JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	5 - 6 MARCH 2025
DELIVERED	**:**	10 APRIL 2025
FILE NO/S	**:**	CORC 3633 of 2022
DECEASED	**:**	LOWE, DANNIELLE STACEY

Legislation:

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

Counsel Appearing:

Mr D. McDonald appeared to assist the coroner.

Ms K. Niclair (State Solicitors Office) appeared for the Department of Justice.

Mr C. Mofflin (instructed by the National Justice Project) appeared for Ms Lowe's family.

Ms J. Earl (Minter Ellison) appeared for Dr Kusumawardhani.

SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, there be no reporting or publication of the name of any prisoner (other than the deceased) housed at Wandoo Rehabilitation Prison in December 2022. Any such prisoner is to be referred to as "Prisoner [*Surname Initial*]".

Order made by: MAG Jenkin, Coroner (05.03.25)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Dannielle Stacey LOWE*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 5 - 6 March 2025, find that the identity of the deceased person was* ***Dannielle Stacey LOWE*** *and that death occurred on 24 December 2022 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch, from complications of intracerebral haemorrhage due to ruptured aneurysm in the following circumstances:*

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INTRODUCTION

1. Dannielle Stacey Lowe (Ms Lowe) was 41 years of age when she died at Fiona Stanley Hospital (FSH) on 24 December 2022 from complications of intracerebral haemorrhage due to ruptured aneurysm.[1,2,3,4,5,6]

2. At the time of her death, Ms Lowe was a sentenced prisoner at Wandoo Rehabilitation Prison (Wandoo) and thereby in the custody of the chief executive officer (Director General) of the Department of Justice (the Department). Accordingly, immediately before her death, Ms Lowe was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and her death was a "*reportable death*".[7]

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.[8,9]

4. I held an inquest into Ms Lowe's death at Perth on 5 - 6 March 2025 which was attended by members of her family. The following witnesses gave evidence at the inquest:

a. Ms Fiona Cobley, (Clinical nurse, Wandoo);
b. Dr Kurniawati Kusumawardhani, (Medical officer, Wandoo);
c. Dr Cherelle Fitzclarence (Independent medical expert);
d. Dr Catherine Gunson, (Dep. Director, Justice Health & Well-being Service); and
e. Ms Toni Palmer, (Senior Review Officer).

5. The documentary evidence adduced at the inquest comprised two volumes, and the inquest focused on the supervision, treatment and care Ms Lowe received in custody and the circumstances of her death.

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[1] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death (08.05.24)
[2] Exhibit 1, Vol 1, Tab 2, Report - Coronial Investigator Fyneman (02.05.24)
[3] Exhibit 1, Vol 1, Tab 2.1, Memorandum - Sen. Const. A Foster (16.02.23)
[4] Exhibit 1, Vol 1, Tab 3, P92 - Identification of deceased (28.12.22)
[5] Exhibit 1, Vol 1, Tab 4, Supplementary Post Mortem Report (23.02.24)
[6] Exhibit 1, Vol 1, Tab 9, Death in Hospital Form (24.12.22)
[7] Sections 3, *Coroners Act 1996* (WA)
[8] Section 16, *Prisons Act 1981* (WA)
[9] Sections 22(1)(a) & 25(3), *Coroners Act 1996* (WA)

MS LOWE

Background[10,11,12]

6. Ms Lowe was born on 2 April 1981, and at the start of the inquest I acknowledged her connection to the lands of the Martu people in central Western Australia. Ms Lowe left school after completing Year 9, and she was employed in various positions in the childcare, retail and cleaning sectors. Ms Lowe had eight children, and was reportedly the victim of serious family violence over an extended period.

7. At the conclusion of the evidence at the inquest, Ms Lowe's daughter, Ms Dakota Mongoo, read a moving statement which included the following tributes to her mother from herself, her brother (Mr Nicholas Mongoo), and her sister Ms Akaycia Mongoo:

> *Ms Mongoo*: Mum was my best friend and she deserved better. She did her life hard though day out and day in but she always kept a smile on her face through the toughest times. She chose some wrong paths but when she finally came around and wanted to change her life for the better and go to rehabilitation, her life came to an end.[13]
>
> *Mr Nicholas Mongoo*: I remember Mum for the kindness she had. She was always there for me. I miss her cooking, going home and seeing her there. I miss our phone calls when we used to call and we'd be on the phone all day just chatting. I miss when it was just me and her in the house and we'd sit out the front just yarning. When she died I felt hollow and didn't know what to do. It was really hard to believe I'd lost my favourite person. I love my Mum very much and miss her a lot.[14]
>
> *Ms Akaycia Mongoo*: Mum you were one of a kind. Strong and beautiful. The kind of person who put a smile on all of our faces, the one we can talk to for hours on end. Knowing I can't just ring you up or come to you when I need you the most makes me lose my mind. It hurts everyday Mum; my heart is broken and I'm lost.[15]

[10] Exhibit 1, Vol 1, Tab 2, Report - Coronial Investigator Fyneman (02.05.24), p4
[11] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), p9
[12] Exhibit 1, Vol 2, Tab 1.2, Level of Service Risk need Responsivity (14.03.22)
[13] Exhibit 1, Vol 2, Tab 3, Statement - Ms D Mongoo (undated), paras 12-13 and ts 06.03.25 (Mongoo), pp158-161
[14] Exhibit 1, Vol 2, Tab 3, Statement - Ms D Mongoo (undated), para15(a)
[15] Exhibit 1, Vol 2, Tab 3, Statement - Ms D Mongoo (undated), para 16(a)

Offending and prison history[16,17,18,19,20]

8. Ms Lowe had an extensive criminal history and as an adult, she accumulated 37 convictions for offences including burglary, stealing, possession of illicit drugs, and driving offences.

9. On 21 January 2022 in the Magistrates Court of Western Australia held at Geraldton, Ms Lowe was sentenced to two years' imprisonment in relation to one count of aggravated home burglary. Her earliest eligibility date for release on parole was calculated as 20 January 2023.

10. Ms Lowe was incarcerated at Greenough Regional Prison (Greenough) on 21 January 2022, and she spent 63 days there until, at her request, she was transferred to Wandoo on 25 March 2022.[21] Ms Lowe remained at Wandoo for 274 days until she was admitted to FSH following a medical emergency on 21 December 2022.[22]

Overview of medical conditions[23,24]

11. Ms Lowe's medical history included: depression, anxiety, and multiple traumatic injuries related to episodes of domestic and family violence (including fractures to her right leg, fingers and jaw, perforated ear drum, lacerations to the scalp, and closed head injuries). Ms Lowe also had a history of polysubstance use including cannabis, and methylamphetamine, as well as a history of self-harm, including a previous suicide attempt.

12. Ms Lowe told prison staff her family medical history included: ischaemic heart disease and type 2 diabetes (both parents), and leukaemia on her father's side of the family. Ms Lowe also said that her mother had died from "*an aneurysm*", although it is unclear whether this was a cerebral aneurysm and whether the cause of her mother's death was aneurysm or "*alcoholism*".[25,26,27]

[16] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), pp4 & 9-10
[17] Exhibit 1, Vol 2, Tab 1.1, Management and Placement - Sentenced (28.01.22)
[18] Exhibit 1, Vol 2, Tab 1.4, History for Court - Criminal and Traffic
[19] Exhibit 1, Vol 2, Tab 1.5, Sentence Summary - Offender
[20] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), p3
[21] Exhibit 1, Vol 2, Tab 1.22, Decision Slip - Management and Placement Checklist (28.03.22)
[22] Exhibit 1, Vol 1, Tab 15, FSH Medical records (21-24.12.22)
[23] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), p5
[24] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records
[25] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), p5

Initial assessment at Greenough[28,29]

13. When Ms Lowe was received at Greenough on 21 January 2022, she was identified as a returning prisoner and she underwent various assessments, including an interview with a reception officer, to evaluate her risk of self-harm and suicide.

14. Ms Lowe told the reception officer she had been cutting her arms and had previously attempted to take her life. She also said she had received treatment for depression, bi-polar disorder, and post-traumatic stress disorder, and disclosed smoking cigarettes, drinking alcohol, and daily use of cannabis. Ms Lowe also said she had injected herself with methylamphetamine that morning, and was feeling anxious and overwhelmed, and she asked for some medication to help her settle.

