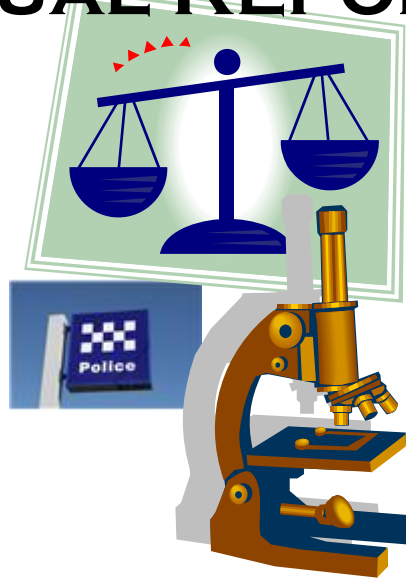


OFFICE OF THE STATE CORONER

ANNUAL REPORT



2009-2010



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The Honourable Christian Porter
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Attorney General

Dear Minister

In accordance with Section 27 of the Coroners Act 1996 I hereby submit for your information and presentation to each House of Parliament the report of the Office of the State Coroner for the year ending 30 June, 2010.

The Coroners Act 1996 was proclaimed on 7 April, 1997 and this is the fourteenth annual report of a State Coroner pursuant to that Act.

Yours sincerely

***Alastair Hope
STATE CORONER***

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State Coroner's Overview

In the year 2009-2010 the number of cases referred for investigation and the number of reportable deaths increased, generally as a result of the population increases across the state.

2,580 deaths were referred to the Coroner's Court, this comprised an increase of 138 deaths over the previous financial year (2008-2009) and 239 additional cases compared with the year before (2007-2008).

The number of deaths ultimately determined to be reportable also increased significantly from 1,776 to 1,860. This number is particularly significant as in respect of each reportable death it is necessary for a coroner investigating the death to make findings pursuant to section 25 of the *Coroner's Act 1996*.

In the year 2009-2010 1,929 findings were completed. While a number of these cases were completed by country magistrates acting as coroners, over 1,400 were completed by the two permanent coroners in Perth. In addition to those cases a considerable number of the cases referred for investigation required finalization by a coroner and a determination as to whether or not the death was reportable.

While there were a number of substantial inquest hearings conducted during the year, none of these were in the category of a "mega" inquest requiring vast resource input.

Additional Resources Provided by Government

Temporary funding was commenced by government on 14 August 2009 in the sum of \$622,000 for additional temporary staff. In addition a one-off payment of \$200,000 was provided for specific purposes. This was the first substantial improvement in the provision of funding for staffing of the Coroner's Court in 13 years and was welcomed by all staff.

Additional funding enabled the appointment of –

1. a dedicated receptionist;
2. a Senior Coronial Counsellor;
3. a medical advisor position (filled by 2 part-time doctors);
4. two counsel assisting (one in addition to previous temporary funding); and
5. a court support officer.



While these additional six temporary staff had limited effect on file closure rates, they provided essential support work to the office.

It was very important to have a dedicated receptionist position created as the Coroner's Court switchboard receives over 1,600 calls per month or approximately 20,000 calls per year. Distressed family members calling in respect of funerals etc expect that most of their telephone calls will be immediately responded to.

The additional position of Senior Grief Counsellor importantly increased the number of counsellors attached to the court to three and enabled some direct counselling to be recommenced in the metropolitan area. While there was no direct provision of counselling to country regions, this improved resourcing enabled the severe cutbacks instigated in 2007-2008 and 2008-2009 to be largely removed.

In those years problems associated with the workload were particularly severe as for periods a second counsellor position was not filled.

The additional temporary positions of counsel assisting and a court support officer enabled some additional inquest preparations to take place although it was not possible to prepare sufficient cases to reduce the backlog of cases to be inquested. Unfortunately changes in staffing and delays associated with replacement significantly reduced the effective benefits of the increased resourcing in this respect.

The \$200,000 one-off payment assisted with addressing the then backlog of cases generally and enabled a reduction of that backlog to be achieved, unfortunately this was largely off-set by the increased number of deaths reported.

During the year decisions relating to the appropriate resourcing of the Coroner's Court were deferred pending a review of coronial practice in Western Australia being conducted by the Law Reform Commission of Western Australia. The Law Reform Commission did not report to government during the year.



Involvement of Relatives

The *Coroners Act 1996* involves relatives of deceased persons in the coronial process to a far greater extent than previously was the case.

The Act requires a Coroner to provide information to one of the deceased person's next of kin about the coronial process in every case where the Coroner has jurisdiction to investigate the death.

In practice the information is contained in a brochure which is provided by a police officer who is also required to explain the brochure. A police officer is further required to record details about the provision of the information on a mortuary admission form which is viewed by the Coroner or a delegate prior to any decision being made about whether or not a post mortem should be conducted.

During the year 1 July 2009 - 30 June 2010 a total of 2,580 deaths were referred to the Coroners Court. In 719 cases a death certificate was issued. Of the remaining 1,860 cases, a total of 138 objections were made to the conducting of a post mortem examination.

In the majority of cases the objection was accepted and no internal post mortem examination was conducted.

In a number of cases the objection was subsequently withdrawn, either immediately or when a Coroner had overruled the objection. In some cases it appears that while family members were at first concerned about a post mortem examination, later the family members realised that it would be important to know the cause of death with reasonable certainty.

Where objections are made, every effort is taken to attempt to ascertain the extent to which a cause of death can be determined without an internal post mortem examination.

It is a rare case in which there are no external factors which would give some insight into a likely cause of death.

The following chart details statistics relating to objections to post mortem examinations for the year. The cases where a death certificate was issued by a doctor not been included.



Deaths Referred to the Coroners Court from
1 July 2009 - 31 December, 2009

	Jul	Aug	Sept	Oct	Nov	Dec	Total
Death Certificate issued although the body was admitted to the Mortuary	0	0	0	0	0	0	0
Immediate post mortem ordered (usually these are homicide cases)	1	1	1	0	1	0	4
No post mortem because body missing etc.	2	6	2	2	3	2	17
No objection to post mortem examination	145	170	130	162	145	153	905
Objection received by the Coroners Court	7	9	6	18	9	15	64
TOTAL NUMBER OF DEATHS	155	186	139	182	158	170	990

Developments in Cases where an Objection was
initially received

	Jul	Aug	Sept	Oct	Nov	Dec	Total
Objection withdrawn prior to a ruling being given by a Coroner	1	2	4	12	3	3	25
Objection accepted by a Coroner and no post mortem ordered	6	7	2	5	5	12	37
Objection over-ruled by a Coroner	0	0	0	1	1	0	2
TOTAL	7	9	6	18	9	15	64



Deaths Referred to the Coroners Court from
1 January 2010 - 30 June 2010

	Jan	Feb	Mar	Apr	May	Jun	Total
Death Certificate issued although the body was admitted to the Mortuary	0	0	0	0	0	0	0
Immediate post mortem ordered (usually these are homicide cases)	0	3	1	0	2	0	6
No post mortem because body missing etc.	2	2	0	0	6	3	13
No objection to post mortem examination	157	119	125	120	134	122	777
Objection received by the Coroners Court	11	13	11	13	15	11	74
TOTAL NUMBER OF DEATHS	170	137	137	133	157	136	870

Developments in Cases where an Objection was
initially received

	Jan	Feb	Mar	Apr	May	Jun	Total
Objection withdrawn prior to a ruling being given by a Coroner	5	3	6	8	6	4	32
Objection accepted by a Coroner and no post mortem ordered	6	9	5	5	9	7	41
Objection over-ruled by a Coroner	0	1	0	0	0	0	1
TOTAL	11	13	11	13	15	11	74



It can be seen from the chart that of the total number of deaths referred to the Coroner's Court there were relatively few objections to the conducting of post mortem examinations.

In the majority of cases where an objection was received the decision which was ultimately made was in accordance with the wishes of the family. There were a total of 138 objections of which 57 were withdrawn prior to a ruling being given by a coroner and 78 were accepted by a coroner and no post mortem examinations were ordered. In only 3 cases where an objection had been received did a coroner order that a post mortem examination should be conducted.

In the vast majority of cases relatives of deceased persons who died suddenly during the year appreciated the importance of a thorough examination of the circumstances of the deaths. In many cases the results of the post mortem examinations provided important information for family members who would otherwise have been left with many unanswered questions surrounding the deaths.

Counselling Service

With the provision of temporary additional funding to the Office of the State Coroner for the 2009/2010 financial year, a Senior Coronial Counsellor position was created. Ms Kristine Trevaskis was the successful applicant and commenced in that position on 11 January 2010. As a consequence Ms Trevaskis' substantive position became vacant and was subsequently filled on a fixed term contract. This additional counselling position now brings the number of coronial counsellors up to three and begins to address some of the capacity constraints that the counselling service has suffered from in the past few years.

Apart from providing counselling and support to bereaved families, the Coronial Counselling Service also has an important role in educating the community about the coronial system and its processes. In the past year a number of presentations have been undertaken including the following:

Victim Support Service Conference – Paper entitled “Responding to Secondary Victims of Homicide.” Attended by metropolitan and regional counsellors.

Bunbury Court Regional Visit – Liaison visit and educational presentation to government and non government agencies on the coronial system.

Disaster Victim Identification Media Briefing – in collaboration with WA Police to members of the print and electronic media.



Australian Funeral Directors Association/Mortuary Briefing – Liaison visit and educational presentation for the funeral industry involving coronial multidisciplinary team members.

In November 2009 one of our counsellors undertook a liaison visit to the Queensland Health Scientific Services facility to meet with coronial counsellors working within that jurisdiction. The Queensland team comprises seven counsellors who provide a similar range of services to those in Western Australia. The major differences are that Queensland counsellors do not provide an after hours on call service as in Western Australia, but they can provide more long term counselling to coronial families than is possible in Western Australia. Due to the fact that there are only 27 counsellors Australia wide that work in coronial jurisdictions, any opportunity to meet with counterparts in other states is always a valuable learning experience.

The Disaster Victim Identification work of the Coroner’s Office continued with the plane crash in the Republic of Congo in June 2010, which took the lives of 4 Western Australian mining executives. In collaboration with the Australian Federal Police and WA Police a coronial counsellor visited each family to facilitate the victim identification interviews. Due to excellent inter-agency cooperation at a state, national and international level, the deceased were identified and repatriated home for funerals in the space of three weeks. This was an outstanding effort given the logistic and access issues which were involved.

On a very sad note, September saw the passing of forensic pathologist Dr Karin Margolius after losing her courageous and long battle with cancer. Dr Margolius was a highly valued and respected colleague and a great supporter of the Coronial Counselling Service. She maintained a close working relationship with all coronial counsellors for over 15 years. Dr Margolius will be sadly missed by all who worked with her.

REFERRALS – CORONIAL COUNSELLING SERVICE
1 July, 2009 – 30 June, 2010

Total New Contacts (Including client self referrals, police and community agencies)	Counselling Provided (Phone, Office and Home)	Letters Sent for Offers of Support	Other Services (Liaison, referral and file viewings)
5,784	3,626	960	1,198



Coronial Ethics Committee

The Coronial Ethics Committee was set up under the auspices of the *Coroners Act 1996* and runs in compliance with the National Health and Medical Research Counsel's guidelines in relation to Ethics Committees.

The Committee requires a detailed written submission in relation to requests for Coronial data. It meets quarterly to consider each request and attempts to strike a balance between family concerns (including privacy, confidentiality and consent issues), and the benefits of research to the community at large. The Committee then makes recommendations to the State Coroner about whether the information should be released and with what conditions.

The Coroner's Court is very grateful for the considerable work done by Ethics Committee members both in reading a large amount of material in preparation for meetings and in giving up their time for the meetings. They are people with many commitments elsewhere and they generously do this on a voluntary basis.

The members of the Committee are as follows:

Dr Adrian Charles	<i>Chairperson</i> Pediatric Pathologist, Princess Margaret Hospital
Associate Professor Jennet Harvey	Department of Pathology, UWA
Dr Celia Kemp	<i>Secretary</i> Lawyer, Coroner's Office
Ms Evelyn Vicker	Deputy State Coroner
Dr Jodi White	Forensic Pathologist, PathCentre
Ms Martine Pitt	Executive Director, Communicare
Mr Jim Fitzgerald	Lay member
Ms Heather Leaney	Lay member
Mr Neville Collard	Aboriginal member

The Committee met 4 times this financial year and has addressed the following new projects as indicated in the table below.

Number of Projects Considered	Number of projects approved	Number of projects not approved
9	8	1



The Committee also considered annual reports and amendment requests from existing projects and made a submission to the NHMRC in relation to a proposal for streamlining ethics processes that require application to multiple ethics committees.

The Committee requires significant Secretarial support which is provided by a Counsel Assisting the State Coroner with administrative assistance from Court officers. This necessarily takes time away from inquest work as these staff members would otherwise be working on the preparation of files for inquest and appearing at inquests.

Counsel to Assist Coroners

Dr Celia Kemp joined the Coroner's Court in November 2009 replacing Mrs Felicity Zempilas as Senior Counsel Assisting.

Mrs Zempilas was appointed as a Magistrate. She was a dedicated worker over many years as Counsel Assisting and we all wish her the very best for the future.

Mr Jeremy Johnston and Mr Scott Schaudin commenced at the Coroner's Court as Counsel Assisting in December 2009 on temporary contracts.

In addition the Police Service continued to provide direct assistance to the Coroner's Court in the form of two police officers, Sergeant Geoff Sorrell and Sergeant Lyle Housieux, whose main duties involved liaison with WA Police in relation to investigations but also appeared in court to assist on a number of occasions. These officers brought a wealth of experience and relevant knowledge to the task.

Inquests

A chart follows detailing the Inquests conducted during the year.

It should be noted that in respect of the reportable cases which are not Inquested, each of these cases is investigated and in every case findings are made by a coroner and a Record of Investigation into Death document is completed detailing the results of the investigations which have been conducted.



INQUESTS FOR THE YEAR 1 JULY, 2009 ~ 30 JUNE, 2010

Name Of Deceased	Date Of Death	Date Of Inquest	Number Of Sitting Days	Coroner	Court Sitting	Finding	Date Of Finding
PARTINGTON Pauline Margaret	5/5/2008	8-10/4/2009	3	State	Albany	Accident	25/8/2009
GORDON Jezelle Lisa	26/2/2006	29-31/7/2009	3	State	Broome	Misadventure	11/9/2009
*LOVELESS Simon	18/8/2007	21-23/7/2009	3	Deputy	Roebourne	Suicide	6/8/2009
MUIR Daureen Faye	8/2/2007	18-20/8/2009	3	State	Perth	Natural Causes	16/9/2009
WILSON William Ross	4/8/2008	27/8/2009	1	Deputy	Albany	Accident	10/9/2009
McKENZIE James Henry	18/7/1984	29/9/2009	1	Deputy	Perth	Accident	1/10/2009
HURLEY Trevor George BEDFORD Lewis Kenneth TAYLOR Robert Wayne	30/12/2007	15-19/10/2009	5	State	Perth	Accident	20/11/2009
WISHART Stephen Frank	25/5/2007	29/10/2009	1	Deputy	Perth	Accident	23/11/2009
HALL Nancy Cloonan	13/1/2008	8/12/2009	1	Deputy	Perth	Natural Causes	22/12/2009
HATHAWAY Craig Anthony	10/4/2009	21/12/2009	1	Deputy	Perth	Accident	21/12/2009
WEST Nathaniel	4/5/2006	11-13/1/2010	3	Deputy	Kalgoorlie	Accident	28/1/2010
McLEVIE Susannah Helen	6/4/2006	8-16/2/2010	7	State	Perth	Misadventure	3/3/2010
HUDSON Allan Kevin	3/8/2006	19-20/1/2010 29/1/2010 03/2/2010	4	State	Perth	Suicide	4/2/2010
HETT Johnathon Garry	2/12/2007	2/2/2010	1	Deputy	Perth	Natural Causes	17/2/2010
*GARDNER Terrence Sydney Graham	15/6/2008	19/2/2010	1	Deputy	Perth	Natural Causes	23/2/2010
FRIEDERICH Pieter Gerhardt	5/5/2006	25/2/2010	1	State	Perth	Unlawful Homicide	25/2/2010
CONWAY Mark Lewis	14/8/2007	9-12/3/2010	4	Deputy	Perth	Misadventure	22/4/2010
*REX Justin Wayne	18/09/2008	23-26/3/2010	4	Deputy	Geraldton	Natural Causes	27/4/2010
*WINMAR Ian Frank	22/8/2008	27-30/4/2010	3	Deputy	Albany	Misadventure	1/6/2010



GRANT Debbie Lynne	3- 24/5/2008	29/4/2010	1	State	Perth	Suicide	4/6/2010
* WONGAWOL Phillip Maitland	17/10/2004	30/4/2010	1	State	Perth	Natural Causes	7/5/2010
JAMES John Richard CHAMBERS Charles Douglas	28/9/2003	3-6/5/2010	4	Deputy	Perth	Accident	24/9/2010
TIMLIN Stanley Hugh PEDERSEN Asgar STOCK Norma Jean STOCK Frank Sydney	18/3/2007	17-28/5/2010	10	State	Carnarvon	Accident	28/5/2010
DARBYSHIRE Glen BUTCHER Matthew LYNE Nathan	2/10/2008 8/12/2008	18-19/5/2010	2	Deputy	Perth	Accident	9/7/2010
DAJEWSKI Leon James	15/5/2003	27/5/2010 8-9/6/2010	3	Deputy	Perth	Accident	6/7/2010
DINGLE Penelope Judith	25/8/2008	9-24/6/2010	13	State	Perth	Natural Causes	30/6/3020
*EGAN Alan	2/3/2008	22-23/6/2010	2	Deputy	Perth	Natural Causes	2/9/2010

Mr Hope heard 13 Inquests 56 sitting days Ms Vicker heard 16 Inquests 35 sitting days	Total Inquests heard 29 Number of Sitting Days 92 6 Prison Deaths In Custody 2 Police Deaths In Custody or presence 9 Country deaths conducted by the State Coroner and Deputy State Coroner
* Death In Custody (DIC)	



The following is a brief summary of a number of inquest findings.

Kieran Darragh WATMORE

Kieran Darragh Watmore (the deceased) died on 28 August 2008 at the Albany Regional Hospital as a result of fatal asphyxia. The inquest was conducted on 21- 22 July 2009 and 26-28 August 2009 at the Albany Court House before the State Coroner.

The State Coroner found that the deceased was an otherwise healthy and robust 17 year old male who had a history of tonsillitis and who attended at Albany Regional Hospital on the early afternoon of 27 August 2008 suffering from a bad case of tonsillitis.

At the time of his attendance at the hospital the deceased had been taking panadeine forte tablets which had not relieved his pain and an order was given by telephone for him to receive patient controlled analgesia in the form of morphine.

The deceased was transferred from the Emergency Department to ward C of the Albany Regional Hospital at 7:25pm that evening where his primary care was provided by Enrolled Nurse Teresa Featon.

The deceased was seen by a medical practitioner, Dr Knight, at 9:30pm, following which he was given penicillin and the level of his patient controlled analgesia in the form of morphine was increased.

The increased level of morphine was commenced at 10pm and at that stage the deceased's oxygen saturation levels were normal at 97% in room air.

The next observations taken at 2am recorded an alarming change in his condition as at that time his oxygen saturation levels had dropped to 88% and his respiration rate had increased from 22 to 26.

After that time it appears that observations were not taken on a regular basis and no further entries were made in the Temperature and General Observation Chart. No doctor was contacted and the deceased was not medically reviewed.

At about 6:55am on that morning, 28 August 2008, the deceased was found collapsed in his bed. It is possible that he had already died and although resuscitation efforts were made, by 7:42am it was clear that he had passed away.

The deceased died as a result of a number of factors which appear to have had a cumulative effect including the severe compromise of his upper airway which resulted from his acute tonsillitis and very swollen



tonsils, the fact that he was receiving relatively high levels of morphine and the fact that as a result of his problems with breathing he may have suffered carbon dioxide retention. These factors together appear to have caused the death by way of fatal asphyxia.

The deceased should not have died when he did and had robust action been taken at the time of his ongoing deterioration which commenced at some time after 10pm on 27 August 2008 and was manifest by 2am, he would not have died when he did.

The State Coroner found that while the evidence revealed a failure by nursing staff to adequately monitor or address a significant deterioration in the deceased's condition which was identified by observations taken at 2am, it also revealed a number of systemic deficiencies which also contributed to the failure to adequately treat the deceased's worsening condition. Several of these systemic deficiencies do not appear to have been restricted to Albany Regional Hospital and exist to a differing extent in other hospitals in Western Australia.

The State Coroner found the death arose by way of Misadventure.

The State Coroner made a number of recommendations as follows –

Recommendation No. 1

I recommend that the Health Department work with hospitals which do not have medical staff on duty at all times and are reliant on nursing staff contacting on-call doctors to ensure that there are in place clear policies or guidelines which will provide guidance to nursing staff as to when to call the on-call doctors and what to do in the event that a doctor is unable or reluctant to attend or cannot attend within a reasonable timeframe. As much as possible the policies and guidelines should be consistent throughout the state.

Recommendation No. 2

I recommend that Albany Regional Hospital review arrangements so far as is practicable to limit the hours worked by medical practitioners and to, if possible, increase the after hours availability of doctors to the hospital.

Recommendation No. 3

I recommend that hospitals throughout Western Australia adopt a policy which would require medical review of any patient who experiences an unexplained drop in oxygen saturations from a relatively normal level to a level of 90% or below.

Recommendation No. 4

I recommend that all hospitals in Western Australia adopt a policy in respect of oxygen therapy to the effect that while no patient is to ever be denied oxygen in an emergency situation and the first attending nurse, midwife, medical practitioner or physiotherapist can administer oxygen without an order, once the patient is stabilised a written order for future oxygen therapy management of the patient is required and that order should be retained at the same location or form part of the medication or drug chart.

