JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Michael Andrew Gliddon Jenkin, Coroner
HEARD	**:**	1 NOVEMBER 2022
DELIVERED	**:**	3 NOVEMBER 2022
FILE NO/S	**:**	CORC 1739 of 2021
DECEASED	**:**	ROONEY, JEFFERY WILLIAM

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sergeant A Becker assisted the coroner.

Ms A Westerside (State Solicitor's Office) appeared for the Department of Justice.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Jeffery William ROONEY*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 1 November 2022, find that the identity of the deceased person was* ***Jeffery William ROONEY*** *and that death occurred on 1 July 2021 at Sir Charles Gairdner Hospital from subarachnoid haemorrhage due to rupture of a berry aneurysm in the following circumstances:*

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INTRODUCTION

1. Jeffery William Rooney (Mr Rooney) died on 1 July 2021 at Sir Charles Gairdner Hospital (SCGH) from subarachnoid haemorrhage caused by the rupture of a blood vessel in his brain.[1,2,3] At the time of his death, Mr Rooney was a sentenced prisoner at Wooroloo Prison Farm (WPF), and thereby in the custody of the Chief Executive Officer (CEO) of the Department of Justice (DOJ).[4]

2. Accordingly, immediately before his death, Mr Rooney was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[5] In such circumstances, a coronial inquest is mandatory.[6] 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]

3. On 1 November 2022, I held an inquest into Mr Rooney's death at Perth. The documentary evidence adduced at the inquest comprised one volume and the following witnesses gave evidence:

a. Ms Toni Palmer, (Senior Review Officer, DOJ);[8] and

b. Dr Joy Rowland, (Director Medical Services, DOJ).[9]

4. The inquest focused on the care, treatment and supervision provided to Mr Rooney while he was in custody, as well as the circumstances of his death.

[1] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of Deceased (07.07.21)
[2] Exhibit 1, Vol. 1, Tab 5, Death in Hospital form (01.07.21)
[3] Exhibit 1, Vol. 1, Tab 6A, Confidential Report to the Coroner - Supplementary (Post Mortem Report) (09.09.21)
[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 17, Death in Custody Review (15.08.22) and ts 01.11.22 (Palmer), pp25-30
[9] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22) and ts 01.11.22 (Rowland), pp4-24

MR ROONEY

Background[10,11,12]

5. Mr Rooney was born in Mount Lawley on 2 January 1980. At the time of his death he was 41-years of age.[13] He was raised by adoptive parents, and variously worked as a labourer, barman, gardener, rail track maintenance worker, and machine operator. Prior to his incarceration, Mr Rooney lived with his partner and children.

Medical history[14]

6. Mr Rooney's medical history included long-standing migraines and headaches, chronic low back pain, hepatitis C and high blood pressure. He reportedly sustained a head injury when he was about 20-years of age and further head injuries in 2018 and 2020. Mr Rooney had also sustained facial fractures following an incident in 2016. Mr Rooney smoked cigarettes and had a history of polysubstance use including methylamphetamine, cannabis and alcohol.

7. In terms of his mental health, Mr Rooney was diagnosed with antisocial personality disorder whilst in the Frankland Centre in 2008. He had also experienced episodes of drug-indued psychosis, and anxiety. In 1998, he reportedly attempted to take his life using a firearm and in 2014, he sustained stab wounds, which were thought to have been self-inflicted.

Offending History[15,16]

8. Mr Rooney had an extensive criminal history. As an adult, he accumulated 80 convictions for offences including robbery, assault, breaches of violence restraining orders and breaches of various community orders. In relation to some of these offences, Mr Rooney served various terms of imprisonment between 2005 and 2019.

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[10] Exhibit 1, Vol. 1, Tab 11, Background Information obtained from Mr D Rooney (18.07.21)
[11] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. F Thorp (15.11.21), pp2-3
[12] Exhibit 1, Vol. 1, Tab 17, Death in Custody Review (15.08.22), p7
[13] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (05.07.21)
[14] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22), p4 and ts 01.11.22 (Rowland), pp4-24
[15] Exhibit 1, Vol. 1, Tabs 15 & 17B, History for the Court - Traffic and Criminal
[16] Exhibit 1, Vol. 1, Tab 17, Death in Custody Review (15.08.22), p7

RECEPTION AT GREENOUGH REGIONAL PRISON

Circumstances of most recent incarceration[17,18]

9. On 20 August 2020 in the Magistrate's Court of Western Australia at Geraldton, Mr Rooney received a nine-month term of imprisonment (conditionally suspended for 12-months) for breaching a police order.[19] On 22 December 2020, Mr Rooney was remanded in custody to Greenough Regional Prison (GRP) after he allegedly breached the previously imposed police order.

