[2024] WACOR 6

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	8 JANUARY 2024
DELIVERED	**:**	23 FEBRUARY 2024
FILE NO/S	**:**	CORC 2334 of 2022
DECEASED	**:**	HEAD, IAN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

A/Sgt C Robertson assisted the Coroner.
Ms S Walsh (SSO) appeared for the Department of Justice.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Ian HEAD*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 8 January 2024, find that the identity of the deceased person was* ***Ian HEAD*** *and that death occurred on or about 25 August 2022 at Acacia Prison, Great Eastern Highway, Wooroloo, from cardiac arrhythmia in an elderly man with chronic obstructive pulmonary disease with COVID-19 infection, hypertension and kidney impairment in the following circumstances:*

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INTRODUCTION

1. On 24 February 2022, Ian Head was convicted on his plea of guilty of an historical offence of sexual penetration of a child between 13 and 16 years. He was sentenced to two years and ten months' imprisonment, backdated to commence on 23 June 2021.

2. In August 2022, Mr Head was serving his sentence at Acacia Prison in Wooroloo. On the evening of 24 August 2022, Mr Head went to sleep in his cell. At about 7.30 am the following morning, being 25 August 2022, Mr Head was discovered cold and unresponsive in his bed by his cell mate. He alerted prison staff and prison officers commenced performing CPR and notified emergency services. St John Ambulance officers attended and assessed Mr Head before confirming he was deceased. His death was certified at 8.24 am by a SJA paramedic.

3. As Mr Head was a serving prisoner at the time of his death, he came within the definition of a 'person held in care' under the terms of the *Coroners Act 1996* (WA) and a coronial inquest into his death was, therefore, mandatory and I am required to comment on the quality of his treatment, supervision and care while in custody prior to his death.[1]

4. I held an inquest on 8 January 2024. Documentary evidence was tendered that indicated a forensic pathologist had formed the opinion Mr Head's death was consistent with natural causes. Mr Head had a significant medical history, including chronic obstructive pulmonary disease. It appears he had been infected with COVID-19 prior to his death, which on a background of his pre-existing airways disease, hypertension and kidney impairment, led him to develop a cardiac arrhythmia, which caused his death. There had been a documented COVID-19 outbreak at the prison in the two weeks leading up to Mr Head's death, but it does not seem he had been diagnosed prior to his death.

5. Oral evidence was heard from Dr Joy Rowland, the Director of Medical Services for the Department of Justice, as well as Ms Storm Duvall, who is a review officer at the Department of Justice and was involved in reviewing the custodial management, supervision and care provided to Mr Head prior to his death and preparing a report to the State Coroner.

6. At the conclusion of the inquest, I indicated that I was interested in receiving some more information from Acacia Prison about whether some proposed changes had been implemented, as well as information on the medical staffing at the prison. That information was provided promptly via counsel for the Department, for which I am grateful.[2]

BACKGROUND

7. Mr Head was born in the United Kingdom. He emigrated to Queensland with his parents when he was 12 years old. He eventually relocated to Western Australia,

[1] Sections 22(1)(a) and 25(3) *Coroners Act 1996* (WA).
[2] Emails to A/Sgt Robertson dated 10 January 2024 and 15 January 2024.

where he was living at the time of his death. Mr Head completed high school at Year 10 level and then worked for a telecommunications company for two decades. He was made redundant from his role in 1984 and then worked intermittently as a caretaker for various residential complexes. He had a number of short-term relationships but had never married and had no children.[3]

8. Mr Head began receiving a disability pension in 2003 due to various health issues. He had been diagnosed with chronic obstructive pulmonary disease and had an historical back injury for which he was prescribed medication for chronic pain management. He had a history of problematic alcohol use in the past and suffered from chronic renal failure - Stage 2 and hay fever.[4]

9. Mr Head also had a history of sexual offending. He admitted to a longstanding attraction to pubescent boys aged between 14 to 16 years. He had a large number of convictions for offences involving children, including possession of child pornography. His criminal record includes offences in both Western Australia and Victoria and he had served time in custody as a result of those offences prior to receiving this most recent term of imprisonment.[5]

