JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	5 JULY 2024
DELIVERED	**:**	10 JULY 2024
FILE NO/S	**:**	CORC 2403 of 2023
DECEASED	**:**	KEATH, KEVIN JOHN

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Senior Constable C Robertson assisted the coroner.

Ms R Cook (State Solicitor's Office) appeared for the Department of Justice.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Kevin John KEATH*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 5 July 2024, find that the identity of the deceased person was* ***Kevin John KEATH*** *and that death occurred on 20 August 2023 at Bethesda Health Care, 25 Queenslea Drive, Claremont, from metastatic prostate cancer with terminal palliative care in the following circumstances:*

Table of Contents

INTRODUCTION

1. Kevin John Keath (Mr Keath) died on 20 August 2023 at Bethesda Health Care (Bethesda) from metastatic prostate cancer. He was 76 years of age.[1,2,3,4,5,6] At the time of his death, Mr Keath was a sentenced prisoner at Casuarina and thereby in the custody of the Chief Executive Officer of the Department of Justice (the Department).[7]

2. Accordingly, immediately before his death, Mr Keath was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*". In such circumstances, a coronial inquest is mandatory, and where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[8]

3. I held an inquest into Mr Keath's death at Perth on 5 July 2024, which focused on the care, treatment and supervision provided to Mr Keath while he was in custody, as well as the circumstances of his death.

4. The documentary evidence adduced at the inquest comprised two volumes and included separate reviews by the Department of Mr Keath's management in custody, and reviews of the medical and mental health care he received while incarcerated.[9,10]

5. The following witnesses from the Department gave evidence at the inquest:

a. Dr Catherine Gunson (Acting Director, Medical Services);[11] and

b. Ms Storm Duval (Review Officer).[12]

---

[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (26.03.24)
[2] Exhibit 1, Vol. 1, Tab 4, Death in Hospital Form (20.08.23)
[3] Exhibit 1, Vol. 1, Tab 5, P92 - Identification of Deceased Person (20.08.23)
[4] Exhibit 1, Vol. 1, Tab 6, Supplementary Post Mortem Report (29.01.24)
[5] Exhibit 1, Vol. 1, Tab 6.1, Post Mortem Report (30.08.23)
[6] Exhibit 1, Vol. 1, Tab 6, Supplementary Post Mortem Report (29.01.24)
[7] Section 16, *Prisons Act 1981* (WA)
[8] Sections 3, 22(1)(a) & 25(3), *Coroners Act 1996* (WA)
[9] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24)
[10] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24)
[11] ts 05.07.24 (Gunson), pp5-15
[12] ts 05.07.24 (Duval), pp16-22

MR KEATH

Background[13,14]

6. Mr Keath was born in Victoria in 1947. He completed Year 12 at a technical college and was a qualified heavy duty fitter, diesel mechanic, crane driver, and rigger. Mr Keath also had qualifications in contract management, and he had worked in Papua New Guinea, and in the mining industry in Western Australia. Mr Keath came to Western Australia in 1972, and reportedly had one child with his first wife, and two with his second. Mr Keath and his third wife were married for 33 years, although there were no children from this union.

Medical history[15,16,17]

7. Mr Keath's medical history included high blood pressure, high cholesterol, arthritis, type-II diabetes, peripheral vascular disease, chronic obstructive pulmonary disease (COPD), insomnia, osteopaenia, and osteoporosis. In 2007 Mr Keath was diagnosed with depression and he took prescribed anti-depressants until 2017. Mr Keath also reported a history of suicidal ideation and past self-harm and suicide attempts.

Circumstances of imprisonment[18,19,20]

8. On 8 March 2018, Mr Keath murdered his third wife by slashing her throat, in what was reportedly a "*murder/suicide pact*". After his wife's death, Mr Keath handed himself in to police. He later said he and his wife had attempted to take their lives on other occasions, and that he had not taken his own life after murdering his wife because he wanted to ensure that her body was treated with dignity.

