JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	26 AUGUST - 27 AUGUST 2021
DELIVERED	**:**	14 SEPTEMBER 2021
FILE NO/S	**:**	CORC 107 of 2017
DECEASED	**:**	SCOTT, JEREMY MICHAEL

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Prisons Act 1981 (WA)
Sentence Administration Act 2003 (WA)

Counsel Appearing:

Mr W Stops appeared to assist the Coroner.

Mr B Nelson and Mr C Arnold (State Solicitor's Office) appeared on behalf of the Department of Justice and WA Country Health Service.

Ms R Sorgiovanni (Soul Legal) appeared for Mr Colin Nugent.

Mr M Williams (Minter Ellison) appeared for Dr Craig Hendry.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Jeremy Michael SCOTT*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 26 - 27 August 2021, find that the identity of the deceased person was* ***Jeremy Michael SCOTT*** *and that death occurred on 3 July 2017 at St John of God Hospital, Bunbury, from metastatic rectal carcinoma in the following circumstances:*

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INTRODUCTION

1. Jeremy Michael Scott (Mr Scott) was 63 years of age when he died on 3 July 2017 at St John of God Hospital, Bunbury (SJOG), from metastatic rectal carcinoma. At the time of his death, he was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (CEO). Thus, immediately before his death, Mr Scott was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*". In such circumstances, 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 the person received while in that care.[7] On 26 - 27 August 2021, I held an inquest into Mr Scott's death which was attended by his partner, Mr Colin Nugent. The documentary evidence adduced at the inquest included reports from medical experts, the Western Australia Police Force[8] and the Department of Justice (DOJ),[9] with the Brief comprising five volumes.

3. The inquest focused on the care Mr Scott received while he was in custody, as well as on the circumstances of his death. The following witnesses gave evidence at the inquest:

a. Mr Richard Martin (Independent expert, surgeon);
b. Dr Princewill Chuka (treated Mr Scott at Bunbury Regional Prison);
c. Dr Aran Thillainathan (treated Mr Scott at Bunbury Regional Prison);
d. Dr Craig Hendry (Surgeon, treated Mr Scott);
e. Dr Nseabasi (Lilian) Mark-Johnson (Registrar, treated Mr Scott);
f. Dr Cherelle Fitzclarence (reviewed Mr Scott's medical care);
g. Dr Jacinta Cover (Surgeon, treated Mr Scott);
h. Ms Toni Palmer, (Performance Analyst, DOJ); and
i. Dr Joy Rowland, (Director of Medical Services, DOJ).

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[1] Exhibit 1, Vol 1, Tab 5A, Supplementary Post Mortem Report (05.07.17)
[2] Exhibit 1, Vol 1, Tab 3, P92 Identification of deceased person (03.07.17)
[3] Exhibit 1, Vol 1, Tab 4, Death in Hospital form - St John of God Hospital, Bunbury (03.07.17)
[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] Exhibit 1, Vol 1, Tab 2, Police Investigation Report (20.10.17)
[9] Exhibit 1, Vol 2, Tab 15, Death in Custody Review (27.09.19)

MR SCOTT

Background and offending history[10,11,12]

4. Mr Scott was born in England on 5 March 1954, as the youngest of three children. He described his childhood as "*blissfully happy*" and said that as a child, he lived overseas for a time because of his father's postings as a diplomat. After finishing school, Mr Scott was briefly employed as an insurance clerk and then as a salesperson, before coming to Australia in about 1974. In Australia he worked in sales before a brief career as a professional musician. After his band broke up, Mr Scott worked in various roles including as the maintenance manager of a fast-food outlet.

5. In September 1998, in the District Court of Western Australia, Mr Scott was convicted of numerous child sex offences and sentenced to an indefinite term of imprisonment, which was backdated to 17 May 1996. In accordance with relevant legislation, Mr Scott's term was reviewed by the Prisoner Review Board (PRB) every three years.[13]

6. At the completion of his sentence in Western Australia, Mr Scott was to have been deported to New South Wales to be dealt with in relation to historical child sex offences. He was ultimately to have been deported to the United Kingdom (UK). In February 2003, Mr Scott was sentenced to a further six months imprisonment after child pornography was discovered on his prison computer.

Prison History[14,15,16]

7. During his incarceration, Mr Scott had the following placements:

a. ***Casuarina Prison:*** 17.05.96 - 25.08.04 (3,022 days);
b. ***Bunbury Regional Prison:*** 25.08.04 - 21.06.17 (4,682 days);
c. ***South West Health Campus:*** 21.06.17 - 30.06.17 (10 days); and
c. ***St John of God Hospital:*** 30.06.17 - 03.07.17 (4 days).

[10] Exhibit 1, Vol 1, Tab 2, Police Investigation Report (20.10.17), p2
[11] Exhibit 1, Vol 2, Tab 15, Death in Custody Review (27.09.19), pp4-6
[12] Exhibit 1, Vol 2, Tab 15.1, Independent Clinical Review/Assessment (22.04.05), pp7-10
[13] See: *Sentence Administration Act 2003* (WA), s12A & Sch. 3, item 3
[14] Exhibit 1, Vol 2, Tab 15, Death in Custody Review (26.09.19), pp7-10 and ts 27.08.21 (Palmer), p199-204
[15] Exhibit 1, Vol 1, Tab 8, Letter - St John of God Hospital, Bunbury (19.07.17)
[16] Exhibit 1, Vol 2, Tab 15.19, PIC Record of events (21.06.17 - 03.07.17)

8. On admission to prison, Mr Scott was granted protection status due to the nature of his offending and for the first five years of his incarceration, he was a maximum-security prisoner. At Casuarina Prison he was employed in the garments workshop, and although he was assessed as suitable to attend the sex offender's treatment program (SOTP), he declined to engage in any form of treatment.

9. Mr Scott's security rating was reduced to medium in July 2001, and in October 2002, he asked to be assessed for the SOTP. As it happens, his participation in that program was affected by his conviction, in 2003, for possession of child pornography.

10. Mr Scott completed a cognitive skills program in January 2004, and on 25 August 2004, he was transferred to the Bunbury Regional Prison (BRP). While at BRP he was employed as a unit cook/cleaner and he provided hairdressing services to other prisoners.

11. Mr Scott completed the SOTP in October 2007, and a clinical assessment found that although he had made some treatment gains, his risk of re-offending remained high.

12. Although the PRB regularly reviewed Mr Scott's indefinite term, it repeatedly declined to recommend his early release on parole. As a result in 2010, Mr Scott wrote to the Commissioner of Corrections and the Minister for Corrective Services to challenge the assessment that he was at high risk of re-offending and to ask for further counselling to address any outstanding treatment needs. These requests were refused.

13. In January 2011, Mr Scott underwent a psychological assessment to determine his suitability for parole and deportation as well as his risk of reoffending. The assessment recommended that Mr Scott undergo another SOTP, which he completed in September 2011. A further assessment concluded that Mr Scott was now at moderate risk of reoffending but in July 2012, the PRB determined that Mr Scott remained an unacceptable risk to community safety and declined to recommend his early release.

14. In August 2012, Mr Scott applied for an international prison transfer to the UK and in 2014, the PRB recommended he be released on parole, prior to his deportation to the UK. However, the Attorney General decided that Mr Scott's international prison transfer application (which was still outstanding) should be determined first. As it happens, Mr Scott withdrew his international prison transfer application on 12 May 2015 and the Commonwealth Attorney General's Department advised that Mr Scott's application would "*not be progressed any further*".[17,18]

15. At a further review in March 2017, the PRB recommended Mr Scott's early release and immediate deportation to the UK, but Mr Scott's health declined before this recommendation could be acted on. Following abnormal blood test results, Mr Scott was transferred to the Bunbury Regional Hospital (BRH) on 21 June 2017, by staff from Broadspectrum Ltd, who provide contract security services to DOJ.

