JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	MICHAEL ANDREW GLIDDON JENKIN
HEARD	:	6 SEPTEMBER 2022
DELIVERED	:	15 SEPTEMBER 2022
FILE NO/S	:	CORC 346 of 2020
DECEASED	:	SHORTTE, LESLIE

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Sergeant A. Becker assisted the Coroner.

Ms M. Barry (State Solicitor's Office) appeared for the Department of Justice.

Mr C. Beetham (of counsel) appeared for Serco Australia and Dr D. Theron.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Leslie SHORTTE*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 6 September 2022, find that the identity of the deceased person was* ***Leslie SHORTTE*** *and that death occurred on 3 March 2020 at Bethesda Health Care from complications of metastatic squamous cell carcinoma (terminal palliation) in the following circumstances:*

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INTRODUCTION

1. Mr Leslie Shortte (Mr Shortte) died on 3 March 2020 at Bethesda Health Care from complications of metastatic squamous cell carcinoma. At the time of his death, Mr Shortte was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (DOJ). Accordingly, Mr Shortte was a "*person held in care*" and his death was a "*reportable death*".[1,2,3,4,5,6]

2. In such circumstances, a coronial inquest is mandatory.[7] Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care that the person received whilst in that care.[8]

3. Accordingly, on 6 September 2022, I held an inquest into Mr Shortte's death. The documentary evidence adduced at the inquest included reports prepared by the Western Australia Police Force[9] and DOJ[10] respectively, which together comprised two volumes.

4. The following witnesses gave evidence at the inquest:

a. Dr Doret Theron, Medical Officer, Acacia Prison;[11]

b. Dr Joy Rowland, Medical Director, DOJ;[12] and

c. Ms Toni Palmer, Senior Review Officer, DOJ.[13]

5. The inquest focused on the care provided to Mr Shortte while he was in custody and the circumstances of his death.

[1] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (24.03.20)
[2] Exhibit 1, Vol 1, Tab 4, P92 - Identification of deceased person by visual means (09.03.20)
[3] Exhibit 1, Vol 1, Tab 5, Death in hospital form (03.03.20)
[4] Exhibit 1, Vol 1, Tab 6, Post Mortem Report (10.03.20)
[5] Section 16, *Prisons Act 1981* (WA)
[6] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[7] Section 22(1)(a), *Coroners Act 1996* (WA)
[8] Section 25(3) *Coroners Act 1996* (WA)
[9] Exhibit 1, Vol 1, Tab 2, Report - Sen. Const. A. May (24.03.20)
[10] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22)
[11] Exhibit 1, Vol 2, Tab 19, Statement - Dr D Thoron (undated) and ts 28.07.22 (Theron), pp4-31
[12] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22) and ts 06.09.22 (Rowland), pp32-52
[13] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), pp19-20 and ts 06.09.22 (Palmer), pp52-57

MR SHORTTE

Background[14,15]

6. Mr Shortte was born in Fremantle on 27 December 1948 and was 71-years of age when he died. He had seven brothers and two sisters and it appears he left school after Year 8. He worked as a wool presser for many years, and as a storeman.

7. Mr Shortte and his first wife had a son, but they subsequently divorced. In 1993, Mr Shortte married his second wife, but they separated in late 2005. Mr Shortte was described by a family member as a "*lost soul*" and as "*the black sheep of the family*".

Circumstances of last incarceration[16,17]

8. On 29 August 2006, in the Supreme Court of Western Australia at Perth, Mr Shortte was convicted of the wilful murder of his second wife, who had refused to reconcile with him after they had separated. Mr Shortte was sentenced to life imprisonment, and ordered to serve a minimum term of 17-years before being eligible for parole. His sentence was backdated to the date he was taken into custody, and his earliest parole eligibility date was calculated as 28 December 2022.[18,19]

Prison history[20]

9. Mr Shortte was admitted to Hakea Prison on 29 December 2005, and his prison placements thereafter were as follows:

a. ***Hakea Prison*** (Hakea)***:***
29.12.05 - 13.10.06 (288 days)

b. ***Casuarina Prison*** (Casuarina)***:***
13.10.06 - 14.01.15 (3,015 days) & 27.01.20 - 02.03.20 (35 days)

c. ***Acacia Prison*** (Acacia)***:***
14.01.15 - 27.01.20 (1,839 days)

[14] Exhibit 1, Vol 1, Tab 8, Statement - Sen. Const. A May (11.04.20), paras 5-18
[15] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), p8
[16] Exhibit 1, Vol 1, Tab 13, Sentence Summary - Offender
[17] Exhibit 1, Vol 1, Tab 14, Criminal history - Mr L Shortte
[18] Exhibit 1, Vol 1, Tab 9, Sentencing remarks, Miller J, (29.08.06), pp1-6
[19] Exhibit 1, Vol 1, Tab 2, Report - Sen. Const. A. May (24.03.20), 2
[20] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), pp9-16

10. Assessments in September 2006 determined that Mr Shortte might benefit from programs dealing with cognitive skills, domestic violence, and substance use "*in the latter portion of his sentence*". Mr Shortte disclosed a pattern of heavy alcohol use from the age of 16-years, and acknowledged that alcohol had been his "*primary coping mechanism*" for most of his life. Nevertheless, he was reportedly "*reluctant to accept his alcohol use as problematic*".[21,22,23]

11. An education and vocational assessment determined that Mr Shortte's communication skills were satisfactory, and that his numeracy skills were very good. Mr Shortte had a strong work history in the wool industry but in view of his age and the length of his sentence, it was determined that career guidance was not a priority. Mr Shortte declined to undertake any educational courses, and said that his family would accommodate him when he was eventually released.[24]

12. Whilst incarcerated, Mr Shortte underwent numerous classification reviews to assess his security rating and placement. His initial security rating of "*maximum*" was reduced to "*medium*" in 2007. In 2014, Mr Shortte was employed as a unit worker in the self-care unit, and was described as "*an above average worker*" who was "*quiet, polite and respectful*".[25,26]

