[2021] WACOR 1

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	22 SEPTEMBER 2020
DELIVERED	**:**	15 JANUARY 2021
FILE NO/S	**:**	CORC 620 of 2017
DECEASED	**:**	DUGAN, STUART WILLIAM

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms R Collins assisted the Coroner.
Ms S Keighery (SSO) appeared for the Department of Justice and South Metropolitan Health Service.
Ms H M Cormann (Wotton Kearney) appeared for Serco Asia Pacific.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of **Stuart William DUGAN** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on **22 September 2020**, find that the identity of the deceased person was **Stuart William DUGAN** and that death occurred on 4 May 2017 at Kalamunda Hospital Hospice, from carcinoma of the lung in the following circumstances:*

TABLE OF CONTENTS

INTRODUCTION

1. Stuart Dugan was a sentenced prisoner at Acacia Prison when he became unwell in early 2017. Following medical investigations, he was diagnosed with advanced inoperable lung cancer in late February 2017. His prognosis was poor and it was estimated he only had weeks to live. Mr Dugan accepted the medical advice to commence palliative management only. Mr Dugan received palliative care at various locations until he was eventually moved to Kalamunda Hospital Hospice in early April 2017, where he remained until his death on 4 May 2017.

2. As a sentenced prisoner, Mr Dugan's came within the definition of a person held in care under the *Coroners Act 1996* (WA). Under the Act, where the death is of a person held in care, a coroner must hold an inquest into the death and must also comment on the quality of the supervision, treatment and care of that person while in that care.

3. An inquest was initially listed to commence on 4 August 2020. Due to some issues raised in relation to the health care Mr Dugan received while in custody, the inquest hearing was adjourned to allow an opportunity for the parties to provide additional information and for Serco Asia Pacific to obtain representation for the inquest.

4. In the end, I held an inquest on 22 September 2020, during which I was assisted by counsel and witnesses on behalf of both the Department of Justice and Serco. The evidence was focussed on the medical care Mr Dugan received while in custody.

BACKGROUND

5. Mr Dugan was born in Victoria and moved between Victoria and Western Australia during his adult life. He qualified as a motor mechanic and worked as a mechanic and driver. He married in 1984 and had four children. The marriage ended in late 1997.

6. Between 1997 and 2001, while living in Western Australia, Mr Dugan committed a number of sexual offences. The offending was not identified before Mr Dugan moved back to Victoria permanently in 2001. After the offending eventually came to light and a police investigation was conducted, Mr Dugan was extradited to Western Australia in 2010 to face criminal charges. He was tried before a Judge and jury in the District Court of Western Australia and convicted. On 29 April 2011, Mr Dugan was sentenced to a total term of 14 years' imprisonment for his crimes. The sentence commenced on 1 February

2010 so his earliest date to be eligible for parole was 31 January 2022.[1] Mr Dugan unsuccessfully appealed against his convictions.[2]

7. Mr Dugan was initially held at Hakea Prison (Hakea) before being moved to Acacia Prison in June 2011, where he served the majority of his sentence.[3]

8. The Department of Justice subcontracts management of Acacia Prison (Acacia) to Serco. Serco has been contracted to perform this role since 2006. As part of the contract, the healthcare management must be in line with the Department's policies and procedure and the Department retains ultimate responsibility for Acacia and provides onsite monitoring services to ensure Serco is meeting its contractual requirements.[4]

9. The standard of health care Acacia is required to provide to prisoners is aligned with a community GP service and any specialist care is provided through collaboration with public hospitals. The health service holds appropriate RACGP accreditation, current until 2 September 2021. The Department and Serco all share the same electronic medical record so there is continuity between the health services when prisoners move between the public and privately run prisons, and they also share information and discussion about clinical incidents and quality improvement activities.[5]

ADMISSION TO PRISON

10. On his initial admission into custody on 3 February 2010, at Hakea, Mr Dugan underwent an initial health screen completed by a nurse. He reported he had undergone previous shoulder surgery and he had been on a waitlist in Victoria for further surgery to his right shoulder. Mr Dugan took tramadol and paracetamol for pain relief for his right shoulder pain and he was later charted with the same medications by the prison medical officer. No other significant medical history or psychiatric concerns were reported, although it was noted that Mr Dugan was a cigarette smoker.[6]

11. At the time of his admission Mr Dugan's weight was recorded as 72 kg, with a BMI of 24.9. Mr Dugan's blood pressure reading was too high, so nursing staff

[1] Exhibit 1, Tab 31.
[2] *SWD v The State of Western Australia* [2017] WASCA 39.
[3] Exhibit 2, Tab 1.
[4] T 32 - 33; Exhibit 1, Tab 43; Submissions filed on behalf of Serco Asia Pacific, 23.10.2020, [5].
[5] Submissions filed on behalf of Serco Asia Pacific, 23.10.2020, [6].
[6] Exhibit 1, Tab 39; Exhibit 2, Tab 10.1.

organised to recheck it a few days later. It had come down at this stage to an acceptable level.[7]

12. Following his initial prison medical officer review in February 2010 Mr Dugan was not referred for orthopaedic review because he was on remand and he suggested that he might be released soon or transferred to Victoria. At that time, this was considered a reason not to progress his referral.[8] It was noted that if Mr Dugan was eventually sentenced he would need to be referred to orthopaedics and be put on a public waiting list. It was not possible to transfer him directly from the Victorian public waiting list to the WA health system, despite the fact he had been in the queue in Victoria for some time.[9]

13. Mr Dugan continued to have problems with his right shoulder. On 22 June 2010 he complained to nurses that his shoulder was 'playing up' but admitted he wasn't taking his scripted medications as he didn't like taking tablets. He was given Voltaren gel to use instead. He was given more Voltaren on 9 December 2010 for the same reason.[10]

14. By 1 March 2011 Mr Dugan's shoulder issues appeared to have worsened. He was noted to be complaining of pain, tingling, pins and needles and decreased function in his right arm. He was seen by the physiotherapist, who noted Mr Dugan had very restricted movement in his right shoulder and there was little outside of surgery that could be offered to him. Mr Dugan saw the prison medical officer on 10 March 2011 and was approved to be given paracetamol and ibuprofen. Despite his ongoing shoulder issues, a note was made that Mr Dugan would be reviewed with respect to orthopaedic referral only after sentencing. By this stage he had been in custody for more than a year without a referral being made but his status was not revisited.[11]

15. It was not until 24 May 2011, when Mr Dugan was seen by a prison medical officer after being sentenced nearly a month before, that he was referred for an x-ray and ultrasound of his right shoulder and also referred to Orthopaedics at Royal Perth Hospital. This was some 15 months after his admission to prison, on a background of already spending time on the waiting list for shoulder surgery in Victoria.[12]

[7] Exhibit 1, Tab 39; Exhibit 2, Tab 10.1.
[8] T 34.
[9] Exhibit 1, Tab 39.
[10] Exhibit 1, Tab 39.
[11] Exhibit 1, Tab 39.
[12] Exhibit 1, Tab 39.

