JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	BRENDYN DEAN NELSON, CORONER
HEARD	**:**	4 NOVEMBER 2025
DELIVERED	**:**	27 NOVEMBER 2025
FILE NO/S	**:**	CORC 136 of 2024
DECEASED	**:**	SCHIPP, STEPHEN JOSEPH

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)

Counsel Appearing:

Sergeant C Martin assisted the Coroner
Ms N Worthy, of the State Solicitor's Office, appeared for the Department of Justice

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Brendyn Dean Nelson, Coroner, having investigated the death of ***Stephen Joseph SCHIPP*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 4 November 2025, find that the identity of the deceased person was* ***Stephen Joseph SCHIPP*** *and that death occurred* ***on 24 May 2024*** *at* ***Bunbury Regional Hospital, Bussell Highway, Bunbury****, from* ***complications of oesophageal cancer, with terminal palliative care*** *in the following circumstances:*

1 In January 2023, Stephen Joseph Schipp, a sentenced prisoner at Bunbury Regional Prison (**BRP**), was diagnosed with carcinoma of the oesophagus.

2 He underwent chemotherapy and radiotherapy, and scans showed a metabolic response. However, in January 2024 he was diagnosed with a recurrence of the carcinoma. Palliative chemotherapy was commenced.

3 On 19 May 2024, Mr Schipp became unwell with a COVID-19 infection. He commenced anti-viral treatment, with some improvement.

4 On 23 May 2024, Mr Schipp was in his allocated unit within the BRP's Pre-Release Unit (**PRU**) when he began to vomit blood.

5 A prison officer spoke to Mr Schipp, who was in the toilet at the time, before calling for medical attention. A nurse attended from the main area of the prison and assessed Mr Schipp in his cell. He was subsequently taken by ambulance to Bunbury Regional Hospital (**BRH**).

6 Following assessment at the hospital, Mr Schipp was provided palliative care and at about 5.40 am on 24 May, Mr Schipp lost consciousness, and he was pronounced deceased shortly after. He was 58 years of age.

7 A forensic pathologist concluded that Mr Schipp died from complications of oesophageal cancer, with terminal palliative care.

8 As Mr Schipp was a person held in care immediately before his death, an inquest was mandatory.[1] I held an inquest on 4 November 2025, receiving

[1] *Coroners Act 1996* (WA) s 3 (definition of 'person held in care'); s 22(1)(a).

evidence in the form of the coronial brief and oral evidence from Ms Toni Palmer, a review officer with the Department of Justice, and Dr Catherine Gunson, the Department's Deputy Director of Medical Services.

9 I am required to comment on the quality of the supervision, treatment and care provided to Mr Schipp whilst he was held in custody.[2]

10 For reasons outlined further below, I am satisfied that the supervision, treatment, and care provided to Mr Schipp by the Department during his imprisonment was satisfactory.

11 The evidence raised an issue about the timing of any response by medical staff to an emergency in the PRU, given the physical layout of the BRP. My consideration of that issue is detailed further below.

12 Mr Schipp's brother and sister attended the inquest and through Sergeant Assisting raised a concern about the response on 23 May, namely whether the prison officer who first attended to Mr Schipp should have called an ambulance immediately. I consider that issue below.

13 Mr Schipp's brother also addressed the Court about:

(a) whether, upon the recurrence of his cancer, Mr Schipp was denied the ability to use a NutriBullet in the PRU (where he had been permitted to have one after his initial diagnosis); and

(b) whether Mr Schipp should have undergone another Positron Emission Tomography (**PET**) scan before his death.

14 After the inquest, the solicitors acting for the Department of Justice provided a response to both concerns. I address the responses below.

Summary of the evidence

Circumstances of imprisonment

15 On 10 September 2020, Mr Schipp was convicted after trial in the District Court of three child sex offences,[3] and remanded in custody at BRP.[4]

[2] *Coroners Act 1996* (WA) s 25(3).
[3] Exhibit 1, tab 8.2, p 2.
[4] Exhibit 1, tab 8, p 4.