Recommendation No. 5



I recommend that for patients given patient controlled analgesia a standard form should be in use throughout Western Australia to record observations. The form should enable multiple entries to be made and record observations such as the rousability score of the patient in addition to vital signs including oxygen saturations as well as recording the infusion rate, bolus amounts given etc.

Recommendation No. 6

I recommend that all hospitals in Western Australia adopt an agreed policy in respect of observations of patients receiving patient controlled analgesia. I recommend that consideration be given to adopting the practice recommended by Dr Pearlman in this regard, namely that there should be full observations conducted on at least a half hourly basis for the first two hours in an opiate naïve patient, decreasing to one hourly for the next two hours and then two hourly for the next four hours, or as determined by the patient's condition. I further recommend that the policy should require the regime to recommence in the event of any significant variation of the dose which could impact on the patient's condition.

The Department of Health Response of August 2010 advised the State Coroner of the following –

Recommendation No. 1

Work on clinical deterioration in WA Health includes the development piloting of an adult observation chart and escalation processes through the WA Country Health Service. WA Health is supporting the implementation of initiatives from the national Recognising and responding to clinical deterioration program currently being coordinated by the Australian Commission on Safety and Quality in Health Care. Planned work will include disseminating clinical deterioration information to Area Health services, establishing a steering group and developing a WA policy for clinical deterioration.

Recommendation No. 4

The Office of the Chief Medical Officer, working in concert with the Respiratory health Network, has developed a state oxygen policy which is currently open for consultation with nursing and medical stakeholders across WA Health.

Recommendation 5 & 6

A draft policy is being developed and will be distributed for consultation upon completion.

Pauline Margaret PARTINGTON

Pauline Margaret Partington died on 5 May 2008 at Albany Regional Hospital as a result of pneumonia and morphine toxicity. The inquest hearing was held at the Albany Court House on 8-10 April 2009 and the findings were delivered by the State Coroner on 25 August 2009.

The deceased was an 88 year old lady who suffered a fall at the aged care facility where she was staying which was unwitnessed on the morning of 4 May 2008.



The deceased was taken from the residential aged care facility to the Denmark Hospital and from there to the Albany Regional Hospital where on the evening of 5 May 2008 she died.

As the deceased was very frail it was considered by medical staff that it was not appropriate to actively treat her in respect of her various injuries and pneumonia and she was treated palliatively.

The deceased was given large quantities of morphine in order to manage her pain and ultimately the deceased died as a result of pneumonia and morphine toxicity in the context of her recent left leg and left arm fracture.

Issues of concern addressed at the inquest included the fact that morphine toxicity was present at the time of death and may have been sufficient to cause death and the fact that amounts of morphine taken from stock did not appear to match amounts written on prescription charts.

While a number of factors contributed to the death, it was the fall suffered by the deceased which necessitated her medical treatment and contributed to her pneumonia and in those circumstances the State Coroner found that the death arose by way of Accident.

The State Coroner made a number of recommendations as follows –

Recommendation No. 1

I recommend that when the Department of Health prints register of drugs books for the purposes of the Poisons Act 1964 (Schedule 8) that consideration be given to including separate columns to record the discarding of Schedule 8 drugs and to allow for a signature to be placed in the book by the person who has discarded the drugs and by a witness to the discard. In the case of the books which have already been printed, I recommend that nursing staff specifically record the fact that drugs have been discarded by making a short entry in one of the existing columns.

Recommendation No. 2

I recommend that the Department of Health adopt a uniform procedure throughout the state that unused Schedule 8 medications which are to be discarded be discarded into a sink, and where this is not practicable due to the layout of the hospital, then into a sharps container.

Recommendation No. 3

I recommend that there be a review of the documentation used to record medications given to patients so that any bolus doses given from a quantity of a medication being provided by way of an infusion can be recorded as such.



The Department of Health responded to the State Coroner's recommendations in the followings terms –

Recommendation No. 1

The approved Drugs of Addiction Register for use in hospitals has been revised to include a discard column (specifications currently being developed).

Recommendation No. 2

It is planned that the Poisons Regulations will be amended to provide for unused Schedule 8 medicines to be discarded in accordance with Recommendation 2.

Findings have been forwarded to the Office of the Chief Nursing and Midwifery Officer for further review.

This matter is ongoing.

Trevor George MURLEY; Lewis Kenneth BEDFORD and Robert Wayne TAYLOR

Trevor George Murley, Lewis Kenneth Bedford and Robert Wayne Taylor died on 30 December 2008 on Great Eastern Highway Boorabbin, all deceased men died as a result of combined effects of smoke inhalation and burns. The inquest hearing was held at the Perth on 5-19 October 2009 and the findings were delivered by the State Coroner on 20 November 2009.

On 30 December 2007 the three deceased men all died when an uncontrolled bushfire crossed the Great Eastern Highway at about 8:45pm. All three men died as a result of the fire.

The fire started on 28 December 2007 in an area of heath/scrub vegetation near a parking bay on the northern side of the Great Eastern Highway, Boorabbin, approximately 85km east of Southern Cross and 104kms west of Coolgardie.

The fire was started by human activity although it is not known whether it was the intention of the person or persons responsible to cause a bushfire. In other words, human involvement, either accidental or deliberate, appears to have been the cause of the fire.

The fire started at or about midday on 28 December 2007 and over the following days was driven by changes in prevailing wind and weather conditions. After initially travelling north of the Great Eastern Highway on the first day, the fire was pushed to the west until 30 December 2007.



On 30 December 2007 the fire was pushed south by changing wind direction causing it to cross the Great Eastern Highway and make an approximate 12km run south of the highway.

At about 8pm on the evening of 30 December 2007 a wind shift to the south-south-west, which had been predicted by the Bureau of Meteorology, resulted in the fire being pushed back across the highway. Coincidentally the fire re-crossed the highway straddling the area in which it had started two days previously.

It was as a result of the fire crossing the highway that vehicles were damaged and the fatalities occurred.

The course of the fire on the evening of 30 December 2007 was predictable and should have been predicted by the Incident Management Team comprising DEC staff. The Incident Controller made a decision to open the road in circumstances where it appears that no attention was paid to available specific and high quality weather information.

The decision to open the highway which was made at about 7:15pm was a very bad one.

The three deceased had been in two trucks stopped at Coolgardie at a roadblock in place as a result of the fire earlier crossing the road and travelled to the fire scene unaware of the extent of potential danger involved in doing so. At the fire zone there were no officials placed in position to warn oncoming motorists and the three men travelled into that zone unaware of the extent of the danger which they faced.

The person (or persons) who was responsible for the initial fire clearly contributed to the deaths and the behaviour of that person (or persons) was inexcusable.

The action of the Incident Controller in opening the highway when he did in spite of the cogent evidence available to him, which should have alerted him to the dangers involved in doing so, also contributed to the deaths.

None of the three Incident Management Team members located in Kalgoorlie paid sufficient attention to the information contained in high quality forecasts prepared by the Bureau of Meteorology specifically for the purposes of fire management at Boorabbin which accurately predicted the fatal wind change. None of those three appears to have appreciated the fundamental importance of doing so. The failure by DEC to ensure that staff forming the Incident Management Team had an adequate appreciation of the need to monitor wind changes at a fire scene contributed to the deaths.



The State Coroner found that the deaths arose by way of Accident.

The State Coroner made the following recommendations –

I recommend that arrangements be put in place for signage to be retained at Norseman and available at short notice to enable motorists to be warned of potential problems existing on the Great Eastern Highway west of Coolgardie.

I recommend that to the extent it has not already done so, DEC take action to ensure that in future cases relevant weather forecast information, particularly information as to significant wind changes, is promptly transmitted through the Incident Management Team and made available to persons with field operation responsibility.

I recommend that if the Bushfires Amendment Bill 2009 is to be enacted, procedures be put in place which would ensure that in the event of an escalating fire, FESA would receive sufficient information to make an informed judgment as to whether or not to take control of all operations.

I recommend that in any consideration being given to the allocation of responsibility for control of operations in respect of major fires, consideration be given to the availability of technology and other resources, particularly when particular skills are required to make best use of such technology or resources.

I recommend that a review be conducted of DEC's ability to manage major fires and consideration be given to increased direct involvement by FESA in fire management role in the case of major fires on reserves or on unallocated Crown lands.

In a letter dated 18 January 2010 the Minister for Police; Emergency Services; Road Safety Leader of the House in the Legislative Assembly responded to the State Coroner's recommendations in the following terms –





**Minister for Police; Emergency Services; Road Safety
Leader of the House in the Legislative Assembly**

Our Ref: 31-06217

PERTH CORONERS COURT

20 JAN 2010

RECEIVED

Ms Dawn Wright
Administrator
Office of the State Coroner
Level 10
30 St Georges Terrace
PERTH WA 6000

Dear Ms Wright

Thank you for your letter of 20 November 2009 seeking advice as to any actions that are proposed to be taken as a result of the Coroner's findings.

I provide the following advice in relation to those recommendations:

1. **Recommend that the arrangements be put in place for signage to be retained at Norseman and available at short notice to enable motorists to be warned of potential problems existing on the Great Eastern Highway west of Coolgardie.**

Following consultation with Western Australia Police and Main Roads Western Australia, a temporary variable sign has been placed in the locality whilst permanent signage is currently being manufactured.

2. **Recommend that DEC take action to ensure that in future cases relevant weather forecast information, particularly information as to significant wind changes, is promptly transmitted through the Incident Management Team and made available to persons with field operation responsibility.**

While this recommendation is primarily directed at the Department of Environment and Conservation (DEC), the Fire and Emergency Services Authority of Western Australia (FESA) has also undertaken a review of its Incident Management Team training. The review, which has commenced, has identified current control measures as well as actions to enhance our procedures. This includes systems to improve distribution of key information to members in field operations. It will also include an appropriate communication plan being established as a priority in major bush fire incidents.

The *Westplan Bushfire* (Emergency Response Plan) – has also been reviewed and implemented by FESA, in collaboration with DEC and the Western Australian Local Government Association, following the implementation of the *Bush Fires Amendment Act 2009*.

The revised *Westplan Bushfire* requires the establishment of multi-agency Incident Management Teams that are appropriate for the level of incident being managed.

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Telephone: +61 8 9222 9211 Facsimile: +61 8 9321 6003 Email: Minister.Johnson@dpc.wa.gov.au



- 3. Recommend that if the Bush Fires Amendment Bill 2009 is to be enacted, procedures be put in place which would ensure that in the event of an escalating fire, FESA would receive sufficient information to make an informed judgement as to whether or not to take control of all operations.**

The provisions of the *Bush Fires Amendment Act 2009* relating to the assumption of control of a bush fire commenced on 1 December 2009. FESA in conjunction with the DEC and local governments has developed standard operating procedures (SOP's) to ensure that FESA is kept informed about escalating fire incidents throughout the State. Part of this SOP is the requirement that all bush fire incidents will be reported to FESA's Communication Centre.

Furthermore, *Westplan Bushfire* requires that the DEC and local governments keep FESA informed of fire activity, and in particular those bushfires that have potential to escalate beyond the routine.

- 4. Recommend that in any consideration being given to the allocation of responsibility for control of operations in respect of major fires, consideration be given to the availability of technology and other resources, particularly when particular skills are required to make best use of such technology or resources.**

FESA is conducting a statewide review of its existing resources on fire management. The revised *Westplan Bushfire* requires that one resource database be developed across all fire agencies and the establishment of multi-agency Incident Management Teams. It is intended that during major operations one State Operation Centre nominated by FESA will be overseeing and coordinating operations in support of all agencies. This will work in concert with the State Emergency Management arrangements.

In addition, the Minister for Emergency Services requested FESA to conduct a review of emergency services communication systems across relevant agencies to identify any opportunity to improve interoperability and to reduce unnecessary duplication.

The review is nearing completion and involved consultation with key stakeholder groups. It is intended the review will identify opportunities or systems that could maximise the ability to communicate and coordinate between emergency services groups and ensure rapid and effective response to incidents.

- 5. Recommend that a review be conducted of DEC's ability to manage major fires and consideration be given to increased direct involvement by FESA in a fire management role in the case of major fires on reserves or on unallocated Crown land.**

Recent amendments to the *Bush Fires Act 1954* via the *Bush Fires Amendment Act 2009* now provide FESA with the authority to take control of major fires (if circumstances require) from both DEC and local governments.

FESA's assumption of control, where an incident has escalated to a major incident or incidents, would involve it taking responsibility for the coordination of all response organisations involved.

In the event FESA does take control of a major bush fire, it would nominate the most competent person (a Bush Fire Liaison Officer or another person) as Incident Controller and that person (regardless of their agency) would have access to a range of powers to effect timely fire control.

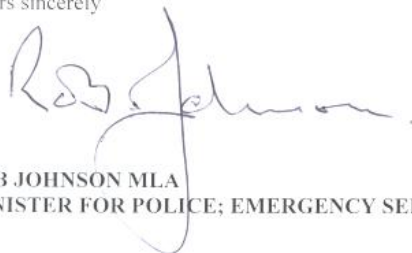


These amendments have introduced clear guidelines and coordinated arrangements to enhance fire management and control of major fires and ensure legislative protection for volunteer fire fighters and DEC personnel.

Importantly, public information is now being managed through one lead agency (FESA) to ensure convenient and accurate community advice.

I trust the above information will assist in the preparation of your annual report. If you require more information or further clarification on any of the issues raised then please contact my Chief of Staff, Mr Richard Lange on 9222-9236 or via e-mail Richard.Lange@dpc.wa.gov.au for assistance.

Yours sincerely



ROB JOHNSON MLA
MINISTER FOR POLICE; EMERGENCY SERVICES; ROAD SAFETY

18 JAN 2010



Nathaniel WEST

Nathaniel West died on 4 May 2006 at Princess Margaret Hospital, Perth as a result of hypoxic ischaemic encephalopathy in an infant who was co-sleeping (bed sharing). The inquest hearing was held at the Kalgoorlie Courthouse on 11-13 January 2010 and the findings were delivered by the Deputy State Coroner in January 2010.

The Deputy State Coroner was satisfied that Nathaniel West (baby West) was a small, eight day old aboriginal baby who had been born on 26 April 2006 via a normal vaginal delivery.

His mother was a teenager. She had a history of substance abuse and had her own health and welfare issues which reduced her ability to care for a new born baby. It was believed she had suffered a seizure and had possible brain damage as a result of her substance abuse. The 14 year old support person sent with Ms West from Warburton Community was inappropriate in all these circumstances.

On the night of the 29 -30 April 2006 Ms West who was then in Kalgoorlie Regional Hospital (KRH) was restless due to pain and irritation. By the time she did settle to sleep it is not unreasonable to infer she would have been quite fatigued. It was recognised she was difficult to rouse once asleep.

The nurses and midwives were busy that shift and baby West was difficult to settle. Staff had attempted to remain with baby West whilst his mother fed him due to the difficulties she was experiencing in effective breast feeding. Once baby West was properly breast feeding staff left the room to attend to other duties.

Baby West was allowed to remain in bed with his mother on at least one occasion while breast feeding and his mother probably dozing.

Thereafter he was left to sleep with his sleeping mother in the same bed. This is co-sleeping.

In 2006 KRH did not have a specific policy in place with respect to the issue of co-sleeping in the hospital maternity ward.

KRH provided separate cots/cribs for babies which could be placed alongside the bed of the mother. This promoted room sharing while sleeping and allowed for proximity of the mother and baby during sleep. However the evidence was that in 2006 co-sleeping was not discouraged in KRH and regularly occurred.



RM Cocks gave evidence she was only at KRH for a period of five weeks and observed co-sleeping was not discouraged in circumstances where she believed it to be undesirable in 2006

The midwives in the maternity ward that night were not aware of all the risk factors relevant to baby West and his mother, but did know of his age and his mother's tendency to be un-rousable once asleep despite baby West crying.

Once the morning shift had taken over from the night shift efforts were made to "catch up" on chores which had been omitted due to the work load overnight. Ms West's antibiotics had not been provided and RM Cocks went to provide Ms West with her antibiotics. She discovered baby West unconscious under his mother's breast.

RM Cocks described baby West as under his mother's right breast while Ms West was on her left side. She believed his face was turned into the mattress but may have been between Ms West's breasts. He was pale, limp and floppy.

All actions taken from that time onward were appropriate. The staff immediately instigated resuscitation of baby West. They were conscientious enough that a heart beat was re-established for baby West and he became perfused. Unfortunately baby West had already sustained irreversible brain damage as the result of a lack of sufficient oxygenation of the blood flow to the brain.

Appropriate transfer of baby West was arranged by WANTS to PMH where baby West received appropriate and ongoing treatment.

Appropriate arrangements were made for relatives to travel from Warburton Community to support Ms West.

Unfortunately the extent of the hypoxic brain injury could not be reversed.

Baby West was removed from life support on 4 May 2006. He died soon after in his mother's arms as a result of the hypoxic brain injury suffered during his asphyxiation while under his mother's breast in the early hours of 30 April 2006.

The Deputy State Coroner found that the death arose by way of Accident.

The Deputy State Coroner made a number of recommendations in the following terms –



1. SIDS and Kids remove the current Safe Sleeping National Brochure from distribution and replace it with one more in line with contemporary medical knowledge with respect to the risks associated with co-sleeping
2. KRH actively promote its own policy based on the Health Department Operational Directive and Clinical Guidelines with respect to safe sleeping practices by way of formal training and education of midwife/nurses to ensure implementation and consistency of education *by example* for its patients.
3. Hospitals be required to show they have implemented the Health Department Operational Directive (139/08), including co-sleeping should be avoided *"if the baby is under 11 weeks of age"*, before they can be accredited as baby friendly.
4. Resources be provided to country hospitals in particular to encourage staff participation in education from either the Health Department with respect to Operational Directive 0139/08 or SIDS and Kids as to safe sleeping practices for babies by way of funding for back filling of staff attending such education.
5. Medical practitioners understand and use terms associated with the sudden and unexpected death of infants (SUDI) with care to promote an understanding of the complexity of issues involved in unexpected baby deaths.
6. Health practitioners avoid the use of the term 'cot death' and show great care in using the term 'SIDS' in order to assist the public in understanding the complex issues involved in unexpected baby deaths.

A response by the Department of Health was received in a report dated August 2010 in the following terms –

WA Health has reviewed the Deputy State Coroner's recommendation and forwarded the inquest finding for consideration and action to –

- SIDS and Kids
- WA Country Health service and Kalgoorlie Regional Hospital
- NMAHS, CAHS & SMAHS Chief Executives
- Office of the Chief Nursing and Midwifery Officer
- Australian Medical Association
- Australian Nursing Federation
- Medical and Nursing Schools (UWA Faculty of Medicine, Dentistry and Health Sciences and Curtin University School of Nursing and Midwifery)

WA Country Health Services WACHS)

The case of baby West has been reviewed extensively by Kalgoorlie Regional Hospital. Action has been taken to ensure that co-sleeping does not occur and the hospital is continuing to work with patients and their families to ensure safe sleeping practices for infants.

Recommendation 1

WACHS has assigned responsibility for removing outdated brochures to the Regional Nurse Directors. An audit across the Regions is to be undertaken to ensure compliance with this recommendation.



Kalgoorlie Regional Hospital has removed current Safe Sleeping National Brochures and replaced these with brochures for indigenous patients, "Reducing the Risk of SIDS" and "Easy Read" for non-indigenous patients.

SIDS and Kids have advised that they have withdrawn the SIDS and Kids Safety Sleeping National Brochure and replaced it with more appropriate resources. WA hospitals and health services have been formally notified by SIDS and Kids WA of the withdrawal of the resources.

The SIDS and Kids National Office have been notified of the inquest recommendations and the National Scientific Advisory Group is conducting a formal review of the safe sleeping resources in October 2010. SIDS and Kids will update the Deputy State Coroner on the review and its progress.

Recommendation 2

WACHS has re-distributed the DoH operational directive on co-sleeping. An audit across the Regions is to be undertaken to ensure compliance with this operational directive.

WACHS has links on its intranet policy site to the WNHS guideline "Strategies to Reduce Sudden Infant Death Syndrome (SIDS)". In addition, WACHS obstetric units abide by the WNHS obstetric and midwifery guidelines.

Kalgoorlie Regional Hospital actively promotes the DoH co-sleeping operational directive. The policy and operational directive are read and signed by all staff and discussed at ward meetings and documented in meeting minutes. Signage is placed through the maternity and labour unit on co-sleeping/bed sharing. A workshop was held in March 2010 conducted by SIDS and Kids WA and attended by 19 midwifery staff.

Recommendation 3

Correspondence has been sent to the Area Health services requesting feedback on how the Operational State wide Policy for Identifying and Responding to Mother Baby Co-sleeping/Bed-sharing in WSA Health Hospitals and Health Services (OD0139/08) has been implemented.

WACHS has undertaken an audit of regional obstetric units in January 2010. This initial audit showed partial implementation of the DoH co-sleeping operational directive across the Regions. A second audit is scheduled to assess compliance.

Kalgoorlie Regional Hospital is accredited as baby friendly and actively maintains the Baby Friendly Hospital Initiative ideals in conjunction with the co-sleeping policy by –

- Supervising breast feeding until mothers are proficient.
- Supervising breastfeeds of women who have had caesarean sections, who are sleep deprived or taking analgesics.
- Reinforcing the co-sleeping policy to parents and placing babies in their own beds or the nursery to sleep.
- Providing information on co-sleeping to patients at antenatal classes as part of the course content and to all women booking into the hospital for birthing.

The Child and Adolescent Health Service have advised that the clinical guidelines developed by the WNHS (Bed-sharing/Co-sleeping : Strategies to reduce sudden infant death syndrome 9SIDS) are utilized for their inpatient maternity beds on the neonatal ward.



