JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	6 DECEMBER 2024
DELIVERED	**:**	23 DECEMBER 2024
FILE NO/S	**:**	CORC 489 of 2023
DECEASED	**:**	MIKHAIL, FRANK

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Ms S Markham appeared to assist the coroner.

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

Mr D Vijayakumar (Wotton Kearney) appeared for Serco Australia Pty Ltd.

Mr J Winton (instructed by Mr G French, DLA Piper) appeared for St John of God Healthcare Incorporated.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Frank MIKHAIL*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 6 December 2024, find that the identity of the deceased person was* ***Frank MIKHAIL*** *and that death occurred on 23 February 2023 at Acacia Prison, Great Eastern Highway, Wooroloo from bronchopneumonia in a man with carcinoma in the lung and chronic obstructive pulmonary disease in the following circumstances:*

Table of Contents

INTRODUCTION **3**
MR MIKHAIL **4**
Background and offending history 4
Prison History 4
MEDICAL ISSUES **5**
Medical history and management 5
Attendance at SJOG - 29 January 2023 6
Subsequent management at Acacia 15
Mr Mikhail is found in his cell 19
CAUSE AND MANNER OF DEATH **21**
QUALITY OF SUPERVISION, TREATMENT AND CARE **23**
Overview 23
Standard of supervision 23
Standard of care and treatment 24
Missed opportunities 24
CONCLUSION **27**

INTRODUCTION

1. Frank Mikhail (Mr Mikhail) was 68 years of age when he died at Acacia Prison (Acacia) on 23 February 2023. Acacia is managed by a private company called Serco Australia Pty Ltd (Serco). In any case, at the time of his death, Mr Mikhail was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Justice (CEO).[1,2,3,4,5]

2. By virtue of his incarceration immediately before his death, Mr Mikhail 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.[6]

3. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[7] In Mr Mikhail's case this includes an assessment of the care he received at St John of God Midland Public Hospital (SJOG) where he was seen on 29 January 2023.

4. On 6 December 2024, I held an inquest into Mr Mikhail's death which focused on the care Mr Mikhail received while he was in custody, as well as the circumstances of his death. The Brief of evidence adduced at the inquest included reports from medical experts, the Western Australia Police Force and the Department of Justice (DOJ) and comprised two volumes. The following witnesses gave evidence at the inquest:

a. Prof. E Gabbay (Independent expert, respiratory physician);
b. Dr E Henry (Consultant, SJOG);
c. Dr T Ginimalage (Resident, SJOG);
d. Ms A McNally (Health Services Director, Acacia);
e. Dr Q Summers (Independent expert, respiratory physician);
f. Ms C Ziino (Review Analyst, DOJ); and
g. Dr C Gunson, (Acting Deputy Director of Medical Services, DOJ).

[1] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (14.06.23)
[2] Exhibit 1, Vol 1, Tab 4, Life Extinct certificate (23.02.23)
[3] Exhibit 1, Vol 1, Tab 5, P92 Identification of deceased person (23.02.23)
[4] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report (19.04.23)
[5] Section 16, *Prisons Act 1981* (WA)
[6] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[7] Section 25(3) *Coroners Act 1996* (WA)

MR MIKHAIL

Background and offending history[8,9,10]

5. Mr Mikhail was born in Egypt on 14 April 1954. There is no record of when Mr Mikhail emigrated to Australia, however he obtained Australian citizenship in 1989. After arriving in Australia, Mr Mikhail obtained a real estate qualification, and he was also registered with the Builders Registration Board.

6. Although there is limited information about Mr Mikhail's family status, departmental records mention his "*defacto*" being removed as his next-of-kin in favour of his daughter, and Mr Mikhail also had a son.[11]

7. On 22 June 2011 in the Supreme Court of Western Australia, Mr Mikhail was convicted of two counts of murder. Mr Mikhail was sentenced to life imprisonment with a minimum non-parole period of 37 years and his earliest release date was calculated as 31 December 2046.[12,13]

Prison History[14]

8. During his incarceration, Mr Mikhail was accommodated at Hakea Prison, and Albany Regional Prison. He was transferred to Acacia on 15 November 2016 at his own request to facilitate visits from his family. At the time of his death, Mr Mikhail was accommodated in a single cell in Mike Block, and his security rating was medium.[15]

9. An Individual Management Plan described Mr Mikhail as a courteous and polite person who abided by prison rules, and maintained appropriate levels of personal and cell hygiene.[16] With one exception, routine searches of Mr Mikhail's cell found no items of concern. In the two years before his death Mr Mikhail tested positive for buprenorphine on 6 January 2023, and "*opiates*" on 13 February 2023.[17,18]

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[8] Exhibit 1, Vol 1, Tab 2, Report - Coronial Investigator R Fyneman (14.06.23), pp4-5
[9] Exhibit 1, Vol 2, Tab 18, Review of Death in Custody (05.11.24), pp4 & 7
[10] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), pp5-6
[11] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), p9
[12] Exhibit 1, Vol 2, Tab 18.4, History for Court - Criminal & Traffic
[13] Exhibit 1, Vol 2, Tab 18.5, Sentence Summary - Offender
[14] Exhibit 1, Vol 2, Tab 18, Review of Death in Custody (05.11.24), pp8-15 and ts 06.12.24 (Ziino), pp72-77
[15] Exhibit 1, Vol 2, Tab 18.22, Cell occupancy (03.02.23 - 23.02.23)
[16] Exhibit 1, Vol 2, Tab 18.6, Individual Management Plan (03.11.16)
[17] Exhibit 1, Vol 2, Tab 18.40, Cell Searches - Offender (23.02.21 - 23.03.23)
[18] Exhibit 1, Vol 2, Tab 18.39, Substance Use Test Results (23.02.21 - 23.03.23)

MEDICAL ISSUES

Medical history and management[19,20,21]

10. Mr Mikhail's medical history included: post-traumatic stress disorder, depressive disorder, sciatica, scoliosis of the lumbar spine, gastritis, and severe chronic obstructive pulmonary disease (COPD) related to his history of heavy smoking.

11. Whilst he was at Acacia Mr Mikhail regularly attended the medical centre for treatment of various minor ailments and conditions. He would often do so without an appointment, or outside standard clinic times, and he would often present in a demanding and argumentative manner.

12. Mr Mikhail also made frequent complaints about his care and expressed his belief that his "*ongoing issues were not being resolved*".[22] Despite repeated suggestions that he cease smoking, Mr Mikhail declined to do so. Although he claimed he had stopped smoking at the end of 2022, it is possible he may have resumed smoking shortly before his death.

