JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Michael Andrew Gliddon Jenkin, Coroner
HEARD	**:**	18 FEBRUARY 2025
DELIVERED	**:**	21 FEBRUARY 2025
FILE NO/S	**:**	CORC 359 of 2024
DECEASED	**:**	COFFIN, FABIAN ALEC

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Dangerous Sexual Offenders Act 2006 (WA)
High Risk Serious Offenders Act 2020 (WA)
Prisons Act 1981 (WA)

Counsel Appearing:

Sergeant C Martin assisted the coroner.

Ms T Richards (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 **Fabian Alec COFFIN** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 18 February 2025, find that the identity of the deceased person was* **Fabian Alec COFFIN** *and that death occurred on 5 February 2024 at Fiona Stanley Hospital, 102-118 Murdoch Drive, Murdoch, from complications of myocardial infarction, ischaemic heart disease in the following circumstances:*

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INTRODUCTION

1. Fabian Alec Coffin (Mr Coffin) died on 5 February 2024 at Fiona Stanley Hospital (FSH) from complications of myocardial infarction in association with ischaemic heart disease. He was 51 years of age.[1,2,3,4,5,6,7,8,9,10,11,12,13] At the time of his death, Mr Coffin was a sentenced prisoner at Hakea Prison (Hakea) and thereby in the custody of the Chief Executive Officer of the Department of Justice (the Department).[14]

2. Accordingly, immediately before his death, Mr Coffin was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[15]

3. 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.[16]

4. I held an inquest into Mr Coffin's death at Perth on 18 February 2025, which focused on the care, treatment and supervision Mr Coffin received while he was in custody, as well as the circumstances of his death. The documentary evidence adduced at the inquest comprised one volume, and the following departmental witnesses gave oral evidence:

a. Dr C Gunson (Deputy Director, Justice Health & Well-being Service),[17] and
b. Ms C Ziino (Review Officer)[18].

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[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (05.02.24)
[2] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator Ms E Trinder (07.06.24)
[3] Exhibit 1, Vol. 1, Tab 3, Report - Det. FC Const. B Baird (06.02.24)
[4] Exhibit 1, Vol. 1, Tab 4, Medical Certificate of Cause of Death (05.02.24)
[5] Exhibit 1, Vol. 1, Tab 14, FSH Death in Hospital Form (05.02.24)
[6] Exhibit 1, Vol. 1, Tab 5, P98 - Mortuary Admission Form (05.02.24)
[7] Exhibit 1, Vol. 1, Tab 6, P92 - Identification of Deceased Person - Other than by Visual Means (07.02.24)
[8] Exhibit 1, Vol. 1, Tab 6, Coronial Identification Report (07.02.24)
[9] Exhibit 1, Vol. 1, Tab 6, Affidavit - Sen. Const. R Simpson (07.02.24)
[10] Exhibit 1, Vol. 1, Tab 6, Affidavit - Sen. Const. W Chandler (07.02.24)
[11] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (02.04.24)
[12] Exhibit 1, Vol. 1, Tab 7.1, Post Mortem Report (08.02.24)
[13] Exhibit 1, Vol. 1, Tab 8, Toxicology Report (13.03.24)
[14] Section 16, *Prisons Act 1981* (WA)
[15] Sections 3, *Coroners Act 1996* (WA)
[16] Sections 22(1)(a) & 25(3), *Coroners Act 1996* (WA)
[17] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25) and ts 18.02.25 (Gunson), pp4-14
[18] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25) and ts 18.02.25 (Ziino), pp14-18

MR COFFIN

Background[19,20,21,22]

5. Mr Coffin was born on 13 January 1973,[23] and departmental records note that he left school part way through Year 11 due to a death in the family, and did not return. Mr Coffin reportedly completed a traineeship as a mechanical fitter in 1992, and had worked on various community development projects. It is also recorded that he had five children.

Medical history[24,25]

6. Mr Coffin's medical history included: type-2 diabetes, high blood pressure, high cholesterol, chronic kidney disease secondary to diabetic neuropathy, proteinuria renal disease, diabetic retinopathy, obesity, hypothyroidism, low back pain, and infective exacerbation of undiagnosed airways disease.