15. The reception officer concluded that Ms Lowe was at risk of suicide and/or self-harm, and recommended that she be placed on two hourly observations under the At Risk Management System (ARMS). The reception officer's summary in the ARMS Intake Reception Assessment form included the following comments:

> Prisoner has cut her arms in the last 48 hours to take away the pain, she is stating she has finished now and will have to work through the pain. Prisoner is stating she has no family. Surrendered her daughter to DCP yesterday before her court date. Has her head down for most of the interview but did engage with conversation and knows she needs help and wants that to happen. Prisoner was made aware of who was in the unit and said she should get support from them. Hasn't eaten Wednesday has lost her appetite, says she forgot.[30]

16. ARMS is the Department's primary suicide prevention strategy and aims to provide staff with guidelines to assist with the identification and Prisoners deemed to be at risk (as Ms Lowe was) are subjected to observations at high (one-hourly), moderate (two-hourly) or low (four-hourly) levels.[31]

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[26] Exhibit 1, Vol 1, Tab 14, Report - Dr C Fitzclarence (03.02.23)
[27] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records, p4
[28] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), p10
[29] Exhibit 1, Vol 2, Tab 1.6, ARMS Reception Intake Assessment (21.01.22)
[30] Exhibit 1, Vol 2, Tab 1.6, ARMS Reception Intake Assessment (21.01.22), pp5-6
[31] ARMS Manual (2019), pp2-13

17. As noted, Ms Lowe had disclosed she was withdrawing from methylamphetamine and cannabis, and was feeling "*anxious and overwhelmed*". Although the prison nurse reviewing Ms Lowe had quite reasonably requested some anti-anxiety/withdrawal medication from the on-call Prison Medical officer (PMO) using an electronic referral (e-consultation), the PMO's response was: "*Request denied*".[32]

18. Dr Cherelle Fitzclarence (an experienced general practitioner and former Deputy Director of Prison Health in Western Australia) reviewed Ms Lowe's medical care and prepared a report. Dr Fitzclarence made the following comments (with which I agree) about the on-call PMO's curt refusal to prescribe medication to assist Ms Lowe on her admission:

> The on-call doctor when Ms Lowe was admitted did not demonstrate holistic nor compassionate care when he declined to consider her situation on admission. There is little excuse for not supplying Ms Lowe with some medication to ease her withdrawal from substances and to prevent withdrawal from her usual antidepressant/anti-anxiety medications.[33]

19. In the review of Ms Lowe's health care completed after her death (the Health Review) Dr Catherine Gunson noted she had discussed the concerns raised by Dr Fitzclarence with the on-call PMO, and that:

> [T]he PMO…conceded that he could have given his reasoning, or requested more information. He stated that more information was not likely to have changed his position in this particular case, but that it would have been reasonable to obtain more history before responding.[34]

20. At the inquest Dr Gunson said: "*I have at times suggested that our role is not to prescribe punitively…as in we should not be withholding medications that we would think perfectly reasonable to prescribe in the community unless we're worried about those other issues like dependence or diversion or overdose*".[35]

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[32] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), pp13-14
[33] Exhibit 1, Vol 1, Tab 14, Report - Dr C Fitzclarence (03.02.23), p4 and see also: ts 05.03.25 (Fitzclarence), pp93-95
[34] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), p13
[35] ts 05.03.25 (Gunson), pp107-108 and see also: ts 05.03.25 (Gunson), pp106 & 113-114

General management issues[36,37,38,39,40]

21. During the period 21 January to 24 December 2022, Ms Lowe:

a. was variously employed as a kitchenhand, gardener, and cleaner;[41]

b. received 20 social visits and e-visits (Skype calls), 10 official visits, and three inter-facility visits, and she sent 182 items of mail;[42]

c. lost privileges for seven days for smoking in her cell, but was not the subject of any other disciplinary or prison offences;[43,44]

d. had no active alerts on TOMS;[45]

e. was regularly the subject of random drug and alcohol tests, the results of which were all negative;[46] and

f. was the subject of 25 cell searches, all bar one of which were unremarkable. The exception occurred on 29 January 2022, when: "*suspected alcohol brew was located in tub under the bed*".[47]

22. A parole review report dated 23 November 2022, noted Ms Lowe's positive prison behaviour, and that her voluntary participation in programs and education "*demonstrates a willingness to address offending behaviour*". However, the review recommended that consideration of Ms Lowe's parole be adjourned until at least 9 February 2022, to enable "*completion of the Wandoo Therapeutic Community Program*".[48]

23. Although Ms Lowe completed the Wandoo Therapeutic Community Program, she died before she could attend her graduation. At the graduation ceremony which was conducted, Ms Lowe was awarded her certificate posthumously, and a family member read the speech which Ms Lowe had prepared for the occasion.[49]

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[36] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), pp25-26 and ts 05.03.25 (Palmer), pp119-126
[37] Exhibit 1, Vol 2, Tab 1.8, Orientation Checklist (21.01.22)
[38] Exhibit 1, Vol 2, Tab 1.21, Treatment Assessment Report (14.03.22)
[39] Exhibit 1, Vol 2, Tabs 1.27 & 1.29, Individual Plans (26.04.22 and 17.11.22))
[40] Exhibit 1, Vol 2, Tabs 1.29, Classification Review (17.11.22))
[41] Exhibit 1, Vol 2, Tab 1.41, Work history (21.01.22 - 24.12.22)
[42] Exhibit 1, Vol 2, Tab 1.39, Visits history (21.01.22 - 24.12.22) and Tab 1.39 & 1.40, Prisoner Mail (21.01.22 - 24.12.22)
[43] Exhibit 1, Vol 2, Tab 1.42, Charge history (21.01.22 - 24.12.22)
[44] Exhibit 1, Vol 2, Tab 1.42, Loss of privileges history (21.01.22 - 24.12.22)
[45] Exhibit 1, Vol 2, Tab 1.38, Alerts history (21.01.22 - 24.12.22)
[46] Exhibit 1, Vol 2, Tab 1.44, Substance use test results (21.01.22 - 24.12.22)
[47] Exhibit 1, Vol 2, Tab 1.45, Cell searches (21.01.22 - 24.12.22)
[48] Exhibit 1, Vol 2, Tab 30, Parole Review Report (23.11.22)
[49] ts 05.03.25 (Palmer), p123

Management of medical issues[50,51,52]

24. The available evidence establishes that Ms Lowe was seen regularly at prison medical centres for a variety of minor ailments. She was variously assessed by a psychiatrist, PMOs, and prison nurses. Ms Lowe also saw an optometrist after complaining of blurred vision, and a dentist who extracted a number of her teeth.

25. On several occasions Ms Lowe was assessed as being at heightened risk of self-harm, and she was appropriately managed on either ARMS or the Support and Management System (SAMS). SAMS is the Department's secondary suicide prevention measure and 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[53] of self-harm or suicide.[54]

26. Ms Lowe's medical care in the period January to November 2022 may be summarised as follows:

a. *25 January 2022*: Ms Lowe was reviewed by a psychiatrist and after it was established she had not been taking medication in the community, she was prescribed mirtazapine to treat her depression;

b. *26 January 2022*: Ms Lowe was seen by a nurse and was prescribed Panadol Osteo for rheumatoid arthritis pain. At 5.20 pm, a Code Red Medical Emergency was called when Ms Lowe had an anaphylactic reaction after consuming pepper. An ambulance was called but Ms Lowe refused to go to hospital and was monitored in the medical centre. Her TOMS[55] profile was updated, and the prison kitchen was alerted;[56,57]

c. *31 January 2022*: following a review, Ms Lowe was removed from ARMS and placed on SAMS for ongoing support;[58,59]

[50] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), pp10-21
[51] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), pp6-12
[52] Exhibit 1, Vol 1, Tab 13, EcHO Medical records, pp1-110
[53] Chronic in this context means "elevated lifetime risk"
[54] SAMS Manual (June 2009), pp1-5
[55] TOMS stands for "*Total Offender Management Solutions*", the computer system the Department uses for prisoner management
[56] Exhibit 1, Vol 2, Tab 1.10, Incident Description Report - Nurse T Tierney (26.01.22)
[57] Exhibit 1, Vol 2, Tab 1.11, Confinement Regime Rules (26.01.22)
[58] Exhibit 1, Vol 2, Tab 1.13, PRAG Minutes (31.01.22)
[59] Exhibit 1, Vol 2, Tab 1.14, SAMS Module Case Conference screenshot (03.02.22)

d. *10 February 2022*: Ms Lowe had another anaphylactic reaction after accidentally eating pepper and received treatment in the medical centre;[60]

e. *20 February 2022*: Ms Lowe made superficial cuts to her arm using a pen, and was placed on ARMS and moved to an observation cell. She denied suicidal thoughts and said she was having issues with her cell mate and cut herself to see "*if she was still alive*" and "*still felt something*";[61,62,63]

f. *6 March 2022*: Ms Lowe was the subject of a Code Red Medical Emergency after she complained of abdominal pain. At the medical centre she disclosed feeling anxious and having had a "*panic attack*";[64]

g. *8 March 2022*: following a review, it was decided Ms Lowe did not require ongoing monitoring and she was removed from SAMS;[65]

h. *5 April 2022*: Ms Lowe was seen by a PMO and prescribed fluoxetine after she reported experiencing a "*panic attack*";

i. *8 April 2022*: Ms Lowe was placed on low ARMS after she was unable to guarantee her safety overnight, and she was later placed on SAMS;[66,67]

j. *10 May 2022*: following a review, Ms Lowe was removed from SAMS;[68]

k. *20 May 2022 - 16 November 2022*: Ms Lowe was seen on various occasions by a PMO and/or nurses after complaining of shortness of breath and a hoarse voice. Ms Lowe tested negative to COVID-19, and an electrocardiogram and chest x-ray were both normal. She was given education about vocal hygiene strategies including stopping smoking.