10. The offence for which Mr Head was serving his sentence at the time he died had occurred on an unknown date between 9 November 2009 and 20 August 2011 at a time when Mr Head was working as a caretaker at a unit block and through that position came in contact with a child on whom he committed the offence. Mr Head was not arrested and interviewed by police until 23 June 2021. He initially denied the offence, but not long after made admissions and eventually pleaded guilty to the charge in the District Court of Western Australia.[6]

11. Mr Head was 74 years of age at the time he was sentenced to the term of imprisonment and his admissions, advanced age and medical history were taken into account when the learned sentencing Judge imposed the sentence of imprisonment. However, at the time of sentencing, there was no information before his Honour to suggest that Mr Head's health was such that he was likely to die in prison and, even if that had been the case, he was still likely to have received a similar sentence. Mr Head was granted eligibility for parole, which resulted in his earliest eligibility date for release being 21 November 2022.[7]

HEALTH HISTORY WHILE IN PRISON

12. Mr Head was initially held in Hakea Remand Prison. He was medically assessed at Hakea Prison by Dr Venkata Akula on 20 July 2021, not long after admission to the prison. He was identified as a returning prisoner and his medical history from a previous period of incarceration was available, as well as recent information from his time in the police lock up. A full history was also taken by Dr Akula during the consultation and Mr Head's long history of COPD, secondary to heavy smoking, and

[3] Exhibit 1, Tab 11 and Tab 15.2.
[4] Exhibit 1, Tab 11.
[5] Exhibit 1, Tab 11.
[6] Exhibit 1, Tab 11.
[7] Exhibit 1, Tab 11 and Tab 13.

chronic back pain related to injuries from a motor vehicle accident was noted. It was indicated he would need to be put on a chronic disease plan and he was given prescriptions for his regular medications. His blood pressure was monitored and he was diagnosed with hypertension on 16 August 2021 and commenced on blood pressure medication. Mr Head indicated he had decided to give up smoking and was encouraged to reduce his salt intake.[8]

13. On 31 January 2022, Mr Head was booked for a medical review in relation to his medications. He was also due to have a blood pressure check. His blood pressure was in the target range and he appeared well. His chest and heart were examined during the consultation. His medications were rescripted and he was scheduled for another review in three months' time.[9]

14. Mr Head was given his first COVID-19 vaccination on 29 July 2021 and his second vaccination on 6 November 2021. He was administered a booster on 8 March 2022.

15. Mr Head was transferred from Hakea to Acacia Medium Security Prison on 15 April 2022 as a permanent transfer following a reduction in his security rating. He was up to date with his COVID-19 vaccinations at that time and had a negative rapid antigen test result immediately before transfer. It was noted in the medical records that he was scheduled for a comprehensive medical management review on 30 April 2022. A doctor reviewed Mr Head's medical history administratively on 19 April 2022 and ensured his scripts and profile were up to date. Mr Head was not seen by a doctor at that time. His scheduled medical review was changed to 19 June 2022, although the reason for the change is unclear.[10]

16. Mr Head received an annual flu vaccination on 10 June 2022 and no adverse effects were noted. However, on 14 June 2022, Mr Head tested positive for COVID-19. He was given a COVID-19 booster dose due to his level of risk and kept in isolation until he was symptom free and medically cleared on 26 June 2022.[11]

17. Mr Head underwent a comprehensive annual health assessment with a clinical nurse on 6 July 2022. He was advised to book a doctor's appointment for his chronic aches and pain, which were thought to be related to arthritis. He was referred for metabolic review, with blood work booked in for 2 August 2022, and also referred to a doctor for examination of a right breast lump. Mr Head was given education around ceasing smoking (as he had taken up smoking again) and increasing his exercise as part of the general health review, and an itchy skin rash was addressed. His blood pressure was mildly elevated and he was referred for a blood pressure check.[12]

18. Mr Head did not attend a nurse appointment on 14 July 2022 that had been booked for his blood pressure review. He was rebooked for 23 July 2022. Mr Head did present on 21 July 2022 at the Walk-In Clinic due to ongoing concerns about his skin rash and he was given some fungal cream. No blood pressure check appears to have been done at that time, and some outstanding blood work doesn't seem to have been followed up.

