JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	27 APRIL 2022
DELIVERED	**:**	20 MAY 2022
FILE NO/S	**:**	CORC 129 of 2020
DECEASED	**:**	MCCRACKEN, KEVIN ERNEST

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Sergeant Alan Becker assisted the Coroner
Mr Christian A Payne (State Solicitor's Office) appeared on behalf of the Department of Justice

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Kevin Ernest MCCRACKEN*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 27 April 2022, find that the identity of the deceased person was* ***Kevin Ernest MCCRACKEN*** *and that death occurred on 11 July 2020 at Bunbury Regional Hospital, South Bunbury, from hypertensive and valvular heart disease in the following circumstances:*

Contents

INTRODUCTION

1 The deceased (Mr McCracken) died on 11 July 2020 at Bunbury Regional Hospital (BRH), South Bunbury, from hypertensive and valvular heart disease. He was 58 years old.

2 At the time of his death, Mr McCracken was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (the Department). Accordingly, immediately before his death, Mr McCracken was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[1] In such circumstances, a coronial inquest is mandatory.[2]

3 I held an inquest into Mr McCracken's death at Perth on 27 April 2022. The following witnesses gave oral evidence at the inquest:

i. Dr Joy Rowland, (Director of Medical Services with the Department); and

ii. Toni Palmer, (Senior Review Officer with the Department).

4 The documentary evidence at the inquest comprised of two volumes which were tendered as exhibit 1. At my request, two further documents were provided after the inquest by the Department, which became exhibits 2A and 2B.

5 The inquest focused on the medical care provided to Mr McCracken while he was a prisoner, with an emphasis on the care provided to him in relation to his pre-existing cardiac issues.

[1] Sections 3, 22(1)(a), *Coroners Act 1996* (WA)
[2] Section 25(3), *Coroners Act 1996* (WA)

THE DECEASED

Background [3]

6 Mr McCracken was born on 11 January 1962 and he was raised on a farm in Newdegate, where he resided with his parents and two younger brothers.

7 During high school, Mr McCracken was a boarder at a private boys' school in Perth. He later reported he was bullied and sexually abused when there. Mr McCracken returned to the family farm after completing Year 11.

8 In his early 20's, Mr McCracken left the family farm and moved to Geraldton to pursue a career in truck driving, which he did for over 30 years. He had to stop driving trucks after injuring his leg.

9 Mr McCracken was married twice. He had two daughters from his first marriage, both of whom moved to Canada with their mother following the divorce. He had three daughters and a son from his second marriage. His son died in 2016, from a long-standing heart condition. He was 16 years old.

Offending history [4]

10 Prior to 2016, Mr McCracken only had two minor traffic convictions, for which he was fined.

11 However, on 12 May 2016, Mr McCracken was sentenced in the District Court, following his pleas of guilty to seven counts of child sexual abuse that were committed between 1981 and 2009. He was sentenced to a term of imprisonment of 4½ years, backdated to 6 March 2015. He was made eligible for parole after serving 2½ years of that prison term.

[3] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022
[4] Exhibit 1, Volume 2, Tab 2, WA Court History for Mr McCracken – Criminal and Traffic; Exhibit 1, Volume 1, Tab 10 A, District Court of Western Australia transcripts

Circumstances of Mr McCracken's final imprisonment [5]

12 When he was still serving the above term of imprisonment, Mr McCracken was charged with a further 30 counts of child sexual abuse; of which 29 counts occurred between 1980 and 1986, and one count in 1999.

13 On 6 April 2018, following his pleas of guilty, the District Court sentenced Mr McCracken to a term of imprisonment of 7½ years. The sentencing for this offending was structured so that the earliest date Mr McCracken would be eligible for parole was 5 March 2025.

Prison history [6]

14 Mr McCracken had the following prison placements and transfers:

i. Hakea Prison: 7 March 2015 – 17 April 2015 (41 days)

ii. Casuarina Prison: 17 April 2015 – 31 May 2016 (410 days)

iii. Acacia Prison: 31 May 2016 – 24 March 2017 (297 days)

iv. Casuarina Prison: 24 March 2017 – 10 May 2017 (47 days)

v. Acacia Prison: 10 May 2017 – 9 October 2018 (517 days)

vi. Bunbury Regional Prison: 9 October 2018 – 11 July 2020 (641 days)

15 Throughout his incarceration, Mr McCracken was reported to be a polite prisoner who did not pose a security risk. His personal and cell hygiene were always maintained to an acceptable level. Whenever his health permitted, Mr McCracken had short periods of employment in prison as a general worker, block worker and part-time programmes worker. He did not incur any formal prison charges or loss of privileges. He maintained regular contact with family and friends through written correspondence and telephone contact. Mr McCracken had regular contact visits with friends and, for a number of years, his wife.