7. Mr Coffin was also noted to have a history of lactose intolerance, oesophagitis, gastritis, and a possible seizure disorder (with complex partial seizures). On his admission to prison, Mr Coffin advised that he was likely to experience withdrawal symptoms from alcohol and cannabis.

8. Following Mr Coffin's death, Dr Gunson conducted a review of the health services Mr Coffin was provided whilst he was incarcerated (Health Review). In relation to Mr Coffin's psychiatric history, the Health Review notes:

> Mr Coffin had a diagnosis of "probable schizophreniform disorder/probable schizophrenia." He had previously been admitted (as an involuntary patient) with psychosis to Graylands Psychiatric Hospital in August 2001, which was when this diagnosis was made.[26]

[19] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator Ms E Trinder (07.06.24), pp4-5
[20] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p5
[21] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25), p8
[22] Exhibit 1, Vol. 1, Tab 13.2, Education and Vocational Training Checklist (01.11.02)
[23] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (05.02.24)
[24] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), pp4-5 and ts 18.02.25 (Gunson), pp4-14
[25] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator Ms E Trinder (07.06.24), p5
[26] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p4

Circumstances of imprisonment[27,28,29,30,31,32]

9. On 21 July 2002, in the Court of Petty Sessions in Paraburdoo, Mr Coffin was sentenced to a total of two years' imprisonment in relation to two counts of assaulting a public officer, and one count each resisting arrest and disorderly conduct.[33]

10. On 15 October 2002, in the District Court of Western Australia at Port Hedland, Mr Coffin was sentenced to six years' imprisonment cumulative on the term he was serving) in relation to child sexual offences.[34]

11. On 9 June 2003, in the District Court of Western Australia at Karratha, Mr Coffin was sentenced to six years' imprisonment cumulative on the term he was serving) in relation to numerous sexual offences.[35]

12. On 18 August 2014, in the Supreme Court of Western Australia, Mr Coffin was made the subject of an order under the *Dangerous Sexual Offenders Act 2006* (WA), and later the *High Risk Serious Offenders Act 2020* (WA), (the Order) meaning he was detained for an indefinite term for "*control, care and treatment*". The Order was regularly reviewed, with the next review due on 16 April 2024.[36]

Prison history[37,38]

13. When Mr Coffin was remanded in custody at Roebourne Prison in 2002, he was identified as a returning prisoner, as his adult incarceration history dated back to 1993. Mr Coffin spent 21 years and 6 months in custody at various prisons. At the time of his death, Mr Coffin was at Hakea Prison, and his security rating was "*maximum*".[39,40,41,42]

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[27] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p3
[28] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25), pp4 & 8
[29] Exhibit 1, Vol. 1, Tab 13.1, Case Conference Report (30.12.02)
[30] Exhibit 1, Vol. 1, Tab 13.3, Court History WA - Criminal & Traffic
[31] Exhibit 1, Vol. 1, Tab 13.4, Sentence Summary Report (07.10.24)
[32] Exhibit 1, Vol. 1, Tab 13.3, Court History WA - Criminal & Traffic
[33] Exhibit 1, Vol. 1, Tab 11, Warrant of Commitment (21.07.02)
[34] Exhibit 1, Vol. 1, Tab 11, Warrant of Commitment (15.10.02)
[35] Exhibit 1, Vol. 1, Tab 11, Warrant of Commitment (09.06.03)
[36] Exhibit 1, Vol. 1, Tab 11, Warrant of Commitments (18.08.14, 16.11.15, 15.08.17 & 14.10.21)
[37] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p3
[38] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25), p4
[39] Exhibit 1, Vol. 1, Tab 13.6, Prison History - Security Rating (09.10.24)
[40] Exhibit 1, Vol. 1, Tab 13.7, Decision Slip (10.01.20)
[41] Exhibit 1, Vol. 1, Tab 13.8, Classification Review (19.10.22)
[42] Exhibit 1, Vol. 1, Tab 13.8, Individual Management Plan (15.05.23)

MANAGEMENT IN CUSTODY

General management issues[43]