16. On 28 June 2017, Mr Scott was listed as a "*Terminally ill prisoner - Stage 4*" in accordance with departmental policy, meaning it was expected that his death was imminent. On the same day, approval was given for Mr Scott to be restrained by means of an ankle restraint only. Approval was also given for Mr Scott to receive extended visits and phone calls from Mr Nugent and visits from various prison staff members.[19,20,21]

17. Mr Scott was transferred to SJOG on 30 June 2017, where he was treated palliatively until he died, in the presence of Mr Nugent, at about 7.00 am on 3 July 2017.[22,23,24]

[17] Exhibit 5A, Withdrawal of International Prisoner Transfer Application (12.05.15)
[18] Exhibit 5B, Letter from the Commonwealth Attorney-General's Department (21.05.15)
[19] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021)
[20] Exhibit 1, Vol 2, Tab 15.22, Policy Directive 8: Prisoners with a Terminal Medical Condition
[21] Exhibit 1, Vol 2, Tab 15.19, Email - Bunbury Regional Prison (28.06.17)
[22] Exhibit 1, Vol 1, Tab 4, Death in Hospital form - SJOG (03.07.17)
[23] Exhibit 1, Vol 2, Tab 15.20A, Incident Description Report (03.07.17)
[24] Exhibit 1, Vol 5, Tab 24, Statement - Mr C Nugent, paras 19-22

MEDICAL ISSUES

Overview[25,26,27,28,29,30]

18. During his incarceration, Mr Scott regularly attended prison medical centres for treatment of various minor ailments and conditions. His medical history included: intermittent high blood pressure, high cholesterol, episodes of tinnitus and vertigo, an enlarged prostate, osteoarthritis and migraines.

19. In April 2012, Mr Scott underwent surgery to repair an umbilical hernia which had been detected in November 2011, and in 2014, he underwent cryotherapy for skin tags in his left armpit. Mr Scott also had a long-standing history of an anal fissure and apparent haemorrhoids, and it was subsequently discovered he had metastatic rectal cancer.

Anal/rectal symptoms before 2015[31,32]

20. DOJ records show that Mr Scott regularly complained of rectal and/or anal symptoms from at least 2006. In that year, he complained of rectal bleeding which he blamed on the cholesterol lowering medication he had been prescribed. A Prison Medical Officer (PMO) documented that Mr Scott had a long-standing history of haemorrhoids and had declined a rectal examination. There is no evidence that a colonoscopy or a surgical review was considered at that time.

21. Mr Scott experienced further episodes of rectal bleeding in November 2009 and October 2010, an anal itch in September 2013 and haemorrhoids in September 2014. Further, between July 2015 and November 2016, Mr Scott periodically complained of altered bowel habits, pain on defecation, rectal bleeding and/or haemorrhoids which did not respond to topical creams. He underwent screens for bowel cancer in 2010 and in 2014 which were reported as negative.

[25] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), p1
[26] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p3
[27] Exhibit 1, Vol 1, Tab 11B, Patient Referral - Dr S Churchill (08.11.11)
[28] Exhibit 1, Vol 1, Tab 11B, Letters - Dr C Hendry (16.11.11) & (11.04.12)
[29] Exhibit 1, Vol 1, Tab 11B, Patient Referral - Dr C Gunson (27.10.14)
[30] Exhibit 1, Vol 1, Tab 11B, Letter - Dr C Hendry (12.11.14), p1
[31] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), pp3-4
[32] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021)

Consultation with Dr Chuka - 17 September 2015[33,34,35]

22. On 19 August 2015, Mr Scott was seen by a prison nurse. He reported pain on defecation and said he had been using Rectinol (a topical cream applied to the anus) which was "*not really effective*". The nurse recorded an "*exacerbation of haemorrhoids*" and noted there was "*no protrusion through [the] rectum*". Mr Scott was advised to use ice packs and/or salt baths for pain relief, and a review by a PMO was arranged.

23. On 17 September 2015, Mr Scott saw Dr Princewill Chuka, a visiting PMO at BRP for a "*review of haemorrhoids*". Mr Scott told Dr Chuka that he could feel a haemorrhoid inside his rectum on the left side that was "*not very big*". He said he had been using Rectinol but that his anus had become painful and itchy. He thought this may have been be an allergic reaction and for that reason had started using Baby Oil which "*seemed to have settled it*".

24. Mr Scott denied any rectal bleeding and said that his stool was "*good*". Although not recorded in the consultation notes, Dr Chuka's statement says that Mr Scott mentioned wanting to lose weight which he (Dr Chuka) took to mean that Mr Scott had not been losing weight up to that point.[36,37] Dr Chuka's consultation notes record the fact that Mr Scott was "*not really keen*" to allow him to conduct a rectal examination and that instead, Mr Scott said he would have his haemorrhoids looked at when he was released from prison because he did not like going to hospital in the prison van.

25. Dr Chuka's notes make it clear that Mr Scott wanted to discuss how to best manage the haemorrhoids which he (Mr Scott) assumed he was suffering from. For that reason, Dr Chuka says he suggested a high-fibre diet, drinking plenty of water and that if pain persisted, Mr Scott could try an alternative to Rectinol, namely Rectogesic. The notes also state: "*Advised if the above fail, then surgical approach is indicated*".

[33] Exhibit 1, Vol 5, Tab 25A, Statement - Dr P Chuka, paras 25-33 and ts 26.08.21 (Chuka), pp77-78
[34] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (19.08.15, pp45-46 of 108)
[35] ts 26.08.21 (Chuka), pp77-84 and ts 26.08.21 (Martin), pp 60-65
[36] Exhibit 1, Vol 5, Tab 25A, Statement - Dr P Chuka, para 37
[37] ts 26.08.21 (Martin), pp 61-62

26. Mr Richard Martin is a general surgeon who was engaged by the Court to review Mr Scott's medical care. In Mr Martin's opinion it is likely that the lump Mr Scott felt in his rectum in September 2015, "*was in fact the cancer he eventually died from*". Mr Martin felt that an incorrect assumption by both Mr Scott and Dr Chuka that the "*internal mass*" was a haemorrhoid, had delayed proper diagnosis and treatment.[38]

27. Mr Martin's observations, which were obviously made with the benefit of hindsight, assumes that Mr Scott's rectal tumour was present when Dr Chuka reviewed Mr Scott. Although, as Dr Chuka noted, this is a matter about which no one could be 100% certain,[39] Mr Martin's view was that it was most likely that Mr Scott's tumour was present in September 2015, taking account of cancer growth rates and the fact that a large rectal mass was found on 22 June 2017.[40]

28. Dr Cherelle Fitzclarence (formerly DOJ's Deputy Director of Medical Services) carried out an independent review of Mr Scott's care. She agreed there was a possibility that Mr Scott's rectal mass may have been present in 2015, but noted he had haemorrhoids and an anal fissure which can present in a similar way.[41] Dr Jacinta Cover (the general surgeon who examined Mr Scott under anaesthetic on 22 June 2017) said she was confident that Mr Scott's mass had been present for months but was less confident saying it had been there for years. Dr Cover said that whilst Mr Scott's rectal mass may have been present in 2015, it was also possible it had developed after that time.[42]

29. In any case, Mr Martin noted that a mass in the rectum associated with pain was a "*red flag*" that: "*[S]hould precipitate an urgent investigation of that mass*" and further that: "*Any rectal mass should be referred urgently for a colonoscopy*".[43] At the inquest, Dr Chuka agreed that with the benefit of hindsight, a rectal mass with pain was a red flag that warranted further investigation.[44]

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[38] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), pp4-6 and ts 26.08.21 (Martin), pp12-17
[39] Exhibit 1, Vol 5, Tab 25A, Statement - Dr P Chuka, para 35 and ts 26.08.21 (Chuka), pp79-80
[40] ts 26.08.21 (Martin), pp16-17
[41] ts 27.08.21 (Fitzclarence), pp177-178
[42] ts 27.08.21 (Cover), p195
[43] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), p6 and ts 26.08.21 (Martin), p13
[44] ts 26.08.21 (Chuka), p84

30. It is clearly unfortunate that Mr Scott declined a rectal examination when he was seen by Dr Chuka on 17 September 2015. Such an examination may have detected signs which warranted further investigation. With the benefit of hindsight, it is also regrettable that Dr Chuka did not refer Mr Scott for a colonoscopy at that time. Had this occurred, there is at least a possibility that Mr Scott's rectal mass (if present) may have been detected. There is also the tantalising prospect that had the tumour been detected, Mr Scott might have been offered treatment and possibly even cured.[45,46,47]

31. However, just as there is no way knowing for certain whether Mr Scott's rectal cancer was present in September 2015, there is no way of knowing whether Mr Scott would have consented to a colonoscopy had one been offered by Dr Chuka. Mr Scott had previously declined rectal examinations and had also refused to travel to external appointments in the prison van because of anxiety related to his claustrophobia.[48,49]

32. However, if the rationale for the colonoscopy had been carefully explained, Mr Scott may have agreed to the procedure and, as he had done on 26 separate occasions between 2003 and 2013, he may have consented to travel to hospital using prison transport.[50]

