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| **JURISDICTION** | : | CORONER'S COURT OF WESTERN AUSTRALIA |
| **ACT** | : | CORONERS ACT 1996 |
| **CORONER** | : | MICHAEL ANDREW GLIDDON JENKIN, CORONER |
| **HEARD** | : | 2 JULY 2024 |
| **DELIVERED** | : | 10 JULY 2024 |
| **FILE NO/S** | : | CORC 1189 of 2023 |
| **DECEASED** | : | THOMPSON, JASON ANTHONY |

*Catchwords:*

Nil

*Legislation:*

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

**Counsel Appearing:**

Senior Constable C Robertson assisted the coroner.

Ms T Wilker (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* ***Jason Anthony THOMPSON*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 2 July 2024, find that the identity of the deceased person was* ***Jason Anthony THOMPSON*** *and that death occurred on 5 May 2023 at Casuarina Prison, 288 Orton Road, Casuarina, from metastatic lung cancer with terminal palliative care in the following circumstances:*

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## INTRODUCTION

**1.** Jason Anthony Thompson (Mr Thompson) died on 5 May 2023 at Casuarina Prison (Casuarina) from metastatic lung cancer. He was 54 years of age.[1,2,3,4,5] At the time of his death, Mr Thompson was a sentenced prisoner at Casuarina and thereby in the custody of the Chief Executive Officer of the Department of Justice (the Department).[6]

**2.** Accordingly, immediately before his death, Mr Thompson 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.[7]

**3.** I held an inquest into Mr Thompson's death at Perth on 2 July 2024, which focused on the care, treatment and supervision provided to Mr Thompson 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 Thompson's management in custody, and reviews of the medical and mental health care he received while incarcerated.[8,9,10] The following witnesses from the Department gave evidence at the inquest:

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

b. Ms Toni Palmer (Senior Review Officer).[12]

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[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (05.05.23)
[2] Exhibit 1, Vol. 1, Tab 3, Notification of Death - Dr H Nazarian (05.05.23)
[3] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of Deceased Person (05.05.23)
[4] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (08.06.23)
[5] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (15.05.23)
[6] Section 16, *Prisons Act 1981* (WA)
[7] Sections 3, 22(1)(a) & 25(3), *Coroners Act 1996* (WA)
[8] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24)
[9] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24)
[10] Exhibit 1, Vol. 1, Tab 13, MHAOD Death in Custody report (12.06.24)
[11] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24) and ts 02.07.24 (Gunson), pp6-20
[12] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24) and ts 02.07.24 (Palmer), pp21-23

## MR THOMPSON

### *Background and medical history*[13,14,15,16]

**5.** Mr Thompson was born in Papua New Guinea, and when he was six years of age he was reportedly abducted by his father and brought to Australia. Mr Thompson's father subsequently abandoned him, and Mr Thompson was placed in Bridgewater Boy's Home, where he alleged he was sexually abused.

**6.** Mr Thompson had a history of polysubstance use including heroin, cannabis, methylamphetamine, and alcohol, and he had chronic hepatitis C which was successfully treated in 2019. It was initially thought that Mr Thompson was in the early stages of a psychotic illness (schizophreniform prodrome), but he was subsequently diagnosed with antisocial/paranoid personality disorder. He also experienced chronic back pain following a gunshot injury when he was about 13 years of age.

### *Offending history*[17,18,19,20]

**7.** Mr Thompson had an extensive criminal record, and on 20 March 1998 in the District Court of Western Australia, he was sentenced to a term of 10 years' imprisonment for burglary, with a concurrent 5-year term for "*attempted child stealing*". Mr Thompson was also the subject of a deportation order to Papua New Guinea, and he made unsuccessful appeals against his sentence in 1998 and 2002.

**8.** At the end of his sentence Mr Thompson was not released as he had not completed the rehabilitation programs required by his sentence. Whilst in custody Mr Thompson continued to commit offences, and he was made the subject of a high risk and serious offender interim detention order on 12 November 2021 in the Supreme Court of Western Australia (Supreme Court). This meant he could not be released without further order by the Supreme Court.