16 On 15 October 2020 Mr Schipp was sentenced to 6 years and 3 months imprisonment, with parole eligibility.[5] His earliest eligible date for parole was 9 December 2024.[6]

Healthcare prior to 23 May 2024

17 Upon his incarceration, Mr Schipp underwent an initial health screening and had prescriptions for pre-existing conditions filled.[7] Mr Schipp was being treated for chronic health conditions including atrial fibrillation, congestive cardiac failure, osteoarthritis and hypertension.[8]

18 From the time of his reception into BRP, Mr Schipp's existing conditions were closely monitored, and he was referred for investigations and reviews as indicated.[9] He attended the BRP medical centre regularly.[10]

19 On 2 December 2022, Mr Schipp presented to nursing staff describing a history of gastrointestinal symptoms, and some unintentional weight loss. He saw the medical officer, who ordered urgent imaging and referred him to a general surgeon for a gastroscopy.[11]

20 During the procedure, a distal oesophageal mass was found,[12] and Mr Schipp received a formal diagnosis of carcinoma of the oesophagus on 5 January 2023.[13] He was referred for procedures at Fiona Stanley Hospital and was transferred to Acacia Prison for a short time for that purpose.[14]

21 Mr Schipp was found to be unfit for surgical resection due to his cardiac issues[15] and upon return to the BRP, he commenced chemotherapy and radiotherapy.[16] During this time, he received assistance in relation to diet and pain management.[17]

22 A PET scan in September 2023 showed a complete metabolic and anatomic response, with no evidence of nodal and solid organ metastatic

[5] Exhibit 1, tab 8.2, p 9.
[6] Exhibit 1, tab 8.4.
[7] Exhibit 1, tab 8, p 9.
[8] Exhibit 1, tab 8, pp 4-5; exhibit 2, p 4.
[9] Exhibit 2, p 5.
[10] Exhibit 1, tab 8 pp 9-10.
[11] Exhibit 2, p 5.
[12] Exhibit 1, tab 8, p 10.
[13] Exhibit 1, tab 8, p 11.
[14] Exhibit 1, tab 8, p 11; exhibit 2, p 3.
[15] Exhibit 1, tab 11; exhibit 2, p 5.
[16] Exhibit 1, tab 8.15.
[17] Exhibit 1, tab 8, pp 11-12.

disease.[18] However, following a scan in January 2024 and a gastroscopy and biopsy in February 2024, Mr Schipp was diagnosed with a recurrence of oesophageal junction adenocarcinoma.[19]

23 In early March 2024 he was transported by ambulance to Fiona Stanley Hospital for further treatment and held at Casuarina Prison.[20] He was found unfit for surgery due to competing medical comorbidities,[21] and palliative chemotherapy was recommended.[22]

24 Mr Schipp returned to BRP on 26 March 2024, and continued to have ongoing appointments with integrated cancer services and medical staff as required, and recommenced chemotherapy on 16 April 2024.[23]

25 On 30 April 2024, Mr Schipp presented to the medical centre with worsening pain and nausea. With Mr Schipp's agreement, a referral to palliative care was made on 2 May 2024.[24]

26 On 14 May 2024, Mr Schipp consulted with a palliative care specialist at St John of God Hospital in Bunbury. By that time, his nausea and vomiting had settled, he was eating more, and his pain was better controlled.[25] He advised that he did not want to be resuscitated but would like treatment of all reversible conditions including admission into an ICU if required.[26]

27 Mr Schipp tested positive for COVID-19 on 18 May 2024. He was placed into medical isolation and commenced anti-viral treatment, with some improvement. He was provided ongoing welfare checks during this time.[27]

Events on 23 and 24 May 2024

28 At about 5.30 pm on 23 May 2024, Mr Schipp informed a prison officer at the PRU that he was vomiting blood.[28] Mr Schipp was in the toilet at the time, so the prison officer was unable to see him, but identified that Mr Schipp was able to communicate clearly, and did not sound distressed.[29]

[18] Exhibit 1, tab 11.
[19] Exhibit 1, tab 11.
[20] Exhibit 1, tab 8.13; exhibit 2, p 3.
[21] Exhibit 1, tab 10.
[22] Exhibit 1, tab 11.
[23] Exhibit 1, tab 16.
[24] Exhibit 1, tab 8, p 14.
[25] Exhibit 1, tab 11.
[26] Exhibit 1, tab 11.
[27] Exhibit 1, tab 8, p 14.
[28] Exhibit 1, tab 8.16, par [27].
[29] Exhibit 1, tab 8.16, par [30].