9. On 5 October 2018 in the Supreme Court of Western Australia, Mr Keath was sentenced to life imprisonment (with a minimum term of 10 years) for his wife's murder. Mr Keath was made eligible for parole, and his earliest release date was 7 March 2028.

[13] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), p9
[14] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), pp3-5
[15] Exhibit 1, Vol. 1, Tab 2, Investigation report - Coronial Investigator R Fyneman (26.03.24), p4
[16] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), pp4-5
[17] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), pp4-5
[18] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), p9
[19] Exhibit 1, Vol. 1, Tab 11, History for Court - Criminal & Traffic
[20] Exhibit 1, Vol. 1, Tabs 12 & 12.1, ABC News reports (26.09.18 & 05.10.18)

MANAGEMENT IN PRISON

General management issues[21,22]

10. Mr Keath was incarcerated for a period of just over five years and 5 months, and was received into custody at Hakea Prison (Hakea) on 10 March 2018. He was transferred to Casuarina Prison (Casuarina) on 13 October 2018, and was subsequently transferred to Bunbury Regional Prison (Bunbury), where he remained until 10 August 2022, when he was returned to Casuarina for medical care.[23]

11. After Mr Keath's medical condition improved, he was returned to Bunbury on 13 September 2022. When it became clear he required a higher level of medical care, he was transferred back to Casuarina on 14 June 2023.

12. Mr Keath was described by staff as: "*a quiet individual who rarely came to their attention, and was respectful*". He was also reported to associate "*appropriately*" with other prisoners and to maintain an "*acceptable level*" of cell and personal hygiene. Aspects of Mr Keath's supervision and general management include:[24]

a. Mr Keath received 16 social visits from family members between August 2021 and his death. Departmental records indicate he did not send any mail;[25,26]

b. Mr Keath was the subject of random substance use tests, all of which were negative. His cell was also randomly searched, but nothing of consequence was ever found;[27,28] and

c. Mr Keath was employed at various times as a "*general unit worker*",[29] and was never charged with any prison offences.[30]

[21] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), pp4-8 & 10-29
[22] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), pp3-4
[23] Exhibit 1, Vol. 2, Tab 1.15, Cell Placement History
[24] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), pp 11& 29
[25] Exhibit 1, Vol. 2, Tab 1.31, Visits History
[26] Exhibit 1, Vol. 2, Tab 1.32, Prisoner Mail - Offender
[27] Exhibit 1, Vol. 2, Tab 1.34, Substance Use Test Results - Prisoner
[28] Exhibit 1, Vol. 2, Tab 1.35, Cell searches - Offender
[29] Exhibit 1, Vol. 2, Tab 1.33, Work History - Offender
[30] Exhibit 1, Vol. 2, Tab 1.36, Charge History - Prisoner

Management of medical issues[31,32]

13. Following Mr Keath's death, Dr Gunson conducted a review of the health services he was provided during his incarceration (Health Review). The Health Review establishes that Mr Keath was regularly reviewed by health professionals and he was treated for various medical issues. Mr Keath was also seen by dentists, physiotherapists, optometrists, and podiatrists. He was also the subject of treatment plans for diabetes and COPD.

14. In relation to screening for prostate cancer by testing for blood levels of prostate-specific antigen (PSA), current GP guidelines (in place since 2015) do not mandate routine PSA screening for males aged between 50 - 69 years of age. Nevertheless, whilst he was in the community, Mr Keath had PSA tests in 2015 and 2016, both of which returned normal results. At the inquest Dr Gunson explained that the current guidelines are under review, and that it may be that routine PSA testing for older males will be recommended in the future.[33]

15. Mr Keath underwent a colonoscopy in 2017 in the community to screen for colorectal cancer. Several polyps were identified and Mr Keath's GP recommended a repeat colonoscopy in 2020. Although Mr Keath was received into custody on 10 March 2018, he was not booked for a colonoscopy until November 2022, and this procedure was actually cancelled due to issues related to the COVID-19 pandemic.