16. An x-ray of Mr Dugan's shoulder was performed on 8 June 2011 and he was reviewed by a prison medical officer a week later. It was noted that the x-ray demonstrated a fractured neck of the right humerus (upper arm bone), which had been repaired with a plate and screws but demonstrated no signs of healing. There was a note that Mr Dugan was still waiting for his ultrasound. He had also been referred to Royal Perth Hospital for an orthopaedic opinion but unfortunately it seems no orthopaedic review eventuated.[13]

17. Mr Dugan was transferred to Acacia Prison at Wooroolloo on 19 June 2011, prior to the ultrasound occurring. From this time, Serco Australia were responsible for ensuring he received appropriate health and medical services, although the Department retained an overarching responsibility for his care. I am informed the Department's health staff worked with the Acacia health staff to maintain good information sharing to ensure continuity in his care.[14]

18. Mr Dugan was given prescriptions for his preferred medications, ibuprofen and paracetamol, on 26 June 2011 by an Acacia prison medical officer. On 13 July 2011 there is a note that Mr Dugan missed a medical appointment but no note as to the reason. There are no further entries in his medical notes until 30 January 2012, when he was seen by a nurse and given a medical note indicating he should be put on 'light duties' due to his shoulder.[15]

19. At his annual health review on 2 March 2012, conducted by a nurse at Acacia, Mr Dugan told the nurse that he was not ready to quit smoking yet. He weighed 69 kg and his blood pressure was within the normal range. He was referred by the nurse to the prison medical officer for review in relation to his prostate and for a bowel cancer check, presumably as an age related screening rather than for any noted symptoms. A comment was made in the notes that Mr Dugan had a shoulder issue and he had had a scan but nothing more was done about this and it was not recognised by the nurse that Mr Dugan was still waiting to see an orthopaedic surgeon.[16]

20. Mr Dugan was seen by the Acacia prison medical officer on 26 March 2012 and blood tests and a bowel cancer screening test were ordered. The medical officer did note that Mr Dugan had been referred for orthopaedic an opinion but nothing was done to chase this referral up.[17]

[13] Exhibit 1, Tab 39.
[14] T 33.
[15] Exhibit 1, Tab 39.
[16] Exhibit 1, Tab 39.
[17] Exhibit 1, Tab 39.

21. Mr Dugan's blood tests in early May revealed he was not immune to hepatitis B, a disease easily spread in the prison system, and had significant dyslipidaemia (high cholesterol and blood fats), putting him at risk of vascular disease. He was vaccinated against hepatitis B.[18]

22. Mr Dugan was seen by a physiotherapist on 27 September and 18 October 2012, during which his shoulder was strapped. The physiotherapist noted Mr Dugan was still awaiting an orthopaedic appointment, that had been ordered months earlier, but nothing more was done to chase up the appointment.[19] Mr Dugan was obviously still experiencing pain as he was scripted Voltaren gel by a medical officer on 3 October 2012, although this was ceased again three days later by a different medical officer without Mr Dugan being reviewed.[20]

23. On 5 February 2013, Mr Dugan told the Acacia prison nurse at his annual health review that he did not smoke a lot, but would find it difficult to give up altogether. He was still complaining of right shoulder pain and it was noted that he had now spent a long time on the waiting list for an operation but once again his referral was not followed up. During this review Mr Dugan's weight was recorded as 87kg, which was an anomaly as all his other recorded weights trended down from his admission weight of 72kg.[21]

24. Other than a medical note in March 2013, in relation to Mr Dugan's failure to develop antibodies to hepatitis B and a cancelled appointment due to operational requirements around that time, there are no more entries in Mr Dugan's health record for the next two and a half years. Mr Dugan did not have any medical reviews from April 2013 (including no annual health review in 2014 and 2015) until 27 July 2015, when he presented with a painful tooth.

25. Mr Dugan reported he had been experiencing dental pain for several months and had been awaiting a dental appointment but it hadn't occurred. He was told he would have to attend the dental parade in the hope the dentist had spare appointments available. He was seen the next morning, still with significant tooth pain and a plan was made for the emergency dentist to be advised. It is unclear what happened next, but a dental appointment was not scheduled until 23 November 2015. On that date a note was made by the dentist that Mr Dugan did not attend the appointment. His reason for non-attendance is not noted. There is no record in the notes of how Mr Dugan coped with his dental pain without intervention.[22]

[18] Exhibit 1, Tab 39.
[19] Exhibit 2, Tab 10.1.
[20] Exhibit 1, Tab 39.
[21] Exhibit 2, Tab 10.1.
[22] Exhibit 1, Tab 39; Exhibit 2, Tab 10.1.

26. Mr Dugan did finally have another 'annual' health review on 1 February 2016. It was noted that he weighed 61 kg, which was 16 kg less than the previous year and 11 kg less than his prison admission weight, but it doesn't appear that this significant change was noted, probably because his medical notes were not reviewed. His recorded pulse rate was also elevated but this did not appear to be recognised. At this time Mr Dugan was still smoking. Mr Dugan reported a longstanding hernia and osteoarthritis, for which he wanted analgesia. He was booked and seen several days later by a prison medical officer, who noted a scrotal mass and referred Mr Dugan for surgical review. He was prescribed Panadol osteo and difflam gel for his osteoarthritis, which presumably related to his shoulder.[23]

27. Mr Dugan was later admitted for elective inguinal hernia repair at Fremantle Hospital on 15 July 2016. He returned to Acacia from hospital the following day and appeared to recover well.[24] Mr Dugan returned to the Acacia Clinic the following day. On 18 July 2016 the prison medical officer made a medical note that Mr Dugan had had his hernia operation but he did not personally review the patient. Mr Dugan was not seen again until December 2016, and there was no further management of his shoulder issue.[25]

FIRST SIGNS OF RESPIRATORY ILLNESS

28. On 9 December 2016 Mr Dugan was reviewed by a prison medical officer. He complained of an intermittent cough with white sputum after having ceased smoking six months earlier in July 2016. He had crackles in the left upper lung lobe, an abnormal finding. His pulse and blood pressure were normal but no respiratory rate was recorded. It appears the medical officer suspected pneumonia, so Mr Dugan was prescribed antibiotics, routine blood tests were ordered and a review was planned for four weeks. This was the first time that a respiratory complaint of any type was recorded in Mr Dugan's prison medical notes.[26]

29. Mr Dugan was not reviewed again in a month as planned. On 4 January 2017 blood tests showed slightly elevated levels of infection fighting cells and a low vitamin D level. He was not reviewed by a nurse or medical officer.[27] Mr Dugan was not seen again by health services staff until 31 January 2017,

[23] Exhibit 1, Tab 39.
[24] Exhibit 2, Tab 10.1.
[25] Exhibit 1, Tab 39.
[26] Exhibit 2, Tab 10.1.
[27] Exhibit 2, Tab 10.1.

when Mr Dugan was reviewed by a prison nurse. At that time he reported that he had been coughing up blood for the last couple of weeks. He also reported experiencing chest pain since the coughing episodes started. Observations, including oxygen saturations, were said to be normal, apart from a raised pulse at 110 beats per minute, which I am told is very abnormal.[28] An ECG was done by the nurse, but it is unclear what it showed.[29]

30. Expert evidence suggests that these symptoms, in combination, indicated that Mr Dugan was very unwell but there was no indication from the notes that the nurse recognised that Mr Dugan was sick. There was no recognition of a number of red flags, including the coughing of blood, high pulse rate and chest pain, and the nurse did not escalate his care to seek a medical review, either in person or by e-consult. The nurse also did not document a plan of action.[30]

31. The health appointment took place at 7.27 am that morning, and during the afternoon of the same day, the acting prison nurse manager recorded that Mr Dugan's family member (noted as his mother but in fact his daughter) rang expressing concern about reports he had been excessively vomiting. The nurse manager advised Mr Dugan's daughter that Mr Dugan had been seen that morning and that he would see the doctor the following week. In the meantime, it was said that Mr Dugan would be reviewed by nurses weekly.[31] It does not appear that any attempt was made to review Mr Dugan again, after this phone call, despite the fact a different serious symptom was being described, and there was no escalation of care.

