JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	22 AUGUST 2024
DELIVERED	**:**	24 SEPTEMBER 2024
FILE NO/S	**:**	CORC 2474 of 2021
DECEASED	**:**	CHEEK, RAYMOND SYDNEY

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Markham assisting the Coroner
Ms G. Due (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 ***Raymond Sydney CHEEK*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 22 August 2024, find that the identity of the deceased person was* ***Raymond Sydney CHEEK*** *and that death occurred on 19 September 2021 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch, from complications in association with a gastrointestinal illness in an elderly man with diabetes mellitus, chronic liver disease and atherosclerotic heart disease medically palliated in the following circumstances:*

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INTRODUCTION

"Imprisonment is as irrevocable as death." - George Bernard Shaw

1. Raymond Sydney Cheek (Mr Cheek) died on 19 September 2021 at Fiona Stanley Hospital (FSH), Murdoch, from complications in association with a gastrointestinal illness. At the time of his death, Mr Cheek was 89 years old. He was also a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (the Department).[1]

2. Accordingly, immediately before his death, Mr Cheek was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[2] In such circumstances, a coronial inquest is mandatory.[3]

3. I held an inquest into Mr Cheek's death at Perth on 22 August 2024. The following witnesses gave oral evidence:

    i. Storm Duval (Review Officer with the Department); and
    ii. Dr Catherine Gunson (Deputy Director of Medical Services with the Department)

4. The documentary evidence at the inquest comprised of two volumes of the brief, which was tendered as exhibit 1 at the inquest's commencement.

5. During the inquest, I asked the Department to provide the Court with a copy of the policy that existed at the time of Mr Cheek's death regarding the restraining of prisoners being transferred and admitted to hospital. I also asked for a copy of the current version. In addition, I sought the Department's response as to whether it accepted that the use of restraints on Mr Cheek during his final transfer and admission to FSH complied with the Department's policies and procedures. That additional material was provided by email to the Court on 29 August 2024.

6. Included in that email was a further statement from Ms Duval dated 29 August 2024. The inquest focused on the medical care and treatment provided to Mr Cheek in Casuarina Prison (Casuarina) from 7 August 2021 until his final transfer to FSH on 12 September 2021, with a particular emphasis on the care provided to him regarding his insulin-dependent diabetes.

7. The inquest also examined the use of restraints on Mr Cheek in the final days of his life when he was transferred to FSH.

[1] *Prisons Act 1981* (WA) s 16
[2] *Coroners Act 1996* (WA) s 3 and s 22(1)(a)
[3] *Coroners Act 1996* (WA) s 25(3)

8. In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a matter adverse in nature has been proven on the balance of probabilities.

9. I am also mindful not to insert hindsight bias into my assessment of the actions taken by Mr Cheek's prison health service providers and custodial staff in their treatment of him. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it was at the time.[4]

MR CHEEK [5]

10. Mr Cheek was born on 20 January 1932 in Perth.

11. After completing high school, he worked in his father's grocery store before training to become an Anglican priest. He never married and had no children.

12. Mr Cheek was placed in the south west of Western Australia for 30 years as the Anglican parish priest in Lake Grace, Margaret River, Williams, Pingelly, Bunbury and Ravensthorpe. He was the parish priest in Como before he retired in 2002.

13. Mr Cheek had previously been convicted of sexual offending that was historical in nature. These offences were committed on various dates between 1955 and 1985. On 10 February 2017, Mr Cheek was imprisoned for a total of 2 years for this offending by the District Court of Western Australia (the District Court).

14. For the most part of this imprisonment, Mr Cheek was managed in the infirmary at Casuarina.

Circumstances of Mr Cheek's final imprisonment

15. On 6 August 2021, Mr Cheek pleaded guilty to five sexual offences committed against a young man in 1967, and three sexual offences committed against another young man between November 1998 and June 1999.