16. Although Mr Keath did eventually have a colonoscopy during a hospital admission, this did not occur until June 2023. In the Health Review and at the inquest, Dr Gunson explained that when Mr Keath was received at Hakea in 2018, his GP health summary was unusually voluminous (i.e.: 134 pages), and prison medical officers typically only have about 10 minutes to transcribe a prisoner's GP health summary information into their prison file. It appears that Mr Keath's repeat colonoscopy was missed because it was not listed in the "*key information*" section at the front of his GP health summary.[34]

[31] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), pp6-9 and ts 05.07.24 (Gunson), pp5-15
[32] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), pp13-28
[33] ts 05.07.24 (Gunson), pp7-9
[34] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), pp12-13 and ts 05.07.24 (Gunson), pp6-7

17. Although Mr Keath's situation was somewhat unusual, in terms of avoiding these sorts of lapses in the future, the Health Review notes that a coordinator for chronic diseases completes "*regular and ongoing audits of the prison population*" to identify prisoners (like Mr Keath) who are due for routine "*age-related investigations*". Prison medical officers and nurses now also use "*older person health assessment templates*" which help identify when routine screening tests are due.[35]

18. At the inquest Dr Gunson confirmed that although Mr Keath had not undergone a repeat colonoscopy until 2023, this did not have any significant impact on his clinical journey. That is because although the repeat colonoscopy did identify some "*flat polyps*", it did not detect anything of a sinister nature.[36]

19. Key aspects of Mr Keath's medical management from 2022 until his death may be summarised as follows:[37]

a. 17 - 19 February 2022: a prostate mass (subsequently identified as a malignancy) was identified, and Mr Keath underwent a transurethral resection of the prostate;

b. 3 March 2022: a prison medical officer advised Mr Keath he had "*an aggressive type of prostate cancer that had spread to the bladder neck*", and this explained Mr Keath's voiding difficulties. When Mr Keath reported upper back pain that was keeping him awake, he was referred for a bone scan to investigate metastasis (secondary malignant growth);

c. 5 - 6 March 2022: Mr Keath was hospitalised for treatment of acute infective exacerbation of COPD and acute urinary infection;

d. 22 March 2022: scans identified widespread "*osteoblastic metastasis*" typical for metastatic cancer. Mr Keath commenced a course of chemotherapy in March 2022;

[35] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), p13
[36] ts 05.07.24 (Gunson), p6
[37] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), pp6-7

e. 5 - 10 August 2022: Mr Keath was hospitalised for treatment of acute infective exacerbation of COPD and neutropaenic sepsis;

f. October 2022: a PET scan showed some improvement on Mr Keath's prostate cancer metastases, and he underwent a course of radiotherapy which began in November 2022, and was completed in January 2023;

g. 19 February 2023: scans confirmed lesions in Mr Keath's brain and lungs and he underwent a craniotomy on 28 February 2023, during which his brain lesion was successfully removed;

h. 22 May - 2 June 2023: Mr Keath was hospitalised for treatment of rectal bleeding (of unknown cause), and a urinary tract infection;

i. June 2023: Mr Keath was taken to hospital after he fell and fractured his left collar bone (clavicle);

j. June - August 2023: Mr Keath was regularly reviewed by the Metropolitan Palliative Care Consultation Service; and

k. 19 - 20 August 2023: Mr Keath's medical condition deteriorated and he was transferred to Bethesda by ambulance.