33. At the inquest, Dr Joy Rowland (DOJ's Director of Medical Services) confirmed that PMOs can (and do) write medical certificates recommending alternative transport (e.g.: maxi-taxis etc) for prisoners attending external appointments. Prisoners may also be given medication to assist them to manage their anxiety. However, it is worth noting that decisions about alternative transport arrangements for prisoners attending appointments are made by the Superintendent of the relevant prison, not by a PMO.[51,52]

[45] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (17.09.15, p45 of 108)
[46] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), pp4-6 & pp10-11 ts 26.08.21 (Martin), p28
[47] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), pp4-6 and 27.08.21 (Fitzclarence), pp173-175
[48] See: Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (10.12.14, p54of 108), re cardiac appointment
[49] See: Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (12.03.15, p52 of 108), re dental appointment
[50] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p13
[51] ts 27.08.21 (Fitzclarence), p173; ts 27.08.21 (Rowland), pp221 and ts 27.08.21 (Nelson), p238
[52] ts 26.08.21 (Martin), p37

34. Given the imponderables to which I have referred, all that can really be said is that with the benefit of hindsight it is regrettable that Mr Scott's reports of pain and a lump in his rectum were not fully investigated in September 2015. However, as Dr Rowland pointed out, following Mr Scott's consultation with Dr Chuka, the next recorded mention by Mr Scott of any anal or rectal symptoms (e.g.: lumps, bleeding and/or pain) was not until 20 November 2016.[53,54]

35. Had Mr Scott complained of anal or rectal symptoms prior to 20 November 2016, it is possible that Dr Chuka's plan of a "*surgical approach*" if other measures failed, may have been put into action. Instead, for a period of about 14-months Mr Scott made no recorded complaints about anal or rectal symptoms, even though he was seen by Dr Chuka on several occasions during this period.[55]

Consultation with Dr Thillainathan - 22 November 2016[56]

36. On 20 November 2016, Mr Scott left a message for nursing staff at the medical centre at BRP complaining of increased bleeding and pain from his haemorrhoids, especially after a bowel motion. Mr Scott said he did not require laxatives as his bowel motions were soft, but that he had performed a self-examination and was "*...certain of a large soft body, assuming* (sic) *to be a haemorrhoid*".[57] Following this interaction, a prison nurse arranged for Mr Scott to be reviewed by a PMO.

37. Dr Aran Thillainathan was a PMO who, at the relevant time, was travelling from Perth to provide medical cover at BRP two days per week. Dr Thillainathan reviewed Mr Scott on 22 November 2016, and the consultation notes for that appointment state:

> *Subjective*: Haemorrhoids getting worse, agrees to be referred to a surgeon. Previously declined referrals as [he] did not like getting into a van. *Plan*: Referred to Dr Hendry. Has review in Oct 2017.[58]

[53] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p10
[54] ts 27.08.21 (Rowland), pp205-206
[55] ts 26.08.21 (Martin), pp65-66
[56] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p5
[57] Vol 3, Tab 16, Echo Prison Medical Notes (20.11.16, p24 of 108)
[58] Vol 3, Tab 16, Echo Prison Medical Notes (22.11.16, p24 of 108)

38. Although not mentioned in the notes, Dr Thillainathan recalls asking Mr Scott about the "*large soft body*" and Mr Scott telling him: "*I think it is my haemorrhoid acting up*". Dr Thillainathan also had a clear recollection of his efforts to convince Mr Scott to agree to a surgical review. As well as concerns about claustrophobia whilst travelling in prison vans, Dr Thillainathan says that Mr Scott was also concerned that because he would be accompanied to the surgical review by prison officers, he would be obliged to discuss his sexual practices in their presence.[59]

39. According to Dr Thillainathan, although Mr Scott had disclosed his sexual habits to nursing staff and PMOs, he was very concerned that this information would become more widely known. Interestingly though, Mr Nugent says Mr Scott was "*openly gay while in prison*" and that he had told him (Mr Nugent) that "*he was having anal sex with someone*".[60,61]

40. Dr Thillainathan says Mr Scott declined a rectal examination and although this is not recorded in the notes, Dr Thillainathan recalled that:

> I offered to examine him internally, but he declined. He asked me whether I would find anything other than what the surgeon was going to find. I told him the surgeon would be able to do a more thorough job. He was in pain and did not want to be examined twice given he was going to be referred to the surgeon anyway.[62]

41. In his statement, Dr Thillainathan also said he did not recall asking Mr Scott about rectal pain or bleeding, but he remembered Mr Scott saying that his haemorrhoids were getting worse. Dr Thillainathan also said that if Mr Scott had consented to a rectal examination, he would have performed one. It is particularly unfortunate that Mr Scott declined a rectal examination at this time because Dr Thillainathan may have been able to identify the "*large soft body*" Mr Scott had reported finding.[63]

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[59] Exhibit 1, Vol 5, Tab 22A, Statement - Dr A Thillainathan, paras 38-41
[60] Exhibit 1, Vol 5, Tab 24, Statement - Mr C Nugent, para 30
[61] Exhibit 1, Vol 5, Tab 22A, Statement - Dr A Thillainathan, paras 28 & 42-43
[62] Exhibit 1, Vol 5, Tab 22A, Statement - Dr A Thillainathan, para 44 and ts 26.08.21 (Thillainathan), p141
[63] Exhibit 1, Vol 5, Tab 22A, Statement - Dr A Thillainathan, paras 45-51

42. In any event, Dr Thillainathan diagnosed Mr Scott with haemorrhoids and referred him to Dr Craig Hendry (a general surgeon who conducted clinics at BRP and who had seen Mr Scott on other occasions for other unrelated issues). The purpose of the referral was said to be "*assessment*" and the assigned priority was "*urgent*", meaning Mr Scott was asked to be seen within 30 days. Mr Scott's current clinical condition was described as: "*Worsening haemorrhoids. Previously refused referral but condition has got worse*".[64,65]

43. Dr Thillainathan's referral also listed Mr Scott's usual medications and other medical issues but significantly, there was no mention of the "*large soft mass*" that Mr Scott had reported discovering in his rectum.[66] In my view, this is a particularly unfortunate omission, even in circumstances where Dr Thillainathan was unable to confirm the presence of the mass because Mr Scott had declined a rectal examination.[67]

44. Had Dr Thillainathan's referral included words to the effect of "*patient reports feeling a large soft body in the rectum but declined a rectal examination, so this cannot be confirmed*", Dr Hendry would have been in full possession of the facts. Further, had anyone in the prison system been monitoring delays in the referral being acted on, the reference to a "*large soft mass*" may have prompted urgent follow-up action.

45. At the inquest, Dr Hendry said that he did not rely solely on the information contained in referrals he received and instead took a detailed history from the patient and conducted his own examination. Nevertheless, it is difficult to argue with the proposition that Dr Thillainathan's referral should have referred to the possible presence of a rectal mass because this may have led Dr Hendry to order more urgent investigations.[68]

[64] Exhibit 1, Vol 1, Tab 11B, Patient Referral - Dr A Thillainathan (22.11.16)
[65] Exhibit 1, Vol 5, Tab 22A, Statement - Dr A Thillainathan, paras 51-57
[66] Exhibit 1, Vol 1, Tab 11B, Patient Referral - Dr A Thillainathan (22.11.16)
[67] ts 26.08.21 (Martin), p69
[68] ts 26.08.21 (Hendry), p94

46. The documentary evidence establishes that Dr Hendry's rooms received Dr Thillainathan's referral on 23 November 2016.[69] However despite the referral being marked "*urgent*", Mr Scott was not reviewed until 1 March 2017, when Dr Hendry conducted a clinic at BRP. It appears that Dr Hendry did not conduct clinics at BRP in December 2016 or January 2017 and that nobody in the prison system queried why Mr Scott had not been seen within the requested 30 days.[70,71]

47. As Dr Thillainathan noted in his statement:

> It is possible that Dr Hendry may have been away on a holiday at around the time that I made the referral as he usually took holidays in December and January.
>
> If Dr Hendry was not able to see Mr Scott within 30 days of my referral, I would have expected someone to get in touch to let me know. Ordinarily if I put 'urgent' I would expect to hear back from someone else, either within the Department or Dr Hendry's rooms, saying 'actually the specialist won't be available, would you like to refer to someone else?' I don't recall anyone telling me that Dr Hendry was going to be away on this occasion.[72]