29 The prison officer called for medical attention by phone,[30] and at about 5.55 pm a nurse attended the PRU and assessed Mr Schipp in his cell.[31]

30 The nurse requested that an ambulance be called as a 'priority two'.[32]

31 Mr Schipp was taken to the medical centre while awaiting the ambulance, before being taken to BRH by ambulance, arriving at about 7.10 pm.[33]

32 Following assessment, a doctor advised Mr Schipp that due to his deteriorating condition, if he were to suffer a cardiac arrest neither surgery nor resuscitation could be performed.[34]

33 At about 5.38 am on 24 May, Mr Schipp lost consciousness in the presence of a nurse. The nurse called for a doctor and other medical staff who attended and assessed Mr Schipp.[35] Mr Schipp was declared deceased.[36]

Cause and manner of death

34 A forensic pathologist performed an external post-mortem examination on 30 May 2024,[37] and concluded that the cause of Mr Schipp's death was complications of oesophageal cancer, with terminal palliative care.[38]

35 I accept and adopt that conclusion as to the cause of Mr Schipp's death.

36 The manner of Mr Schipp's death was natural causes.

Treatment, supervision, and care

Mr Schipp's ongoing medical care while in custody

Departmental medical review

37 Dr Gunson performed a review of the health care provided to Mr Schipp while he was in custody.

[30] Exhibit 1, tab 8.16, par [36].
[31] Exhibit 1, tab 8, p 5; Exhibit 1, tab 8.16, par [44].
[32] Exhibit 1, tab 8, p 5; Exhibit 1, tab 8.16, par [44].
[33] Exhibit 1, tab 8.22; Exhibit 1, tab 9, par [7].
[34] Exhibit 1, tab 9, par [9].
[35] Exhibit 1, tab 8, p 16.
[36] Exhibit 1, tab 4.
[37] Exhibit 1, tab 6.
[38] Exhibit 1, tab 6.1.

38 Her opinion, based on her review of the medical records, was that Mr Schipp was provided health care of a standard equivalent to, at least, the standard he would have received in the community.[39]

39 On my independent review of the records, and having regard to Dr Gunson's opinion, I am satisfied that Mr Schipp's medical treatment and care whilst in custody – primarily at BRP – was satisfactory. Treating clinicians provided timely, considered and holistic approaches to their treatment of Mr Schipp's serious medical conditions.

Royal Prerogative of Mercy

40 There is no evidence that Mr Schipp was ever considered for the exercise of the Royal Prerogative of Mercy.

41 Prior to the inquest, I asked the Department if there was any evidence that Mr Schipp had applied for early release, given on 14 May 2024 he advised the palliative care specialist that he was working on getting early release at that time.[40] Ms Palmer undertook searches, and confirmed that there is no available record indicating Mr Schipp made any application.[41]

42 Mr Schipp's designation as a Terminally Ill Prisoner (as defined in the 'Commissioner's Operating Policy and Procedure 6.2 – Prisoners with a Terminal Medical Condition') remained at Stage 1[42] or Stage 2[43] during his imprisonment. As such, there was no catalyst under existing policy for any consideration to be given for Mr Schipp's early release due to his medical condition, absent application.

43 In her review, Dr Gunson notes that Mr Schipp's escalation to Stage 2 occurred on 1 May 2024, based on a prognosis, in April 2024, of a life expectancy of 12 months as a 'worst case scenario'.[44] Based on that prognosis, the designation conforms with the staging within COPP 6.2.