13. Although Mr Mikhail was booked for a colonoscopy on 7 February 2023 to investigate precancerous growths in his colon (tubular adenoma), he declined the procedure the day before. Mr Mikhail told Ms McNally he had "*no interest in knowing if he has cancer*" and "*did not want to have his life prolonged any longer than God's will*". Mr Mikhail signed a waiver of medical treatment form and was returned to his cell.[23,24]

14. On a number of occasions Mr Mikhail was managed on the At Risk Management System (ARMS) when he threatened self-harm or suicide. Several of these episodes related to Mr Mikhail's perceptions about the care and treatment of his medical issues.[25,26] ARMS is DOJ's primary suicide prevention strategy and provides guidelines to assist staff to identify and manage prisoners at risk of self-harm and/or suicide.[27]

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[19] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records
[20] Exhibit 1, Vol 1, Tab 15, Medication list
[21] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24) and ts 06.12.24 (McNally), pp49-71
[22] See also: Exhibit 1, Vol 2, Tab 18.12 ACCESS Complaint IO57860 (05.10.22)
[23] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records (06.02.23), p6
[24] Exhibit 1, Vol 1, Tab 14, Refusal to Attend a Medical Appointment form (06.02.23)
[25] See for example: Exhibit 1, Vol 1, Tab 12, PHS ARMS File Notes (various dates 03.05.21 - 03.02.23)
[26] See for example: Exhibit 1, Vol 2, Tab 18.14, ARMS Interim Management Plan (11.01.23)
[27] See: DOJ's ARMS Manual (2019)

15. After reviewing the available material, I am satisfied that the management of Mr Mikhail's mental health whilst he was incarcerated at Acacia was appropriate, and was in accordance with the provisions of DOJ's ARMS Manual.[28,29,30,31,32,33,34,35,36]

Attendance at SJOG - 29 January 2023[37,38,39,40,41,42,43,44,4546]

16. At about 12.15 am on 29 January 2023, a custodial officer at Acacia (Officer Anderson) received an intercom call from Mr Mikhail's cell. When asked about the nature of his medical emergency, Mr Mikhail "*gave a panicked reply along the lines of 'there's blood coming out of me'*".[47]

17. Officer Anderson initiated a "*Code Blue*" medical emergency[48] and in response, custodial and nursing staff attended Mr Mikhail's cell a short time later. Mr Mikhail complained of shortness of breath and chest pain, and reported he had been "*coughing up blood*" (haemoptysis).

18. Incident reports completed by custodial and clinical staff at Acacia who attended to Mr Mikhail include the following observations:

> *Custodial Officer Thomson*: I looked through the viewing window and saw a prisoner that I now know to be (Mr Mikhail) with what appeared to be blood around his mouth and on the floor.[49]
>
> *Registered Nurse Moyo*: (Mr Mikhail) was experiencing shortness of breath and coughing up blood. (Mr Mikhail) was alert when I quickly assessed his oxygen levels which were very low.[50]

[28] Exhibit 1, Vol 2, Tab 18.8, TOMS Incident Report (03.05.21)
[29] Exhibit 1, Vol 2, Tabs 18.9-18.11, ARMS Minutes (04.05.21, 05.05.21 & 18.05.21)
[30] Exhibit 1, Vol 2, Tab 18.14, ARMS Interim Management Plan (11.01.23)
[31] Exhibit 1, Vol 2, Tabs 18.15 & 18.16, ARMS Minutes (12.01.23 & 19.01.23)
[32] Exhibit 1, Vol 2, Tabs 18.17 & 18.8, TOMS Incident Reports (29.01.23 & 31.01.23)
[33] Exhibit 1, Vol 2, Tab 18.19, ARMS Referral (31.01.23)
[34] Exhibit 1, Vol 2, Tabs 18.20 & 18.21, ARMS Minutes (01.02.23 & 03.02.23)
[35] ts 06.12.24 (McNally), pp56-57
[36] See: DOJ's ARMS Manual (2019)
[37] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24) and ts 06.12.24 (McNally), pp58-59
[38] Exhibit 1, Vol 2, Tab 18, Review of Death in Custody (05.11.24), pp5 & 12-13
[39] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), pp8-9
[40] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records (29.01.23), pp16-17
[41] Exhibit 1, Vol 1, Tab 9, SJOG Short Triage form (29.01.23) & SJOG Nursing & Progress notes (29.01.23)
[42] Exhibit 1, Vol 1, Tab 9, SJOG Emergency Department Discharge Summary (Downtime) (29.01.23)
[43] Exhibit 1, Vol 1, Tab 16, Report - Dr Q Summers (16.09.24) and ts 06.12.24 (Summers), pp77-87
[44] Exhibit 1, Vol 2, Tab 18.31.1, Report - Dr P Myers (11.03.24)
[45] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24) and ts 06.12.24 (Gabbay), pp9-31
[46] Exhibit 1, Vol 2, Tab 21, Statement - Dr E Henry (22.11.24) and ts 06.12.24 (Henry), pp32-40
[47] Exhibit 1, Vol 2, Tab 18.17, Incident Description Report - Custodial Officer V Anderson (29.01.23)
[48] Acacia is the only prison in WA that uses "Code Blue" for medical emergencies. All other prisons use "Code Red"
[49] Exhibit 1, Vol 2, Tab 18.17, Incident Description Report - Custodial Officer D Tomson (29.01.23)
[50] Exhibit 1, Vol 2, Tab 18.17, Incident Description Report - Registered Nurse T Moyo (29.01.23)

> *Custodial Officer Feeney*: there was blood around (Mr Mikhail's) mouth, floor and on the wall. He was visibly in distress and it was deemed necessary for him to be relocated to medical for further assessment.[51]
>
> *Custodial Officer Cuthbertson*: (Mr Mikhail) was the subject of a medical code blue emergency in Mike block unit 4 cell 27. Upon arrival prisoner was coughing up blood. Prisoner assessed by the duty nurse and relocated to the medical centre. Prisoner is Covid Positive. After further assessment it was deemed necessary to relocate the prisoner offsite to an external medical facility. Prisoner Offsite at 0201 hours.[52]

19. The chronology of events in the Post Incident Review completed by Serco (the Review) refers to Mr Mikhail "*stating there was blood coming out of him*" during his cell call, and to the observations of custodial staff about blood coming from Mr Mikhail's mouth and being on the wall and floor of his cell. The chronology also notes an entry in the "*escort log book*" at 7.15 am on 29 January 2023 that states Mr Mikhail "*is telling a doctor he is coughing up blood and the prison is not doing enough for him*".[53]

20. An ambulance arrived at Acacia at 1.42 am, and Mr Mikhail left for SJOG at 2.09 am. The St John Ambulance patient care record prepared by the attending ambulance officers notes the following history:

> Tested POS for Covid 19 (two days) ago. Found by prison staff this morning at (12.14 am) experiencing (shortness of breath), single word dyspnoea, and **haemoptysis (Mr Mikhail) states 1000 ml of blood and fluid**. Prison nurse administered 15L (of oxygen) via NRB mask with good effect, raised saturations from 70% to 100% and (respiration rate) from 40 to 28.[54,55] [Emphasis added]

21. A SJOG nursing assessment form notes that Mr Mikhail had been brought in by ambulance officers and Acacia staff with shortness of breath and a productive cough.[56]