48. At the inquest, Dr Rowland said that at metropolitan prisons, referrals are generally processed by a central agency. However, in regional areas, referrals are often managed directly with the local health provider. As to monitoring whether referrals made by PMOs have been actioned, Dr Rowland said that the present system relies on staff to check this has occurred. She noted that there are ongoing attempts to incorporate a "*hardwire*" solution into Echo, the system used to manage prisoner health records.[73]

49. However, as with all enhancements to electronic systems, the devil is in the detail.

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[69] ts 26.08.21 (Hendry), pp92-93
[70] Exhibit 1, Vol 1, Tab 11B, Patient Referral - Dr A Thillainathan (22.11.16)
[71] Exhibit 1, Vol 1, Tab 11A, Report - Dr C Hendry (28.01.20) and ts 26.08.21 (Hendry), p93
[72] Exhibit 1, Vol 5, Tab 22A, Statement - Dr A Thillainathan, paras 55-56
[73] ts 27.08.21 (Rowland), p224

50. As Dr Rowland explained, a solution which generated alerts in Echo would need to monitor not just the initial referral and whether the prisoner attends their first appointment, but also whether additional appointments have been booked; whether the prisoner has been placed on a waitlist for further treatment; what the treatment outcomes were and/or whether any further treatment was recommended. A key stumbling block has been to identify a "*source of truth*" within the Department of Health (and the various Health Services). This is to ensure that any alerts generated in Echo (that are based on externally provided data) can be relied on as accurate.[74]

51. Dr Rowland said she had recently obtained six spreadsheets from the Department of Health containing "data dumps" and relevant treatment codes which could form the basis of alerts within Echo. But, and this is a very big but, a major upgrade to Echo like this one requires a team staffed with appropriately skilled people who can dedicate their energies to the task. As Dr Rowland observed:

> [W]ith projects such as these, in the absence of someone whose job it can be to run with it as their prime focus, it falls down to be incrementally divided amongst a bunch of busy staff trying to do it as an add-on…Being able to have project officers or staff who we can give such projects to, to run it from the whole building it, process mapping, identifying issues, implementation, staff education, monitoring it afterwards, etcetera, that's a resource we don't have.[75]

52. The issue of appropriately managing referrals has arisen in other inquests involving deaths in custody and is a matter which ought to be addressed on a priority basis. When PMOs make external referrals, they do so for good reason and with the expectation that those referrals will be actioned in a timely manner. Section 7(1) of the *Prisons Act 1981* (WA) places important statutory responsibilities on the CEO and relevantly provides:

> Subject to this Act and to the control of the Minister, the chief executive officer is responsible for the management, control, and security of all prisons and the welfare and safe custody of all prisoners.

[74] ts 27.08.21 (Rowland), p225
[75] ts 27.08.21 (Rowland), pp224-225

53. The concept of prisoner welfare clearly includes managing the health of prisoners, and it is therefore incumbent on the CEO to ensure that appropriate systems are in place for that purpose. The fact that four years after Mr Scott's death, there is still no system in place to manage external referrals made by PMOs, is clearly unacceptable. In Mr Scott's case, although his referral was marked urgent with an expectation he would be seen within 30 days, Mr Scott was not seen for 100 days.[76]

54. Had an alert system been in place within Echo prior to Mr Scott's death, it seems likely that Dr Thillainathan's referral would have been identified as overdue and managed appropriately. Because of the importance of ensuring that referrals made by PMOs are actioned in a timely manner, I urge the Department to allocate appropriate resources, including the establishment of a project team, so that this long-standing issue can be promptly resolved.

Consultation with Prison Nurse - 26 January 2017[77]

55. Mr Scott saw a prison nurse on 26 January 2017, with "*increased intensity rectal pain on [an] intermittent basis*". He said his bowel movements were "*very painful*" and he had been having "*runny stools*" for months. He also said he was using a sauce bottle to squirt warm salty water into his rectum whilst showering, to ease his bowel movements.[78]

56. The nursing entry for 26 January 2017, also notes that Mr Scott reported using copious amounts of Rectinol as a "*comfort measure*" and that he had been able to "*palpate a hard lump in [his] rectum, which he thinks is a haemorrhoid*". Mr Scott disclosed that he had engaged in anal sex for many years but had not done so for the "*past few years*" because of discomfort. The prison nurse performed an external examination and noted a small flat haemorrhoid but no anal fissure. Mr Scott was given Anusol (a topical cream for haemorrhoids) for "*comfort pre-bowel movements*".[79,80]

[76] Exhibit 1, Vol 1, Tab 11B, Patient Referral - Dr A Thillainathan (22.11.16)
[77] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (26.01.17, p22 of 108)
[78] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (26.01.17, p22 of 108)
[79] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (26.01.17, p22-23 of 108)
[80] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p5

57. The prison nurse also noted that Mr Scott was due to see Dr Hendry on 1 March 2017, for: "*?colonoscopy and investigations for internal haemorrhoids*", but the fact that this urgent referral was by then, 66 days old, does not appear to have been recognised.[81,82,83]

58. In my view it is surprising that even though Mr Scott was now reporting a "*hard lump*" in his rectum having previously reported a "*large soft mass*", he was not booked in to see a PMO on an urgent basis. Instead, the nursing notes merely record the fact that Mr Scott was due to see a PMO on 7 February 2017, with respect to blood test results.[84]

59. In passing I note that there is no documentation to explain how Mr Scott was able to access Rectinol (and/or other creams) whilst in prison or indeed the quantity and frequency of his use of these products. Dr Rowland noted that although prison nurses are authorised to dispense products such as Rectinol, this usage should be recorded.[85]

60. Apart from the need to account for the expenditure of public money, an important benefit of keeping a visible record of nurse-initiated medications is that ongoing use may indicate a chronic condition warranting a review by a PMO. As noted, Mr Scott did not complain of anal or rectal symptoms for a 14-month period after 17 September 2015. However, had prison clinical staff been able to monitor Mr Scott's use of Rectinol, it may have prompted a PMO review before November 2016.[86]

Consultation with Dr Hendry - 1 March 2017

61. Dr Hendry saw Mr Scott at BRP on 1 March 2017 and although he conducted an external examination of Mr Scott's anal area, due to "*patient reluctance and discomfort*", Dr Hendry did not perform a rectal examination.

62. Dr Hendry wrote to Dr Thillainathan on the day of his examination and described Mr Scott's presentation in these terms:

[81] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (26.01.17, p22 of 108)
[82] Exhibit 1, Vol 1, Tab 11B, Patient Referral - Dr A Thillainathan (22.11.16)
[83] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p5
[84] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (26.01.17, p22-23 of 108)
[85] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p14 and ts 27.08.21 (Rowland), p213-214
[86] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p14 and ts 27.08.21 (Rowland), p213

> Thank you for your referral of this 62-year-old chap who has had quite severe anal pain with defecation and intermittent bleeding for over 12 months. His bowel habit tends to be soft even loose at times. The problem does seem to have [a]risen following 12 months of anal intercourse. There is no known family history of colorectal disease. On examination there is some perianal excoriation and a posterior sentinel pile. A chronic fissure is present which no doubt accounts for the symptoms.[87]

63. It appears that Dr Hendry was not made aware that Mr Scott had previously reported feeling both soft and hard lumps in his rectum, either by Dr Thillainathan or by Mr Scott. At the inquest, Dr Hendry explained that the "*posterior sentinel pile*" he saw was not a haemorrhoid, but rather scar tissue associated with an anal fissure.[88]

64. As noted, when Mr Scott saw Dr Thillainathan on 22 November 2016, he reportedly declined a rectal examination reportedly because he didn't want to undergo the procedure twice. Mr Scott had agreed to be referred for a surgical review and was aware that Dr Hendry would perform a rectal examination during their consultation. In those circumstances, it is perhaps surprising that Mr Scott refused an internal examination when he was eventually seen by Dr Hendry.[89]

65. In any event, Dr Hendry identified an anal fissure which he thought accounted for Mr Scott's symptoms. Further, as noted, Mr Scott reported no family history of colorectal cancer and does not appear to have mentioned the internal masses he had told other clinicians about.

66. With the benefit of hindsight, it is obviously unfortunate that Dr Hendry did not conduct an internal examination when he reviewed Mr Scott. Had this occurred, it is almost certain that Mr Scott's rectal cancer would have been detected. However, Mr Scott's cancer must have been in an advanced state by that stage and it seems unlikely that his clinical outcome would have been any different had the mass been found at that time.

