A, Statement - Dr E Ng, paras 35-38 and ts 23.08.21 (Ng), pp31-33
[104] Exhibit 1, Vol 1, Tab 44C, Letter - Dr E Ng to Dr M Salamonsen (21.04.17)

Review by Dr Troon - 16 May 2017[105]

62. Dr Troon, who saw Mr Craig on 16 May 2017, explained that referrals to the Medical Oncology department were triaged by an advanced trainee or registrar before allocation to the most appropriate team. As noted, the Medical Oncology referral received on 1 March 2017, did not indicate which of Mr Craig's two cancers chemotherapy was being requested for, although both cancers were mentioned in the eReferral.

63. Dr Troon does not recall reading the referral before reviewing Mr Craig, but was not surprised to see him in his clinic. This is because Dr Troon was involved in (and therefore familiar with) the treatment plan discussed at the Head and Neck MDT on 10 April 2017,[106] namely that Mr Craig was to receive PORT for his oral cancer.

64. From his conversation with him on 16 May 2017, Dr Troon believed that Mr Craig appreciated they were discussing PORT for his oral cancer. Dr Troon therefore assumed that he had been asked to see Mr Craig in relation to the radiosensitising agent, Cetuximab, which was designed to boost the effects and benefits of radiotherapy for his oral cancer. Mr Craig was given printed information about the proposed treatment and provided his written consent.

65. Dr Troon made notes about his review of Mr Craig, including a treatment plan,[107] and wrote to Dr Ng in these terms:

> We discussed radiosensitising Cetuximab with radiation and he is happy to accept this and has consented to treatment and is awaiting a start date. I will be happy to get going with Cetuximab a week before the radiation commences. He will be given seven doses over the course of his treatment. He will need definitive management of his lung lesion post radiation but this is yet to be sorted out.[108]

[105] Exhibit 1, Vol 1, Tab 41A, Statement - Dr S Troon, paras 35-45 and ts 24.08.21 (Troon), pp98-113
[106] Exhibit 1, Vol 1, Tab 41E, FSH Head & Neck MDT Treatment Plan (10.04.17)
[107] Exhibit 1, Vol 1, Tab 41G, FSH Outpatient progress notes (16.05.17)
[108] Exhibit 1, Vol 1, Tab 41H, Letter - Dr S Troon to Dr E Ng (16.05.17)

66. Dr Troon said that after he dictates a letter, it is typed and returned to him for checking and signing, before being sent off in the internal post. Dr Troon said that it would usually take one to two-weeks for a letter he dictates to reach the intended recipient.[109] In this case, Dr Troon's letter was not received by the Radiation Oncology department until 15 July 2017. This represents a delay of 61-days which is clearly unacceptable.

67. As Dr Cannell acknowledged, all consultant's letters must be checked by the relevant clinician before being posted. This is clearly sensible. Dr Cannell also said he has visibility of all letters awaiting approval and actively chases up all correspondence that is more than two-weeks old.[110]

68. The prompt transmission of correspondence between clinicians is clearly a critical aspect of patient care, especially in cancer cases where time is usually of the essence. I accept that attending to correspondence is an onerous task, especially when caseloads are large. Therefore, anything that can be done to help clinicians attend to this task is welcome.

69. Dr Salamonsen called for an additional full-time Respiratory Physician to assist with the oppressive workload faced in his clinical speciality.[111] He said that an additional physician would be helpful in several ways. First, existing cases could be shared more equitably. Second, clinicians could spend additional time with those patients who needed it. Third, the extra physician would enable clinicians to attend to administrative tasks, such as approving and signing letters, in a timelier manner.