[4] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

[5] Exhibit 1, Volume 1, Tab 2, Report of Coronial Investigator dated 27 February 2023; Exhibit 1, Volume 1, Tab 23, District Court sentencing transcript dated 20 August 2021; Exhibit 1, Volume 1, Tab 24, List of Criminal Court Outcomes for Raymond Cheek dated 16 August 2022; Exhibit 1, Volume 2, Tab A, Review of Death in Custody dated April 2024

16. On 20 August 2021, the District Court sentenced Mr Cheek to 4½ years' imprisonment with eligibility for parole. His earliest date for release on parole was 5 February 2024.

Prison history for Mr Cheek's final imprisonment

17. After pleading guilty to the above offending, Mr Cheek was remanded in custody at Hakea Prison on 6 August 2021. During the reception process, it was noted that Mr Cheek did not appear well. He had difficulties walking and standing on his account.

18. Consequently, on 7 August 2021, Mr Cheek was transferred to Casuarina. He was placed in the Crisis Care Unit within the infirmary and he was to remain in that unit for the duration of his time in prison.

OVERVIEW OF THE MEDICAL TREATMENT AND CARE PROVIDED TO MR CHEEK [6]

19. By the time of his final imprisonment, Mr Cheek had multiple comorbidities. These included chronic renal failure, type-2 diabetes, hypertension, a complete heart block managed by a permanent pacemaker, cerebrovascular disease, hypothyroidism, abdominal aortic aneurysm, dyslipidaemia, prostatic enlargement, duodenal ulcer, poor mobility and an inability to attend to his own activities of daily living. Mr Cheek had been in an aged care facility for about 12 months before he was imprisoned.

20. Amongst the numerous medications prescribed to treat his various health conditions, Mr Cheek required a daily injection of insulin to manage his diabetes.

Mr Cheek is taken to FSH

21. On 9 August 2021, Mr Cheek was taken to FSH for back pain and low blood pressure. At FSH, he was found to have a skin infection (cellulitis) on his right leg which was treated with antibiotics. On 11 August 2021, he was discharged from FSH and returned to the Crisis Care Unit in the Casuarina infirmary.

22. After returning to Casuarina, Mr Cheek's observations continued to be performed daily. He had his usual medications for his diabetes which included

[6] Exhibit 1, Volume 1, Tab 10, Report from Dr Ken Thong to the Court dated 7 February 2024; Exhibit 1, Volume 1, Tab 27, Extracted EcHO medical records; Exhibit 1, Volume 1, Tab 29.1, FSH Discharge Summary dated 11 August 2021; Exhibit 1, Volume 1, Tab 32, Report of Dr Cherelle Fitzclarence dated 24 July 2024

a daily injection of 18 units of Ryzodeg[7] with breakfast. These injections were administered by prison nursing staff.

23. Given his multiple comorbidities and advanced age, Mr Cheek had a very high risk of health complications. As a result, on 18 August 2021, he was classified at Stage 3 on the Department's terminally ill register. A Stage 3 classification for a prisoner meant it was considered that their death may occur either suddenly due to their medical conditions or within three months.

Mr Cheek's hypoglycaemic episodes

24. Between 12 August 2021 and 6 September 2021, Mr Cheek's blood glucose levels were in an acceptable range between 4.9 mmol/L and 10.5 mmol/L.[8]

25. On 6 September 2021, Mr Cheek was started on a five-day course of amoxicillin (an antibiotic) for a suspected chest infection.

26. On 7 September 2021, Mr Cheek's blood glucose level was within the hypoglycaemic range[9] at 3.8 mmol/L. He was given glucose tablets to elevate his blood glucose to an acceptable level.

27. On the morning of 9 September 2021, Mr Cheek had another hypoglycaemic episode with an even lower blood glucose reading of just 2.3 mmol/L. As a result, Mr Cheek's morning dose of Ryzodeg was withheld and the prison doctor gave instructions for subsequent morning doses of Ryzodeg to be reduced by half to nine units.