14. In the two years prior to his death Mr Coffin was employed as a unit cleaner. During the same period he received 34 official visits from departmental staff, a psychologist, and a psychiatrist, and four social visits from family members. Mr Coffin also sent 13 items of mail.[44,45,46]

15. Mr Coffin was the subject of five targeted, and two random drug searches in the period 5 February 2022 to 5 February 2004, all of which returned negative results. Mr Coffin's cell was searched on 48 occasions during that same period, and apart from excess laundry on one occasion, nothing of concern was ever located.[47,48]

16. A the time of his death, Mr Coffin was the subject of various alerts on the computer system used by the Department for prisoner management, known as Total Offender Management Solutions (TOMS). The alerts related to the High Risk Sexual Offender Order he was subject to, and imposed restrictions on his visits and movements.[49]

Management of medical issues[50,51]

17. The Health Review establishes that between 2002 and 2024, Mr Coffin was regularly seen at prison medical for various minor ailments. Mr Coffin's diabetes was regularly monitored, and his cardiovascular risk factors were addressed on an ongoing basis. On three occasions between 2022 and 2024, Mr Coffin complained of chest pain, and appropriate assessments were carried out on each occasion.

18. Mr Coffin reportedly gave up smoking in 2008, and appears to have refrained from smoking for several years. However, in 2013 and 2014 Mr Coffin reported using tobacco mixed with cannabis, and subsequently gave conflicting answers about his smoking habits.

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[43] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25), pp13-14
[44] Exhibit 1, Vol. 1, Tab 13.21, TOMS Work History report
[45] Exhibit 1, Vol. 1, Tab 13.19, TOMS Visits History report
[46] Exhibit 1, Vol. 1, Tab 13.20, TOMS Prisoner Mail report
[47] Exhibit 1, Vol. 1, Tab 13.24, TOMS Substance Use Test Results report
[48] Exhibit 1, Vol. 1, Tab 13.25, TOMS Cell Search History
[49] Exhibit 1, Vol. 1, Tab 13.18, TOMS Alert History
[50] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), pp6-16 and ts 18.02.25 (Gunson), pp4-14
[51] Email - Dr C Gunson to Sgt. C martin (03.02.25)

19. As the Health Review noted on this issue:

> Subsequently, health staff provided extensive education and regularly discussed quitting with him, but (Mr Coffin) consistently stated that he did not want to stop smoking. It was noted in 2020 that he was smoking around 20 cigarettes per day.[52,53]

20. Mr Coffin was on maximal therapy for his high cholesterol levels (dyslipidaemia), and in addition to insulin for his diabetes (which he declined to take), he was also prescribed three medications for his high blood pressure, which was maintained within the normal range. Mr Coffin was also seen regularly by a nephrology clinic for his kidney disease (likely secondary to his diabetes), with his last review in November 2023.

21. Unfortunately, although Mr Coffin's blood pressure was normal, it appears that his diabetes control worsened from late-2020 onwards, and did not improve despite adjustments to his medication. Mr Coffin's elevated triglyceride level improved with the addition of a second medication, but his weight (which had been problematic since about 2014) remained high. Despite ongoing encouragement to lose weight, Mr Coffin's body mass index remained in the high 30s.

22. On 26 January 2024, Mr Coffin presented to the medical centre complaining of jaw pain extending to his chest, and chest tightness. He was reviewed by a nurse and reported experiencing similar symptoms "*a few years ago*". Although Mr Coffin said he assumed that his current issues were an adverse reaction to his medication, there had been no recent changes to his medication regime.

23. Mr Coffin was alert and speaking in full sentences, and he was not experiencing sweating or clamminess. Although an electrocardiogram (ECG) was conducted and the results were normal, with the benefit of hindsight, it may be that Mr Coffins' symptoms warranted an admission to hospital for further assessment.