70. Unfortunately, despite the obvious benefits an additional Respiratory Physician would bring, Dr Cannell said that funding constraints meant it would not be possible to employ additional physicians at FSH for the foreseeable future.[112]

[109] ts 24.08.21 (Troon), p99
[110] Exhibit 1, Vol 1, Tab 42A, Statement - Dr P Cannell, para 41 and ts 24.08.21 (Cannell), pp127-128
[111] Exhibit 1, Vol 1, Tab 43A, Statement - Dr M Salamonsen, paras 58-60 and ts 23.08.21 (Salamonsen), pp75-76
[112] ts 24.08.21 (Cannell), pp134-135

Mr Craig's chemotherapy treatment[113]

71. Mr Craig had been due to start chemotherapy on 6 June 2017, but presumably due to his incarceration he did not attend this appointment and it was rescheduled. Mr Craig eventually received his first dose of Cetuximab on 13 June 2017 and had completed both chemotherapy and radiotherapy by 18 July 2017.

Mr Craig's radiotherapy and his review by Dr Ng - 14 July 2017[114]

72. After Mr Craig missed appointments with Dr Ng on 28 April 2017 and 5 May 2017, Dr Ng wrote to Mr Craig's solicitor expressing concern about the delay in commencing radiotherapy.[115] Radiotherapy was eventually started on 7 June 2017, by which stage Mr Craig had been imprisoned. Dr Ng last saw Mr Craig on 14 July 2017 and noted he was "*well, with no shortness of breath or pleuritic chest pain*".

73. Dr Ng wrote to the Prison Medical Centre advising that Mr Craig had received "*radical chemoradiotherapy*" and that his radiotherapy was due to be completed on 18 July 2017. Dr Ng also suggested Mr Craig be reviewed by a medical officer in six-weeks.[116]

74. On 15 July 2017, the Radiation Oncology department received Dr Troon's letter dated 16 May 2017. It is unclear why Dr Troon's letter took so long to arrive, but it appears that there may have been a delay in Dr Troon authorising its release.

75. The contents of Dr Troon's letter surprised Dr Ng, who was aware that Cetuximab is generally used to treat colorectal cancer or head and neck cancer, rather than lung cancer. After reading Dr Troon's letter and speaking with the Medical Oncology department, Dr Ng referred Mr Craig to his colleague, Dr Jackson.[117]

[113] Exhibit 1, Vol 1, Tab 41A, Statement - Dr S Troon, paras 35-50 and ts 24.08.21 (Troon), pp99-100
[114] Exhibit 1, Vol 1, Tab 44A, Statement - Dr E Ng, paras 39-45 and ts 23.08.21 (Ng), p39-42
[115] Exhibit 1, Vol 1, Tab 44D, Letter - Dr E Ng to Legal Aid (22.05.17)
[116] Exhibit 1, Vol 1, Tab 44E, Letter - Dr E Ng to Prison Medical Centre (14.07.17)
[117] Exhibit 1, Vol 3, Tab 51, Attachment 1, Referral - Dr E Ng to Dr M Jackson (14.07.17)

Medical Oncology review - 18 July 2017[118]

76. Meanwhile, a CT scan on 31 July 2017, confirmed that Mr Craig had developed metastatic liver disease, most probably from his lung cancer. On 18 July 2017, Mr Craig was reviewed by a registrar in the Medical Oncology department, and it was at that time that Dr Troon became aware that he had been receiving radiotherapy for his lung cancer (not his oral cancer), whilst at the same time receiving radiosensiting chemotherapy (i.e.: Cetuximab) more suited to his oral cancer.

Review by Dr Jackson - 7 August 2017[119]

77. Dr Jackson reviewed Mr Craig on 7 August 2017 and noted that there had been no referral for PORT for Mr Craig's oral cancer. Her view was that the treatment of Mr Craig's metastatic cancer now took priority over PORT for his oral cancer and in her letter to Dr Ng, she stated:

> As it has been five months since his last operation, I think the window of benefit from postoperative radiation therapy has passed. Additionally, given the new liver lesions, he has other medical issues that take precedence. I have explained all of this to Mr Craig. He has a Medical Oncology follow up soon and an appointment to see yourself again in two months as well. I have not made him any further appointments at this stage, but am happy to see him again in the future should the need arise.[120]

78. At the inquest, Dr Jackson clarified her view about the window of benefit for PORT for Mr Craig's oral cancer and said that after five-months, the benefits would have been "*much less*". Dr Jackson noted that:

> [U]sually I like to give postoperative radiotherapy within a three-month window. Anything beyond that…I have a discussion with [the] patients about the pros and cons of radiation and…whether it would be of any therapeutic benefit to them and then make a decision based on what they say as to whether I would offer it or not.[121]

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[118] Exhibit 1, Vol 1, Tab 41A, Statement - Dr S Troon, paras 51-52 & 54 and ts 24.08.21 (Troon), p100
[119] Exhibit 1, Vol 3, Tab 51, Statement - Dr M Jackson, paras 12-17 and ts 24.08.21 (Jackson), pp114-115
[120] Exhibit 1, Vol 3, Tab 51, Attachment 2, Letter - Dr M Jackson to Dr E Ng (07.08.17)
[121] ts 24.08.21 (Jackson), p115

Review by Dr Troon - 8 August 2017[122]

79. After reviewing Mr Craig again on 8 August 2017, Dr Troon concurred with Dr Jackson's conclusion. Dr Troon told Mr Craig about the errors that had occurred in his treatment and that he should have been given carboplatin and etoposide (standard agents used for lung cancer), instead of the Cetuximab he had received.

80. Dr Troon explained to Mr Craig that the recommended treatment plan was now palliative chemotherapy for his lung cancer, which as noted, had spread to his liver. Mr Craig said that he wanted to consider his options and he was referred to a Medical Oncologist.

81. Dr Troon says that if he had checked the Medical Oncology eReferral before seeing Mr Craig on 16 May 2017, he believes he would have noted that the referral had come from the Respiratory Medicine team and would have concluded it most likely related to lung cancer not oral cancer.[123]

82. At the time Dr Troon was treating Mr Craig, it was not standard practice for the Medical Oncology department to receive a detailed radiotherapy treatment plan from Genesis for patients like Mr Craig. Instead, the Medical Oncology department would simply be told the start and finish dates for the patient's course of radiotherapy.

83. The current practice is that Genesis now provides the patient's radiotherapy treatment plan which includes the treatment to be given as well as the site of the cancer. The benefit of the new system is that when a patient attends the Medical Oncology department, the oncologist can check the radiotherapy plan to ensure that the proposed chemotherapy is appropriate.

84. Dr Troon also stated that since Mr Craig's death, there was a greater awareness of the need to be vigilant with patients who have synchronous cancers and who will, of necessity, be treated by different clinical teams with respect to each cancer.

[122] Exhibit 1, Vol 1, Tab 41A, Statement - Dr S Troon, paras 55-66 and ts 24.08.21 (Troon), p101
[123] ts 24.08.21 (Troon), p100

OPPORTUNITIES FOR IMPROVEMENT

MDTs

85. The evidence before me is that the standard of notes published following MDTs at FSH varies.[124] In cases where the scribe is a less experienced practitioner, the MDT notes may not be as comprehensive or as accurate as might be desirable.

86. In my view, given that MDTs are a crucial aspect of the management of cancer patients, it is essential that notes published after such meetings are of the highest possible quality. Amongst other things, this is because MDT notes are relied on by clinicians to access clinical information, including the patient's most recent treatment plan.

87. It follows that rather than delegate the admittedly onerous task of taking notes at MDTs to the most junior attendee, the task should be undertaken by a suitably experienced clinician, perhaps an experienced registrar or a clinical nurse specialist. Where this is not possible then, as noted earlier, an experienced practitioner who attended the relevant MDT should carefully review the draft MDT notes before they are published.

88. Two other minor suggestions arise. The first is that a patient's most recent treatment plan appear at the top of the MDT notes. This would avoid the need for clinicians to scroll through several pages of notes to find it. Obviously, wherever it appears in the MDT, the patient's most recent treatment plan should be clearly and unambiguously labelled.

89. The second suggestion, which was made by Dr Yagnik, is that MDT notes be placed in their own folder within BossNet. I accept that BossNet already has numerous folders and that too many folders can be as problematic as too few. However, MDT notes currently reside within BossNet in a folder labelled "*Discharge Summaries*".[125] The current placement of MDT notes within BossNet doesn't appear to have much logic to it, it is simply where the MDT notes have always been placed.