13. During his incarceration, Mr Shortte was subjected to 10 drug and alcohol screens, all of which were negative. He was not convicted of any prison offences, and he had regular visits from members of his family. It appears that Mr Shortte wrote few letters and made no phone calls. Several alerts were current at the time of his death including risks to/from other prisoners, and a notification that he required a soft vehicle seat when being transferred.[27,28,29,30,31]

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[21] Exhibit 1, Vol 2, Tab 16.4, Cognitive skills - Initial assessment (13.9.06)
[22] Exhibit 1, Vol 2, Tab 16.4, Treatment - Violent offending checklist (13.9.06)
[23] Exhibit 1, Vol 2, Tab 16.4, Treatment - Substance use offending checklist (13.9.06)
[24] Exhibit 1, Vol 2, Tab 16.5, Education and vocational training checklist (14.9.06)
[25] Exhibit 1, Vol 2, Tab 16.6, Classification Reviews (Various dates: 2006 - 2014)
[26] Exhibit 1, Vol 2, Tab 16.6, Classification Reviews (29.09.14)
[27] Exhibit 1, Vol 2, Tab 16.20, Substance use test results
[28] Exhibit 1, Vol 2, Tab 16.19, Loss of privileges & charge history
[29] Exhibit 1, Vol 2, Tab 16.21, Visit history - Offender
[30] Exhibit 1, Vol 2, Tab 16.22, Prisoner Mail & Prisoner Telephone system records
[31] Exhibit 1, Vol 2, Tab 16.23, Alert history

14. Whilst he was in prison, Mr Shortte completed the following programs: Cognitive Skills Think First (19.08.16); Addictions Offending Pathways (19.02.18); and Violent Offending/Domestic Violence (01.03.19). He was the subject of a series of individual management plans (IMP), the last of which was approved in September 2019. At the time, Mr Shortte was housed at Acacia where he was employed as a unit cleaner. Mr Shortte was regarded as a "*valued employee*" and his IMP notes:

> Mr Shortte resides in the November Block (Self Care) on an earned level of supervision. He abides by the rules and regulations of the prison and responds well to authority. He does not come to the attention of the staff in a negative way, is self-sufficient and maintains his personal and cell hygiene to an acceptable standard. He interacts with his peers on a regular basis and appears to be functioning well within the Unit.[32]

Management on ARMS[33,34]

15. The At Risk Management System (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. When a prisoner is placed on ARMS, an interim management plan is developed and the prisoner is subject to observations of either high, moderate or low frequency. In mid-2016, ARMS observation levels were changed and are now: high (one-hourly), moderate (2-hourly), and low (4-hourly).[35]

16. During his incarceration, Mr Shortte was managed on ARMS on several occasions. On 9 January 2015, he was placed on moderate ARMS after threatening self-harm if he was transferred to Acacia. He was subsequently removed from ARMS on 28 January 2015 and placed on the Support and Management System (SAMS) for ongoing monitoring. He was eventually removed from SAMS on 5 March 2015 on the basis that he was no longer at risk.[36,37,38,39]

[32] Exhibit 1, Vol 2, Tab 16.7, Individual Management Plan (25.09.19)
[33] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), pp11-12 & 18 and ts 06.09.22 (Palmer), p56
[34] Exhibit 1, Vol 2, Tab 16.25, Prison counselling notes (2006 - 2020)
[35] Exhibit 2, ARMS Manual (2019), pp2-13 & 21-24
[36] Exhibit 1, Vol 2, Tab 16.25, Prison counselling notes (09.01.15)
[37] Exhibit 1, Vol 2, Tab 16.12, Case Conference (05.03.15)
[38] Exhibit 2, ARMS Manual (2019), pp3, 9 & 24
[39] Exhibit 1, Vol 2, Tabs 16.8 – 16.11, PRAG Minutes (09, 15, 21 & 28.01.15)

17. Mr Shortte was seen by counsellors from what was then known as the Prisoner Counselling Service (PCS) on various occasions. During these sessions, he verbalised negative thoughts about his offending behaviour and openly expressed suicidal and self-harm ideation. However, he also routinely reassured PCS staff that he would not act on these thoughts, citing the negative impact that his death would have on his siblings.

18. Mr Shortte's PCS sessions generally coincided with so called "*dates of interest*". These included the anniversaries of his wedding and his dog's death, and Christmas time, which was around the time of his son's birthday and the date he murdered his second wife.

19. On 17 December 2015, Mr Shortte was placed on low ARMS after he said he was having difficulty coping. He remained on low ARMS until 31 December 2015, and was then placed on SAMS. He was finally removed from SAMS on 22 March 2016.[40,41,42]

20. Mr Shortte's last recorded interaction with PCS was on 28 January 2020. On that occasion he was described as "*tearful*" and said he may need counselling as it was around the time of the offence for which he was imprisoned. The PCS notes for this session state:

> On review of notes, this prisoner is always upset around this time of year but has declined PCS contact for the last 3-years. Currently undergoing palliative care and in regular contact with nursing staff. Is aware how to self-refer to PCS, so this referral will be closed.[43]

21. Having reviewed the available evidence, I am satisfied that Mr Shortte's self-harm/suicide risk was appropriately managed, and that he had access to PCS staff when he required it.