28. On the morning of 10 September 2021, Mr Cheek's blood glucose level was 2.9 mmol/L. He was given glucose tablets which elevated his blood to an acceptable level (5.2 mmol/L) and the half dosage of nine units of Ryzodeg was then administered.

29. On the morning of 11 September 2021, Mr Cheek's blood glucose level was 5.2 mmol/L. However, instead of the lower dose of nine units as amended by the prison doctor, he was injected with 18 units of Ryzodeg in error by a prison nurse. Mr Cheek subsequently had hypoglycaemic blood glucose levels throughout the day and he was treated with glucose tablets and glucose solutions. By 2.50 pm, his blood glucose had returned to an appropriate level

[7] Ryzodeg is a mixed insulin made from a combination of 70% long-acting basal insulin and 30% rapid-acting insulin. It has a quick onset action of about 15 minutes, peaking at 20 minutes to 2½ hours and lasting for greater than 42 hours.
[8] mmol/L is an abbreviation for "millimoles per litre" and is a common unit of measurement for blood glucose levels
[9] The hypoglycaemic (low blood glucose) range is a level that is below 3.9 mmol/L

(5.4 mmol/L). Nevertheless, the prison doctor instructed nursing staff that Ryzodeg was to be withheld the following morning.

Mr Cheek is taken to FSH for the final time

30. At 6.51 am on 12 September 2021, Mr Cheek's blood glucose level was only 2.7 mmol/L. He was treated with a glucose drink and glucose tablets. About 40 minutes later, Mr Cheek was found on the floor. His blood glucose level was 2.8 mmol/L, his body temperature was at a very low 35°C, and his oxygen saturation was low at 87%. However, his Glasgow Coma Scale of 15 was normal. Mr Cheek's mouth was dry and he had very bad diarrhoea. He was provided with oxygen and a call was made for an ambulance to attend.

31. At 8.25 am, the ambulance arrived at Casuarina and ambulance officers began treating Mr Cheek a short time later. He was noted to have a blood glucose level of 2.5 mmol/L, and was given an oral glucose gel and intravenous glucose. His blood glucose level was able to be raised to 7.0 mmol/L. Mr Cheek was then taken by ambulance to FSH where he was admitted at 10.25 am.

32. Treating doctors at FSH noted Mr Cheek's diarrhoea had started after his recent course of antibiotics and that he had not been eating much. He was admitted to the Medical Admissions Unit and given oxygen, intravenous dextrose, hydration and magnesium. Blood tests indicated he was in acute renal failure.

33. Over the next several days, Mr Cheek was treated with fluids, frusemide, albumin and bicarbonate. However, his renal function did not improve, and he was not deemed suitable for kidney dialysis in view of his age and comorbidities. Mr Cheek continued to eat very little and it was suspected he had an underlying infection, possibly from an infected foot ulcer or chest infection. A chest x-ray noted a left basal atelectasis/consolidation (collapsed lung) and he commenced taking an antibiotic on 15 September 2021.

34. Mr Cheek remained drowsy and his treating medical team at FSH was of the view that he had severe acute kidney injury in the setting of pre-renal loss, hypoglycaemia, and a possible period of kidney hypoperfusion, with a likely occult infection.

EVENTS LEADING TO MR CHEEK'S DEATH [10]

35. On 16 September 2021, Mr Cheek's treating medical team at FSH concluded he lacked the capacity to make decisions for himself, and it was noted he had a Guardianship Order with an Advanced Health Directive and Do Not Resuscitate Order.

36. On 17 September 2021, Mr Cheek was escalated to Stage 4 on the Department's terminally ill register. The reasons given were that he had significant pulmonary oedema (build-up of fluids on the lungs), aortic stenosis (narrowing of the heart valves) and uraemia (raised levels of protein in the blood). Stage 4 classification was the final stage and meant it was considered the prisoner's death was imminent. The Department notified Mr Cheek's next of kin, who advised his wishes would be that he was kept comfortable.