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[87] Exhibit 1, Vol 1, Tab 11B, Letter - Dr C Hendry to Dr A Thillainathan (01.03.17) and ts 26.08.21 (Hendry), p105
[88] ts 26.08.21 (Hendry), p97
[89] Exhibit 1, Vol 5, Tab 22A, Statement - Dr A Thillainathan, para 44 and ts 26.08.21 (Thillainathan), p141

67. Dr Hendry's letter to Dr Thillainathan following the consultation recommended that Mr Scott's anal fissure be surgically repaired (by a procedure known as a sphincterotomy) due to the chronic nature and severity of Mr Scott's symptoms.[90] Dr Hendry said he had advised Mr Scott of the small risk of bleeding and minor incontinence following the procedure and the surgery was booked for 17 May 2017, although as I will explain, the procedure was subsequently deferred.[91,92]

68. After Mr Scott's death, Dr Hendry prepared a "*Case Summary*" for the purposes of the WA Audit of Surgical Mortality, which reviews all patients who die under surgical care (the Summary). At the time the Summary was prepared, Dr Hendry was aware that a coronial investigation into Mr Scott's death was either on foot or would be conducted.[93] In the Summary, Dr Hendry addressed the deferral of Mr Scott's surgical procedure in these terms:

> The surgery booking was given an intermediate urgency (intervention within 90 days) and a date was allocated 17th May 2017. The logistics of managing prisoners at Bunbury Regional Hospital includes allowing only one prisoner per list, and last minute cancellation due to hospital capacity limits is more likely due to the requirement that all cases are managed as inpatients. This in fact occurred and the operation was rescheduled to 26th July 2017.[94]

69. At the inquest, Dr Hendry said that although he was "*98%*" certain that Mr Scott's symptoms were related to his chronic anal fissure, he planned to examine Mr Scott under anaesthetic to exclude a more sinister cause for his symptoms.[95] Unfortunately, the consent and admission paperwork for the booked surgery appears to have gone missing from Mr Scott's BRH medical record. Nevertheless, Dr Hendry says that on the consent form Mr Scott signed, he (Dr Hendry) would "*have put it down as anorectal examination and then query…anal sphincterotomy*".[96]

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[90] See: https://www.healthdirect.gov.au/surgery/lateral-internal-sphincterotomy
[91] Exhibit 1, Vol 1, Tab 11B, Letter - Dr C Hendry to Dr A Thillainathan (01.03.17)
[92] Exhibit 1, Vol 5, Tab 28 - BRH screenshot re Mr Scott's anorectal examination
[93] ts 26.08.17 (Hendry), p104
[94] Exhibit 1, Vol 1, Tab 11C, Case Summary - Dr C Hendry (17.08.17), p2
[95] ts 26.08.21 (Hendry), p108
[96] ts 26.08.21 (Hendry), p100

70. A screenshot from BRH's "*WebPAS*" system appears to show Mr Scott being scheduled for an "*anorectal examination*" on 17 May 2017.[97] Further, although not directly corroborative, there is an entry in Mr Scott's Echo record (after he was seen by Dr Thillainathan on 14 March 2017 to discuss blood tests results) that states: "*Has aptt [booked] for colonoscopy and surgical repair of anal fistula*".[98]

71. I accept that this entry appears to suggest that Dr Thillainathan was under the impression that Mr Scott was to undergo some form of rectal investigation in addition to a sphincterotomy.

72. I also note that in the Summary, Dr Hendry states that the history he obtained from Mr Scott on 1 March 2017, "*was fully consistent with ano-rectal pathology*". Dr Hendry noted a "*chronic posterior fissure*", but found no features of complicated haemorrhoids. Dr Hendry also confirmed that a digital examination was not performed due to patient reluctance and discomfort, and despite what he said in his earlier letter to Dr Thillainathan, Dr Hendry states:

> Surgical intervention by anal examination under anaesthesia was advised due to the chronicity and severity of the symptoms.[99]

73. Regardless of what Dr Hendry's plan was, in my view his letter to Dr Thillainathan on 1 March 2017, was seriously deficient. In that letter, there is no mention whatsoever of the plan to conduct an anal examination under anaesthesia.

74. Instead on its face, the letter makes clear that Mr Scott was to undergo a sphincterotomy to deal with his chronic anal fissure which: "*no doubt accounts for the symptoms*".[100] At the inquest, Dr Hendry conceded that his letter to Dr Thillainathan "*could have been made more comprehensive*".[101]

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[97] Exhibit 1, Vol 5, Tab 28 - BRH screenshot re Mr Scott's anorectal examination and ts 26.08.21 (Hendry), p59
[98] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (14.03.17, pp21-22 of 108)
[99] Exhibit 1, Vol 1, Tab 11C, Case Summary - Dr C Hendry (17.08.17), p1
[100] Exhibit 1, Vol 1, Tab 11B, Letter - Dr C Hendry to Dr A Thillainathan (01.03.17)
[101] ts 26.08.21 (Hendry), pp105-106

75. In my view, Dr Hendry's letter should have referred to his plan to examine Mr Scott's rectum under anaesthetic to exclude any sinister explanation for Mr Scott's symptoms. This would have put prison clinical staff on notice that there was at least the possibility that Mr Scott's symptoms may not be related to his chronic anal fissure and perhaps have made them more vigilant with respect to the anal or rectal symptoms being reported by Mr Scott.

Consultations with Prison Health Service after 1 March 2017

76. When seen by a prison nurse on 25 April 2017, Mr Scott complained of ongoing rectal pain and said he was dismayed that his surgery had been deferred until July 2017.[102] On 20 May 2017, Mr Scott reported that although he had previously had diarrhoea, he had experienced constipation for the previous five days. He also reported feeling a constant need to empty his bowels but being unable to do so. He declined a rectal examination and was given a "*Fleet enema*" (with limited effect) as well as Panadeine Forte. He reported feeling "*somewhat better*" the following day but that his urge to empty his bowels continued "*unabated*".[103,104]

77. On 22 May 2017, a prison nurse was asked to review Mr Scott after he was found lying curled up on the bed in his cell, crying. Mr Scott reported a bowel motion that morning but that he felt continued pressure to open his bowels. He said he was "*depressed*" and "*feeling a bit overwhelmed at the moment about his medical problems, in light of the fact that his operation was cancelled last week and rebooked*". Mr Scott reportedly agreed that his current issue was "*emotional*" and the nurse "*strongly encouraged*" him to return to the prison medical centre if he had any ongoing issues or concerns.[105]

78. Mr Scott saw PMO, Dr Philip Hames, on 24 May 2017, and complained of increased pain related to his anal fissure. He asked Dr Hames to let Dr Hendry know "*how much he is struggling*" and it appears that Dr Hames did so.[106,107]

[102] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p6
[103] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), p4
[104] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p6
[105] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (22.05.17, p16 of 108)
[106] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (24.05.17, p16 of 108)

79. Dr Hendry says that on 24 May 2017, he was made aware that Mr Scott's anal symptoms were becoming "*very severe*" and Mr Scott was "*becoming incapacitated by pain and faecal urgency*". As a result, Dr Hendry's office "*reshuffled cases*" and allocated an earlier date for Mr Scott's surgery, namely 3 July 2017. Dr Hendry says he advised the prison to send Mr Scott to the emergency department at BRH (ED) "*if the situation became urgent enough*".[108]

Examination by Dr Mark-Johnson - 26 May 2017

80. On 26 May 2017, Mr Scott attended the prison medical centre, complaining of urine retention and constipation. He was reviewed by a nurse and found to be "*anxious*$^{+++}$*, shaking and generally very distressed*". Mr Scott described a history of nausea, shakes and anal pain and said he had not had a "*decent*" bowel motion for a week. After an electronic consultation with Dr Hames, Mr Scott was taken to BRH.[109,110]

81. Sometime after his admission to the ED at 11.10 am, Mr Scott was reviewed by a registrar, Dr Nseabasi Mark-Johnson who has no specific recollection of doing so. In any case, the discharge summary states:

> Brought in from the prison by police for anal pain. Patient reports to have not been able to pass a stool for about a week. Was given a fleet enema a week ago to no avail. Reports that now the pain is excruciating, waxing and waning.[111,112]

82. The discharge summary also notes that Mr Scott was a patient of Dr Hendry "*because there was a concern for haemorrhoids*" and that Mr Scott had asked if the planned surgery to address his symptoms could be brought forward.[113] When reviewed, Mr Scott denied rectal bleeding but described alternating diarrhoea, which Dr Mark-Johnson thought was "*overflow diarrhoea*" related to his constipation.[114]