[40] Exhibit 1, Vol 2, Tab 16.13, PRAG Minutes (18, 24 & 31.12.15)
[41] Exhibit 1, Vol 2, Tab 16.14, Case Conference (28.01.16)
[42] Exhibit 1, Vol 2, Tab 16.15, Case Conference (22.03.16)
[43] Exhibit 1, Vol 2, Tab 16.25, PCS File Note (28.01.20)

Management on the terminally ill register[44]

22. At the time of Mr Shortte's death, prisoners with a terminal illness were managed in accordance with a DOJ policy known as "*Policy Directive 8 Prisoners with a Terminal Medical Condition*" (PD8).[45] From 28 June 2021, prisoners with a terminal illness have been managed under a new policy referred to as "*COPP 6.2 Prisoners with a Terminal Medical Condition*" (COPP6.2), which is in similar terms to PD8.[46] At the relevant time, PD8 defined "*terminal illness*" in these terms:

> One or more medical conditions that on their own or as a group may significantly increase a prisoner's potential to die in custody, having regard to the nature of the condition(s) and the length of the prisoner's sentence.[47]

23. Under PD8, once a prisoner was identified as having a terminal illness, a note was made in the terminally ill module of the TOMS (Total Offender Management Solution, the computer system DOJ uses for prisoner management). The prisoner's expected prognosis is designated by identifying them as Stages 1, 2, 3, or 4. Mr Shortte was identified as a Stage 2 prisoner on 31 January 2020, meaning his death was expected within 12-months. His status was escalated to Stage 4 on 6 February 2020, but then deescalated to Stage 3 on 10 February 2020 before being escalated to Stage 4 again on 21 February 2020. Stage 4 meant that Mr Shortte's death was expected imminently.[48,49]

24. One implication for a prisoner being identified as terminally ill relates to the monitoring the prisoner receives. However, all prisoners with serious health conditions are subject to regular reviews, regardless of whether they are on the terminally ill list or not. Another implication is that Stage 3 and 4 sentenced prisoners may be considered for early release pursuant to an exercise of the Royal Prerogative of Mercy (RPOM).[50]

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[44] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), pp7 & 19-20 and ts 06.09.22 (Palmer), pp53-55
[45] Exhibit 1, Vol 2, Tab 16.26, Policy Directive 8 Prisoners with a Terminal Medical Condition
[46] ts 06.09.22 (Palmer), p56
[47] Exhibit 1, Vol 2, Tab 16.26, Policy Directive 8 Prisoners with a Terminal Medical Condition, p2 (para 4)
[48] Exhibit 1, Vol 2, Tab 17, Health Services Summary - Acacia Prison (10.07.22)
[49] Exhibit 1, Vol 2, Tab 16.26, Policy Directive 8 Prisoners with a Terminal Medical Condition, pp2-5 (paras 4.1.1-4.4.6)
[50] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), p19

25. Following Mr Shortte's death, Ms Toni Palmer (a senior review officer with DOJ) conducted a review of the circumstances of his death "*for the purposes of supporting the Department in proactively identifying systemic issues and operational risks that may need to be addressed to prevent similar deaths from happening in the future*".[51] Ms Palmer made one finding which she set out in a document entitled "*Review of Death in Custody*" (DIC Review).

26. Ms Palmer found that contrary to the provisions of PD8, a briefing note in relation to Mr Shortte's early release under the RPOM was not sent to the Minister for Corrective Services (the Minister) when Mr Shortte was identified as a Stage 3 terminally ill prisoner, or when he was elevated to Stage 4. This failure occurred because the position of the person responsible for drafting such briefing notes was abolished in 2017.[52]

27. Given the nature of Mr Shortte's offending behaviour and his medical condition, it is probably unlikely he would have been released pursuant to an exercise of the RPOM in any event. Nevertheless, as Ms Palmer relevantly pointed out in the DIC Review:

> By not preparing the briefing note to the Minister as required by the policy, Mr Shortte could not be considered for early release through the exercise of RPOM unless he (Mr Shortte) made such an application to the Attorney General himself.[53]

28. Having made that finding, Ms Palmer recommended that the requirements of COPP6.2 be reinforced so as to ensure that briefing notes in relation to the early release of Stage 3 or Stage 4 terminally ill prisoners under the RPOM, are prepared in a timely manner. Ms Palmer confirmed that since mid-2020, DOJ's sentence management unit:

> [H]as been provided with an additional position in their establishment, and the provision of Terminally Ill briefings is one of the tasks being undertaken in that role.[54]

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[51] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), p4
[52] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), pp19-20 and ts 06.09.22 (Palmer), p55
[53] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), p20 and ts 06.09.22 (Palmer), p55
[54] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), p20 and ts 06.09.22 (Palmer), p55

MEDICAL ISSUES

Overview of medical conditions[55,56]

29. Mr Shortte was a life-long heavy smoker of cigarettes and in the community, he was a heavy drinker who consumed alcohol on a daily basis. Despite this, Mr Shortte had no recorded medical conditions on his admission to prison.

Medical management during incarceration[57,58,59,60,61,62]

30. Mr Shortte was regularly seen in prison medical centres (PMC), although departmental records show he routinely declined recommended diagnostic tests and/or referrals to specialist medical practitioners. For example, in 2015, Mr Shortte complained of a painful left shoulder and was diagnosed with adhesive capsulitis, but declined treatment. That same year, he also complained of abdominal pain, which was thought to be related to kidney stones, but he refused to attend hospital for an ultrasound. In May 2018 he was diagnosed with a right inguinal hernia but again, he declined any treatment.

31. On 11 March 2019, Mr Shortte was seen by a prison nurse for a "*burst abscess*" on his right shoulder which he said had been present for "*a few weeks*". When reviewed on 14 March 2019, Mr Shortte said the lesion had been there for 6-months. He admitted "*picking at*" the wound and was advised to stop doing so, before being prescribed antibiotics.[63]

32. On 21 March 2019, Mr Shortte was reviewed by Dr Doret Theron, a prison medical officer (PMO) at Acacia, who diagnosed the shoulder lesion as a basal cell carcinoma (BCC). Mr Shortte also had a "*wart like lesion*" on his left foot which he said had been there for 18-months. The foot lesion was treated with cryotherapy (i.e.: liquid nitrogen) and both lesions were scheduled for removal on 2 April 2019.[64]