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[51] Exhibit 1, Vol 2, Tab 18.17, Incident Description Report - Custodial Officer T Feeney (29.01.23)
[52] Exhibit 1, Vol 2, Tab 18.17, Incident Report Minutes - Custodial Officer A Cuthbertson (29.01.23)
[53] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24)
[54] Exhibit 1, Vol 1, Tab 8.1, SJA Patient Care Record MUN21N2 (29.01.23)
[55] In his report, Dr Myers says that an earlier reading of 71% in the medical centre "*could not have been a true reading*"
[56] Exhibit 1, Vol 1, Tab 9, SJOG Nursing A-E Assessment (12.30 am, 29.01.23)

22. The "*presenting complaint*" section of the nursing assessment form states: "*(Mr Mikhail) reports bleeding from the mouth due to coughing. No obvious wheeze on assessment. Talking in sentences*". Mr Mikhail's vital signs were assessed as normal, and the treatment plan stated on the nursing assessment form was: "*Awaiting doctor review*".[57]

23. A SJOG "*Short Triage*" form notes Mr Mikhail's "*triage time in*" was 2.56 am. However, despite Mr Mikhail's self-reports of haemoptysis (which had been noted in the SJA Patient Care record, and the SJOG nursing assessment form), the "*Short Triage*" form simply records Mr Mikhail's presenting history as "*Short of Breath*" and notes he had a "*productive cough*". In addition to recording Mr Mikhail's vital signs, his past medical history of asthma and COPD were also noted.

24. Mr Mikhail was reviewed by a resident medical officer (RMO). In an entry at 7.30 am, the RMO noted that Mr Mikhail had presented from Acacia with "*haemoptysis and productive cough with COVID positive on a background of known COPD and asthma*". In relation to Mr Mikhail's self-reports of haemoptysis, the RMO's entry states:

> Awoke early today 0100 and had episode of haemoptysis → (Mr Mikhail) states **1 small cup's worth of bright red mixed with phlegm**.[58] [Emphasis added]

25. In addition to this mention of Mr Mikhail's self-reported history of haemoptysis, at 10.45 am a clinical nurse made the following entry in the progress notes: "*(Mr Mikhail) called for assistance, having episode of haemoptysis, informed ED RMO*".[59]

26. Regrettably this entry does not record the amount of blood and/or sputum Mr Mikhail coughed up, or the RMO to whom the incident was apparently reported. There are no further entries in the progress notes following the nursing entry about Mr Mikhail's episode of haemoptysis at 10.45 am.

[57] Exhibit 1, Vol 1, Tab 9, SJOG Nursing A-E Assessment (12.30 am, 29.01.23)
[58] Exhibit 1, Vol 1, Tab 9, SJOG Progress Notes (7.30 am, 29.01.23)
[59] Exhibit 1, Vol 1, Tab 9, SJOG Progress Notes (10.45 am, 29.01.23)

27. In her statement, and at the inquest, Dr Ginimalage (one of the RMO's on duty in the emergency department at SJOG at the relevant time) said she did not recall Mr Mikhail's episode of haemoptysis being reported to her. Dr Ginimalage said that although she did not remember this particular case, her "*standard practice*" would have been to speak with the patient and verify their symptoms before speaking with a more senior doctor to determine whether there was to be any change to the discharge plan.[60]

28. Professor Gabbay is an experienced respiratory physician who was engaged by SJOG to review Mr Mikhail's care. In his report, Professor Gabbay made the following observation about the lack of any further entries in the SJOG progress notes about the reported episode of haemoptysis: "*At the very least the lack of any documentation by medical staff following being informed of this development raises the possibility that this subsequent episode may have been inadequately assessed*".[61]

29. In my view, the wording of the nursing entry at 10.45 am about Mr Mikhail's episode of haemoptysis leaves open several possibilities, none of which reflect any credit on SJOG. First, the entry may have been written prospectively, meaning that although the nurse had intended to report the matter to an RMO, they did not do so. Alternatively, although the haemoptysis event may have been reported, the RMO may not have taken any action. Finally, it is possible that the haemoptysis episode was reported to an RMO who assessed Mr Mikhail, but then failed to make any entry in the progress notes.

30. As I have explained, Mr Mikhail's self-reports of his haemoptysis varied from "*1,000 ml of blood and fluid*" to "*1 small cup's worth of bright red mixed with phlegm*". Clearly this was a significant event, although given the observations of custodial staff at Acacia, and the fact that Mr Mikhail's physiological presentation on arrival at SJOG was relatively normal, it is perhaps unlikely that his self-report to ambulance officers (i.e.: of having coughed up 1,000 ml of blood and fluid) was accurate.[62,63,64,65]

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[60] Exhibit 1, Vol 2, Tab 20, Statement - Dr T Ginimalage (08.11.24), paras 23-25 and ts 06.12.24 (Ginimalage), pp46-48
[61] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), para 85 and ts 06.12.24 (Gabbay), pp19-20 & 25-26
[62] Exhibit 1, Vol 1, Tab 8.1, SJA Patient Care Record MUN21N2 (29.01.23)
[63] Exhibit 1, Vol 1, Tab 9, SJOG Progress Notes (7.30 am, 29.01.23) and ts 06.12.24 (Gabbay), pp25-26
[64] Exhibit 1, Vol 2, Tab 18.17, Incident Description Reports - Various Custodial Officers (29.01.23)
[65] ts 06.12.24 (Henry), pp36-37 and ts 06.12.24 (Summers), pp81-82

31. Nevertheless, for reasons I will explain later in this finding, after carefully considering the available evidence, I have concluded that the failure of SJOG clinical staff to investigate the cause of Mr Mikhail's haemoptysis more aggressively before he was discharged back to Acacia was a missed opportunity to have provided him with a higher standard of care.

32. Dr Henry was one of the consultant physicians on duty in the emergency department at SJOG although he was not involved in Mr Mikhail's care. In his statement, Dr Henry expressed the opinion that Mr Mikhail was "*appropriately managed within the usual framework of delegation and oversight*". Dr Henry said that based on the notes he had seen, Mr Mikhail's working diagnosis was "*pneumonia on the basis of corona virus disease (COVID-19)*" which was not severe on the basis of a recognised scoring system known as CURB-65.[66,67,68]

33. Dr Henry said Mr Mikhail's observations during his stay in the emergency department had been "*normal*", with the exception of a temperature spike closer to discharge. Dr Henry also said: "*There was nothing in (Mr Mikhail's) clinical notes indicating a need for admission*".[69]

34. Dr Henry noted that the "*volume of haemoptysis*" coughed up by Mr Mikhail remained unclear as it was not documented or escalated to him, unless Mr Mikhail was "*having profuse haemoptysis*" his discharge plan would not necessarily have changed as Mr Mikhail's heart rate and haemoglobin levels were "*within normal limits*".[70]

35. Mr Mikhail was discharged from SJOG and returned to Acacia at about 12.20 pm. A discharge summary noted that Mr Mikhail had been diagnosed with an acute lower respiratory tract infection and prescribed oral antibiotics. The discharge summary also requested that Mr Mikhail undergo a repeat X-ray of his chest in six weeks. At the inquest Professor Gabbay and Dr Henry explained that this was done to ensure the pneumonia had resolved.[71,72]