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[13] Exhibit 1, Vol. 1, Tab 2, Investigation report - Sen. Const. K Cooper (05.05.23), p3
[14] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), pp3-7 and ts 02.07.24 (Gunson), p7
[15] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24), pp4-5
[16] Exhibit 1, Vol. 2, Tab 1.1, Transcript of Proceedings: District Court of WA (20.03.98), p298 per Yeats DCJ
[17] Exhibit 1, Vol. 1, Tab 2, Investigation report - Sen. Const. K Cooper (05.05.23), p3
[18] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24), pp4 & 8
[19] Exhibit 1, Vol. 1, Tab 9, Transcript of Proceedings: District Court of WA (20.03.98)
[20] Exhibit 1, Vol. 1, Tab 10, Court Outcomes History - Traffic and Criminal

## MANAGEMENT IN PRISON[21,22,23]

**9.** Mr Thompson was incarcerated for just over 27½ years, during which time he was transferred between various metropolitan and country prisons on 35 occasions, although he spent the majority of his time at Casuarina.

**10.** During his incarceration, Mr Thompson's compliance with his medication and treatment regime was variable. At the inquest, Dr Gunson made the following observation about Mr Thompson's acceptance of recommended treatments:

> It was variable, or he would agree or want something, but then not engage subsequently. He would be reappointed many times and not attend, but then he would ask for that investigation or that…intervention again, and then they would do that again. So he was challenging, and a little unpredictable in that way.[24]

**11.** As early as 1997, Mr Thompson was reviewed by a psychiatrist, and it was initially thought he may be in the early stages of a psychotic illness (schizophreniform prodrome). However, he was subsequently diagnosed with antisocial/paranoid personality disorder, and he was also periodically treated for depression whilst he was in custody.

**12.** Mr Thompson also had a history of self-harm, although it was noted that he used "*self-harm and threats to manipulate placements and medications*".[25] Mr Thompson's manipulative and anti-social behaviour included going on a hunger strike, and setting fire to his cell.

**13.** Departmental records establish that Mr Thompson was a complex and difficult prisoner. In relation to his mental health, he had intermittent contact with the Mental Health, Alcohol and Other Drugs Team (MHAOD) during his incarceration at times when his "*dysregulated and antisocial personality disorder traits were at their peak*".[26]

[21] Exhibit 1, Vol. 1, Tab 2, Investigation report - Sen. Const. K Cooper (05.05.23), p3
[22] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24) and ts 02.07.24 (Gunson), pp7-21
[23] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24), pp4-5
[24] ts 02.07.24 (Gunson), p7
[25] Exhibit 1, Vol. 1, Tab 13, MHAOD Death in Custody report (12.06.24), p3
[26] Exhibit 1, Vol. 1, Tab 13, MHAOD Death in Custody report (12.06.24), p3

**14.** Mr Thompson was also managed under the Department's At Risk Management System (ARMS) at various times in relation to his self-harm risk, and antisocial behaviour.[27,28] ARMS is the Department's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide.[29]

**15.** On 17 February 2023, Mr Thompson was placed on "*high*" ARMS meaning he was observed hourly, after he refused his medication. Mr Thompson denied any thoughts of self-harm, and he was reduced to "*low*" ARMS, meaning four-hourly observations, on 9 March 2023. On 16 March 2023, Mr Thompson was removed from ARMS and transferred to the Support and Management System (SAMS) to provide support in relation to his chronic health issues.[30]

**16.** SAMS is the Department's secondary suicide prevention measure that targets prisoners deemed to be at a higher risk of suicide. This includes first-time and/or younger prisoners, socially isolated or vulnerable prisoners and prisoners who have been identified as being at chronic risk[31] of self-harm or suicide.[32]

**17.** At the time of his death, Mr Thompson was the subject of numerous alerts on TOMS[33] relating to his antisocial behaviour.[34] He received a number of official visits between May 2021 and April 2023, and sent and received various items of mail during that period.[35,36] Mr Thompson was the subject of various prison offences including insubordination, failing to supply a urine sample, and use of methylamphetamine.[37]

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[27] See for example: Exhibit 1, Vol. 2, Tabs 1.11 & 1.12, PRAG Minutes (03-04.11.22)
[28] Exhibit 1, Vol. 1, Tab 13, MHAOD Death in Custody report (12.06.24), pp4-8
[29] ARMS Manual (2019)
[30] Exhibit 1, Vol. 1, Tab 13, MHAOD Death in Custody report (12.06.24), pp7-8
[31] Chronic in this context means "*elevated lifetime risk*"
[32] SAMS Manual (June 2009), pp1-5
[33] Total Offender Management Solutions, the computer system the Department uses for prisoner management
[34] Exhibit 1, Vol. 2, Tab 1.54, Alert history - Offender
[35] Exhibit 1, Vol. 2, Tab 1.52, Visits history - Offender
[36] Exhibit 1, Vol. 2, Tab 1.53, Prisoner mail - Offender
[37] Exhibit 1, Vol. 2, Tab 1.51, Charge history - Offender