In addition, patient's parents are provided with all information required to make an informed choice regarding co-sleeping and for those who choose to share a bed with their baby, to do so as safely as possible.

Information provided to parents includes –

- “Co-sleeping/Bed Sharing Information for Parent” Brochure to reduce the risk of SIDS
- “Four Important Things to Remember” handout
- Summary of research on co-sleeping
- Situations when bed-sharing/co-sleeping is considered high risk
- Safe sleeping in maternity facilities
- Risks and benefits of co-sleeping
- Evidence of co-sleeping and SIDS
- Safety of the physical environment

In the event that a parent chooses to bed-share against medical advice this is documented in the medical record.

North Metropolitan Area Health Service have advised –

Swan Kalamunda Health Service follows the WNHS policy on co-sleeping. Staff on both the maternity ward and paediatric ward have been advised of this directive and policy requirements. In addition, on the paediatric ward where a parent co-sleeps against medical advice and hospital policy, staff immediately notifies the treating consultant. Whilst rare, in cases where this has occurred, Consultant instruction has been to affix monitor to the infant.

Osborne Park Hospital is implementing posters to go on the side of baby cots for safe sleeping (as per SIDS Guide). Posters are already on display in the dining room and bedrooms in three languages. Pamphlets are given to all mothers (available in three languages).

In addition, night shift staff does hourly checks on all patients to observe for overall safety and watch for co-sleeping. At ante-natal classes education is provided on safe sleeping. Osborne Park Hospital has a co-sleeping policy in place that is currently being reviewed and updated.

The WNHS/KEMH has in place a policy and clinical guidelines on co-sleeping (10.2.5.1. Bed-sharing/Co-sleeping).

South Metropolitan Area Health Service have advised –

Rockingham General Hospital has a Mother and Baby co-Sleeping/Bed Sharing policy in place which was developed inline with the statewide operational directive and which is followed in the obstetric and paediatric units.

The paediatric/neonatal policies at Fremantle Hospital are in line with the recommendations on co-sleeping/bed sharing. Fremantle Hospital follows the KEMH policy.

At Kaleeya Hospital (Fremantle Hospital Health Service) the hand held pregnancy record will be revised and updated with safe sleeping information consistent with wording at KEMH. Information will be made available for parents and consideration will be given to include safe sleeping information in the patient information booklet.



A the "Maternity Matters" training day (education for midwives) scheduled for August up to date (verified) information will be shared with all the staff attending. KEMH guidelines will be integrated into the presentation. In addition, the clinical pathway for vaginal births trial includes a section on co-sleeping and SIDS information.

At Armadale Health Service –

- SIDS and Kids have presented in-service on the maternity unit twice in the last 18 months
- All mothers are given a copy of the KEMH pamphlet on co-sleeping after birth
- A copy of the KEMH guideline on co-sleeping has already been prominently displayed for the last two months. All staff on the unit have been asked to familiarise themselves with it and sign that they have done so
- Policy stating that Armadale Health Service complies with the operational directive, with a link to the KEMH guidelines is to be presented at the Women's Health Review Group and the Paediatric Review Group, which can then sit in policy manual
- Mention of co-sleeping (and discouragement of same) to be soon to be a printed brochure on "Having a Baby at Armadale Health Service".

Susannah Helen McLEVIE

Susannah Helen McLevie (the deceased) died on 6 April 2006 at Sir Charles Gairdner Hospital as a result of Streptococcus Group A Septicaemia Post Partum-Puerperal Sepsis. The inquest hearing was held at the Perth Coroners Court on 11 & 13 January and 8-16 February 2010 and the findings were delivered by the State Coroner in 3 March 2010.

The State Coroner concluded that the deceased was a 38 year old healthy woman who died following childbirth as a result of untreated Streptococcus group A infection.

The bacterial infection from which she died is susceptible to antibiotic therapy, including penicillin therapy. The State Coroner observed that it is remarkable that in the 21st Century an otherwise healthy woman should die in a metropolitan hospital from a bacterial infection without having received any antibiotic therapy.

By 3am on 5 April 2006, only about three hours after the birth, the deceased had a fever of 38^oC and this alone could have been a trigger for the prescription of antibiotic therapy.

At 6:50am the deceased had a temperature 38.7^oC and by 7:10am she was experiencing such pain that she was prescribed morphine. It was the State Coroner's view that it is clear that the deceased should have been provided with antibiotic therapy at this time and the hospital should have had in place guidelines to encourage provision of such treatment.



At the time of the ward round at about 8am conducted by the consultant, Dr Rowlands, it appears that these issues were not adequately addressed. According to Dr Rowlands had he been adequately informed as to the two high temperatures, he would have instituted antibiotic therapy.

From the time of the ward round until the time when the deceased was taken from Osborne Park Hospital at 2:30am her condition deteriorated as the group A streptococcal septicaemia from which she was suffering became more advanced and was not treated.

It appears that a series of individual errors and system inadequacies contributed to this wholly unnecessary death of an otherwise healthy woman.

Osborne Park Hospital clearly failed the deceased.

There were a litany of errors in this case. Dr Simon Hockley, Director of Intensive Care at Calvary Wakefield Hospital in South Australia, who reviewed the case, described it as "...a truly sad and distressing case of preventable death" and identified at least 14 instances of what he characterised as system failures. In addition there were many failures on the part of individual health professionals. Many of these failures contributed to the death.

In the context where the deceased died from a very treatable condition in circumstances where treatment should have been provided the State Coroner found that the death arose by way of Misadventure.

The State Coroner made a number of recommendations as follows –

Recommendation No. 1

That consideration be given to the appointment of obstetric registrars who would actually be on site so that at no stage would the most senior doctor present at the Hospital be a resident.

Recommendation No. 2

That the Osborne Park Hospital Medical Emergency calling criteria be available in a laminated document placed at strategic points within the hospital.

Recommendation No. 3

That training for both medical and nursing practitioners should provide greater focus on appreciation of the significance of vital sign observations and a proper understanding of the criteria which constitute a medical emergency

Recommendation No. 4

That the Osborne Park Hospital review its systems relating to the involvement of registrars to ensure that registrars take a close supervisory role in relation to inexperienced resident medical officers and involve themselves in the treatment of all unwell patients.



Recommendation No. 5

That there be a review of the puerperal pyrexia guidelines in place in Osborne Park Hospital to ensure that when an otherwise healthy mother gives birth to a baby and subsequently has an elevated temperature of 38°C or more on two occasions separated by a significant period of time, there is immediate introduction of appropriate antibiotics.

Recommendation No. 6

That the Osborne Park Hospital review its protocols and procedures to ensure that there is an immediate response to concerning observations which reflect a significant deterioration in a patient's condition.

Recommendation No. 7

That training for both medical and nursing practitioners should provide greater focus on the importance of accurate and complete communication of significant changes in patients' conditions to senior practitioners. In particular I recommend that the training of resident medical officers should include a component focused on effective communication with registrars and consultants.

Recommendation No. 8

That the Health Department take action to improve the training of nursing staff to ensure that there is consistency in the recording of both Integrated Progress Notes and Nursing Observations. In respect of Integrated Progress Notes, it appears that the common practice is that the time entered in the margin relates to the time of the making of the note. If this is the commonly used practice of nursing staff, in my view it should be mandated so that there is uniformity in that regard.

In respect of the taking of Observation Records I recommend that the Health Department take steps to ensure that Nurses are alert to the importance of recording the actual time of the taking of observations in the date/time column of the documentation.

The Department of Health responded to the State Coroner's recommendation in a report dated August 2010 in the following terms –

WA Health has reviewed the State Coroner's recommendations and forwarded the inquest findings for consideration and action to –

- ✚ Director of Clinical Services Osborne Park Hospital;
- ✚ Chief Nursing and Midwifery Officer
- ✚ Women's and Newborns Health Network;
- ✚ Royal Australian College of Obstetricians;
- ✚ State-wide Obstetric Support Unit;
- ✚ Area Health Services [review of puerperal pyrexia guidelines]

Recommendation No. 5

Child and Adolescent Health Service has informed that Princess Margaret Hospital (PMH) has three inpatient maternity beds associated with the Neonatal Unit (Ward 6B). The clinical guidelines developed by the Women and Newborn Health Service (WNHS) with respect to puerperal pyrexia are utilised on Ward 6B. PMH does not accept unwell, including febrile, mothers, but if those on Ward 6B became unwell they would be transferred to King Edward Memorial Hospital (KEMH) for treatment. The guidelines and processes developed for patients



care on Ward 6B affords assurance that steps have been taken to meet the recommendations arising from the McLevie inquest.

North Metropolitan Rea Health Service have advised the following –

The WNHS/KEMH have reviewed the State Coroner's report of the McLevie case and are reviewing the KEMH clinical guidelines 9.2.1 on puerperal pyrexia in line with evidence and coronial recommendations.

KEMH are also developing an early warning system alert for inclusion on observation charts to be trialled following endorsement by clinicians. This is also in response to the state-wide/national work around observational charts in general.

KEMH has also reviewed the Code Blue response system which is in place for occasions where patient deterioration requiring resuscitation occurs and an external department team response is actioned.

KEMH has also nominated a representative/s to the local (WA) clinical deterioration project group facilitated by the OSQH.

Osborne Park Hospital has updated their guideline in May 2010.

Swan/Kalamunda Health Service follows the WNHS policy on puerperal pyrexia which complies with the respective recommendations. Staff on the maternity ward have been advised of the guidelines and are aware of the policy requirements.

The WA Country Health Service (WACHS) has advised that all obstetric units abide by the WNHS evidence based obstetric guidelines including that on puerperal pyrexia. In addition, while the guidelines are being reviewed by the WNHS, the WACHS Clinical Lead for Obstetrics and Gynaecology has been asked to review the inquest summary and determine the need for any further action pending release of the revised guidelines.

South Metropolitan Area Health Service have advised –

All Obstetric staff at Rockingham General Hospital have been made aware of the coronial report and a puerperal pyrexia guideline has been developed and endorsed by the Obstetric, Gynaecology and Neonatal Committee, final endorsement will be provided in August followed by immediate implementation.

The KEMH guidelines are used for management of puerperal pyrexia at Kaleeya Hospital, who plan to undertake an audit against the guidelines.

Fremantle Hospital Health Service (including Kaleeya Hospital) does not currently have any RMO's in the maternity unit. There are Obstetric Registrars who only currently cover in hours. Out of hours the clinical load and decision making sits on the shoulders of the midwives, the coordinator and the after-hours nurse manager to make contact as needed with the on call obstetrician. Kaleeya Hospital is following up the handover communication guidelines in order to optimise the information that is passed from midwife to obstetrician (or other consultant i.e. neonatologist).



Kaleeya Hospital has recently reviewed their deterioration (Medical Emergency Team (MET) Call) guidelines and is considering implementing that all midwives/staff wear the MET guidelines on their lanyards. On the back of the MET guidelines are the handover communication guidelines.

Training sessions i.e. "In-Time" is conducted four times per year at Kaleeya Hospital and attempts are made to ensure that all midwifery staff have the opportunity to attend. Other disciplines also attend including medical staff, theatre staff and the after hours nurse managers. Major components of the In-Time training area communication and teamwork. Other training for staff, including maternity staff, are safety skills day including ALS, BLS and MET training sessions.

Kaleeya Hospital has reviewed documentation standards and identified that this matter needs addressing. The new clinical pathway for vaginal births will assist with encouraging staff to identify variances and plans of action to address them.

Armadale Health Service has no policy at present on management of puerperal sepsis, but has a default policy stating that KEMH guidelines should be used in the absence of an Armadale Health Service specific policy.

The usual practice is for blood cultures, FBC and swabs as appropriate to be taken if a patient becomes febrile post delivery. Patients who become febrile are routinely treated as possible sepsis until excluded.

An Armadale Health Service specific policy on management of puerperal sepsis is to be discussed and passed through the Women's Health Review Group.

The obstetric emergency training "In Time" course is run at Armadale Health Service four times a year. Part of this course deals with communication during emergencies, and situational awareness.

Staff development midwives currently present in service education on the importance of documentation, one component of which is accurate recording of observations on observation charts, to enable visualisation of "trends".

At Armadale Health Service GP Obstetricians and Specialist Obstetricians are on call for 24 hours a day, but not required to be on site. A MET team is available, but have limited (or no) obstetric experience.

ONGOING.

Allan Kevin HUDSON

Allan Kevin Hudson (the deceased) died on 13 August 2006 in the grounds of Sir Charles Gairdner Hospital, Nedlands as a result of Ligature Compression of the Neck (Hanging). The inquest hearing was held at the Perth Coroners Court on 19-20 January 2010 and 29 January 2010 and 3 February 2010 and the findings were delivered by the State Coroner in 4 February 2010.



The deceased was a 20 year old man who had been a voluntary patient at Sir Charles Gairdner Hospital.

The deceased was a very troubled young man who had substantial psychosocial problems. It appears that he did have temporal lobe pathology which may have contributed to his experiencing difficulty managing his emotional health and personality development.

In addition a female partner of the deceased died approximately two months prior to his presentation at Sir Charles Gairdner Hospital.

The deceased had an extensive history of substance abuse, recurrent depressive symptoms, recurrent suicidal thoughts and behaviour and a history of antisocial behaviour.

It appears clear that the deceased was alert to the dangers associated with his own condition and it was as a result of this that he had contacted Quairading Hospital on the evening of 23 July 2006 requesting admission to Graylands Hospital.

Unfortunately there were no vacant beds at Graylands Hospital and he was taken to Sir Charles Gairdner Hospital Emergency Department and was subsequently admitted as a voluntary patient at Ward D20 of that hospital.

While he was at Ward D20 the deceased exhibited significant fluctuations in mental state, with a wide range of emotions including rage, fear, depression and emotional withdrawal. He began talking about suicide and his plans to act upon that, particularly from 12 August 2006.

On or before 11 August 2006 it appears that the deceased obtained a hose from a garden section within the ward which he subsequently left outside the ward at a suitable location for future use as a ligature.

Over 12 August and 13 August 2006 the deceased's mental state varied but he regularly expressed self-harm ideation and spoke of a deterioration in his own mood.

The deceased was seen by two on-call medical practitioners, Dr Stone and Dr Hussain, both of whom were concerned as to his condition but did not consider it was then appropriate to make arrangements for him to become an involuntary patient, which would have necessitated his transfer to a different hospital.



On the morning of 13 August 2006 Dr Hussain instituted 30 minute observations of the deceased which were intended to ensure that he was seen on at least 30 minute intervals and that on at least these occasions there would be some endeavour taken to ensure that he was safe.

During the afternoon of 13 August 2006 it appears that the deceased spent a considerable period asleep in his bed as a result of the medications which he had recently been given.

At some time on the later afternoon or evening of 13 August 2006 the deceased left Ward D20, obtained the hose which he had previously placed outside the ward and hanged himself from a foot bridge located nearby. At the time the deceased was not being subjected to the regular observations ordered by the medical practitioner earlier that day. It appeared that the death took place prior to 8pm on the evening of 13 August 2006.

An issue at the inquest related to the fact that records of the ward recorded that the deceased had been seen at 8pm in his bedroom and his Medication Chart initially recorded that he had received medications at 2000 hours (although that entry was subsequently crossed out) when it appeared that he was dead outside the hospital at that time.

The State Coroner found that the death arose by way of Suicide.

The State Coroner made a number of following recommendations –

Recommendation No. 1

That the Health Department conducts a review of the process for providing medications to mental health patients to ensure that patients do receive medications at about the times ordered and the time of the provision of the medications is accurately recorded in the medication charts.

Recommendation No. 2

That the observations chart be altered so that the time column not contain pre-entered times, but that the nurse should enter the actual time when the patient has been observed.

Recommendation No. 3

That an additional column be inserted in the observations chart to record actual observations made of the patient by the nurse conducting the observations

Recommendation No. 4

That a copy of the Nursing Guidelines relating to nursing observations be retained at the same location where the observations charts are located on the ward and that the nursing observations chart be amended by adding a brief reference to the importance of ensuring that on close observations the designated nurse must be able to satisfy himself or herself that the patient is safe.



Recommendation No. 5

That the Health Department review the practicalities associated with conducting high quality observations of at risk patients to ensure that there is consistency in nursing practice in that regard and to reduce unnecessary inconvenience in the conducting and recording of the observations.

Recommendation No. 6

That in all future plans for mental health units there be provision for authorised beds and the construction of the units should be such that staff are able to monitor all persons entering or leaving the ward

The Department of Health responded to the State Coroner's recommendation in a report dated August 2010 in the following terms –

The recommendations will be referred to the recently established Department of Health Mental Health Operations Review Committee to consider what actions are to be taken in regard to the recommendations.

At the time of publishing this report a response from the Department of Health Mental Health Operations Review Committee had not been received.

Debbie Lynn GRANT

Debbie Lynn Grant (the deceased) died between 3 May and 24 May 2008 in Lesmurdie. The inquest hearing was held at the Perth Coroners Court on 29 April 2010 and the findings were delivered by the State Coroner in 4 June 2010. The State Coroner found that the deceased died of a Acute Drug Toxicity.

The State Coroner concluded that the deceased was a 47 year old intellectually disabled woman who died alone in her home.

The State Coroner also concluded that in the context of the post mortem findings it appeared that the deceased consumed a fatal quantity of fluvoxamine tablets which had been prescribed for her at some time between 3 May 2008 and 24 May 2008.

Unfortunately it appears that the deceased, who had suffered from an intellectual disability, mental illness and had limited ability to cope with problems, had been alone at the time of her death.

It was a most unsatisfactory situation where such a vulnerable person was left alone and the community care service provider charged with the responsibility of her care, Tia Tremills trading as Carealot South Metro, did not make efforts to contact her between 6 May and 24 May 2008.



That unsatisfactory situation largely resulted from a failure on the part of the Commonwealth to provide any effective guidance or supervision to Ms Tremills either directly or indirectly through the Australian Red Cross and then Carealot Home Health Services Pty Ltd.

As the death was unwitnessed and the date of death unknown it could not be now determined whether or not the failure to provide respite care was a factor in the death, but it was also not possible to exclude that possibility.

The State Coroner found that the death arose by way of Suicide.

The State Coroner made the following recommendations –

Recommendation No. 1

That if the Commonwealth wishes to continue to outsource services such as the provision of home respite services, that it puts in place simple procedures which would ensure that providers satisfy basic safety requirements and are aware of and bound by contractual obligations requiring compliance with responsibilities of a service provider and clearly outline the functions and services to be provided. Ideally the Commonwealth should deal directly with service providers to ensure compliance with appropriate requirements. In the event that arrangements with suppliers are to be outsourced or brokered, however, rules need to be in place which would require adequate monitoring of the services actually being provided and the entering into of appropriate agreements, binding on service providers.

The State Coroner also made a comment in the following terms –

In the context of the present case it is important that all Commonwealth Respite and Carelink Centres, including Australian Red Cross, ensure that any Service Agreements are entered into with legal entities correctly identified in the documentation and that the agreements are executed in accordance with current law. Individual Service Agreements should be entered into with each service provider and in the case of franchise arrangements, with each individual franchisee.

A response was received from the Hon Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs dated 19 July 2010 in the following terms -





**The Hon Jenny Macklin MP
Minister for Families, Housing, Community Services
and Indigenous Affairs**

Parliament House
CANBERRA ACT 2600

Telephone: (02) 6277 7560
Facsimile: (02) 6273 4122

19 JUL 2010

MC10-010390

Ms Dawn Wright
Administrator
Office of the State Coroner
Level 10 Central Law Courts
30 St George's Terrace
PERTH WA 6000

PERTH CORONERS COURT

22 JUL 2010

RECEIVED

Dear Ms Wright

Thank you for your letter of 4 June 2010 about the Western Australian State Coroner report into the death of Mrs Debbie Lynn Grant.

I have noted the findings of the Western Australian State Coroner in relation to the death of Mrs Grant and recognise the personal tragedy involved in this case.

Since the tragic death of Mrs Grant in May 2008, the Commonwealth Government has implemented, or is in the process of implementing the following measures:

- *The Guide for Community Care Service Providers on how to respond when a community care client does not respond to a scheduled visit* was released on 11 September 2009 and has been distributed to community care service providers, including Commonwealth Respite and Carelink Centres. It provides guidance about what local service providers should do when confronted with a situation where a care recipient does not respond when visited by a service provider. The Guide directs community care service providers to put their own policies and procedures in place for when clients do not respond to a scheduled visit.
- A trial is planned for a new intake and needs assessment approach in a small number of Commonwealth Respite and Carelink Centres. The trial will test whether the new assessment approach effectively establishes the needs of clients and refers them to appropriate services. The assessment covers a range of physical, emotional and mental wellbeing factors to identify risks, supports and appropriate responses for clients.

The new assessment approach will promote consistent processes across all Commonwealth Respite and Carelink Centres. As part of this, personal information will be collected and stored electronically to enable client care needs and contact details to be shared easily and quickly between service providers. Printed and electronic information will minimise the risk of incorrect information about clients being shared between service providers and an electronic format will allow information to be easily updated.



- As part of the Commonwealth Government's continuous program improvement, a major evaluation of the Targeted Community Care (Mental Health) Program, including the Mental Health Respite (MHR) initiative has been completed. My Department will be undertaking a further review of the MHR initiative to explore other options for respite service delivery models. These options will incorporate the insights about carer needs and priorities for the initiative that have emerged over time.

The Commonwealth Government continues to require Commonwealth Respite and Carelink Centres to:

- comply with the National Respite for Carers Program National Service Standards;
- participate in the Quality Reporting Program; and
- adhere to relevant Commonwealth Government guidelines, including the Centre Guidelines.