[5] Exhibit 1, Volume 1, Tab 10B-C, District Court of Western Australia transcripts
[6] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022

OVERVIEW OF MR MCCRACKEN'S MEDICAL CONDITIONS AND TREATMENT IN PRISON AND IN HOSPITAL [7]

Pre-existing medical conditions

16 Mr McCracken had a number of significant medical conditions when he was admitted on remand to Hakea Prison on 7 March 2015. He already had a complex cardiac disease, which included a heart valve replacement surgery in 1990, aortic arch surgery in 1997 and a severe ventricular hypertrophy (a thickening of the wall of the heart's main pumping chamber). In addition, he had been diagnosed with hypertension, pulmonary embolism, gastro-oesophageal reflux, osteoarthritis in the lumbar spine and osteoporosis. He also had complex regional pain syndrome in his right leg, following an injury in a 2013 workplace accident which resulted in chronic pain and issues with mobility.

17 At the time of his admission into prison, Mr McCracken took daily blood pressure medications, analgesia and warfarin (a blood thinning agent).

Medical treatment when in prison

18 During his imprisonment, Mr McCracken was seen at prison medical services for a variety of minor issues. These included skin lesions, chronic pain management, injuries, regular blood tests and immunisations. With respect to his cardiac issues, Mr McCracken was placed on a care plan which was regularly reviewed. He experienced recurrent episodes of chest pain, which were addressed in a timely fashion, and his blood pressure, blood test results and warfarin dosage were monitored regularly. The following medical episodes are those I have identified as being at a more serious level.

[7] Exhibit 1, Volume 1, Tab 13, Health Services Summary into the Death in Custody dated April 2022; Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022

19 On 10 February 2016, Mr McCracken was diagnosed with neuropathic chest pain and was treated within the prison environment after an electrocardiogram (ECG) noted no hyperacute changes or significant changes compared to a previous ECG taken in March 2015.

20 On 22 October 2016, Mr McCracken had an episode of crushing chest pain. After an ECG was taken, he was transferred by ambulance to St John of God Hospital, Midland (SJOG). Whilst at SJOG, he had an episode of ventricular tachycardia (abnormal heart rhythm) and was transferred to Royal Perth Hospital (RPH), where a coronary angiogram showed normal coronary arteries and an ECG confirmed severe concentric left ventricular hypertrophy. Mr McCracken then underwent a surgical procedure which involved the insertion of a cardiac monitor, which was placed under the skin of his chest. He was provided with a wireless reader, so that his heart monitor readings could be transmitted remotely to the cardiology team. By chance, a computerised tomography (CT) scan showed a lesion in Mr McCracken's left kidney, which was later confirmed to be cancerous.

21 In February 2017, Mr McCracken was admitted to RPH for a radio frequency ablation and biopsy of the kidney lesion. Unfortunately, he suffered post-operative complications of a retroperitoneal bleed, which required embolisation.

22 Following his discharge, Mr McCracken was shortly readmitted, this time to SJOG, where he was diagnosed with hospital-acquired pneumonia and contrast-induced nephropathy. He was admitted to the intensive care unit (ICU) of SJOG before he was transferred to the ICU at RPH on 16 March 2017. He was discharged from RPH on 24 March 2017.

23 On 13 July 2017, Mr McCracken was reviewed by the prison doctor. He complained of a pain in his back and an urgent chest x-ray was requested.

24 On 9 August 2017, Mr McCracken reported further ongoing back pain and an ECG was later performed, which noted no major changes, apart from a low heart rate. Mr McCracken's medication was adjusted accordingly.

25 On 30 May 2018, Mr McCracken was reviewed by the prison doctor after he reported chest tightness since waking that morning. An ECG showed no acute changes, and he was diagnosed with musculoskeletal pain. Mr McCracken declined anti-inflammatory medication and was advised to attend the prison medical centre if he experienced further pain. The ECG noted no significant changes compared to the previous ECG.

26 On 16 October 2018, after his transfer to Bunbury Regional Prison one week earlier, Mr McCracken was commenced on an anti-depressant medication to manage his low mood and chronic pain.