Palliative care and death[38,39,40,41,42]

20. At about 11.45 am on 20 August 2023, Mr Keath was transferred to Bethesda for palliative care. In accordance with departmental policy, he was not restrained during his transfer, or whilst he was at Bethesda. During the day, Mr Keath's medical condition continued to deteriorate, and he was declared deceased at 5.39 pm.[43]

21. Mr Keath had reportedly asked to be transferred to Bethesda around 10 August 2023 but as noted, his transfer did not occur until 10 days later. At the inquest, Dr Gunson explained that bed availability is always an issue, and that beds at Bethesda are not always available when required by a prisoner.[44]

[38] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), pp27-28
[39] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), pp7, 11-12 & 14
[40] Exhibit 1, Vol. 1, Tab 10, SJA Patient Care Record KWI21D2 (20.08.23)
[41] Exhibit 1, Vol. 1, Tab 9, Bethesda Health Service Medical Records (20.08.23)
[42] Exhibit 1, Vol. 1, Tab 4, Death in Hospital Form (20.08.23)
[43] Exhibit 1, Vol. 1, Tab 4, Death in Hospital Form (20.08.23)
[44] ts 05.07.24 (Gunson), pp10-11

22. Dr Gunson also noted that the timing of admissions at Bethesda can be problematic because of the logistics involved in transferring prisoners to external palliative services for an extended stay. However, although the available evidence establishes that Mr Keath received high quality, compassionate palliative care at Casuarina, at the inquest, Dr Gunson agreed that with the benefit of hindsight, it would have been preferable to have transferred Mr Keath to Bethesda at an early stage.[45]

23. In my view, there are two reasons why this is the case. The first relates to the Casuarina infirmary. Having visited the facility, it is my view that the infirmary is dilapidated and depressing, and is an unsuitable environment for the delivery of end-of-life care. The fact that clinical staff are able to provide high quality palliative care in this place is to their great credit, but is hardly a compelling reason to do so.[46]

24. As I have pointed out in other findings relating to deaths in custody, the only punishment the State may lawfully impose on an accused person (other than fines and community orders) is deprivation of liberty. It follows that prisoners are entitled to a standard of medical care (including palliative care) that is broadly commensurate with reasonable community standards.[47]

25. In my view, notwithstanding the fact that clinical staff are able to provide quality palliative care to prisoners in the infirmary at Casuarina, the majority of Western Australians would be appalled at the current state of the facilities there.

26. The other compelling reason to transfer prisoners to external facilities for palliative care relates to the prisoner's support network including family and friends. When prisoners receive palliative care at facilities such as Bethesda, family and friends are generally able to visit their dying loved one freely. However, when a prisoner is receiving palliative care at Casuarina, this is not possible for security reasons.[48]

[45] ts 05.07.24 (Gunson), pp10-12
[46] ts 05.07.24 (Gunson), p14
[47] ts 05.07.24 (Gunson), p13
[48] See also: ts 05.07.24 (Gunson), pp11-12

The terminally ill register[49,50,51]

27. Prisoners with a terminal illness[52] are managed in accordance with a departmental policy known as *COPP 6.2 Prisoners with a Terminal Medical Condition* (COPP 6.2). Once a prisoner is identified as having a terminal illness, a note is made in the terminally ill module of the Total Offender Management Solutions (TOMS), the Department's prisoner management database.

28. Prisoners in the terminally ill module of TOMS are identified as Stage 1, 2, 3 or 4 prisoners, depending on their expected lifespan. For example, Stage 3 prisoners are expected to die within three months, whereas at Stage 4, the prisoner's death is regarded as imminent.

29. On 3 April 2022, Mr Keath was identified as a Stage 1 terminally ill prisoner (meaning his death was expected within 12 months) after he was diagnosed with prostate cancer. Mr Keath was escalated and deescalated to various levels on the terminally ill register, until he was escalated to Stage 3 on 7 June 2023, after his admission to hospital with rectal bleeding and a urinary tract infection.[53,54,55,56,57,58]

30. During his admission, Mr Keath lost four kilograms in weight, and on his return to Casuarina, he continued to eat very little, and declined his prescribed medications. He was also refusing to get out of bed and mobilise. On 20 August 2023, Mr Keath was escalated to Stage 4, after his medical condition deteriorated significantly over the previous 24 hours. As noted, he was transferred to Bethesda on 20 August 2023, and died that afternoon.