## EVENTS LEADING UP TO MR THOMPSON'S DEATH

### *Mr Thompson's collapse on 17 February 2023*[38,39]

**18.** Mr Thompson was found on the floor of his cell at about 7.05 am on 17 February 2023. He appeared drowsy and was unsteady on his feet, and was not engaging with custodial staff. Possible injection sites were observed on Mr Thompson's arms, and it was suspected that he was experiencing an opioid drug overdose.

**19.** Mr Thompson was given intranasal naloxone, a medication used to reverse or reduce the effects of opioids. This was followed up by four intravenous doses of naloxone, and although there was "*some mild improvement with intranasal naloxone*" it is unclear from subsequent entries in Mr Thompson's notes whether there was an improvement in his presentation.

**20.** Although Mr Thompson was monitored in the infirmary at Casuarina, he remained drowsy, and he nodded affirmatively when asked if he had injected a drug. Mr Thompson was eventually transferred to Fiona Stanley Hospital (FSH) at about 5.50 pm, about 10 hours after his original collapse had been discovered.

**21.** At the inquest, Dr Gunson noted that where an opioid overdose is suspected and repeated doses of naloxone are administered, best practice was to transfer the patient to an emergency department at a hospital for observation and further management. However, Dr Gunson also noted that it is not entirely clear that Mr Thompson was experiencing an opioid overdose.

**22.** The Health Review noted that the best predictor of opioid toxicity was a respiratory rate of less than 12 breaths per minute.[40] Mr Thompson's respiration rate does not appear to have done this, and as the Health Review noted:

[38] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24) and 02.07.24 (Gunson), pp9-20
[39] Exhibit 1, Vol. 1, Tab 13, MHAOD Death in Custody report (12.06.24)
[40] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), pp11-12

> Based on his serial observations and lack of any meaningful response to treatment, it was clear quite early on that this was either not an opioid overdose, or that this might be a polysubstance overdose. Additionally, the absence of any significant respiratory depression made an opioid overdose less likely. Therefore, **best practice** would have been to transfer (Mr Thompson) to a hospital Emergency Department as soon as this was apparent.[41] [Original emphasis]

**23.** Mr Thompson was medically cleared at FSH on the day of his presentation, and the Health Review noted that "*it was not obvious that his conscious state had returned completely to normal*". At the time of his discharge from FSH, Mr Thompson's observations were "*within normal limits*", and this was the case at the time he was transferred. On his return to Casuarina, Mr Thompson remained flat and confused and he was returned to FSH late on 19 February 2023.

**24.** During his subsequent admission to FSH, scans found that Mr Thompson had a brain lesion, and subsequently a lung lesion was also identified. At the inquest, Dr Gunson noted that it was possible that Mr Thompson's brain lesion may have been responsible for his original collapse and initial presentation.[42] Although nothing seems to turn on the fact that Mr Thompson was not immediately transferred to FSH after he was suspected to have had an opioid overdose, the fact remains that it would have been best practice for this to have occurred.

***Subsequent hospital admissions***[43,44]

**25.** As noted, Mr Thompson was returned to FSH on 19 February 2023, and following scans a brain lesion was identified, subsequently a lesion was found in Mr Thompson's lung, along with a "*possible new large lesion on the brain*". Mr Thompson was transferred to Sir Charles Gairdner Hospital (SCGH), and after receiving medication to reduce the size of the brain lesion, he underwent a surgical procedure (craniotomy) on 28 February 2023, during which the brain lesion was successfully removed.

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[41] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), p12
[42] ts 02.07.24 (Gunson), pp10-11
[43] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), pp51-72
[44] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24), pp19-28

**26.** Mr Thompson was returned to the Casuarina infirmary on 8 March 2023, where he was managed until his death. On 14 March 2023, Mr Thompson was reviewed by a prison medical officer and the implications of his lung cancer and likely poor prognosis were discussed. On 17 March 2023, Mr Thompson declined to attend a neurological review at SCGH and told prison staff he would remove the staples in his head (inserted after the craniotomy) himself. He also refused to sign a medical waiver, and declined a review by a prison medical officer.