[8] Exhibit 1, Tab 14 and Tab 16.
[9] Exhibit 1, Tab 16.
[10] Exhibit 1, Tab 14 and Tab 16.
[11] Exhibit 1, Tab 14 and Tab 16.
[12] Exhibit 1, Tab 14 and Tab 16.

Mr Head did not attend his scheduled nurse appointment two days later on 28 July 2022.[13]

19. Mr Head failed to attend two booked medical appointments on 28 July 2022 and 3 August 2022 in relation to the lump in his breast tissue. It was noted he 'did not show' for the first appointment, and no reason was documented for his failure to attend the second appointment. Follow up was planned, with a note by the doctor that outstanding bloodwork and urine testing was to be completed before the next medical review. It appears Mr Head's attendance at a follow up medical appointment was not arranged before his collapse a few weeks later.[14]

20. The Department's Health Services Summary indicates that on 11 August 2022 a COVID-19 outbreak was identified in Uniform Block at Acacia through routine screening of prisoners who had visits. It was identified that the initial case had been symptomatic for several days but had not reported this to staff. The whole of Uniform Block was screened and over the next week a total of 11 cases were identified. The last case was cleared on 25 August 2022, which was the same day of Mr Head's death.[15]

EVENTS ON 24 TO 25 AUGUST 2022

21. Mr Head was sharing a cell at Acacia with three cellmates in Juliet Block in August 2022. The COVID-19 outbreak had been in a different cell block, and there were steps taken to try to prevent spread to other units, but it seems that Mr Head had been exposed to the disease prior to his death, although no outbreak had been recorded in Juliet block at that time.

22. Mr Head worked sometimes as a general cleaner in the prison. He had no recorded infractions while in prison and no known issues with other prisoners. He appeared to get on well with his three cell mates, who had requested he move in with them as they all got along with him.[16]

23. Mr Head's cellmates later told investigators that Mr Head had seemed a bit down in the days prior to his death, as he had been unwell and experiencing diarrhoea. He blamed the diarrhoea on some soup he had eaten, although in hindsight this was probably a symptom of the COVID-19 infection. Dr Rowland gave evidence it is a very common symptom of the disease[17] It does not appear Mr Head sought medical treatment for his symptoms, despite encouragement from at least one cell mate. He was otherwise said to be his 'usual chirpy self'.[18]

24. On the evening of 24 August 2022, Mr Head and his cellmates were all in bed watching movies. It's unclear exactly what time Mr Head went to sleep, although one

[13] Exhibit 1, Tab 16.
[14] Exhibit 1, Tab 14 and Tab 16.
[15] Exhibit 1, Tab 16.
[16] Exhibit 1, Tab 2.
[17] T 9.
[18] Exhibit 1, Tab 8 and Tab 15.2.

of Mr Head's cellmates recalled speaking to Mr Head at about 1.00 am on 25 August 2022 about what they should watch on television.[19]

25. The Juliet Block occurrence book indicates that in the early hours of 25 August 2022 a welfare and observation check was conducted at 4.10 am. The identity of the officer recording the formal count in the occurrence book could not be established due to illegible handwriting. Another headcount was said to have been completed by Prison Officer Blackburn at 6.20 am, but he could not recall what movement he saw from Mr Head. Officer Blackburn had been assisting the night shift staff with the count as they were short-staffed. Further, due to staff shortages, only a head count was conducted at that time, rather than an unlock and welfare check.[20]