[124] ts 23.08.21 (Ng), pp52-54 and ts 23.08.21 (Foo), pp64-65
[125] ts 23.08.21 (Yagnik), p88

90. To my mind, it would make more sense for MDT notes to be placed in a separate folder. I would have thought this would make the task of accessing MDT notes more efficient and I invite FSH to consider whether this change would be appropriate.

91. Following an MDT at FSH, it is common for some teams to delegate the task of making relevant referrals to a junior practitioner in the team. This practice has understandable benefits in terms of efficiency and the development of junior staff.[126]

92. Nevertheless, clearly the responsibility for ensuring that referrals made after an MDT are accurate and are actioned in a timely manner, rests on the patient's treating clinician. This is because the role of the MDT is to make recommendations about the patient's care. It is the treating team who will need to explain the recommended plan to the patient and obtain consent. Only then can a referral be made.[127,128]

93. At the inquest, Dr Foo appeared to suggest that because Dr Jackson had been present at the Head and Neck MDT at which it was decided that Mr Craig should be referred for PORT for his oral cancer, she (Dr Jackson) bore some responsibility for chasing up the fact that no referral for PORT was received.[129] With respect, I reject this assertion and repeat that the responsibility for ensuring referrals are appropriately actioned rests on (and remains with) the referring clinician.[130,131]

Cancer Care Coordinators

94. One of the compounding issues in Mr Craig's case was that treatment for his two cancers was delivered by separate teams. Dr Hasani pointed out that given the complexity of Mr Craig's case, it may have been preferable for the chemotherapy for both of his cancers to have been supervised by a single Medical Oncologist.

[126] ts 24.08.21 (Cannell), p131
[127] ts 23.08.21 (Yagnik), pp82-83 & 86-87 and ts 24.08.21 (Troon), pp97-98
[128] ts 24.08.21 (Jackson), pp117-119 and ts 24.08.21 (Cannell), p131
[129] ts 23.08.21 (Foo), pp62 & 66 and see also: ts 24.08.21 (Panetta), pp159-162
[130] ts 23.08.21 (Yagnik), pp82-83 & 86-87 and ts 24.08.21 (Troon), pp97-98
[131] ts 24.08.21 (Jackson), pp117-119 and ts 24.08.21 (Cannell), p131

95. Where this is not possible because, for example, a clinician with the relevant expertise is unavailable, Dr Hasani suggested:

> [I]t would have been reasonable to consider regular meetings or email communications regarding Robert Craig's complete oncology plan for both cancers...It would also have been preferable for the Head and Neck Cancer Nurse Coordinator and the Lung Cancer Nurse Coordinator to ensure that there was communication and clear plans regarding Robert Craig's case.[132]

96. Dr Cannell confirmed that FSH had very limited access to Complex Cancer Care Coordinators (Care Coordinators). Care Coordinators are experienced clinical nurses specialised in supporting cancer patients through their treatment journey. They help support vulnerable patients undergoing complex treatment by ensuring that treatment modalities are coordinated and delivered in accordance with the treatment plan.[133]

97. It seems likely that had Mr Craig's care been supervised by a Care Coordinator, the errors that occurred in his treatment would have been identified at a much earlier point. Dr Cannell confirmed that although a "*cancer pathway navigator*" had recently been funded for the lung cancer service at FSH, there were issues relating to the management of some Care Coordinators who support patients at FSH.[134]

98. While Care Coordinators employed by FSH are subject to Dr Cannell's direction, those provided by the Western Australian Cancer Palliative Care Network (WACPCN) are not.[135] WACPCN Care Coordinators are managed by the North Metropolitan Health Service and were introduced about 15 years ago. At that time, the aim was to introduce Care Coordinators into Western Australia, but it appears that the original concept is no longer fit for purpose. According to Dr Cannell, WACPCN Care Coordinators are "*very much focussed on patient support rather than operational support*", by which he meant the coordination of treatment modalities.[136]