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[66] Exhibit 1, Vol 2, Tab 19.11, Zak H et al, The Battle of Pneumonia Predictors (2023) PMID: 37649936 & PMC10462911
[67] Exhibit 1, Vol 2, Tab 21, Statement - Dr E Henry (22.11.24), paras 27-31 and ts 06.12.24 (Henry), pp34-35
[68] See also: ts 06.12.24 (Gabbay), pp16-17
[69] Exhibit 1, Vol 2, Tab 21, Statement - Dr E Henry (22.11.24), paras 27-31
[70] Exhibit 1, Vol 2, Tab 21, Statement - Dr E Henry (22.11.24), para 45
[71] Exhibit 1, Vol 1, Tab 9, SJOG Emergency Department Discharge Summary (Downtime) (29.01.23)
[72] ts 06.12.24 (Gabbay), p14 and ts 06.12.24 (Gabbay), p40

36. In his report and at the inquest, Professor Gabbay noted there was a small, but not immaterial risk of mortality with "low severity" pneumonia, and it was therefore appropriate to notify the Acacia clinical team that if Mr Mikhail were to deteriorate despite his dual antibiotic therapy, he should be returned to SJOG for reassessment.[73]

37. In Mr Mikhail's case, this important information was relayed to the Acacia clinical team by way of a discharge summary, which as noted set out Mr Mikhail's diagnosis (acute lower respiratory tract infection) and his medication regime. Under the heading "patient information", the document contained the printed words: "*Please seek medical attention if you have any new concerns, your condition deteriorates or your condition does not resolve as advised*".[74]

38. Although the discharge summary does request a repeat chest X-ray in six weeks, it does not indicate what symptoms (if any) the clinical team at Acacia should have been looking out for, and/or what Mr Mikhail may have been told about how his condition should resolve. In my view this is particularly significant given Mr Mikhail's frequent attendances at the medical centre with similar presentations, and his history of severe COPD.[75,76,77]

39. Professor Gabbay said that based on the quality of summaries he received from emergency departments, Mr Mikhail's discharge summary was "*significantly better than average*".[78] Nevertheless, in my view the discharge summary could (and should) have been more fulsome about symptoms to watch for, particularly in a patient like Mr Mikhail who had severe COPD.

40. The significance of Mr Mikhail's haemoptysis was the subject of discussion on his return to Acacia. In the Review, a chronology of events refers to the following email sent at 2.32 pm on 29 January 2023 by a registered nurse in Acacia's medical centre to Mr Mikhail's unit manager:

[73] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), paras 62-62 and ts 06.12.24 (Gabbay), pp20-21
[74] Exhibit 1, Vol 1, Tab 9, SJOG Emergency Department Discharge Summary (Downtime) (29.01.23)
[75] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records
[76] Exhibit 1, Vol 1, Tab 9, SJOG Emergency Department Discharge Summary (Downtime) (29.01.23)
[77] Exhibit 1, Vol 2, Tab 22, Email - Dr C Gunson to Ms T Palmer (03.12.24), p1
[78] ts 06.12.24 (Gabbay), pp20-21

> Prisoner Mikhail had been medically cleared by St John of God Hospital, Midland and the Acacia Medical Centre RN, and was deemed suitable to be housed in his current block with the understanding that any deterioration would be escalated to medical staff.[79]

41. At 3.40 pm on 29 January 2023, the unit manager sent the following email to a registered nurse at the medical centre:

> Thanks for the email. As mentioned on the phone prisoner MIKHAIL is currently coughing blood and has been since returning to Mike Block. As below I am raising this as I believe this is a deterioration in his condition that requires further medical observation. I would like to remove prisoner MIKHAIL from Mike Block to the Medical Centre or a cell with camera in the Detention Unit (DU) if possible. Can this be looked at please. **I don't think it is safe to have prisoner MIKHAIL remaining in Mike Block whilst he is coughing up blood and not appearing well**.[80] [Emphasis added]

42. Despite the concerns expressed by Mr Mikhail's unit manager, the Review's chronology records an email from a registered nurse in the medical centre to the unit manager at 5.52 am on 30 January 2023 which effectively dismisses the concerns raised in these terms:

> Can you give myself or the Health Services Manager (HSM) a call today as it sounds like you believe he should be observed 24/7 which isn't the case. I think it would help if we discuss directly with you.[81]

43. It is unclear what further discussions (if any) occurred between the registered nurse and/or the Health Services Manager and the unit manager, but there is no evidence that Mr Mikhail was subsequently transferred to the medical centre, or to a cell with a camera as had been requested.

44. In his report, Dr Gabbay concluded that the management of Mr Mikhail's likely right upper lobe pneumonia at SJOG "*fell within an acceptable standard of care*".[82]

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[79] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), p9
[80] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), p9
[81] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), p9
[82] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), para 74

45. Despite this positive assessment of Mr Mikhail's care at SJOG, in my view it is **highly significant** that Professor Gabbay went on to make the following observations about the care provided to Mr Mikhail by SJOG:

> However, in my view it would also **not have been unreasonable** for the Emergency Department staff to elect to admit Mr Mikhail for inpatient care rather than electing to discharge him back to Acacia prison. [Original emphasis]
>
> This is particularly relevant when considering Mr Mikhail's comorbidities, including the presence of severe COPD, concurrent COVID infection, the fact that he was relatively immunocompromised (having a past history of hepatitis and previous use of Prednisolone).
>
> Further, Mr Mikhail had significant mental health comorbidities including the requirement for psychotropic medication as well as significant requirement for opiate medication in the setting of known Sciatica. Both of these factors make management in ambulatory care more challenging.
>
> The Emergency Department could have also taken into account that Mr Mikhail presented with a right upper lobe pneumonia despite having recently been treated with oral antibiotics at Acacia Prison of which, based on the emergency department medical notes, they were aware.
>
> That is, it would have been reasonable to consider the possibility that Mr Mikhail had already received appropriate oral antibiotic care at Acacia Prison and had not responded optimally thus giving further weight to the option of admitting him for Intravenous Antibiotic therapy.[83]

46. Dr Summers is an experienced respiratory physician who was engaged by the Court to review Mr Mikhail's care. In his report, Dr Summers made the following comments about SJOG's decision not to admit Mr Mikhail on 29 January 2023:

> On the day that (Mr Mikhail) presented to (SJOG), he had been coughing up blood, and there is clear documentation that he felt he had coughed up to a cup full of blood. Unfortunately the medical notes from his ED presentation are deficient...