26. The occurrence book indicates that at 7.16 am an unlock and welfare check was conducted. This involved counting all prisoners, and policy required a visual check of each prisoner at that time, as well as unlocking cell doors. It seems Mr Head's death was not discovered at that time, despite the requirement for a visual check. The Serco Post Incident Review suggested the count and unlock process was rushed due to the fact it was late and utilising other staff members to assist, which might explain why Mr Head's unresponsive state was not identified at that time. Although it was unclear who opened Mr Head's cell, the Unit Manager believed it might have been him, and he may have thought he saw movement from Mr Head but was mistaken.[21]

27. One of Mr Head's cellmates went to wake him up at around 7.40 am as he needed to get ready for work at 8.00 am. He initially though Mr Head was sleeping as he had his duvet pulled up to his face and only his right arm exposed. However, Mr Head did not respond to his cellmate and when he put his hand under Mr Head's nose, he felt no air or breath. Mr Head also felt cold to the touch. The cell mate asked another cell mate to go and inform a prison officer that Mr Head might be dead.[22]

28. At 7.48 am, one of Mr Head's cell mates informed a prison officer that Mr Head was not moving or breathing. The prison officer requested assistance from another prison officer and the two of them went together to Mr Head's cell. At 7.51 am, prison officers entered Mr Head's cell and found him lying on his back in his bed under his duvet. The officers attempted to rouse Mr Head by squeezing his shoulder, but he did not respond and they noted he appeared cold and white and grey in colour. A Code Blue (medical emergency) was called over the prison radio. Officers attempted to check Mr Head's airways, but could not because his jaw was locked. They commenced CPR in the form of chest compressions at approximately 7.54 am. A nurse arrived shortly after and a defibrillator was applied, which indicated no shock was advised. At 7.55 am, a nurse called for St John Ambulance to attend.[23]

29. The Code Blue notes indicated that Mr Head was found unresponsive in his cell by cellmates just before 7.50 am. When nurses arrived, they found him lying on his bed, uncovered, and a prison officer was performing CPR. Mr Head's skin was noted to be cool, mottled and discoloured. There was pooling of blood to his limbs and back (livor

[19] Exhibit 1, Tab 15.2.18.
[20] Exhibit 1, Tab 15.2, pp. 5 and 13 and Tab 15.2.11.
[21] Exhibit 1, Tab 15.2, p. 20.
[22] Exhibit 1, Tab 8.3.
[23] Exhibit 1 Tab 15.2.

mortis) and he had stiff limbs (rigor mortis). His body temperature was 29°C. These are all indicators that Mr Head had likely been deceased for some time before CPR began. The defibrillator was applied while CPR continued, but no shocks were advised. When the doctor arrived at the scene at 8.11 am, the doctor instructed that CPR should still continue until the ambulance arrived, out of an abundance of caution, although all evidence indicated Mr Head had been deceased for some time prior to commencement of CPR.[24]

30. When St John Ambulance officers arrived at about 8.17 am, Mr Head was confirmed to be asystole (in cardiac arrest). After an assessment of vital signs and noting he showed obvious rigor mortis to all limbs and lividity was present, his death was declared by a SJA paramedic at 8.25 am.[25]

31. Detectives from the WA Police attended Acacia Prison that morning. They viewed Mr Head's body in situ, spoke to his cell mates and some prison officers. The detectives found no evidence to indicate there were any suspicious circumstances in relation to Mr Head's death. They arranged for photographs to be taken and seized the relevant documentation for the coronial investigation.[26]

32. The Acacia Prison Internal Health Review noted Mr Head's medical records were sealed at the time of being notified of his death. The internal review by nursing staff at Acacia Prison later concluded that his medical care appeared to have been appropriate and timely.[27]

CAUSE AND MANNER OF DEATH

33. At the request of Mr Head's next of kin, an internal post mortem examination was not performed. Forensic Pathologist Dr Jodi White performed an external post mortem examination, including CT scan, on 7 September 2022. Mortuary screening indicated Mr Head tested positive for COVID-19. His past medical history was reviewed by Dr White and his history of chronic obstructive airways disease, hypertension and renal failure was noted, along with his other diagnoses.[28]

34. Toxicology analysis was undertaken, which showed prescription medications and Panadol. No alcohol or illicit drugs were detected.[29]

35. At the conclusion of the limited post mortem investigations, Dr White formed the opinion the cause of death was cardiac arrhythmia in an elderly man with chronic obstructive pulmonary disease with COVID-19 infection, hypertension and kidney impairment. Dr White expressed the opinion the death was consistent with natural causes.