27 On 13 November 2018, Mr McCracken was referred to a cardiologist to review the management of his warfarin medication.

28 On 3 October 2019, Mr McCracken was seen by a cardiologist who noted that the intermittent chest pains he had been experiencing were not typical of angina and were thought to be musculoskeletal, possibly nerve related. It was also noted that Mr McCracken's heart rate was dropping and that his ECG at times appeared abnormal, with some form of escape rhythm, at about 30 beats per minute. As Mr McCracken had not been using the wireless reader correctly, it was not possible to determine his heart rhythm at the time his feelings of light-headedness had occurred. The cardiologist did not attribute the severe left ventricular hypertrophy to Mr McCracken's aortic valve replacement, believing it was something unrelated, such as amyloidosis (the build-up of abnormal proteins in the heart). A magnetic resonance imaging (MRI) scan was not possible due to Mr

McCracken's metal mechanical valve. A review was planned for three months' time to consider the insertion of a pacemaker.

29 After complaining of chest tightness and fatigue, Mr McCracken was taken to BRH on 1 February 2020. An ECG was taken which showed no acute changes and a chest x-ray was normal. Mr McCracken was discharged after a diagnosis of non-cardiac chest pain.

30 On 3 February 2020, a further review was undertaken by the cardiologist. It was determined that there were no discernible arrythmias present necessitating a pacemaker and Mr McCracken's blood pressure and heart rate were stable. A Dobutamine Stress ECG (to evaluate the heart and valve function without having to exercise) was planned to examine more closely the left ventricular hypertrophy.

31 At the next three-month review by the cardiologist on 6 May 2020, it was noted that the above-mentioned ECG showed possible minor hyperkinesis of the basal inferior wall of Mr McCracken's heart. As the cardiologist was not of the view Mr McCracken's chest pain symptoms were heart related and that the results of the ECG appeared to be marginally positive, it was decided that a trial of a vasodilator medication would take place. A coronary angiogram would be performed if symptoms worsened, although this would be a high-risk procedure due to Mr McCracken's anticoagulant medication.

Events leading to death

32 On 11 July 2020, Mr McCracken was housed in the pre-release unit at Bunbury Regional Prison. At about 3.10 pm, Mr McCracken walked into the kitchen area, paused for a moment, and then fell face-forward onto the floor. Another prisoner grabbed his arm as he fell, in an attempt to break his fall, and placed Mr McCracken in the recovery position. This prisoner believed that

Mr McCracken was having a fit. After about a minute, the prisoner noticed Mr McCracken was still gasping for air and so he used the unit intercom to call for the assistance of prison staff.

33 Three prison officers quickly attended the kitchen with an Oxy-Boot and Oxy-Viva (oxygen resuscitators), and a defibrillator. A short time after that, a prison nurse also attended. By that stage, prison officers had already placed one of the oxygen resuscitators on Mr McCracken's face. After the nurse had repositioned his neck to ensure his airway was clear, she observed that Mr McCracken was breathing abnormally, was incoherent and not responding to questions. When the nurse was unable to feel a pulse and saw that Mr McCracken had stopped breathing, she instructed prison staff to call a Priority 1 ambulance. The nurse then had Mr McCracken placed on his back, attached the defibrillator and commenced cardiopulmonary resuscitation (CPR). St John Ambulance received the call at 3.21 pm and arrived at the scene at 3.32 pm. Ambulance officers observed that Mr McCracken was in ventricular fibrillation (irregular heartbeat), despite multiple shocks and doses of adrenaline being administered. His condition deteriorated to asystole (cardiac flatline), prior to being placed in the ambulance. Resuscitation efforts were maintained in transit to BRH.

34 Despite extensive resuscitation efforts, Mr McCracken was pronounced dead at BRH at 4.24 pm on 11 July 2020.[8]

CAUSE AND MANNER OF DEATH [9]

35 Two forensic pathologists (Dr Kueppers and Dr Junckerstoff) conducted a post mortem examination of Mr McCracken's body on 20 July 2020.

[8] Exhibit 1, Volume 1, Tab 4, Life Extinct Form dated 11 July 2020
[9] Exhibit 1, Volume 1, Tab 5, Supplementary Post Mortem Report by Dr V Kueppers and Dr R Junckerstoff dated 20 July 2020; Exhibit 1, Volume 1, Tab 6, Toxicology Report dated 3 August 2020

36 The post mortem examination noted there were signs of attempted resuscitation. There was a marked enlargement of Mr McCracken's heart (cardiomegaly), thickening of the heart muscle (left ventricular hypertrophy), narrowing of the arteries supplying oxygen to the heart (coronary artery atherosclerosis) and signs of previous cardiac surgery (aortic graph and mechanic aortic valve prosthesis). There was an old blood clot in the abdomen at the sight of the previously treated left kidney cancer.