l. *14 - 22 June 2022*: during this period Wandoo received three complaints from two prisoners about the quality of Ms Lowe's treatment in relation to her breathing issues.[69] Ms Lowe's care was reviewed by an independent clinical nurse who said: *I am satisfied (Ms Lowe) has received excellent care from the medical staff and they will continue to do so as necessary*".[70]

[60] Exhibit 1, Vol 2, Tab 1.15, Incident Description Report - Nurse B Ellis (10.02.22)
[61] Exhibit 1, Vol 2, Tab 1.18, Incident Description Reports & Minutes (20.02.22)
[62] Exhibit 1, Vol 2, Tab 1.16, ARMS Offender Referral (20.02.22)
[63] Exhibit 1, Vol 2, Tab 1.17, PRAG Minutes (21.02.22)
[64] Exhibit 1, Vol 2, Tab 1.19, Incident Description Reports & Summaries (06.03.22)
[65] Exhibit 1, Vol 2, Tab 1.20, SAMS Case Conference Minutes (08.03.22)
[66] Exhibit 1, Vol 2, Tab 1.24, PRAG Minutes (08.04.22)
[67] Exhibit 1, Vol 2, Tabs 1.25 & 1.26, SAMS Case Conference Minutes (08.04.22)
[68] Exhibit 1, Vol 2, Tabs 1.28, SAMS Case Conference Minutes (10.05.22)
[69] Exhibit 1, Vol 2, Tabs 1.46.1-1.46.3, Complaints by Prisoner L (14.06.22), Prisoner M & Prisoner L (21.06.22)
[70] Exhibit 1, Vol 2, Tab 1.46.4, Email - Ms I Richardson to Complaints Access (17.06.22)

m. *24 August 2022*: Ms Lowe had dental surgery, and five of her teeth were extracted. Following the surgery, she was prescribed pain relief medication.

n. *23 September 2022* and *8 October 2022*: on both occasions, Ms Lowe used her cell call button "after hours" to request pain medication, and she was given Panadol by a prison officer. On 8 October 2022, she was seen twice by clinical staff and given extra Panadol and ibuprofen for dental pain.[71]

o. *11 October 2022*: Ms Lowe was seen by a PMO who removed her contraceptive implant, and gave her Panadol. Ms Lowe told the PMO that since her dental surgery she had regained her voice, and no longer had a hoarse throat.

p. *10 - 22 October 2022*: during this period, Ms Lowe used her cell call button "after-hours" on six occasions to request Panadol, which she was given by prison officers. With the exception of two occasions, these episodes were recorded in her EcHO medical notes (EcHO notes).[72]

q. *23 October 2022*: Ms Lowe went to the medical centre and complained of abdominal pain. She was given pain relief and her prescription medication, and returned to her cell.

q. *27 October 2022 - 15 November 2022*: during this period, Ms Lowe used her cell call button "after-hours" on three occasions to request Panadol, which she was given by prison officers. Departmental records show that only the Panadol Ms Lowe was given on 11 November 2022 was recorded in her EcHO notes.[73]

27. At the inquest, Ms Toni Palmer confirmed that for unknown reasons (and contrary to departmental policy) between about November 2022 and March 2023 at Wandoo, the after-hours dispensing of medication by prison officers was not recorded in a medication log.[74]

28. I will explain the significance of this reckless (and in my view appalling) decision later in this finding.

[71] Exhibit 1, Vol 1, Tab 12, Cell Call Forms (23.09.22 & 08.10.22)
[72] Exhibit 1, Vol 1, Tab 12, Cell Call Forms (10, 11, 16, 17, 19, & 21.10.22)
[73] Exhibit 1, Vol 1, Tab 12, Cell Call Forms (27.10.22 & 11 & 15.11.22)
[74] ts 05.03.25 (Palmer), pp119-120 and see also: ts 05.03.25 (Cobley), pp23-26 & 50

MISSED OPPORTUNITIES IN MS LOWE'S CARE

Overview

29. Having reviewed the available evidence, it is my view that there were four missed opportunities where the treatment and care provided to Ms Lowe in relation to her complaints of severe headache and episodes of nausea and vomiting should have been better.

30. Further, as I will explain, the evidence before me also establishes that had Ms Lowe's cerebral aneurysm been identified earlier, it would have been possible to provide her with treatment, and there is at least a possibility that Ms Lowe may not have died when she did.

Consultation - 6 December 2022[75,76,77]

31. The first missed opportunity in relation to Ms Lowe's care and treatment occurred on 6 December 2022, when at about 1.10 pm Ms Lowe went to the medical centre complaining of the sudden onset of severe headache. Ms Lowe was seen by a nurse (Ms Fiona Wang), and she reported "*high pressure*" behind her eyes, and said that she had been vomiting constantly "*for three hours*".[78]

32. After Ms Wang had recorded Ms Lowe's vital signs, she spoke briefly with a PMO (i.e.: Dr Kurniawati Kusumawardhani) who was then at Wandoo, and was in the process of working through the prisoners on her appointment list.

33. In a statement she provided to the Court, Dr Kusumawardhani said she recalled that Ms Wang had asked her to prescribe some medication for Ms Lowe, who Ms Wang said: "*had a headache since that morning and had vomited the analgesia she had previously taken*". Dr Kusumawardhani says she recalled asking to see Ms Lowe "*to see if I should prescribe oral medication or if I should prescribe intramuscular medication in case she was still vomiting*.[79]

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[75] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), p20
[76] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), p7
[77] ts 05.03.25 (Kusumawardhani), pp56-92
[78] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records (06.12.22), p11
[79] Exhibit 1, Vol 1, Tab 24, Statement - Dr K Kusumawardhani (28.02.25), paras 65-69

34. Dr Kusumawardhani says she briefly assessed Ms Lowe, who was lying on a bed in the examination room holding her head, and that to the best of her recollection Ms Lowe was not vomiting at that time. When asked, Ms Lowe said her headache was on "*both sides of her head*", and Dr Kusumawardhani says Ms Lowe was "*very apologetic for having vomited the medication*". Dr Kusumawardhani says she reassured Ms Lowe and told her she would prescribe "*more medication so she was able to rest*".[80]

35. Dr Kusumawardhani prescribed two Panadeine Forte tablets for pain relief, and an intramuscular injection of Maxolon (metoclopramide), which is an anti-emetic medication used to treat nausea and vomiting.[81,82]

36. Ms Lowe was given the prescribed medication at 1.25 pm, and her condition appears to have improved quickly. An EcHO notes entry at 1.55 pm states: "*nausea subsides, no more vomiting, stat dose of panadeine forte x2 tablets given to (patient) as per MO request*". An EcHO notes entry at 2.35 pm states: "*pt (patient) states feeling much improved, headache alleviated, pt (patient) went back to her unit without assistance*".[83]

37. At the inquest, Dr Kusumawardhani said she did not review Ms Lowe's EcHO notes before briefly reviewing her in the examination room. Further, Dr Kusumawardhani said that before seeing Ms Lowe, she was unaware that Ms Lowe's headache "*had come on quite suddenly*" or that Mr Lowe had complained of vomiting for three hours.[84]

38. At 3.32 pm, Dr Kusumawardhani made an entry in Ms Lowe's EcHO notes and under the heading "*Subjective*", she recorded the following information she had obtained from Ms Wang and Ms Lowe: "*Referred by CN (clinical nurse) c/o (complaining of) severe headache, pain in both temple sides, throbbing pain behind her eyes, started this morning*".[85]

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[80] Exhibit 1, Vol 1, Tab 24, Statement - Dr K Kusumawardhani (28.02.25), paras 70-73
[81] Exhibit 1, Vol 1, Tab 24, Statement - Dr K Kusumawardhani (28.02.25), paras 74-75
[82] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records (06.12.22), p11
[83] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records (06.12.22), p11
[84] ts 05.03.25 (Kusumawardhani), pp58-59
[85] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records (06.12.22), p11

39. Under the heading "*Objective*" Dr Kusumawardhani made the following entry in Ms Lowe's EcHO notes: "*laying on the exam bed - holding her head, vomit++*". However, at the inquest Dr Kusumawardhani said this entry was a mistake and that: "*I should put the vomit in the Subjective because Ms Lowe didn't vomit in the nurses' room when I was there*".[86]

40. At the inquest, Dr Kusumawardhani said that if she had had more time, she would have assessed Ms Lowe "*a bit more extensively*". When asked if she would have done anything differently if she had known Ms Lowe had reported vomiting for "*three hours*", Dr Kusumawardhani said: "*If I had…known that she has been vomiting for three hours…I will probably…ask to book another appointment later on the day*".[87]

41. Dr Fitzclarence said that sudden onset headache associated with vomiting "*should be considered as an emergency and would require transfer to hospital to exclude a life threatening cause of the symptoms*." Dr Fitzclarence also queried whether Ms Lowe's presentation represented a "*herald bleed*" in relation to a cerebral aneurysm, noting:

> Ms Lowe had given a history of her mother passing from an aneurysm. While it is not clear what sort of aneurysm, this was significant additional information that should have further raised suspicion in this presentation. Ms Lowe should have been sent to the Emergency Department at this presentation.[88,89]