The Commonwealth Government will strengthen the brokerage arrangements in the Funding Agreements with Commonwealth Respite and Carelink Centres in relation to service provision obligations, managing relationships with service providers, staffing and qualification checks, improving assessment of need and sharing of information, and moving to a more evidence-based approach to quality reporting.

The Commonwealth Government aims for continuous improvement in quality of service provision in all its community care programs. To this end, my Department in conjunction with the Department of Health and Ageing, are carefully considering the findings and their implications for current and future arrangements.

Thank you again for writing.

Yours sincerely



JENNY MACKLIN MP



Frank Sydney Stock, Norma Jean Stock, Stanley Hugh Timlin and Asgar Pedersen (Norma Jean Vessel)

Frank Sydney Stock, Norma Jean Stock, Stanley Hugh Timlin and Asgar Pedersen (the deceased) all died on 18 March 2007 at Carnarvon following a collision in their recreational boat with a 85 metre long barge anchored directly in the path. The inquest hearing was held at the Carnarvon Courthouse on 17-28 May 2010 and the findings were delivered by the State Coroner on 28 May 2010.

The State Coroner concluded that all deceased persons died as a result of their injuries sustained in the crash.

The State Coroner further concluded that the collision resulted from a hazardous situation caused by an unlit barge anchored at night on a heading used by many persons to reach popular fishing destinations.

The major factor in the fatal collision was the fact that the barge was unlit, however, it appears that even if the barge had been lit as intended with two anchor lights, those lights would have been inadequate in the circumstances.

The fatal collision could have been prevented if Sea-Tow Limited, the owner of the barge, had taken more positive action following the "Alfred" tragedy in New Zealand and had ensured that the hulls of its barges were illuminated or at least more visible, particularly when anchored overnight at locations regularly traversed by boats.

The collision would have been prevented if the crew of the tug had better monitored the barge lighting and if checks of that lighting had been conducted at least nightly.

It was also apparent that the collision may not have occurred if the lighting had not failed or if there had been a backup system of powering the batteries, assuming generator failure leading to battery failure was the cause of the light failure, or there had been other lights powered by different sources, for example, solar lighting.

The State Coroner found that a further significant factor in the collision was the fact that the Harbour Master, in determining the anchor positioning for the barge, was not aware of and did not take into account activities of local recreational fishers, he did not advise the tug Master of the fact that there could be fishing traffic in the area or, if the barge was to be located in the way of many recreational fishers, require that additional safety precautions be taken such as requiring the tug to stand by the barge at periods when recreational fishers would be likely to be leaving the boat harbour in darkness or requiring the barge's floodlights



be illuminated and in that event that regular checks be made to ensure the reliability of the generators and lighting.

The State Coroner found that the deaths all arose by way of Accident.

The State Coroner made a number of recommendations as follows –

Recommendation No. 1

That the Department of Transport make appropriate representations with a view to amendments taking place in the *International Regulations for Preventing Collisions at Sea 1972* so as to require improved standards of lighting of large vessels at anchor and in particular so that the regulations require some illumination of the hulls of unmanned barges of substantial length.

Recommendation No. 2

That action be taken by the Department of Transport to amend Port By-Laws so that for every port in Western Australia those By-Laws require unmanned barges to be lit in ways which would enable the hulls to be visible or identifiable.

Recommendation No. 3

That the Department of Transport ensure that any certificate of survey provided in respect of an unmanned barge of substantial size require in the special conditions that the barge have the ability to illuminate its hulls while at anchor and have additional lighting to that presently required in accordance with the Prevention of Collisions at Sea Regulations 1983.

Recommendation No. 4

1. That suitable anchorages be identified in each port within Western Australia by the relevant Harbour Master for use by large and other vessels.
2. That the anchorages be identified in consultation with professional and recreational fishers and other users of the port.
3. That the Department of Transport make an appropriate submission to request changes to the Admiralty Sailing Directions which contain the Australian Pilot Documentation to ensure that the anchorages so determined are clearly identified within the Australian Pilot Documentation.

Recommendation No. 5

That the Department of Transport take steps to improve systems available for communication with fishers and users of Western Australian waters in consultation with organisations such as Carnarvon Sea Rescue and the Bureau of Meteorology.

Consideration should be given to means of communicating with recreational fishers in addition to those now available such as in the case of the Carnarvon Boat Ramp placing a sign close to the boat ramp, used by almost all recreational fishers, on which the existence of any identified hazard could be stated.

Recommendation No. 6

That the Department of Transport communicate with and support local water safety organisations like Carnarvon Sea Rescue so that a 24 hour service can be provided which can take calls and relay important information to those on the water or about to go out.



Recommendation No. 7

That the Department of Transport promote the availability of red lights or other lighting which does not detract from night vision for recreational vessels

The State Coroner received a letter dated 23 June 2010 from the Hon Simon O'Brien MLC, Minister for Transport; Disability Services in the following terms –





Minister for Transport; Disability Services

Hon. Simon O'Brien MLC

PERTH CORONERS COURT

24 JUN 2010

RECEIVED

Our ref: 29-13844

23 JUN 2010

Ms Dawn Wright
Administrator
Office of the State Coroner
Level 10, Central Law Courts
501 Hay Street
PERTH WA 6000

Dear Ms Wright

State Coroner - Inquest into the Deaths of Frank Stock, Norma Stock, Stanley Timlin and Asgar Pedersen

Thank you for your letter dated 31 May 2010 enclosing the Coroner's Findings regarding the circumstances surrounding the deaths of Frank Stock, Norma Stock, Stanley Timlin and Asgar Pedersen.

The Department of Transport (Transport) has carefully considered each of the seven recommendations made by the Coroner. Please find comments below relating to each recommendation.

Recommendation No. 1

I recommend that the Department of Transport make appropriate representations with a view to amendments taking place in the *International Regulations for Preventing Collisions at Sea 1972* so as to require improved standards of lighting of large vessels at anchor and in particular so that the regulations require some illumination of the hulls of unmanned barges of substantial length.

Transport accepts Recommendation No. 1: correspondence has been entered into with the Australian Transport Safety Bureau (ATSB) and Australian Maritime Safety Authority (AMSA) with a view to seeking AMSA intervention at International Maritime Organisation (IMO) to amend rules 22 and 30 relating to light requirements for vessels.

13th Floor, Dumas House, 2 Havelock Street, West Perth Western Australia 6005
Telephone: +61 8 9213 6400 Facsimile: +61 8 9213 6401 Email: Minister.Obrien@dpc.wa.gov.au



Recommendation No. 2

I recommend that action be taken by the Department of Transport to amend Port By-Laws so that for every port in Western Australia those By-Laws require unmanned barges to be lit in ways which would enable the hulls to be visible or identifiable.

Transport accepts Recommendation No. 2: Regulations pursuant to S12 (1) (a) and S12 (1) (aa) will be developed to require additional lighting in appropriate circumstances as either a condition of entry or subject to the direction of the Harbour Master.

Recommendation No. 3

I recommend that the Department of Transport ensure that any certificate of survey provided in respect of an unmanned barge of substantial size require in the special conditions that the barge have the ability to illuminate its hulls while at anchor and have additional lighting to that presently required in accordance with the Prevention of Collisions at Sea Regulations 1983.

Transport does not accept Recommendation No. 3: to comply with this Recommendation all vessels would have to be re-surveyed and new certificates issued (at a substantial cost to industry). Additional surveys will be required to determine compliance, which would necessitate travel, scheduling and other expenses over and above routine activities.

This would be a complex and costly process for little benefit beyond that which could be achieved through the implementation of Recommendation No.2.

Recommendation No. 4

- 1. That suitable anchorages be identified in each port within Western Australia by the relevant Harbour Master for use by large and other vessels.**
- 2. That the anchorages be identified in consultation with professional and recreational fishers and other users of the port.**
- 3. That the Department of Transport make an appropriate submission to request changes to the Admiralty Sailing Directions which contain the Australian Pilot Documentation to ensure that the anchorages so determined are clearly identified within the Australian Pilot Documentation.**

Transport accepts part of Recommendation No. 4: not all ports have the frequency or size of traffic to warrant the identification of individual anchorages. In many cases it is sufficient to designate roadstead (a partly



sheltered anchorage outside of a harbour). However, to clarify the purpose of a roadstead, it is proposed to amend the Western Australian series charts to contain an appropriate notation alerting mariners to the possibility of vessels anchored in the vicinity. The Western Australian local boating guides and the West Australian Cruising Manual can also be amended to carry this advice.

Similarly, the Hydrographer will be advised of those ports which have a significant level of recreational boating activity and will be requested to amend the notations in the Australia Pilot Volume 1 to advise mariners accordingly. Additionally, the Hydrographer will be requested to make a notation against roadsteads on appropriate AUS series charts to advise mariners to expect recreational boating activity in these areas. This has already been done in respect of Carnarvon.

Recommendation No. 5

I recommend that the Department of Transport take steps to improve systems available for communication with fishers and users of Western Australian waters in consultation with organisations such as Carnarvon Sea Rescue and the Bureau of Meteorology.

Consideration should be given to means of communicating with recreational fishers in addition to those now available such as in the case of the Carnarvon boat ramp placing a sign close to the boat ramp, used by almost all recreational fishers, on which the existence of any identified hazard could be stated.

Transport accepts Recommendation No. 5: will hold discussions with Fire and Emergency Services Authority of Western Australia (FESA), Bureau of Meteorology (BoM) and volunteer organisations with a view to reviewing existing communications systems to optimise communications and ensure notifications, information and warnings are timely and appropriate.

Transport is reviewing 'at ramp' notifications and will examine methods to improve communication in the pre-launch situation.

Recommendation No. 6

I recommend that the Department of Transport communicate with and support local water safety organisations like Carnarvon Sea Rescue so that a 24 hour service can be provided which can take calls and relay important information to those on the water or about to go out.

Transport accepts part of Recommendation No. 6: will review its existing communications with volunteer organisations State-wide and will also consider extending its volunteer marine officer program into the Gascoyne to enhance safety awareness amongst boaters.



Additionally, Transport will discuss with FESA the potential for enhanced Volunteer Marine Rescue (VMR) coverage and the means by which it might be achieved. VMR services are funded by FESA so it is appropriate that they be involved.

Recommendation No. 7

I recommend that the Department of Transport promote the availability of red lights or other lighting which does not detract from night vision for recreational vessels.

Transport accepts Recommendation No. 7: will promote the installation and use of red lighting for night vision in its summer safety campaigns as well as discussing with manufacturers the possibility of fitting red cabin lighting at the point of sale.

Transport will also continue to promote the wearing of properly designed and fitted lifejackets.

Thank you for the opportunity to provide comment on the Coroner's Findings.

Yours sincerely



SIMON O'BRIEN MLC
MINISTER FOR TRANSPORT



Penelope Judith DINGLE (nee Brown)

Penelope Judith Dingle (the deceased) died on 25 August 2005 at Paull's Valley Road, Kalamunda. The inquest hearing was held at the Perth Coroner's Court on 9-24 June 2010 and the findings were delivered by the State Coroner on 30 July 2010.

The State Coroner found that the deceased died as a result of complications of metastatic rectal cancer.

On 25 February 2003 the deceased had a colonoscopy which confirmed a rectal tumour. She was referred to Professor Cameron Platell by Dr Trevor Claridge on 27 February 2003.

Professor Platell examined the deceased on 27 February 2003 and discussed with her the findings of the colonoscopy and biopsy. He advised that if the cancer was localised to just the rectal area she should have a course of adjunctive pre-operative chemotherapy and radiotherapy, followed by surgery to remove the cancer and reconstruct the bowel.

The advice given by Professor Platell was excellent and the quality of care which he offered to the deceased was of the highest order.

Unfortunately the deceased did not accept the treatment plan offered by Professor Platell.

In respect of pre-operative chemotherapy and radiotherapy the deceased, together with her partner Dr Dingle, (who was not medically trained) were reluctant from the outset. In the case of the deceased her reluctance to undergo chemotherapy and radiotherapy resulted, at least in part, from the fact that Professor Platell had explained that such treatment would remove the possibility of her being able to have children in the future, something she very much wanted. In the case of Dr Dingle the State Coroner was convinced that he was opposed to chemotherapy because of a past unfortunate experience in his own life and had for some time, and continued to have, a generally negative view of that form of treatment.

Initially after receiving the advice about the cancer the deceased and Dr Dingle were open to the possibility of surgical intervention, although they both looked into the possibility of alternative treatments.

In May 2003 the deceased underwent an MRI scan and on 14 May 2003 Professor Platell reviewed her condition in the context of a report on that scan. At that stage Professor Platell believed that the MRI did not clearly demonstrate a metastatic pattern and there was, for example, no tumour spread to the liver. At that stage Professor Platell still believed that the deceased had a realistic chance to survive her cancer and wished to look at a curative approach to her management.



Sadly in the period April and May 2003 it appears that the deceased decided to reject the mainstream treatment offered by Professor Platell and turned to homeopathic remedies offered by Mrs Scrayen. The State Coroner was satisfied that Mrs Scrayen did convince the deceased that the homeopathy treatment which she was providing could provide a cure for her cancer.

Mrs Scrayen was not a competent health professional. The State Coroner accepted that Mrs Scrayen had minimal understanding of relevant health issues, unfortunately that did not prevent her from treating the deceased as a patient.

In the months of April, May and June 2003 the deceased became increasingly reliant on Mrs Scrayen and by July 2003 she was in contact with her almost every single day. By this stage the relationship between the deceased and Mrs Scrayen had gone far beyond a normal patient/health provider relationship and the deceased had become increasingly dependent on Mrs Scrayen.

The deceased's condition continued to deteriorate over July, August and September 2003 until by October 2003 she was close to death. At that stage she was suffering from a complete bowel obstruction and when she was finally taken to Fremantle Hospital on 12 October 2003 she would have been unlikely to have survived for more than 24 hours without surgery.

In spite of extreme surgery of the highest quality performed on 12 October 2003 by Professor Platell, it was not possible to remove all of the cancer and so the procedure was essentially a palliative operation, in that there was still residual tumour left in the pelvis.

After the surgery the deceased recovered to a significant extent, but the cancer was too advanced and on 25 August 2005 caused her death.

While the cause of death, rectal cancer, was a natural cause, the deceased's life might have been saved if she had made different choices. As time passed from 31 October 2001, when she was reporting blood in her stool to Mrs Scrayen, until 12 October 2003, when she was taken to Fremantle Hospital and received emergency surgery, the deceased's cancer developed and spread and her chances of survival diminished from very good to being non-existent.

Apart from receiving limited and inadequate pain relief the deceased did not receive any medical treatment from a mainstream medical practitioner over the latter part of this period and relied on the treatments provided by Mrs Scrayen.



The State Coroner made comments on public health and safety issues in the following terms -

Informed Consent

This case has highlighted the importance of patients suffering from cancer making informed, sound decisions in relation to their treatment. In this case the deceased paid a terrible price for poor decision making.

Unfortunately the deceased was surrounded by misinformation and poor science. Although her treating surgeon and mainstream general practitioner provided clear and reliable information, she received mixed messages from a number of different sources which caused her to initially delay necessary surgery and ultimately decide not to have surgery until it was too late.

Alternative Medicine Practitioners

Evidence at the inquest revealed that homeopathic remedies are sold in pharmacies in Western Australia and homeopathic practitioners, such as Mrs Scrayen, have affiliation with private health insurance companies.

In a context where health costs are increasing at an alarming rate and private health insurance companies struggle to meet the full costs of procedures, medications and hospital beds, it is a matter of concern that funds which could be allocated to such fundamental health needs are being allocated to non-science based alternative medicine practitioners.

The State Coroner made a number of recommendations as follows –

Recommendation No. 1

That the Commonwealth and State Departments of Health review the legislative framework relating to complimentary and alternative medicine practitioners and practices with a view to ensuring that there are no mixed messages provided to vulnerable patients and that science based medicine and alternative medicine are treated differently.

The State Coroner went on to comment on –

Medical Practitioners providing complimentary and alternative medicine

In this case the choice for the deceased should have been a simple one between accepting the surgical option offered by Professor Platell or facing a painful death. That choice was made more difficult because the deceased was offered other “alternatives”.

While doctors Barnes and Tabrizian both made it clear to the deceased that they favoured her undergoing surgery, both offered alternative treatments which added to the confusion of the situation.



The State Coroner noted that the Medical Board of Western Australia has prepared a draft document titled Complementary Alternative and Conventional Medicine which provides guidance to medical practitioners in relation to when they may recommend unproved or experimental treatments. It is important that this document be finalised, if this has not already been done, and communicated to medical practitioners.

In this context the State Coroner made the following recommendation –

Recommendation No. 2

That the Medical Board of Western Australia finalise its document Complementary Alternative and Unconventional Medicine if it has not already done so and take steps to ensure that the document is promulgated to the profession and complied with.

Reference to Disciplinary Body – Section 50 of the *Coroners Act 1996*

In this case neither Dr Barnes nor Dr Tabrizian caused or contributed to the death. The State Coroner was satisfied that both doctors recommended that the deceased undergo surgery and that her decision to reject mainstream treatment until it was too late did not result from any advice or action on the part of either doctor. The State Coroner, however, did consider it appropriate to refer the evidence received relating to the actions of the two doctors concerned to the Medical Board of Western Australia.

Dr William Barnes

The State Coroner commented that it was a matter of concern that Dr Barnes offered the deceased intravenous carnitine and vitamin C treatment in circumstances where she was suffering from an aggressive form of cancer and required surgery. The State Coroner was particularly concerned that Dr Barnes told the deceased that these treatments had the potential to stop her tumour growing.

Dr Igor Tabrizian

In the case of Dr Tabrizian the State Coroner was satisfied that Dr Tabrizian did provide the deceased with at least some nutritional advice and may have performed hair analysis as claimed by her.

The State Coroner, however, was concerned that Dr Tabrizian saw the deceased, an extremely unwell patient, and did not take adequate notes of the attendances. The State Coroner was particularly concerned that Dr Tabrizian does not appear to have requested access to the deceased's colonoscopy results or MRI scan. He did not take a detailed history from her or examine her or even suggest adequate monitoring. He did not ask questions about other doctors whom she may have been seeing or make efforts to contact them.



The State Coroner was concerned that Dr Tabrizian did not appear to have been acting as a doctor normally would in his treatment of the deceased and the State Coroner did have some difficulty understanding in what capacity he considered that he was seeing her.

The Department of Health responded to the State Coroner's recommendation in a report dated February 2011 in the following terms –

Legal and Legislative Services Division have provided the following feedback with respect to –
recommendation one:

Health practitioner registration in WA:

- WA does not have legislation that provides for registration or disciplinary mechanisms in relation to complimentary or alternative medicine practitioners.
 - WA is party to a new National Registration and Accreditation Scheme for ten health professions, which will be expanded to include another four health professions from 1/7/2012. Inclusion of additional health professionals in the National Scheme:
 - Australian Health Ministers (as the Ministerial Council) make the decision to include additional health professionals in the National Scheme.
 - The process was set out by the Intergovernmental Agreement (IGA) for a National Registration and Accreditation Scheme for Health Professionals (National Scheme) signed by the Commonwealth and all State and Territory Governments (COAG) 26/3/2008.
 - The IGA requires that the AHMAC1 "criteria for assessing the need for statutory regulation of unregulated health occupations" be applied to submissions from health professionals seeking to be registered under the National Scheme.
 - In addition, Health professionals are also required to develop their own nationally-consistent registration proposal for consideration by the Australian Health Workforce Ministerial Council. Unregistered Health Practitioners
 - In February 2010 the Ministerial Council agreed that a national consultation be undertaken to assess whether additional public protection measures are required nationally in relation to health services delivered by health practitioners not registered under the National Scheme.
 - The national consultation is being run by Victoria on behalf of the Health Workforce Principal Committee, which reports to AHMAC.
 - Homeopathy is one of the modalities to be included in the consultation paper (due for release early 2011 following approval from the Ministerial Council).
 - The national consultation will consider:
 - o The need to strengthen regulatory protections for consumers with respect to the services provided by unregistered health practitioners.
 - o If further public protection measures are required, what these should be and how they should be structured and administered.
 - The national consultation is intended to include a forum in WA in April 2011.
 - Practitioners who may be affected by these regulatory processes include homeopaths, naturopaths and western herbalists (amongst many others).
- Given WA is a signatory to the ICA, which provides for the National Scheme it is not envisaged that WA will take any action on legislative reform in this area until an outcome



is reached following the national consultation on unregistered health practitioners. The Minister for Health as a member of the Ministerial Council would be involved in the decision making process regarding legislative reform.

Correspondence has been sent to the Medical Board of WA (then to the Australian Health Practitioner Regulation Agency) with respect to recommendation two.
Nil response to date.



Deaths In Custody

An important function of the Coronial System is to ensure that deaths in custody are thoroughly examined. Section 22 of the Coroners Act 1996 provides that an Inquest must be held into all deaths in custody.

Pursuant to section 27 of the Coroners Act 1996 the State Coroner is required to provide a specific report on the death of each person held in care. The following contains reports on Inquests held during the year into deaths in care together with charts detailing the position of all deaths in care during the year.

Inquests – Persons Under Care of a Member of the Police Service

The definition of a **“person held in care”** includes the case of a person under, or escaping from, the control, care or custody of a member of the Police Service. Section 22(1)(b) of the Act provides that a Coroner who has jurisdiction to investigate a death must hold an Inquest if it appears that the death was caused, or contributed to, by any action by a member of the Police Service.

Pieter Gerhardt FRIEDERICH

Pieter Gerhardt Friederich (the deceased) died on 5 May 2006 on Labourchere Road, South Perth. The inquest hearing was held at the Perth Coroner’s Court on 25 February 2010 and the findings were delivered by the State Coroner on 12 April 2010.

The State Coroner concluded that the deceased was a wholly innocent victim who was killed by Glenn Brown who at the time was driving a stolen motor vehicle in an extremely dangerous manner in an effort to avoid apprehension by police.