[55] Exhibit 1, Vol 2, Tab 17, Health Services Summary - Acacia Prison (10.07.22)
[56] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22)
[57] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), pp17-18
[58] Exhibit 1, Vol 2, Tab 17, Health Services Summary - Acacia Prison (10.07.22) and ts 06.09.22 (Theron), pp4-31
[59] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22) and ts 06.09.22 (Rowland), pp32-52
[60] Exhibit 1, Vol 1, Tab 12, EcHO medical records (2009-2020)
[61] Exhibit 1, Vol 2, Tab 18, Report - Dr C Fitzclarence (21.07.22)
[62] Exhibit 1, Vol 2, Tab 19, Statement - Dr D Theron (undated), paras 4-13
[63] Exhibit 1, Vol 1, Tab 12, EcHO medical records (11 03.19 & 14.03.19)
[64] Exhibit 1, Vol 1, Tab 12, EcHO medical records (21.03.19) and ts 06.09.22 (Theron), p6

33. What was thought to be a BCC on Mr Shortte's right shoulder was removed as planned in the PMC on 2 April 2019. However, subsequent histopathological analysis confirmed that the BCC was actually an invasive, moderately differentiated, squamous cell carcinoma (SCC), a lesion with a known high-risk of spreading. Entries in EcHO (the computer system used by DOJ to record health interactions with prisoners) states that half of the lesion on Mr Shortte's left foot had fallen off, and that Mr Shortte subsequently attended the PMC for daily dressings.[65,66]

34. On 30 April 2019, after reviewing the histopathological analysis, Dr Theron told Mr Shortte that she recommended a further excision of his SCC as well as the removal of the lesion on his foot. In accordance with procedures in place at Acacia at the time, Dr Theron gave Mr Shortte a "*paper slip*" on which was written "*removal of lesion*". The system relied on Mr Shortte handing this paper slip to the PMC receptionist so that an appointment for the planned procedures could be booked. However, it appears that Mr Shortte failed to do so.[67]

35. When Mr Shortte presented to the PMC on 17 August 2019, he asked for the lesion on his foot to be removed and said he had "*forgotten*" about his previous appointment. In fact, an appointment for the removal of the SCC on his shoulder was never booked in April 2019. Further, despite the fact that the SCC was a high-risk lesion, in terms of the risk of it spreading, Mr Shortte was never followed up by the PMC.

36. In any case, an appointment for the removal of Mr Shortte's SCC and his foot lesion was booked for 10 September 2019. However, once again when Mr Shortte did not attend the appointment, there was no follow up by the PMC. Acacia's failure in this regard is significant given that the need to remove the SCC had been identified some five months previously on 30 April 2019. Despite the importance of re-excising the SCC, it appears that there was no effective system in place at Acacia to follow up non-attendances of this kind.[68,69]

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[65] Exhibit 1, Vol 1, Tab 12, EcHO medical records (02.04.19) and ts 06.09.22 (Theron), p6 and ts 06.09.22 (Theron), pp27-28
[66] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22), pp5 & 6
[67] Exhibit 1, Vol 1, Tab 12, EcHO medical records (30.04.19) and ts 06.09.22 (Theron), pp6-7
[68] Exhibit 1, Vol 1, Tab 12, EcHO medical records (17.08.19)

37. When Mr Shortte next presented to the PMC on 20 November 2019, he complained of a weeping lesion on his neck. A different PMO (Dr de Bruin) noted a large solid mass at the right base of Mr Shortte's neck, which he (Dr de Bruin) thought might be a sebaceous cyst or possibly an enlarged lymph node.

38. Mr Shortte was started on antibiotics and an ultrasound was planned. However, although Mr Shortte was supposed to attend the PMC for daily dressings for his neck lesion, he failed to do so, and once again there is no evidence of any follow up by the PMC.[70] When Dr de Bruin saw Mr Shortte again on 25 November 2019, he made the following note in EcHO: "*Still possible sebaceous cyst. Need to exclude* ***sinister origin***" [Emphasis added].[71]

39. It seems clear Dr de Bruin's expectation was that an ultrasound would be booked, because an entry in EcHO by a prison nurse on 26 November 2019 states "*Awaiting US (ultrasound) as o/pt* (i.e.: outpatient)". However, notwithstanding Dr de Bruin's justifiable desire to exclude a "*sinister*" explanation for the mass at the base of Mr Shortte's neck, no immediate steps were taken to arrange the ultrasound, and on 2 December 2019, it was noted that the ultrasound had still not been booked.[72]

40. An entry in EcHO on 5 December 2019 states that Mr Shortte was still waiting for an ultrasound and that no appointment had been booked. An EcHO entry on 6 December 2019 states: "*Awaiting referral to hospital for assessment and management of lesion*".[73]

41. Despite the fact that the need for an ultrasound had been identified almost two weeks previously, and Dr de Bruin's sensible desire to exclude a "*sinister*" explanation for the mass at the base of Mr Shortte's neck, the requested ultrasound went unperformed. Acacia's failure to arrange the ultrasound in a timely manner has not been explained.

[69] ts 06.09.22 (Theron), pp28-29
[70] Exhibit 1, Vol 1, Tab 12, EcHO medical records (20.11.19)
[71] Exhibit 1, Vol 1, Tab 12, EcHO medical records (25.11.19)
[72] Exhibit 1, Vol 1, Tab 12, EcHO medical records (26.11.19 & 02.12.19)
[73] Exhibit 1, Vol 1, Tab 12, EcHO medical records (05 & 06.12.19)

Admission to SJOG Midland Hospital: 9 - 12 December 2019[74,75,76]

42. Mr Shortte was finally admitted to SJOG Midland Hospital (SJOG) on 9 December 2019, for "*assessment and management of lesion*" which presumably included the much discussed ultrasound. The EcHO entry in relation to this transfer records Mr Shortte's diagnosis as: "*??sebaceous cyst ??more sinister pathology*", and notes that the mass at the base of Mr Shortte's neck had been getting larger over the previous four months. On 11 December 2019, Mr Shortte underwent a procedure to drain the "*lesion*" on his neck and was discharged back to Acacia with a course of antibiotics the following day.