10. On 24 December 2020, in the Magistrate's Court of Western Australia at Geraldton, Mr Rooney was convicted of breaching the police order, triggering the nine-month suspended term that had been imposed on 20 August 2020. He was also sentenced to a concurrent term of seven days' imprisonment for breaching a bail undertaking[20] and was returned to GRP. His earliest eligibility date for parole date was 9 May 2021.[21]

At Risk Management System and initial assessment[22,23]

11. When a prisoner is received at prison, they are interviewed by a reception officer who conducts a risk assessment to determine whether they need to managed under the At Risk Management System (ARMS). ARMS is DOJ's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide.

12. Mr Rooney underwent an ARMS risk assessment at GRP on 22 December 2020. He told the reception officer he had received treatment for unspecified mental health issues "*many years previously*", but denied any current self-harm or suicidal ideation. He said his family were supportive and that he expected to receive visits from his partner. The reception officer concluded that Mr Rooney: "*[W]as calm and settled at reception and no concerns are held for him at this time*".[24]

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[17] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. F Thorp (15.11.21), p5
[18] Exhibit 1, Vol. 1, Tab 17, Death in Custody Review (15.08.22), p
[19] Exhibit 1, Vol. 1, Tab 16A, Transcript of proceedings - Magistrates Court of WA at Geraldton (20.08.20), pp1-5
[20] Exhibit 1, Vol. 1, Tab 16B, Transcript of proceedings - Magistrates Court of WA at Geraldton (24.12.20), pp1-2
[21] Exhibit 1, Vol. 1, Tab 17C, Sentence Summary - Offender
[22] ARMS Manual (2019), pp2-13 & 21-24
[23] Exhibit 1, Vol. 1, Tab 17, Death in Custody Review (15.08.22), pp7-8
[24] Exhibit 1, Vol. 1, Tab 17A, At Risk Reception Intake Assessment (22.12.20), pp4 & 7

MANAGEMENT IN CUSTODY

Supervision issues[25]

13. During a multiple cell occupancy assessment on 22 December 2020, Mr Rooney indicated he had no issues sharing a cell with a smoker. He said he had friends in GRP and was willing to be employed in any available prison job. The assessment noted that Mr Rooney was a "*returning prisoner with a significant prison history*" and in accordance with departmental policy, he was initially assigned a maximum security rating.[26,27]

14. A management and placement report (MAP) dated 4 February 2021, noted that Mr Rooney's security rating had been reduced to "*minimum*" and he remained at GRP until 12 March 2021, when, at his request, he was transferred to WPF.[28,29]

15. On 4 March 2021, Mr Rooney signed a document stating he did not wish to be released on parole, and a copy was forwarded to the Prisoner Review Board (PRB).[30,31]

16. On 26 March 2021, the PRB wrote to Mr Rooney, "*confirming his decision and advising that, at the time, no parole order would be made*". The PRB's letter invited Mr Rooney to "*reapply if he did wish to be considered for release on parole*".[32]

17. Whilst he was at GRP, Mr Rooney was variously employed as a cleaner and a labourer and at WPF, he was employed as a kitchen worker. Departmental records show that Mr Rooney was subjected to random substance use tests, all of which were negative and he received regular visits from family and friends and made numerous phone calls.[33,34,35]

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[25] Exhibit 1, Vol. 1, Tab 17, Death in Custody Review (15.08.22), pp7-10 and ts 01.11.22 (Palmer), pp25-30
[26] Exhibit 1, Vol. 1, Tab 17E, Multiple Cell Occupancy - Risk Assessment (22.12.20)
[27] Exhibit 1, Vol. 1, Tab 17D, Management and Placement Report (31.12.20) and ts 01.11.22 (Palmer), p26
[28] Exhibit 1, Vol. 1, Tab 17G, Management and Placement Report (04.02.21) and ts 01.11.22 (Palmer), pp28-30
[29] Note: Tab 17D states Mr Rooney was reduced to "*minimum*" on 04.02.21, whereas Tab 17G gives the date as 05.02.21
[30] Exhibit 1, Vol. 1, Tab 17H, Prisoner Refusal to be Released on Parole form (04.03.21)
[31] Exhibit 1, Vol. 1, Tab 17H, Parole Review Report (09.03.21)
[32] Exhibit 1, Vol. 1, Tab 17I, Email - Ms R Silvia, Prison Review Board delegate (10.08.22)
[33] Exhibit 1, Vol. 1, Tab 17S, Work History - Offender
[34] Exhibit 1, Vol. 1, Tab 17T, Visits History - Offender & Recorded Call Report
[35] Exhibit 1, Vol. 1, Tab 17V, Substance Use Test Results - Offender