32. Mr Dugan's daughter, Ms Drage, was asked about this call and she provided information that she had rung the prison several times and eventually demanded to speak to a nurse about her father's condition as he had told her he was concerned that he was really unwell and had lost so much weight and was coughing up a cup of blood a day. When Ms Drage was eventually put through to the nurse, she recalled the nurse told her Mr Dugan had a chest infection and was on oral antibiotics. Ms Drage was an experienced critical care nurse and she told the nurse she did not believe the symptoms were consistent with a chest infection. Rather, she believed (correctly) they were typical symptoms for cancer and she felt he needed more tests. The nurse indicated to Ms Drage they would not be ordering any further tests while he was being treated with the antibiotics.[32]

[28] Exhibit 1, Tab 39, p. 5.
[29] Exhibit 1, Tab 39; Exhibit 2, Tab 10.1.
[30] Exhibit 1, Tab 39; Exhibit 2, Tab 10.1.
[31] Exhibit 1, Tab 39.
[32] Exhibit 1, Tab 40.

33. The following day, Mr Dugan's Panadol osteo prescription was renewed by a prison medical officer without Mr Dugan being seen by a doctor. There is no indication the doctor reviewed the notes from the previous day and was aware of Mr Dugan's disturbing set of symptoms.[33]

34. On Thursday, 2 February 2017, two days after Mr Dugan's first report of coughing blood, he attended the nursing parade and stated that he was still coughing up blood and this had been occurring every day for the last three weeks. He mentioned he had been given the antibiotic medication doxycycline by the nurse the preceding Tuesday, although this is not documented in the notes and it is a medication a medical officer would ordinarily prescribe. His pulse rate was still abnormal and his oxygen saturations were 94% on room air. Again, despite concerning signs, the nurse did not seek a doctor's advice or escalate his care, although she did put Mr Dugan on daily review until his next medical appointment, scheduled for the following Monday.

35. Despite being noted for a daily welfare check, Mr Dugan was not seen the next day, being Friday, 3 February 2017.[34]

36. He was seen on 4 February 2017 and confirmed his previous report of coughing up blood for the last three weeks. He also mentioned losing weight. His chest had rattles and he exhibited shortness of breath and reduced oxygen saturations on room air. It appears an 'e-consult' was conducted with a doctor that day by a nurse and instructions were given for Mr Dugan to be commenced on antibiotics and checked the following morning. Serco has advised that the doctor was provided with e-consult notes prior to this consultation.[35]

37. Mr Dugan was seen for a welfare check on 5 February 2017 and he again had low oxygen levels on room air at 91%.[36] A nurse also listened to his chest and noted there were reduced breath sounds on the left side. This nurse also recognised his weight loss, which at 52 kg was 9 kg less than the previous year (but in fact 20 kg less than his admission weight). A doctor's review was scheduled for the following day and it was noted he required further investigations as to the cause of his coughing up blood (haemoptysis) and weight loss to determine if it was due to an infection or a "more sinister pathology."[37] It seems that because he had a doctor's appointment the following day, the nurse did nothing more to escalate Mr Dugan's care.[38]

[33] Exhibit 2, Tab 10.1.
[34] Exhibit 1, Tab 39; Exhibit 2, Tab 10.1.
[35] Exhibit 1, Tab 39 and Tab 41; Exhibit 2, Tab 10.1.
[36] Exhibit 1, Tab 39.
[37] Exhibit 2, Tab 10.1, EcHO note 5.2.17, 7.41 am.
[38] Exhibit 1, Tab 39.

38. Mr Dugan was seen by a prison medical officer the next day, being 6 February 2017. The same doctor had seen Mr Dugan on 9 December 2016, when he first reported respiratory symptoms, but not specifically haemoptysis. Mr Dugan described coughing up almost half a cup of blood and thick phlegm every night for the last three weeks. He discussed his weight loss and reported feeling weak and short of breath even at rest and had been using a wheelchair. The doctor formed a working diagnosis of pneumonia or possible malignancy. Broad spectrum antibiotics and inhalers were prescribed and an urgent chest x-ray, blood tests and sputum samples were ordered, but the doctor did not take the extra step of referring Mr Dugan to hospital for urgent investigations. Instead, he simply ordered the investigations and indicated he wanted to review Mr Dugan again in four days.[39]

39. Expert evidence at the inquest indicated that, without Mr Dugan being referred immediately to a hospital, there was no realistic prospect that he would undergo the requested chest x-ray in that time frame. Rather, it would generally take two and a half to three weeks for that to occur. It does not appear the medical officer understood the likely delay when the request was made.[40]

40. The sputum sample returned as blood stained, with no pathogenic bacteria. The blood tests showed raised markers of infection fighting cells and the haemoglobin was stable, suggesting that there had not been significant blood loss. The urgent chest x-ray was not, however, performed.[41]

41. The doctor saw Mr Dugan again on 10 February 2017, four days after the last appointment, for a scheduled review. His chest apparently sounded better at this time, although there were still crackles present on the left side, and the blood tests suggestive of infection were discussed. No record of a pulse rate, respiratory rate, blood pressure or oxygen saturations were noted. A repeat course of antibiotics was prescribed and a chest x-ray was still planned. The doctor was clearly working on the basis that the most likely diagnosis was pneumonia at this stage, as it was noted that he reassured Mr Dugan that he "was getting better," although in hindsight this was clearly not the case.[42] The doctor noted that he would await the chest x-ray results but was ready to review Mr Dugan earlier if he deteriorated.

[39] Exhibit 1, Tab 39.
[40] T 41.
[41] Exhibit 2, Tab 10.1.
[42] Exhibit 2, Tab 10.1, EcHO note 10.2.17, 12.34 am.

42. No chest x-ray was performed, but nothing was done to follow this up, despite the investigation being ordered as urgent. Mr Dugan did not attend for a welfare check with a nurse on 15 February 2017 and there was a note that he be rebooked but he was not followed up.

43. Indeed, Mr Dugan was not seen again by any nursing or medical staff until 19 February 2017, when a Code Blue medical emergency was called.

44. Just before 4.00 am on 19 February, Mr Dugan made an intercom call from his cell and told a prison officer that he was unable to breathe properly. The prison officer called the Code Blue over the radio and prison officers then opened his cell.[43] A nurse had gone to the cell and found Mr Dugan short of breath and coughing up thick, blood stained sputum. Mr Dugan was escorted to the health centre, where he was assessed. He had lost a further 5 kg in weight (he weighed only 47 kg) and had low oxygen saturations. His breathing and oxygen saturation improved with support. It was decided that he should be sent to the Emergency Department for urgent medical review. An ambulance arrived on site at 4.34 am and left with Mr Dugan at 4.45 am to take him to St John of God Hospital Midland.[44]

LUNG CANCER DIAGNOSIS

45. When assessed at the hospital, Mr Dugan was recorded as having a two month history of worsening haemoptysis (coughing up blood) and dyspnoea (shortness of breath) and respiratory distress. He was admitted for the management of suspected pneumonia, with a differential diagnosis of locally advanced lung cancer or tuberculosis. He was given oxygen and intravenous antibiotics while he underwent further investigations. Sputum samples were sent for cytology, and they showed adenocarcinoma. He was eventually diagnosed with locally advanced inoperable left upper lobe cancer of the lung.[45]

46. Mr Dugan's case was discussed at the Sir Charles Gairdner Hospital respiratory multidisciplinary team meeting. He was considered to be a poor surgical candidate given his functional status, the tumour was too big for radiotherapy and he was felt to be currently too weak for chemotherapy. Palliative radiotherapy was considered a possible option for his haemoptysis but was deemed not suitable due to potential damage to lung tissues. It was decided he would be treated symptomatically with supplementary oxygen and opioid

[43] Exhibit 2, Tab 8 and Tab 10.1.
[44] Exhibit 1, Tab 39; Exhibit 2, Tab 8 and Tab 10.1.
[45] Exhibit 1, Tab 34, Tab 36 and Tab 37.