Admission to SJOG Midland Hospital: 2 - 23 January 2020[77,78,79]

43. After his return to Acacia, Mr Shortte attended the PMC for daily dressings, but the wound on his neck failed to heal, and the mass continued to grow. On 2 January 2020, Mr Shortte was readmitted to SJOG, where he underwent a biopsy and CT and PET scans. As a result of these investigations, Mr Shortte was diagnosed with an invasive SCC of the neck with secondary tumours (metastases) in his rear neck lymph nodes, right parotid gland and both lungs. The lesion on his left foot was also thought to be a secondary tumour. Mr Shortte's admission was complicated by elevated calcium levels (hypercalcaemia), but following treatment, he was returned to Acacia on 23 January 2020.

Transfer to Casuarina infirmary: 27 January 2020[80,81,82]

44. After returning to Acacia, Mr Shortte's condition deteriorated and he was transferred to the Casuarina infirmary on 27 January 2020, where he was given a frame as he was having trouble walking. Mr Shortte started a course of radiotherapy at Sir Charles Gairdner Hospital (SCGH) on 30 January 2020, the aim of which was to reduce the size of the tumour in his neck, and hopefully alleviate pain symptoms.

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[74] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), p14
[75] Exhibit 1, Vol 2, Tab 17, Health Services Summary - Acacia Prison (10.07.22), pp23-25
[76] Exhibit 1, Vol 1, Tab 12, EcHO medical records (09-12.12.19)
[77] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), p14
[78] Exhibit 1, Vol 2, Tab 17, Health Services Summary - Acacia Prison (10.07.22), pp32-36
[79] Exhibit 1, Vol 1, Tab 12, EcHO medical records (02-23.01.20)
[80] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), pp14-15
[81] Exhibit 1, Vol 1, Tab 12, EcHO medical records (27-31.01.20)
[82] Exhibit 1, Vol 2, Tab 16.16, Letter SCGH (Radiation Oncology) to SJOG (30.01.20)

45. On 31 January 2020, Mr Shortte was vomiting and weak and although he was taken to FSH for assessment he was returned to the Casuarina infirmary the same day at his request.[83]

46. On 5 February 2020, Mr Shortte attended SCGH for further radiotherapy and was noted to have been exhausted on his return to the Casuarina infirmary. Mr Shortte attended SCGH for his next dose of radiotherapy on 6 February 2020, but was noted to be confused and lethargic and was re-admitted to FSH for assessment.[84]

47. Mr Shortte was diagnosed with hypercalcaemia and after treatment, he was transferred to Fremantle Hospital on 10 February 2020 for further management. He was eventually returned to the Casuarina infirmary on 20 February 2020.[85]

[83] Exhibit 1, Vol 1, Tab 12, EcHO medical records (31.01.20)
[84] Exhibit 1, Vol 1, Tab 12, EcHO medical records (05.02.20 & 06.02.20)
[85] Exhibit 1, Vol 1, Tab 12, EcHO medical records (10.02.20 & 20.02.20)

EVENTS LEADING TO DEATH[86]

Transfer to FSH: 21 - 28 February 2020[87]

48. On 21 February 2020, Mr Shortte was readmitted to FSH with fever, increased pulse rate and laboured breathing. He was diagnosed with delirium and aspiration pneumonia, and his admission was further complicated by clots in the arteries of both lungs (bilateral pulmonary emboli) and hypercalcaemia. He was treated with anticoagulants, antibiotics, and intravenous fluids, and his calcium levels and mental state gradually improved.

49. During his hospital admissions, Mr Shortte's ongoing supervision was handled by Broadspectrum, a departmental contractor that provides custodial officers for this purpose. Broadspectrum records indicate that Mr Shortte was transferred to Bethesda Health Care (BHC) for palliative care at 9.30 am on 29 February 2020, although the FSH discharge summary suggests the transfer occurred on 28 February 2020.[88,89]

Palliative care: 29 February - 3 March 2020[90,91,92,93,94]

50. On arrival at BHC, Mr Shortte was assessed as "*terminally restless and confused*" and he complained of neck pain. He was given pain relief and on 1 March 2020, the Superintendent of Casuarina approved the removal of Mr Shortte's restraints.[95,96]

51. Mr Shortte's condition continued to deteriorate, and at about 7.15 am on 3 March 2020, Broadspectrum officers noticed he had stopped breathing. Nursing staff were alerted and Mr Shortte was declared deceased at 7.20 am.[97,98]

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[86] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), pp15-16
[87] Exhibit 1, Vol 1, Tab 10, Fiona Stanley Hospital Discharge summary (28.02.20)
[88] Exhibit 1, Vol 2, Tab 16.17, PIC Record of events: 233949 (9.30 am, 29.02.20)
[89] Exhibit 1, Vol 1, Tab 10, FSH Discharge Summary (28.02.20)
[90] Exhibit 1, Vol 1, Tab 11, Bethesda Palliative Care Unit Inpatient notes (29.02.20 - 03.03.20)
[91] Exhibit 1, Vol 1, Tab 11, Bethesda Palliative Care Unit Discharge summary (03.03.20)
[92] Exhibit 1, Vol 2, Tab 16, Death in Custody Review (30.06.22), pp15-16
[93] Exhibit 1, Vol 2, Tab 16.17, PIC Record of events: 233949- 233979 (29.02.20 - 03.03.20)
[94] Exhibit 1, Vol 2, Tab 16.17, Death in custody package relating to admission to BHC (29.02.20 - 03.03.20)
[95] Exhibit 1, Vol 2, Tab 16.17, Letter - Dr S Kondasinghe to OIC Casuarina Prison (01.03.20)
[96] Exhibit 1, Vol 2, Tab 16.17, PIC Record of events - 233962 (10.42 am, 01.03.20)
[97] Exhibit 1, Vol 1, Tab 5, Death in Hospital form - Bethesda Hospital(03.03.20)
[98] Exhibit 1, Vol 1, Tab 3, Memorandum - Sen. Const. A May (03.03.20)

CAUSE AND MANNER OF DEATH[99,100]

52. A forensic pathologist, (Dr Varaja), conducted an external post mortem examination of Mr Shortte's body on 10 March 2020 and reviewed CT scans and his hospital medical notes.