42. A consultant neurosurgeon (Dr Stephen Honeybul) was engaged by the Court to review Ms Lowe's medical care and he provided a report. Dr Honeybul said he agreed with the majority of Dr Fitzclarence's comments, and said:

> Specifically, I agree that sudden onset of severe headache is a red flag for possible underlying aneurysm; however, aneurysmal subarachnoid haemorrhage normally leads to prolonged headaches and these do not settle within the relatively short time period with relatively simple antiemetic and analgesic therapy…

[86] ts 05.03.25 (Kusumawardhani), pp59 & 79-83
[87] ts 05.03.25 (Kusumawardhani), pp60 & 62-63
[88] Exhibit 1, Vol 1, Tab 14, Report - Dr C Fitzclarence (03.02.23), p4
[89] See also: ts 05.03.25 (Fitzclarence), pp99-100 & 103

> I agree, in hindsight, that the sudden onset of severe headache should probably have precipitated transfer to a hospital Emergency Department for further assessment **but again, given that her symptoms settled relatively quickly with simple analgesia, I can understand the reason for ongoing conservative treatment**.[90,91]
> [Emphasis added]

43. I also note that Dr Honeybul expressed the following opinion about the significance of Ms Lowe's presentation on 6 December 2022:

> However, there is no doubt in hindsight that there is a strong possibility that her (Ms Lowe's) headache on 6 December 2022 relates to a possible subarachnoid haemorrhage. This is thought to be an episode where an aneurysm leaks a small amount of blood, which is not usually visible on a CT scan or alternatively it may represent a small expansion of the aneurysm, such as it is enlarging and is likely to rupture in the near future.[92]

44. In his report Dr Honeybul also expressed the following opinion as to what treatment could have been provided to Ms Lowe if her cerebral aneurysm had been identified earlier:

> Whilst this is an easy assessment to make in hindsight, there is no doubt that if the aneurysm had been detected on 6 December 2022, it could have been treated either surgically or endovascularly. If it had been a strong suspicion that she had had a small haemorrhage, she should have been referred to the Emergency Department for a CT scan. If this was negative, she would require a lumbar puncture to look for xanthochromia.[93] She would then have required an angiogram and either endovascular treatment (which is more common these days) or surgical clipping of the aneurysm.[94]

45. At the inquest, Dr Kusumawardhani said that with the benefit of hindsight, she agreed with Dr Honeybul's views about transferring Ms Lowe to hospital on 6 December 2022.[95]

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[90] Exhibit 1, Vol 1, Tab 22.1, Report - Dr S Honeybul (20.12.24), p4
[91] See also: ts 05.03.25 (Gunson), pp114-115
[92] Exhibit 1, Vol 1, Tab 22.1, Report - Dr S Honeybul (20.12.24), p4
[93] Yellowish discoloration of cerebrospinal fluid often indicating a subarachnoid haemorrhage
[94] Exhibit 1, Vol 1, Tab 22.1, Report - Dr S Honeybul (20.12.24), p4
[95] ts 05.03.25 (Kusumawardhani), pp64-65 and see also: ts 05.03.25 (Gunson), pp108-109

Ms Lowe's requests for overnight analgesia[96]

46. The second missed opportunity in Ms Lowe's care and treatment relates to the failure to appreciate the significance of her regular and ongoing requests for Panadol in the period October to December 2022. It appears that Ms Lowe's presentations to the medical centre on 6, 11,[97] and 21 December 2022 in relation to headaches were regarded as episodic, rather than being part of an ongoing issue.[98,99]

47. In addition to her 10 requests for overnight Panadol in the period October to November 2022, Ms Lowe also used her cell call button after-hours to request Panadol on 7, 9, 17 and 18 December 2022. Some of these call calls specifically referred to headaches, but none of these instances were recorded in Ms Lowe's EcHO notes.[100]

48. It appears that the significance of Ms Lowe's ongoing overnight requests for Panadol was not appreciated because between about November 2022 and March 2023 prison officers at Wandoo were not required to record overnight medications issued to prisoners in a medication log, as they had previously. Under the previous regime, the medication log would be examined by the clinical nurse manager each morning, and any issues regarding ongoing requests for medication could then be addressed.[101]

49. As a direct result of this decision, the Panadol issued to Ms Lowe by prison officers on several occasions in December 2022 was not recorded, meaning that the reason(s) why Ms Lowe was requiring ongoing analgesia were not explored.

50. At the inquest, Ms Palmer said that she had made enquiries about the recording of out of hours dispensing of medication at Wandoo, and that: "*Apparently an email was sent to the staff saying that boxes of Panadol were now going to be provided to the units and that they were there for the officers to administer overnight, and that they didn't need to be recorded*".[102]

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[96] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records
[97] The day before Ms Lowe had asked to be seen about "*headache and back pain*" but only mentioned back pain when reviewed
[98] See for example: ts 05.03.25 (Cobley), pp23-24, ts 05.03.25 (Kusumawardhani), pp68 & 86-87
[99] See also: ts 05.03.25 (Fitzclarence), p104-105 and ts 05.03.25 (Gunson), pp111-112
[100] Exhibit 1, Vol 1, Tab 12, Cell Call Forms (17 & 18.12.22)
[101] ts 05.03.25 (Palmer), pp119-120
[102] ts 05.03.25 (Palmer), pp119-120

51. At the inquest, Ms Cobley said that by March or April 2023, the practice of recording after-hours medication issued to prisoners by prison officers in the medication log had been reinstated.[103,104] Further, by way of an email dated 13 March 2025, Ms Kelly Niclair (counsel for the Department) advised that:

> In relation to the medication log, the Clinical Nurse Manager of the Wandoo Rehabilitation Prison has confirmed that the logbook for paracetamol is in use by custodial officers and is checked by nurses daily. This practice is consistent with (COPP 6.4).[105,106]

Consultation – 11 December 2022 [107,108]

52. The third missed opportunity in Ms Lowe's care and treatment occurred on 11 December 2022. On 10 December 2022, in accordance with procedures at Wandoo, Ms Lowe submitted a written request to see a prison nurse listing her medical issues as "*back pain and headaches*".

53. An appointment was booked and on 11 December 2022, Ms Lowe was brought to the medical centre by a member of the administrative team at about 9.10 am. Ms Lowe was assessed by clinical nurse, Ms Fiona Cobley, who made the following entry in Ms Lowe's EcHO notes:

> *Assessment*: complaining of paravertebral muscular discomfort thoracic region past 3 days. Noticed this after coughing spell, worse on deep inspiration, movement and cough/sneezing. Patient already scripted for prn (i.e.: as required) panadol and ibuprofen and has been taking this twice daily for past 2 days.
>
> *On examination*: no bruising, deformity or step offs (i.e.: deformity of lower spine), slight discomfort on palpation of paravertebral muscles thoracic region and upper lumbar region.
>
> *Plan*: continue with bd analgesia for next few days, heat pack issued and advised on use. Voltaren gel issued and advised on use. Patient to monitor and advise if not resolving.[109]

[103] ts 05.03.25 (Cobley), p26
[104] See also: ts 05.03.25 (Palmer), p120
[105] COPP 6.4 - Officers issuing Medication, para 3.1.4
[106] Email - Ms N Niclair to Mr D McDonald (13.03.25)
[107] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records, pp9-10 and ts 05.03.25 (Cobley), pp10-53
[108] ts 05.03.25 (Cobley), pp16-21

54. As can be seen, there is no mention of "*headaches*" in Ms Cobley's EcHO notes entry, and at the inquest Ms Cobley conceded that she had not asked Ms Lowe about her "*headaches*" notwithstanding the fact that she (Ms Lowe) had written this issue on her appointment request form.[110] Ms Cobley also said Ms Lowe had "*only discussed her back pain*" during the consultation, and Ms Cobley offered the following explanation for her failure to ask Ms Lowe about "*headaches*":

> (Ms Lowe) did not discuss her headaches with me. Now, as part of the therapeutic community at Wandoo, we are encouraged to allow the resident to find their voice and to speak on their behalf, and we're mindful not to lead the patient or lead them into with questioning, so - and that's part of the program, so we follow that as much as possible…she didn't mention she got headaches so I didn't document anything about the headaches.[111]

55. In my view Ms Cobley's explanation is extraordinary, especially considering the fact that at the inquest, she agreed that she was aware of Ms Lowe's presentation to the medical centre of 6 December 2022, when Ms Lowe had complained of the sudden onset of a severe headache and vomiting for three hours.[112]

56. When I pressed Ms Cobley on her understanding of the "*therapeutic program*" at Wandoo and whether it struck her as odd that she was apparently not required to raise with a prisoner an issue that was stated on the appointment request form, but which the prisoner didn't raise at the consultation, she replied: "*I have no opinion on - like, I really can't answer that. I follow the program*".[113]

57. In her evidence, Dr Gunson said she was unaware of any policy or procedure mandating that a clinician at Wandoo should not deal with an issue which was listed on an appointment request form, but which was not raised by a prisoner during the consultation.[114]

