Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref : 28/13

I, Barry Paul King, Coroner, having investigated the death of ***Robert Charles Bropho*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***27 and 28 June 2013****, find the identity of the deceased person was* ***Robert Charles Bropho*** *and that death occurred on* ***24 October 2011*** *at* ***Royal Perth Hospital*** *as a result of* ***Acute Myocardial Infarction in association with Coronary Artery Atherosclerosis*** *in the following circumstances:*

Counsel Appearing :

Sergeant Lyle Housiaux assisting the Coroner
Robyn Hartley on behalf of the Department of Corrective Services
Paul Gazia and Carla Yazmadjian on behalf of the family of the deceased

Table of Contents

INTRODUCTION

1. Robert Charles Bropho **(the deceased)** died in Royal Perth Hospital **(RPH)** from acute myocardial infarction in association with coronary artery atherosclerosis.
2. At the time of his death[1], the deceased was a sentenced prisoner, so under s 16 of the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services **(the Department)** and was thereby a 'person held in care' under the *Coroners Act 1996* **(the Act)**. His death was, therefore, a 'reportable death' under the Act.
3. Under s 19 of the Act, a coroner has jurisdiction to investigate a death if it appears that the death is or may be a reportable death. Section 22(e) of the Act requires a coroner who has jurisdiction to investigate a death to hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.
4. Under s 25(2) of the Act, where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.
5. An inquest into the deceased's death was held on 27 and 28 June 2013.
6. The documentary evidence adduced at the inquest primarily comprised two comprehensive reports into the circumstances of the deceased's death and of his treatment while in custody. One of the reports was prepared by Detective Senior Constable (now Sergeant) Roy Begg of the Western Australian Police Service. The other was prepared by Richard Mudford of the Western Australian Department of Corrective Services.
7. Senior Constable Begg and Mr Mudford were called to give oral testimony relating to their respective reports.

[1] The *Coroners Act 1996* provides: 'immediately before death'.

8. The deceased's daughter, Ms Bella Bropho, gave oral testimony on behalf of the family of the deceased. Her evidence included a number of allegations relayed by the deceased to her relating to the deceased's treatment and care while in prison.

THE DECEASED

9. The deceased was a Nyungah[2] Aboriginal man who rose to prominence in the Western Australian community in the 1970's as a result of public protests in relation to land rights.
10. He was born in Toodyay on 9 February 1930 and lived with his parents in camps in the Claremont, Eden Hill, Lockridge and Stratton areas. He had seven siblings. He had received little by way of formal education but was able to read.
11. The deceased was a widower with eight children and two step-children.
12. He was the leader of the Swan Valley Nyungah Community where he and his extended family lived for many years before it was closed by the Western Australian government in 2003.

CRIMINAL HISTORY

13. The deceased had an extensive criminal history from 1948 when he was first sentenced as an adult to imprisonment for stealing. For the next 19 years he was convicted for 27 offences relating mostly to dishonesty, public nuisance and alcohol-related matters. He then had no further convictions for 23 years.
14. From 1997 to 2002 the deceased was convicted of four assaults, including an assault of a public officer and an assault occasioning bodily harm, for which he received fines or suspended sentences.
15. In January 2006 he was convicted for indecent dealing with a child less than 6 years of age and was imprisoned for 12 months.

[2] This spelling was used by the deceased's family in correspondence: Exhibit 2

16. In February 2008 the deceased was convicted of five counts of unlawful carnal knowledge of a child less than 13 years of age for which he was ultimately sentenced to six years imprisonment from 28 February 2008. His earliest date of release was 27 February 2014.

MEDICAL HISTORY

17. When the deceased began his sentence of imprisonment on 28 February 2008, he had a number of serious medical conditions as identified by his doctor. In particular he suffered from longstanding insulin dependent diabetes mellitus, hypertension, chronic renal failure, severe ischaemic heart disease with angina, regular cardiac failure, underactive thyroid and depression.
18. The deceased was on a complicated insulin regime to try to improve his diabetic control, and he was prescribed more than ten separate medications.
19. Overall, it is clear that the deceased was in very poor health at the time he was first imprisoned in February 2008.