[52] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), pp24-26
[53] See also: ts 18.02.25 (Gunson), p7

24. At the inquest, Dr Gunson made the following observations about Mr Coffin's presentation on 26 January 2024:

> [W]hen a person has diabetes, the way they might present with cardiac-related pain can be what they call atypical. With that said, jaw pain is often a feature of cardiovascular pain in almost any patient. I think it may be that because he described it as starting in the jaw and extending to the chest, rather than the other way around, that the flag…wasn't raised for the nurse, but, nonetheless, jaw pain and chest pain, together, would be, in hindsight, a redder flag than was noted at the time…
>
> [T]he only other thing was that, I suppose, because he didn't describe any other symptoms, they may have thought that it was as he said, and that he thought he was reacting to his medications. Although I don't believe any of them had been changed recently, so that didn't seem all that logical in hindsight.[54]

25. Dr Gunson agreed that it was impossible to know whether an admission to FSH on 26 January 2024 would have altered Mr Coffin's clinical journey, and she noted that: "*It might...have just brought all those events forward. We can't know*".[55]

26. In any case, Mr Coffin was booked to see Dr Gunson at the Hakea Prison medical centre on 30 January 2024, although he did not attend this appointment. At the inquest, Dr Gunson noted that Mr Coffin had a past history of gastritis and oesophagitis, and had been given antacid medication in 2023 for his symptoms. It was therefore possible that Mr Coffin may have attributed his chest pain to his gastritis and oesophagitis rather that to his heart.[56]

27. On 31 January 2024, Mr Coffin approached staff and requested a medical appointment, as he suspected he had a chest infection. Following this request, an appointment was booked for Mr Coffin to see a prison doctor on 1 February 2024.

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[54] ts 18.02.25 (Gunson), pp5-6
ts 18.02.25 (Gunson), p13
[56] ts 18.02.25 (Gunson), pp13-14

Admission to Fiona Stanley Hospital[57,58,59,60,61,62]

28. Mr Coffin saw a prison doctor on 1 February 2024, and complained of worsening intermittent chest pain for about three days. Although he denied experiencing any current chest pain and an ECG was normal, his oxygen saturation levels were low (89%), and the prison doctor decided to send Mr Coffin to FSH for further assessment.

29. At the inquest, Dr Gunson was asked about the prison doctor's decision to send Mr Coffin to hospital and stated that in her view this decision demonstrated "*appropriate caution*". Dr Gunson also said that:

> I think also a good clinician will pick up on a lot of cues that they may not be able to consciously describe afterwards, but add up to that they think that this person has a problem that needs to be assessed in hospital.[63]

30. In accordance with departmental policy, hand cuffs and a security link chain were applied, and Mr Coffin was placed in an ambulance. Mr Coffin arrived at FSH about 11.00 am, and was noted to be short of breath with a productive cough. Following various investigations, he was diagnosed with non-ST segment elevation myocardial infarction and was admitted to the cardiology ward.[64,65,66]

31. On 2 February 2024, Mr Coffin underwent cardiac catheterisation and angiography, and was found to have severe disease in the left circumflex artery, and the right coronary artery. A stent was successfully inserted into his left circumflex artery, and the plan was to insert a stent into his right coronary artery during a subsequent procedure.

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[57] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), pp24-25 and ts 18.02.25 (Gunson), p6
[58] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25), pp8-13
[59] Exhibit 1, Vol. 1, Tab 14, FSH Adult Triage Nursing Assessment (01.02.24)
[60] Exhibit 1, Vol. 1, Tab 14, FSH Transthoracic Echo Report (02.02.24)
[61] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator Ms E Trinder (07.06.24), pp1-3
[62] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (02.04.24)
[63] ts 18.02.25 (Gunson), p6
[64] Exhibit 1, Vol. 1, Tab 13.12, Incident Summary Report (01.02.24)
[65] Exhibit 1, Vol. 1, Tab 13.13, Hospital Admittance Advice - Prisoner (01.02.24)
[66] Exhibit 1, Vol. 1, Tab 9, SJA Patient Care Record RIV21D2 (01.02.24)

32. At about 1.20 am on 4 February 2024, Mr Coffin went into cardiac arrest. His restraints were removed and CPR (including use of a defibrillator) was commenced. A spontaneous return of circulation was achieved at about 2.15 am and Mr Coffin was taken to the catheterisation laboratory where a stent was inserted into his right coronary artery.[67][68]