44 I also note that Dr Gunson had no difficulty with the designation when asked at the inquest.[45] As she observed in her review report, despite best efforts by those providing treatment, Mr Schipp's condition deteriorated

[39] Exhibit 2, p 21.
[40] Exhibit 1, tab 11.
[41] Ts 13.
[42] Exhibit 1, tab 8, p 11.
[43] Exhibit 1, tab 8, p 14.
[44] Exhibit 2, p 18.
[45] T 21.

more rapidly than expected, and there was no occasion to further escalate his status as a terminally ill prisoner.[46]

45 Based on the above, I am satisfied that the Department complied with its procedures in relation to prisoners with a terminal medical condition.[47]

PET scan

46 As identified above, at the inquest Mr Schipp's brother raised a concern that Mr Schipp did not undergo a further PET scan prior to his death.

47 The Department of Justice, through its solicitors, confirmed that:

(a) a further PET scan was recommended by a doctor who reviewed Mr Schipp on 4 April 2024;

(b) on 12 April 2024, Mr Schipp voiced concerns about not having undergone the recommended PET scan; and

(c) there is no Departmental record indicating that the recommended PET scan had been scheduled prior to Mr Schipp's death.

48 I find that, prior to Mr Schipp's death, a date for a PET scan should have at least been scheduled. There was a clear oversight.

49 If the PET scan could have been performed prior to his death (which is not known), I am satisfied that its utility was, necessarily, limited to reviewing the progression of Mr Schipp's cancer.

50 The results of the scan could have been relevant to Mr Schipp's Terminally Ill Prisoner designation, and any application for early release that he might have ultimately made.

51 However, I am satisfied that the oversight in relation to the scheduling of the further PET scan did not materially prejudice Mr Schipp's ongoing medical treatment. I reach that conclusion where Mr Schipp was already receiving palliative chemotherapy at that time, and I infer (assuming Mr Schipp continued to consent) that such treatment would likely have been maintained following a further PET scan.

[46] Exhibit 2, pp 18-19.
[47] Exhibit 2, Appendix B.

Mr Schipp's general care and treatment in custody

52 The Department of Justice's Performance and Assurance Risk Directorate conducted an independent review of Mr Schipp's death to:

(a) identify any systemic issues that may need to be addressed to prevent similar deaths from happening in the future; and

(b) identify policy or procedural opportunities for improvement.[48]

53 The review found that Mr Schipp's management, supervision, and care while in prison was in accordance with the Department's policies and procedures, and that the response by custodial staff to Mr Schipp on 23 May 2024 was prompt and appropriate.[49]

54 Based on my review of the evidence, I agree with that general conclusion, subject to the three matters which I address in greater detail below (two of which arise in part due to concerns raised by Mr Schipp's siblings).

Call for medical assistance

55 At the inquest, Mr Schipp's siblings raised a concern about why the prison officer who was notified by Mr Schipp that he was vomiting blood did not immediately call for an ambulance. Relatedly, as part of the Departmental review, the prison officer was asked why he did not call a code red when told by Mr Schipp that he was vomiting blood.

56 The prison officer explained that he did not call a code red because Mr Schipp did not appear to be distressed and was able to speak clearly with the officer, so the officer did not perceive there to be a medical emergency warranting a code.[50] I infer his position would have been the same in relation to immediately calling an ambulance.

57 The prison officer's risk assessment, and his decision to make a call for medical assistance by phone, was endorsed by the Superintendent of the prison as being appropriate and proportionate.[51]

58 The nurse who ultimately attended to Mr Schipp on 23 May 2024, and the nurse manager at BRP, both expressed the view that a code red would have been appropriate but acknowledged that calling a code red would not have changed the outcome,[52] and that custodial staff will not necessarily be

[48] Exhibit 1, tab 8, p 4.
[49] Exhibit 1, tab 8, p 6.
[50] Exhibit 1, tab 8, pp 14-15; Exhibit 1, tab 8.16, par [32].
[51] Exhibit 1, tab 8.17.
[52] Exhibit 1, tab 8.18, par [27].

aware of a prisoner's diagnosis if they do not consent to its disclosure so officers will always be aware of the severity of a prisoner's illness.[53]

59 Ms Palmer confirmed at the inquest that there is no reason why a prison officer cannot call an ambulance immediately (including before calling a code, or prison medical staff), if they consider it necessary.[54]

60 I note the views expressed by others, and the concerns raised by Mr Schipp's siblings, but make no criticism of the decision by the prison officer not to call a code, or for an ambulance immediately, in the circumstances.