53. Dr Varaja noted a large fungating tumour at the base of Mr Shortte's neck and that his right lung had collapsed. There was fluid in his chest cavity (pleural effusions) and hardening and thickening of his arteries (arterial atherosclerosis), but no evidence of injury was identified.

54. Toxicological analysis found a number of medications in Mr Shortte's system that were consistent with his hospital care, namely lignocaine, midazolam, morphine, and paracetamol. Alcohol and other common drugs were not detected.[101]

55. Following her external post mortem examination, Dr Varaja expressed the opinion that the cause of Mr Shortte's death was:

> Complications of metastatic squamous cell carcinoma (terminal palliation).[102]

56. I accept and adopt Dr Varaja's conclusion as to the cause of Mr Shortte's death and further, I find that his death occurred by way of natural causes.

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[99] Exhibit 1, Vol 1, Tab 6, Post Mortem Report (10.03.20)
[100] Exhibit 1, Vol 1, Tab 6, Letter - Dr Vagaja to State Coroner(10.03.20)
[101] Exhibit 1, Vol 1, Tab 7, ChemCentre Report (07.04.20)
[102] Exhibit 1, Vol 1, Tab 6, Letter - Dr Vagaja to State Coroner(10.03.20), p2

ISSUES IDENTIFIED IN MR SHORTTE'S CARE

Overview[103,104]

57. At DOJ's request, Dr Cherelle Fitzclarence conducted a review of Mr Shortte's medical care whilst he was incarcerated. Dr Fitzclarence had been a PMO for about 10-years and was previously the Deputy Director of Health Services. She is therefore in an excellent position to assess Mr Shortte's care.

58. Dr Fitzclarence identified several concerning issues relating to Mr Shortte's care, including: a lack of annual health assessments between 2016 and 2019, the fact that Mr Shortte's heavy smoking was not adequately addressed, and the fact that there was a lack of follow up in relation to key clinical issues.

59. Following Mr Shortte's death, DOJ also conducted a review of the health services provided to him during his incarceration (the Review). The Review identified similar issues to those flagged by Dr Fitzclarence and provided additional information and context.

60. Before turning to address the issues raised by Dr Fitzclarence and the Review, I note that Dr Fitzclarence also commented on Mr Shortte's management on the Terminally Ill list and his possible release pursuant to an exercise of the RPOM. As I have already addressed both of these issues, I do not propose to make further comments about them here.

Annual health assessments not completed

61. Annual health assessments of prisoners are conducted by prison nurses and take about 45-minutes. During the assessment, basic observations, such as height, weight, blood pressure and pulse rate are taken, and the prisoner is asked a series of questions about their general health. The assessment relies heavily on prisoners providing accurate answers to these questions, and does not routinely include a skin check.[105]

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[103] Exhibit 1, Vol 2, Tab 18, Report - Dr C Fitzclarence (21.07.22)
[104] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22)
[105] ts 06.09.22 (Rowland), p36

62. The current DOJ policy is that health assessments will be conducted annually for all prisoners. Previously this was not required where the prisoner was being seen regularly at a PMC for other issues. The number of available nurses, a rising prison muster, and restrictions imposed because of the COVID-19 pandemic have all impacted on DOJ's goal of completing an annual health assessment for every prisoner. The current state-wide average for compliance is a rather dismal 46.9%, with Casuarina at 13.9%, Hakea at 40.6%, and Acacia faring much better at 65.2%.[106]

63. Mr Shortte's last recorded annual health assessment occurred on 2 December 2015. No major issues were identified at that time and his vital signs were within the normal limits. After 2015, no further annual health assessments are recorded and Mr Shortte had minimal contact with the PMC until 2019. Mr Shortte clearly had the right to refuse annual assessments, but it would have been appropriate to document any such refusals, including any reasons Mr Shortte may have given.[107,108]

64. Had Mr Shortte been the subject of annual health assessments after 2015, it is possible his skin lesions might have been identified earlier. However, this is by no means certain because it is not known when the lesions actually became obvious to Mr Shortte. Further, as I have mentioned, Mr Shortte had a propensity to refuse medical assessments in any event. Perhaps all that can be said with any confidence is that it would have been preferable for Mr Shortte to have been offered annual health assessments and, if he refused them, for this to have been documented.

Was Mr Shortte's smoking adequately addressed?

65. DOJ policy is that all prisons in Western Australia will eventually be smoke-free. As I have already noted on his admission to prison, Mr Shortte was a heavy smoker and he continued to smoke throughout his incarceration.[109,110,111]

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[106] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22), pp5-6 and ts 06.09.22 (Rowland), pp29-30
[107] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22), p5 and ts 06.09.22 (Rowland), pp33-38
[108] ts 06.09.22 (Theron), pp15-16
[109] ts 06.09.22 (Rowland), pp49-50
[110] ts 06.09.22 (Theron), pp19-20
[111] See also: ts 06.09.22 (Beetham), pp59-60

66. Although his smoking habit was raised with him during his last annual health assessment in 2015, the relevant EcHO entry states: "*Is a heavy smoker but has no interest in quitting*".[112] Whilst it is possible that the issue of smoking cessation was raised with Mr Shortte on other occasions, as Dr Fitzclarence relevantly noted:

> Mr Shortte was a heavy smoker. Preventative care and brief interventions were not carried out or if they were, they were not documented. Smoking is a risk factor of squamous cell carcinoma.[113]

67. It would obviously have been preferable for Mr Shortte to have stopped smoking. However, given he was a lifelong smoker and was 56-years of age when admitted to prison, it is probably unrealistic to have expected that Mr Shortte would have stopped smoking, even with encouragement. Further, Mr Shortte had referred to smoking as one of his coping mechanisms whilst he was in prison (along with watching cricket, horse racing, prison employment, and his rapport with custodial officers).[114]

68. Mr Shortte had also previously expressed concern about the prospect of prisons becoming "smoke free", and once told a PCS counsellor that he would: "*...go for the fence if they force me to give up smoking*". The PCS notes for the counselling session in which Mr Shortte made this remark state:

> By his own admission, he's a very heavy / chain smoker and relies on this habit to distract him and give him some personal relief. Whereas the abovementioned figure of speech may not be meant literally, the author would suggest that the impact of withdrawal of the tobacco would have a particularly drastic effect on (Mr Shortte).[115]

Lack of follow up in relation to important medical care

69. As outlined earlier, on several occasions, no action was taken to follow-up on Mr Shortte's failure to attend important medical and clinical appointments, and there was an unacceptable delay in arranging an ultrasound of the mass in his neck.