EVENTS LEADING TO THE DEATH

20. At about 6.00am on 24 October 2011 the deceased was in his cell in the infirmary in Casuarina Prison. He had been seen at midnight and 5.00am that morning sitting on the edge of his bed. He had made no complaints during the previous night.
21. At 7.30 that morning a nurse employed at the prison noted that the deceased had failed to attend the diabetic parade, so she went to his cell where she administered insulin to him and carried out standard medical observations.
22. At 8.45am a prisoner found the deceased collapsed on the floor of his cell, so he activated the cell call alarm in order to summons

assistance. When a nurse attended, the deceased said that he felt dizzy and his feet went out from under him. He had not lost consciousness and had no chest pain. Nurses carried out observations again, and the deceased was taken to the toilet and shower.

23. About half an hour later, the deceased was accompanied by a nurse back to the day room in the infirmary where he sat in a chair. He got out of the chair, took a few steps and collapsed to the floor.

24. Nursing staff responded immediately and moved the deceased to a nearby resuscitation room where oxygen was administered and observations, including an EEG, were taken. The on-call doctor arrived and requested a priority one ambulance. A troponin blood test was positive for a heart attack. Throughout this, the deceased was conscious and able to carry on a conversation.

25. At 10.45am the ambulance arrived and conveyed the deceased to RPH where he arrived at 11.40am. The deceased was conscious during the trip to RPH, but upon arrival his condition rapidly deteriorated. He had a cardiac arrest at 12.17pm from which he could not be resuscitated.

POST MORTEM EXAMINATION

26. Forensic Pathologist Dr D M Moss made a post mortem examination of the deceased on 27 October 2011.

27. Dr Moss found widespread areas of severe stenosis in the blood vessels of the heart. A microscopic examination of the tissues showed areas of acute myocardial infarction and severe coronary artery atherosclerosis. The kidneys showed changes consistent with diabetes and hypertension and there were areas of calcification in the lungs. Neuropathology showed no significant abnormality of the brain.

28. Dr Moss's conclusion, which I accept, is that the cause of death was acute myocardial infarction in association with coronary artery atheroslerosis.[3]

SUPERVISON, TREATMENT AND CARE

29. On 28 February 2008 the deceased was imprisoned at Hakea Prison.

30. He underwent a standard at-risk assessment and an initial health screen. The next day he was reviewed by medical staff and issued with medications. He was placed on a special diet and exempted from work. On 3 March 2008 a medical certificate was issued to note that the deceased was a diabetic needing "supper provided and special diet requirement.'

31. At some stage in his incarceration, the deceased was classified as a Special Profile Offender, being an offender whose profile is of specific interest to the media and/or community, though the effect of that classification is not clear.[4]

32. In late April 2008 the deceased was admitted for three days at Royal Perth Hospital (RPH) with complaints of chest pain while at rest. He underwent an angiogram which confirmed his coronary artery disease, and he was prescribed new medications.[5]

33. From then the deceased made relatively frequent trips to RPH to be seen by consultants in general medicine, the cardiology clinic and the renal clinic. He also underwent a cataract operation and follow-up at the RPH ophthalmology department in March to May 2010. Overall he attended RPH on 40 occasions, 12 of which were emergencies.

---

[3] Exhibit 1, Volume 1, Tab 5
[4] Exhibit 1 Volume 2 Tab 1 p3; Assistant Commissioner Custodial Operations Notice No 40/2009
[5] Royal Perth Hospital records: discharge summary

34. In May 2008 the deceased was moved to Acacia Prison in order to avoid the difficulties in administering his insulin regime in Hakea Prison due to the number of lock-downs there.

35. Shortly after arriving at Acacia Prison, the deceased was placed on a Diabetes Care Plan which provided for regular monitoring and assessments of his on-going condition at three-monthly intervals.