37 Microscopic examination of Mr McCracken's heart showed multifocal scarring (fibrosis) and mild coronary artery disease (atherosclerosis). No viral infection of his heart was detected. There was no evidence of bronchopneumonia and microbiology testing of the old blood clot around the left kidney found that it had not contributed to Mr McCracken's death.

38 Toxicological analysis detected the presence of an anti-arrhythmic medication, an anti-depressant, a diuretic, paracetamol and the anticoagulant, warfarin. These medications were all at therapeutic levels. Alcohol, cannabinoids and other commons drugs were not detected.

39 At the conclusion of the post mortem examination, and upon reviewing the results of the further investigations, the forensic pathologists expressed the opinion that the cause of Mr McCracken's death was hypertensive and valvular heart disease. The forensic pathologists noted:

> Marked enlargement of a heart (cardiomegaly) and thickening of the heart muscle (left ventricular hypertrophy) are strongly associated with the development of an abnormal beating rhythm of the heart (cardiac arrythmia) and subsequent sudden death. The presence of scarring (fibrosis) of the heart muscle increases this risk further. The enlarged heart in this man is likely to be due to a combination of valvular heart disease (congenital aortic stenosis, treated surgically) and the clinical history of high blood pressure (hypertension) listed in the hospital medical records. It is likely that Mr McCracken has died as a result of the abnormal beating rhythm of the heart (cardiac arrythmia) on the background of hypertensive and valvular heart disease.

40 I accept and adopt the conclusion expressed by Dr Kueppers and Dr Junckerstoff that the cause of death was hypertensive and valvular heart disease. Accordingly, I find that Mr McCracken's death occurred by way of natural causes.

ISSUES RAISED BY THE EVIDENCE

Failure to call a Code Red medical emergency

41 Like the procedures in every prison, whenever an incident that occurs at the Bunbury Regional Prison which is "*serious or life-threatening*", a Code Red medical emergency should be called immediately over the prison radio, along with the location of the incident.[10] A Code Red medical emergency was not called by any prison officer when Mr McCracken was discovered in a collapsed state. It was accepted by Ms Palmer that a Code Red medical emergency should have been called, as required by the Bunbury Regional Prison's medical emergency procedures.[11]

42 As noted in Ms Palmer's report, "*a Code Red emergency would have resulted in* [the prison] *going onto alert, radio traffic would have stopped, and prison management would have monitored the situation, ensuring that staff were coping adequately*".[12] The prison officer responsible for calling the Code Red medical emergency was the first attending officer to the incident.[13]

43 It was unfortunate that a Code Red medical emergency was never called by any prison officers attending the incident. Clearly, it should have been. However, I am prepared to find that this failure was not detrimental to the treatment of Mr McCracken, as it is evident there was a very quick response by prison officers and the attending nurse.

[10] Exhibit 1, Volume 2, Tab 25, Bunbury Regional Prison Emergency Management Plan
[11] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022, p.19
[12] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022, p.19
[13] ts 27.4.22 (Palmer), p.19

44 The first two prison officers in attendance had the necessary emergency medical equipment with them. By good fortune, a prison nurse was already in the pre-release unit completing a medication round. That meant the nurse was able to attend shortly after the prompt arrival of the prison officers.[14] The decision by the nurse that an ambulance was required was subsequently made without undue delay.

45 I agree with the following assessment made by Ms Palmer:[15]

> By not calling a Code Red medical emergency, radio transmissions continued, and the prison management were not fully aware of the evolving incident. Furthermore, the responding officers did not follow the internal procedures relating to emergencies. However, as all the relevant and necessary staff were already present, the need for urgency was not negatively impacted.

46 Ms Palmer correctly identified that, as a result of this incident, the Emergency Management Plan for Bunbury Regional Prison should be reinforced to prison officers so that a Code Red is always called in line with medical emergency procedures.[16] To achieve this aim, Ms Palmer recommended the following action:[17]

> Educate staff on the Code Red requirements for medical emergencies and the importance of ensuring processes are initiated to ensure adequate staff are in attendance and radio traffic is stopped during a Code Red.

47 The target date for that action was 17 April 2022 (10 days before the inquest).[18] At the inquest, I asked Ms Palmer to find out if that action had been taken, and by what means.