analgesia and it was agreed he was not for resuscitation. He was given an estimated survival of two months and his daughters in Victoria were notified.[46]

47. The Department was notified by Acacia Prison nursing staff of Mr Dugan's prognosis and he was entered in the Department's Terminally Ill module as 'Stage 4 – death imminent'.[47]

48. Acacia Prison nursing staff were kept informed by the hospital staff of Mr Dugan's care and progress and also conducted welfare visits to hospital to review Mr Dugan. The nursing staff were also actively involved in keeping Mr Dugan's family in Victoria informed.[48]

49. Mr Dugan was discharged from hospital to Casuarina Prison, which has an infirmary, on 2 March 2017. Mr Dugan had been reluctant to go to the Casuarina Infirmary and on his arrival the nursing staff immediately expressed concern as his room was very humid and hot and he complained of shortness of breath. He was given some analgesia and attempts were made to keep him cool overnight with the use of a wet towel. The next day a prison medical officer, Dr Princewell Chuka, reviewed Mr Dugan's hospital discharge summary and spoke to the nursing staff, who expressed concerns that they did not feel they were able to manage his care safely in the infirmary. After making some enquiries, Dr Chuka organised to transfer Mr Dugan by ambulance to St John of God Midland Hospice. Mr Dugan was advised and indicated he was happy with this arrangement.[49]

END OF LIFE CARE

50. Therefore, on 3 March 2017, after spending one night in the Casuarina Prison Infirmary, Mr Dugan was admitted to the St John of God Midland Hospice at about midday.[50]

51. After several days, a prison nursing note on 7 March 2017 indicated that St John of God Hospice staff wished to discharge Mr Dugan back to the Casuarina prison infirmary as they believed he was doing well and was self-caring and well managed on his analgesia and did not require extra medication out of hours.[51]

[46] Exhibit 1, Tab 34 and Tab 36.
[47] Exhibit 1, Tab 39.
[48] Exhibit 2, Tab 10.1.
[49] Exhibit 2, Tab 10.1.
[50] Exhibit 1, Tab 39.
[51] Exhibit 2, Tab 10.1.

52. However, when Mr Dugan did return to Casuarina Prison infirmary on 10 March 2017, it was immediately apparent to the prison nursing staff that they did not have the ability to manage his care in the prison. Although he was allegedly self-caring, Mr Dugan arrived at the prison via ambulance on a stretcher and he told staff he could not care for himself. He was also sent back after hours to the prison at the beginning of the weekend without any of his medication except Schedule 8 medications, which was problematic as it is difficult to access medication prescription out of hours and on weekends at the prison.[52]

53. The nursing staff arranged an urgent e-consult with a doctor to pass on the nurses' concerns about their ability to care for him appropriately. The nursing staff then tried to keep Mr Dugan as comfortable as possible while seeking a resolution.[53] The electric bed in Mr Dugan's cell was not working and Mr Dugan found it hard to breathe in his room without air conditioning, so the nurses brought in a fan to try to keep him cool.

54. A further e-consult with a doctor was conducted just after lunchtime on 11 March 2017. It was noted that Mr Dugan had reported that he fell early in the morning trying to reach the toilet in his cell and he was said to be very frail and weak. The nursing staff had firmly formed the opinion that they would be unable to provide the appropriate care that he required and also noted that he had a non-resuscitation order, which could not be complied with in the prison setting. A decision was made to return Mr Dugan to hospital, and he was sent by ambulance to the Fiona Stanley Hospital Emergency Department.[54]

55. Mr Dugan was admitted for further care to Fiona Stanley Hospital. A chest x-ray showed the tumour had grown and completely infiltrated the left lung. He was referred to the palliative care team and reviewed by the palliative care consultant on 14 March 2017 and then the radiation oncologist on 15 March 2017 to consider palliative radiation for pain control. He eventually had one dose of radiation the following day, but it did not help with his pain control, so he was given increasing analgesia for pain control. While in hospital, Mr Dugan complained of toothache. Evidence of active dental cavities and signs of dental abscess were discovered and he was referred to the inpatient dental service and had a tooth extraction on 30 March 2017. The tooth

[52] Exhibit 1, Tab 39.
[53] Exhibit 2, Tab 10.1.
[54] Exhibit 2, Tab 10.1.

extraction apparently afforded him "significant relief of pain."[55] This suggests he had still been suffering from dental issues all this time.[56]

56. The hospital staff were helpful in arranging further care for Mr Dugan and he was eventually transferred to Kalamunda Hospice on 6 April 2017 for end of life care.[57] He remained at the hospice and received palliative care until his death on the morning of 4 May 2017.[58]

CAUSE AND MANNER OF DEATH

57. Following an external examination of Mr Dugan, which showed generalised wasting of his body and cachexia and changes of recent medical care, and a review of the medical notes and limited toxicology analysis, Forensic Pathologist Dr Clive Cooke formed the opinion the cause of death was consistent with carcinoma of the lung. I accept and adopt the opinion of Dr Cooke as to the cause of death.[59] It follows that the manner of death was by way of natural causes.

TREATMENT, SUPERVISION & CARE

58. I am required under the Act to consider and make comment on Mr Dugan's treatment, supervision and care while in custody.

59. As noted above, Mr Dugan's daughter, Ms Melissa Drage, raised concerns about her father's care while at Acacia Prison. Ms Drage has a nursing background and she told a coronial investigator that she believed Mr Dugan did not receive medical treatment when he should have, and she believes his life could have been saved if he had received prompt medical care. Ms Drage said she reported her concerns to prison staff on numerous occasions prior to his cancer diagnosis.[60] Her account is supported by the nursing note on 31 January 2017.

60. In order to assist me in considering the treatment, supervision and care Mr Dugan received before his death, the Department arranged for Dr Cherelle Fitzclarence to review the medical records of Mr Dugan and prepare a report with respect to his medical management in prison. Dr Fitzclarence is a qualified

[55] Exhibit 1, Tab 36, p. 2.
[56] Exhibit 1, Tab 35.
[57] Exhibit 2, Tab 10.2, Fiona Stanley Hospital Discharge Summary 6 April 2017.
[58] Exhibit 1, Tab 2 and Tab 39.
[59] Exhibit 1, Tab 6 and Tab 7.
[60] Exhibit 1, Tab 8.

general practitioner with extended post graduate qualifications in a number of areas of medicine and a special interest in chronic disease, Aboriginal health and lifestyle medicine. Dr Fitzclarence previously worked for the Department, both as a prison medical officer and the Deputy Director of Medical Services, and has undertaken similar reviews for other coronial matters, so she is well placed to provide such a report. Dr Fitzclarence worked for the Department for a period when Mr Dugan was incarcerated, and had some dealings with his case on an administrative level, but she did not provide any treatment or care to Mr Dugan herself.[61]

61. Dr Fitzclarence provided a comprehensive chronology of Mr Dugan's medical issues and the care he received in custody. Dr Fitzclarence expressed her considered opinion that the care Mr Dugan received while in the care of the Department and while his care was outsourced to Acacia Prison was "less than ideal"[62] and "fell short of community standards of care on multiple occasions."[63] Dr Fitzclarence identified a number of issues, the ones that I consider particularly important, set out below.