36. In August 2008 the deceased was placed on a Cardiac Care Plan which was reviewed annually by a cardiologist at the RPH cardiology clinic. On 9 October 2008 the cardiologist indicated that the deceased's condition appeared stable, his medication appeared to provide relief from angina symptoms and that the deceased was "not keen to consider going ahead with an interventionist approach."[6]

37. The care plan forms indicate that the deceased was on 'healthy' or 'low fat' or 'diabetic' diets.

38. In December 2008 the deceased's health care was reviewed by a general practitioner , Dr John Hardy, who noted in a report that the deceased's diabetes-related complications will inevitably continue to progress. He stated that the deceased had severe coronary artery disease and was at significant risk of another myocardial infarction. As to the medical implication of remaining in custody, Dr Hardy noted that any proximity to a coronary care unit that might be available in the community would have to be balanced against the potentially more rapid availability of defibrillation in prison.[7]

39. Due to his upgrade to maximum security following the State's successful appeal against sentence, on 7 September 2009 the deceased was transferred to Casuarina Prison where he remained until his death.

40. Following the deceased's death, an independent medical report was commissioned by the Department from Emeritus Professor Dr Max

[6] Letter from Dr V Paul to Dr M Ireland, 9 October 2008, Health Services records.
[7] Exhibit 1, Volume 2, Tab 10

Kamien, a specialist in Aboriginal and rural health. Professor Kamien's report was based on his review of seven folders of prison medical records relating to the deceased's condition from 2006 to October 2011. Co-incidently, Professor Kamien had treated the deceased when the deceased had lived at the Swan Valley Nyungah Community, so had some personal familiarity with him.

41. Professor Kamien's report contained the following summary:

> Mr Bropho suffered from atherosclerosis. He also had several metabolic disorders that contributed to coronary artery occlusion. It is remarkable that he nearly reached 82 years of age. His medical, and particularly his nursing care in prison was compassionate and competent and undoubtedly contributed to the unexpected extension of his life, 26 years more than the average life expectancy of an Aboriginal male.

42. During the inquest Professor Kamien also gave oral evidence by way of a telephone connection from the Aboriginal Medical Service clinic in Kununurra. He emphasised that the deceased was a very sick man before he died and that little could have been done to preserve his life.

43. Despite his depression and poor health, the deceased was rarely considered a risk of self-harm. In November 2010 he was placed on the At Risk Management System (ARMS) for five days after appearing depressed and speaking of self-harm, but was removed from ARMS after only a week. His thoughts of self-harm appeared to depend on whether he thought that his concerns for his health were being properly considered and met.

44. Due to the terminal nature of his condition, on 9 August 2010 the deceased was registered as a Phase 1 terminally ill prisoner under the Department's Policy Directive 8. The criterion for Phase 1 was a high probability of death.

45. The purpose of registering terminally ill prisoners under Policy Directive 8 was to identify prisoners who, because they are in their last stages of life, may be considered for placement in a non-custodial setting prior to death.

46. The more immediate effect of the registration of the deceased was that he was moved from the prison's mainstream population into the infirmary. His condition was to be continuously monitored by the prison's health service provider, in this case the Department's Health Services, which was to provide updated reports on the Total Offender Management System (TOMS), the Department's electronic information system.[8]

47. On 23 November 2010 the deceased's status as a terminally ill prisoner was changed to Phase 2, whereby his death was acknowledged as imminent. As a result of the deceased's Phase 2 status, steps were taken to ascertain his suitability for the exercise by the Governor of the Royal Prerogative of Mercy.

48. Recommendations were provided by the Department to the Attorney General on 19 July 2011. On 12 September 2011, the Attorney General decided not to recommend to the Governor that the prerogative be exercised.

THE DECEASED'S BEHAVIOUR IN CUSTODY

49. During the deceased's initial placement at Hakea Prison he appeared to be settling well with support from staff and prisoners.[9]

50. Due to the nature of his convictions, the deceased was placed in a protection unit. Because he denied having committed the offences, he was not eligible for sex offending treatment.