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[107] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), pp6-7
[108] Exhibit 1, Vol 1, Tab 11C, Case Summary - Dr C Hendry (17.08.17), p1 and ts 26.08.17 (Hendry), p103
[109] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (26.05.17, p14 of 108)
[110] Exhibit 1, Vol 5, Tab 23, Email - Dr P Hames to BRP Clinical Nurse (26.05.17)
[111] Exhibit 1, Vol 5, Tab 26, Attachment LMJ1 - BRH Discharge Summary (27.05.17), p1
[112] Exhibit 1, Vol 5, Tab 26, Statement - Dr N Mark-Johnson, paras 19-27
[113] Exhibit 1, Vol 5, Tab 26, Attachment LMJ1 - BRH Discharge Summary (27.05.17), p1
[114] Exhibit 1, Vol 5, Tab 26, Statement - Dr N Mark-Johnson, paras 19-26

83. Dr Mark-Johnson said that when dealing with a patient presenting with anal pain, she would want to determine whether the patient had "*a fissure, haemorrhoids or other mass*", by means of a rectal examination. Notwithstanding the fact that Mr Scott was reportedly in "*acute pain*" when she saw him, Dr Mark-Johnson was certain that she had performed a rectal examination whilst Mr Scott was in the ED.[115]

84. Dr Mark-Johnson explained that her usual practice when performing a rectal examination was to inspect the patient's anus externally and then insert her right index finger into the patient's anus to perform an internal examination of the rectum. In her letter to Dr Hendry, dated 26 May 2017, Dr Mark-Johnson reported: "*No obvious anal fissure visualised, but tenderness in the anal canal at about 5 o'clock*[116] *with no palpable mass. Other systems examined well*".[117,118,119]

85. Dr Mark-Johnson was aware that Mr Scott was due to have anal surgery and the discharge summary states: "*Patient discussed with the surgical registrar who has recommended to fax a letter to Dr Craig [Hendry's] rooms, conservative management until an appointment is got*". Given Mr Scott's reports of "*excruciating pain*" and his alternating diarrhoea, it is unfortunate that a more active surgical review was not pursued. Had the surgical registrar examined Mr Scott in the ED, it seems likely that Mr Scott's large rectal mass would have been found.[120,121,122]

86. Although Mr Scott's respiration rate was elevated and he was in "*excruciating pain*" on his admission to the ED at 11.10 am, he was discharged to BRP at about 2.32 pm. Dr Mark-Johnson said Mr Scott would not have been discharged from the ED unless his pain had been appropriately managed. Although she was unable to recall how Mr Scott's pain was managed, records show he was given paracetamol and ibuprofen at 1.45 pm, which was presumably effective.[123,124,125]

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[115] Exhibit 1, Vol 5, Tab 26, Statement - Dr N Mark-Johnson, para 28 and ts 27.08.21 (Mark-Johnson), p152
[116] With the patient lying on their back, the 12 o'clock position is at the top of the patient's body.
[117] Exhibit 1, Vol 5, Tab 26, Attachment LMJ1 - BRH Discharge Summary (27.05.17), p2
[118] Exhibit 1, Vol 5, Tab 26, Statement - Dr N Mark-Johnson, paras 29-33
[119] Exhibit 1, Vol 1, Tab 11B, Letter - Dr L Mark-Johnson to Dr C Hendry, (26.05.17)
[120] Exhibit 1, Vol 5, Tab 26, Statement - Dr N Mark-Johnson, paras 18, 39 & 41
[121] Exhibit 1, Vol 5, Tab 26, Attachment LMJ1 - BRH Discharge Summary (27.05.17), p2
[122] Exhibit 1, Vol 1, Tab 11B, Letter - Dr L Mark-Johnson to Dr C Hendry, (26.05.17)
[123] Exhibit 1, Vol 5, Tab 26, Attachment LMJ1 - BRH Discharge Summary (27.05.17), p1

87. In her review of Mr Scott's care, Dr Fitzclarence was critical of the fact that Mr Scott was discharged from the ED with "*no definitive treatment*" and that no blood tests were performed. She was also critical of the fact that no effort was made to facilitate a more urgent review.[126]

88. Mr Martin also felt that further tests should have been undertaken whilst Mr Scott was in the ED, and that his overflow diarrhoea, which is a symptom not a diagnosis, should have been investigated. This is because although overflow diarrhoea can be caused by constipation, it can also be associated with rectal cancer.[127]

89. When Mr Scott was examined under anaesthetic on 22 June 2017, he was found to have a very large rectal mass just inside his anus. It is therefore surprising that this was not detected by Dr Mark-Johnson during her examination on 26 May 2017. The evidence before me is that if Mr Scott had been thoroughly examined in the ED, his rectal mass would have been detected.[128,129]

90. If Dr Mark-Johnson performed a rectal examination when she saw Mr Scott in the ED, the question that arises is how she managed to miss the large mass that must have been present in Mr Scott's rectum at that time. First, it is possible that although she palpated the tumour, she did not realise what she was feeling because of the size of the mass and its poorly differentiated margins.[130,131] Further, as Dr Hendry noted:

> The digital examination in the emergency department [on] 26th May 2017 would have been challenging under the circumstances and in all likelihood performed by an inexperienced medical officer who failed to make the diagnosis.[132]

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[124] Exhibit 1, Vol 1, Tab 11B, Letter - Dr L Mark-Johnson to Dr C Hendry, (26.05.17)
[125] Exhibit 1, Vol 5, Tab 23, BRH Medication chart (26.05.17)
[126] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), p4
[127] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), p10
[128] Exhibit 1, Vol 1, Tab 7, Report - Dr A Pardhan (20.09.17) and ts 27.08.21 (Cover), pp188-189 & 194
[129] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), p10 and ts 26.08.21 (Martin), pp70-71
[130] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), p10 and ts 26.08.21 (Martin), pp170-171
[131] Exhibit 1, Vol 1, Tab 7, Report - Dr A Pardhan (20.09.17), p1
[132] Exhibit 1, Vol 1, Tab 11C, Case Summary - Dr C Hendry (17.08.17), p2

91. A more likely explanation for why Dr Mark-Johnson's rectal examination missed the mass in Mr Scott's rectum could be that her examination was significantly curtailed because of the "*acute pain*" Mr Scott was experiencing whilst he was at the ED.[133]

92. For the sake of completeness, I note that Dr Mark-Johnson did not observe any "*obvious anal fissure*" when she examined Mr Scott, even though Dr Hendry described finding a "*chronic anal fissure*" during his examination on 1 March 2017. This is apparently explicable because anal fissures can be difficult to identify. At the inquest, Dr Hendry said that some fissures (like Mr Scott's) can only be seen when the anus is exposed by pulling aside the patient's buttocks. In circumstances where a patient is in severe pain, as Mr Scott was when seen at the ED, this can be difficult to achieve.[134,135]

93. For her part, Dr Mark-Johnson said she would have initiated further investigations, including a colonoscopy, if she had located a mass in Mr Scott's rectum. Moreover, had Mr Scott complained of abdominal pain or been found to have a tender abdomen, she would have ordered CT scans to investigate intestinal obstruction.

94. Dr Mark-Johnson did not feel blood tests were warranted, and even with the benefit of hindsight did not think that any of Mr Scott's symptoms suggested rectal cancer. Further, on the basis of the available records, Dr Mark-Johnson considered that her clinical approach was appropriate.[136]

95. Nevertheless, it is clearly unfortunate that Mr Scott's rectal cancer was not identified by Dr Mark-Johnson on 26 May 2017. However, given the advanced state of Mr Scott's cancer at that time, it is unlikely that his clinical outcome would have been any different even if his mass had been discovered whilst he was in the ED.

