Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 03/13

I, Alastair Neil Hope, State Coroner, having investigated the death of David Maxwell Hale, with an Inquest held at Perth Coroner's Court on 22 January 2013 find that the identity of the deceased person was David Maxwell HALE and that the death occurred on 20 July 2011 at St John of God Hospice, Murdoch as a result of complications of metastatic pancreatic cancer in the following circumstances –

Counsel Appearing:

Sergeant Lyle Housiaux assisted the Coroner

David Anderson (State Solicitor's Office) appearing on behalf of the Department of Corrective Services.

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INTRODUCTION

David Maxwell Hale (the deceased) was at the time of his death on 20 July 2011 a 32 year old male sentenced prisoner who had been housed at Casuarina Prison, but had been transferred to St John of God Hospital, Murdoch.

As the deceased was a 'person held in care' for the purposes of the Coroners Act 1996[1], it has been necessary for an inquest to be conducted and for a coroner to comment on the supervision, treatment and care of the deceased while in that care.[2]

INVESTIGATIONS INTO THE DEATH

Following the death investigations were conducted by WA Police and the Department of Corrective Services Professional Standards Division.

The WA Police investigation commenced shortly after the death when a clinical nurse on duty and Corrective Services staff advised Police Operations Centre of the death.

Detective Senior Sergeant James Bradley and Detective First Class Constable Carter from the Major Crime Squad were advised and attended Murdoch St John of God Hospice.

The detectives conducted comprehensive investigations

following which Detective Senior Sergeant Bradley provided a comprehensive report to the State Coroner.

That investigation revealed that there were no suspicious circumstances surrounding the death which appeared to have resulted from natural causes.

The Professional Standards Division of the Department of Corrective Services conducted a comprehensive review of the circumstances of the death which included examining all relevant documentation and, where considered necessary, conducting interviews with staff and stakeholders in relation to the management of the deceased person to identify:

- the level of compliance of existing policies;
- critical policy gaps for early consideration by the relevant business area;
- opportunities for business improvements;
- the established level of training and any development opportunities; and
- shared learning opportunities enabling proactive risk reduction strategies across the Department of Corrective Services.

As the deceased was in the custody of the contractor G4S during the period when he was hospitalised from 28 June to 20 July 2011, G4S Officer Incident Reports and other relevant documents were reviewed. The investigation conclusion in respect of G4S involvement was that all required hospital procedures were adhered to and following notification of the death, all relevant policies and procedures were followed.

At the inquest Richard Mudford, Senior Review Officer, spoke to the final report and it was clear that the outcome of

this investigation also was that the deceased had died as a result of natural causes and that he had received ongoing support, monitoring and counselling.

PANCREATIC CANCER

The exact cause of pancreatic cancer is unknown. It has been found to be more common in:

- people with diabetes;
- people with long term inflammation of the pancreas (chronic pancreatitis) and
- smokers.

Pancreatic cancer may grow without any symptoms and is often advanced and inoperable when it is first found. Jaundice is often an initial clinical feature detected. The average survival of sufferers is usually less than one year.

The deceased had advanced pancreatic cancer, which was suspected when he was noticed to be jaundiced on arrival at Hakea Prison in November 2010. He was then referred to Royal Perth Hospital in a timely manner where the diagnosis was confirmed. His cancer was inoperable and progressed to metastatic terminal cancer by June 2011.

CONCLUSION

The deceased died on 20 July 2011 from complications of metastatic pancreatic cancer.

At the time of his death the deceased was at St John of God Murdoch Community Hospice where he was receiving terminal care.

I find the death arose by way of natural causes.

COMMENTS ON THE QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED WHILE IN CARE

Following the deceased's sentence commencing on 2 November 2010, during his initial health check at Hakea Prison, he was found to be jaundiced and was referred to Royal Perth Hospital where he was diagnosed with an inoperable cancer of the head of the pancreas.

From that time on the deceased received regular treatment for his cancer which was generally of a high quality.

The deceased was transferred to Casuarina Prison on 17 November 2010 so that he could receive ongoing medical care at the Casuarina Prison Infirmary. That was appropriate housing for a prisoner suffering from such a condition.

The deceased's condition was regularly monitored and it is noted that he was transferred to hospital on

52 occasions while at Casuarina Prison during the period 5 November 2010 until 28 June 2011.

On 28 June 2011 the deceased was transferred to Royal Perth Hospital Oncology Department where he was treated appropriately. On 19 July 2011 he was transferred to St John of God Hospice, Murdoch, for ongoing palliative care.

The treatment of the deceased during his period in custody appears to have been consistently appropriate. In my view the quality of supervision, treatment and care of the deceased while in care was of a high level.

DELAY IN PROGRESSING POSSIBLE RELEASE UNDER THE ROYAL PREROGATIVE OF MERCY

It is clear that shortly after the deceased commenced to serve his sentence on 2 November 2010 he was known to be terminally ill. The deceased was assessed as being death imminent on 12 November 2010, though when his condition stabilised on 9 December 2010 he was assessed as being a high probability of death.

Policy Directive 8 provides that in those cases where a prisoner's condition becomes end stage, the Manager Sentence Management is to be notified and is required to arrange for correspondence detailing the circumstances of

the case to be prepared for urgent submission to the Minister through the Executive Director, Prisons.

The deceased was classified as Phase 2 – Death Imminent on 24 June 2011.

It appears, however, that it was not until 13 and 14 July 2011 that Ministerial briefings were prepared enabling the Minister to give consideration to the matter.

The reasons for this delay were provided by Mr Ian Johnson, Commissioner, Department of Corrective Services, by letter dated 7 February 2013 which attached a chronology of events. The information provided was further explained by Mr Johnson in a letter dated 11 February 2013 which explained what appeared to be an inconsistency in the timeline.

The chronology of events provided detailed a number of investigations which were undertaken to enable the ministerial briefings to be prepared and explain the delay.

There were certainly a number of complications in this case and a number of issues needed to be addressed.

The purpose of Policy Directive 8 is to ensure that necessary documentation is prepared promptly and will enable decisions to be made while prisoners are still alive.

While the information provided by Mr Johnson explains the delay, the deceased's deterioration in health was not a surprise and it is most unfortunate that all necessary inquiries were not completed sooner.

In this case when the Minister, the Honourable Christian Porter MLA, reviewed the Ministerial briefings he recommended that the sentence be remitted. Sadly for practical reasons the recommendation did not receive Executive Council approval prior to the death.

Delays of this type defeat the entire purpose of the Royal Prerogative of Mercy provisions and the apparent intent of Policy Directive 8. While in this instance the delays were explained and were generally reasonable, this case has highlighted the fact that there can be a number of issues which need to be addressed quickly.

> I RECOMMEND that the Department of Corrective Services review its practices relating to terminally ill prisoners to ensure that in cases where a prisoner's condition deteriorates so death is imminent there are no unnecessary delays in assessing the possibility of early release under Royal Prerogative of Mercy Provisions.

A N HOPE
STATE CORONER
February 2013