37. On 18 September 2021, treating doctors held discussions with the next of kin and prison doctors regarding Mr Cheek's very poor prognosis. It was decided that active medical treatment would end and Mr Cheek would receive palliative care only.

38. On 19 September 2021, officers guarding Mr Cheek observed that his breathing had changed and notified nursing staff. A check of Mr Cheek found there were no signs of life and he was subsequently declared life extinct at 1.50 pm on 19 September 2021.[11]

CAUSE AND MANNER OF DEATH [12]

39. On 1 October 2021, two forensic pathologists, Dr Jodi White and Dr Jagbir Grewal, conducted a post mortem examination of Mr Cheek's body. The forensic pathologists also reviewed the medical notes from FSH.

40. The post mortem examination found Mr Cheek had an enlarged heart with a permanent pacemaker in place. The vessels supplying the heart muscle had been narrowed by calcified plaques (coronary artery atherosclerosis). The lungs were congested, a finding that maybe seen in the setting of heart disease. A possible infection was present within the lungs and the kidneys were

[10] Exhibit 1, Volume 1, Tab 29, FSH Discharge Summary dated 19 September 2021, exhibit 1, Volume 1, Tab 30, FSH Goals of Patient Care dated 16 September 2021; Exhibit 1, Volume 2, Tab A, Review of Death in Custody dated April 2024.
[11] Exhibit 1, Volume 1, Tab 4, Death in Hospital Form dated 19 September 2021.
[12] Exhibit 1, Volume 1, Tab 7 and Tabs 7.1-7.3, Second Supplementary Post Mortem Report dated 28 January 2023, Supplementary Post Mortem Report dated 28 January 2023, Full Post Mortem Report dated 1 October 2021, and Interim Post Mortem Report dated 1 October 2021; Exhibit 1, Volume 1, Tab 8, Toxicology Report dated 14 October 2021

scarred. There was widespread calcification within the larger arteries of the body.

41. Post mortem histology confirmed a patchy bronchopneumonia, cirrhosis of the liver, and end-stage changes in the kidneys consistent with nephrosclerosis and diabetic nephropathy. The forensic pathologists also noted that Mr Cheek's medical history was extensive and included insulin-dependent diabetes with chronic kidney disease, abdominal aortic aneurysm, hypothyroidism and heart disease

42. Toxicological analysis of post mortem samples taken from Mr Cheek confirmed the presence of medications consistent with his treatment at FSH, including his palliative care.

43. At the conclusion of the post mortem examination, and after reviewing the results of the other investigations, the forensic pathologists expressed the opinion that the cause of Mr Cheek's death was complications in association with a gastrointestinal illness in an elderly man with diabetes mellitus, chronic liver disease and atherosclerotic heart disease, medically palliated.

44. I accept and adopt the opinion expressed by the forensic pathologists as to the cause of death, and I find that Mr Cheek's death occurred by way of natural causes.

ISSUES RAISED BY THE EVIDENCE

Did the incorrect dosage of insulin contribute to Mr Cheek's death?

45. As outlined above, Mr Cheek was injected with 18 units of Ryzodeg insulin instead of nine units on 11 September 2021. The next day, he was admitted to FSH. Given the short space of time between the incorrect dosage and the hospital admission, the coronial investigation examined whether the incorrect dose had contributed to Mr Cheek's death.

46. As to this question, the Court initially sought an opinion from one of the forensic pathologists who had performed the post mortem examination. In her report to the Court, Dr Jodi White advised:[13]

> … it is difficult to determine the significance of the incorrect insulin dose on that particular day, particularly given that he was becoming unwell with the unchecked diarrhoeal illness, with dehydration and associated acute on chronic renal failure which was his main issue once hospitalised and his other comorbidities.

[13] Exhibit 1, Volume 1, Tab 6, Letter from Dr Jodi White to the Court dated 17 November 2023, p.5

> …
>
> Whilst I can't exclude a contribution of the excess insulin here, I am not sure of its level of significance, given the circumstances as described in the days leading up to the death. For further advice, you would be better placed to contact an endocrinologist who could give you advice about this particular insulin and management of his brittle diabetes.