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[132] Exhibit 1, Vol 1, Tab 39B, Report - Dr A Hasani, p3 and ts 23.08.21 (Hasani), pp26-27
[133] Exhibit 1, Vol 1, Tab 42A, Statement - Dr P Cannell, para 53
[134] ts 24.08.21 (Cannell), pp122-123
[135] ts 24.08.21 (Cannell), p122
[136] ts 24.08.21 (Cannell), pp122-123, 124 & 135

99. Further, despite the fact that WACPCN Care Coordinators provide services to patients at FSH, they are neither based at FSH nor are they subject to direction from the FSH clinical leadership team. As Dr Cannell observed, although he can ask WACPCN Care Coordinators to perform particular tasks: "*you won't always get what you need*".[137]

100. This situation is clearly unsatisfactory. It seems patently obvious that the supervision of complex cancer care for patients at FSH would be more effective if it was carried out by Care Coordinators who are based at FSH and who are subject to direction by FSH clinical leadership team.

101. In her statement, Dr Foo advised that the Head and Neck cancer team now has a Care Coordinator and Dr Cannell confirmed that funding was recently secured to enable the appointment of a Care Coordinator for the Lung cancer team.[138,139] However, more needs to be done and I strongly urge South Metropolitan Health Service (SMHS) to support the employment of additional Care Coordinators at FSH in other cancer specialties.

Oncology information system[140,141]

102. In my view, the treatment of cancer patients at FSH is being hampered by the fact that incompatible computer systems are used to deliver oncology services. As Dr Cannell explained, the preferred solution is a single "*Oncology Information System*" (OIS), versions of which are used in all other mainland states, except Western Australia. Admittedly, OIS programs are expensive. For example, the solution used in South Australia reportedly cost some $35 million, whilst the solution in Queensland cost about $80 million.

103. According to Dr Cannell, when FSH was established, funds were made available to implement a "*site oncology information system*". However, no tender compliant bids were received and the allocated funds were used elsewhere. Clearly an OIS system in Western Australia is justified.

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[137] ts 24.08.21 (Cannell), pp122 & 124
[138] Exhibit 1, Vol 1, Tab 40A, Statement - Dr M Foo, para 62
[139] ts 24.08.21 (Cannell), pp134-135
[140] Exhibit 1, Vol 1, Tab 42A, Statement - Dr P Cannell, paras 42-45
[141] ts 24.08.21 (Cannell), pp128-130

104. Apart from the fact that Western Australia is the only mainland state without one, the volume and complexity of cancer cases has led to the occurrence of what Dr Cannell referred to as "*simpler chemotherapy mistakes*".

105. The evidence before me is that had Mr Craig's treatment been managed by an OIS, it is very unlikely that the treatment errors in his case would have occurred.

106. I accept that the implementation of an OIS will be expensive and will bring with it challenges and hurdles. Nevertheless, cancer care is becoming increasingly more complex and it is unacceptable for treatment at one of Western Australia's major hospitals to be managed by incompatible computer systems.

107. I therefore urge SMHS to urgently liaise with the Western Australian Health Department with a view to prioritising the implementation of a state-wide OIS. The fact that to date, the introduction of an OIS in Western Australia has been thwarted by lack of funds should not continue to be a barrier to this much needed reform.

CAUSE AND MANNER OF DEATH[142,143]

108. A forensic pathologist, Dr Gerard Cadden, carried out an external post mortem examination of Mr Craig's body at the State Mortuary on 5 February 2018 and reviewed Mr Craig's notes. There were no significant findings.

109. Toxicological analysis found a range of medications in Mr Craig's system that were consistent with his palliative care at BHC. The medications included: frusemide, haloperidol, midazolam, morphine, lignocaine and metabolites of ranitidine. Alcohol and common drugs were not detected.[144]

110. At the conclusion of the post mortem examination, Dr Cadden expressed the opinion that the cause of Mr Craig's death was disseminated malignancy (known advanced lung carcinoma and tongue carcinoma) in a man with co-morbidities including chronic obstructive pulmonary disease.