48 By email dated 29 April 2022, Mr Payne (counsel for the Department) forwarded to Counsel Assisting a copy of a Staff Notice dated 29 April 2022 issued by the Superintendent of Bunbury Regional Prison (Staff Notice).[19] The Staff Notice

[14] ts 27.4.22 (Palmer), p.15
[15] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022, p.20
[16] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022, p.20
[17] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022, p.20
[18] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022, p.20
[19] Exhibit 2A

"*was circulated to staff at Bunbury Regional Prison in response to Recommendation R1.1 found on page 20 of the Death in Custody report by Ms Toni Palmer*".[20]

49 A Code Red may be called for situations other than medical emergencies (such as for a fire or a security breach). Unfortunately, the Staff Notice only addressed the general requirements for a Code Red and failed to specifically address the circumstances in which a Code Red was required in a medical emergency. I therefore provided the opportunity for the Department to address the further education of staff at Bunbury Regional Prison regarding the calling of a Code Red medical emergency before I handed down my inquest findings.[21]

50 By email dated 20 May 2022, Mr Payne forwarded to Counsel Assisting a copy of another Staff Notice dated 19 May 2022 issued by the Superintendent of Bunbury Regional Prison (second Staff Notice).[22] I am satisfied this second Staff Notice addressed Ms Palmer's recommendation and I also note that Mr Payne has received advice from the Department, "*that the relevant Standing Order 11.1 'Security & Control' will be amended to reflect this content in due course.*"[23]

51 In light of the second Staff Notice and the Department's advice to Mr Payne, it is not necessary for me to make a recommendation regarding the need for prison officers at Bunbury Regional Prison to receive further education regarding the circumstances in which a Code Red medical emergency must be called.

Medication errors

52 According to the Department's Electronic Health Online (EcHo) records for Mr McCracken, he was given incorrect medication on five separate occasions

[20] Email from Mr Payne to Sergeant Becker dated 29 April 2022
[21] Email from Sergeant Becker to Mr Payne dated 3 May 2022
[22] Exhibit 2B
[23] Email from Mr Payne to Sergeant Becker dated 20 May 2022

between March 2015 and February 2018.[24] These errors were discovered within a short space of time as Mr McCracken was transferred to the prison medical centre on each occasion for observation and no side effects were observed.[25]

53 The Department's relevant Health Services policy states that prison registered nurses are responsible for ensuring that all medications are provided to prisoners as prescribed and are recorded as required by the policy. In providing medication, prison nursing staff must adhere to the "*six rights of medication administration*", namely right drug, right patient, right dose, right time, right route and right documentation.[26]

54 At the inquest, I asked Dr Rowland about this matter. Dr Rowland noted that medication errors occur throughout all health services; be it in hospitals, in the community, in GP clinics or in prison settings.[27] The goal is to have systems in place that are built around trying to make sure errors in medications do not occur (which include the "six rights" referred to above). Nevertheless, Dr Rowland accepted that within the prison system, "*it appears, despite all these measures, just the volume of incidents, the volume of medications and the volume of time people are handing out medicine means, even if the error is only one in 1,000, it's going to keep on happening*".[28]

55 Dr Rowland also noted that an additional factor in a prison setting involves the "*speed in which everything needs to occur*".[29] As Dr Rowland explained:[30]

> The period of time available to provide medications to a prisoner at medication rounds is restricted by prison regimes and pressure and the processes. So, the people doing medications are frequently under time pressure. There's also quite a noisy and busy environment, so [it's] difficult concentrating on one

[24] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022, p.17
[25] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022, p.17
[26] Exhibit 1, Volume 2, Death in Custody Report by Toni Palmer dated February 2022, pp.17-18
[27] ts 27.4.22 (Dr Rowland), p.10
[28] ts 27.4.22 (Dr Rowland), p.11
[29] ts 27.4.22 (Dr Rowland), p.11
[30] ts 27.4.22 (Dr Rowland), p.11

> thing at a time, and the complexity of checking who someone is when relying on them to actually *(indistinct)* and then comparing it to the chart, etcetera, and the space just means that errors are easy to creep in because of speed, rush. We also have a lot of people with similar names, or the same names which makes it extra complex.