47. The Court subsequently obtained a report from Dr Ken Thong (Dr Thong), a consultant endocrinologist at Rockingham General Hospital. Dr Thong reviewed the relevant material and provided the following conclusion:[14]

> The deceased had a significant list of medical comorbidities [and] … had declining health with poor oral intake and hypotension prior to his final admission. In my opinion, his prognosis was already poor prior to the occurrence of hypoglycaemia.
>
> In my opinion, the administration of excess insulin on the 11/9/21 was not the cause of the deceased's death, but rather his death was due to background illnesses. In my opinion as well, the unintended use of a higher then prescribed insulin dose was unlikely to be a significant contributor to the cause of the deceased's death. There was [a] lack of symptoms documented in most of his hypoglycaemic episodes, the deceased had confusion even when BGLs[15] were in normal range and there were no improvements in medical status despite normal BGLs at FSH. Besides an unintended higher insulin dose being administered on the 11/9/21, hypoglycaemia may have been contributed by advanced age and renal failure which are known risk factors for hypoglycaemia.

48. Given the conclusions made by Dr Thong, I am satisfied that the incorrect dosage of Ryzodeg insulin administered to Mr Cheek on 11 September 2021 did not contribute to his death.

49. Based on all the information available, I am not able to determine precisely how this error was made. The nurse who administered the incorrect dosage to Mr Cheek no longer works for the Department as they had voluntarily resigned to take up employment elsewhere before the inquest had commenced.[16]

50. Nevertheless, Dr Thong provided some possible explanations for the error:[17]

> It is unclear from my review whether the administration of 18 units of Ryzodeg on the 11/9/21, rather than 9 units, was as a result of late entry of the Ryzodeg 9 units prescription onto the Diabetic Treatment Chart, the 9 units prescription was missed by the prison staff administering insulin, or whether the prison staff administered Ryzodeg 18 units based on looking at an insulin script elsewhere and not from the Diabetic Treatment Chart.

[14] Exhibit 1, Volume 1, Tab 10, Report from Dr Ken Thong to the Court dated 7 February 2024, p.4
[15] Abbreviation for "blood glucose levels"
[16] Ts (Dr Gunson), p.28
[17] Exhibit 1, Volume 1, Tab 10, Report from Dr Ken Thong to the Court dated 7 February 2024, p.4

51. At the inquest, Dr Gunson also provided the possible explanation that the nurse had looked at the script that had the details of the previous prescribed amount rather than the Diabetic Treatment Chart which had the amended amount.[18] In my view, this would appear to be the most likely explanation.

Use of restraints on Mr Cheek for his final hospital admission

52. On 12 September 2021, the guarding of Mr Cheek during his transfer by ambulance from Casuarina to FSH was the responsibility of prison officers from Casuarina. At 5.56 pm on that day, escorting prison officers from Casuarina transferred the responsibility of guarding Mr Cheek at FSH to officers from the private contractor, Broadspectrum (BRS).[19] This is known as a hospital sit and the Department has had a longstanding contract with BRS to provide this service.

53. For the transfer from Casuarina to FSH, Mr Cheek was restrained with handcuffs and a security chain link. There was no record that a risk assessment had been completed by the Department prior to Mr Cheek leaving Casuarina.[20] Once BRS took over, a standard three-point leg restraint regime was applied.[21] It is my understanding this was the same regime that Mr Cheek was subjected to when he was transferred to FSH. The metal leg restraints continued to remain on Mr Cheek despite one of his ankles being red and sore.[22]

54. On 13 September 2021, one of Mr Cheek's treating doctors at FSH wrote to Casuarina requesting a restraint variation to plastic leg restraints to prevent further pressure injures to Mr Cheek's ankle. Later that same day, this variation was approved and BRS officers replaced Mr Cheek's ankle restraint with a plastic flexi cuff.[23]

55. Mr Cheek's restraints were not "*officially removed*" until 1.55 pm on 19 September 2021.[24] This was seven days after Mr Cheek had been admitted to FSH and five minutes after he had been declared "life extinct".