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[112] Exhibit 1, Vol 1, Tab 12, EcHO medical records (02.12.15)
[113] Exhibit 1, Vol 2, Tab 18, Report - Dr C Fitzclarence (21.07.22), p4
[114] Exhibit 1, Vol 2, Tab 16.25, Prison counselling notes (17.12.15), p2
[115] Exhibit 1, Vol 2, Tab 16.25, Prison counselling notes (20.06.08)

70. One of these failures in care occurred because Acacia used a "*paper slip*" system to book follow up appointments. Under the paper slip system, prisoners were given pieces of paper setting out the date and reason for their next appointment which they were expected to hand to the PMC receptionist, who would then book the relevant appointment.[116]

71. The paper slip system used at Acacia was apparently unique, and appears to have been based (at least in part) on Acacia's "*responsible prisoner model*". That model encourages self-management on the part of prisoners and has much to commend it, especially as it aims to prepare prisoners for life in the general community upon their eventual release.[117]

72. However, what appears to have been overlooked is the notorious fact that as a group, prisoners have higher levels of chronic illness and disease and lower levels of "*health literacy*". The Australian Institute of Health and Welfare says this about health literacy:

> Health literacy relates to how people access, understand and use health information in ways that benefit their health. People with low health literacy are at higher risk of worse health outcomes and poorer health behaviours.[118]

73. In relation to Acacia's paper slip system as it applied to Mr Shortte, the Review observed (correctly in my view) that:

> Relying on the patient to book his own follow-up when he had a history of non-attendance unless acutely symptomatic **was unsafe** but was in line with the 'responsible prisoner' model operating at Acacia.[119] [Emphasis added]

74. In Mr Shortte's case, Acacia's paper slip system spectacularly failed in circumstances where the further excision of Mr Shortte's SCC was important because the SCC was a known "*high-risk*" lesion.

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[116] Exhibit 1, Vol 2, Tab 19, Statement - Dr D Theron (undated), paras 25-26
[117] ts 06.09.22 (Theron), p10 and ts 06.09.22 (Rowland), pp40
[118] See: www.aihw.gov.au/reports/australias-health/health-literacy
[119] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22), p7

75. The fact that the paper slip system was demonstrably unfit for purpose was eventually recognised by Acacia, because shortly after Mr Shortte's death, the responsibility for handing the paper slip to the PMC receptionist was assumed by the PMO. Even that change was deemed insufficient and the system was eventually abandoned altogether.[120]

76. The system now used at Acacia is that follow up appointments are booked using EcHO. PMO's create an "*intervention*" in EcHO which records the relevant action or follow up appointment. The intervention remains active until formally closed by a PMO, and where a prisoner does not attend an appointment, EcHO alerts clinicians. Depending on the urgency of the situation, action can be taken to offer the prisoner an alternative appointment. At Acacia at the relevant time, the intervention functionality of EcHO was being used, but only where the relevant appointment was more than three months away.[121]

77. To the uninitiated, EcHO is not without considerable complexity. At the inquest, Dr Theron said that although she had been a PMO at Acacia for over four years, she still felt she required further training in how to use the system. I note with approval that at the inquest, Dr Rowland undertook to liaise with the clinical team at Acacia to ensure that all relevant staff understand how to maximise EcHO's functionality.[122]

78. A second example of Acacia's failure to follow up Mr Shortte's care cannot be attributed to its use of the flawed paper slip system. When Mr Shortte attended the PMC on 17 August 2019 to ask for the lesion on his foot to be removed, it was realised that the SCC on his shoulder had not been further excised. Although an appointment for this purpose was made for 10 September 2019, when Mr Shortte did not attend no follow up action was taken.

79. So it was that the September 2019 appointment came and went, and Mr Shortte was not seen again at the PMC until 20 November 2019 - and only then because he happened to attend under his own steam.

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[120] Exhibit 1, Vol 2, Tab 19, Statement - Dr D Theron (undated), paras 27-30 and ts 06.09.22 (Theron), pp29-30
[121] ts 06.09.22 (Theron), p11-13
[122] ts 06.09.22 (Theron), pp31 and ts 06.09.22 (Rowland), pp40-43 & 46-47

80. For reasons which were unexplained, Acacia had no "*backup system*" in place at the relevant time. Thus, if important clinical appointments were missed by prisoners, no action was taken. This was an appalling state of affairs.[123]

81. Mr Shortte's failure to attend for daily dressings after being seen at the PMC on 20 November 2019, was similarly not followed up and there was an unacceptable delay in arranging an ultrasound thereafter. Admittedly, even when Mr Shortte was finally admitted to SJOG on 9 December 2019, he was treated for what was thought to be a sebaceous cyst and the lesion was surgically drained. Nevertheless, the requested ultrasound should have been more aggressively pursued by Acacia.