33. After the procedure, Mr Coffin was sedated and taken to the intensive care unit. At about 4.45 am on 5 February 2024, Mr Coffin went into cardiac arrest, and CPR was commenced. Although Mr Coffin appeared to revive, he experienced a further cardiac arrest at about 5.18 am, and CPR was recommenced. Despite concerted resuscitation efforts, Mr Coffin could not be revived, and he was declared deceased at 5.28 am on 5 February 2024.[69,70,71]

The terminally ill register and supervision issues[72,73,74]

34. On his admission to FSH, Mr Coffin was initially supervised by custodial officers but on 3 February 2024, his care was assumed by staff from Ventia, the private company used by the Department to supervise prisoners during hospital inpatient stays.[75]

35. Prisoners with a terminal illness[76] are managed in accordance with a departmental policy known as *COPP 6.2 Prisoners with a Terminal Medical Condition* (COPP 6.2).[77] Once a prisoner is identified as having a terminal illness, a note is made in the terminally ill module of TOMS.

36. Prisoners in the terminally ill module of TOMS are identified as Stage 1, 2, 3 or 4 prisoners, depending on their expected lifespan. Following his cardiac arrest on 4 February 2024, Mr Coffin was identified as a Stage 4 terminally ill prisoner (meaning his death was expected imminently).[78,79]

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[67] Exhibit 1, Vol. 1, Tab 13.15, Incident Summary Report (04.02.24)
[68] Exhibit 1, Vol. 1, Tab 14, FSH Medical Emergency Record (04.02.24)
[69] Exhibit 1, Vol. 1, Tab 14, FSH Death in Hospital Form (05.02.24)
[70] Exhibit 1, Vol. 1, Tab 4, Medical Certificate of Cause of Death (05.02.24)
[71] Exhibit 1, Vol. 1, Tab 10, WAPOL Incident Report LWP24020500092992 (05.02.24)
[72] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), pp11 & 27-28 and ts 18.02.25 (Gunson), pp8-10
[73] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25), p6 and ts 18.02.25 (Ziino), pp16-18
[74] COPP 6.2 - Prisoners with a Terminal Medical Condition, pp4-6
[75] Exhibit 1, Vol. 1, Tab 13.14, Ventia Death in Custody documents
[76] One or more conditions that on their own or as a group, significantly increase the likelihood of a prisoner's death
[77] See extract at: Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), Appendix B, pp27-27
[78] Exhibit 1, Vol. 1, Tab 13.16, Terminally Ill Health Advice (04.02.24)
[79] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p11

37. From previous inquests I have conducted, I am aware that Stage 3 and 4 terminally ill prisoners may be considered for early release pursuant to the Royal Prerogative of Mercy (RPOM). However, given the nature of Mr Coffin's criminal history, I accept that it is highly unlikely he would have been recommended for early release. In any case, Mr Coffin died before his release under the RPOM could be considered.

38. I note that when Mr Coffin was made a Stage 4 Terminally Ill prisoner on 4 February 2024, his restraints were briefly removed in accordance with departmental policy.[80,81,82]

39. However, although Mr Coffin was in an induced coma, he was showing signs of brain activity. As a result, Mr Coffin's treating team expressed concerns for the safety of FSH staff if he were to be brought out of his induced coma whilst unrestrained. In light of these safety concerns, a further risk assessment was conducted and Mr Coffin's restraints were reapplied at about 8.05 pm on 4 February 2024.[83,84,85]

40. At the inquest, Dr Gunson noted that with the benefit of hindsight, it was perhaps unlikely that Mr Coffin would actually have posed a security risk if he had remained unrestrained.[86] Having given the matter careful consideration, I have concluded that the reapplication of Mr Coffin's restraints was not unreasonable. Although Mr Coffin had never previously demonstrated any inappropriate behaviour and was very unwell, the concerns for staff safety expressed by his treating team were not fanciful or far-fetched.