**27.** On 28 March 2023, Mr Thompson was transferred to FSH following a review by a prison medical officer who noted an acute deterioration in Mr Thompson's mental and physical condition. Mr Thompson required four-point restraints as he was aggressive and threatening, and a spit hood was applied when he began spitting at staff, although it was subsequently removed when he ceased to do so.

**28.** On 31 March 2023, Mr Thompson was returned to the infirmary at Casuarina. Further scans had identified bleeding and recurrence at the site of his previous brain lesion and further brain metastases were identified. Mr Thompson was identified as requiring palliative care, and he continued to be managed in the infirmary. He was transferred to FSH again on 2 April 2023 when he was found to be confused and disorientated, but returned the following day.

**29.** It appears that during this admission, the risks and benefits of brain radiotherapy were discussed with Mr Thompson and that he indicated his willingness to undergo "*all available treatment if it was going to improve the quality of his life or increase his life duration*". As a result, Mr Thompson underwent a course of palliative radiotherapy at FSH, which was completed on 20 April 2023.[45]

**30.** On 21 April 2023, although Mr Thompson was advised that his prognosis was one to three weeks, he reportedly took this information "*well*". He subsequently became the first prisoner in Western Australia to be managed palliatively in the Casuarina infirmary.[46]

[45] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), p28
[46] ts 02.07.24 (Gunson), pp11-12

***Palliative care and death at Casuarina***[47,48,49]

**31.** Mr Thompson was monitored by nursing staff in the infirmary and regularly reviewed and given pain relief. On 4 May 2023, Mr Thompson's condition significantly deteriorated, and his next-of-kin was contacted and advised that death was imminent. At about 9.00 pm, Mr Thompson was found on the floor of his cell near his shower. No apparent injuries were noted, and Mr Thompson was returned to bed.[50]

**32.** At 11.15 am on 5 May 2023, secretions were suctioned from Mr Thompson's mouth, and he was responsive when his face was cleaned. Palliative care was continued, and at 1.23 pm, it was discovered Mr Thompson had stopped breathing. A prison medical officer attended and assessed Mr Thompson, before declaring him deceased at 1.30 pm on 5 May 2023.[51]

**33.** The Health Review notes that Mr Thompson was designated as "*not for resuscitation*", on the basis that any attempt to resuscitate him if he did "*decompensate*" would "*either be unsuccessful, or if successful would substantially worsen the quality of life he had remaining*". Despite this very sensible position, the Health Review also notes that custodial staff had expressed concerns that any failing to attempt to resuscitate Mr Thompson could lead to some form of negative consequence such as legal action, media attention, or disciplinary action.

**34.** Given these concerns, there was close liaison between the clinical and custodial staff "*to ensure that all staff involved in Mr Thompson's care were fully aware of the reasons for this designation, and to reassure them that this was the only compassionate approach possible in his situation*". In any event, as the Health Review notes, departmental policy now permits prisoners to engage in advance care planning and sets out the processes "*by which this planning can be respected by the health team*".[52]

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[47] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), pp15-17 & 60-74
[48] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24), pp28-30
[49] ts 02.07.24 (Gunson), pp10-11 & 15-18
[50] Exhibit 1, Vol. 2, Tab 1.49, Incident Description Report (04.05.23)
[51] Exhibit 1, Vol. 1, Tab 3, Notification of Death - Dr H Nazarian (05.05.23)
[52] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), pp15-17

***The terminally ill register***[53,54]

**35.** Prisoners with a terminal illness[55] 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 TOMS. Prisoners in the terminally ill module of TOMS are identified as either Stage 1, 2, 3 or 4 prisoners depending on their expected lifespan. Stage 3 prisoners are expected to die within three months, whereas at Stage 4, the prisoner's death is regarded as imminent.

**36.** On 20 February 2023, Mr Thompson was identified as a Stage 3 terminally ill prisoner, and he was escalated and deescalated between Stages 3 and 4 on several occasions before he was escalated to Stage 4 for the last time on 4 May 2023 after his condition deteriorated significantly and Mr Thompson: "*was assessed as entering the terminal phase*".[56,57,58,59,60,61]

**37.** From previous inquests I have conducted, I am aware that Stage 3 and 4 sentenced prisoners may be considered for early release pursuant to the Royal Prerogative of Mercy (RPOM). In Mr Thompson's case, although briefing notes were sent to the Minister for Corrective Services (the last on 31 March 2023), his early release was not recommended because of the serious nature of Mr Thompson's offences, his poor prison conduct, and his lack of community supports.[62]