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[133] ts 26.08.21 (Martin), pp70-71 and ts 27.08.21 (Mark-Johnson), p152
[134] Exhibit 1, Vol 5, Tab 26, Attachment LMJ1 - BRH Discharge Summary (27.05.17), p1
[135] Exhibit 1, Vol 1, Tab 11B, Letter - Dr C Hendry to Dr A Thillainathan (01.03.17) and ts 26.08.21 (Hendry), p97
[136] Exhibit 1, Vol 5, Tab 26, Statement - Dr N Mark-Johnson, paras 34-41 and ts 27.08.21 (Mark-Johnson), p151

Admission to hospital - 21 June 2017[137,138,139,140,141]

96. In the two weeks following his discharge from the ED, Mr Scott reported ongoing issues with constipation and was noted to have lost weight. On 13 June 2017, he complained of "*ongoing anal pain from [his] anal fissure*" and was prescribed tramadol.[142]

97. In his statement, Mr Nugent says that at a memorial service after Mr Scott's death, he was told by a prison chaplain that: "*Jerry was required to get out of bed and crawl on [his] hands and knees to the nursing station to get his painkillers*".[143] There is no evidence that this was the case and indeed, on 22 May 2017, when Mr Scott was escorted to the prison medical centre by a prisoner officer, he is reported to have walked there "*unassisted*".[144]

98. However, on 18 June 2017, a prison nurse noted that Mr Scott was "*obviously having great difficulty coping with the pain and is requiring [a] wheelchair transfer to obtain medication*". When seen by a prison nurse on 19 June 2017, Mr Scott complained of ongoing nausea, weight loss and rectal pain. He was reviewed by a PMO on 21 June 2017, and results from blood tests suggested significantly abnormal liver function and a likely acute infective or malignant process. As a result, it was decided to refer Mr Scott for urgent imaging and further testing.[145]

99. Mr Scott was transferred to BRH for further tests on 21 June 2017. He underwent an examination under anaesthetic on the following day and was found to have an eight-centimetre tumour about one centimetre inside his rectum, in the five 5 o'clock to ten o'clock position. The mass was subsequently biopsied and found to be a: "*poorly differentiated carcinoma with adeno-squamous differentiation and poorly differentiated squamous carcinoma*".[146,147]

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[137] Exhibit 1, Vol 1, Tab 7, Report - Dr A Pardhan (20.09.17) and ts 27.08.21 (Cover), p187-199
[138] Exhibit 1, Vol 1, Tab 8, Report - Mr M Grime (19.07.17)
[139] Exhibit 1, Vol 1, Tab 9, Police Incident Report (03.07.17)
[140] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), pp4-5
[141] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 21), pp8-9
[142] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (31.05.17 - 13.06.17, p12 of 108)
[143] Exhibit 1, Vol 5, Tab 24, Statement - Mr C Nugent, para 28
[144] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (22.05.17, p16 of 108)
[145] Exhibit 1, Vol 3, Tab 16, Echo Prison Medical Notes (18-21.06.17, pp7-11 of 108)
[146] Exhibit 1, Vol 5, Tab 23, Hospital Operation record (22.06.17)

100. CT and MRI scans revealed secondary tumours in Mr Scott's liver, lungs, adrenal glands and his abdominal lymph nodes and a multi-disciplinary team meeting was held on 22 June 2017. The meeting recommended that Mr Scott be offered palliative chemoradiotherapy, and an infuser port to deliver this treatment was surgically inserted on 23 June 2017. Following the procedure, Mr Scott showed signs of liver failure, secondary to metastatic disease, and his overall medical condition deteriorated. He also developed abdominal distension which affected his breathing and showed signs of bleeding from his urinary system.[148]

101. Following a lengthy discussion between Mr Scott, Mr Nugent and Dr Cover, it was decided that Mr Scott was too unwell to undergo chemoradiotherapy and he was referred to the palliative care team. Mr Scott was transferred to SJOG on 30 June 2017, where he remained until his death on 3 July 2017.[149,150,151,152]

Mr Scott's risk factors for colorectal cancer

102. According to Mr Martin and Dr Fitzclarence, Mr Scott had several recognised risk factors for colorectal cancer. These included his age and obesity and the fact that he ate a low-fibre diet and led a sedentary lifestyle. Mr Scott's disclosure that he had engaged in receptive anal sex with multiple partners over a number years was also a risk factor because of the increased risk of contracting the human papillomavirus (HPV), which Mr Scott tested positive for in June 2017.[153,154]

103. Testing for HPV involves collecting cells from a mass in the body, which are then analysed in a laboratory. For that reason, in Mr Scott's case, HPV testing would not have been routine. In any event, it was found that Mr Scott had HPV genotypes 16 and 18, which are associated with an increased risk of developing colorectal cancer.[155,156]

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147 Exhibit 1, Vol 1, Tab 7, Report - Dr A Pardhan (20.09.17), p1 and ts 27.08.21 (Cover), p188
148 Exhibit 1, Vol 1, Tab 7, Report - Dr A Pardhan (20.09.17), pp1-2 and ts 27.08.21 (Cover), pp189-190
149 Exhibit 1, Vol 1, Tab 7, Report - Dr A Pardhan (20.09.17), p2 and ts 27.08.21 (Cover), p190
150 Exhibit 1, Vol 1, Tab 4, Death in Hospital form - SJOG (03.07.17)
151 Exhibit 1, Vol 2, Tab 15.20, Incident Description Report (03.07.17)
152 Exhibit 1, Vol 5, Tab 24, Statement - Mr C Nugent, paras 19-22
153 Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), p5
154 Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), p10
155 Exhibit 1, Vol 5, Tab 23, Patient results - HPV screen (22.06.17)

104. Dr Fitzclarence noted that in 2018, colorectal cancer was the second highest cause of cancer deaths in Australia and that the risk of developing this form of cancer increased with age. At the time he saw Dr Chuka in September 2015, Mr Scott was 61-years of age. In Dr Fitzclarence's view, because of Mr Scott's risk factors and age, there should have been "*a high index of suspicion*" for colorectal cancer.

Issues with Mr Scott's medical care - Missed opportunities

105. According to the Mayo Clinic, a colonoscopy is the "*gold standard*" screening tool for colorectal cancer. A colonoscopy is indicated where a patient experiences: changes in bowel habits, (e.g.: alternating diarrhoea/constipation), rectal bleeding, persistent abdominal cramps, pain, a sense that the bowel is not fully emptying, weakness, fatigue and/or unexplained weight loss. As Dr Fitzclarence pointed out, Mr Scott had all of these symptoms from 2015 onwards.[157]

106. In Mr Martin's view, there was an assumption by clinicians that Mr Scott's symptoms were consistent with his long-standing self-reported history of haemorrhoids.[158] As Dr Rowland pointed out, this was a risk factor in and of itself:

> A confident patient stating a known cause for their symptom is also a risk as in many cases patients do know their own health and patients can feel disrespected and resentful if they are doubted, hence determining which patient to doubt and question and which to trust is not straightforward.[159]

107. Both Dr Fitzclarence and Mr Martin expressed the view that in a man like Mr Scott, his alternating bowel habits and recurrent rectal bleeding meant that his self-diagnosis of haemorrhoids should not have been taken at face value. Whilst it is certainly possible that Mr Scott had haemorrhoids, given his age and other risk factors "*bowel cancer should have been actively excluded*".[160,161]

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[156] ts 26.08.21 (Martin), pp29-30
[157] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), p5
[158] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), p11
[159] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p11
[160] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), pp5-6
[161] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), p11

108. As Dr Fitzclarence pointed out, Mr Scott's symptoms were not just consistent with haemorrhoids, and especially from the beginning of 2015, were not just consistent with an anal fissure.[162,163]

109. With the benefit of hindsight, further investigations of Mr Scott's symptoms were clearly warranted. In addition, opportunities to potentially identify Mr Scott's rectal cancer were missed in September 2015, November 2016, March 2017 and May 2017. It is notable that with the apparent exception of May 2017, on each of these occasions Mr Scott declined a rectal examination.

110. It is certainly possible that by repeatedly declining rectal examinations, Mr Scott may have been partly responsible for the delay in his rectal cancer being diagnosed and therefore treated. However, when a patient declines an examination or treatment, the risks associated with that decision should be fully explained and documented. In Mr Scott's case, there is no such documentation.[164]

111. Mr Scott's reluctance to undergo a rectal examination could have been managed by conducting the examination under sedation or anaesthetic, as happened during his final admission to BRH. Further, despite Mr Scott's anxiety about being transported to external appointments in prison vans, he was often persuaded to do so.[165,166]

112. In her review of Mr Scott's care, Dr Rowland identified routine tests which had not been conducted. Had these tests been undertaken, Mr Scott's rectal cancer might have been identified at an earlier stage. The missed tests were:

- No annual health reviews: 2015 - 2017;
- No faecal occult blood tests: 2015 - 2017;
- No blood tests to check for anaemia or other abnormalities; and
- No regular weight recording to monitor weight loss.[167]

[162] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), pp5-6
[163] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), p11
[164] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), pp5-6
[165] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p13
[166] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), p6
[167] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), pp11-12

113. Dr Rowland noted that prompts for bowel screening are now included in the annual health review form and the PMO admission template, when a prisoner's demographic profile makes this appropriate. An audit has been conducted of bowel screening initiated by Health Services within DOJ and results have been shared with clinical staff.[168]

114. Dr Rowland said that options for ensuring consistency in documentation and optimal compliance are currently being explored. She also noted that because prisoners are not covered by Medicare, notifications from the Commonwealth Government's bowel screening program are not always available. For that reason, options for flagging bowel screening requirements within Echo are being investigated.[169]

115. In relation to annual health reviews, Dr Rowland's report notes: "*As Mr Scott had been seen by clinical staff on multiple occasions, he would not have routinely required an Annual Health Assessment*".[170] With respect, that proposition cannot be correct. As Dr Thillainathan noted, PMOs only have time to deal with a prisoner's presenting issue. Further, it is well known that the general prison population has much higher rates of chronic health issues than the general community. For that reason, and given that the risk of certain conditions (including cancer) increases with age, there is a clear mandate for prioritising routine annual screening of older and/or vulnerable prisoners.[171]

116. Dr Rowland noted that since September 2020, the relevant DOJ health policy recommends an annual health review for all prisoners who have not had any form of comprehensive health review in the previous 12-months. Full implementation of this recommended change has not been achieved and is rather said to be "*ongoing*", largely it seems because of inadequate resources.[172,173] This is very unsatisfactory and should be addressed by DOJ on a priority basis.