Management of medical issues[36,37]

18. On 23 December 2020, a prison nurse conducted an initial health assessment. Mr Rooney disclosed social drinking, daily use of cannabis and that he had been prescribed amitriptyline to help him sleep. He also mentioned he had anxiety and chronic low back pain, and his diagnosis of antisocial personality disorder was noted once his community medical records were obtained. During a health check on 26 December 2020, it was found that Mr Rooney had high blood pressure and this was checked twice weekly for the next fortnight.

19. On 10 January 20201, Mr Rooney saw a prion nurse and complained of episodes of muscle twitches, altered sense of smell and sweating which he said were related to an alleged assault in the community in August 2020, during which he was "*king hit*". Mr Rooney also said he had been waiting for a CT scan whilst in the community, and that the last time he had experienced these unusual symptoms had been 10-days prior.

20. The prison nurse scheduled a medical review, and Mr Rooney attended a tele-health appointment with a prison medical officer (PMO), on 14 January 2021. During that consultation, Mr Rooney reported a history of anger issues, antisocial personality disorder, and gastric reflux. He also claimed to have limited neck movements, although a neurological examination was normal.

21. Although there is no indication Mr Rooney repeated his history of unusual symptoms to the PMO, his history of migraines and head injuries was noted. It appears that the PMO's intention had been to investigate Mr Rooney's history of head injuries, but there is no evidence a Head CT scan was ordered. At the inquest, Dr Rowland said it appeared the booking of the CT scan was simply overlooked.[38]

22. Mr Rooney was subsequently seen in prison medical centres on several occasions for routine issues. For example on 24 February 2021, he was taken to hospital for sutures after he fell and lacerated his right eyebrow.

[36] Exhibit 1, Vol. 1, Tab 17, Death in Custody Review (15.08.22), pp8-10
[37] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22), pp3-10 and ts 01.11.22 (Rowland), pp4-24
[38] ts 01.11.22 (Rowland), pp7-9

23. On 2 June 2021, Mr Rooney presented to the WPF medical centre complaining of right facial pain, centred on his cheek. Mr Rooney also reported a blocked nose and sniffles over the previous few days, and it was noted he had a loose right upper tooth. Mr Rooney was diagnosed with sinusitis and treated with oral antibiotics.

24. When Mr Rooney was seen by a prison nurse on 16 June 2021, he was still experiencing right facial pain in his cheek, tooth, and ear but his sinuses were found to be clear, and he was still on antibiotics. During a review by a PMO on 22 June 2021, Mr Rooney reported "*some slight easing of pain but not much*" and he said he had ongoing sinus pain in the "*frontal area and cheek*".[39]

25. Although a head CT was ordered by the PMO, the scan was not performed before Mr Rooney's death. At the inquest, Dr Rowland said that the request had probably gone to Fiona Stanley Hospital, but because the requested scan was to investigate sinusitis, it would not have been treated as a priority. Dr Rowland said she would have expected a wait time of around one-month for a non-urgent CT scan.[40]

26. Following his collapse on 30 June 2021, Mr Rooney was entered into the Terminally Ill module of the Total Offender Management Solution (the electronic system DOJ uses to manage patients). Mr Rooney was identified as a Stage 4 prisoner, meaning that his death was expected imminently. Efforts were made to release Mr Rooney from custody pursuant to an exercise of the Royal Prerogative of Mercy, but he died before the necessary approvals could be obtained.[41,42,43]

27. DOJ conducted a review of the health services Mr Rooney was provided while he was incarcerated (the Review). The Review noted that although Mr Rooney had been treated for high blood pressure at various times and his blood pressure had been episodically monitored, this had not been added to the "*Active Problem List*" in EcHO (the computer system DOJ uses to manage the health care provided to prisoners).[44]

[39] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22), p6
[40] ts 01.11.22 (Rowland), pp10-12
[41] Exhibit 1, Vol. 1, Tab 17N, Terminally Ill health advice (30.06.21)
[42] Exhibit 1, Vol. 1, Tab 17O, External Movement Risk Assessment (30.06.21) and ts 01.11.22 (Palmer), pp25-26
[43] Exhibit 1, Vol. 1, Tab 17P, Email - Ms R Silvia, Prison Review Board Delegate (03.08.21)
[44] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22), p9, para 4.2.3 and ts 01.11.22 (Rowland), pp16-17

28. The Review also noted that whilst Mr Rooney was in the community in 2019, he had seen a cardiologist, following a history of cardiac arrythmias. An electrocardiogram had shown a mild enlargement of his heart's main pumping chamber (left ventricular hypertrophy) and although this information was written in a progress note by a prison nurse, it was never added to Mr Rooney's Active Problem List.