Orthopaedic Referral

62. Dr Fitzclarence first pointed to the non-referral of Mr Dugan to orthopaedics for his shoulder issue while he was on remand and awaiting sentencing for a period of over 12 months. It was known from the time of Mr Dugan's extradition that he had a shoulder issue and was on the orthopaedic waiting list, and Dr Fitzclarence commented that his referral could have been facilitated much earlier while he was held at Hakea.[64] However, she indicated that the policy at the time was not to refer patients to specialties for non-critical issues if they were not sentenced.[65] This appears to have been the reason for the delay in referring Mr Dugan, and was referred to in the medical notes on occasion. Dr Fitzclarence felt that, given the length of his period on remand, consideration should still have been given to a referral despite the usual policy.[66]

63. However, Dr Fitzclarence further noted that once the orthopaedic referral was made, after Mr Dugan became a sentenced prisoner, it was not followed up and there is no indication that Mr Dugan ever saw the orthopodaedic surgeron for his chronic shoulder issues, which clearly caused him quite some pain and distress.

[61] Exhibit 1, Tab 39.
[62] Exhibit 1, Tab 39, p. 8.
[63] Exhibit 1, Tab 39, p. 8.
[64] Exhibit 1, Tab 39.
[65] T 16.
[66] T 16.

Dental issues

64. Dr Fitzclarence noted there was inadequate follow up of Mr Dugan's dental issues in 2016. It is apparent from the medical records he had been experiencing dental pain for several months and when a dental appointment was finally scheduled, he did not attend and there is no follow-up in relation to his non-attendance. I infer that he continued to suffer dental pain as there was evidence of active dental cavities and signs of dental abscess when he was admitted to hospital in mid-March 2017, leading to a tooth extraction at the end of March 2017, which was said to have afforded him "significant relief of pain."[67]

65. In addition, it is well known that poor dentition and dental pathology has a direct association with chronic disease, so ongoing untreated dental issues was likely to have had an adverse effect on Mr Dugan's general state of health.[68]

Annual health assessments and follow up

66. Dr Fitzclarence observed that the annual health assessments while Mr Dugan was held at Acacia did not, in fact, occur annually and none of them were completed in their entirety. The gaps meant that outstanding referrals were not recognised. Dr Fitzclarence considered the missed annual health assessments could be regarded as missed opportunities where interventions could have been made, as part of general preventive healthcare, and they could have provided an opportunity for Mr Dugan to raise any symptoms he was experiencing, such as a cough. It is possible, although obviously not certain, that the cancer could have in that way been detected at an earlier stage [69]

67. There was no recognition in early 2016 by clinical staff that Mr Dugan had lost significant weight while in prison, which is unusual (as most people put on weight in a prison setting) and warranted investigation to exclude any sinister cause.[70] There was also no apparent recognition that a pulse rate over 100 is not normal. Although there can be many explanations for a high pulse rate, Dr Fitzclarence noted that, as medical professionals, they "ideally do not ignore a high pulse rate"[71] and consider the possible causes, and re-check, before deciding there is a non-sinister cause. Dr Fitzclarence believes an appropriate review at this point might have prompted a chest x-ray (given he was a long-term smoker), which may well have picked up his lung cancer at a point when treatment may have been a viable option.[72]

[67] Exhibit 1, Tab 36, p. 2.
[68] T 25.
[69] T 17, 19.
[70] T 20.
[71] T 20.
[72] T 19 – 20; Exhibit 1, Tab 39.

68. Dr Fitzclarence accepted that it is easier in retrospect to find things that could have been done better, but emphasised that preventive care is still a big part of GP health care in prisons (as it is in the community) and she believes this was not properly prioritised in Mr Dugan's case. Dr Fitzclarence accepted that there is a potential Mr Dugan's lung cancer would have gone undiagnosed, even with earlier review, and she agreed it probably wouldn't have altered the outcome, but in her opinion general check-ups would at least have had the potential to identify issues earlier and it may also have improved Mr Dugan's quality of life in the months prior to his death.[73]

Events from 9 December 2016 onwards

69. Dr Fitzclarence expressed the opinion that from 9 December 2016, when Mr Dugan presented to Acacia health services reporting respiratory symptoms until 19 February 2017 when he was transferred to hospital, there were "many missed opportunities to intervene."[74] In Dr Fitzclarence's opinion, the care Mr Dugan received throughout this time appeared to be "considerably less than would be expected in a community setting."[75] Dr Fitzclarence accepted that at this stage intervention would have been unlikely to have altered his long term outcome, it may well have impacted on Mr Dugan's overall quality of life.

70. Dr Fitzclarence accepted that it was reasonable on 9 December 2016 for the medical officer to have formed a working diagnosis of pneumonia or alternative of chronic obstructive airways disease.[76] However, Dr Fitzclarence commented that after Mr Dugan was prescribed antibiotics on 9 December 2016, she thought a plan for a one month review was unusual, as this was clearly felt to be a case of pneumonia and it would have been prudent to review Mr Dugan again within a couple of days.[77] Further, Mr Dugan was not even reviewed by the prison medical officer after a month as planned. Mr Dugan was not reviewed by anyone from health services again until 31 January 2017, after nearly two months had elapsed, and then only by a nurse.[78]

71. In addition, Dr Fitzclarence expressed the opinion that after the call was received from Mr Dugan's daughter on 9 December 2016 referring to excessive vomiting, this should have prompted a further review as it was important information that had not been mentioned earlier, and may have indicated that

[73] T 21 - 23.
[74] Exhibit 1, Tab 39, p. 8.
[75] Exhibit 1, Tab 39, p. 8.
[76] T 26, 30.
[77] Exhibit 1, Tab 39.
[78] Exhibit 1, Tab 39.

Mr Dugan was "sicker than was realised."[79] Dr Fitzclarence accepted that vomiting can be a symptom of pneumonia but it can also be a sign of an allergy reaction to medication or multiple other things, so this reported symptom warranted review.[80]

72. Dr Fitzclarence was concerned that there was no recognition by the nurse on 31 January 2017 of a number of red flags,[81] including haemoptysis (coughing blood), tachycardia (high pulse rate) and chest pain. Despite these serious symptoms, the nurse did not escalate Mr Dugan's care to a doctor, either on site or by e-consult. Dr Fitzcalrence also expressed the opinion that the call from Mr Dugan's daughter that afternoon was another red flag that together with the other obvious red flags noted that day, "should have guaranteed an immediate escalation of care."[82]

73. Even when Mr Dugan finally saw a doctor on 6 February 2017, things did not improve. It appears the doctor felt Mr Dugan could either have had pneumonia or lung cancer, but there was no urgent referral to hospital for investigation. The doctor did request an urgent x-ray, but Dr Fitzclarence explained at the inquest that unless you transfer a prisoner to hospital to be reviewed in the emergency department, it is unlikely you would order a test one day and get it the next day because of transport and logistics issues. Indeed, there was other evidence at the inquest that the usual wait time for an urgent x-ray request directly from Acacia can be two and a half to three weeks.[83] It would appear that the prison medical officer was unaware that this was the likely timeframe at the time they made the request.

74. Dr Fitzclarence expressed the opinion that from 31 January 2017, or on any of the days after, it would have been reasonable to transfer Mr Dugan to hospital to get help from the Emergency Department physicians as they are able to do things that are unable to be done in the prison setting, including urgent chest x-rays.[84] It was explained that in an Emergency Department, all investigations can be done and a firm diagnosis and treatment plan achieved often within 24 to 48 hours.[85]

[79] T 31.
[80] T 31.
[81] T 26.
[82] Exhibit 1, Tab 39, p. 5.
[83] T 41.
[84] T 26 - 27.
[85] T 42.