56. The Department has a number of policies and procedures that govern the use of restraints when prisoners are transferred to a hospital for treatment. BRS also has its own procedures which largely mirror those of the Department.

[18] Ts (Dr Gunson), p.28
[19] Exhibit 1, Volume 2, Tab A, Review of Death in Custody dated April 2024, p.6
[20] Exhibit 1, Volume 2, Tab A, Review of Death in Custody dated April 2024, pp.14-15
[21] Exhibit 1, Volume 2, Tab A, Review of Death in Custody dated April 2024, p.15
[22] Exhibit 1, Volume 2, Tab A, Review of Death in Custody dated April 2024, p.15
[23] Exhibit 1, Volume 2, Tab A, Review of Death in Custody dated April 2024, p.17
[24] Exhibit 1, Volume 2, Tab 20, BRS - Record of Events dated 19 September 2021

57. As of September 2021, the relevant Commissioner's Operating Policy and Procedure (COPP) was version 2.0 of COPP 12.3 Conducting Escorts (COPP 12.3).[25] It states that the escort of prisoners includes escorts from prison to hospital.[26]

58. The use of handcuffs and a security chain link on Mr Cheek followed the general requirements for the restraining of prisoners during a transfer as set out in Appendix C of COPP 12.3 (Appendix C). The use of handcuffs and a security chain link also followed the general requirements for the restraining of prisoners in hospital as set out in Appendix C.[27]

59. However, Mr Cheek did not fall within the general cohort of prisoners requiring restraints during an escort. This is because of section 5.2 of COPP 12.3 which is titled "*Reasons prohibiting the use of restraints*". Section 5.2.1 of COPP 12.3 states:[28]

> Prisoners with significant medical and/or mobility issues shall not be placed in restraints unless there is a requirement following the completion of a risk assessment by prison staff and approval by the Superintendent/OIC. Particular consideration shall be given, but not limited, to the following cohorts:
>
> a) prisoners who are not conscious
> b) prisoners who are terminally ill
> c) prisoners who are elderly and frail
> d) prisoners with significant mobility issues
> e) prisoners with significant injuries whereby handcuffs/ankle-cuffs or hobbles cannot be used

60. From 12 September to 19 September 2021, I am satisfied, to the required standard, that Mr Cheek clearly fell within section 5.2.1 b), c) and d) of COPP 12.3. The Department properly conceded this point:[29]

> The Department acknowledges that Mr Cheek satisfied section 5.2.1 of COPP 12.3 (version 2) and should therefore have not been placed in restraints either during his transfer to hospital on 12 September 2021 or subsequent stay in hospital unless a risk assessment determined otherwise.
>
> The Department has been unable to locate a completed risk assessment prior to Mr Cheek's transfer to hospital on 12 September 2021 and during his subsequent stay in hospital.

[25] Unless otherwise specified, a citing of COPP 12.3 Conducting Escorts in this finding is a reference to version 2.0
[26] COPP 12.3 Conducting Escorts, p.4
[27] COPP 12.3 Conducting Escorts, p.29
[28] COPP 12.3 Conducting Escorts, p.7
[29] Letter from the SSO to the Court dated 29 August 2024

61. In light of those concessions from the Department, I am satisfied that no risk assessment was completed. The likely explanation for this oversight was that Mr Cheek was transferred to FSH on a weekend[30] and these assessments are only undertaken by authorised custodial staff who work during usual business hours.[31]

62. I am also satisfied that if a risk assessment had been undertaken then it would have found there was no requirement for any restraints, given Mr Cheek's advanced age, frailty, immobility and his extremely poor health.