The deceased was driving a Daihatsu Sedan in a northerly direction on Labouchere Road in a safe manner when the stolen Commodore Sedan travelling on the incorrect side of the carriageway collided head on with that vehicle.

The driver of the Commodore Sedan was subsequently convicted of manslaughter in relation to the death and in that context the State Coroner found that the death arose by way of Unlawful Homicide.

In this case the police vehicle reached a speed of 140kph, 80kph over the applicable speed limit, without any specific approval being given by the Police Operations Centre.



The State Coroner expressed concerns that the applicable WA Police Policy and Guidelines only required such approval if 140kph was exceeded, irrespective of the applicable speed limit, presence of school zones, carparks, areas frequented by children and the elderly or other circumstances which could make such a speed inadvisable.

The State Coroner made a recommendation in the following terms –

Recommendation No. 1

That consideration be given to amending the instructions for the guidance of police members undertaking emergency driving so that they contain an instruction that the maximum speed obtained by any police vehicle should not exceed a specified speed in excess of the statutory speed limit of the location unless permission to exceed that speed be obtained from a commissioned officer or an acting commissioned officer.

The State Coroner received a response from Mr Rob Johnson MLA, Minister for Police, Emergency Services; Road Safety dated 24 May 2010 in the following terms –





Minister for Police; Emergency Services; Road Safety
Leader of the House in the Legislative Assembly

Our Ref: 31-08375

RECEIVED

7 MAY 2010

PERTH DISTRICT COURT

Mr Alastair Hope
State Coroner
10th Floor, Central Law Courts
501 Hay Street
PERTH WA 6000

Dear Mr Hope

Thank you for your letter of 19 April 2010 concerning your recommendation contained in the findings from the inquest into the circumstances surrounding the death of Pieter Gerhardt Friederich.

The Western Australia Police have advised that the agency has reviewed and considered your recommendation.

WA Police acknowledge that high speed driving and vehicle pursuits involve risks to the offender, the general public and the police officers involved. These risks must be assessed against the public benefit and reasonable expectations that Police will provide a proportionate response in order to prevent crime, ensure public safety and apprehend offenders.

The debate surrounding police pursuits centres on the balance between the potential dangers to public safety and the benefits of the pursuit, including the apprehension of offenders. The time, place and circumstance of any incident will therefore dictate whether police are required to pursue offenders.

I am advised that WA Police actions in relation to pursuits are regulated by the WA Police Urgent Duty Driving Policy, which has recently been reviewed and updated. The new policy, entitled Emergency Driving Policy and Guidelines, defines four distinct categories and places an emphasis on the safety of officers and the community. The policy defines the risk assessment process that accompanies Emergency Driving together with the continual oversight and situational reporting which will occur during these incidents.

WA Police have advised that this new policy becomes operational on 1 July 2010 and will ensure a balance between Police actions, community expectations and the ongoing safety of police officers and road users.

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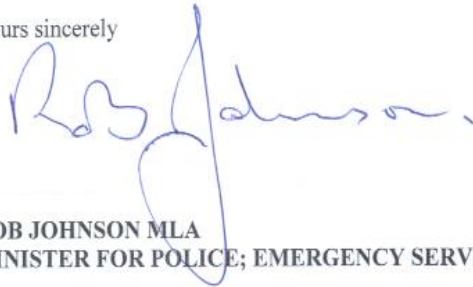


I am advised that given the dynamic and changing nature of policing, WA Police consider that the recommendation as specifically outlined would not be practical in application and operation.

I understand that a copy of the new WA Police Emergency Driving Policy and Guidelines have been provided to you for your information.

I trust the above information is of assistance.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Rob Johnson', written over a faint circular stamp.

**ROB JOHNSON MLA
MINISTER FOR POLICE; EMERGENCY SERVICES; ROAD SAFETY**

24 MAY 2010



Mark Lewis CONWAY

Mark Lewis Conway (the deceased) died on 14 August 2007 at Fremantle Hospital. The inquest hearing was held at the Perth Coroner's Court on 9-12 March 2010 and the findings were delivered by the Deputy State Coroner on 22 April 2010.

The Deputy State Coroner found that the deceased died as a result of Acute Methylamphetamine Toxicity.

The Deputy State Coroner was satisfied that the deceased was a 49 year old male with underlying moderate coronary vessel disease despite his fit physical appearance.

Since the death of his father he had been in a position to use amphetamines as a drug of choice without financial restriction. There are many recorded cases of fatal cardiac arrhythmia arising out of even moderate methylamphetamine use in situations of exertion such as marathon cycling or other physically strenuous activity.

On 14 August 2007 the deceased purchased in the vicinity of 27 grams of methylamphetamine. It is difficult to say with precision how much exactly there was on Ms Sheiner's description of a golf ball/ping-pong ball size of wet sticky substance. Ms Sheiner, with the deceased, used some of that methylamphetamine and she confirmed the effect on her was that of amphetamines, however, she thought it may not have been as strong as some she had used.

After that use, sometime before noon, I am satisfied the deceased exhibited bizarre behaviour on the way to the police lock-up to sign his bail undertaking. It was the evidence of friends of the deceased he had exhibited that sort of behaviour more frequently in the last few weeks. The deceased was exhibiting some drug induced psychosis, however, no-one seems to have thought to have the deceased assessed during one of these periods of apparently bizarre and paranoid behaviour. He was not known to the local Community Mental Health Unit at Alma Street.

At approximately 1:20pm the deceased attended at the police station. He was either able to mask his behaviour or was past the effect of his earlier use as there appears to have been a lull in his extreme behaviour. He was observed shortly thereafter to be again behaving bizarrely. Part of his bizarre behaviour appears to have been of compulsive chewing or eating. It seems likely the deceased had consumed more of the amphetamines observed by Ms Sheiner earlier in the day.

As a direct result of the deceased's bizarre behaviour, which witnesses deemed placed both the deceased and others at risk on a busy road, the police were asked to attend to deal with the situation.



The first two police constables tasked with attending at South Terrace were Constables Saxina and Giftakis. Both officers were junior in policing and neither had Taser training or psycho-stimulant awareness. Constable Giftakis thought, given the circumstances, there may well be a need for a Taser competent component and asked for back-up from officers with Taser qualification. As a result Constables Montgomery and O'Toole also attended at the scene. Again these two police officers were relatively inexperienced, however, both had completed Taser training.

On sighting police, who were obviously interested in him, the deceased absconded. How serious this was is a matter of conjecture, however, on the evidence from his friends I have no doubt he had little intention of letting the police apprehend him before he had disposed of the drugs secreted on his person.

A short pursuit ensued which resulted in the deceased falling on the central median strip in South Terrace and caused superficial injury to his face. The deceased's one purpose on being caught by the police appears to have been concealment of the drugs on his person by ingestion.

On the description given by Mr Avino the deceased was determined to place any remaining amphetamines in his mouth before the police could prevent that action. None of the police observed the deceased place a package in his mouth.

Constables Montgomery and O'Toole reached the deceased seconds behind Constables Giftakis and Saxina and attempted to assist in handcuffing the deceased who was struggling fiercely. This is entirely consistent with the reported behaviours of people under the influence of methylamphetamine although the police officers did not understand the deceased was under the influence of a psycho-stimulant.

Constable Montgomery realised there was something in the deceased's mouth and attempted to remove it, believing it may be drugs. She eventually managed to remove some pieces of plastic from the deceased's mouth and a substance which she believed to be food. She viewed the package as more like that of a sandwich bag and with the evidence of food matter assumed she had been mistaken about the ingestion of drugs. She was consequently less anxious about the deceased's condition.

None of the four police officers had received training about the effects of psycho stimulant use and had no reason to believe they may be about to experience a medical emergency associated with the consumption of drugs. Most of the civilian witnesses believed the deceased was either drug affected or a mental health patient.



The position of the deceased on the median strip and the efforts he was making to throw the police officers aside in his endeavours to escape gave the officers' cause for concern there may be a spill over into the roadway which could cause a traffic accident.

Constable O'Toole made a decision to use his Taser. He consciously removed the cartridge to use it in drive stun mode which he believed to be necessary for control of the deceased. At the time he made this decision the deceased had one handcuff on his left arm and was struggling violently with a view to apparently escape, rather than to harm. This does not alter the fact an unsecured handcuff can cause considerable harm.

The Deputy State Coroner was satisfied that, despite difficulty in being able to verbalise his training, Constable O'Toole was putting his training into practice appropriately.

While the police officers were a little hazy about the powers under which they were acting, it is clear that in the circumstances with which they were confronted, which involved complaints and concerns from members of the public about the deceased's, and other road users' safety, they needed to contain the situation before properly appreciating the full circumstances. In an ideal world it would be preferable the exact circumstances surrounding his detainment were explained to the deceased, however, it would seem to have been a somewhat difficult goal to achieve on the median strip. At the time the deceased appeared to be healthy and his actions in attempting to walk away from the van can hardly be called bizarre, leaving the police officers with little alternative but to take him to the lock-up for further assessment.

The police officers did not understand he had ingested a fatal quantity of drugs and the very close hospital would be a preferable option.

The police left the scene and returned to the police station within minutes. It would seem during the course of the journey the deceased suffered a cardiac arrhythmia and vomited quite copiously. The fact the deceased had collapsed was not detectable until he was removed from the rear of the police van, still breathing, but in an obviously distressed state.

From that time he was monitored, an ambulance called and resuscitation commenced the minute it appeared he had stopped breathing. The Deputy State Coroner did not believe any more could have been done by that point in time.

The forensic pathologist examining the medical circumstances of the deceased's demise was quite clear the commencement of the chain of events was the extraordinarily high level of methylamphetamine in the deceased's system. This was despite not all of the drug having been absorbed at the time of his death, as evidenced by his stomach contents



and drugs found in substance cleared from his airways in the lock-up. It is difficult to separate out the all pathways contributing to the death in that it is possible airway obstruction caused by his vomit may have exacerbated his circumstances. The Deputy State Coroner was satisfied it was the ingestion of the excessive amount of drug in a system which was already drug affected, which precipitated his death.

The Deputy State Coroner did not believe the deceased intended to die, merely conceal the drugs.

Further, the Deputy State Coroner speculated that the transporting of the deceased directly to hospital, if the police officers had understood the potential for the imminent emergency, would not have assisted the deceased's survival. The level of amphetamine in the deceased's system, for which there is no reversant treatment, did not bode well for his prognosis. Methylamphetamine/amphetamine overdoses cannot be treated by way of reversing the effect of the drug. The support provided in an ICU environment consists of treating the symptoms and hoping they are by that support brought under control. If they cannot be controlled then death will result.

The Deputy State Coroner found death arose by way of Misadventure.

Inquests – Deaths In Care – Department for Corrective Services

During the year 5 Inquests were conducted into the deaths of persons who died while in the custody of the Department for Corrective Services.

The following chart details the position in respect of all deaths in care since January 2006 where the deceased was either in prison custody or there was police involvement.



Date of Death	Date of Inquest	Name of Deceased	Custody	Place of Death	Finding
26/7/2007		McDONALD Charles Edward	Prison	Hakea Prison	
14/8/2007	9-12/3/2010	CONWAY Mark Lewis	Police	Sally Port Fremantle Police Station	Misadventure
26/8/2007	5/6/2009	GALLOP Benjamin Ivan Bryan	Police	Bush track Boulder	Accident
18/8/2007	14-16/7/2009	LOVELESS Simon John	Prison	Roebourne Regional Prison	Suicide
27/1/2008	10-20/3/2009 11-14/5/2009	WARD Ian	Prison	Transported in Prison van from Warburton to Kalgoorlie	Open Finding
28/4/2008		BRENNAN Declan John Paul	Prison	Acacia Prison	
15/6/2008	19/2/2010	GARDINER Terrence Sydney Graham	Prison	RPH	Natural Causes
1/6/2008		NJAMME Dennis	Prison	Greenough Regional Prison	
22/8/2008	27-30/4/2010	WINMAR Ian Frank	Prison	Albany Regional Prison	Misadventure
18/9/2008	23-26/3/2010	REX Justin	Prison	RPH	Natural Causes
20/9/2008		TUCKER Alan Murray	Prison	Casuarina Prison	
9/10/2008		MORATO Henrique Gregory	Prison	Hakea Prison	
7/11/2008		MILLER Matthew James	Police	Chase at Munster	
20/11/2008		HIGGINS Jarrod	Police	Chase at Koondoola	
14/8/2008		SHEEHY Andrew Michael Brian	Prison	Casuarina Prison	
30/12/08		NJANA Hendrik (a)	Police	Broome Lockup	
3/7/2009		NEBRO Daniel Rowley	Prison	Bunbury Prison	
14/8/2009		SHEEHY Andrew Michael Brian	Prison	Casuarina Prison	
24/9/2009		NEUMANN Karl	Prison	Hakea Prison	
2/11/2009		TJOE Matthew	Police	Victoria Park	
25/11/2009		DOYLE Blake Michael	Prison	Hakea Prison	
13/12/2009		HERBERT Troy	Police	Lesmurdie	
19/1/2010		JAMIESON Sandy	Prison	Albany Regional Prison	
8/2/2010		SAMSON Keannita	Police	Port Hedland	
14/2/2010		WILLIAMS Brian William	Prison	Albany Regional Prison	
14/3/2010		WOODS Deon David	Police	Perth Watch House	
21/3/2010		KIMOTO Ayumi	Prison	Hakea Prison	
22/3/2010		WINMAR Grantley Ross	Prison	Acacia Prison	



A brief summary of deaths which occurred in the care of the Department of Corrective Services and which were inquested follows –

Simon LOVELESS

Simon Loveless (the deceased) died on 18 August 2008 at Roebourne Regional Prison (RRP) as a result of Ligature Compression of the Neck (Hanging). The inquest hearing was held at the Roebourne Court House on 21-23 July 2009 and the findings were delivered by the Deputy State Coroner on 6 August 2010.

The Deputy State Coroner was satisfied that the deceased was a 32 year old single male facing the prospect of his first term of imprisonment. He appeared to have been somewhat of a loner, or at least fairly selective about his social and domestic situation, and the prospect of a term of incarceration may well have been particularly daunting.

He was on remand at RRP for the second time. These had been his only two experiences of imprisonment. He gave the impression of having been very frustrated and disappointed with himself for having put himself in the position of breaching his prior suspended prison term. He told medical staff the reason for his rampage on 14 August 2007 was a failed suicide attempt at the prospect of imprisonment after having breached his suspended prison term by an offence on 11 August 2007, for which he had received bail.

The Deputy State Coroner was satisfied his CCO officer in Newman was concerned with the deceased's behaviour and attempted to persuade him to return to Nullagine rather than stay in Newman to ensure he remain offence free. However, for whatever reason the deceased on 14 August 2007, instead of returning to Nullagine, allegedly attempted to take his life with a mixture of alcohol and what he believed were sleeping tablets but turned out to be anti-depressants. He claimed he could remember nothing about his behaviour until he awoke in a police cell.

This appears to have been a very active suicide attempt and was clearly an indicator of his vulnerability to impulsive self harm while at large in the community. The CCO in Newman contacted RRP on 15 August 2007 to advise them the deceased would be presenting and was in a distressed state of mind. The Operations Manager informed both PCS and Reception to expect the arrival of the deceased and when he arrived on the afternoon of 16 August 2007 he was placed on ARMS, and reviewed by nursing staff who confirmed ARMS status. It was late and the deceased was placed on an interim management plan.



He was placed in the maximum security yard, however, was in a single cell under normal conditions with four-hourly observations. This appeared to work quite well.

In the morning the deceased needed to finalise his health checks and while that occurred his situation was discussed by PRAG. It was decided he would remain on ARMS but his final status was to be determined after assessment by PCS.

As a result of the deceased's discussion with the Prison Counsellor Ms Lohf, it was recommended he remain as a moderate risk on ARMS but be doubled-up as form of protection over the weekend when he would not have access to Ms Lohf. Attempts were made to put this into operation, however, the only reasonable accommodation of a double-up system had to be in Unit 2. The deceased was resistant. It was decided by the Operations Manager to return the deceased to Unit 1, which he stated was his preference.

Ms Lohf, aware of his recent suicide attempt, was concerned and tried to persuade the deceased to change his mind. He was adamant he did not want to be in a double-up system and preferred Unit 1, which realistically was much quieter than Unit 2. This was not perceived as suspicious in the circumstances.

Ms Lohf certainly explained to the deceased she was concerned as to his welfare and, if he were to remain in Unit 1, would only sanction it if he went into a safe cell at night. The deceased was not happy, however, appeared to prefer the concept of a safe cell overnight to sharing a cell with another prisoner.

The deceased was placed in a safe cell overnight for 17 - 18 August 2007 and was apparently not comfortable with that regime even though he was given normal cell conditions during the day. Ms Lohf believed, in hindsight, the deceased may have had a plan, however, the Deputy State Coroner was not convinced his situation was quite so clear. He seemed to be fairly positive in his responses to people and his environment once back in the day regime.

The Deputy State Coroner noted Ms Lohf had observed the deceased seemed to be "picking" as though in association with a substance abuse problem. While she accepted the deceased no longer had any amphetamines in his system and claimed not to have used amphetamines for three months, the Deputy State Coroner also noted he had consumed an excessive amount of alcohol on 14 August 2007 and certainly appears to have been somewhat melancholic over the rest of that week.



The Deputy State Coroner believed Ms Lohf was correct when she decided she was not confident as to his mood, but also concerned to give him the best possible environment for improving his mood by adapting her care regime for him to one with more freedom during the day when he could interact with other people.

Unfortunately it was this attempt to treat the deceased with some compassion and provide him with a more therapeutic environment which appears to have exacerbated his fluctuating mood.

The Deputy State Coroner found that during the day of 18 August 2007 the deceased began to consider his position and his prospects for a period of incarceration. The Deputy State Coroner suspected he again contemplated suicide. Knowing he would be unable to complete that in the safe cell, his option for the next night, she speculated he began to look around opportunistically for means to achieve his purpose. He considered the coaxial cord would suit his purpose, however, there were no obvious hanging points in his day cell and he moved to the day room. Having then located a suitable hanging point he fashioned his suicide note and implemented the plan he had now formed.

The Deputy State Coroner found that sometime after 1:15pm the deceased took the coaxial cord from his cell and went into the day room and suspended himself from the bars in the day room. He was not located until approximately 2:15pm when Mr Murray went to make a drink. Unfortunately too much time had by then elapsed to allow the deceased to be successfully resuscitated although the Deputy State Coroner was satisfied everything was done that could be done to resuscitate the deceased, had it been possible.

The Deputy State Coroner found death occurred by way of suicide.

The Deputy State Coroner recommended the following –

- (i) Department of Corrective Services investigate the desirability of a Special Purpose Unit somewhere in the Northwest of the State (RRP would seem to be reasonably central) which can be adapted to accommodate prisoners requiring different care regimes to ensure their safety.
- (ii) Department of Corrective Services ensure appropriate transfer from regional lockups or prisons to and from that facility.
- (iii) In any event funding be provided to RRP to ensure adequate CCTV monitoring of all special and general use areas of the prison.



The Department of Corrective Services responded to the recommendation by letter dated 18 February 2010 in the following terms –

**DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE
TO THE FINDINGS OF THE CORONER
INTO THE MANNER AND CAUSE OF DEATH OF
MR SIMON JOHN LOVELESS**

Background

The Deputy State Coroner held an inquest into the death in custody of Mr Simon John Loveless at Roebourne Court House on 21 – 23 July 2009, and released her findings on 6 August 2009.

Mr Loveless, a 32 year old remand prisoner, died in Roebourne Regional Prison (RRP) on 18 August 2007 of an apparent suicide. At approximately 2.15pm, Mr Loveless was discovered suspended from metal bars by a coaxial cord in the day room of the maximum security area, Unit 1, of RRP.

On 14 August 2007, whilst in the community, Mr Loveless attempted to take his own life. The following day he appeared before the Newman Magistrate's Court and was remanded in custody until 21 August 2007. Information regarding his suicide attempt was relayed to RRP by his Community Corrections Officer.

Mr Loveless was received at RRP on 16 August 2007 and was placed on the At Risk Management System (ARMS) in Unit 1 on 4 hourly observations. The following day he met with the Prison Counselling Service (PCS), who recommended he remain on ARMS but be transferred to a double up cell. Mr Loveless refused this placement so arrangements were made to place him in a safe cell overnight and a normal cell during the day to enable him access to facilities.

On the morning of 18 August 2007 Mr Loveless was moved to a normal cell and entered the day room, which is out of the line of sight from the control room of Unit 1 and does not have CCTV coverage. He was discovered hanging by another prisoner. Resuscitation attempts were unsuccessful and life was declared extinct at 3:44pm.

Findings

Mr Loveless died as a result of Ligature Compression of the Neck (hanging) and death arose by way of suicide (page 24 of the Coroner's Report refers)¹.

Comments and Recommendations on Supervision, Treatment and Care

The Coroner's report concluded the following in relation to the management of Simon Loveless while at RRP:

1. Loveless was identified to be at risk and placed on ARMS. "The Operations Manager informed both PCS and Reception to expect the arrival of the deceased and when he arrived on the afternoon of 16 August 2007 he was placed on ARMS, and reviewed by nursing staff who confirmed ARMS status. It was late and the deceased was placed on an interim management plan. He was placed in the maximum security yard, however, was in a single cell under normal conditions with four-hourly observations. This appeared to work quite well" (page 21).

¹ All future reference to page numbers refers to the Coroner's report.