56 Dr Rowland further stated that medications are discussed frequently at the Department's Clinical Incident Review Committee and the Clinical Governance Advisory Committee, where reports of errors are sent through. Dr Rowland emphasised that "*it is an area that we are constantly looking at trying to improve*".[31] Dr Rowland, nevertheless, conceded that it is very difficult to prevent errors from occurring because "*people are people*".[32]

57 In light of Dr Rowland's explanations, I am not critical of the medication errors made in Mr McCracken's case. I am satisfied that the Department is striving for continual improvement in this area. It was commendable that the Department was able to identify these errors shortly after they were made and then arrange for Mr McCracken to be placed in the prison medical centre for observation. In that regard, I note Dr Rowland's observation that:[33]

> You know it's impressive that we know about those errors because it makes people acknowledge them. They wrote them in the notes, and they responded appropriately. So, developing a system and a culture that says errors are going to happen; we need to know about them to prevent the next one. It's about the system, not about the individual, so that staff feel confident in coming forward and admitting they've made an error – is hugely important and takes quite a lot of work.

QUALITY OF THE DEPARTMENT'S SUPERVISION, TREATMENT AND CARE

58 Mr McCracken was only 53 years old when he was remanded into custody in March 2015. However, he had significant underlying health issues; predominately

[31] ts 27.4.22 (Dr Rowland), p.11
[32] ts 27.4.22 (Dr Rowland), p.11
[33] ts 27.4.22 (Dr Rowland), p.12

cardiac and chronic pain related to various injuries. He had already been under the care of cardiologists for a number of years.

59 Having carefully considered the documents tendered into evidence and the evidence of Dr Rowland at the inquest, I am satisfied that Mr McCracken's various medical conditions, most notably his pre-existing cardiac issues, were appropriately managed by the Department. Accordingly, I am satisfied that the standard of supervision, treatment and care he received whilst he was in custody (including when he was hospitalised) was appropriate. I accept the following observations by Dr Rowland:[34]

> There were no significant issues identified, relating to the provision of clinical care to Mr McCracken during his incarceration. His management was commensurate with standards for community care, and his issues were thoroughly documented and managed appropriately. He was reviewed by Prison Medical Officers at least every three months and as required when acute issues developed. He underwent comprehensive annual health assessments and regular care plan visits for his cardiac conditions. Lifestyle issues (weight and exercise) were discussed and addressed regularly. He received appropriate investigations for his age and health status, including a check for prostate specific antigen; he attended regular care plan reviews for his cardiac conditions. He was up to date with all vaccinations appropriate to his age and health status (apart from missing an influenza immunisation in 2017). Borderline lipids levels were being regularly monitored as was his renal function and iron levels (a low iron level was identified and treated with supplementation).
>
> …
>
> Despite Mr McCracken experiencing multiple serious health problems, it must be noted that in all encounters with health staff, these issues were taken seriously, and the appropriate actions were undertaken in a timely manner.
>
> It appears that Mr McCracken's cause of death was likely to have been a cardiac arrythmia. Mr McCracken was investigated extensively for any cardiac arrythmias that could have been prevented by implantation of a pacemaker, and was seen regularly by a cardiologist; however, it had not been possible to identify a treatable problem prior to his death.

60 When asked at the inquest how the Department deals with prisoners who have the complex medical health issues that Mr McCracken had, Dr Rowland responded:[35]

[34] Exhibit 1, Volume 1, Tab 13, Health Services Summary into the Death in Custody dated April 2022, p.20
[35] ts 27.4.22 (Dr Rowland), p.9

> I think this is a good example of how the system actually works, in that the acquisition of the information, the putting it into the summary, the continuity of care, the care plans by the nurses, the referrals, the doctors reviewing the management of medication, the response to acute events, I think, was actually a good example of good, comprehensive care for this man…

CONCLUSION

61 Although convicted of particularly serious offending and being sentenced to a lengthy term of imprisonment, Mr McCracken, as a prisoner, was never recorded as being a management issue and he was, by all accounts, well-behaved.

62 Mr McCracken's serious pre-existing health complications regarding his cardiac functioning remained a concern throughout the time he was imprisoned. Although the treatment and care he received at prison medical centres and tertiary hospitals were of a high standard, he was always at an increased risk of a sudden death due to his long-standing cardiac conditions. On 11 July 2020, that risk materialised when he unexpectedly collapsed in Bunbury Regional Prison. Despite prompt resuscitative actions by prison staff and then by attending ambulances officers, Mr McCracken could not be revived.

63 I am satisfied that the medical care and treatment provided by the Department and the treating hospitals for Mr McCracken were of the same standard that a person living in the general community would have expected to receive.

64 Accordingly, I have found that the supervision, treatment and care Mr McCracken received from the Department was appropriate.

PJ Urquhart
Coroner
20 May 2022