63. It was a serious failure by the Department to have Mr Cheek restrained in the manner that he was. The Department did not apply section 3.1.12 of the "Guiding Principles for Corrections in Australia, 2018" that it quotes on the front page of its COPP 12.3: "*Transport of persons in custody is conducted in a safe and humane manner, taking into account the dignity of the person being transported.*"[32]

64. The Department also failed to adhere to its stated policy within COPP 12.3 that: "*Prisoners are transported in a safe, humane and efficient manner that meets their individual needs, ensures self-respect and privacy as required …*"[33]

65. The restraining of Mr Cheek from 12 September 2021 until he died seven days later ignored his dignity and self-respect, and paid scant regard for his individual needs.

66. I am therefore satisfied, to the required standard, that Mr Cheek was dealt with in an inhumane manner by the Department in the last seven days of his life. The entity responsible for that sad state of affairs was the Department.

67. In finding that the Department is solely responsible for the unjustified restraining of Mr Cheek, I should make it clear that I do not cast any blame on BRS for the ongoing restraining of Mr Cheek in the last seven days of his life. I am satisfied the BRS officers responsible for Mr Cheek's hospital sit were entitled to assume that as he had been handed over in restraints, the Department had completed a risk assessment which determined he was to be restrained in this manner. In those circumstances, it would be unfair to criticise the officers at BRS for simply maintaining the status quo regarding the restraining of Mr Cheek once he was in their care.

[30] 12 September 2021 was a Sunday
[31] ***Inquest into the death of Matthew John Pickin*** [2024] WACOR 36 at [115]
[32] COPP 12.3 Conducting Escorts, p.1
[33] COPP 12.3 Conducting Escorts, p.4

CHANGES AND IMPROVEMENTS SINCE MR CHEEK'S DEATH

68. As would be expected of all government departments, the Department is always on the pathway of continual improvement with respect to its obligations, including the provision of health services to prisoners.

Monitoring of prisoners with insulin-dependent diabetes

69. This case highlighted a need for the Department to review its processes in the monitoring of diabetic prisoners, especially those who require insulin and who are suspect to hypoglycaemic episodes.

70. There is frequently a gap of some duration between the date of the death requiring a mandatory inquest and the inquest's date. In those circumstances, the entities connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard. The actions taken by the Department as a result of Mr Cheek's death have reflected that. I was advised of the following:[34]

> Since this incident Prison Health advised that they have made some changes. There is a diabetic plan developed by the multidisciplinary team which clearly documents type, dosage, timing of insulin and a regime for blood sugar checks. I am advised that diabetic charts are reviewed monthly by the medical officer. I am additionally advised that some education has been provided to medical, nursing and carer staff as to how to recognise and managed hypoglycaemia. There is now an EcHO[35] template that provides instructions as to management and what to record in instances of hypoglycaemia.

71. As to ongoing education for nursing staff with respect to the management of diabetes, Dr Gunson outlined that the Department has had a dedicated nurse education coordinator since October 2023 to provide education in this area (and other specialised areas) if and when required.[36]

72. Dr Gunson also noted there are weekly meetings and an annual two day forum for prison doctors that involve specialist teaching in areas where reskilling or upskilling is required.[37]

73. In light of this progress, I have not made any recommendations regarding the care of prisoners with insulin-dependent diabetes.

[34] Exhibit 1, Volume 1, Tab 32, Report from Dr Cherelle Fitzclarence dated 24 July 2024, p. 6
[35] The Department's electronic database that contains a prisoner's medical records
[36] Ts (Dr Gunson), p.26
[37] Ts (Dr Gunson), p.26

Improper restraining of prisoners

74. The inappropriate use of restraints during the hospitalisation of prisoners who are elderly, terminally ill, and/or in palliative care has already been the subject of comment by the Court in a number of previous inquests which concerned the deaths of such prisoners that occurred in 2021 and 2022.[38]

75. I am satisfied that the Department's policies and procedures have been updated as a result of recommendations made from some of these earlier inquests. The Court is therefore optimistic that it is very unlikely a prisoner in such poor health as Mr Cheek would be restrained in the manner that he was if that prisoner was admitted to hospital today.