29. Had Mr Rooney's left ventricular hypertrophy been noted, it would have justified calculation of his cardiovascular risk score, although the fact this did not occur was unrelated to the cause of his death. Interestingly, Mr Rooney's heart size was deemed "*normal*" following a chest x-ray in 2020.[45]

Mr Rooney's collapse on 30 June 2021[46,47,48,49,50,51,52,53,54]

30. At about 4.30 pm on 30 June 2021, a prisoner alerted prison officers supervising dinner on Unit 2 at WPF (where Mr Rooney was accommodated) that Mr Rooney needed urgent help. The officers rushed to Mr Rooney's cell and found him lying, unresponsive, on the floor. Mr Rooney had reportedly earlier told his cellmate he felt like "*[S]omeone is stabbing me inside my head*".

31. Officers initiated a Code Red medical emergency and Mr Rooney was given oxygen using an oxy-boot.[55] Prison medical staff arrived shortly afterwards and although Mr Rooney's breathing had stabilised by about 5.00 pm, he remained unresponsive. Ambulance officers arrived at WPF at 5.16 pm and took Mr Rooney to St John of God Public Hospital, Midland.[56,57] Scans showed extensive bleeding around the brain and dilation of the right internal carotid artery (subarachnoid haemorrhage and berry aneurysm).

[45] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22), pp9-10, paras 4.2.4-4.2.5
[46] Exhibit 1, Vol. 1, Tab 17, Death in Custody Review (15.08.22), pp10-11
[47] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. F Thorp (15.11.21), p3
[48] Exhibit 1, Vol. 1, Tab 3, Memorandum - Sen. Const. M Purver (07.07.21)
[49] Exhibit 1, Vol. 1, Tab 18, Health Services review (10.10.22), pp6-7
[50] Exhibit 1, Vol. 1, Tabs 14 & 17R, Reports and Occurrences Register (30.06.21 - 02.07.21), 340023-340028
[51] Exhibit 1, Vol. 1, Tab 17L, Incident Description Reports (30.06.21), Officers A Marshall; S Whykes; and G O'Bree
[52] Exhibit 1, Vol. 1, Tab 17L, Incident Description Reports (30.06.21), Officers B Curtis; R Dabra and A Mustapha
[53] Exhibit 1, Vol. 1, Tab 17L, Incident Description Reports (30.06.21), Nurses P Kent and C Gamble
[54] Exhibit 1, Vol. 1, Tab 17Q, Critical Incident Brief - Part 2 (19.07.21)
[55] An Oxiboot is an oxygen resuscitator that can provide supplemental oxygen to a patient
[56] Exhibit 1, Vol. 1, Tab 17L, Wooroloo Prison Farm Incident Report Minutes (04.07.21)
[57] Exhibit 1, Vol. 1, Tab 10, St John Ambulance Patient Care Record, MRP21DC (30.06.21)

32. Mr Rooney's family were advised of his medical condition at about 7.45 pm, and he was transferred to Sir Charles Gairdner Hospital (SCGH) at 9.10 pm. Mr Rooney's prognosis remained poor and on 1 July 2021, doctors at SCGH confirmed that Mr Rooney had experienced a rupture of an aneurysm of his right internal carotid artery and that he was not a candidate for surgery.[58,59,60]

33. A family meeting was held at which Mr Rooney's medical condition was outlined, and following extensive testing, he was declared brain dead at 5.25 pm on 1 July 2021.[61,62,63]

Could Mr Rooney's aneurysm have been detected prior to his death?[64,65]

34. An intracranial berry aneurysm is a round or berry-like weaknesses in an artery in the brain. They occur in 3% - 5% of the general population, and risk factors include: high blood pressure, smoking, illicit drug use (including cocaine and amphetamines), heavy alcohol intake, head injuries, family history and certain genetic disorders. It is estimated that between 0.7% - 1.9% of berry aneurysms rupture. Although these events cannot be predicted, it appears that larger aneurysms rupture more frequently than smaller ones.[66]