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[109] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records, pp9-10
[110] ts 05.03.25 (Cobley), pp17-18 & 41-43
[111] ts 05.03.25 (Cobley), p17
[112] ts 05.03.25 (Cobley), p18
[113] ts 05.03.25 (Cobley), p42
[114] ts 05.03.25 (Gunson), p109

58. I note the following observations made by Dr Gunson during her evidence at the inquest about Ms Cobley's apparent misapprehension about Wandoo's therapeutic program:

> I absolutely…have not heard of that, and I do not believe it is a policy at Wandoo. If there is anything written about interacting in that way, it's likely to be when the…inmates are in therapy groups, or they're seeing somebody one-on-one for counselling where they would be bringing up what they choose to bring up…I can't imagine that there is any good reason not to, even in passing just say, well you said headaches on this form as well, what's that about? What has been going on because I see five days ago you were really unwell?[115]

59. At the inquest, Dr Fitzclarence said she was unaware of any departmental policy which would have prevented Ms Cobley from asking Ms Lowe about the "*headache*" mentioned on her appointment request form.[116]

60. To the extent that Ms Cobley's response genuinely represents her understanding of the ethos at Wandoo, she is clearly mistaken. Ms Cobley's fundamental misunderstanding about her role as a clinical nurse at Wandoo is clearly perplexing given her many years of nursing experience.[117]

61. In any case, to ensure other clinical staff at Wandoo were not under a similar misapprehension, I made the following recommendation (which I note has already been acted on by the Department):[118]

> For the avoidance of doubt, the Department of Justice should issue an instruction to all nursing and medical staff providing health services at Wandoo Rehabilitation Prison, that where a prisoner makes a written request to be reviewed by a nurse or doctor, the health professional conducting that review must ensure that all of the issues referred to by the prisoner in their written request form are addressed, whether raised by the prisoner at the review or not.[119]

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[115] ts 05.03.25 (Gunson), p109
[116] ts 05.03.25 (Fitzclarence), p98
[117] See: ts 05.03.25 (Cobley), p11 where Ms Cobley says she qualified as a nurse in 1984
[118] Letter - Ms K Niclair emailed to Mr D McDonald (31.03.25)
[119] See: Recommendation 3 and the Department's response: Letter - Ms K Niclair to Mr D McDonald (31.03.25)

62. For the sake of completeness, I note that in her report, Dr Fitzclarence noted that Ms Lowe had not been reviewed by a PMO on 11 December 2022, and that her presentation to the medical centre on this day was a "*further opportunity for investigation*".[120]

Consultation - 21 December 2022[121,122]

63. The fourth missed opportunity in Ms Lowe's care and treatment occurred on 21 December 2022, when at about 8.55 am Ms Lowe was brought into the medical centre complaining of "*migraine pain*".

64. Ms Lowe accompanied by Prisoner G and a member of the administrative staff, and when she first saw Ms Lowe, Ms Cobley says she held Ms Lowe's arm to steady her, and said: "*No, not this again*".[123]

65. At the inquest, Ms Cobley said this remark was not directed at Ms Lowe, but rather to the person accompanying her who was not a custodial officer as should have been the case. Ms Cobley conceded that her remark could easily be misunderstood, as it was by Prisoner G.[124,125]

66. Ms Lowe was seen by Ms Cobley who gave her Panadol and ibuprofen and advised her to return to her unit "*until pain relief takes effect*", before making the following entry in Ms Lowe's EcHO notes:

> *Assessment*: cleaning in admin this morning and bent over to pick up vacuum, states migraine pain started as she stood up, attends with wet paper towel covering her eyes, walking unaided. Patient very anxious and stressed today and has had previous episode of similar.[126]

67. At the inquest, Ms Cobley confirmed that Ms Lowe's vital signs were "*within normal limits*" and that as a result, she did not consider consulting with a PMO. Ms Cobley also said:

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[120] Exhibit 1, Vol 1, Tab 14, Report - Dr C Fitzclarence (03.02.23), p3 and ts.05.24 (Fitzclarence), pp97-98
[121] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), p21 and ts 05.03.25 (Cobley), pp20-28
[122] Exhibit 1, Vol 1, Tab 22.1, Report - Dr S Honeybul (20.12.24), p8
[123] ts 05.03.25 (Cobley), pp16-17 & 32
[124] ts 05.03.25 (Cobley), pp16-17 & 32
[125] Exhibit 1, Vol 1, Tab 23.1, Letter - Prisoner G (undated)
[126] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records, p9

> So had those (i.e.: vital signs) been different, had I had any raised suspicion or concern at that point, I definitely either would have done an e-consult to the on-call medical (officer), because Dr Ardi (i.e.: Dr Kusumawardhani) on that day was tele-healthing[127] for another facility, or I would have gone to see Dr Ardi.[128]

68. Dr Fitzclarence made the following comments about the fact that Ms Lowe was not transferred to hospital when she presented to the medical centre on the morning of 21 December 2022:

> There was another opportunity to transfer Ms Lowe to hospital on the morning of December 21, when she presented again with sudden onset of headache after leaning her head down - pathognomonic (i.e.: indicative of a particular condition) for raised intracranial pressure.
>
> The nurse missed this opportunity due in the very least, to the cognitive bias caused by the previous episode of similar pain on December 6 which had not been managed appropriately.
>
> It is my understanding that there was a doctor on site who could have reviewed Ms Lowe at this early presentation, but she was not made aware of the presentation.[129]

69. At the inquest, Dr Fitzclarence also noted that in the context of headache, "*normal*" vital signs did not "*rule out a problem*" or provide a sound basis for concluding nothing sinister was occurring.[130]

70. Dr Fitzclarence also noted that headache is a "*very common presentation*",[131] but that:

> [A] 'thunderclap' sudden onset headache is a "red flag" symptom that needs to be treated as an emergency even in someone with a history of other types of headache. This requires transfer to an emergency department for full assessment and head scanning".[132]

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[127] This is a reference to the conduct of medical consultations using a video-link
[128] ts 05.03.25 (Cobley), p23
[129] Exhibit 1, Vol 1, Tab 14, Report - Dr C Fitzclarence (03.02.23), p4
[130] ts.05.24 (Fitzclarence), p97
[131] See also: ts 05.03.25 (Kusumawardhani), pp63-64
[132] Exhibit 1, Vol 1, Tab 14, Report - Dr C Fitzclarence (03.02.23), p5 and ts.05.24 (Fitzclarence), p97

71. In his report, Dr Honeybul noted:

> I agree that there was a further opportunity for early investigation on the morning of 21 December 2022 when she again had a sudden onset of severe headache. Unfortunately, at this time she was not reviewed by a doctor and the nurse involved managed her situation, which she would have found appropriate given the previous episodes of headache. Ideally, she (Ms Lowe) would have been reviewed by a doctor and this may have precipitated earlier investigation. I agree that thunderclap headache is a red flag; however, there are a number of people who do develop thunderclap headaches without an underlying aneurysm, and these can be very difficult to manage.[133]

72. I note with concern that despite the outcome in this case, at the inquest, Ms Cobley maintained that even with the benefit of hindsight her assessment would have be the same and she would not have arranged for Ms Lowe to have been seen by a PMO. In my view this is regrettable because it tends to demonstrate an unfortunate unwillingness to be open to learning from critical incidents.[134]

Ms Lowe's collapse – 21 December 2022[135,136,137,138]

73. At 3.45 pm several prisoners attended the Control Office and asked for help on Ms Lowe's behalf. Prison officers attended Ms Lowe's cell immediately and noted she appeared to be unwell. Ms Lowe was lying in her cell on her bed complaining of a headache. She was cradling her head and had an ice pack on the back of her neck.

74. Prison officers contacted the medical centre and spoke with Ms Cobley, who asked if Ms Lowe was able to walk to the medical centre. When told she was not, Ms Cobley and another nurse attended Ms Lowe's cell at 3.49 pm. Ms Lowe was initially responsive and complained of a headache, but as Ms Cobley was helping her to sit up, Ms Lowe's breathing became laboured, and she went "*very stiff*".

[133] Exhibit 1, Vol 1, Tab 22.1, Report - Dr S Honeybul (20.12.24), p5
[134] ts 05.03.25 (Cobley), pp23 & 51
[135] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), pp21-24 and ts 05.03.25 (Cobley), pp28-29
[136] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), pp8-10
[137] Exhibit 1, Vol 2, Tab 1.36, Incident Reports - Officer T Tooby & Supt. J Miller (24.12.22)
[138] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records, pp8-9

75. Ms Cobley placed Ms Lowe in the recovery position as the other nurse returned to the medical centre to get the emergency equipment trolley. Prison officers called a Code Red Medical Emergency at 3.53 pm, and a short time later, Ms Lowe's condition deteriorated and she became unresponsive to stimuli and her pupils became dilated and very sluggish.