51. When the deceased was transferred to Acacia Prison on 12 May 2008, he was considered a co-operative prisoner who related well to staff and got along with other prisoners.

[8] Exhibit 1, Volume 2, Tab 38
[9] Exhibit 1, Volume 2, Tab 13

52. In early 2009 a new Integrated Management Plan **(IMP)** was completed for the deceased. Over the preceding three months he had been the subject of a number of incident reports, but he remained at a medium security rating.

53. In May 2009 a State appeal of his sentence was upheld and his sentence increased from three years to six years. A new IMP in early September 2009 included a classification review which changed his security rating from medium to maximum until 28 February 2011. As a result, he was transferred to Casuarina Prison.

54. While at Acacia and Casuarina Prisons, the deceased was found guilty of 17 charges of prison offences, primarily relating to insulting or threatening language to prison officers. As a result, he was disciplined by confinement to punishment cells some 13 times over that period.[10] That the charges could be punished in that way indicates that the charges were dealt with as minor prison offences.[11]

55. The TOMS incident module contains 97 items[12] for the deceased. A cursory perusal of the items reveals that officers considered the deceased to be regularly: argumentative, demanding, complaining, defamatory, manipulative, paranoid, unco-operative, belligerent, insulting, and abusive. He often threatened officers that he would 'take it further' if his demands for attention or special treatment were not met, and he used his medical condition as a means of disrupting the prison routine for the same purpose.

56. Even taking into account the possibility that the authors of the items in the incident module were biased against the deceased, the litany of references to anti-social attitude and behaviour suggests that he was a difficult prisoner.

---

[10] Exhibit 1, Volume 2, Tab 29
[11] *Prison Act 1981* Part VII
[12] According to Mr Mudford's report: Exhibit 1, Volume 2, Tab 1 p12

57. Professor Kamien's reading of the Department's medical records together with his experiences with the deceased when the deceased lived at the Swan Valley Nyungah Community led Professor Kamien to consider that the deceased had paranoid ideation about his treatment, his management and his imprisonment.

THE DECEASED'S FAMILY'S CONCERNS ABOUT HIS TREATMENT

58. As noted above, the evidence of Ms Bella Bropho included allegations that the deceased had complained to her of several instances where he had suffered mistreatment in prison. The particular issues identified by Ms Bropho were:

    a. the deceased was not provided with snacks at night so had to use his spends in order to provide for himself;

    b. the deceased suffered from a tantrum-like episode due to a diabetic attack and was dragged from his cell, stripped, placed in a plastic garment and splashed with water by prison staff. This was said to have happened a long time before his death, perhaps months;

    c. the deceased felt that he was not getting the correct dosages of medication from prison infirmary staff. He felt safe in RPH rather than the infirmary;

    d. there was ongoing abuse from prison officers and other prisoners. Once, prison officers allowed another prisoner to assault the deceased;

    e. the deceased was sent "down the back" (a term for the detention unit) where he was given only bread and water;

    f. once, while in the detention unit, the deceased was not provided with water so he was forced to drink from a toilet; and

g. the deceased was terminally ill and should have been allowed to die surrounded by family in a culturally appropriate way.

59. Ms Bropho also stated that, when the deceased was taken to RPH on the day he died, the family was not notified by the Department. After she heard rumours that the deceased had been transferred to hospital, Ms Bropho rang the prison and was told that the deceased had died at 12.40pm. As a result of failures by the Department and the Police, the deceased's wider family could not be properly notified of his death before some of them heard about it on the television news at 5.00pm that day.

60. Ms Bropho was also critical of the Department's failure to notify the deceased's family when the deceased was registered as a Phase 2 terminally ill prisoner.

COMMENTS ON THE FAMILY'S CONCERNS

61. One difficulty in considering the allegations made by Ms Bropho is that she was unable to provide a specific time at which the events were said to occur.

62. A related and more significant problem is that the allegations made by Ms Bropho in relation to mistreatment of the deceased were made with very little notice to the Court.