61 The evidence is clear that it was open to the prison officer to have called an ambulance directly, or a code red, but he took a different course for reasons that he has explained. I agree with Ms Palmer that most prison officers, in these circumstances, would have erred toward calling for assistance from available medical staff at the prison rather than calling for an ambulance immediately.[55]

62 It is important that in analysing the prison officer's decision, I do so without hindsight bias, meaning that I do not assess the reasonableness of the decision taken at the time solely having regard to the fact of Mr Schipp's subsequent demise.

63 In my view, the prison officer's decision was based on a clear and defensible risk assessment. There is no suggestion that his approach was inconsistent with any policy of the Department, or any Standing Order.

64 I find that the calling of a code red would have resulted in the clinical nurse arriving at most, a few minutes earlier to assess Mr Schipp. That very brief delay did not alter Mr Schipp's outcome.

65 I find that had the prison officer called for an ambulance directly, the ambulance would have arrived earlier than it did and, as noted by Dr Gunson, Mr Schipp might have been provided greater relief from the very uncomfortable symptoms he was experiencing sooner.

66 That possibility does not cause me to reflect adversely on the prison officer's risk assessment and decision, particularly where there would have been no difference in overall outcome.

[53] Exhibit 1, tab 8.19, par [21].
[54] Ts 11.
[55] Ts 11.

Nursing presence in PRU

67 The PAR Directorate review identified one issue that represented an opportunity for improvement, being the time taken for medical staff to arrive at the PRU from the time of the call by the prison officer.[56]

68 I accept that had a nurse attended to Mr Schipp in a shorter timeframe, Mr Schipp might have been provided greater relief from sooner but that there is nothing that could have been done to prevent the outcome.

69 The evidence is that it can take medical staff 5 to 6 minutes to leave the main area of the prison, pass through several secure doors that are required to be operated by prison officers, return keys, travel to the PRU (by walking or driving) and obtain keys upon arrival at the PRU.[57]

70 Medical staff would still need to move through secured doors operated by custodial staff and return keys even if a code red had been called.[58]

71 At my request, I was provided a plan of the prison after the inquest. There is a significant distance between the main area of the prison, and the PRU - some five hundred metres.[59]

72 The plan also raises the issue that because the PRU is set up in an enclosed 'village' style, it is possible that medical staff would also need to travel some further distance if the medical emergency was occurring in a cell located at the northern end of the PRU grounds.

73 It should be noted that the nurse who attended to Mr Schipp stated that because the call was made other than as a code red, she finished the medication parade that she was engaged in when the call came through. If a code red had been called, she would have attended immediately.[60]

74 Therefore, part of the 20-minute delay between the call and attendance in this case can be attributed to the nurse completing other duties.

75 That does not detract from the fact that this incident demonstrates the prospect of, by my assessment and understanding of the evidence, a 10-minute delay between medical staff based in the main area of the prison receiving a code red relating to an emergency in the PRU after 3.30 pm,

[56] Exhibit 1, tab 8, p 6.
[57] Exhibit 1, tab 8 p 15.
[58] Exhibit 1, tab 8.19, par [16].
[59] Exhibit 1, tab 8.19, par [12].
[60] Exhibit 1, tab 8.18, par [16]-[17].

and being able to attend such emergency.[61] That estimate also operates on the assumption that in the hypothetical scenario nothing else causes any interruption or delay to medical staff.

76 It is reasonable to suppose that such a delay could alter the outcome of a prisoner suffering a critical medical incident.

77 The review indicates that there is a medical centre within the area of the prison in which the PRU is located, however it is not staffed by a nurse after approximately 3.30 pm to 4.00 pm each day.[62] The review recommended that consideration be given to that centre being staffed from 7.00 am to 7.00 pm, mirroring the hours of the medical centre in the main area of the prison.[63]

78 The Department determined that an increase in the operating hours of the medical centre at the PRU 'was not currently feasible'.[64]

79 I accept the evidence that the process required to exit and enter the main part of the prison and the PRU cannot be shortened. However, that practical impediment simply highlights that an increase in the presence of staff in the medical centre at the PRU is the only possible improvement.