[24] Exhibit 1, Tab 16.
[25] Exhibit 1, Tab 15.2 and Tab 15.2.16.
[26] Exhibit 1, Tab 2 and Tab 3.
[27] Exhibit 1, Tab 15.2.18.
[28] Exhibit 1, Tab 6.
[29] Exhibit 1, Tab 6 and Tab 7.

36. I accept Dr White's opinion as to the cause of death and find that Mr Head died by way of natural causes after developing a COVID-19 infection on a background of his pre-existing co-morbidities.

DEPARTMENT'S DEATH IN CUSTODY REVIEW

37. The Department of Justice prepared a Death In Custody Review Report for Mr Head, which was provided to the Court on 13 November 2023. The review found that Mr Head's custodial management, supervision and care was generally in accordance with the Department's policy and procedures. Records indicated the critical incident response was prompt following Mr Head's discovery. However, the review found there may have been a missed opportunity to provide Mr Head with earlier support, had the formal counts and unlock process been followed per existing policy and procedures. This was directed to the fact that the officers completing the head counts and the cell unlock failed to satisfy themselves of Mr Head's general health and wellbeing.[30]

38. In response to the Department's finding, Acacia management were proposing to amend and reinforce Acacia's Standing Order 10.2 Daily Prison Routine and Populations Counts, as well as reinforcing record-keeping obligations to ensure that counts and welfare checks are appropriately performed (emphasising the need to check for movement) and recorded.[31] The target date for completeness was 31 December 2023.

39. At the time of the inquest hearing, it had not been confirmed whether this had been completed, despite Ms Duvall seeking to confirm with Deputy Superintendents Shaun Horseman and John Couttie by email on 21 December 2023. Following the inquest, Deputy Superintendent Horseman advised that the policy review in relation to Standing Order 10.2, particularly concerning the need to determine the apparent good health of the prisoners, was not yet complete. No explanation was provided for the delay, and no estimate of time frame for completion was given.

DEPARTMENT'S HEALTH SERVICES SUMMARY

40. It was noted in the Department's Health Services Summary that Mr Head's transfer to Acacia "coincided with rising state-wide impacts of COVID-19." This affected the timelines for booked reviews and it was suggested some of Mr Head's non-attendance at appointments may have been due to disruptions to prison movements as a result of COVID-19 regimes and/or staff absences, noting he had previously attended his appointments and also utilised the walk-in clinic. When he did not attend, his case notes were still reviewed by a doctor and appropriate follow up appointments were made.[32]

41. Dr Rowland accepted that there were some efforts to follow up Mr Head, but said it was not clear at Acacia how the health staff would ensure he was going to be seen in a

[30] Exhibit 1, Tab 15.1 and 15.2.
[31] Exhibit 1, Tab 15.1.
[32] Exhibit 1, Tab 16, p. 11.

timely manner. It was suggested by Dr Rowland that more could have been done to review Mr Head when he came to see the nurse practitioner at the acute walk-in clinic for treatment for a rash that was bothering him. Dr Rowland noted that Mr Head was at that time a man with COPD, hypertension, renal impairment, overdue bloods and he was overdue for a doctor's review. Given he was not in front of a nurse practitioner, Dr Rowland felt it was a missed opportunity for a nurse to do more than just deal with the issue of the rash and, instead, try to address some of the other issues that were outstanding for Mr Head. Dr Rowland acknowledged that the clinic is designed as a "rapid-fire clinic for small issues" but commented that the nursing staff may then be blinkered to their specific purpose of addressing the issue the patient raises, instead of considering whether this was a chance to cover some of the other issues the health staff at the prison had been pursuing for Mr Head. Dr Rowland noted the ratio of GPs to patients is not high at Acacia, and there are waitlists, which means more should be done when the opportunity presents itself.[33]