35. As to whether a head CT scan could have detected a berry aneurysm, the Review relevantly notes:

> [I]t is evident that Mr Rooney had a long history of headaches which ranged in nature and severity and response to treatment, and he had had previous brain imaging, none of which had reported the existence of an aneurysm. A plain CT scan might easily miss a small aneurysm, but there had been no recorded indication for an MRI or angiography. In general, the management of his headaches, and medications offered and provided for these whilst in custody, is considered to have been appropriate.[67]

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[58] Exhibit 1, Vol. 1, Tab 12, SJOG Patient Results Report and SJOG Progress notes (30.06.21)
[59] Exhibit 1, Vol. 1, Tab 13, SCGH Progress notes (30.06.21 - 01.07.21)
[60] Exhibit 1, Vol. 1, Tab 17M, Hospital Admittance Advice - Prisoner (30.06.22)
[61] Exhibit 1, Vol. 1, Tab 13, SCGH Progress notes (30.06.21 - 01.07.21)
[62] Exhibit 1, Vol. 1, Tab 13, SCGH Determination of Brain Death (01.07.21)
[63] Exhibit 1, Vol. 1, Tab 5, Death in Hospital Form (01.07.21)
[64] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22), pp8-9 and ts 01.11.22 (Rowland), pp14-15 & 22-24
[65] Kousothanasis GA & Sampath R *Berry Aneurysm*, Stat Pearls Publishing LLC. (26.09.22), See: www.ncbi.nlm.nih.gov
[66] Exhibit 1, Vol. 1, Tab 9B, Email - Dr S Honeybul to Sgt. A Becker (11.10.22)
[67] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22), p7

36. The Court asked a consultant neurologist (Dr Stephen Honeybul) to comment on whether it was likely that Mr Rooney's aneurysm would have been seen on a CT scan and his response was:

> Apparently one month prior to death Mr Rooney had been reviewed by a prison doctor with a one-day history of right-sided facial pain with blocked nose and sinus. He was assessed that he had sinusitis however there was only minimal easing of his pain following three weeks of therapy by way of antibiotics and analgesia. A plain CT scan would have been unlikely to reveal an underlying aneurysm. In order to detect an intracranial aneurysm a more detailed specific scan such as a CT angiogram would be required to assess the vascular anatomy and detect any underlying aneurysm. **A plain CT scan would have been unlikely to detect an aneurysm in these circumstances.**[68] [Emphasis added]

37. Dr Honeybul was also asked whether it was likely that Mr Rooney's facial pain had been due to the aneurysm and his response was:

> I think this is highly unlikely. A cerebral aneurysm generally ruptures and causes a sudden onset of severe headache, and often collapse with loss of consciousness and subsequent death. **Symptoms such as facial pain and tenderness cannot be ascribed to an aneurysm**, and most aneurysms present with an acute event and with no preceding signs or symptoms.[69] [Emphasis added]

38. For the sake of completeness, I note the police investigation report states that the symptoms of berry aneurysms include "*headache in a particular area, pain above or behind the eye, nausea and double vision*".[70] Dr Honeybul disagreed with this assertion, commenting that:

> Contrary to the Police Report, **berry aneurysms usually cause no symptoms or signs and will most commonly rupture suddenly as the result of an acute event**…they usually cause no symptoms until they rupture.[71] [Emphasis added]

[68] Exhibit 1, Vol. 1, Tab 9A, Report - Dr S Honeybul (24.06.22)
[69] Exhibit 1, Vol. 1, Tab 9A, Report - Dr S Honeybul (24.06.22)
[70] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. F Thorp (15.11.21), p5
[71] Exhibit 1, Vol. 1, Tab 9B, Email - Dr S Honeybul to Sgt. A Becker (11.10.22)

CAUSE AND MANNER OF DEATH

39. A forensic pathologist (Dr C Cooke) conducted a post mortem of Mr Rooney's body on 9 July 2021 and found evidence of the recent medical care. Specialist examination found bleeding around the brain (subarachnoid haemorrhage) associated with a ruptured dilation of one of the arteries at the base of his brain (ruptured berry aneurysm).[72,73,74]

40. Toxicological examination found amitriptyline, pantoprazole, paracetamol and tramadol in Mr Rooney's system. Alcohol, cannabis, and other common drugs were not detected.[75]

41. At the conclusion of the post mortem examination, Dr Cooke expressed the opinion that the cause of death was subarachnoid haemorrhage due to rupture of a berry aneurysm. Dr Cooke also expressed the opinion that Mr Rooney's death was consistent with natural causes.