63. Some weeks before the inquest, Counsel Assisting requested Ms Bropho to identify any such issues in order for potential witnesses to be identified and, if considered appropriate, called to give evidence. About a week before the inquest, the family's representatives were provided with a brief of the evidence in order to allow them to advise the family of the evidence likely to be adduced.

64. Counsel appearing for the family notified Counsel Assisting on the day before the inquest of some of the issues likely to be raised by Ms Bropho.

65. Counsel Assisting then passed along that information to counsel appearing for the Department, who attempted to extract from voluminous departmental records any documents relevant to the issues identified. Those documents, which were accepted into evidence as Exhibit 2, indicate that the deceased had made complaints to Ms Bropho who then complained in writing on the deceased's behalf to departmental authorities as well as to various Ministers, the Inspector of Prisons, the Ombudsman and the Aboriginal Legal Service among others. Exhibit 2 also contains responses sent to Ms Bropho by or on behalf of relevant Ministers.

66. Following discussion with counsel during the first day of the inquest, counsel for the Department made the Department's offender management files available to counsel appearing for the family in order to allow them to determine whether there was any documentary evidence in those files to support Ms Bropho's accusations.

67. Mr Mudford provided evidence about the various channels that were available to the deceased himself to make complaints, including to independent entities such as the Ombudsman, the Aboriginal Legal Service and the media,[13] so if there was any substance to the deceased's complaints, it is likely in my view that that they would have been investigated and the results of the investigations attached to the Department's offender management file in relation to the deceased.

68. I am grateful to counsel for the family for examining those files before the inquest resumed on 28 June 2013. Mr Gazia informed me that there were no documents that I needed to see, implying

[13] T. 28/6/13 p.16, 17, 18-20

that no documents existed in the Department's offender management files supporting Ms Bropho's allegations. In closing submissions he made no direct reference to Ms Bropho's allegations of mistreatment.

69. From this I infer the probability that the complaints were groundless or related to incidents that were much less significant than was alleged.

70. In addition, the Court also had in its possession the Department's Health Services files relating to the deceased's last period of imprisonment. I have examined those files, particularly with a view to determine whether there was any documentary evidence relevant to the specific allegations made by Ms Bropho or to the complaints found in the documents in Exhibit 2. I should note in passing my understanding that those were the files that Professor Kamien had examined in order to report on the quality of the care and treatment of the deceased while in the custody of the Department.

71. The progress notes found in the Department's Health Services file are replete with references to the deceased's complaints and demands in relation to his medical condition, but I was unable to find any reference of:

    a. a complaint by the deceased of being provided only bread and water in the detention unit. He was visited in that unit daily by nursing staff but made no complaints about the food provided. Of note is an entry dated 22 January 2009, the same date as that of the first document in Exhibit 2 in which the deceased states that he had to drink out of the toilet, and the same date as the second and third documents which relate to the provision of special food. That entry and the entry for the following day both indicate that the

deceased was seen in the discipline unit and that he raised no issues;

b. a complaint by the deceased of having to eat brown bread and jam because special food was unavailable. An entry made at 4.30pm on 5 March 2009 indicates that the deceased told infirmary staff that he was on a hunger strike but the entry does not say why. At 4.55pm that day an entry records that the deceased was seen eating two slices of bread with jam, a cup of tea with sugar and two servings of ice cream. Following that entry, the entries indicate that the deceased was seen in the discipline unit and that he raised no issues. An entry on 21 August 2011 indicates that the deceased did not want to eat the food provided as part of his diabetic diet, so he ate bread and jam;

c. a complaint by the deceased of needing and not being provided with snacks to have at night; or

d. a complaint by the deceased of an incident relevant to a tantrum caused by a diabetic attack. There is, however, reference to the deceased banging on the window of the nurses' station in the infirmary and demanding pain killers. He was apparently warned not to act aggressively and was removed to the Multi-purpose Unit overnight. This occurred two months before his death on 24 August 2011 and involved the nurses' response to the deceased's behaviour rather than prison officers' response. There is no reference to the deceased being stripped or splashed with water. It is also relevant to note that the documents collected in Exhibit 2 contain no allegation of this incident.