42. In terms of that ratio of health staff to prisoners generally at Acacia, Dr Rowland indicated her understanding is that there are no physical space restrictions at Acacia in terms of clinic rooms, but she understands the low doctor to prisoner ratio may stem from staffing costs and availability of doctors. In addition, she noted traditionally Acacia has a more nurse-focussed primary point of care.[34] Dr Rowland expressed about medical staffing at Acacia, noting her opinion that "Acacia are probably running with inadequate GP's for the patient load that they have.[35]

43. Enquiries with Acacia after the inquest ascertained that on the day of Mr Head's death, there were two medical doctors, one nurse practitioner, seven primary care nurses, one chronic disease nurse, two mental health nurses and two alcohol and other drug nurses on duty. The total staffing FTE for health staff at Acacia at the time was 41 FTE's, excluding Psychological Health Services. Today, it is 47.2 FTE's, but that number includes Psychological Health Services, so it does not reflect just an increase in ordinary health staff numbers.[36]

44. Information was provided by the Department of Justice that Department's Medical Services team considers the ideal ratio for good patient care and safety would be around one full-time GP to about 250 patients, especially bearing in mind the very vulnerable population that is being treated, whom generally have more health conditions and risk factors compared to the population in the community. I note that based on information provided by the Department, that ratio is not generally met in a number of Western Australia's prisons. It is unclear, from the information provided, what is the current ratio of GP's to prisoners/patients at Acacia Prison, so at this stage I note the desired ratio for the benefit of the management of Acacia Prison, to give consideration to whether their current staffing levels of doctors are appropriate to meet the needs of their prison population. In my view, all prisons should be aiming to have sufficient medical officers on duty to meet the one GP to 250 patient ratio, in order to provide good patient care and safety for all prisoners in the State's care.[37]

[33] T 21.
[34] T 22.
[35] T 22.
[36] Letter to A/Sgt Robertson from SSO dated 15 January 2024.
[37] Exhibit 2.

45. The resuscitation notes indicate that a call could have been made by the prison's health staff that CPR should be ceased, before the arrival of the SJA officers, but it was noted in the Health Services Summary that health staff were likely to be reluctant to cease CPR as they were aware Mr Head's death, as a death in custody, would be closely scrutinised. The Health Services Summary indicated that the Department's Policy and Procedure PM05 was being updated (as at 7 December 2023) to include more detailed guidance for health staff, in alignment with the Department of Health and WA Country Health Service policies, which allow for Registered Nurses to declare life extinct.[38]

46. The conclusion of the Department's own internal Health Services Summary indicated that Mr Head had several chronic diseases on reception into custody and new conditions identified shortly afterwards, which were all well managed. The comment was made that while there were delays in follow up appointments for Mr Head in 2022, during the state-wide COVID-19 outbreak, essential care had continued. He was up to date with COVID-19 vaccinations at the time he acquired COVID-19 for the first time in June 2022, and he recovered from this first bout. He then became infected for a second time, and sadly did not recover.[39]

COMMENTS ON TREATMENT, SUPERVISION AND CARE

47. While I accept the validity of Dr Rowland's concerns, acknowledging her wealth of experience and general oversight of all of the health services within WA's prisons, I also accept that Mr Head had a number of co-morbidities that predisposed him to complications if he contracted COVID-19. He also had only recently recovered from one bout of COVID-19, which could have predisposed him to further complications, as secondary infection can be worse in some cases. Further, he did not report his bouts of diarrhoea to anyone other than his cellmates, which meant that health staff were not aware that he was unwell and, therefore, did not offer him the kinds of further support that were available. Accordingly, whilst I agree that there were missed opportunities to provide Mr Head with more comprehensive health care while at Acacia, it is not clear to me that his death would necessarily have been prevented if that had been done. I also note that it was accepted that COVID-19 was creating additional challenges for all health services, both within prisons and outside in the community, at that time.[40]