[168] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), pp14-15 and ts 27.08.21 (Rowland), pp211-212
[169] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), pp14-15
[170] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p11
[171] ts 26.08.21 (Thillainathan), pp133-134 and ts 27.08.21 (Rowland), pp209-212
[172] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p14
[173] ts 27.08.21 (Fitzclarence), p186 and ts 27.08.21 (Rowland), pp208-209

Would an earlier diagnosis have made a difference?

117. In her review, Dr Fitzclarence said that even if Mr Scott's rectal cancer had been diagnosed earlier, his outcome may not have been different. Nevertheless, it may have been possible to have offered treatments that could have increased the length and quality of his life. Dr Fitzclarence also thought that an earlier diagnosis may have led to more appropriate pain management which, of itself, may have improved Mr Scott's quality of life.[174] Mr Martin's view was that if Mr Scott's rectal cancer had been diagnosed in 2015, Mr Scott could potentially have been cured, but: "*After that time, diagnosis may have prolonged life and reduced symptoms to some degree*".[175]

118. Dr Hendry put Mr Scott's situation this way:

> The unfortunate delay in diagnosis in this patient has contributed to significant suffering and the ultimate death from a malignancy which was potentially curable. The full extent of the patient's symptoms till reviewed by me was not communicated in the referral or in the available patient record. Digital anal examination on the 1st March 2017 would have allowed [a] more timely treatment, but was declined by the patient.[176]

119. Since Mr Scott's death, PMOs have undergone professional education to reinforce the importance of rectal examinations in patient care and have been reminded of the importance of making detailed referrals. The need to carefully monitor prisoners waiting for specialist medical and/or surgical review has also been emphasised. These are welcome developments.[177]

120. In my view, given the imponderables associated with Mr Scott's case, it is impossible to determine what path his clinical journey would have taken had his rectal cancer been detected earlier. All that can be said with any certainty is that his chances of a cure and/or of treatment that might have improved his quality of life decreased the longer his rectal cancer went undiagnosed.[178]

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[174] Exhibit 1, Vol 1, Tab 13, Report - Dr C Fitzclarence (01.10.20), p6 and ts 27.08.21 (Fitzclarence), p178
[175] Exhibit 1, Vol 1, Tab 12, Report - Mr R Martin (02.04.20), p11 and ts 26.08.21 (Martin), p28
[176] Exhibit 1, Vol 1, Tab 11C, Case Summary - Dr C Hendry (17.08.17), p2
[177] Exhibit 1, Vol 5, Tab 27, Report - Dr J Rowland (August 2021), p15 and ts 27.08.21 (Rowland), pp215-216
[178] ts 26.08.21 (Martin), p28

CAUSE AND MANNER OF DEATH[179,180,181]

121. A forensic pathologist, Dr Dan Moss (Dr Moss) carried out an external post mortem examination of Mr Scott's body at the State Mortuary on 5 July 2017. Dr Moss reviewed Mr Scott's BRH medical notes and observed that Mr Scott's body showed marked jaundice (indicating liver impairment) and evidence of medical intervention.

122. Toxicological analysis found a range of medications in Mr Scott's system that were consistent with his palliative care at BRH. The medications included hyoscine butylbromide, morphine, tramadol and buprenorphine (pain relief medications), midazolam (a sedative) and ondansetron (used to treat nausea). Alcohol and common drugs were not detected.

123. At the conclusion of his external post mortem examination, Dr Moss expressed the opinion that the cause of Mr Scott's death was metastatic rectal carcinoma.

124. I accept and adopt Dr Moss' opinion as to the cause of Mr Scott's death and further, in view of the circumstances, I find that death occurred by way of natural causes.

[179] Exhibit 1, Vol 1, Tab 5A, Supplementary Post Mortem Report (19.10.17)
[180] Exhibit 1, Vol 1, Tab 5C, Letter from Dr Moss to Coroner (05.07.17)
[181] Exhibit 1, Vol 1, Tab 6, ChemCentre Report (01.09.17)

QUALITY OF SUPERVISION, TREATMENT AND CARE

125. After carefully considering the available evidence, I am satisfied that during the time he was incarcerated, Mr Scott's supervision was appropriate. Until his health declined, Mr Scott was gainfully employed and he attended treatment programs to address his offending. Mr Scott was regarded as well-behaved and courteous prisoner and in the latter stages of his incarceration, he received regular visits from Mr Nugent.

126. The evidence before me establishes that Mr Scott's medical care was commensurate with community standards until September 2015. However, from that time onwards there were several missed opportunities to diagnose the rectal cancer to which Mr Scott eventually succumbed.

127. With the benefit of hindsight, these missed opportunities are clearly regrettable and may have deprived Mr Scott of the possibility of a cure or at the very least, treatment that might have prolonged and/or improved the quality of his life.

128. Although Mr Scott's rectal cancer was not diagnosed in a timely manner, clinical staff at both BRP and BRH appear to have responded to his presentations sensitively and with compassion. Given that this issue was raised by Mr Nugent in a written statement he provided to the Court,[182] I am obliged to point out that there is no evidence before me that Mr Scott's sexuality impacted on the care and treatment he received whilst he was incarcerated.

[182] Exhibit 1, Vol 5, Tab 24, Statement - Mr C Nugent, paras 30-32

RECOMMENDATIONS

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

> **Recommendation No. 1**
> To ensure that when prisoners are referred to external agencies those referrals are managed in a timely and appropriate manner, the Department of Justice (DOJ) should consider establishing a system that alerts the Prison Health Service when such referrals are overdue. DOJ should also consider allocating sufficient resources to enable a project team to be established to finalise the work currently being undertaken by Dr Joy Rowland in establishing a system to monitor and track these referrals.

> **Recommendation No. 2**
> The Department of Justice (DOJ) should consider amending the Health Services Policy relating to annual health reviews so that priority is given to reviewing vulnerable and older prisoners. Further, DOJ should allocate appropriate resources to enable these annual reviews to be conducted in a timely manner.

Comments relating to recommendations

130. After reviewing the available evidence, I determined it would be appropriate to make the above two recommendations. In accordance with my usual practice, a draft of these recommendations was forwarded to all counsel by Mr William Stops on 8 September 2021.[183]

131. Helpful comments were received from counsel for DOJ,[184] whilst counsel for Dr Hendry indicated that as the draft recommendations were directed to DOJ, his client had no comments.[185]

[183] Email - Mr W Stops (08.09.21)
[184] Email - Mr B Nelson (DOJ) to Counsel Assisting (13.09.21)
[185] Email - Mr M Williams to Counsel Assisting (08.09.21)

CONCLUSION

132. Mr Scott's case highlights the difficulties facing clinicians when a patient becomes fixed on a diagnosis for their condition and then declines relevant examinations and tests.

133. Despite Mr Scott's firm belief that he had haemorrhoids, given he was a person with several risk factors for colorectal cancer, greater efforts should have been taken to exclude alternative causes for his symptoms. There were several missed opportunities to discover Mr Scott's rectal cancer and had he undergone a colonoscopy at an earlier stage, it may have been possible to have cured him.

134. I can only hope that the improvements outlined by Dr Rowland, and the two recommendations I have made, may if implemented, improve the health outcomes for at-risk prisoners and offer Mr Nugent some solace for the loss of his partner.

MAG Jenkin
Coroner
14 September 2021