76. Emergency services were contacted, and Ms Lowe was taken to FSH by ambulance. Ms Lowe was transported unrestrained, and tests at FSH confirmed she had experienced a catastrophic, non-survivable intracerebral haemorrhage. After an assessment, Ms Lowe was deemed an unsuitable candidate for neurosurgical intervention.[139,140,141,142]

77. On 21 December 2022, Ms Lowe was entered into TOMS as Stage 4 the terminally ill prisoner (meaning her death was expected imminently) and placed on life support. Ms Lowe was kept comfortable, but her condition did not improve.[143,144]

78. On 24 December 2022, Ms Lowe's breathing tube was removed and she stopped breathing a short time later. Ms Lowe was declared deceased at 6.27 pm on 24 December 2022.[145,146,147]

[139] Exhibit 1, Vol 1, Tab 8, SJA Patient Care Record OCN44DD (21.12.22)
[140] Exhibit 1, Vol 1, Tab 15, FSH Medical records (21-24.12.22)
[141] Exhibit 1, Vol 2, Tab 31, Prisoner Movement Risk Assessment (21.12.22)
[142] Exhibit 1, Vol 2, Tab 32, Hospital Admittance Advice (21.12.22)
[143] Exhibit 1, Vol 2, Tabs 1.33 & 1.35, Terminally Ill Health Advice (21.12.22 & 23.12.22)
[144] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), pp12 & 19-20
[145] Exhibit 1, Vol 2, Tab 1.36, Incident Report - Supt. J Miller (24.12.22)
[146] Exhibit 1, Vol 1, Tab 9, Death in Hospital Form (24.12.22)
[147] Exhibit 1, Vol 2, Tab 1.36, Incident Description Reports & Minutes (24.12.22)

CAUSE AND MANNER OF DEATH[148,149,150]

79. Two forensic pathologists (Dr Daniel Moss and Dr Kiralee Patton) conducted a post mortem examination of Ms Lowe's body at the State Mortuary on 3 January 2023, and reviewed post mortem CT scans and Ms Lowe's medical notes.

80. Dr Moss and Dr Patton noted that specialist examination of Ms Lowe's brain had found she had a ruptured right frontal arterial aneurysm, and an intracerebral haemorrhage in her right frontal lobe. A "*thin subdural haemorrhage and minimal patchy subarachnoid haemorrhage in the distribution of the right frontal lobe*" were also noted.[151]

81. Dr Moss and Dr Patton observed that some chronic inflammation within the aneurysm wall raised the possibility of a mycotic aneurysm (i.e.: an infected aneurysm), but that "*there was insufficient material to perform the special bacterial stains needed to confirm or exclude this*.[152]

82. Mild narrowing of one of the blood vessels supplying Ms Lowe's heart muscle (coronary artery atherosclerosis) was noted, and there were stones in her gallbladder (cholelithiasis).

83. Microscopic examination of tissues noted bronchopneumonia in Ms Lowe's lungs and inflammation of the liver, which Dr Moss and Dr Patton said were commonly seen in people on life support. Background changes in keeping with chronic asthma and emphysema were also noted in Ms Lowe's lungs.

84. Toxicological analysis found the anti-depressant medications amitriptyline and fluoxetine (and their respective metabolites) in Ms Lowe's system, along with paracetamol and morphine (which was consistent with her terminal palliative care). Alcohol, cannabinoids and other common basic drugs were not detected.[153,154]

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[148] Exhibit 1, Vol 1, Tab 4, Supplementary Post Mortem Report (23.02.24)
[149] Exhibit 1, Vol 1, Tab 4.1, Post Mortem Report (03.01.23)
[150] Exhibit 1, Vol 1, Tab 6, Neuropathology Report (05.04.24)
[151] Exhibit 1, Vol 1, Tab 4, Supplementary Post Mortem Report (23.02.24), p2
[152] Exhibit 1, Vol 1, Tab 4, Supplementary Post Mortem Report (23.02.24), p2
[153] Exhibit 1, Vol 1, Tab 5, Final Toxicological Report - ChemCentre WA (03.03.23)
[154] Exhibit 1, Vol 1, Tab 5.1, Interim Toxicological Report - ChemCentre WA (16.01.23)

Cause and manner of death

85. At the conclusion of their post mortem examination, Dr Moss and Dr Patton expressed the opinion that the cause of Ms Lowe's death was "*complications of intracerebral haemorrhage due to ruptured aneurysm*", and that "*the death was due to natural causes*".[155]

86. I accept and respectfully adopt the opinion expressed by Dr Moss and Dr Patton and find Ms Lowe died from complications of intracerebral haemorrhage due to ruptured aneurysm.

87. Further, on the basis of the available evidence as to the circumstances of Ms Lowe's death, I find death her occurred by way of natural causes.

Comments in post mortem report directed to Ms Lowe's family

88. I would like to bring the following comments made by Dr Moss and Dr Patton in their post mortem report to the attention of Ms Lowe's family:

> The mortuary admission form (P98) states there is a history of 'strokes/bleeds/aneurysms' in Ms Lowe's family.
>
> Although many cerebral aneurysms occur spontaneously, risk factors have been identified that can contribute towards the formation or rupture of an aneurysm; these include family history of an aneurysm in a first-degree family member (child, sibling, or parent), untreated high blood pressure, cigarette smoking, stimulant use (cocaine and amphetamines), intravenous drug use (infections mycotic aneurysms), female sex, increasing age and some rare genetic diseases.
>
> **It may be appropriate for Ms Lowe's immediate family, including siblings and children, to consult with their General Practitioner with regards to the risks of cerebral aneurysm.**[156]
>
> [Emphasis added]

[155] Exhibit 1, Vol 1, Tab 4, Supplementary Post Mortem Report (23.02.24), pp1 & 3
[156] Exhibit 1, Vol 1, Tab 4, Supplementary Post Mortem Report (23.02.24)

OTHER ISSUES RAISED BY THE EVIDENCE

Culturally safe care of Aboriginal prisoners

89. In separate reports provided to the Court Professor Pat Dudgeon, AM and Professor Yin Paradies assessed Ms Lowe's care and treatment, and outlined their respective views on the importance of culturally safe care for Aboriginal prisoners.

90. Professor Dudgeon's qualifications include a Bachelor of Applied Science in psychology, a Graduate Diploma in psychology/counselling, and a PhD in psychology. Professor Dudgeon is the Director of the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, and the chief investigator on an Indigenous mental health and wellbeing research project at the University of Western Australia.[157]

91. Professor Paradies' qualifications include: a Bachelor of Science in mathematics and computer science, a Master of medical statistics, a Master public health, and a PhD in public health. Professor Paradies is the Deakin Distinguished Professor and Chair in Race relations in the School of Humanities and Social Sciences at Deakin University.[158,159]

92. In her report, Professor Dudgeon outlines how culturally safe care can be provided in the prison system, and the positive benefits of doing so. Professor Dudgeon also explained how prisons could monitor whether they are providing culturally safe care, and the link between lack of access to culturally safe care and the deterioration in a prisoner's mental and physical health.[160]

93. In his report, Professor Paradies concluded that on the basis of the materials he was provided, it appeared that "*the care (Ms Lowe) received was not culturally safe*". Professor Paradies explained how, in his view, Ms Lowe could have been provided with culturally safe care, and he outlined the experiences of explicit and implicit biases he says are faced by Aboriginal women in prison.[161]

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[157] Exhibit 1, Vol 2, Tab 4, Report - Prof. P Dudgeon (03.05.25), p1
[158] Exhibit 1, Vol 2, Tab 4, Report - Prof. Y Paradies (03.05.25), p1
[159] See also: https://experts.deakin.edu.au/1159-yin-paradies
[160] Exhibit 1, Vol 2, Tab 4, Report - Prof. P Dudgeon (03.05.25)
[161] Exhibit 1, Vol 2, Tab 4, Report - Prof. Y Paradies (03.05.25)

94. The positive benefits of providing culturally safe care to Aboriginal prisoners are obvious and appear to be well established. In their respective reports, Professor Dudgeon and Professor Paradies canvass a range of issues, and outline ways in which culturally safe practices could be implemented, fostered, and enhanced in the prison system.

95. Although there are currently **no** Aboriginal staff at Wandoo,[162] the Department's stated focus is on increasing the number of Aboriginal Health workers within the prison system, and the development of relationships with Aboriginal Community Controlled Health Organisations, and Aboriginal Medical Services.

96. Whilst these measures are praiseworthy, I **strongly** urge the Department to carefully consider the contents of the reports of Professor Dudgeon, and Professor Paradies to determine whether their respective observations and recommendations about culturally safe care can be incorporated into departmental practice.