2. Attempts were made to have Loveless double up with another prisoner as a form of protection. "As a result of the deceased's discussion with the Prison Counsellor Ms. Lohf, it was recommended he remain as a moderate risk on ARMS but be doubled up as a form of protection over the weekend when he wouldn't have access to Ms. Lohf (page 22).
3. Loveless opposed the double-up arrangement and expressed a preference for being in a cell alone, which led to the decision to leave him in Unit 1. "Attempts were made to put this into operation; however, the only reasonable accommodation of a double-up system had to be in Unit 2. The deceased was resistant. It was decided by the Operations Manager to return the deceased to Unit 1, which he stated was his preference" (page 22).
4. Loveless maintained an outwardly positive demeanour while in the day regime, which made it difficult to suspect that he may have had self-harm in mind. "The deceased was placed in a safe cell overnight for 17-18 August 2007 and was apparently not comfortable with that regime even if he was given normal cell conditions during the day. Ms Lohf believed, in hindsight, the deceased may have had a plan; however, I am not convinced his situation was quite so clear. He seemed to be fairly positive in his responses to people and his environment once back in the day regime" (page 23).
5. The intent to provide Loveless with a more comfortable and compassionate environment in order to improve his outlook and mood had an unfortunate opposite effect. "I believe Ms Lohf was correct when she decided she was not confident as to his mood, but also concerned to give him the best possible environment for improving his mood by adapting her care regime for him to one with more freedom during the day when he could interact with other people. Unfortunately it was this attempt to treat the deceased with some compassion and provide him with a more therapeutic environment which appears to have exacerbated his fluctuating mood" (page 23).

The Coroner commented that "it would be easy to state the deceased should have been maintained on high ARMS rating and placed in an observation cell...in reality the environment in a safe cell is far from therapeutic and...in the absence of other more suitable environments, a management plan which allows an individual some freedom is generally more constructive for a prisoner, especially a new prisoner's welfare" (page 25).

In this context, the Coroner further commented that "the real problem with this set of circumstances is the fact that there are no suitable compromises for the accommodation of a potentially at risk prisoner" (page 25).

In addition to the lack of facilities, the Coroner also stated "in addition to the lack of facilities to properly accommodate vulnerable prisoners, is the fact RRP also suffers significant staffing shortages, which makes continuous supervision of individuals an impossibility" (page 26).

The Coroner commented that "it is clear the personnel involved in attempting to care for the deceased certainly did so with the deceased's best interests and welfare at heart" (page 26).

The Coroner stated "I understand the difficulty is staff shortages but that fact also relates to the problem facing RRP when trying to accommodate a special care regime for vulnerable prisoners. I believe it is highly desirable there be at least one prison facility in the Northwest of the State which has the ability to house and care for vulnerable prisoners and there be some acceptable means of transferring prisoners to and from that facility" (page 28).



The Coroner made the following three recommendations in relation to the death of Mr Loveless.

Two recommendations made by the Coroner relate to her concern about a lack of facilities to accommodate vulnerable prisoners at RRP (page 28).

Recommendation 1 – I recommend the Department of Corrective Services investigate the desirability of a Special Purpose Unit somewhere in the Northwest of the State (RRP would seem to be reasonably central) which can be adapted to accommodate prisoners requiring different care regimes to ensure their safety.

This recommendation is not supported.

The Department acknowledges the limited accommodation options at Roebourne Regional Prison for managing vulnerable and/or at risk prisoners over an extended period. However, the Department continues to have the option of transferring a prisoner to a facility which has a Crisis Care Unit if the prison feels it would be a more appropriate placement option. A variety of transport options are considered in transferring prisoners at risk of self-harm to Crisis Care and have been exercised in the past. Crisis Care accommodation provides specialised treatment and support interventions within a therapeutic environment for prisoners who are acutely in need of such care.

The Department notes the difficulty in recruiting and retaining specialist support staff to appropriately manage and operate the facility proposed by the Coroner in regional locations.

Recommendation 2 - I recommend the Department of Corrective Services ensure appropriate transfer from regional lockups or prisons to and from that facility.

This recommendation is not supported. The Department's response in relation to this recommendation is dependent on and related to the previous recommendation which is also not supported.

The Department is of the view that it has adequate procedures in place that ensure prisoners are transported in a safe manner with due regard to their mental and physical well being. As previously noted, the Department has escorted and will continue to escort prisoners from regional areas to Crisis Care accommodation for this purpose.

The Coroner made the following recommendation in relation to CCTV monitoring as a result of her concern regarding the ligature points in the day room. The Coroner noted "there were no obvious hanging points in his day cell and he moved to the day room" (page 24). The Department notes the Coroner's attendance at Roebourne Regional Prison during the inquest, and her observations of the configuration of the maximum security unit in relation to the lack of a direct line of sight from the control room to the day room. It is noted that the ligature point utilised by Mr Loveless was modified following his death.

The Internal Investigations (IIU) Report, tendered during the inquest, advised that following Mr Loveless' death, the day room window grilles in the maximum security yard at Roebourne Regional Prison were covered with framed steel security mesh to minimise the risk that these grilles could be used as a ligature point in the future.

Recommendation 3 - I recommend in the event funding be provided to RRP to ensure adequate CCTV monitoring of all special and general use areas of the prison.



The Department supports this recommendation, subject to funding.

The Department acknowledges that the absence of a direct line of vision to the day room remains a security and safety concern. The Department supports the installation of CCTV cameras at several locations in Roebourne Regional Prison and proposes to roll out an installation program over two years. The areas targeted for installation of CCTV will include the day room in the maximum security area as well as other key locations within Roebourne Regional Prison.

Preparation of this Report

This report was prepared by Nicole King, Acting Coordinator Coronial Inquests, and revised by Sue Holt, Manager Critical Reviews and Maria Jimenez, Acting Coordinator Coronial Inquests.

Sue Holt
Manager Critical Reviews

28 January 2010

Endorsed: 
Assistant Commissioner
Custodial Operations

Endorsed: 
Deputy Commissioner
Adult Custodial
2-2-10

Endorsed: 
Deputy Commissioner
Offender Management & Professional Development
9.2.10

Endorsed: 
Assistant Commissioner
Corporate Support
12-2-10

Endorsed: 
Assistant Commissioner
Professional Standards
5.2.10



Terrence Sydney Graham GARDINER

Terrence Sydney Graham Gardiner (the deceased) died on 15 June 2008 at Royal Perth Hospital as a result of Pulmonary Thromboembolism in the Right Lung in Association with Left Calf Deep Vein Thrombosis. The inquest hearing was held at the Perth Coroner's Court on 19 February 2010 and the findings were delivered by the Deputy State Coroner on 23 February 2010.

The Deputy State Coroner was satisfied that the deceased was a detained prisoner at Acacia Prison, maintained in custody under the provisions of *The Criminal Law (Mentally Impaired Accused) Act 1996* with respect to a significant number of sexual offences.

He appears to have been well cared for in the assessed care unit where he was occupied with caring for other vulnerable prisoners. He was required to undergo mental health review as part of his detention and this was done.

The deceased appears to have received appropriate medical intervention whenever he presented for assistance. When he complained of symptoms which could not be explained by medical review carried out at Acacia, he was immediately transferred to Swan District Hospital then RPH by ambulance on 17 May 2008.

He remained at RPH for just under one month during which time he was investigated to confirm a diagnosis of lymphomatoid granulomatosis prior to treatment. Part of the investigative process involved a biopsy procedure which appears to have triggered a pulmonary thromboembolism arising out of a DVT.

Unfortunately, he died as the result of a cardiac arrest brought on by the pulmonary thromboembolism prior to confirmation of any diagnosis. However, his prognosis with a confirmed diagnosis of lymphomatoid granulomatosis was still highly speculative.

Post mortem examination confirmed lymphomatoid granulomatosis.

The Deputy State Coroner found death arose by way of Natural Causes.

The Deputy State Coroner made comments in respect to supervision, treatment and care of the deceased in the following terms -

Review of the deceased's prison medical file and RPH medical notes indicate the deceased's medical care to have been appropriate.



The physicians tending the deceased were still attempting to confirm a diagnosis prior to commencing targeted treatment. The provision of a prophylaxis to prevent the formation of DVT was apparently unable to prevent the deceased experiencing a pulmonary thrombo- embolism resulting in cardiac arrest and death.

For the reasons outlined above the Deputy State Coroner was satisfied the deceased received appropriate supervision, treatment and care while detained under the terms of his incarceration order.

The Department of Corrective Services responded on the 8 March 2010 to the recommendations in the following terms –



**DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE
TO THE FINDINGS OF THE CORONER
INTO THE MANNER AND CAUSE OF DEATH OF
MR TERRENCE SYDNEY GRAHAM GARDINER**

Background

A coronial inquest into the death in prison custody of Terrence Sydney Graham Gardiner was held in the Perth Coroner's Court on 19 February 2010 by Deputy State Coroner Ms Evelyn Vicker.

On Sunday 15 June 2008 Mr Gardiner, a 63 year old Caucasian prisoner, died at Royal Perth Hospital while in the custody of Acacia Prison. Mr Gardiner had undergone an open lung biopsy at RPH on 13 June 2008. His condition deteriorated on the afternoon of 15 June 2008 and life was declared extinct at 6.20 pm following unsuccessful resuscitation attempts.

Mr Gardiner was detained under the Criminal Law (Mentally Impaired Accused) Act 1996, at the Governor's Pleasure. Mr Gardiner was ordered into custody under the MIA Act on 2 February 2000 for sexual offences against children.

Findings

The State Coroner found Mr Gardiner died of natural causes, as a result of pulmonary thromboembolism in the right lung in association with left calf deep vein thrombosis.

The Coroner further found that Mr Gardiner "appears to have been well cared for [...]. He was required to undergo mental health review as part of his detention and this was done." (Page 11).

The Coroner also stated in her report that "the deceased appears to have received appropriate medical intervention whenever he presented for assistance." (Page 11).

The Coroner concluded her report with the following: "I am satisfied the deceased received appropriate supervision, treatment and care while detained under the terms of his incarceration order." (Page 13).

The Coroner did not make any recommendations with regard to this inquest.

Preparation of this Report

This report was prepared by Maria Jimenez, Acting Coordinator Coronial Inquests, Professional Standards Division.

Maria Jimenez
A/ Coordinator, Coronial Inquests
Critical Reviews Unit

4 March 2010

Endorsed: _____
Assistant Commissioner
Professional Standards



2010/110



Justin Wayne REX

Justin Wayne Rex (the deceased) all died on 18 September 2008 at Sir Charles Gairdner Hospital as a result of Intracerebral Haemorrhage. The inquest hearing was held at the Geraldton Court House on 23-24 March 2010 and the findings were delivered by the Deputy State Coroner on 6 April 2010.

The Deputy State Coroner was satisfied that the deceased was 30 year old Aboriginal male with an extensive and complicated medical history, not assisted by his heavy smoking and drinking while at large in the community. Following his mitral valve prosthesis he was placed on Warfarin therapy to avoid the formation of clots on the prosthesis. He later had a pacemaker inserted but still required ongoing Warfarin therapy.

In July 2008 he was sentenced to a term of imprisonment, initially being served at Broome Regional Prison, prior to his transfer to GRP to enable him to be closer to family.

The deceased's Warfarin therapy was monitored while at GRP and remained in the therapeutic range.

On 17 September 2008, in the early afternoon, he experienced a severe onset headache with vomiting and was transferred to the medical centre where, fortuitously, Dr Bulten was involved in a clinic.

The deceased received immediate medical input from Dr Bulten who suspected the origin of the deceased's headache may be an intracerebral haemorrhage. He requested the attendance of an ambulance, due to his knowledge the deceased could not be adequately cared for in the prison medical centre.

Unfortunately, it was one of those rare occasions when both available Geraldton based ambulances were already involved in a medical transfer. Unusually there was a need to prioritise requests for ambulance assistance and SJA needed relevant medical input.

The SJA call-takers appear not to have been confident the information with which they were provided was relevant and particular to the request for an ambulance. It appears to have been interpreted as general and unspecific. It certainly was not seen as a potentially life threatening situation.



The information provided by Dr Bulten was in fact extremely relevant to the condition from which he suspected the deceased may be suffering. He proved to be correct.

In the particular circumstances of this case the immediate dispatch of an ambulance Priority One is very unlikely to have made a difference to the survivability of the deceased.

The seriousness of the relevant information was not fully appreciated and the fact the deceased was classed as “*stable*”, resulted in the matter being classified, in SJA terms, as a Priority Four. This means an ambulance will deal with the situation when one becomes available. Initially the call was to have been dealt with by the Geraldton Duty ambulance (21) once it left the airport, however, by a means which is not clear the fact it would be necessary to call out the third ambulance (23) was somehow communicated. That ambulance was dispatched as a Priority Three.

The deceased’s condition deteriorated to the extent he became unconscious and Dr Bulten requested the ambulance be notified his condition had changed and that his status was now urgent. The dispatch of the third ambulance was not raised to a Priority One, due to total lack of appropriate communication, and they arrived at the prison as a Priority Three. By that time it had been realised the situation now warranted a Priority One and as a result the senior paramedic attending at the airport in Geraldton 22 travelled on to the prison and was effectively able to assist Dr Bulten with the transfer of the deceased from the prison to GRH. This was done under Priority One conditions with Dr Bulten travelling in the ambulance to ventilate the deceased.

A CT scan which had been arranged by Dr Bulten from the prison was undertaken at GRH and indicated the deceased had a catastrophic and un-survivable brain haemorrhage. It was not possible to look after him appropriately in the GRH and he was transferred by RFDS to SCGH where his prognosis was confirmed as un-survivable. He was maintained on life support until his family could be present for his removal from life support. He died on 18 September 2008 as the result of a catastrophic and un-survivable intracerebral haemorrhage.

The Deputy State Coroner found death arose by way of Natural Causes



The Deputy State Coroner made comments on the Supervision, Treatment and care of the deceased in the following terms –

The reality of the circumstances surrounding the deceased's death indicated his death could not have been avoided due to the severity of his intracerebral haemorrhage. Whether or not the extent of the bleed was exacerbated by Warfarin is unknowable, however, the Warfarin therapy was essential to the deceased's ability to survive his cardiac conditions.

It so happens more prompt arrival of an ambulance at GRP would not have altered the life threatening nature of the deceased's bleed and in these particular circumstances had no bearing on his subsequent death.

This may not always be the situation and it is essential the type of communication error which arose is avoided in future.

In all these circumstances I find the supervision, treatment and care of the deceased's medical condition was appropriate and timely. Quite fortuitously Dr Bulten was in attendance at the prison, at the time of the deceased's intracerebral bleed and very quickly correctly identified the probable cause of deceased's signs and symptoms. Dr Bulten had already organised for a CT scan to be performed on the deceased's arrival at GRH by the time he was taken there. This confirmed the extent of the bleed and the fact the deceased's prognosis was extremely poor.

It is quite possible the deceased would not have received such prompt medical input had he not been in custody in an environment familiar with his specific medical issues.

The circumstances surrounding the death of the deceased have enabled GRH and SJA to become aware of certain indicators which suggest the protocols and policies surrounding the calling of ambulance services to GRP should be improved for future incidents which may be time critical.

It was clear in the course of the evidence heard during the inquest SJA lacked confidence in the quality of the information they were given, possibly due to the fact it was communicated as the result of quite extensive questioning by the SJA call-taker. As a result the significance of the information which was provided was dismissed as not indicating any specificity as to the problem. This reflects a dysfunction in both the way the information was communicated and received.

Due to the severity of the deceased's bleed, the prompt attendance of the ambulance would not have altered the outcome. However, in a situation where a patient had not had such a severe bleed the attendance of an



ambulance promptly to transfer someone to hospital for appropriate life support and reversal of anti-coagulation therapy may save a life.

It is for this reason it is considered essential by both GRH and SJA any information critical to the efficient call out of an ambulance be provided at first instance. This will allow SJA to be effective in its prioritisation when resources are stretched.

It also became apparent, due to the mixed responses to questions asked during the course of the inquest, it may be the information received needed to be more critically assessed than was done in this case.

Senior Paramedic Byrnes indicated he understood “*stable*” included a situation which was life threatening. He interpreted it to mean the patient was stable in his vital signs at that precise moment in time but could change at any moment. Dr Bulten confirmed he indicated when he used the term “*stable at the moment*” he was communicating a patient was haemodynamically stable but the situation could change at any time. This is what the term means in medical usage and communicates an urgency to respond before a situation deteriorates. Both Ms Drummond and the Operations Manager for SJA, Mr Smith, stated they believed the term “*stable*” indicated the situation was not life threatening. This is clearly unsatisfactory.

Further, Mr Smith indicated ambulances are often called, mostly in the metropolitan area, from a doctor’s surgery, which are not time critical. Consequently, he considered just because a doctor was asking for an ambulance it did not necessarily mean the situation warranted immediate response. At the least a medically trained person was in attendance.

This is a different situation from a Prison Medical Centre where nurses and prison officers on duty generally have some first-aid experience and will deal with medical issues which are capable of being dealt with in a prison environment. If a prison is asking for an ambulance, and more especially a prison doctor is asking for an ambulance in a rural area, it is more likely than not the situation is serious, otherwise it would be dealt with in the medical facilities in the prison.

In addition in a life threatening situation the medical personnel are likely to be involved in keeping the patient alive and so not in a position to explore the relevance of all the surrounding circumstances to the SJA call-taker.



The Deputy State Coroner made a number of recommendations as follows –

- There be some protocols, or at least discussion, between Department of Corrective Services, SJA and the rural sub-centres establishing policies and procedures for calls for ambulance services from any prison.
- Correspondingly, it is essential those policies and protocols establish a workable prison check list with which call-takers are satisfied they can suitably prioritise regional ambulances if there are a number of call-outs for areas with limited resources.

In the case of GRP it became obvious the relevant check-list of information to be provided to who ever calls the ambulance service must:

- ✚ indicate the address of the prison in a format which can be entered into SJA computer screens;
- ✚ include contact telephone numbers which can be rung from the sub-centre or ambulance to someone in the prison with relevant information with respect to the specific medical emergency;
- ✚ provide some basic information upon which SJA can make an assessment.

The Deputy State Coroner suggested the failure to be able to provide information other than the fact someone requires an ambulance should be taken to mean it is a high priority. That would mean people with some first-aid knowledge in the prison were unable to identify the problem and therefore it should be treated as serious. If the seriousness is known obviously that should also be communicated.

It also became apparent, due to Prison Officer Barton's difficulty in communicating with the medical centre, it is important the initial call to the SJA Service be made on a telephone which is capable of being transferred to another telephone within the prison. This will not assist where the medical emergency is in a location not serviced by a telephone but will hopefully provide input from an area with more proximity to the emergency than the front gate.

The Deputy State Coroner accepted the requirement the initial call for an ambulance be made from the front gate. There are good security reasons relating to efficiency of transfer within the prison which make it essential the front gate be fully aware of the need for an ambulance and its urgency.



However, after that initial call, which should be made on a telephone capable of being transferred to another telephone within the prison, it is desirable a regional sub-centre or ambulance have direct communication with the most relevant person in the prison to the patient's contemporaneous condition. Where the medical centre is involved in the emergency, then obviously it should be both permissible and possible for the medical centre to be able to communicate directly with the attending ambulance. Where the emergency is in an area that does not have a telephone which can communicate with the ambulance then it would be necessary there be some ability to communicate between the ambulance and somebody in the prison in contact with those tending the patient.

Mr Smith outlined a number of changes which have occurred at SJA in the taking of calls since September 2008. One of these is the creation of a position of Clinical Team Leader in the call centre. This enables call takers to discuss medical information received with someone with more senior medical background than the average call taker.

The Deputy State Coroner observed, in the situation faced by GRP on 17 September 2008, a Clinical Team Leader at the SJA call-centre would have understood the significance of the information communicated by Dr Bulten via Prison Officer Barton to the centre. The Deputy State Coroner commented, if it became necessary for the Clinical Team Leader to speak directly with an attending doctor, the fact the attending doctor believed those matters to be relevant to the crisis with which he was dealing would be understood by the recipient.

The Deputy State Coroner observed, however, in this particular case the information given by Dr Bulten was all the information upon which he based his provisional diagnosis of intracerebral haemorrhage. It was an unconfirmed suspicion at that stage and she appreciated Dr Bulten would not have been confident of communicating an unconfirmed diagnosis in circumstances where an ambulance was being called, and which under normal conditions, would have been dispatched immediately. Everyone called to give evidence indicated it was a very unusual situation for Geraldton to be in a position where more than one ambulance was already attending a call out. Geraldton now has four ambulances available but still only has three effective crews.

The Deputy State Coroner further observed it had been brought to her attention that there was apparently a problem with the deceased's personal property and notification to his family of its location. The Deputy State Coroner suspected this was more a miscommunication than lack of communication. However, to alleviate such situations in the future the Deputy State Coroner suggested GRP, where there has been a death in



custody which of itself necessitates an inquest under the *Coroners Act 1996*, write to the nominated next-of-kin in the prison files, and advise them the property and personal effects of the deceased person not held by police will be held by the prison until the conclusion of the inquest. This will ensure family members are aware of the location of any personal property not held by police.

The Department of Corrective Services responded to the recommendations by letter dated 4 August 2010 in the following terms –



**DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE
TO THE FINDINGS OF THE CORONER
INTO THE MANNER AND CAUSE OF DEATH OF
MR JUSTIN WAYNE REX**

Background

The Deputy State Coroner, Ms Evelyn Vicker, held an inquest into the death in custody of Mr Justin Wayne Rex at Geraldton Coroner's Court, on 23 and 24 March 2010, and released her findings on 27 April 2010.

Mr Rex, a 30 year old Indigenous prisoner serving a 14 month sentence at Greenough Regional Prison (GRP), died on 18 September 2008 at Sir Charles Gairdner Hospital (SCGH) as a result of Intracerebral Haemorrhage.