[83] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), paras 79-83 and ts 06.12.24 (Gabbay), pp17-18

> There is little mention of haemoptysis, even though this is documented in both the prison and (SJA) notes. There is no mention of a provisional diagnosis, and no differential diagnosis. The potential for an underlying lung cancer to be the cause of (Mr Mikhail's) presentation did not seem to be considered. Coughing up this much blood is a red flag. **In my opinion, because of the history of haemoptysis, Mr Mikhail should have been kept in hospital and both investigated and treated more aggressively.**[84] [Emphasis added]

47. Dr Summers noted that typical symptoms of COPD are "*breathlessness and cough with sputum production*". Dr Summers said that although bleeding from the lungs is not a symptom of COPD, this can occur in very severe pneumonia and that:

> Any individual with a history of heavy smoking who is bleeding from the lung is at high risk for lung cancer, and the diagnosis needs to be considered in this setting.[85,86]

48. Dr Summers also observed coughing up "*large amounts of blood is a highly unusual feature of pneumonia, particularly when there isn't diffuse and/or severe involvement of the lungs*", and that even if SJOG believed Mr Mikhail's haemoptysis was being caused by his lung infection:

> Mr Mikhail should have been admitted and treated with intravenous antibiotics because of the reported bleeding, along with appropriate investigations to determine the cause of the bleeding. **The most important and urgent test was a CT of (Mr Mikhail's) chest. This would, very likely, have led to the discovery of the malignant tumour found at this autopsy.**[87] [Emphasis added]

49. In a supplementary report (prepared after Dr Summers had reviewed Professor Gabbay's reports), Dr Summers expressed the opinion that Mr Mikhail had a "*patchy bronchopneumonia of his right upper lobe*", which in the absence of high fevers, rapid breathing, hypoxia, or low blood pressure was "*not a severe pneumonia*".[88]

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[84] Exhibit 1, Vol 1, Tab 16, Report - Dr Q Summers (16.09.24), para 9 and ts 06.12.24 (Summers), p84
[85] Exhibit 1, Vol 1, Tab 16, Report - Dr Q Summers (16.09.24), para 8
[86] See also: Exhibit 1, Vol 1, Tab 16.2, Evaluation & Management of life-threatening haemoptysis
[87] Exhibit 1, Vol 1, Tab 16, Report - Dr Q Summers (16.09.24), para 10
[88] Exhibit 1, Vol 1, Tab 16.6, Report - Dr Q Summers (29.11.24), para 2

50. Dr Summers stated that the fact Mr Mikhail's pneumonia was not severe reduced the likelihood that his haemoptysis was due to infection. Dr Summers also said that in his opinion, this "*should have led to further investigation*".[89]

51. Dr Summers and Professor Gabbay both agreed that if the source of Mr Mikhail's bleeding had been identified as the "*haemorrhagic lesion*" in the right upper lobe of Mr Mikhail's lung (which was noted by Dr Ong during his post mortem examination),[90] then several treatment options may have been used to address the bleeding.[91,92]

52. These treatments may have included targeted radiotherapy, intravenous antibiotics, high dose corticosteroids, and/or a bronchial embolisation (a surgical technique aimed at blocking blood flow to the tumour). Had some or all of these treatments been employed, it is possible that Mr Mikhail's lifespan and the quality of his life may have been improved.[93]

Subsequent management at Acacia[94,95,96,]

53. At 8.30 am on 31 January 2023, a Code Blue medical emergency was initiated by custodial staff after Mr Mikhail complained of "a headache" which he said he had been experiencing since the previous night. Prison nurses attended his cell and Mr Mikhail was given paracetamol.[97]

54. Later that day Mr Mikhail was placed on ARMS on high (one-hourly) observations and moved to a safe cell after refusing food. He had also complained about his ongoing illness and expressed "*his wish to die in prison*". A Code Blue medical emergency was also called on 1 February 2023, after Mr Mikhail complained of shortness of breath, but his symptoms appeared to resolve. After Mr Mikhail denied he was on a "*hunger strike*" he was returned to his unit on 3 February 2023.[98,99,100]

[89] Exhibit 1, Vol 1, Tab 16.6, Report - Dr Q Summers (29.11.24), para 2
[90] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report (19.04.23)
[91] Exhibit 1, Vol 1, Tab 16.5, Email - Dr Q Summers to Ms S Markham (18.09.24)
[92] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), paras 96 & 96.1-96.4
[93] Exhibit 1, Vol 1, Tab 16.5, Email - Dr Q Summers to Ms S Markham (18.09.24)
[94] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24)
[95] Exhibit 1, Vol 2, Tab 18, Review of Death in Custody (05.11.24)
[96] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23)
[97] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24), pp34-35
[98] Exhibit 1, Vol 2, Tab 18.18, Incident Description, Summary & Minutes (31.01.23)
[99] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), p9
[100] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24), pp35-37

55. On 8 February 2023, Mr Mikhail was seen by a doctor at the medical centre. He was "*very unhappy*" and complained about his treatment, saying he was "*dying*" and "*coughing up shit*". Mr Mikhail also said he had given up smoking "*15 days earlier*", and he was advised not to restart, as cessation of smoking would assist his symptoms.[101,102]

56. On examination, Mr Mikhail had a mostly non-productive cough and was speaking in full sentences with "*no clinical shortness of breath*". His chest had a minor wheeze and there was no significant swelling of his legs. Mr Mikhail was diagnosed with "*non-infective exacerbation of his COPD*", and he agreed to take a short course of prednisolone "*to see if it helps*", and a CT of his chest to "*exclude any sinister problems*".[103,104]

57. The referral form requesting the chest CT for Mr Mikhail completed by the prison doctor included the following history: "*Patient known COPD - smoked 40 years. Past few months had a few episodes of haemoptysis. Chest x-ray shows scarring right lung apex. Exclude sinister lesion lung*".[105] Once completed these types of referral forms are forwarded to an external service which "triages" the urgency of the request and books the relevant appointment.[106]

58. The prison doctor who completed the referral form noted that although an urgent CT could be requested, in Mr Mikhail's case, "*there seemed to be no immediate urgency*".[107]

59. Dr Gunson (who is DOJ's Acting Deputy Director of Medical Services) said her impression was that although the prison doctor had "*definitely recognised*" that a sinister cause for Mr Mikhail's presentation was likely, they had "*unfortunately under-estimated the urgency*" of the requested chest CT.[108]

[101] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records (08.02.23), pp5-6
[102] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24), p38
[103] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records (08.02.23), pp5-6
[104] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24), p38
[105] Exhibit 1, Vol 2, Tab 18.31.1, Report - Dr P Myers (11.03.24), p11
[106] ts 06.12.24 (McNally), pp61-62
[107] Exhibit 1, Vol 2, Tab 18.31.1, Report - Dr P Myers (11.03.24), pp11-12
[108] Exhibit 1, Vol 2, Tab 22, Email - Dr C Gunson to Ms T Palmer (03.12.24), p3

60. Dr Gunson also said that although the request form for the chest CT had not been marked "*urgent*" by the prison doctor, the stated history "*did suggest that the scan should have been booked within a reasonably short time*". In her email and at the inquest, Dr Gunson confirmed that at the time of Mr Mikhail's death no appointment for a chest CT had been made by the external agency.[109]

61. On 15 February 2023, Mr Mikhail presented to the medical centre at Acacia and reported he was still coughing up some "*dried blood*", and that his sputum was coloured. He asked for "*something to clear out the sputum*" and also told the prison nurse he was "*dying*" and "*had cancer*". Mr Mikhail denied smoking, and on examination was found to have an occasional dry cough with "*added right sided chest signs*".[110,111]