QUALITY OF THE SUPERVISION, TREATMENT AND CARE PROVIDED TO MR CHEEK

At Casuarina

76. Mr Cheek was an elderly man who already had multiple comorbidities with terminal conditions before he had commenced his final term of imprisonment.

77. I am satisfied that, with one exception, the supervision, treatment and care provided to Mr Cheek by prison health service providers at Casuarina was appropriate. This exception involved the incorrect insulin dosage administered to Mr Cheek on the morning of 11 September 2021. I am satisfied that this oversight did not contribute to Mr Cheek's death eight days later.

78. Accordingly, I agree with the assessment by Dr Fitzclarence that, "*in general Mr Cheek was treated well above community standards in a caring manner*."[39]

79. However, applying the ***Briginshaw*** principle and having considered all available information, I am satisfied that the use of restraints by the Department on Mr Cheek during his transfer and subsequent admission at FSH from 12 September to 19 September 2021 was entirely inappropriate as it failed to comply with the Department's own policies and procedures. Because of the Department's error in having Mr Cheek held in handcuffs and leg restraints when he was handed over into the care of officers from BRS, I have found that the Department was also solely responsible for the continued inappropriate use of restraints after he had been admitted to FSH.

[38] See ***Inquest into the death of Errol Warren Bartlett-Torr*** [2023] WACOR 11; ***Inquest into the death of Edward Ivan Africh*** [2023] WACOR 14; ***Inquest into the death of Frank Kenneth Major*** [2023] WACOR 23; ***Inquest into the death of Alan David Ratcliff*** [2024] WACOR 18; ***Inquest into the death of Matthew John Pickin*** [2024] WACOR 36

[39] Exhibit 1, Volume 1, Tab 32, Report from Dr Cherelle Fitzclarence dated 24 July 2024, p.6

At FSH

80. I am satisfied that the care and treatment provided to Mr Cheek during his admission to FSH was appropriate. It is obvious that Mr Cheek was already gravely unwell when he was admitted on 12 September 2021 and that given his advanced age and medical comorbidities, it was almost inevitable that he would eventually be transitioned to palliative care during that admission

CONCLUSION

81. Mr Cheek was already a very old man with serious health conditions when he was imprisoned on 6 August 2021. Included amongst his multiple comorbidities was acute chronic renal failure. It was always likely Mr Cheek would not remain alive to complete his prison term.

82. Aside from one incorrect insulin dose, I am satisfied that the medical supervision, treatment and care Mr Cheek received in prison was appropriate. Although he was hypoglycaemic on a number of occasions in the days before his final admission to FSH, I accept Mr Cheek's blood glucose levels would have been difficult to control given his low food intake, his lack of awareness he was experiencing hypocalcaemia, and his advanced renal failure and age.

83. The most glaring failure to provide appropriate care to Mr Cheek was the use of restraints when he was transferred and admitted to FSH for the final time. I have found that given his age, frailty, immobility and extremely poor health, the use of restraints failed to comply with the Department's policies and procedures regarding the non-use of restraints on gravely ill prisoners being admitted to hospital. I am satisfied it was not only completely unnecessary, but it would have been entirely humiliating for Mr Cheek to endure these restraints in the final days of his life.

84. Notwithstanding this finding, I am satisfied that the Department has taken actions since Mr Cheek's death to promote compliance with its policies and procedures regarding the treatment of terminally ill prisoners who have been transferred to hospitals.

85. I am also satisfied of the actions taken by the Department to ensure those prisoners with insulin-dependent diabetes and who are at risk of hypoglycaemia are monitored appropriately.

86. I extend my condolences to the family of Mr Cheek, particularly his niece, Brigitte Cheek.

PJ Urquhart
Coroner
24 September 2024