75. Dr Fitzclarence also commented that the medical officer did not order cytology, which might (and later did) demonstrate cancer cells, although he did order an urgent sputum and some blood tests.[86]

76. On 8 February 2017 the blood results returned with an elevated white cell count and neutrophilia, which in this setting were indicative of infection, but Dr Fitzclarence notes there is no indication in the medical record that this was recognised or any action taken.[87]

77. On 10 February 2017, when the doctor reviewed Mr Dugan again, there had still been no chest x-ray performed, and there is no record of a pulse rate or respiratory rate, blood pressure or oxygen saturations. Nevertheless, the doctor reassured Mr Dugan he was getting better. This appears to have been based on the fact that he could hear less crackles in Mr Dugan's chest after he had taken a course of different antibiotics. Dr Fitzclarence observes that there is "no evidence from the notes to support the fact that Mr Dugan was improving."[88] However, working on the belief that he was, the doctor simply prescribed another course of antibiotics and scheduled another review the following Wednesday, being another five days away.[89]

78. In any event, Mr Dugan was not reviewed again the following Wednesday. In fact, he was not reviewed at all until a medical emergency was called in the early hours of 19 February 2017, nine days later. At this point, Mr Dugan was complaining of difficulty breathing and was bringing up thick blood-stained sputum. He weighed only 47 kg. At this stage, Acacia prison health staff finally sent Mr Dugan to the Emergency Department at Midland Hospital.[90]

79. Dr Fitzclarence acknowledged that "there are many imposts and obstructions in delivering adequate health care in prison settings related to staff adequacy, access to prisoners and access to transport to appointments."[91] However, even making allowance for these difficulties, Dr Fitzclarence stated that in her opinion the health care Mr Dugan received while at Acacia prison was not commensurate with community standards.[92] Dr Fitzclarence also noted the delay in referral for orthopaedic review while Mr Dugan was in the care of the

[86] Exhibit 1, Tab 39.
[87] Exhibit 1, Tab 39.
[88] Exhibit 1, Tab 39, p. 6.
[89] Exhibit 1, Tab 39, p. 6.
[90] Exhibit 1, Tab 39, p. 6.
[91] Exhibit 1, Tab 39 p. 8.
[92] Exhibit 1, Tab 39.

Department's Prison Health services, but otherwise felt that the care he received from the Department was commensurate with community standards.[93]

80. Dr Fitzclarence commented that once Mr Dugan was in hospital Acacia staff were quite diligent in their advocacy for him and liaised with his family to keep them informed.

81. Dr Fitzclarence acknowledged that since Mr Dugan's death it appears there have been a lot of attempts to "address the gaps"[94] in healthcare at Acacia Prison that were highlighted in her report, which she commented is to be commended. Dr Fitzclarence emphasised the need for ongoing education of all doctors to ensure good documentation and good reviews, including always reviewing the documentation when seeing a patient or even if just writing a prescription, in order to create a "safety net"[95] to prevent similar cases to Mr Dugan's.

Professor Myers

82. After being provided with a copy of Dr Fitzclarence's report, Serco engaged its own expert to conduct an independent review of the matter and consider the issues raised and provide a report to the Court. Associate Professor Paul Myers undertook that review and prepared a report and also spoke to that report at the inquest. A/Professor Myers is a General and Vascular Surgeon with wide experience in general surgery, including at times thoracic surgery. He is based in New South Wales and regularly provides medico-legal services in Australia, having ceased operative surgery at the end of 2016 and retired from clinical consulting work in 2017. A/Professor Myers does not claim expertise in the specific treatment of carcinoma of the lung, nor in the provision of health care for people in custody, but he was able to provide an opinion based upon his general knowledge of those areas as well as his specialist knowledge.[96]

83. A/Professor Myers noted in his report that Carcinoma of the lung is, in Western societies, the major type of cancer causing death. This is because of the inherent nature of cancer of the lung, but also because the diagnosis is often made at a late stage when the cancer is no longer curable. There are currently no generalised screening tests for lung cancer that are accepted as applicable to populations as a whole and many of the symptoms of lung cancer (such as fatigue and weight loss) are very generalised and not specific to, or especially indicative of, lung cancer. A/Professor Myers indicated that more specific

[93] Exhibit 1, Tab 39.
[94] T 19.
[95] T 23.
[96] T 4; Exhibit 1, Tab 42.2.

symptoms that might direct attention to the lungs, such as coughing up of blood (haemoptysis) tend to occur relatively late.[97] Professor Myers also noted that the most common cause of coughing up blood is from chronic bronchitis or chronic obstructive airways disease, so it is not only a sign of lung cancer and there can be a non-sinister cause.[98]

84. A/Professor Myers noted that Mr Dugan's first recorded significant weight loss was on 5 February 2017, when he had dropped 9 kg in a year, and he had dropped a further 5 kg in weight within two weeks when he was seen again on 19 February 2017. He stated that "these measurements were very highly significant of some major health issue."[99] A/Professor Myers stated that the significant weight loss, which was otherwise unexplained, was something that he would expect a medical officer to take some notice of and start to try to investigate the cause.[100]

85. The other significant symptoms was Mr Dugan's complaints of coughing up blood, with a cough (productive but with white sputum, not blood) first noted on 9 December 2016.

86. A/Professor Myers agreed with Dr Fitzclarence that from December 2016 there were signs indicative of a more major problem for Mr Dugan.[101]

87. This was followed by complaints of coughing up blood on 31 January 2017 and thereafter. A/Professor Myers explained that expectorating white sputum is very common, and not specific to lung cancer, and when associated with some crackles in the lung in December 2016, it was not unreasonable in isolation at that point to think it was most likely to be from an infection, for which he was then prescribed antibiotics.[102] A/Professor Myers noted he was seen again on 31 January 2017 and at this stage Mr Dugan complained of blood in his sputum, which was the first signs of his specific disease of lung cancer, and he had also lost a significant amount of weight.[103] A/Professor Myers noted that Mr Dugan was also a smoker, which is the major risk factor for lung cancer, so in the context of Mr Dugan being a known cigarette smoker, the other symptoms should have raised "a lot of red flags"[104] and "indicated that lung cancer was

[97] T 6; Exhibit 1, Tab 42.2.
[98] T 5, 13.
[99] Exhibit 1, Tab 42.2, p. 5.
[100] T 8.
[101] Exhibit 1, Tab 42.2, p. 9.
[102] Exhibit 1, Tab 42.2.
[103] T 6 - 7.
[104] T 7; Exhibit 1, Tab 42.2, p. 7.

very high on the list of possible diagnoses."[105] His elevated pulse rate, in that context, would have added to the picture.[106]

88. A chest x-ray was ordered, but not completed, and Mr Dugan was not sent to hospital until he collapsed in prison on 19 February 2017 for a specialist review. A/Professor Myers acknowledged that this indicated there was a delay in assessing Mr Dugan, once he was showing specific symptoms of his lung disease, although he was unable on the materials before him to identify why that was the case.[107]

89. As to the other issues identified by Dr Fitzclarence, Professor Myers accepted that Mr Dugan's orthopaedic issues, lack of regular checks and failed follow-up of his dental issues and after his inguinal hernia repair were not ideal, but he felt they were relatively minor matters and had no bearing on Mr Dugan's demise.[108] A/Professor Myers did note that, in retrospect, Mr Dugan's care appeared to have been a little discontinuous and 'jerky' and he agrees it would be reasonable to ensure prisoners, particularly those over 60 years of age, have annual healthchecks.[109] However, in the case of Mr Dugan he still felt it would have made little difference.[110]

90. A/Professor Myers doubted Dr Fitzclarence's opinion that if there had been earlier intervention, it may well have impacted on his overall quality of life. Although he conceded his care from early December through to his diagnosis of lung cancer could have been smoother. In his opinion, Mr Dugan was inevitably going to decline rapidly from December until his death in early May.[111]

Dr Rowland

91. Dr Joy Rowland is the current Director of Medical Services for the Department. Dr Rowland gave evidence at the inquest in relation to the healthcare provided to Mr Dugan, both by the Department and by Acacia as a subcontractor for the Department.