72. The progress notes also show that the deceased's dosage of medications was continually monitored and adjusted. There were, however, occasions where the deceased flatly refused to take or administer his medication or to undergo testing, and there was one occasion where he used another prisoner's insulin pen by mistake.

73. I accept the contents of the progress notes as true and correct records of the Department's nursing and medical staff. In addition, in my view, the nature of the notes is such that it is unlikely that complaints made by the deceased about his treatment would not have been recorded.

74. The notes contain references to the deceased's complaints about the actions or attitudes of prison staff, but only two indicating any physical abuse; namely, an allegation that a prison officer held the deceased by the front of his shirt and told him to sit[14], and another that he was grabbed by the back of the neck, presumably by a prison officer, and told to keep walking.[15] In relation to the first of these two incidents, a clinical nurse supervisor was asked to accompany a Senior Officer Security while the deceased was interviewed about the alleged assault, indicating that the deceased's allegation was taken seriously and was recorded.

75. The deceased also complained about the chest pain he suffered regularly, presumably from angina. It seems that it would be worse after he exerted himself or entered into arguments with prison staff, but the pain could be treated readily with his nitrolingual spray which he failed to use from time to time.

76. As time went on, it appears that his pain symptoms increased, requiring a commensurate increase in analgesia. There are several records indicating that the deceased summonsed staff with his cell

[14] 3/05/11 per J Pinkham CNS
[15] 9/04/10 per Richard Wee MD

call after hours and was provided with painkillers or told to use his nitrolingual spray.

77. The records contain several references to complaints by the deceased of delays in responses to his demands for attention, but it is not possible in most cases to be able to form a view as to whether the complaints were at all justified. In some cases it is clear that there was no justification, casting doubt on the veracity of other complaints. As one of the deceased's fellow prisoner stated, the deceased cried wolf continually.[16]

78. For example, with respect to allegations made in a letter of 16 August 2010 in Exhibit 2 to the effect that the deceased had been refused medical attention and that he had suffered ongoing pain as a result, the medical notes for the relevant dates make clear that the decease received a considerable amount of attention from doctors and nursing staff.

79. An indication of the deceased's state of health at the time can be found in the notes of Dr Fitzclarence at 3.57pm on 13 August 2010 and Dr Wee 15 minutes later. Dr Fitzclarence noted that the deceased

> … has been refusing medication on and off. He is mobilising well. He is interacting well. No resp(iratory) distress. Speaking in sentences. Phone call from Margaret Jeffries stating that Mr Bropho has been coughing blood and phlegm for days and no one had seen him. She demands that he be sent to RPH as he is likely to die with his pneumonia.

[16] Exhibit 1, Volume 1 Tab 9, p.1 per M A Galluccio

80. Dr Wee then noted that the deceased was not in acute distress and that his impression was that the deceased had a respiratory tract infection. Dr Wee recorded

> (the deceased) Terminated consult midway through – "I need to go back, I think my chips are getting cold" will review patient with results next week – patient happy with the plan.

81. A similar story was behind the complaints made on the deceased's behalf by a letter in Exhibit 2 dated 6 September 2010 and numerous instances can be found in the records up to the few weeks before his death.
82. In October 2010 the deceased was moved from the infirmary back into Unit 6. He complained about chest pain from having to climb 5 steps. On 26 October 2010 he was seen by a doctor who had a 'long discussion about his behaviour and inappropriate manipulation and abuse of staff'. The doctor agreed to move him back to the infirmary. The deceased agreed 'to behave in an appropriate fashion and say he was grateful to be brought back'.[17] But it appears that by the afternoon of 30 October 2010, he was behaving as unreasonably as previously.[18]
83. The impression I gained from the notes was that overall the deceased was a difficult and demanding patient. He made so many complaints about staff that, on more than once occasion, nurses thought that it was worth noting days on which he made no complaints.[19]

[17] 26/10/2010 per C Fitzclarence MD
[18] 30/10/2010 per M Moldrich CN
[19] For example: 22/07/10 per H White CN; 6/09/10 per D Venables CN

84. He elicited the assistance of his family to attempt to get attention when he felt that he was being neglected and, not surprisingly, his family were concerned for his welfare.