48. However, I do make the comment at this stage that there is perceived to be a pattern at Acacia Prison for pushing back the scheduled medical review dates and other testing administratively when prisoners are first transferred there. In this case, Mr Head was overdue for his scheduled comprehensive medical review (including blood tests) when he arrived at Acacia, but the due date for this to occur was still changed administratively by a doctor from April to June 2022, without Mr Head being seen by a doctor. Hs first medical appointment was not actually then booked until 28 July 2022. Mr Head did not actually attend this appointment, nor the rescheduled appointment booked for 3 August 2022, so it is difficult to say if an appointment booked earlier would have made any difference, but it would perhaps have given more

[38] Exhibit 1, Tab 16, p. 11.
[39] Exhibit 1, Tab 16.
[40] Exhibit 1, Tab 16.

opportunity for arrangements to be made to get Mr Head medically reviewed before his death. I do not take the matter any further at this stage, but simply note that there is a possible issue with access to early GP appointments at Acacia Prison when prisoners are transferred, so that it can be considered by the relevant staff at Acacia and thought given to whether the current GP to patient staff loading is sufficient. Alternatively, Dr Rowland's suggestion that nurse practitioners might be encouraged to take a more proactive role in assessing prisoner's overall health status when they have the opportunity, might need to be addressed further.

49. As to the timing of Mr Head's death, I note the evidence of Mr Head's appearance when found unresponsive by his cellmates and seen by prison officers shortly afterwards very clearly supports the conclusion he had been deceased for a long time. Without attempting to put a time frame on it, he exhibited obvious livor mortis and rigor mortis, both of which take some time to establish, and his body temperature was well below the normal adult body temperature of around 37°C. My understanding, from hearing relevant expert evidence in other coronial matters, is that he was likely to have been deceased for at least a couple of hours by that time.

50. This suggests the head counts during the night would have been the primary opportunities to identify Mr Head was requiring medical treatment. This clearly did not occur, as at no stage was it identified that Mr Head was unresponsive, including after the cells were opened and the morning head count completed.

51. I understand that there are limitations on what can be seen during such checks at night time as it is conducted through the cell hatch windows and is intended to be conducted without waking the prisoners unless an officer is concerned about a prisoner's wellbeing. However, the morning count clearly was a time when Mr Head's condition should have been identified. It appears it would not have made any difference to the outcome in this case, but it might in another case. Accordingly, it is important for the management of Acacia Prison to act upon the Department of Justice's recommendation in relation to Standing Order 10.2 to ensure population counts and welfare checks are appropriately performed and recorded. As the Department's own recommendation has already been made and I understand Acacia Management accept the recommendation, it does not seem to me to be necessary to make my own recommendation. However, I note it in this finding, so that if a similar issue arises in a future coronial case, it can be considered and an explanation sought as to why the carrying out of these important procedures have not improved.[41]

52. As for the actions of the various prison officers and health staff in performing CPR on Mr Head, I make absolutely no criticism of their endeavours. However, I did raise with Dr Rowland a question as to why a qualified medical practitioner did not feel comfortable making the call to cease CPR efforts for Mr Head prior to the arrival of SJA staff. Dr Rowland explained that there is a lot of concern, uncertainty and anxiety amongst nursing and medical staff within the prison environment about making the decision to end resuscitation efforts when it is known that the death will result in a mandatory coronial inquest and there is a possibility their conduct may be criticised. Dr Rowland commented that the same anxiety does not appear to arise in other medical settings, noting the doctor in this case was an experienced emergency

[41] Exhibit 1, Tab 15.

department doctor and she believes he would have happily called the death in any other setting.[42]

53. Dr Rowland also noted that there is a clear conflict between the need to continue CPR without interruption and the processes required to declare life extinct, which in some cases in the grey zone may lead health staff to err on the side of continuing CPR when there is any doubt. However, in this case Dr Rowland accepted there are cases where it is absolutely clear, and Mr Head's case is such an example.[43]