On 17 September 2008 Mr Rex was taken to the Greenough Regional Prison Medical Centre suffering a severe headache and vomiting. At the request of the duty prison doctor Mr Rex was transferred to Geraldton Regional Hospital (GRH). He was stabilised and flown to SCGH where he died on 18 September 2008 in the presence of his family.

Findings

"Mr Rex died as a result of a catastrophic and un-survivable intracerebral haemorrhage and death arose by way of Natural Causes" (Page 23).

The Deputy Coroner noted in the Post Mortem Report "There was no evidence of external injury having contributed to the bleed. It was a naturally occurring haemorrhage. It is possible the extent of the bleed could have been contributed to by the Warfarin therapy necessary for Mr Rex's cardiac condition" (Page 20).

The Deputy Coroner detailed the communication issues arising from the "000 calls from GRP", and the breakdown in articulating the medical status of Mr Rex in an efficient manner that would have allowed the more timely arrival of an ambulance to GRP (Page 7-16).

The Deputy Coroner said "The SJA call-takers appear not to have been confident the information with which they were provided was relevant and particular to the request for an ambulance. It appears to have been interpreted as general and unspecific. It certainly was not seen as a potentially life threatening situation" (Page 21).

The Deputy Coroner noted "It is quite possible Mr Rex would not have received such prompt medical input had he not been in custody in an environment familiar with his specific medical issues" (Page 24).

Comments on Supervision, Treatment and Care

The Deputy Coroner's report concluded the following in relation to the management of Mr Rex while at GRP:



1. "The reality of the circumstances surrounding Mr Rex's death indicated his death could not have been avoided due to the severity of his intracerebral haemorrhage" (Page 23).
2. "Whether or not the extent of the bleed was exacerbated by Warfarin is unknowable, however, the Warfarin therapy was essential to the deceased's ability to survive his cardiac conditions" (Page 23).
3. "It so happens more prompt arrival of an ambulance at GRP would not have altered the life threatening nature of Mr Rex's bleed and in these particular circumstances had no bearing on his subsequent death. However, this may not always be the situation and it is essential the type of communication error which arose is avoided in future" (Page 23).
4. "In all these circumstances the supervision, treatment and care of the deceased's medical condition was appropriate and timely" (Page 24).

Lessons to be learned

The Deputy Coroner further commented that the circumstances surrounding the death of Mr Rex have enabled GRH and St John Ambulance (SJA) to become aware of certain indicators which suggest the protocols and policies surrounding the calling of ambulance services to GRP should be improved for future incidents which may be time critical (Page 24-27).

Recommendations

The Deputy Coroner made the following two recommendations in relation to the death of Mr Rex.

Two recommendations made by the Deputy Coroner relate to her concern about the current protocols utilised between the Department of Corrective Services (DCS) and SJA and the formulation of a workable prison check list when requesting an ambulance.

Recommendation 1 – "I recommend there be some protocols, or at least discussion, between Department of Corrective Services, SJA and the rural sub-centres establishing policies and procedures for calls for ambulance services from any prison".

This recommendation is supported.

The Department of Corrective Services agrees that better medical emergency communication with SJA is needed. The Department supports the development of protocols between the Department and SJA. The Department will develop improved procedures to better facilitate the transfer of important emergency medical information between SJA and prison medical staff, in conjunction with relevant stakeholders.

The Department recognises the need for the GRP front gate telephone to have transfer capacity. A range of strategies are being considered to facilitate improved communication between the staff on the front gate, medical staff and SJA personnel.

Recommendation 2 – "Correspondingly, it is essential those policies and protocols establish a workable prison check list with which call-takers are satisfied they can suitably prioritise regional ambulances if there are a number of call-outs for areas with limited resources".

This recommendation is supported.



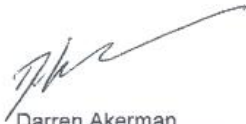
In keeping with the Deputy Coroner's recommendation, a workable check list will be developed that enables call takers to prioritise regional ambulance call-outs.

The Deputy Coroner commented on an apparent problem with Mr Rex's personal property and notification to his family of its location. The Deputy Coroner stated "I suspect this was more a miscommunication than lack of communication. However, to alleviate such situations in the future I suggest GRP, where there has been a death in custody which of itself necessitates an inquest under the *Coroners Act 1996*, write to the nominated next-of-kin in the prison files, and advise them the property and personal effects of the deceased person not held by the police will be held by the prison until the conclusion of the inquest. This will ensure family members are aware of the location of any personal property not held by police" (Page 30).

The Department acknowledges the Deputy Coroner's comments in regard to notification of the nominated next of kin to advise them that the property and personal effects of the deceased person that is not held by the police will be held by the prison until conclusion of the inquest. The Department will consider policy and procedural changes to address this.

Preparation of this Report

This report was prepared by Darren Akerman, Acting Coordinator Coronial Inquests, and revised by Sue Holt, Manager Critical Reviews.



Darren Akerman
A/Coordinator Coronial Inquests


26 July 2010

Endorsed: 
Deputy Commissioner
Adult Custodial

28/7/10

Endorsed: 
Deputy Commissioner
Offender Management & Professional Development

30.7.10

Endorsed: 
Assistant Commissioner
Professional Standards

4.8.10



Ian Frank WINMAR

Ian Frank Winmar (the deceased) died on 22 August 2008 at Cell 11B Unit 1, Albany Regional Prison as a result of Buprenorphine Effect in a man with Ischaemic Heart Disease. The inquest hearing was held at the Albany Court House on 28-29 April 2010 and the findings were delivered by the Deputy State Coroner on 1 June 2010.

The Deputy State Coroner made a Suppression Order in the following terms in this matter –

SUPPRESSION ORDER

1. *Any matter that would tend to identify the Prisoners, Prisoner 1, Prisoner 2 and Prisoner 3, except that it is permissible to refer to the abovementioned as “another prisoner”.*
2. *There is to be no publication of evidence given about:*
 - a) *the means by which drugs are brought into prisons;*
 - b) *the means used to detect, monitor or test for drug use, or to search for items associated with drug use within the prison system;*
 - c) *drug trafficking and methods of using drugs in prison.*

Except that it is permitted to publish evidence that Mr Winmar obtained and used Buprenorphine from a Norspan patch and that patch had been prescribed for the treatment of another prisoner.

The Deputy State Coroner was satisfied that the deceased was a 45 year old Aboriginal male with a serious cardiac condition who had been incarcerated in various prison environments since December 2003.

He had been identified as having a severe cardiovascular problem, however, was non-compliant with care plans or medication. He was also a prolific abuser of whatever illicit drugs or medication he could obtain by way of the prison system.

The inability to engage with Mr Winmar in a medical sense prevented his health education with respect to the dangers of illicit drug use, firstly in the prison environment by way of shared syringes and, secondly with respect to his specific health problems. He had not received particular health education with respect to opiates because he was not recorded as having ever been detected with a urinalysis disclosing inexplicable opiate use.



On 22 August 2008 the deceased obtained via another prisoner, a Norspan patch, which was referred to as a “morph patch”. It contained buprenorphine, an opiate derivative, and provides the recipient with the opiate effect sought by illicit drug users.

He cut the active part of the patch into strips and heated those in water to obtain a solution which could then be injected intravenously. He then injected some of that solution.

The post mortem examination indicated the deceased had suffered a recent heart attack and presumably was recovering from those effects, but he did not recognise that fact. On injecting himself with the buprenorphine he exacerbated any respiratory suppressant effect and as a result of the administering of the buprenorphine experienced further cardiac impairment from which he did not recover. He had complained of a toothache and unexplained pain in the jaw area can be a symptom of heart attack.

Concerned prisoners alerted prison officers to the problem and once it was realised there was a medical emergency he was provided with resuscitation and additional oxygen.

Prison staff were informed he may be suffering the effects of opiate use and were making arrangements to commence Narcan therapy when ambulance officers arrived and administered it themselves. This failed to revive the deceased and he died shortly after his arrival at ARH.

The Deputy State Coroner was satisfied that the deceased’s death resulted from the administration of unknown levels of buprenorphine in a system already compromised by cardiac disease.

The Deputy State Coroner made the following comments on the Supervision, Treatment and Care of the deceased while in prison.

Norspan patches

Norspan patches are a slow release form of buprenorphine, which on adhering to the skin, slowly release the buprenorphine, an opiate derivative, into the recipient’s system. It is intended to act as effective pain control.

The medical staff at ARP understood Norspan patches contained buprenorphine however had been reassured the active ingredient could not be misused and consequently were not adverse to their use provided all the legal and policy requirements of the prison system had been followed.



Evidence indicated prisoners were aware of the effects of the patches although they called them “morph” patches. They understood they were a form of opiate. They also understood the longer the time the active part of the patch was heated in water the stronger the solution of opiate became.

The Director of Health Services for the Department of Corrective Services has issued various policy directives with respect to the use of certain medications in the prison system. There are legal requirements which must be adhered to by all doctors prescribing medication. Over and above the legal requirements there are policy directives in the department to try and ensure the prescription of certain medications are overseen by the Director of Health Services.

Accordingly, where there is a legal prescription for a “desirable” medication it must also be authorised by the Director for Health Services, as well as having a legitimate prescription for the purposes of the relevant legislation. A ‘desirable” medication is one which can be utilised for illicit benefit in the prison system and is highly trafficable.

There are different legal requirements pertaining to Schedule 8 drugs, and Schedule 4 drugs. However the policy requirement that prescribed drugs also have authorisation from the Director of Health Services is not limited to Schedule 8 or 4 drugs. It relates to any prescribed medication which is considered desirable by prisoners and therefore is a trafficable item within the prison system. Any drug containing opiates, in whatever form, is generally considered to be desirable and therefore trafficable.

ARP security was aware of the desirability of opiate medications for bartering in their environment and preferred they did not have prisoners using opiates in that environment due to the trafficability of any opiate substance. Prison management did not specifically know Norspan patches existed or the active ingredient was an opiate.

The legal medical requirements related to buprenorphine being a Schedule 8 drug include very strict legal parameters as to how it may be prescribed and administered. The Department of Corrective Services requirements related to the policy directive from the Director of Health Services that all nominated drugs, of which buprenorphine was one, be authorised by the Director of Health Services over and above a doctor’s prescription, are an attempt to ensure the prescription is necessary for the prisoner concerned and will not be misused in the prison environment.



At the time of the deceased's death the medical staff did not believe a Norspan patch could be misused in the way it was in this case. Prison management/security were unaware any of the prisoners in ARP were being provided with opiates in the form of a patch. As a result it is fair to say supervision of the patches, once applied, was not strict. While the patches were applied by medical staff and removed in front of medical staff they were not checked for tampering between application, nor was the reverse side of the patch examined at any time to establish whether or not the patch had been interfered with inappropriately.

The patch provided to Prisoner 1 was obtained and examined after the death of the deceased and found to only have a thin strip of the active ingredient part of the patch still adherent to the reverse of the adhesive patch. Remnants of the strips were located in the toilet bowl in the deceased's cell indicative of an attempt to destroy the paraphernalia once it became obvious the deceased was unwell and security would need to be called.

Evidence from one of the prisoners indicated removal of buprenorphine from the patch was a regular Friday occurrence and prisoners would patrol the yard while buprenorphine was being extracted to ensure those performing the extraction would not be surprised by prison security during the process.

In addition the Friday afternoon lock-downs were known to take sometime and it was envisaged most drug paraphernalia would be secreted or disposed of during lock-down to avoid detection. Prison inmates have a lot of time in which to be inventive as to ways to circumnavigate measures put in place by security.

If it is accepted Norspan patches are a useful form of pain control in the prison environment then measures need to be put in place to minimise their misuse. Where another form of pain control is as effective, from both the welfare and security aspect it should be utilised. Where patches are considered to be the best option available then the measures mentioned by Dr Moss (current Director of Health Services) would seem to be appropriate. This involves more rigorous checking of the patches between applications and examination of the patches for tampering.

The Deputy State Coroner accepted targeting buprenorphine in urinalysis is costly and should not be a routine requirement. However, where only a handful of prisoners are in receipt of the patches it may be prudent to occasionally and randomly target those prisoners to determine whether or not the levels in their urine are consistent with the level expected for their prescription. It is unlikely Prisoner 1 would have had levels sufficient for



his pain control if the evidence heard with respect to the deceased's regular Friday extraction of Norspan patches was correct.

The Deputy State Coroner accepted that at the time of the deceased's death ARP was aware of the desirability of opiate medications in the prison system from the prisoner trafficability aspect. The Deputy State Coroner also accepted that medical staff were of the belief opiates could not be removed from the patches and so were not concerned as to trafficability, while security staff were unaware of the reality of the patches in their environment and so not alert to the extraction process while conducting random cell checks.

The Deputy State Coroner observed that she understood that procedures are now in place which Dr Moss, as Director of Health Services, believes will minimise the potential for tampering with Norspan patches. The Deputy State Coroner noted that this seems to be appropriate.

In addition the Deputy State Coroner noted that the medical staff now preferred to use other forms of pain relief which are less open to misuse.

DOCTOR'S AUTHORITY FOR SCHEDULE 4 DRUGS

At the inquest hearing evidence was received which indicates the perceived problem with the administration of Schedule 4 drugs, in this case Narcan, should not cause inordinate delays in administration of the drug in ARP where necessary. The emergency kits (crash bags) are updated daily with both Schedule 4 drugs and roster telephone numbers to enable doctor's authorisation for administration of the drugs. The Manager, Prisoner Security, on duty, always attends a medical emergency and carries a portable telephone which would enable direct access to an appropriate on call doctor.

In the case of the deceased the information he may have used opiates was received shortly before the paramedics arrived. They were able to administer Narcan directly without waiting for doctor's authorisation. The time delay would have been minimal and it was his underlying heart disease which was the significant factor in his death, from buprenorphine effect, at that point in time.

CARE PLANS

The Deputy State Coroner noted that there was no doubt the deceased had not had a comprehensive care plan put in place on his arrival at ARP. It would have been preferable he signed the proposed care plan to indicate he would not comply in any event.



His history was such it is clear he had no intention of complying with cardiovascular care plans but it is also clear he made efforts to stay physically fit, apart from his illicit drug use. In these circumstances, and as he was known to use illicit drugs whenever he could obtain them, the Deputy State Coroner noted that she would have preferred documented evidence of attempts to engage him in some form of health education despite his resistance.

From the evidence of Prisoner 3 it is clear he was aware of the need to use clean needles but it is unclear as to how aware he was of the detrimental effects of inappropriate drug use on his cardiovascular condition.

The Deputy State Coroner understood it is possible for medical staff to access some of the information on TOMS which may provide insight into which prisoners are known to use illicit drugs if they can be obtained. Where prisoners with severe health problems refuse to engage in health care plans it may be prudent to check their drug status to determine whether or not a focused attempt be made to engage them in relevant health care education.

The Deputy State Coroner accepted this would not have revealed buprenorphine use, however, any amphetamine based substances would also have warranted a serious discussion about the possible effects of illicit drugs in general on his cardiovascular condition.

The State Coroner received a response from the Department of Corrective Services in the following terms –



**DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE
TO THE FINDINGS OF THE CORONER
INTO THE MANNER AND CAUSE OF DEATH OF
MR IAN FRANK WINMAR**

Background

The Deputy State Coroner held an inquest into the death in custody of Mr Ian Frank WINMAR at Albany Coroner's Court, on 28 & 29 April 2010, and released her findings on 2 June 2010.

Mr Winmar was a 45 year old aboriginal male who died on 22 August 2008 at Albany Regional Hospital (ARH), Western Australia. At the time of his death Mr Winmar (the deceased) was a sentenced prisoner at Albany Regional Prison (ARP) having been sentenced to a period of imprisonment of five years for the combined charges of assault occasioning bodily harm and robbery whilst armed.

Findings

The Deputy Coroner said [in part] about the deceased's background "Mr Winmar was born in Pingelly and was the second eldest of nine children. He was removed from his family at 10 years of age and educated to the end of year 9 when he was 15 years of age. He had a long history of drug and alcohol abuse. Mr Winmar considered himself an elder in the Aboriginal community and was respected by younger Aboriginal prisoners in the prison environment. He had a long criminal history which included some violent offences. He commenced offending at 8 years of age" (Page 3).

The Deputy Coroner remarked [in part] on the deceased's medical history "Mr Winmar had a long-term cardiac condition. In April 2001 he had a Percutaneous Transluminal Coronary Angioplasty (PTCA) inserted as the result of an angiogram. He was identified by the prison system as requiring a cardio vascular health care plan, however, he consistently declined to become engaged in his own health care, both by way of refusing to attend medical appointments and being non compliant with medication, if and when, it was issued. He refused annual health assessments and actively avoided any attempts to engage him in education about his medical care. He was not taking any regular prescribed medications for his diagnosed health problems, and continued to abuse drugs whenever the opportunity arose" (Page 3 & 4).

The Deputy Coroner found [in part] "It was a Friday and it is an accepted part of the medical regime in ARP that Fridays are 'Schedule 8 days'. This relates to the practise of weekly Schedule 8 drugs being dispensed to those prisoners in receipt of prescriptions for Schedule 8 drugs. They are escorted to the medical centre for their weekly Schedule 8 drugs" (Page 6).

The Deputy Coroner further commented [in part] "However, the need for security within the prison for medications ensures prison officers and other inmates are likely to be aware of which prisoners are on some form of medication due to prison officers attendance on the medical rounds in the units and at the medical centre for the dispensation of a specific range of drugs" (Page 6).

The Deputy Coroner was of the view that on the morning of 22 August 2008 another prisoner had attended the medical centre to obtain a weekly Norspan patch for pain control. As part of a plan made the previous evening it was alleged the other prisoner removed his patch and gave

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it to Mr Winmar. Mr Winmar then extracted the buprenorphine from the patch and once dissolved in a heated water solution, injected a quantity of the water in company with another prisoner. A fellow prisoner stated this was a regular Friday occurrence and Mr Winmar would share the buprenorphine solution with pre-arranged prisoners (Page 7).

The Deputy Coroner noted that around lunch time Mr Winmar remained in his cell and told a fellow prisoner he did not feel very well and had a toothache. Other prisoners had become aware of Mr Winmar feeling unwell and a short time later he vomited and was helped to his bed by fellow prisoners and again advised that he had a toothache and his arm hurt (Page 8).

After lock-down on that Friday afternoon approximately 1:00 pm, Mr Winmar advised fellow prisoners he did not need help, however, they were concerned about Mr Winmar and noted he was becoming quite ill, was starting to shake and looked unwell. At that time Prison Officers did not specifically view the prisoners at lock-down to check their status; they merely checked the appropriate prisoners were in their cells. Shortly thereafter two fellow prisoners alerted prison staff via an emergency call button, due to their concern of the deterioration in Mr Winmar's health (Page 8).

As a result of the emergency call, prison staff responded and began to put in place emergency and medical procedures to deal with Mr Winmar's condition, who at the time was displaying signs of life which included several infrequent breaths and after further resuscitation a short time later, circulation was detected with the occasional spontaneous breath (Page 10).

The Coroner made comment regarding the potential use of narkan therapy by Nurse Gunning; in the hope Mr Winmar may respond to treatment after a fellow prisoner advised it was likely he had injected buprenorphine from a Norspan patch. Nurse Gunning was in the process of seeking appropriate authorisation from a doctor for the administration of narkan when ambulance officers arrived at ARP and subsequently administered narkan to Mr Winmar via intramuscular injection negating the need for Nurse Gunning to do so. Cardio Pulmonary Resuscitation (CPR) was continued on Mr Winmar due to the ambulance officer's inability to intubate him and therefore required the reinsertion of an oral-pharyngeal airway (Page 10).

Mr Winmar was then placed on a stretcher and taken to the ambulance and transported to ARH while CPR and resuscitation attempts continued. On arrival at ARH the emergency department staff continued with the resuscitation attempts until at 2:56 pm, at which time Dr DeClerk pronounced Mr Winmar deceased. Resuscitation efforts on the deceased had been undertaken from approximately 1:10 pm onwards (Page 11).

Post Mortem Report

The Deputy Coroner found from the post mortem examination of Mr Winmar conducted by the Pathwest Chief Forensic Pathologist, Dr Clive Cooke, that Mr Winmar had evidence of ischaemic heart disease with myocardial fibrosis, coronary arteriosclerosis and stents in the left anterior descending artery and circumflex artery. Dr Cooke also found pulmonary congestion with early apical emphysema (Page 11).

The Deputy Coroner further noted from the post mortem report microscopy confirmed the presence of lung congestion and aspiration vomit in the small airways. There was a small recent area of myocardial infarction and significant pre-existing ischaemic heart disease.

There were changes of cellular reaction around foreign material in the elbow creases, "indicating previous use at these locations for intravenous drug use" (Page 12).



The Deputy Coroner noted the evidence given by Dr Cooke indicating the extent of heart disease in Mr Winmar was significant and the confirmed histology indicated there had been chronic ischaemic heart disease in the past with more recent cellular changes indicating more recent heart attacks. There had been another very recent heart attack in the last 24-36 hours before death. The Deputy Coroner further found "It would seem to be in the context of having a recent heart attack the deceased injected himself with buprenorphine from the Norspan patch on the morning of 22 August 2008" (Page 12).

Toxicology showed a high level of buprenorphine together with small amounts of paracetamol and cannabis. The Deputy Coroner noted Dr Cooke stated "buprenorphine in high levels can cause confusion, dizziness, reduced blood pressure (hypotension), respiratory difficulty, seizures and coma". Dr Cook further explained in part "a person with existing coronary artery disease the effects of buprenorphine may result in a further reduction of blood flow through an already narrowed coronary artery which may lead to an arrhythmia, heart attack, or fatal heart attack" (Page 12).

The Deputy Coroner remarked "In evidence Dr Cooke indicated Mr Winmar's heart disease was advanced enough for him to have potentially died of a fatal heart attack at any point in time" (Page 13).