111. Other than to note that Mr Craig was diagnosed with cancer of the floor of his mouth (as opposed to his tongue), I accept and adopt Dr Cadden's conclusion as to the cause of Mr Craig's death. Further, in view of the circumstances, I find that Mr Craig's death occurred by way of natural causes.

[142] Exhibit 1, Vol 1, Tab 6A, Post Mortem Report (05.02.18)
[143] Exhibit 1, Vol 1, Tab 6B, Letter from Dr Cadden to Deputy State Coroner (05.02.18)
[144] Exhibit 1, Vol 1, Tab 7, ChemCentre Report (12.04.18)

QUALITY OF SUPERVISION, TREATMENT AND CARE

112. Having carefully reviewed the available evidence, I am satisfied that Mr Craig's supervision during the time he was incarcerated was appropriate. He was allocated a single cell because of his medical conditions and on two occasions, Mr Craig was appropriately placed on ARMS. Further, when he was removed from ARMS on the second occasion, he was placed on SAMS.

113. When Mr Craig's medical condition had clearly become terminal, he was transferred to the hospice at BHC. His restraints were eventually removed and members of Mr Craig's family were able to visit him and were present when he died.

114. In terms of the management of Mr Craig's cancers treatment, as I have outlined, the treatment he received was suboptimal. Admittedly Mr Craig's case was complex and it is uncommon for patients to have two unrelated cancers at the same time. Nevertheless, as a result of the errors I have outlined, Mr Craig received treatment at FSH that was not in accordance with the treatment plans for his cancers.

115. As to why these treatment errors occurred, Ms Mullins advised that despite extensive enquiries SMHS had been unable "*to identify the exact point in time at which an error was made, only that there were missed opportunities along the way*".[145] I would add that despite carefully reviewing the evidence myself, I have similarly been unable to take the matter any further.

116. As I have outlined, since Mr Craig's death there have been a number of procedural improvements and there now appears to be a greater awareness of the need to be vigilant in complex cases like Mr Craig's.

[145] ts 24.08.21 (Mullins), p159

RECOMMENDATIONS

117. In view of the observations I have made, I make the following recommendations:

> **Recommendation No. 1**
> To ensure the accuracy of notes and treatment plans recorded following multidisciplinary team meetings (MDT) held at Fiona Stanley Hospital, MDT notes should be taken by a suitably experienced clinician or health practitioner. Where this is not possible, MDT notes should be checked by a suitably experienced clinician prior to being circulated.

> **Recommendation No. 2**
> To ensure that referrals are triaged appropriately and in a timely manner, the e-Referral system used at Fiona Stanley Hospital should be modified to include a text box requiring the referring clinician to state the reason for the referral and, in general terms, the nature of the treatment or service being requested.

Comments relating to recommendations

118. In accordance with my usual practice, a draft of these recommendations was forwarded to all counsel by Counsel Assisting, Mr William Stops on 22 September 2021.[146]

119. By email dated 23 September 2021, Ms Mullins advised that SMHS had no comment to make with respect to Recommendation No. 1, but suggested that the rationale for Recommendation 2 be explicitly stated.[147] This was a sensible suggestion, which I have adopted. In an email dated 27 September 2021, Ms Catherine Elphick advised that Dr Ng was supportive of both recommendations.[148]

[146] Email - Mr W Stops (22.09.21)
[147] Email - Ms G Mullins (counsel for SMHS) to Counsel Assisting (23.09.21)
[148] Email - Ms C Elphick (counsel for Dr E Ng) to Counsel Assisting (27.09.21)

CONCLUSION

120. In Mr Craig's case, unfortunate errors led to him not receiving optimal treatment for his unrelated lung and oral cancers. However, it appears that even if Mr Craig had received the correct treatment, the aggressive nature of his lung cancer meant that the outcome in his case would not have been significantly different.

121. I hope that the improvements that have been instituted since Mr Craig's death, and the two recommendations I have made may, if implemented, improve the health outcomes for patients with complex care needs and offer Mr Craig's family some solace for their loss.

MAG Jenkin
Coroner
29 September 2021