85. It is not possible to know whether the deceased's behaviour was affected by psychological issues such as the paranoid ideation mentioned by Professor Kamien.

86. I accept that Ms Bropho's allegations were made by her in good faith, but I am satisfied that they were based on information provided by the deceased that was either exaggerated or baseless.

87. As to the issue of the deceased being able to die at home, the deceased was subject to a sentence of imprisonment which, in the absence of further court order, could only be set aside in the exercise of a royal prerogative of mercy. That prerogative is one which, as far as I can ascertain, can only be exercised by the Governor under Part 19 of the *Sentencing Act 1995.* In my view, it is not a matter that is open to scrutiny by this Court. The process by which the Department provides information to the Attorney General may be open to scrutiny as was seen in the inquest into the death of David Maxwell Dale (Ref No. 03/13), but that issue is not relevant to the death of the deceased.

88. I deal with the issue of notification of next of kin below.

COMMENT ON THE STANDARD OF MEDICAL CARE OF THE DECEASED WHILE IN CUSTODY

89. On the information available to me, I am satisfied that the quality of the supervision, treatment and care of the deceased while in the custody of the Chief Executive Officer of the Department of Corrective Services was high.

NOTIFICATION OF NEXT OF KIN

90. As noted above, Ms Bropho's expressed concerns about the delay in the family being notified about the death.

91. Ms Bropho said that, though she was the nominated next of kin, she was not told about the deceased being moved to RPH and only learned about his death when she heard rumours and rang the prison to find out what was going on. She said that she was able to speak to the superintendent who told her that the deceased had died at 12.40pm that day at RPH.[20]

92. Ms Bropho and other members of her family then went to RPH where they were told by a policeman that the deceased's body had been moved to the State Mortuary at Sir Charles Gairdner Hospital. The family members then went to the State Mortuary where Coronial Investigation Unit officers came and told them that the deceased had died. [21] Sergeant Begg's report indicates that two police officers notified Ms Bropho personally of her father's death at 6.00pm on 24 October 2011.

93. Under the protocols between the Department and the WA Police as reflected in the Department's policy and standing orders, responsibility for notification of next of kin rests with the WA Police after being notified of the death by the relevant prison superintendent.[22]

94. Sergeant Begg agreed that notifying next of kin is one, if not the most important, things that police have to do in the case of a death.

95. In this case, Sergeant Begg said that he recalled there being dramas regarding locating the family, but that police officers definitely tried their hardest to locate family members. He said that the practice then and now was for police to try to locate other family members if the senior next of kin is not available.[23]

96. It is possible that Ms Bropho was difficult to find on the early afternoon of 24 October 2011, but that was not explored in the evidence.

---

[20] T. 27/6/13 p. 24-25
[21] T. 27/6/13 p. 25
[22] Exhibit 1 Volume 2 Tab 46 p8/20 and p. 12/16
[23] T. 27/6/13 p. 16-17

97. In the end, I am not able to comment on whether those responsible for notifying the deceased's family of his death had tried their hardest, or who they tried to locate if Ms Bropho was difficult to find, but it is clear that procedures need to be in place to ensure that notification of families of the deaths of loved ones occurs as soon as possible in circumstances where a nominated senior next of kin is not contactable.

98. Common sense suggests there must be a number of possible means by which that could occur; for example, having alternative persons to contact.

99. This precise issue of what might be an efficacious procedure was not canvassed in evidence or submissions, so I am not in a satisfactory position to make a recommendation with respect to it, but I do make the following comment.

COMMENT

> If such a procedure does not already exist, the Department of Corrective Services and the WA Police should implement a procedure to ensure so far as practicable that families of persons who die while in the custody of the Department are notified without delay notwithstanding that a person nominated as next of kin is not able to be contacted.