82. By the time Mr Shortte was diagnosed with an invasive metastatic SCC of the neck in early January 2020, his fate was essentially sealed. However, I should point out there is no evidence that even if Mr Shortte had been the subject of annual health checks after 2015 and/or had his non-attendance at appointments in April and September 2019 been followed up, that his clinical journey would have been any different. As the Review relevantly observes:

> As noted by Dr Fitzclarence in her report, it is quite possible that metastatic disease was already present at the time of the removal of the first identified skin lesion on (Mr Shortte's) shoulder, but it is not possible to know definitively that this was the case. Therefore, it is also not possible to know whether more stringent and pro-active follow-up could have prevented the final outcome.[124,125]

83. In passing, I note with approval that at the inquest, Dr Theron said that following Mr Shortte's death her practice around skin lesions had changed. At that time, it was not common for Dr Theron or her colleagues to conduct a full skin check for patients like Mr Shortte, even after the removal of a SCC. Now apparently, it is.[126]

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[123] ts 06.09.22 (Theron), pp28-29
[124] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22), p7
[125] ts 06.09.22 (Rowland), p50
[126] ts 06.09.22 (Theron), p18-19

84. The evidence before me establishes that when Mr Shortte actually attended the PMC, the care he received was of a good standard. The problem was that at key points in his clinical journey, Mr Shortte was not appropriately followed-up. Having made that observation, I accept that Mr Shortte's medical management was hampered by his refusal to undergo various recommended diagnostic tests and/or to accept medical treatment. As the Review correctly identified:

> Mr Shortte's pattern of selective engagement with health services had an impact on his care, which is likely to have been similar or even more pronounced had he been in the community. There is no suggestion of incompetency or cognitive impairment impeding Mr Shortte's decision making or capacity to seek care. In the community it is very likely he would not have attended or received annual health reviews, including any invitations for skin checks, and would still have presented late with his lesion(s). However, after removal of the first skin malignancy, ensuring the treatment for this was completed would be expected of a community primary health care service.[127]

85. However, after careful consideration, and approaching the issue holistically, I have concluded that Mr Shortte's medical care whilst he was incarcerated was suboptimal. Further, I adopt with approval the following assessment by Dr Fitzclarence:[128]

> It is my considered opinion that the health care Mr Shortte received while in the care of the Department of Justice and while outsourced to Acacia Prison which is a private facility, was less than ideal. Some of this was because Mr Shortte declined recurrently to engage with health services. Some of it was because at recurrent points both in Department sites and at Acacia, where opportunistic screening could have occurred, the opportunities were not taken. It fell short of community standards of care on multiple occasions. It fell short of the Department's own polices on multiple occasions.[129]

[127] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22), p8
[128] See: ts 06.09.22 (Rowland), pp51-52 where Dr Rowland agreed with Dr Fitzclarence's assessment
[129] Exhibit 1, Vol 2, Tab 18, Report - Dr C Fitzclarence (21.07.22), p4

IMPROVEMENTS SINCE MR SHORTTE'S DEATH

Provision of routine care[130]

86. As noted, DOJ policy is that all patients are offered annual health reviews. The Review notes that since Mr Shortte's death, a report on the compliance at each prison has been made available to health service managers and head office staff.

87. The report also provides a list of prisoners who are overdue for an annual assessment, ranked by age. Coloured flags identify those prisoners with "*high-risk conditions*" that have not had an assessment, meaning that assessments for these prisoners can be prioritised. PMO's have been provided with additional training regarding screening guidelines and relevant online resources have been placed in easily accessible folders. Prompts based on an equivalent Medicare item have also been built into the templates for annual health assessments.

Continuity of care[131]

88. As the Review points out: "*There were failures in ensuring follow-up of serious health issues newly identified and a reliance on patient self-management*". One of the issues in Mr Shortte's case was that there was a failure to update his "*active problem list*" on EcHO to include his SCC diagnosis. Had this been done, the next clinician to see Mr Shortte would have been alerted to the issue, and the overdue management of the SCC would have been visible.

89. Further, when Mr Shortte was referred to hospital, the SCC diagnosis would have been automatically included in the referral letter. This may have prompted earlier consideration of whether the lesion had metastasised. Without the SCC diagnosis in the active problem list, the pre-existing SCC would not have come to the PMO's attention, unless they went into EcHO and read the histopathology report. Given the limited time PMO's have with each prisoner they see, this would have been unlikely.

[130] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22), pp6-7 and ts 06.09.22 (Rowland), pp35-38
[131] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22), p7

90. On the important issue of follow-up, the Review identified the following improvements that have been made since Mr Shortte's death:[132]

a. *PMO education sessions*: have been conducted to emphasise the importance of using the "*interventions*" functionality of EcHO to ensure that follow-up appointments are made. PMO's undertake a self-audit to assess their compliance with these policy requirements;

b. *Reminders about updating the active problem list*: education sessions for PMO's have also emphasised the importance of regularly updating a prisoner's active problem list, to ensure visibility of critical diagnoses.

QUALITY OF SUPERVISION, TREATMENT AND CARE

91. On the basis of the evidence before me, I am satisfied that Mr Shortte was appropriately managed whilst he was incarcerated, and that his supervision was of a good standard. Mr Shortte was placed on ARMS on several occasions and he was seen by PCS staff when he required assistance.

92. Mr Shortte was entered into the terminally ill prisoner register on TOMS at the end of January 2020 when his medical condition deteriorated, although arguably this could have occurred earlier that month. Due to a critical staff vacancy, Mr Shortte's early release under the RPOM was not considered when he was made a Stage 3 prisoner, or when his status was elevated to Stage 4.

93. Whilst it is unlikely Mr Shortte's early release would have been authorised, this issue should still have been considered. It is however pleasing that the relevant staff position that generates briefing notes to the Minister about the exercise of the RPOM has been reinstated, so that this issue is unlikely to reoccur.

[132] Exhibit 1, Vol 2, Tab 20, Health Services Summary - DOJ (02.09.22), p7 and ts 06.09.22 (Rowland), pp46-48

94. Finally, as I have outlined, both Dr Fitzclarence and the Review identified a number of deficiencies in Mr Shortte's treatment whilst he was incarcerated. These errors are clearly unfortunate and lead to the inevitable conclusion that, when considered holistically, Mr Shortte's treatment whilst he was in prison was suboptimal. However, as I have pointed out, there is no evidence that Mr Shortte's clinical journey would necessarily have been any different had these errors not been made.

MAG Jenkin
Coroner
15 September 2022