92. Dr Rowland conceded that while Mr Dugan was in the care of the Department his orthopaedic referral should have been revisited earlier than it was. Since that time, there have been improvements in the medical documentation to ensure

[105] Exhibit 1, Tab 42.2, p. 7.
[106] T 12.
[107] Exhibit 1, Tab 42.2, p. 9.
[108] Exhibit 1, Tab 42.2, p 9.
[109] Exhibit 1, Tab 42.2, p. 11.
[110] Exhibit 1, Tab 42.2, p. 12.
[111] Exhibit 1, Tab 42.2 p. 10.

that issues such as this are written down as part of the prisoner's future health plan, to ensure they are revisited at a particular time. There is also no limitation regarding remand status or sentence status in relation to referrals, as there sometimes was in the past.[112]

93. Dr Rowland also conceded that something must have gone wrong with Mr Dugan's orthopaedic referral after it was finally written. Even though prisoners at the mercy of public hospital waiting lists, like any member of the community, Dr Rowland felt the length of time without a response was excessive here. Dr Rowland noted that two doctors had mentioned writing referrals in the medical notes and she had tried to track down the history and outcome of the referral(s) but it was at a time prior to the particular record system being put in place so she was unable to identify who received the referral, what they triaged it at and why he didn't get an appointment with the Department of Health. All she could confirm was that the Department did not receive any offers of an orthopaedic appointment for Mr Dugan. A safety net has now been put in place to ensure that lost referrals are chased up by the Department by the doctors putting in place a future visit where the outcome of the referral is monitored and delays can be identified and attempts made to progress a referral or re-refer if required.[113] The Department is also looking at how it can improve electronic tracking of referrals in conjunction with the Department of Health, to enable them to track the progress of a referral through the Department of Health.[114]

94. As to the opinions on the standard of health care provided to Mr Dugan, Dr Rowland concurred with the opinions of Dr Fitzclarence and Professor Myers, but indicated her expectations are closer to Dr Fitzclarence's in terms of having a higher expectation of what primary healthcare can achieve and a similar view that there needs to be proactive health service provision within prisons given the patient cohort generally have a very poor history of use of healthcare services in the community, which results in many prisoners presenting with unresolved issues, and they continue a poor pattern of self-presentation in prison. Therefore, Dr Rowland agrees with Dr Fitzclarence that there needs to be more regular health reviews to proactively seek out a prisoner's current health status and review what preventative health care they might be due for, rather than relying on a prisoner to self-present if they have symptoms or issues.[115]

[112] T 34 – 35.
[113] T 36, 47.
[114] T 37.
[115] T 37 - 39.

95. In Mr Dugan's case, Dr Rowland felt the planned follow up and ability to follow through intended care was missing at Acacia, with no regular follow ups for a number of years and even once an acute issue was identified, still planned follow-up did not occur. Dr Rowland also commented that the non-recognition of the severity of Mr Dugan's illness suggested issues in the clinical knowledge base, education base and expectation base of staff.[116] Dr Rowland accepted that it was reasonable on 9 December 2015 to presume Mr Dugan was suffering from pneumonia and try some antibiotics, but as a general practitioner she would want to know that the symptoms had completely cleared with successful treatment, or she would be initiating further investigations as to why he has got focal lung signs. This was not done. Dr Rowland noted that Mr Dugan effectively fell "off their radar" until 19 February 2017.[117]

96. Dr Rowland conceded that the new system described by Ms Pansey Stewart, the Head of Health Care for Serco at Acacia Prison in her report, which involves regular review through annual health assessments, with a specific staff member tasked to ensure they are booked and occur, suggests Acacia has now implemented much more robust systems for follow-up of patients.[118]

Could Mr Dugan's death have been prevented?

97. While properly concerned about the lack of regular annual health-checks, and the failure to follow-up Mr Dugan and escalate his care when he was exhibiting symptoms that should have raised suspicions that there was something significantly wrong with Mr Dugan, Dr Fitzclarence accepted that earlier diagnosis probably wouldn't have altered the outcome.[119]

98. Whilst noting that there was some delay in assessing Mr Dugan once he was showing significant symptoms, such as the haemoptysis in late January 2017, A/Professor Myers also indicated that "the likelihood that this delay made any difference to Mr Dugan's outcome is negligible."[120] He stated that it was his "considered opinion that the outcome would have been no different had Mr Dugan been diagnosed … in December 2016."[121] While Mr Dugan was unfortunately only diagnosed at a late stage in his disease, when it had progressed to the stage that it was incurable, A/Professor Myers commented that "this is often the natural history of the diagnosis of lung cancer."[122]

[116] T 39.
[117] T 44.
[118] T 39.
[119] T 23.
[120] Exhibit 1, Tab 42.2 p. 9.
[121] T 7; Exhibit 1, Tab 42.2 p. 9.
[122] Exhibit 1, Tab 42.2 p. 9.

99. A/Professor Myers was unable to say how long Mr Dugan would have had the tumour, as he had not been provided with all of the information and imaging, but he did explain that doubling times are such that the number of cells increases exponentially, so a tumour can go from not particularly large to quite large, quickly. He also indicated that where the lung cancer is in the upper lobe, then there are unlikely to be much in the way of symptoms, other than it causing haemoptysis and perhaps some early infection because the airways get blocked off, which were both present here. Therefore, A/Professor Myers gave evidence that it is impossible to say how quickly Mr Dugan's cancer grew, other than to say it can grow very significantly, very quickly.[123]

100. A/Professor Myers commented that Mr Dugan's form of lung cancer was large cell carcinoma, which in fact has a higher incidence in non-smokers, as opposed to small cell carcinoma, which smokers are more liable to contract. However, smokers can also develop large cell carcinoma, as apparently occurred here.[124] Either way, the cancer can be fast growing and difficult to diagnosis at an early stage. Dr Rowland also noted that the speed at which lung cancers grow is not very well documented.[125]

101. I accept the expert evidence that Mr Dugan's death was unlikely to have been prevented if it had been diagnosed in December 2016, when he first began to have some obvious symptoms. However, I also accept the evidence of Dr Fitzclarence and Dr Rowland that regular annual health checks are an important part of preventative health care and their absence was a missed opportunity to identify Mr Dugan's unexplained weight loss, which may have led to an earlier diagnosis and the possibility of doing more to save his life.

102. I also accept the evidence of Dr Fitzclarence and Dr Rowland that comfort measures are also important. If Mr Dugan had been sent to hospital in early February, at the time it had become clear that an urgent chest x-ray was required, he might have been saved some further unnecessary suffering in those three weeks before he was finally diagnosed and treatment and comfort care initiated.

Recent improvements at Acacia Prison Health Services

103. As noted above, Ms Stewart, the Head of Health Care for Serco at Acacia Prison, provided a statement in relation to the operations and standards of the

[123] T 9 – 10.
[124] Exhibit 1, Tab 42.2 p. 8.
[125] T 44.