NOTIFICATION OF PHASE 2 TERMINAL ILLNESS

100. The deceased was classified as Phase 1 under the Department's Policy Directive 8 on 9 August 2010 and was classified as Phase 2 on 23 November 2010. There was no requirement under the policy to notify either the deceased or his family of those classifications. It appears on the available evidence that the deceased's family were not aware that the deceased was classified as Phase 2 until March 2011.

101. Mr Mudford made the valid point that as soon as a person is classified as Phase 2, urgent steps are taken to gather and organise information to be provided to the Attorney General. That process necessarily requires consultation with the family of the person, who would then be made aware of the possibility that the person may be released under the policy.

102. While that may be the expectation, it appears to me there may be rare occasions where the expectation is not met. In such cases, the relevant family might feel aggrieved enough to remind the Department of its own policy. Families may feel even more aggrieved if they learn too late of the missed opportunity to have done so.

103. That the family is expected to be consulted and therefore made aware indirectly of a person's classification as Phase 2 suggests that there is no perceived detriment to the Department from the family being so aware.

104. Counsel for the Department also made a valid point in submitting that the Department owes a duty of confidentiality to prisoners. While that may be the case, it is difficult to see why prisoners should not be told of a classification under Policy Directive 8 given the potential effect it may have on their future placements. It would then be up to each prisoner to decide whether to inform his or her family before they are consulted by departmental staff.

105. Of course, knowledge of the existence of a classification would only be significant to the prisoner if he or she understands that his or her placement could be affected as a result.

106. In these circumstances, I make the following recommendation.

RECOMMENDATION

> I recommend that the Department of Corrective Services consider amending its Policy Directive 8 to require that a person classified as having a Phase 1 or

> Phase 2 terminal illness be notified of the classification and the ramifications thereof as soon as practicable after the classification occurs.

107. Another matter which was discussed during the inquest was the apparent failure by departmental officers to notify Ms Bropho of the fact that the deceased had been moved to RPH in an emergency situation.
108. In this case, it is clear that there was a failure to do so, and counsel for the Department fairly acknowledged that the relevant Policy Directive was not followed.
109. Why that occurred was not apparent, though it may be that the acting superintendent who made the decision lacked experience in this procedure. That officer was not called to testify, so I am not able to speculate further.
110. That the Department has acknowledged through counsel that a mistake was made leads me to assume that, if it has not done so already, the Department will take the necessary steps to bring to the attention of all officers acting as superintendents that the notification of next of kin is important and that the relevant policies should be followed.
111. One further matter that was raised in evidence in the inquest was the fact that on the day of his death the deceased was placed in handcuffs while in the ambulance on the way to RPH and that, when deceased was undergoing resuscitation at hospital, the restraints were removed in favour of leg restraints.
112. It is difficult to see any need for the deceased to have been placed in restraints of any description for transfer to hospital given his condition, even before his collapse on the day of his death. It is clear that he was not a security and, apart from the unnecessary humiliation that attends being seen in restraints in public, the restraints may have impeded his medical treatment.

113. Mr Mudford said that he thought that as a medium security prisoner the deceased was to be handcuffed unless the superintendent overrode that procedure, and his view is generally consistent with Policy Directive 8.[24] Under that policy, an escorting officer can either seek advice from the superintendent or may remove constraints where the prisoner is seriously ill and it is apparent that security will not be breached.

114. In the circumstances, I consider that I should make the following comment.

COMMENT

The Department should consider reviewing the procedure under Policy Directive 8 to reduce instances where restraints are applied in clearly inappropriate situations.

CONCLUSION

115. The evidence of the deceased's ongoing condition together with the results of Dr Moss' post mortem examination make clear that the cause of death was acute myocardial infarction in association with coronary atherosclerosis, and I so find.

116. I find that the manner of death was Natural Causes.

B P KING
CORONER
19 July 2013

[24] Exhibit 3 para 5.10.1