62. The nurse who reviewed Mr Mikhail liaised with a prison doctor about Mr Mikhail's treatment plan, and the EcHO medical notes record that he was to continue his course of oral prednisolone. The EcHO medical notes also state that Mr Mikhail was still awaiting a CT scan of his chest, which as noted had been requested by the prison doctor on 8 February 2023.[112,113]

63. Professor Gabbay expressed the following opinion about Mr Mikhail's management at Acacia, after his discharge from SJOG:

> Overall, I consider that whilst there are some mitigating circumstances (elaborated in my specific answers to your questions in paragraph 97 (c) (below)[114] I am of the view (that) Mr Mikhail's post Emergency Department management at Acacia Prison fell below an acceptable standard of care.[115]

64. In his report, Professor Gabbay explained that the phrase "*some mitigating circumstances*" referred to Mr Mikhail's multiple comorbidities which could potentially mask new "*worrying*" symptoms of malignancy.[116]

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[109] Exhibit 1, Vol 2, Tab 22, Email - Dr C Gunson to Ms T Palmer (03.12.24), p3 and ts 06.12.24 (Gunson), p70
[110] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records (15.02.23), pp4-5
[111] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24), pp38-39
[112] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records (15.02.23), pp4-5
[113] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24), p39
[114] This is a reference to Mr Mikhail's multiple comorbidities potentially masking new "*worrying*" symptoms of malignancy
[115] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), para 95
[116] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), para 97(c)

65. Professor Gabbay explained that Mr Mikhail had been treated with oral antibiotics for "*community acquired pneumonia*" without resolution of symptoms. He also had discoloured sputum and ongoing haemoptysis. In these circumstances, Professor Gabbay said that in his view "*standard care*" would have been to transfer Mr Mikhail back to SJOG for reassessment.[117]

66. Professor Gabbay also said that although a chest CT scan had been "*appropriately ordered*", the medical team at Acacia had not appreciated the "*time criticality*" of further investigations given Mr Mikhail was "*a patient with severe COPD and recent pneumonia who had not been responsive to oral antibiotic therapy*".[118]

67. Having carefully considered the available evidence, I am satisfied that with the benefit of hindsight, Mr Mikhail should have been transferred back to SJOG for further assessment when his symptoms and episodes of haemoptysis persisted.

68. Dr Gunson reviewed Mr Mikhail's EcHO notes and the Health Summary prepared by Serco (Health Summary), before expressing the following opinion:

> [I]n general I would concur with Professor Gabbay's opinion that (Mr Mikhail) should have been referred for reassessment in hospital, after he did not appear to be improving post diagnosis and treatment of pneumonia, especially on the background of severe COPD.[119]

69. Dr Gunson noted that it may not have been "*completely clear*" that Mr Mikhail's symptoms were "*entirely due to his recent pneumonia*" when he presented to the medical centre on 8 February 2023. That was because prior to his admission to SJOG on 29 January 2023, Mr Mikhail had attended the medical centre on numerous occasions for similar issues.[120,121]

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[117] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), para 95.1
[118] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), para 95.2 and ts 06.12.24 (Gabbay), pp29-30
[119] Exhibit 1, Vol 2, Tab 22, Email - Dr C Gunson to Ms T Palmer (03.12.24), p1 and ts 06.12.24 (Gunson), pp65-66
[120] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records (06.02.23)
[121] Exhibit 1, Vol 2, Tab 22, Email - Dr C Gunson to Ms T Palmer (03.12.24), p1

70. Dr Gunson postulated that Mr Mikhail's "*multiple very similar presentations in the months prior to his hospital transfer (to SJOG) on 29 January 2023*", may have meant that "*an element of cognitive bias*" may have affected Mr Mikhail's assessment on 8 February 2023.[122,123] In any case, Dr Gunson considered that Mr Mikhail's chest CT scan "*could (or should)*" have been ordered earlier, and said:

> I agree that if the presentation (i.e.: on 8 February 2023) had been taken only in the context of the recent pneumonia diagnosis, then the (prison doctor) might well have transferred (Mr Mikhail) back to hospital for further assessment; but a sense of urgency may have been lost because based on the case notes (Mr Mikhail) had presented very similarly in comparison to previous reviews in late 2022.[124]

Mr Mikhail is found in his cell[125,126,127,128,129,130,131]

71. The Review notes that during the night of 22 February 2023, head counts and welfare checks were conducted in Mr Mikhail's unit (Mike Block) in accordance with Acacia's standing orders, and that:

> CCTV footage confirms that (custodial staff) checked Mr Mikhail's welfare at (11.47 pm). The Mike Block Log records that no welfare or security issues (were) identified. Prior to Mr Mikhail being found unresponsive on his bed, two previous welfare checks had been conducted by night shift without any concerns or issues identified.[132]

72. At 11.51 pm, a custodial officer in the "*master control room*" at Acacia (Officer Bejr) received a cell call from Mr Mikhail's cell. Officer Bejr was unable to understand Mr Mikhail because he was mumbling, and the TV in his cell was blaring, but Mr Mikhail did not sound distressed and Officer Bejr "*did not believe the call was urgent*".[133]

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[122] Exhibit 1, Vol 1, Tab 11, EcHO Medical Records (06.02.23)
[123] Exhibit 1, Vol 2, Tab 22, Email - Dr C Gunson to Ms T Palmer (03.12.24), pp1-2 and ts 06.12.24 (Gunson), p67
[124] Exhibit 1, Vol 2, Tab 22, Email - Dr C Gunson to Ms T Palmer (03.12.24), p2 and ts 06.12.24 (Gunson), p68
[125] Exhibit 1, Vol 1, Tab 10 and Exhibit 1, Vol 2, Tabs 18.23 & 18.25-18.27, Various Incident Description Reports (23.02.23)
[126] Exhibit 1, Vol 2, Tab 18.29, Incident Report Minutes (23.02.23)
[127] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), p10
[128] Exhibit 1, Vol 2, Tab 18, Review of Death in Custody (05.11.24) and ts 06.12.24 (Ziino), pp74-75
[129] Exhibit 1, Vol 1, Tab 2, Report - Coronial Investigator R Fyneman (14.06.23)
[130] Exhibit 1, Vol 1, Tab 3, Memo - Sen. Const. D Sheahan (23.02.23)
[131] Exhibit 1, Vol 1, Tabs 13.1 & 13.2, Police Incident Reports 13022023 0200 10429 (23.02.23)
[132] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), p10
[133] Exhibit 1, Vol 2, Tab 18, Review of Death in Custody (05.11.24), pp13-14

73. Shortly after 12.00 am, another custodial officer (Officer McNally) returned after conducting routine welfare checks, and Officer Bejr asked him to go to Mr Mikhail's cell to check on him as she had been unable to understand him during his recent cell call.

74. After completing some entries in the unit logbook, Officer McNally went to Mr Mikhail's cell at about 12.06 am and found him lying on his back in bed with a pool of blood around his head. Officer McNally initiated a Code Blue medical emergency and asked Officer Bejr to call emergency services and request an ambulance.