80 For that reason, prior to the inquest I asked the Department for an explanation as to why the recommendation was not considered to be feasible. The Acting Director of Operational Support, Corrective Services stated that the recommendation was not feasible or practical because:

(a) the majority of nursing duties are concentrated in the main area of the prison, where the prison population is significantly larger;

(b) consequently, resources are more effectively directed towards supporting the medical centre in the main area of the BRP, which operates with extended hours to meet demand; and

(c) even if the operating hours of the PRU were extended, it would not guarantee a nurse being stationed there at all times, given nurses are required to move between units as operational needs arise, and are not fixed to a single location.[65]

[61] This accords with the evidence of the nurse manager: Exhibit 1, tab 8.19.
[62] Exhibit 1, tab 8, p 18.
[63] Exhibit 1, tab 8, p 19.
[64] Exhibit 1, tab 8, p 19.
[65] Exhibit 3.

81 Given the response at (a) above (and where, to an extent, the response at (b) depends on the correctness of (a)), at the end of the inquest I asked the Department to clarify the current population at BRP, including in the PRU.

82 The Department has advised that as of 18 November 2025, BRP housed 586 prisoners, 138 of which are in the PRU.

83 In circumstances where the PRU houses roughly a quarter of the prisoner population at BRP, I am not persuaded by the view expressed at (a) above.

84 However, I acknowledge the point raised at (c) and accept that an expansion of the staffing hours of the nursing station within the PRU would not axiomatically mean that a nurse would be in attendance at all times. At best, an expansion of a few hours of the PRU being operative would only increase the *possibility* of a nurse being present within the PRU at the time of an emergency.

85 Given the above, I will not make a recommendation in this case.

86 However, Mr Schipp's death is a clear opportunity for the Department to carefully consider the overall nursing resource at BRP, and to determine whether the level and allocation of resources is optimal given the likely delay identified above in any medical staff attending an emergency at the PRU outside hours.

Availability of NutriBullet

87 At the inquest, Mr Schipp's siblings raised a concern that following the recurrence of his cancer, Mr Schipp was denied an opportunity to have a NutriBullet in the PRU (in circumstances where had use of a NutriBullet after his initial diagnosis to puree his food).

88 In their response following the inquest, the solicitors acting for the Department clarified the matter as follows:

(a) on 6 January 2023, following his initial diagnosis, Mr Schipp was provided a medical certificate so that he could have a NutriBullet to puree his food;

(b) on 24 January 2023 Mr Schipp was placed in the PRU, and there are no Departmental records indicating that he was prevented from retaining the NutriBullet;

(c) in November 2023, Mr Schipp returned the NutriBullet to the BRP Health Centre, on the basis he no longer required it (I infer because he had responded well to his initial treatment);

(d) on 12 March 2024, Mr Schipp had an oesophageal stent inserted, and was provided a medical certificate for a pureed diet;

(e) from 9 April 2024, Mr Schipp was approved to possess a stick blender; and

(f) at all times while in the PRU, Mr Schipp had access to the communal blender located in the kitchen.

89 The available evidence suggests that Mr Schipp returned the NutriBullet, and there was no reason (at least in policy) as to why he would not have been permitted a NutriBullet again, had he requested one.

90 Even in the hypothetical circumstance that such request were made and denied, it is evident that there were other means available to Mr Schipp to puree his food (which was obviously necessary given the stent insertion), including personal permission to possess and use a stick blender.

Conclusions

91 As noted above, and having reviewed the specific issues arising on the evidence, I am satisfied that the supervision, treatment, and care provided to Mr Schipp by the Department during his imprisonment was satisfactory.

92 I express my condolences to Mr Schipp's siblings and express the Court's gratitude for their engagement in the inquest process.

BD Nelson
Coroner
27 November 2025