Acacia Prison Health Service for this inquest. Ms Stewart is a registered nurse and has been employed by Acacia since 2007 as a nurse, and in her current role since September 2016.[126]

104. Ms Stewart indicates in her report that Serco accepts that there may have been areas where Mr Dugan's access to, and experience with, health care services while he was at Acacia could have been improved. Ms Stewart noted there was no record of Mr Dugan not being granted appointments but she conceded he did not undergo an annual health assessment for every year he was at Acacia, which may have been an appointment was made and he did not present (records were not always kept for such non-attendances at that time) or alternatively, due to resourcing challenges at the particular time, there may have not been sufficient staff to ensure scheduling of annual health assessments. At that time, there were challenges meeting demand for medical appointments requested by patients due to an increasing overall population and an increase in complex acute patients, as well as staffing challenges. Following Mr Dugan's death, these are matters that have been the subject of ongoing scrutiny and improvement.[127]

105. I am advised that Acacia now has a dedicated nurse whose role it is to carry out annual health assessments and a monthly report is produced to identify all patients who do not already regularly access health services and who are due for such an assessment. It is, of course, a matter for the individual patient whether they attend such an appointment, but non-attendance is recorded.[128]

106. Ms Stewart also acknowledged Mr Dugan's long wait time for an orthopaedic review. She noted long wait times in the public system are not unusual and the reason for his delay is unclear but advised that procedures in relation to specialist referrals have since been improved, and outstanding referrals are followed up by a designated staff member to make sure no appointments or referrals slip through the system.[129]

107. Ms Stewart noted Mr Dugan had access to a dentist, and failed to attend a scheduled appointment, so she suggested there were no obvious barriers to him receiving dental treatment. However, as part of Acacia's efforts to improve on services and procedures, the Health Service has conducted extensive work to improve patient access to dental services based on clinical need and priority, and an electronic register is maintained of all patients referred for dental services, so follow-up can be done if required.[130]

[126] Exhibit 1, Tab 43.
[127] Exhibit 1, Tab 43.
[128] Exhibit 1, Tab 43.
[129] Exhibit 1, Tab 43.
[130] Exhibit 1, Tab 43.

108. Ms Stewart also advised that Acacia's Health Service has improved documentation in relation to consultations and patient management to encourage greater detail in the notes to ensure continuity of care of patients. It is now standard and required practice that any nurse or medical officers seeing a patient for a consultation must review the Electronic Health Online (EcHO) medical record from the previous consultation(s) to get a broad comprehensive picture of the patient's history and presentation. This will aid identification of 'patients of concern' and ensure they are followed up and managed appropriately. There is a register for identified patients of concern, which tracks high risk prisoners and ensure they receive regular welfare checks to ensure they do not need escalation of care. It is anticipated that in a case such as Mr Dugan's in the future, there would be a greater level of recognition and follow up based on these new procedures.[131]

Final comments on Treatment, Supervision & Care

109. It will be apparent from my general comments and summary of the expert reports above, that although I am satisfied that Mr Dugan's death was unlikely to have been preventable, I find that there were gaps in his health care that constituted missed opportunities to monitor his health and create an opportunity for Mr Dugan to raise any concerns. While I accept that there was always an option for Mr Dugan to seek out medical appointments, I also accept the comments of Dr Fitzclarence and Dr Rowland that there needs to be a proactive approach to health monitoring for prisoners, and Mr Dugan may also have formed the impression that seeking medical help would not get him any quick results, given the delays in his orthopaedic referral and dental appointments, both before and after he was at Acacia.

110. It is important to note that unlike people in the community, there is no option for prisoners to seek out a healthcare provider of their choice, so they need to have confidence in the people who provide the only healthcare service available to them. Mr Dugan's medical history while incarcerated does not show a level of diligence and proactive involvement that would have instilled that confidence in him.

111. When Mr Dugan did make complaint of respiratory symptoms, in early December 2016 during a scheduled health check, he was seen by a medical officer and appropriate steps were taken to trial him on antibiotics, but there was no follow-up to determine if that treatment was successful. By the time Mr Dugan was seen two months later, he was reporting much more sinister

[131] Exhibit 1, Tab 43.

symptoms, which should have raised red flags with the Acacia health staff, and certainly did with his daughter. However, there was not the level of concern that one might have expected, and again not the level of follow-up and escalation of care that would ordinarily be expected.

112. There was some appreciation of the seriousness of Mr Dugan's symptoms when he was seen by a medical officer on 6 February 2017, but the medical officer did not appear to understand the usual timeframes involved in ordering an urgent chest x-ray at that time. Two experienced prison medical officers indicated that the best course for a quick outcome at that time would have been an immediate referral to a hospital Emergency Department. Unfortunately, that was not understood and the order for an urgent chest x-ray was made instead, with no obvious progress on the matter. When the same doctor saw him four days later, the 'urgent' chest x-ray had still not been performed, but the doctor appeared to feel Mr Dugan was improving (although in hindsight this was clearly not the case) and nothing more was done to progress it until Mr Dugan collapsed and was urgently transferred to hospital on 19 February 2017. From that time, he was cared for appropriately and in a timely manner.

113. I accept that all of the Acacia health staff were working on the premise that Mr Dugan had a chest infection/chronic obstructive pulmonary disease (COPD), and had no idea he had lung cancer. Based upon the expert evidence, this assumption was not unreasonable in December 2016. A more proactive approach to his follow-up care might have alerted them to the possibility it was something more sinister at an earlier stage than late January 2017. However, from 31 January 2017 there were red flags that should have alerted health staff to this possibility and led to an immediate escalation of his care. Unfortunately, and it is not entirely clear why as we do not have accounts from the individual health staff, it was not recognised and Mr Dugan's diagnosis only became clear after he was hospitalised in mid-February 2017.

114. I accept that this late recognition of the seriousness of Mr Dugan's health situation did not ultimately affect the outcome, but I also find that it did adversely affect his level of comfort.

115. I acknowledge that Acacia Prison has made significant changes to its processes and procedures in its health services since Mr Dugan's death, and implemented a more proactive approach to monitoring 'at risk' prisoner's health to ensure that they are monitored and their care escalated quickly when required. There has also been efforts to improve monitoring of referrals to specialist services, to identify and follow-up delays, and improvements to access to dental services. I accept the submission that these changes will limit the likelihood of future

missed opportunities and improve prisoner's connection with regular and vital health services while at Acacia Prison (and also in the Department's prisons, noting the evidence of Dr Rowland).

116. It remains the case that it will be up to the individual patient to choose to accept these services, but it is to be hoped that the improvement in continuity of care and proactive health monitoring will inspire confidence in prisoners to engage with the health services offered.

CONCLUSION

117. Mr Dugan began serving his first term of imprisonment in early 2010, with no expectation of being released until sometime in 2022 at the earliest. His early years in prison appear to have been uneventful, although it was recognised that he had a pre-existing shoulder injury that required surgery. For various reasons, that surgery did not eventuate before he became seriously unwell in early 2017. He was diagnosed with inoperable lung cancer in February 2017 and eventually died in custody, but being cared for at a hospice, in May 2017.

118. Mr Dugan's lung cancer, which ultimately caused his death, most likely arose from his long history of cigarette smoking and was unrelated to his incarceration. The expert evidence indicates that this disease is commonly diagnosed at a late stage, even in the community, and the prognosis (as it sadly was for Mr Dugan) is usually poor. The most that can be said in this case is that there were some missed opportunities, due to a lack of regular annual health checks, to perhaps identify Mr Dugan's lung cancer at an earlier stage, if he was suffering from this disease earlier than when he first began to exhibit symptoms in December 2016. However, this is no more than speculation.

119. What is clear from the evidence is that there was an opportunity to diagnose Mr Dugan's lung cancer earlier than mid-February 2017, which would not have changed the outcome, but might have reduced his suffering for those weeks before he was eventually diagnosed. This is still important as we recognise as a society that we do not wish our loved ones to suffer unnecessary pain when they are dying and comfort care options are available to people with a terminal illness for that reason. This includes for prisoners, who are afforded the same rights to good health care as every member of the community in Australia.

120. Since Mr Dugan's death, Acacia Prison has of its own volition initiated improvements to ensure more regular contact with medical services by prisoners, with an emphasis on monitoring patients' 'at risk' or 'of concern', as well as improved record keeping to ensure continuity of patient care and

treatment. The expert evidence before me acknowledged that these changes will have significantly improved health outcomes for prisoners. In those circumstances, I do not consider it is necessary to make any recommendations arising from Mr Dugan's death.

S H Linton
Deputy State Coroner
15 January 2021