42. I accept and adopt Dr Cooke's conclusion, and find that Mr Rooney died from subarachnoid haemorrhage due to the rupture of a berry aneurysm.

43. In view of all of the circumstances, and given that there is no evidence that Mr Rooney was exposed to any trauma immediately before his collapse, I find that death occurred by way of natural causes.

[72] Exhibit 1, Vol. 1, Tab 6B, Confidential Report to the Coroner -Post Mortem Report (09.07.21)
[73] Exhibit 1, Vol. 1, Tab 6A, Confidential Report to the Coroner - Supplementary Post Mortem Report (09.09.21)
[74] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (14.07.21)
[75] Exhibit 1, Vol. 1, Tab 8, Toxicology Report (19.07.21)

QUALITY OF SUPERVISION, TREATMENT AND CARE

44. Routine screening is not carried out in relation to berry aneurysms due to their rarity, and the need to avoid exposing the brain to unnecessary exposure. In reality, most berry aneurysms are discovered incidentally and as noted, in most cases they cause no symptoms prior to rupturing.[76]

45. For those reasons, and after reviewing the evidence of Dr Honeybul and Dr Rowland, I am satisfied there was no basis on which Mr Rooney should have been subjected to such investigations. Mr Rooney died when his undiagnosed berry aneurysm unexpectedly ruptured. Once this had occurred, his prognosis was necessarily very poor.[77]

46. In relation to the quality of medical care provided to Mr Rooney, the Review observed:

> Mr Rooney received appropriate care from his time of reception, with some improvements in documentation noted.[78] These could have improved preventative health care activity but are unrelated to his ultimate acute event. Mr Rooney had a long complex history of headaches, and the management of his presentation with headache and facial pain in June 2021, associated with blocked nose and dental problem was appropriate, including escalation in treatment and a request for Cranial CT when initial treatment was not effective. Management of his acute collapse was appropriate, and his addition to the Terminally ill list and communication after his deterioration were well done.[79]

47. As for improvements following Mr Rooney's death, the Review noted that the Health Services branch of DOJ had strengthened procedures and policies to improve compliance in relation to the updating of Active Problem Lists on EcHO, the maintenance of prisoner Health Summaries, and the completion of transfer handovers when prisoners are moved between facilities.

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[76] ts 01.11.22 (Rowland), pp15 & 21
[77] ts 01.11.22 (Rowland), pp7-9; 12-13 & 21-22
[78] That is, adding high blood pressure to Mr Rooney's Active Problem List, and noting his left ventricular hypertrophy
[79] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22), p10

48. The review also noted that "*Ongoing education to staff is an ongoing requirement to maintain compliance with standards*", although as Dr Rowland pointed out at the inquest, there is a constant tension between the need for education balanced against the desire not to overload staff with limited available time.[80,81]

49. Dr Rowland also made the following comments about ongoing attempts to monitor and improve the delivery of health services within the prison system and the challenges she and her team face:

> So the education is ongoing. The auditing is ongoing. The feedback systems are ongoing. We try to develop reports. So say for transfer-in and transfer-out, we now have a report that is…available to all staff on the Justice portal, which reports…for each prison (on) how many patients got the transfer-in assessment done when they arrived. So the nurse managers can look at that and check that all the staff working under them are doing the transfer-in assessments…So trying to build in feedback loops to encourage ongoing compliance. **But lack of staff hampers us, and staff turnover, because you are constantly educating new staff.**[82] [Emphasis added]

50. None of the issues identified by the Review as areas for improvement, impacted on Mr Rooney's clinical journey. Further, although the staff shortages highlighted by Dr Rowland no doubt have a profound effect on the ability to deliver appropriate health care within the prison system, staffing shortages were not relevant to Mr Rooney's care.

51. Having carefully considered all of the available evidence, I am satisfied that supervision, treatment and care provided to Mr Rooney whilst he was incarcerated was reasonable and appropriate.

MAG Jenkin
Coroner
3 November 2022

[80] ts 01.11.22 (Rowland), p19
[81] Exhibit 1, Vol. 1, Tab 18, Health Services Review (10.10.22), p10
[82] ts 01.11.22 (Rowland), p19

I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

CORONER M Jenkin

3 NOVEMBER 2022