Complaints by prisoners at Wandoo[163]

97. The Brief contains five letters written by prisoners at Wandoo at the relevant time, as well as an undated "open letter" addressed to "*Fiona and Anne-Marie*" signed "*Residents of Wandoo*" (the Letters).[164,165,166] Although the Letters are somewhat generic in nature, their contents were put to Ms Cobley at the inquest on the basis that she was referred to in several of them.[167]

98. Ms Cobley made the following general observation about the content of the Letters:

> I would like to raise the fact that these letters were all dated 28 December 2022, so a week after the medical event had occurred. I believe they are affected by the grief and the distress that a lot of the residents had…

[162] ts 05.03.25 (Palmer), pp121-122
[163] ts 05.03.25 (Palmer), pp122-123
[164] Exhibit 1, Vol 1, Tabs 23 & 23.1-23.2, Letters - Prisoners P (undated), Prisoner G (undated), and Prisoner P (28.12.22)
[165] Exhibit 1, Vol 1, Tabs 23.3-23.4, Letters -Prisoner M (28.12.22), and Prisoner W (28.12.22)
[166] Exhibit 1, Vol 2, Tab 7, Open letter signed "Residents of Wandoo" (undated)
[167] ts 05.03.25 (Cobley), pp29-33

> Ms Lowe is the first death in custody that we had had at Wandoo, and it's a very close-knit community, so that impacted on them very, very much, as it did indeed the staff. I would also like to point out that the only time a medication would be declined - as several residents have referred to that, especially with analgesia, was had that medication been given less than four hours prior, then we wouldn't have issued it at 5 o'clock. We would have said to them, "*Please call the call bell at nine o'clock, and the officers will come and issue (you) with some*", or we give them an envelope on person if we feel that that resident is capable and trustworthy to take at the appropriate time that we've advised, then we give them an envelope with that medication, so that they can access that when they need.[168]

99. Ms Cobley denied Prisoner G's assertion that she (Ms Cobley) had grabbed Ms Lowe's arm during her presentation to the medical centre on 21 December 2022, and said she had merely held Ms Lowe's arm in order to steady her. Although Ms Cobley agreed she had said: "*No, not this again*" when she first saw Ms Lowe, Ms Cobley said this remark had been directed at the staff member accompanying Ms Lowe, who was an administrative officer rather than a prison officer as should have been the case. However, Ms Cobley accepted that her unfortunate remark could have been perceived differently by others who heard it, as it was in this case by Prisoner G.[169,170]

100. Ms Cobley said she could not recall hearing anyone tell Ms Lowe that her "*illness was all in her head*", nor had she ever made such a comment, as several of the authors of the Letters had alleged.[171] However, for the sake of completeness, I note that when Ms Cobley saw Ms Lowe on 3 June 2022 in relation to a throat issue, she made the following entry in Ms Lowe's EcHO notes:

> [W]hispering hardly audible, however when officer spoke to her she started to reply in audible tone then stopped????? **psychosomatic complaint**.[172] [Emphasis added]

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[168] ts 05.03.25 (Cobley), p32
[169] ts 05.03.25 (Cobley), pp16-17 & 32
[170] Exhibit 1, Vol 1, Tab 23.1, Letter - Prisoners G (undated),
[171] ts 05.03.25 (Cobley), pp32-33
[172] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records (03.06.22), p48

101. The EcHO notes entry also states that prison officers had listened to four phone calls made by Ms Lowe that morning, and that her voice was "*croaky but clearly audible and that this improved towards the end of the conversation*".[173]

102. At the inquest, Ms Cobley made the following comments about her use of the term "*psychosomatic complaint*" in relation to Ms Lowe's presentation on 3 June 2022:

> "Psychosomatic complaints" is where that patient believes that they've got that problem, or it could even be - and I will choose my words carefully here - that they act that they've got that problem. Now, why the question marks and why that is - because I'm behind bullet-proof glass, so I couldn't - I could still hear Dannielle when she whispered, but then I heard her voice increase. So I just documented what I've seen or heard.[174]

103. When Ms Cobley was asked if she had any view about Ms Lowe's presentations to the medical centre, her response was:

> My view with (Ms Lowe) was that, if she presented when she was anxious and slightly distressed, her symptoms were magnified. So they weren't in her head, they were real symptoms that she was feeling, but with anxiety and distress, that manifests in many different ways.[175]

[173] Exhibit 1, Vol 1, Tab 13, EcHO Prison Medical records (03.06.22), p48
[174] ts 05.03.25 (Cobley), p37
[175] ts 05.03.25 (Cobley), p33 and see also: ts 05.03.25 (Cobley), pp37-40

Lessons Learned

104. Following Ms Lowe's death, the "*senior management team*" at Wandoo Department conducted a "*Lessons Learned*" process to identify areas for improvement, and I note that the DIC Review says recommendations arising from the Lessons Learned process have been "*completed and closed*". The lessons learned may be summarised as follows:[176]

a. Further education for prisoners, staff and community members is required on avenues for raising/submitting complaints about prisoner care/management;

b. Medication logs were not maintained at the relevant time, meaning medication given to prisoners overnight by prisoner officers;

c. Prisoners presenting to the medical centre complaining of severe symptoms requiring medication and/or repeated attendances should be the subject of "*increased monitoring*";

d. Staff and residents should receive training on "*working in a therapeutic environment*" to ensure staff respond to prisoners in a way which is consistent with "*Wandoo's therapeutic community ethos*";

e. All cell calls at Wandoo must be recorded and stored;

f. Escorts within the Meekatharra region should be "*streamlined*" to ensure that in exceptional circumstances prisoners are able to attend funerals when the departmental contractor is unavailable;

g. Nurses attending a unit/cell to treat a prisoner who cannot attend the medical centre should bring "*the medical emergency bag*" with them;[177]

h. There were delays in the transfer of Ms Lowe's property to her family because her next-of-kin information was omitted from TOMS; and

i. the Department's compliance with *COPP 13.2 Death of a Prisoner* should be strengthened to ensure that an officer remains with the deceased prisoner until a handover to police has occurred.[178,179]

[176] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), p25
[177] See also: ts 05.03.25 (Palmer), p121
[178] Exhibit 1, Vol 2, Tabs 1.37 & 37.1, Lessons Learned - Ms Lowe & Updated Lessons Learned Table (22.02.25)
[179] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), pp24-25

QUALITY OF SUPERVISION, TREATMENT AND CARE

105. When assessing the evidence in this matter and determining whether I should make any adverse findings or comments, I have been mindful of the need to engage with two key principles. The first is the phenomenon known as "*hindsight bias*", which is the common tendency to perceive events that have occurred as having been more predictable than they actually were.[180]

106. The second is known as the "*Briginshaw test*" and is 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.[181]

107. Essentially, the Briginshaw test requires that 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.

108. In relation to the standard of supervision Ms Lowe received whilst she was incarcerated, the death in custody review completed after her death (DIC Review) expressed the following conclusion:

> The review found Ms Lowe's custodial management, supervision and care were generally in accordance with the Department's policy and procedures as listed in Appendix 1. Records indicate that the response by (Wandoo) was prompt. Relevant death in custody procedures, including Departmental notifications were followed, however, it is noted that no formal handover to WA Police occurred as escorting officers and (Wandoo) Superintendent left Ms Lowe unsupervised at FSH for approximately 40 minutes.[182]

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[180] See for example: www.britannica.com/topic/hindsight-bias
[181] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362
[182] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), p7

109. The DIC Review noted that the issue of Ms Lowe having been left unsupervised was addressed in the "*Lessons Learned*" process and relevant departmental policy had been amended to make it clear that: "*only the Deputy Commissioner can approve the withdrawal of escorting staff prior to handover to police*".[183,184]

110. After carefully reviewing the evidence, I have concluded that with the exception of Ms Lowe being left unsupervised at FSH for a period of time after her death, the standard of supervision Ms Lowe received whilst she was in custody was reasonable.

111. In relation to the standard of treatment and care Ms Lowe received whilst she was incarcerated, the Health Review expresses the following conclusion:

> [Ms Lowe's] overall health care would generally be considered of a standard commensurate with that available in the community, and at times of a higher standard. However, even bearing in mind that her condition was unusual, there were several missed opportunities in the management of her final illness, that may ultimately have changed the outcome for her.
>
> However, that view is only possible through the lens of hindsight. The expert reviews by both Dr Honeybul and Dr Fitzclarence have recognised and been mindful of this possible hindsight bias, in their conclusions. With that said, Justice Health and Wellbeing Services will always take the opportunity to examine our practice and strive for constant improvement. Ultimately, despite this tragic outcome, our team has taken on board lessons that will inform our future practice for the better, to avoid similar tragedies.[185]

112. Apart from the management of Ms Lowe's headaches and nausea, Dr Fitzclarence expressed the following opinion about the general medical care provided to Ms Lowe: "*Other staff consistently throughout Ms Lowe's admission, provided an excellent standard of care*".[186]

[183] Exhibit 1, Vol 2, Tab 1, Death in Custody Review (03.01.25), p25
[184] Exhibit 1, Vol 2, Tabs 1.37 & 37.1, Lessons Learned - Ms Lowe & Updated Lessons Learned Table (22.02.25)
[185] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), p18
[186] Exhibit 1, Vol 1, Tab 14, Report - Dr C Fitzclarence (03.02.23), p4

113. As noted, in his report Dr Honeybul expressed the opinion that, with the benefit of hindsight, Ms Lowe's headache on 6 December 2022 related to "*a possible subarachnoid haemorrhage*". Dr Honeybul also said that in hindsight, Ms Lowe's sudden onset headache: "*should probably have precipitated transfer to a hospital Emergency Department for further assessment*".[187]

114. Dr Honeybul made the following comments about Ms Lowe's general medical care whilst she was incarcerated:

> In my opinion, on balance, the quality of the medical care had been good. I would be slightly concerned that following admission to the prison her normal antidepressants and anti-anxiety medications were withheld but I consider this to be a separate matter. It would appear that her episodes of headaches and musculoskeletal pain were treated appropriately with analgesics and she appeared to respond appropriately.[188]

115. On the basis of the available evidence, I have concluded that the management of Ms Lowe's general health was reasonable. However, I have identified missed opportunities in relation to the management of Ms Lowe's ongoing complaints of headaches, and intermittent nausea and vomiting where, with the benefit of hindsight, her treatment and care should have been better.