75. Acacia's standing orders provide that cell checks must be conducted by two officers, and the cell door was breached at about 12.14 am when other custodial officers and a prison nurse arrived. Large clots of blood were noted in Mr Mikhail's mouth and nose, and there was blood on his bed and in other parts of the cell, including the sink and toilet.[134]

76. Mr Mikhail was placed on the floor and CPR was commenced. A prison nurse (Nurse Jones) attached a defibrillator to Mr Mikhail's chest while custodial staff continued CPR.

77. Mr Mikhail was placed on Acacia's "*internal ambulance buggy*"[135] and taken to the medical centre with custodial officers and nurses continuing CPR on the way.

78. I note that the custodial staff involved in assisting Mr Mikhail all had current first aid and/or CPR certificates,[136] and that resuscitation efforts were continued until ambulance officers arrived at Acacia at about 12.50 am.[137]

79. Despite concerted efforts Mr Mikhail could not be revived. Following an assessment Mr Mikhail was declared deceased by an ambulance officer at 12.57 am on 23 February 2023.[138,139]

[134] Exhibit 1, Vol 2, Tab 18.24, Serco Post Incident Death in Custody Report (15.05.23), pp7-8
[135] Exhibit 1, Vol 2, Tab 18.28, Photographs of Acacia's Internal Ambulance Buggy
[136] Exhibit 1, Vol 2, Tab 18.32, First Aid certificates
[137] Exhibit 1, Vol 1, Tab 8.2, SJA Patient Care Record NOR21NC (23.02.23)
[138] Exhibit 1, Vol 1, Tab 8.2, SJA Patient Care Record NOR21NC (23.02.23)
[139] Exhibit 1, Vol 1, Tab 4, Life Extinct certificate (23.02.23)

CAUSE AND MANNER OF DEATH[140]

80. On 2 March 2023, a forensic pathologist Dr J Ong (Dr Ong) carried out a post mortem examination of Mr Mikhail's body at the State Mortuary. Dr Ong noted that both of Mr Mikhail's lungs were "*hyperinflated and congested*", which is a non-specific finding. Dr Ong also noted a haemorrhagic lesion in the upper lobe of Mr Mikhail's right lung, with "*some associated blood staining within the airways*".[141]

81. Microscopic examination of tissues showed acute infective changes within the lung (acute bronchopneumonia), and chronic structural changes were present, which were consistent with Mr Mikhail's history of COPD. A "*malignant tumour*" was identified in the right lung which Dr Ong described as "*possibly a squamous cell carcinoma*".[142]

82. Microbiological testing of Mr Mikhail's lungs did not isolate a specific bacterial organism and "*no acid-fast bacilli were detected*", and there was no significant viral infection in his heart or lungs.[143]

83. Toxicological analysis detected the prescription medications amitriptyline, celecoxib, duloxetine, tramadol, prednisolone, and olanzapine in Mr Mikhail's system, along with paracetamol. The analysis also found Mr Mikhail had a urine alcohol level of 0.015%, although alcohol was not found in his blood, and common drugs were not detected.[144]

84. In his post mortem report, Dr Ong expressed the following views:

> In the absence of further findings, it appears most likely that Mr Mikhail has died as a result of an acute infection of the lungs (bronchopneumonia), with a malignant tumour in the right lung, on a background of chronic lung disease (chronic obstructive pulmonary disease). **In my opinion, the death was due to natural causes.**[145] [Original emphasis]

[140] Exhibit 1, Vol 1, Tab 6.1, Post Mortem Report (02.03.23)
[141] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report (19.04.23)
[142] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report (19.04.23)
[143] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report (19.04.23)
[144] Exhibit 1, Vol 1, Tab 7, ChemCentre Report (17.03.23)
[145] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report (19.04.23)

85. At the conclusion of his post mortem examination, Dr Ong expressed the opinion that the cause of Mr Mikhail's death was bronchopneumonia in a man with carcinoma in the lung and chronic obstructive pulmonary disease.

86. I note that several of the experts who reviewed Mr Mikhail's care also expressed opinions about the cause of his death, including the possibility that he may have had tuberculosis. Some of these opinions contradicted each other, and several of the experts disagreed with the opinion expressed by Dr Ong.[146,147,148,149,150,151]

87. However, having carefully considered the available evidence, I have decided to accept and adopt Dr Ong's opinion as to the cause of Mr Mikhail's death. Dr Ong is a qualified forensic pathologist, and he had the benefit of conducting a post mortem examination of Mr Mikhail's body and reviewing the results of various post mortem assessments.

88. I therefore find that the cause of Mr Mikhail's death was bronchopneumonia in a man with carcinoma in the lung and chronic obstructive pulmonary disease.

89. Further, and in view of all of the circumstances and the available evidence (including the views expressed by Dr Ong to which I have referred above), I find that Mr Mikhail's death occurred by way of natural causes.

[146] Exhibit 1, Vol 1, Tab 16, Report - Dr Q Summers (16.09.24)
[147] Exhibit 1, Vol 1, Tab 16.6, Report - Dr Q Summers (29.11.24)
[148] Exhibit 1, Vol 2, Tab 18.31.1, Report - Dr P Myers (11.03.24)
[149] Exhibit 1, Vol 2, Tab 18.31.2, Report - Dr P Myers (05.12.24)
[150] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24)
[151] Exhibit 1, Vol 2, Tab 19.4, Report - Prof. E Gabbay (07.11.24)

QUALITY OF SUPERVISION, TREATMENT AND CARE

Overview

90. In assessing the quality of the supervision, treatment and care that Mr Mikhail received whilst he was incarcerated, I have had regard to the principle known as "the Briginshaw test" derived from a High Court judgment of the same name, in which Justice Dixon said:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal.
>
> In such matters "*reasonable satisfaction*" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[152]

91. Essentially, the Briginshaw test requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities. In other words, the more serious the allegation, the higher the degree of probability that is required before I can be satisfied as to the truth of that allegation.

92. I have also been mindful not to insert hindsight bias into my assessment of Mr Mikhail's supervision, treatment and care. Hindsight bias is the tendency, after an event, to assume the event is more predictable or foreseeable than it actually was at the time.[153]

Standard of supervision

93. After carefully considering the available evidence, I have concluded that during the time he was incarcerated, the standard of Mr Mikhail's supervision was appropriate. Mr Mikhail was regarded as a well-behaved and courteous prisoner who maintained adequate levels of hygiene, and he received regular visits from his family.[154]

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[152] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362
[153] Dillon H and Hadley M, *The Australasian Coroner's Manual (2015)*, p10
[154] Exhibit 1, Vol 2, Tab 18.34, Visit history (23.02.21 - 23.02.23)

Standard of care and treatment

94. At various times when there were concerns about his risk of self-harm and/or suicide, Mr Mikhail was appropriately managed on ARMS.[155] The evidence establishes that Mr Mikhail was a difficult person to manage. He was often demanding and unreasonable when he presented to the medical centre at Acacia. Despite this, it appears that clinical staff responded to his presentations sensitively and with compassion.