[49] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), pp9-10
[50] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), pp18-28 and ts 05.07.24 (Duval), pp16-21
[51] COPP 6.2 - Prisoners with a Terminal Medical Condition, pp 4-6
[52] One or more conditions that on their own or as a group, significantly increase the likelihood of a prisoner's death
[53] Exhibit 1, Vol. 2, Tab 1.13, Terminally Ill Health Advice - Stage 1 (03.04.22)
[54] Exhibit 1, Vol. 2, Tab 1.16, Terminally Ill Health Advice - Stage 2 (08.09.22)
[55] Exhibit 1, Vol. 2, Tab 1.19, Terminally Ill Health Advice - Stage 1 (01.11.22)
[56] Exhibit 1, Vol. 2, Tab 1.20, Terminally Ill Health Advice - Stage 2 (22.02.23)
[57] Exhibit 1, Vol. 2, Tab 1.23, Terminally Ill Health Advice - Stage 3 (07.06.23)
[58] Exhibit 1, Vol. 2, Tab 1.29, Terminally Ill Health Advice - Stage 4 (20.08.23)

31. From previous inquests I have conducted, I am aware that Stage 3 and 4 terminally ill prisoners may be considered for early release pursuant to the Royal Prerogative of Mercy (RPOM). In Mr Keath's case, a briefing note was sent to the Minister for Corrective Services on 28 July 2023, however for reasons that were not explained, the briefing note contained no recommendation about Mr Keath's early release.[59,60]

32. In an email to Ms Duval dated 30 April 2024, the Director Sentence Management made the following comments about the release of prisoners under the RPOM:[61]

> When prisoners are terminally ill (stage 3 or 4), Sentence Management provide briefings to our Minister for the purpose of a potential death in custody and consideration of the Royal Prerogative of Mercy (RPOM). Historically, Sentence Management made no recommendations under the RPOM provisions in these Ministerial Briefings. However, after reviewing the process around July 2023, Ministerial Briefings in relation to terminally ill prisoners now include recommendations as to whether or not to release on a RPOM.
>
> Liaison with the Minister's Office also revealed that these Briefings were not historically provided to the Attorney General who is the approving authority for RPOM. This process has now been rectified. Sentence Management are aiming to review the Terminally Ill Policy, COPP6.2, later this year to include the changes in practice.[62]

33. In a letter emailed to the Court on 10 July 2024, Ms Cook confirmed that the Department had advised that terminally ill briefings sent to the Minister for Corrective Services are forwarded by the Minister's Office to the Attorney General. If the Attorney General approved the release of a prisoner under the RPOM, an Executive Council minute would be prepared and forwarded to the Superintendent of the relevant prison. The Sentence Information Unit would then update the prisoner's discharge information on TOMS, and the prisoner would be released.[63]

[59] Exhibit 1, Vol. 2, Tab 1.24, Briefing Note to Min. for Corrective Services (28.07.23)
[60] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), p6
[61] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), p21
[62] Exhibit 1, Vol. 2, Tab 1.24, Email Ms L Allen to Ms S Duval (30.04.24)
[63] Email attaching letter from Ms R Cook (SSO) to the Court (10.07.24)

34. In my view, COPP6.2 should be **immediately** amended to incorporate the changes to policy/practice identified by Ms Allen in her email. Further, the process for the Attorney General to approve a prisoner's early release under the RPOM should also be clarified to ensure there are no delays in the event of a recommendation to release.[64]

35. I accept that given the nature of Mr Keath's offending, it is perhaps unlikely that he would have been recommended for early release under the RPOM. Nevertheless, it is unfortunate that no recommendation was made in the ministerial briefing note that was prepared in his case. However as noted, this lapse in practice has been addressed.