**38.** In passing I note that on 3 March 2023, the Prisoners Review Board had also declined to recommend parole because of Mr Thompson's poor behaviour and his outstanding treatment in the areas of sexual offending and illicit drug use.[63]

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[53] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24), pp11-12
[54] COPP 6.2 - Prisoners with a Terminal Medical Condition, pp4-6
[55] One or more conditions that on their own or as a group, significantly increase the likelihood of a prisoner's death
[56] Exhibit 1, Vol. 2, Tab 1.30 TOMS Terminally Ill Module (20.02.23)
[57] Exhibit 1, Vol. 2, Tab 1.32, Terminally Ill Briefing (01.03.23)
[58] Exhibit 1, Vol. 2, Tab 1.37, Terminally Ill Health Advice (28.03.23)
[59] Exhibit 1, Vol. 2, Tab 1.41, Terminally Ill Action (31.03.23)
[60] Exhibit 1, Vol. 2, Tabs 1.43 - 1.47, Health Advice (07.04.23 - 29.04.23)
[61] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), pp8-9
[62] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24), p6
[63] Exhibit 1, Vol. 2, Tab 1, Death in Custody Review (07.06.24), p21

## CAUSE AND MANNER OF DEATH[64,65]

**39.** A forensic pathologist (Dr V Kueppers) conducted an external post mortem examination of Mr Thompson's body on 15 May 2023 and reviewed CT scans. Dr Kueppers' external examination was "*unremarkable*" and there were "*no suspicious findings*".

**40.** Post mortem CT scans showed "*extensive metastatic disease*" and the previous craniotomy Mr Thompson had undergone. Toxicological analysis found various medications in Mr Thompson's system that were consistent with his recent medical care. Alcohol and illicit drugs were not detected.[66]

**41.** At the conclusion of the external post mortem examination, Dr Kueppers expressed the opinion that the cause of Mr Thompson's death was "*metastatic lung cancer with terminal palliative care*".

**42.** I accept and adopt Dr Kueppers' conclusion as my finding in relation to the cause of Mr Thompson's death, and I find that Mr Thompson's death occurred by way of natural causes.

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[64] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (08.06.23)
[65] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (15.05.23)
[66] Exhibit 1, Vol. 1, Tab 6, Final Toxicology Report (06.06.23)

## QUALITY OF SUPERVISION, TREATMENT AND CARE

**43.** After Mr Thompson's death, Dr Gunson conducted a review of the health services he was provided whilst he was in custody (Health Review). The Health Review noted that since August 2009, Mr Thompson had been seen by health staff on 323 occasions. In relation to Mr Thompson's care and treatment (including his end-of-life care), the Health Review expressed the following conclusion:

> Health Services can confirm that during his time in custody (Mr Thompson) was provided with excellent health care that was patient-centred and holistic. Despite his at-times challenging behaviours, staff always ensured that he was reviewed regularly and in a timely manner for his various health issues. At times he declined appointments and refused to engage, but staff ensured he had opportunities to change his mind…The care afforded to (Mr Thompson) during his final illness was compassionate and cognisant of his needs.
>
> In conclusion, the health care provided to (Mr Thompson) was overall of an excellent standard, especially during his final illness. His management is highly likely to have been better than the standard of care he would have received in the community, due to the availability and accessibility of a highly experienced and compassionate team.
>
> (Mr Thompson's) care team also demonstrated it is possible to effectively provide expert and compassionate end-of-life care to even the most challenging patients, in the equally challenging custodial environment.[67]

**44.** The MHAOD team conducted a review of Mr Thompson's care and noted he had received "*ad hoc support*" from the Psychological Support Service, and Prisoner Support Services. The MHAOD review concluded that Mr Thompson had received an appropriate standard of mental health care that was "*possibly better than the standard he would have received in the community*".[68]

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[67] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24)
[68] Exhibit 1, Vol. 1, Tab 13, MHAOD Death in Custody report (12.06.24), p8

*Comment on standard of supervision, treatment and care*

**45.** Having carefully considered the available evidence, I am satisfied that the supervision, treatment and care that Mr Thompson received whilst he was incarcerated was of an acceptable standard. Mr Thompson was clearly a difficult prisoner to manage, and the evidence before me demonstrates that he was treated with compassion and respect.

**46.** I accept Dr Gunson's comments about the medical care Mr Thompson received while he was in custody. In particular, I acknowledge the efforts of clinical staff who provided palliative care to Mr Thompson in the infirmary at Casuarina. That environment, which I have visited on several occasions, is dilapidated and essentially not fit for purpose.