116. Given the missed opportunities I have identified, I have concluded that the management of Ms Lowe's reports of headaches (and her intermittent episodes of nausea and vomiting) in the period leading up to her death was poor.

117. However, after careful consideration, and given the numerous clinical imponderables in Ms Lowe's case, I have been unable to conclude that any of the missed opportunities I have identified can necessarily be said to have caused Ms Lowe's death.

[187] Exhibit 1, Vol 1, Tab 22.1, Report - Dr S Honeybul (20.12.24), p4
[188] Exhibit 1, Vol 1, Tab 22.1, Report - Dr S Honeybul (20.12.24), p3

RECOMMENDATIONS

118. In light of the observations I have made in this finding, I have decided it is appropriate for me to make four recommendations, which in my view arise from the evidence. These recommendations are designed to improve the care and treatment of prisoners in Western Australia, and I **strongly** urge the Department to embrace them in that spirit.

Recommendation No. 1

The Department of Justice should make it mandatory for all prison nurses and doctors to successfully complete Advance Life Support Course Level 2 (ALS2) or an appropriate alternative course, within six months after their initial employment, and every three years thereafter.

Recommendation No. 2

Given the critical importance of ensuring that all medication issued to prisoners by custodial staff is recorded and can be reviewed daily by nursing staff, the Department of Justice should issue a Commissioner's Bulletin (or similar) reminding all custodial staff of the importance of strict and ongoing compliance with "*COPP 6.4 - Officers issuing medication*".

Recommendation No. 3

For the avoidance of doubt, the Department of Justice should issue an instruction to all nursing and medical staff providing health services at Wandoo Rehabilitation Prison, that where a prisoner makes a written request to be reviewed by a nurse or doctor, the health professional conducting that review ensures that all of the issues referred to by the prisoner in their written request form are addressed, whether raised by the prisoner at the review or not.

Recommendation No. 4

In order to provide culturally safe care to Aboriginal prisoners in Western Australia, the Department of Justice should redouble its efforts to recruit Aboriginal staff at its prisons, including medical officers, nurses, psychologists, social workers, and prisoner support officers.

Culturally safe care for Aboriginal prisoners in Western Australia may also be achieved by establishing partnerships with Aboriginal community controlled health organisations and medical services, to provide access to visits from Aboriginal health practitioners, and by developing an Aboriginal Elders visiting program.

Response to Recommendations

119. At my request, Mr McDonald (Counsel Assisting) emailed a draft of my proposed recommendations to counsel on 6 March 2025.[189] Feedback (if any) was requested no later than the close of business on 31 March 2025.

120. By way of an email dated 11 March 2025, Ms Smith advised that Dr Kusumawardhani was content with the text of the recommendations as drafted.[190]

121. By way of an email dated 21 March 2025, Ms Jeffries identified a typographical error in Recommendation 1, and advised that Ms Lowe's family had some suggested amendments to Recommendation 2 and Recommendation 4.[191]

122. After careful consideration, I decided the proposed amendment to Recommendation 2 was unnecessary. However, I decided proposed amendment to Recommendation 4 was appropriate, and I therefore incorporated the suggested additional text.

[189] Email - Mr D McDonald to Ms N Niclair, Ms R Jeffries and Ms C Smith (06.03.25)
[190] Email - Ms C Smith to Mr D McDonald (11.03.25)
[191] Email - Ms R Jeffries to Mr D McDonald (21.03.25)

123. By way of a letter dated 31 March 2025, Ms Niclair advised that the Department's response to the recommendations was as follows:[192]

a. *Recommendation 1:* Not Supported. In its response, the Department asserts that Advanced Life Support Course Level 2 (ALS2) was:

> [O]utside a primary healthcare nurses' scope and nurses within our custodial facilities (and in a primary health care setting) have no authority to practice this. ALS 2 would be attended predominantly by medical staff and advanced practitioners working in a critical care environment.

The Department also says that an alternative recommendation in relation to Advanced Life Support Course Level 1 (ALS1) is unnecessary because the Department is "*already focussed*" on delivering ALS1 to "*all staff working within the custodial estate*".

In my view, the Department's position is inconsistent with comments in the Health Review,[193] Ms Cobley's evidence,[194] Dr Gunson's evidence[195] and the description of the ALS2 course on the Australian Resuscitation Council's website, which states:

> [H]ealthcare professionals who would be expected to apply those skills taught as part of their clinical duties, or to teach them on a regular basis. Appropriate participants include doctors, and nurses working in critical care areas (e.g. ED, CCU, ICU, HDU, acute admissions units) or in the resuscitation /medical emergency team, and paramedics.[196]

Nevertheless, in order to accommodate the Department's stated concerns, I have amended Recommendation 1 by replacing the word "*equivalent*" with the words "*appropriate alternative*".

In my view the timeframes in Recommendation 1 are entirely reasonable and appropriate, and these would be lost if this recommendation was not made.

[192] Letter - Ms K Niclair emailed to Mr D McDonald (31.03.25)
[193] Exhibit 1, Vol 2, Tab 2, Health Services Review (26.02.25), p14
[194] ts 05.03.25 (Cobley), p34
[195] ts 05.03.25 (Gunson), pp116-118
[196] See: https://resus.org.au/als-courses/

b. *Recommendation 2:* Supported, although the Department advised that a Deputy Commissioner's Broadcast was issued on 20 March 2025 (the Broadcast), to reinforce the requirements of COPP 6.4 Officers Issuing Medication (COPP 6.4).

The Department also advised that: "*Regular compliance testing will also be undertaken to ensure medication logs remain in place at all relevant sites across the estate*". The prompt publication of the Broadcast is praiseworthy, and in relation to ongoing compliance I note that the Broadcast states:

> Superintendents in conjunction with Clinical Nurse Managers must ensure that medication logs are in place and being maintained at all sites where over-the-counter medication is issued by custodial staff.

This section of the Broadcast usefully identifies the positions responsible for ensuring compliance with COPP 6.4. However, I remain of the view that the requirement for strict and ongoing compliance should be **explicitly** stated, and therefore I have decided that Recommendation 2 is appropriate as drafted.

c. *Response to Recommendation 3:* Supported, although the Department advised that an "*instruction*" has been issued "*to address this recommendation*".

Whilst the action referred to in the Department's response appears to be appropriate, in my view this recommendation remains appropriate given the reporting protocols the Minister of Corrective Services follows in relation to coroner's recommendations.

d. *Recommendation 4:* Supported in principle. The Department says it: "*actively promotes the employment of Aboriginal staff across the Department of Justice and Corrective Services*". The Department also says it is finalising its Strategic Plan 2025-2030 and that:

> [O]ne of our Priorities is to 'drive better outcomes and positive change by partnering with Aboriginal People.' In addition, we will focus on supporting the recruitment, retention and progression of Aboriginal employees at all levels within Corrective Services…

> Corrective Services will continue to evaluate its approach to the recruitment of Aboriginal staff into health positions to provide a culturally safe environment for staff to work in.

The Department also identified several Aboriginal Community Controlled Health Organisations and Aboriginal Medical Services and advised that it:

> [E]ngages with these organisations on a regular basis in attempt to enhance the care provided to people in custody across the estate:
>
> • Broome Regional Aboriginal Medical Service (BRAMS);
> • South West Aboriginal Medical Service (SWAMS); and
> • Derby Aboriginal Health Service (DAHS).
>
> The Department is also in discussions with Derbarl Yerrigan health service about providing primary health care to young people in the Banksia Hill Detention Centre.
>
> In addition, the Department also engages with Marr Mooditj Training in attempt to canvass more interest in working within the Department.

CONCLUSION

124. Ms Lowe was a dearly loved family member, who was 41 years of age when she died at FSH on 24 December 2022, from complications of intracerebral haemorrhage due to ruptured aneurysm.

125. Although I concluded that the standard of supervision Ms Lowe received whilst she was in custody was reasonable, I identified missed opportunities in the management of her complaints of headaches and intermittent nausea in the period leading to her death.

126. In my view, Ms Lowe's various complaints of headaches, nausea and/or vomiting should have been managed better, and for that reason I concluded that the treatment and care she received in relation to these issues was poor. However, given the numerous imponderables in this case, I was unable to find (to the relevant standard) that any of the missed opportunities I identified had caused Ms Lowe's death.

127. After careful consideration I made four recommendations aimed at improving the care and treatment of prisoners in Western Australia. I note with approval that the Department has already acted on two of these recommendations, and it is my sincere hope that my other two recommendations will be similarly embraced.

128. Finally, as I did before conclusion of the inquest, I wish to again convey to Ms Lowe's family and loved ones, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
28 MAY 2025