41. In any case, the evidence before me is that on the occasions when Mr Coffin required resuscitation, his restraints were removed immediately. I also note that on two occasions, after this had been done Mr Coffin was successfully revived.[87,88,89]

[80] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p25
[81] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25), p13
[82] See: ts 18.02.25 (Gunson), pp8-10 and ts 18.02.25 (Ziino), pp15-17
[83] Exhibit 1, Vol. 1, Tab 13.14, Ventia Death in Custody documents
[84] Exhibit 1, Vol. 1, Tab 13.17, External Movement Risk Assessment (7.49 pm, 04.02.24)
[85] See also: Exhibit 1, Vol. 1, Tab 13.14, Emails between Hakea Prison and Ventia (04.02.24)
[86] See: ts 18.02.25 (Gunson), pp8-10
[87] See for example: Exhibit 1, Vol. 1, Tab 14, FSH Medical Emergency Record (04.02.24)
[88] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p25
[89] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25), pp12-13

CAUSE AND MANNER OF DEATH[90,91]

42. A forensic pathologist (Dr Moss) conducted an external post mortem examination of Mr Coffin's body at the State Mortuary on 8 February 2024 and reviewed CT scans.

43. Dr Moss noted Mr Coffin had artery calcification and stents, his lungs were congested, and that Mr Coffin's heart appeared enlarged. After setting out Mr Coffin's recent clinical history, Dr Moss noted that:

> In view of the above findings, it was apparent that a reasonable cause of death could be given without the need for a full internal post mortem examination. Following discussion with the deceased's family, the Coroner's office agreed with this course of action.[92]

44. Toxicological analysis of post mortem samples found various medications in Mr Coffin's system that were consistent with his recent medical care. Alcohol and illicit drugs were not detected.[93]

45. At the conclusion of the external post mortem examination, Dr Moss expressed the opinion that the cause of Mr Coffin's death was: "*complications of myocardial infarction in association with ischaemic heart disease*". Dr Moss also expressed the opinion that Mr Coffin's death was consistent with natural causes.[94]

46. I accept and respectfully adopt Dr Moss' conclusion as my finding in relation to the cause of Mr Coffin's death.

47. Further, on the basis of the available evidence, I find that Mr Coffin's death occurred by way of natural causes.

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[90] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (02.04.24)
[91] Exhibit 1, Vol. 1, Tab 7.1, Post Mortem Report (08.02.24)
[92] Exhibit 1, Vol. 1, Tab 7.1, Post Mortem Report (08.02.24), p1
[93] Exhibit 1, Vol. 1, Tab 8, Toxicology Report (13.03.24)
[94] Exhibit 1, Vol. 1, Tab 7, Supplementary Post Mortem Report (02.04.24), pp1-2

QUALITY OF SUPERVISION, TREATMENT AND CARE

48. Following Mr Coffin's death, Ms Ziino conducted a "*death in custody review*" of the supervision and management Mr Coffin received whilst he was in prison (DIC Review). In the DIC Review, Ms Ziino concluded:

> This review found Mr Coffin's custodial management, supervision and care were in accordance with the Department's policy and procedures as listed in Appendix 1. Records indicate prompt and lifesaving measures were conducted as soon as possible. Relevant death in custody procedures, including notifications and handover to WA Police were followed.[95]

49. In the Health Review, Dr Gunson noted that Mr Coffin had numerous cardiovascular risk factors, and that:

> By the time of his final years in prison, (Mr Coffin) had been documented to have multiple serious health problems, including type 2 diabetes mellitus, hypertension, dyslipidaemia, diabetic nephropathy with macroalbuminuria, and gastro-oesophageal reflux disease with Barrett's oesophagitis.
>
> While he had not been diagnosed with ischaemic heart disease, he was recognised to be at a high risk due to the presence of these conditions, as well as being a smoker who was also obese. His past problematic alcohol and amphetamine use also increased his risk of cardiac disease. Non-modifiable risk factors were also present, in that he was of Aboriginal ethnicity.
>
> It is not clear if he had a family history of cardiovascular problems, but he had reported a strong family history of type 2 diabetes, which increases the likelihood that other family members would be vulnerable to cardiac disease.[96]

[95] Exhibit 1, Vol. 1, Tab 13, Death in Custody Review (07.02.25)
[96] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p12

50. Dr Gunson noted that in view of these risk factors, Mr Coffin "*was regularly and comprehensively monitored as part of his pro-active health management*". However, Mr Coffin's smoking, obesity and diabetes control remained problematic, and in the Health Review, Dr Gunson noted that:

> (Mr Coffin) was educated and counselled many times regarding smoking cessation and weight loss, both of which would have significantly improved his cardiovascular health. Additionally, (Mr Coffin's) obesity was noted as being a major reason that his diabetes management was considered sub-optimal to poor (other than between 2017 and 2019), throughout his time in custody. His refusal to consider insulin treatment was also a significant factor.[97]

51. At the inquest, Dr Gunson noted that like any other prisoner, Mr Coffin was at liberty to refuse medication, including daily insulin injections. Nevertheless, his decision had consequences, and as Dr Gunson observed:

> I think (insulin) would have definitely improved his blood sugar levels, his haemoglobin A1c, and then, by extension, his lipids profile. Although, I think that was actually quite reasonable throughout the time he was in custody, because he was on medications that did a good job, and also the diabetes had affected his renal function, and that was why he had the proteinuria, and the renal function was getting worse. So you improve the diabetes. It may not reverse that process, but it might halt it. So it would definitely have made a difference.[98]

52. In the Health Review and at the inquest, Dr Gunson noted that although Mr Coffin had received custodial health care for almost half of his adult life with "*regular reviews*" and "*a focus on preventative medicine, and with timely responses to issues as they arose*", *Mr Coffin's ischaemic heart disease progressed to a point where he was vulnerable to an acute event*".[99]

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[97] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p12
[98] ts 18.02.25 (Gunson), p7
[99] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p12

53. In the Health Review, Dr Gunson expressed the following conclusion about Mr Coffin's medical care and treatment:

> Health Services can confirm that during his time in custody, (Mr Coffin) received appropriate health care. Due to his long period of time in custody, his most important (only) health care and monitoring was achieved in the care of the Department of Justice. When (Mr Coffin) requested additional support, this was always provided in a timely manner, and follow-up reviews were always in place. Although some areas for improvement were identified, it is not likely that these affected the ultimate outcome for (Mr Coffin).
>
> (Mr Coffin) was also provided with compassionate support and care when needed, with input from the Prison Counselling Service when he experienced family losses…The Department also facilitated his attendance at his father's funeral, in 2010. He had also been approved to attend a funeral for another family member in 2024, but unfortunately he passed away before this took place. In conclusion, the health care provided to Mr Coffin was holistic and patient centred, and overall of a standard equivalent to or better than the standard of care he would have received in the community.[100]

Comment on standard of supervision, treatment and care

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

55. In the Health Review Dr Gunson referred to several areas for improvement in relation to Mr Coffin's care. Most relevantly is the fact that diabetic prisoners can now be offered "*glucagon-like peptide antagonists*" (e.g.: Ozempic) to help manage their diabetes. An additional benefit of this type of medication is that it can cause weight loss, and this may have reduce Mr Coffin's cardiovascular risk factors.[101]

[100] Exhibit 1, Vol. 1, Tab 12, Health Services Review (13.02.25), p16
[101] See also: ts 18.02.25 (Gunson), p11

56. However, at the inquest, Dr Gunson agreed that none of the minor issues she had identified in relation to Mr Coffin's care were likely to have impacted on his cause of death.[102]

57. I note that while he was in custody, Mr Coffin received regular health checks and follow-up care in relation to his various serious medical conditions.

58. Having carefully considered the available evidence, I have concluded that the standard of care Mr Coffin received in prison was commensurate with (and was likely better than) the care he would have received had he been in the community.

CONCLUSION

59. Mr Coffin was 51 years of age when he died from complications of myocardial infarction in association with ischaemic heart disease at FSH on 5 February 2025.

60. After carefully considering the available evidence, I concluded that Mr Coffin received an appropriate level of supervision during his incarceration, and that the standard of his treatment and care was commensurate with (and likely exceeded) that which he would have received in the general community.

61. I note that for logistical reasons, Mr Coffin's family were unable to attend the inquest in Perth. Nevertheless, as I did at the conclusion of the inquest, I wish to extend to Mr Coffin's family, on behalf of the Court, my sincere condolences for their loss.

MAG Jenkin
Coroner
21 February 2025

[102] See also: ts 18.02.25 (Gunson), p10