**47.** Nevertheless, in accordance with Mr Thompson's wishes, he received end-of-life care at Casuarina, and Dr Gunson's evidence makes it clear that those clinical staff involved in providing that care were able to make Mr Thompson's final weeks comfortable. They are to be congratulated on their efforts in doing so, in such a difficult and challenging environment.

**48.** In relation to the provision of palliative care services to prisoners in a custodial setting, the Health Review observed:

> It must be noted that the need for palliative care services in prisons is only likely to increase, due to a combination of: the ongoing increases in the overall prison population, and the high rates of multi-morbidity seen in the prison population.[69]

**49.** Whilst I accept that the prison population is ageing, I would be concerned if the care provided to Mr Thompson in the period leading up to his death became the norm, rather than the exception. The reason I say that is two-fold. First, the environment in the infirmary at Casuarina is unsatisfactory to say the least, and whilst it may be (and in Mr Thompson's case was) possible to provide palliative care at Casuarina, that in no way is an argument in favour of doing so.

[69] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), p16 and ts 02.07.24 (Gunson), pp10-11 & 15-18

**50.** In my view, the second (and most obvious reason) why routinely providing palliative care at the present infirmary at Casuarina would be unacceptable relates to the ability of the prisoner's family and friends to visit them in their final days. Whilst this was not an issue in Mr Thompson's case, for many prisoners who receive palliative care in external hospice facilities, family and friends are generally able to visit the prisoner freely. When a prisoner is being managed palliatively at the infirmary at Casuarina, this is not possible for security reasons.[70]

**51.** Further, as the Health Review relevantly points out:

> [P]alliative care is a person and family-centred approach to care. Palliative care services are provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die and for whom the primary treatment goal is to optimise quality of life.[71]

**52.** I accept (as the Health Review points out) that some prisoners (especially long-term prisoners) may have their own support network of fellow prisoners and "*despite less comfortable accommodations*" may prefer to remain in "*a familiar environment*". In Mr Thompson's case, the fact that he was managed at Casuarina meant that restraints (which were needed when he was transferred to hospital) were not required and he was "*able to move about freely, if he needed to do so*".[72]

**53.** Nevertheless, Mr Thompson was very much the exception to the rule. As the Health Review notes, he was "*a dangerous and violent offender*" who had a long history of non-compliance with medical care as well as "*aggressive and unpredictable behaviour*".[73] In that context, managing him palliatively at Casuarina made a great deal of sense.

**54.** However, for prisoners that do not present such management issues, and who have a support network of family and friends, receiving end-of-life care in an external care facility would seem to me to be a far more preferable alternative.

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[70] See also : ts 02.07.24 (Gunson), pp11-12
[71] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), p16
[72] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), p16
[73] Exhibit 1, Vol. 1, Tab 12, Health Services Review (01.07.24), p15

**55.** In relation to the evidence that Mr Thompson continued to use illicit substances during his incarceration, I accept that the Department wages ongoing effort to combat the scourge of illicit substances within the prison estate. In other inquests I have conducted, I have heard evidence about some of those efforts and for obvious reasons I made non-publication orders to protect the integrity of those methods.[74,75]

**56.** I therefore do not propose to canvas the Department's methods to detect and prevent the trafficking of illicit substances here, and I accept the point made by Ms Palmer that prisoners are "*very ingenious, and when we cut off a path, a new path is created. So it's…one of those ones where you try really hard to stay in front*".[76]

## CONCLUSION

**57.** Mr Thompson was 54-years of age when he died on 5 May 2023 at Casuarina from metastatic lung cancer. After carefully considering the available evidence, I concluded that Mr Thompson received appropriate supervision, treatment and care during his incarceration. In particular, I concluded that Mr Thompson's end-of-life care at Casuarina was equal to, and probably exceeded the standard of care he would have received in the community.

**58.** In concluding this finding, I wish to extend to Mr Thompson's family and loved ones, on behalf of the Court, my condolences for their loss.

MAG Jenkin
**Coroner**
10 July 2024

[74] ts 02.07.24 (Palmer), pp22-23
[75] See for example: [2021] WACOR 44 (15.12.21), which investigated the death of Mr O Sathipittayayudh
[76] ts 02.07.24 (Palmer), p22 and see also: ts 02.07.24 (Gunson), pp12-14