CAUSE AND MANNER OF DEATH[65,66]

36. A forensic pathologist (Dr Downs) conducted an external post mortem examination of Mr Keath's body on 30 August 2023 and noted signs of recent medical care and a sacral pressure area. Post mortem CT scans showed "*extensive metastatic disease in the skeletal system, a small chronic subdural haematoma, emphysema, coronary artery calcifications, T5 wedge fracture, and gallstones*".[67]

37. Toxicological analysis found various medications in Mr Keath's system that were consistent with his recent medical care. Alcohol and illicit drugs were not detected.[68]

38. At the conclusion of the external post mortem examination, Dr Downs expressed the opinion that the cause of Mr Keath's death was "*metastatic prostate cancer with terminal palliative care*" and his death was consistent with natural causes.

39. I accept and adopt Dr Downs' conclusion as my finding in relation to the cause of Mr Keath's death, and I find that his death occurred by way of natural causes.

---

[64] See also: ts 05.07.24 (Duval), pp18-21
[65] Exhibit 1, Vol. 1, Tab 6, Supplementary Post Mortem Report (29.01.24)
[66] Exhibit 1, Vol. 1, Tab 6.1, Post Mortem Report (30.08.23)
[67] Exhibit 1, Vol. 1, Tab 6, Supplementary Post Mortem Report (29.01.24)
[68] Exhibit 1, Vol. 1, Tab 7, Final Toxicology Report (15.12.23)

QUALITY OF SUPERVISION, TREATMENT AND CARE

40. Following Mr Keath's death, Ms Duval conducted a death in custody review of the supervision and management Mr Keath was provided whilst he was in custody (DIC Review). The DIC Review found that:

> Mr Keath's custodial management, supervision and care were in accordance with the Department's policy and procedures as listed in Appendix 1. Records indicate that the relevant death in custody procedures, including notifications and handover to WA Police, were followed.[69,70]

41. Similarly, in the Health Review, Dr Gunson expressed the following conclusion about Mr Keath's medical care and treatment:

> Mr Kevin John Keath received holistic, compassionate, and appropriate health care. One issue was identified,[71] but this would have made no difference to his outcome and did not affect his overall care. He was reviewed regularly and promptly as issues arose, and his treating teams worked with his specialist teams to provide the best care for his multiple serious health conditions, in the most timely and efficient manner possible.
>
> Due to the availability of health staff, medical reviews and specialist consultations were able to be organised very quickly when needed - which often in the community can be difficult to manage, especially for an elderly unwell person who might have difficulties attending appointments, or getting to booked tests and procedures.
>
> In conclusion, the health care provided to Mr Keath was overall of an excellent standard, and certainly equivalent to or better than the standard he would have received in the community.[72,73]

[69] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (17.06.24), p8
[70] See also: ts 05.07.24 (Duval), p16
[71] This is a reference to Mr Keath missing a routine colonoscopy to check for bowel cancer
[72] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24), p15
[73] See also: ts 05.07.24 (Gunson), p5

Comment on standard of supervision, treatment and care

42. On the basis of the available evidence, I am satisfied that the supervision Mr Keath received whilst incarcerated was of an acceptable standard. In relation to medical care, I accept Dr Gunson's evidence and find that the standard of care and treatment Mr Keath received whilst in custody was of a very good standard.

43. In particular, I commend the clinical staff who provided palliative care to Mr Keath in the infirmary at Casuarina, prior to his transfer to Bethesda on 20 August 2023.[74]

CONCLUSION

44. Mr Keath was 76 years of age when he died from metastatic prostate cancer at Bethesda on 20 August 2023. After carefully considering the available evidence, I concluded that Mr Keath received an appropriate standard of supervision during his incarceration, and that his treatment and care (particularly his palliative care) was at or above the standard he would have received in the community.

45. In conclusion, as I did at the inquest, I wish to extend to Mr Keath's family, on behalf of the Court, my sincere condolences for their loss.

MAG Jenkin
Coroner
10 July 2024

[74] Exhibit 1, Vol. 1, Tab 13, Health Services Review (04.07.24) and ts 05.07.24 (Gunson), pp6-20