54. In my opinion, the problems arising from this reluctance on behalf of prison nurses and doctors raise are twofold. Firstly, there is a concern for the welfare of the staff who are required to continue CPR on what is, in effect, a cadaver. I understand there is both a physical and emotional toll for those engaged in these kinds of resuscitation efforts, and to have to continue to do so on someone who shows all the signs of having been deceased for some time and without any prospect of a successful outcome, must be distressing. Secondly, it is an unnecessary interference of the body of the deceased person and shows a lack of respect to their memory.

55. Dr Rowland advised that there are three policies that are relevant to the question of resuscitation and there have been ongoing discussions about changing the policies to clarify the decisions around resuscitation and acute collapses, as well as around expectations for decision-making for prisoners in the form of not-for-resuscitation orders and advanced health directives. Dr Rowland noted the issues are problematic when the patient is not in an external hospital setting, but the discussions are ongoing.[44]

56. I accept that there are some additional aspects to deciding whether or not to continue resuscitation of a prisoner, that may not apply in other cases, but in my opinion the issue needs to be approached with common sense and an acknowledgement of the duty or care that extends not only to the prisoner but to the staff. No one wants an opportunity to save a person in extremis to be missed, but it is also important not to prolong resuscitation efforts when it is obvious to trained health professionals that there is no prospect that the person will be revived.

57. Given the Department has indicated that Policy and Procedure 'PM05 Deaths' is currently being updated to include more detailed guidance for health staff able to declare life extinct (both doctors and registered nurses), in alignment with the Department of Health and WA Country Health Service policies, I do not propose to make any further recommendation in relation to the issue. I simply make the comment that, from a coroner's point of view, these are important issues that need to be clarified so that a prisoner can have the same expectation as a person in the community that all reasonable attempts will be made to save their life in an acute situation where there is a chance they can be saved, but their rights will also be respected, including the right for their body not to be unnecessarily interfered with when it is obvious to a doctor or properly qualified nurse that they have died.

[42] T 13 - 16
[43] T 16.
[44] T 19.

CONCLUSION

58. Mr Head was an elderly man who entered prison with a number of chronic health issues, including chronic obstructive airways disease. His medical management while in prison was reasonable and timely until 2022, when he moved to Acacia Prison. For a time, Mr Head engaged well with health services, but he then missed two scheduled medical reviews in late July and early August 2022. While he was being followed-up for review, he died unexpectedly.

59. After his death, Mr Head was found to be positive for COVID-19, which in conjunction with his pre-existing health issues, caused his death. Mr Head had been fully vaccinated against COVID-19 whilst in prison, and had already successfully recovered from an earlier bout of COVID-19 in June 2022. Unfortunately, on the second occasion he became infected, it seems his body did not have the reserves to cope with another infection and he suffered a cardiac arrhythmia and died in his sleep.

60. When his body was discovered in the morning by a cell mate, it was apparent he had been deceased for some time. The investigation into Mr Head's death explored why the fact Mr Head had suffered a medical event was not identified earlier, given he was subject to a number of head counts during the night and was supported to have been sighted for a welfare check when the cell was unlocked that morning. Consideration has also been given to why a doctor did not feel able to declare Mr Head life extinct prior to the arrival of ambulance staff, who made the call very quickly on arrival.

61. I am satisfied that the Department of Justice has already been taking steps to make appropriate changes to relevant policies and training of staff in that regard, and that Acacia Prison management is aware of the Department's recommendations and willing to take steps to implement them. Accordingly, I do not make any recommendations and simply comment that I am satisfied that Mr Head's treatment, supervision and care was commensurate with community standards. Sadly, like many others in the community, Mr Head had a number of health issues that predisposed him to a fatal outcome when he was exposed to the COVID-19 epidemic, and he succumbed on the second occasion he contracted the infection.

S H Linton
Deputy State Coroner
23 February 2024