Missed opportunities

95. The evidence before me establishes that Mr Mikhail's medical care was generally commensurate with community standards. However, in my view, for the reasons I have explained between 29 January 2023 and his death, there were several missed opportunities where the mass in Mr Mikhail's right lung could have been identified and treated.

96. The evidence before me about the significance of haemoptysis in a patient like Mr Mikhail is varied. It seems to be common ground that some patients with pneumonia can cough up blood stained sputum, and in some cases frank blood. However, the question of how serious an episode (or episodes) of haemoptysis may be is the subject of debate.[156]

97. According to several articles provided by SJOG, the range for what constitutes "*massive haemoptysis*" appears to be 100 ml to 600 ml in a 24-hour period.[157] However, in one of the articles massive haemoptysis is defined as: "*>200 ml per 48 hours or >50 ml per episode in patients with chronic pulmonary disease*". Mr Mikhail appears to satisfy this definition given his diagnosis of COPD, and his self-reports of haemoptysis on 29 January 2023.[158,159]

98. As to the clinical significance of Mr Mikhail's haemoptysis, again perspectives differ. In her statement, Dr Ginimalage said it was not uncommon for a patient like Mr Mikhail with "*acute lower respiratory tract infection*" to have haemoptysis, which can vary from blood streaks in the sputum to "*frank blood emission when coughing*".

[155] ts 06.12.24 (McNally), pp56-57
[156] ts 06.12.24 (Gabbay), pp15-16 and ts 06.12.24 (Summers), pp79-80
[157] Exhibit 1, Vol 2, Tab 19.9, Ibrahim WH, Massive Haemoptysis: the definition should be revised, (2008)), European Respiratory Journal
[158] Exhibit 1, Vol 2, Tab 19.10, Earwood JC & Thompson TD, Hemoptysis: Evaluation & Management, (2015) 91(4), Am. Fam. Physician, Table 5
[159] Exhibit 1, Vol 1, Tab 9, SJOG Short Triage form (29.01.23) & SJOG Nursing & Progress notes (29.01.23)

99. In relation to Mr Mikhail's episode of haemoptysis at SJOG, Dr Ginimalage says:

> Noting that (Mr Mikhail) presented with haemoptysis, an episode of haemoptysis within the department would not alter the discharge plan, as this was one of his presenting symptoms. However, if it had been frank blood or high volume haemoptysis, this would be considered a respiratory emergency and I would have activated immediate escalation and a further work up.[160]

100. With respect, this observation is not particularly helpful. Although Mr Mikhail's further episode of haemoptysis was recorded in the SJOG progress notes by a nurse, it is unclear what medical assessment (if any) Mr Mikhail subsequently underwent before being returned to Acacia.[161] It is obvious that depending on the volume of blood and/or fluid Mr Mikhail had coughed up in this further episode of haemoptysis, his discharge plan may well have been altered.

101. On the basis of the available evidence, there is no way of determining whether this further episode of haemoptysis was properly assessed, and I repeat Professor Gabbay's observations about this issue.[162]

102. Whilst I accept that at the relevant time, the emergency department at SJOG was very busy,[163,164] having carefully considered the available evidence, it is my view that Mr Mikhail should have been admitted following his presentation to SJOG. This would have enabled investigation of the cause of his episodes of haemoptysis and would almost certainly have led to the identification and treatment of the "*haemorrhagic lesion*" found in the upper lobe of his right lung.

103. Ultimately, as I have noted, had the source of Mr Mikhail's bleeding been identified as the "*haemorrhagic lesion*" in the upper lobe of his right lung, it is likely that several treatment options may have been used to address the bleeding.[165]

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[160] Exhibit 1, Vol 2, Tab 20, Statement - Dr T Ginimalage (08.11.24), para 26
[161] See also: ts 06.12.24 (Henry), pp37-39
[162] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), para 85
[163] Exhibit 1, Vol 2, Tab 23.1, SJOG ED Patient Census (29.01.23) and ts 06.12.24 (Winton), pp101-102
[164] Exhibit 1, Vol 2, Tab 23.2, Prisoner presentations to SJOG ED (July 2022 - Oct 2024)
[165] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report (19.04.23)

104. As noted, the evidence before me suggests that had some or all of these treatment options been employed, it is possible that Mr Mikhail's lifespan (and the quality of his life) may have been improved.[166,167]

105. In the period after Mr Mikhail was returned to Acacia, it may be correct to say that he did not appear to experience any acute deterioration in his condition. However, it is also true that he did not appear to be getting much better either. Having carefully considered the available evidence I am satisfied that Professor Gabbay is correct when he says that "*standard care*" would have been to transfer Mr Mikhail back to SJOG for reassessment when the symptoms of his "*community acquired pneumonia*" did not resolve after treatment with oral antibiotics.

106. Whilst I accept that Mr Mikhail had severe COPD, his discoloured sputum and his ongoing haemoptysis were signs which called for further assessment and investigation. Therefore, with the benefit of hindsight, and for the reasons I have outlined, it is my view that the care and treatment Mr Mikhail received at Acacia after he was discharged from SJOG was below the standard he should have received.

107. It follows that with respect to the period 29 January - 23 February 2023, I respectfully disagree with the following statement in the Health Summary:

> Conclusion: From the review of the medical notes, I believe (Mr Mikhail's) medical care was delivered appropriately and in a timely manner.[168,169]

108. The missed opportunities I have identified are regrettable. However, given the clinical imponderables in Mr Mikhail's case (including his various co-morbidities), I have been unable to conclude, to the relevant standard, that Mr Mikhail would not have died if the lesion in his right lung had been identified and treated at an earlier stage.

[166] Exhibit 1, Vol 1, Tab 16.5, Email - Dr Q Summers to Ms S Markham (18.09.24) and ts 06.12.24 (Summers), pp82-87
[167] Exhibit 1, Vol 2, Tab 19.2, Report - Prof. E Gabbay (28.10.24), paras 96 & 96.1-96.4
[168] Exhibit 1, Vol 1, Tab 17, Health Services Summary (30.10.24), p40
[169] See also: ts 06.12.24 (McNally), pp59-61

CONCLUSION

109. At the time of his death, Mr Mikhail was serving a lengthy prison term imposed after he was convicted of two counts of murder. I have concluded that during his incarceration, Mr Mikhail was supervised appropriately. On several occasions (when there were concerns about his risk of self-harm or suicide) Mr Mikhail was managed on ARMS and seen by mental health staff.

110. Mr Mikhail was a difficult person to manage, and he frequently complained about the care he was receiving. Nevertheless, I accept that he was treated sensitively and compassionately by clinical staff at Acacia and SJOG.

111. However, after carefully considering the available evidence, I have concluded there were several missed opportunities to diagnose and treat the lesion in Mr Mikhail's right lung.

112. Although it is impossible to know whether Mr Mikhail could have been "cured" if the lesion in his right lung had been identified and treated at an earlier stage, the available evidence suggests that his lifespan may have been extended, and the quality of his life improved.

113. In conclusion, as I did at the end of the inquest, I wish to convey my sincere condolences to Mr Mikhail's family for their loss.

MAG Jenkin
Coroner
23 December 2024