The Deputy Coroner stated "The cause of death was established as buprenorphine effect in a man with ischaemic heart disease" (Page 13).

Conclusion as to the Death of the Deceased

The Deputy Coroner said in part she was satisfied Mr Winmar was a 45 year old aboriginal male with a serious cardiac condition and had been identified as having a severe cardiovascular problem, however, was non-compliant with care plans or medication and was also a prolific abuser of whatever illicit drugs or medication he could obtain by way of the prison system (Page 13).

The Deputy Coroner also spoke about the inability of staff to engage with Mr Winmar, this in a medical sense prevented his health education with respect to the dangers of illicit drug use, firstly in the prison environment by way of shared syringes and, secondly with respect to his specific health problems. He had not received particular health education with respect to opiates because he was not recorded as having ever been detected with a urinalysis disclosing inexplicable opiate use (Page 14).

The Deputy Coroner was satisfied that Mr Winmar obtained via another prisoner a Norspan patch containing buprenorphine, being an opiate derivative, then cut the active part of the patch into strips and heated those in water to obtain a solution, part of which he then injected intravenously (Page 14).

The post mortem examination indicated Mr Winmar had suffered a recent heart attack and presumably was recovering from those effects, but he did not recognise that fact. On injecting himself with the buprenorphine he exacerbated any respiratory suppressant effect and as a result of the administering of the buprenorphine experienced further cardiac impairment from which he did not recover (Page 14 & 15).

Prison staff were informed he may be suffering the effects of opiate use and were making arrangements to commence Narcan therapy when ambulance officers arrived and administered it themselves. This failed to revive Mr Winmar and he died shortly after his arrival at ARH (Page 15).



The Deputy Coroner said "I am satisfied Mr Winmar's death resulted from the administration of unknown levels of buprenorphine in a system already compromised by cardiac disease" (Page 15).

Comments on the Supervision, Treatment and Care of the deceased

The Coroner's report concluded the following in relation to the management of Ian Frank Winmar while in custody:

1. The medical staff at ARP understood Norspan patches contained buprenorphine however had been reassured the active ingredient could not be misused and consequently were not adverse to their use provided all the legal and policy requirements of the prison system had been followed (Page 16).
2. Evidence indicated prisoners were aware of the effects of the patches although they called them morph patches. They understood they were a form of opiate. They also understood the longer the active part of the patch was heated in water the stronger the solution of opiate became (Page 16).
3. ARP security was aware of the desirability of opiate medications for bartering in their environment and preferred they did not have prisoners using opiates in that environment due to the trafficability of any opiate substance (Page 16).
4. The Deputy Coroner said "I accept that at the time of Mr Winmar's death ARP was aware of the desirability of opiate medications in the prison system from the prisoner trafficability aspect. I accept medical staff were of the belief opiates could not be removed from the patches and so were not concerned as to trafficability, while security staff were unaware of the reality of the patches in their environment and so not alert to the extraction process while conducting random cell checks"(Page 20).
5. The Deputy Coroner further stated "I understand procedures are now in place which Dr Moss, as Director of Health services, believes will minimise the potential for tampering with Norspan patches. This seems to be appropriate" (Page 20).
6. The Deputy Coroner remarked on the use of narcan and noted that the time delay between knowledge of Mr Winmar's potential use of a drug and the subsequent administration of narcan by paramedics post their arrival, was minimal and it was his underlying heart disease which was the significant factor in his death, from buprenorphine effect, at that point in time (Page 21).
7. The Deputy Coroner said "There is no doubt Mr Winmar had not had a comprehensive care plan put in place on his arrival at ARP. It would have been preferable he signed the proposed care plan to indicate he would not comply in any event. His history was such it is clear he had no intention of complying with cardiovascular care plans but it is also clear he made efforts to stay physically fit, apart from his illicit drug use. In these circumstances, and as he was known to use illicit drugs whenever he could obtain them, I would have preferred documented evidence of attempts to engage him in some form of health education despite his resistance "(Page 22).



Recommendations

The Coroner did not make any recommendations in relation to the death of Mr Winmar, however, she stated,

"I accept targeting buprenorphine in urinalysis is costly and should not be a routine requirement. However, where only a handful of prisoners are in receipt of the patches it may be prudent to occasionally and randomly target those prisoners to determine whether or not the levels in their urine are consistent with the level expected for their prescription" (Page 19).

As of 8 September 2010 there are currently only five prisoners in receipt of Norspan in the system. All prescriptions for Norspan require the authorisation of the Director Health Services or delegate. Current practise is that an electronic authorisation (e-Authorisation) form is completed and signed by the Director Health Services which contains the following details:

- DHS Response:
- Authorised:
- Authorisation valid until:
- Conditions:
- Comments:
- Signature:
- Date of request:
- Patient Name:
- Location:
- D.O.B:
- TOMS ID:
- Allergies:
- Drug Name:
- Strength:
- Dose:
- Freq:
- Reason for prescribing:
- Start date:
- Cease date:
- Current medications (All):
- Prescriber's Signature:

The Director Health Services will also articulate on the e-Authorisation instructions to help identify if the patch has been tampered with, this may include but not be limited to:

- Application of patch by Nurse;
- Recheck x 3 weekly by Nurse; and
- Removal by Nurse.

DCS is currently formulating a Norspan policy which will include the procedures listed above, but not limited to the following points for consideration:

- Justification/diagnosis;
- Continuity of care;
- Random buprenorphine levels;
- Limited duration of treatment;
- Reassessment by medical officer monthly; and
- Zero Tolerance of non compliance.



The Deputy Coroner further said [in part],

"Where prisoners with severe health problems refuse to engage in health care plans it may be prudent to check their drug status to determine whether or not a focused attempt be made to engage them in relevant health care education. I accept this would not have revealed buprenorphine use, however, any amphetamine based substances would also have warranted a serious discussion about the possible effects of illicit drugs in general on his cardiovascular condition" (Page 22).

DCS agree it would be prudent to undertake screening for illicit psychoactive drugs or mental health problems if a prisoner with a severe health problem refuses to participate in health care planning, provided appropriate consents are obtained and a mini mental state examination is considered.


Preparation of this Report

This report was prepared by Darren Akerman, Acting Coordinator Coronial Inquests.



Darren Akerman
A/Coordinator Coronial Inquests

9 September 2010

Endorsed: 
Deputy Commissioner
Adult Custodial 16.9.2010

Endorsed: 
Deputy Commissioner (MARK GLASSON)
Offender Management & Professional Development

Endorsed: 
Assistant Commissioner
Professional Standards 13.9.10



Phillip Maitland WONGAWOL

Phillip Maitland Wongawol (the deceased) died on 17 October 2004 at Royal Perth Hospital, Wellington Street, Perth as a result of liver failure due to hepatocellular carcinoma complicating cirrhosis of the liver. The inquest hearing was held at the Perth Coroner's Court on 30 April 2010 and the findings were delivered by the State Coroner 7 May 2010.

The State Coroner was satisfied that the deceased was a 44 year old Aboriginal male who was a sentenced prisoner who was serving a sentence of 6 months and 1 day for the offence of unlawful assault at the time of his death on 17 October 2004. The sentence had been imposed on 27 July 2004.

The deceased was initially held at Eastern Goldfields Regional Prison but had been transferred to Acacia Prison on 28 July 2004 and then on 30 September 2004 to Royal Perth Hospital where he died.

An independent review of the deceased's medical treatment conducted for the Coroner's Court noted that he was managed with palliative treatment and quietly passed away. No further medical review of his treatment was considered necessary and the medical treatment appeared to be of a relatively high standard.

A post mortem examination determined that the cause of death was liver failure due to hepatocellular carcinoma complicating cirrhosis of the liver.

The State Coroner found that the death arose by way of Natural Causes.

The State Coroner made comments on the quality of the supervision, treatment and care of the deceased while in custody in the following terms –

The medical treatment of the deceased appeared to have been appropriate and reasonable in the circumstances. A report provided by Dr Gray who saw the deceased as a visiting medical officer at Acacia Prison records the discovery of his deteriorating medical condition and the initial diagnosis of cirrhosis of the liver. Appropriate testing appears to have taken place which recorded the worsening of the deceased's liver function and then on 8 October 2004 the deceased was found to have a large hepatocellular carcinoma causing rapid decompensation of his liver function as a result of bleeding within the tumour tissue in the liver. The deceased's condition was then assessed as terminal and it was expected that he would die within weeks, rather than months.



The “Not for Resuscitation” Order

It appears that the “Not for Resuscitation” order was made taking into account the deceased’s diagnosis, the outcome of departmental discussions, consultation with the deceased himself and consultation between Dr Chin, the Gastroenterology Registrar, and Dr Forbes, Head of Department.

In all of the circumstances the State Coroner found that this was an appropriate order.

The police officer investigated the circumstances surrounding the death, Detective Senior Constable Taylor of the Prison Squad, expressed concerns in respect to inadequate documentation appearing on the medical file relating to this order having been made.

While the notation “Not for Resuscitation” did appear within the medical notes, dated 8 October 2004, no other information was recorded as to how the decision had been reached and the extent to which consultation with the patient, counsellors and other medical staff had been involved.

The officer suggested that Royal Perth Hospital prepare a set of written guidelines for dealing with such situations and adopt a written form to be signed by both doctor and patient detailing and acknowledging the decision, similar to a form then in use at Sir Charles Gairdner Hospital for the same purposes.

This issue appears to have been addressed by the hospital.

In a letter dated 6 September 2010 the Department of Corrective Services responded to the State Coroner findings in the following terms –



**DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE
TO THE FINDINGS OF THE CORONER
INTO THE MANNER AND CAUSE OF DEATH OF
MR PHILLIP MAITLAND WONGAWOL**

Background

The State Coroner held an inquest into the death in custody of Mr Phillip Maitland Wongawol at Perth Coroners Court, on 30 April 2010, and released his findings to the Commissioner on 14 May 2010.

Mr Wongawol was a 44 year old aboriginal male who died on 17 October 2004 at Royal Perth Hospital in Perth, Western Australia. At the time of his death Mr Wongawol (the deceased) was a sentenced prisoner having been sentenced to a period of imprisonment of 6 months and 1 day for 2 charges of common assault by the Leonora Court of Petty Sessions.

Findings

The Coroner said "The deceased was initially held at Eastern Goldfields Regional Prison (EGRP) but had been transferred to Acacia Prison on 28 July 2004 and then on 30 September 2004 to Royal Perth Hospital where he died" (Page 7).

The Coroner highlighted "An independent review of the deceased's medical treatment conducted for the Coroner's Court by Dr Robert Turnbull noted that he was managed with palliative treatment and quietly passed away. No further medical review of his treatment was considered necessary and the medical treatment appeared to be of a relatively high standard" (Page 7).

The Coroner found "A post mortem examination determined that the cause of death was liver failure due to hepatocellular carcinoma complicating cirrhosis of the liver" and he further stated "I find that death arose by way of Natural Causes" (Page 7).

The Coroner noted that the deceased was transferred to RPH as a medium security prisoner with a history of escape, as such he was supervised by two AIMS officers at all times and was mechanically restrained. As he was restricted to a hospital bed, leg restraints were used (Page 6).

On 15 October 2004 the Security Manager AIMS, submitted a report regarding concerns raised by hospital staff over the use of restraints on the deceased given his medical condition. After a risk assessment was conducted on the deceased, authorisation was sought from the General Manager Acacia Prison to remove the restraints. That authorisation was provided and a then existing restriction on visitors was lifted to allow the deceased to receive visits from family and friends (Page 6).

The Coroner made comment regarding the application for Royal Prerogative of Mercy and noted "In the context of the deceased's relatively short prison sentence and terminal illness efforts were made to apply for Royal Prerogative of Mercy and on 13 October 2004 an application was made under section 7(2) of the *Australia Act 1986*". The Coroner then said "The Executive Council met on 18 October 2004 and granted the deceased Royal Prerogative of Mercy, however, he had died the previous day" (Page 7).



Comments on the quality of Supervision, Treatment and Care of the deceased while in custody

The Coroner's report concluded the following in relation to the management of Phillip Wongawol while in custody:

1. "The medical treatment of the deceased as noted earlier in these reasons appeared to have been appropriate and reasonable in the circumstances (Page 8).
2. "A report provided by Dr Gray who saw the deceased as a visiting medical officer at Acacia Prison records the discovery of his deteriorating medical condition and the initial diagnosis of cirrhosis of the liver". Appropriate testing then followed which identified the worsening condition of the deceased's liver function (Page 8).
3. "The deceased's condition was then assessed as terminal and it was expected that he would die within weeks, rather than months" (Page 8).
4. The Coroner found the "Not for Resuscitation" order, in all of the circumstances was an appropriate order (Page 8).

Recommendations

The Coroner did not make any recommendations in relation to the death of Mr Wongawol.

The Coroner did comment "In the context of the deceased's short prison sentence and the fact that he had been transferred away from family and friends, it is unfortunate that these delays were encountered in achieving the deceased's release" (Page 7).

These comments relate to the administrative timeframe (13 Oct 2004 – 18 Oct 2004) taken to apply and grant Royal Prerogative of Mercy to the deceased, who died on 17 Oct 2004, the day prior to being granted the Royal Prerogative of Mercy.

The Department is cognisant of the Coroner's comments above and believes it acted promptly and appropriately when making application for the Royal Prerogative of Mercy.

Preparation of this Report

This report was prepared by Darren Akerman, Acting Coordinator Coronial Inquests.



Darren Akerman
Acting Coordinator Coronial Inquests

| September 2010

Endorsed: 
Assistant Commissioner
Professional Standards



Alan EGAN

Alan Egan (the deceased) died on 2 March 2008 at Fremantle Hospital as a result of Complications of Disseminated Malignancy. The inquest hearing was held at the Perth Coroner's Court on 22-23 June 2010 and the findings were delivered by the Deputy State Coroner September 2010.

The Deputy State Coroner was satisfied that the deceased was a 63 year old Aboriginal male who had been in the prison system continuously from 1986 when he was sentenced to a six year prison term followed by an indefinite sentence where he was held at the Governor's Pleasure.

Once held at the Governor's Pleasure he was subject to annual review by the Parole Board (which later became PRB), but was consistently denied release to the community due to his intransigence with respect to participation in any form of Sex Offenders Treatment Program (SOTP) and the seriousness of his original offending.

The Deputy State Coroner accepted the prison system attempted to engage the deceased in appropriate programs. Originally they were not available to a prisoner such as the deceased due to their restricted placements. As, over time, they became refined, so the deceased's attitude towards any behaviour changes became entrenched.

No progress was made with engaging the deceased in any SOTP program which was a PRB requirement.

Over time he became recognised as an accomplished artist in the prison community and gained great respect for his art work and age.

While accepting the department was attempting to find ways to accommodate the deceased it is also the fact, from the deceased's perspective, there was no ability to compromise over the terms of any appropriate SOTP. Whatever was suggested never closed all his objections and so provided the deceased with a reason to decline to engage. There is no doubt he possessed the cognitive ability to engage if he so chose. It also seems obtuse from a psychological perspective to require aboriginal males be assessed by females, of whatever ethnicity, when considering indigenous appropriate SOTPs.

Unfortunately the deceased became extremely unwell and was diagnosed with terminal cancer. Plans for both release and Clemency were rejected without some input from the deceased with respect to attempts to address any perceived danger to the community into which he was released.



Efforts were made to re-engage the deceased, however, he became severely unwell before it was possible to determine whether or not he would eventually follow through with a culturally appropriate management and behaviour modification plan. The deceased had at times acknowledged he had an alcohol problem and it seems all of his offending had occurred at times when he was severely intoxicated. He appears not to have seen his sexual offending behaviour as separate from his intoxication. He had addressed his alcohol consumption with respect to a healthier lifestyle. It is possible, regardless of the purpose of the alcohol education, his desire to remain alcohol free would have prevented his sexual offending.

The Parole Board followed by the PRB consistently required full SOTP involvement rather than the alcohol or cognitive behaviour therapies.

The deceased died of his disease in Fremantle Hospital on 2 March 2008 before being engaged in any management plan.

The Deputy State Coroner found death arose by way of Natural Causes.

The Deputy State Coroner made comments on the Supervision, Treatment and Care of the deceased while in custody in the following terms –

Community policies, as reflected by the executive and judicial attitudes, have changed since 1986 when the indefinite term of imprisonment was imposed on the deceased. In 1986 a Judge could impose an indefinite sentence without hearing expert evidence as to a prognosis for the offender's future offending behaviour. Case law after that time developed a system whereby the prosecution would make such an application to the judge and the defence would be warned of such an application and both sides would attempt to provide expert input for the benefit of the Judge then imposing an indefinite sentence.

Once the indefinite sentence was imposed, and there had been no appeal over-turning the sentence, then the detainee subject to an indefinite sentence would be annually reviewed as to their circumstances, once into the indefinite term. This occurred with the deceased and it was at those annual reviews the subject of his willingness, or lack thereof, to engage in relevant SOTPs arose. They were relatively new and unsophisticated initially.

One of the people approached by the ALS in late 2007 in an attempt to engage the deceased when requested to do so by the Parole Board was an Aboriginal Psychologist, Mr Darryl Henry. He is the author of the Aboriginal Cognitive Skills Program used in WA prisons at that time



Evidence from Mr Henry during the inquest indicated he believed he would have been able to properly engage the deceased in an appropriate and relevant therapy to progress a pre-release program. Mr Henry also believed the deceased had become resigned to not leaving prison and was to a considerable extent institutionalised.

Working with the deceased would involve allowing him respect for the positives in his life and using that as a basis for addressing the negative aspects of his behaviour. Unfortunately, Mr Henry did not have the opportunity to progress his plan for the deceased and see whether or not he could really be engaged in the way Mr Henry hoped.

However, the very fact he would at least speak with Mr Henry, as he had with the AVS members at Roebourne, may indicate a more culturally appropriate approach could be successful with people such as the deceased at a much earlier stage of their prison life. It may suggest rapid inclusion in appropriate programs would be more successful in engaging indigenous men, in particular, in addressing behavioural problems, before they become lost in a cycle of hopelessness.

The Deputy State Coroner found that evidence from both Mr Parke and Mr Ellis at the inquest indicated, in more recent times, the prison system has very much attempted to provide appropriate treatment programs for a number of offending behaviours, using various assessment methods.

It is essential offenders cooperate with the assessment process to enable an appropriate understanding of the programs which will best build on an individual's needs and circumstances to work towards a positive achievement ultimately for the appropriate program. This has not always been the case and certainly it is fair to say that when the deceased commenced his prison term programs addressing criminogenic needs, whether they be by way of mental health or behavioural issues, were very much more basic than the systems now available. It is entirely possible the deceased became disillusioned and non receptive to attempts to engage with him before prison services had reached a level at which they could suitably deal with him. His offences were serious and the system needed to consider broader community issues.

The Deputy State Coroner was persuaded, as time has progressed, there is becoming available to the prison system a number of options it would be beneficial to consider. Mr Ellis indicated changes in the expectation of workers in the prison system has altered over time. Originally there were no specific requirements for relevant qualifications. This changed in 2001 when it became mandatory for people employed in various counselling and program delivery programs in the system to be relevantly qualified.



This probably precluded satisfactory input in a number of minority groups and includes the indigenous community. Mr Henry believes there are ways indigenous prisoners can be appropriately engaged in rehabilitative programs which address an offender's criminogenic needs. These need to consider skilled workers rather than professionally or tertiary qualified workers. Mr Ellis agreed more recently he believed this was an appropriate matter for the prison system to consider.

The Deputy State Coroner was also concerned better engagement of indigenous prisoners while in the prison system will improve general health expectations. While the deceased does appear to have been prepared to accept medical treatment she noted he appears to have made no complaint leading to earlier diagnosis of his cancer condition, until discovered unconscious.

The Deputy State Coroner was satisfied that it would be beneficial to the prison system to consider more wide spread use of appropriately skilled aboriginal health care workers in an attempt to engage the disproportionate number of indigenous prisoners in the system. As Mr Ellis indicated addressing criminogenic needs is ultimately cost effective. Any strategy which would work towards encouraging offenders to accept some sort of responsibility for their offending behaviour and address it is a benefit to the community as a whole. Generally a community which respects itself finds it easier to respect others and differences in culture are more appropriately resolved and effective compromise obtained.

The Deputy State Coroner accepted the treatment, supervision and care of the deceased was a work in progress which was being addressed as adequately as was possible in the current state of custodial services. It was not possible to engage him at a time which would probably have been most beneficial to him and the community.

The Deputy State Coroner noted there are a number of long time prisoners in the prison system subject to indefinite sentences imposed after relatively short finite terms. This indicates the initiating offence itself is less of a problem than the concern as to the on-going behaviour of the offender. (This was not the case for the deceased who's offences had been serious).

The Deputy State Coroner commented that the sorts of individual therapeutic strategies considered at the end of his life for the deceased may be utilised and refined for the benefit of some of those still incarcerated.



The Deputy State Coroner, however, accepted some of those serving indefinite sentences are, and will always remain, a danger to the community as a whole due to matters wholly individual to themselves.

The Deputy State Coroner made a recommendation in the following terms -

There be serious consideration given to the appointment of skilled Indigenous Health Workers to co-ordinate and assist AVS members in engaging indigenous prisoners in ways considered appropriate to achieve outcomes which will satisfy general community goals.

In a letter dated 13 December 2010 the Department of Corrective Services responded to the Deputy State Coroner's findings in the following terms -



**DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE
TO THE FINDINGS OF THE CORONER
INTO THE MANNER AND CAUSE OF DEATH OF
MR ALAN EGAN**

Background

The Deputy State Coroner held an inquest at the Perth Coroner's Court on 22 and 23 June 2010 into the death in custody of Mr Alan Egan.

Mr Egan, a 63 year old Aboriginal man who was a sentenced prisoner at the time of his death, had an extensive criminal history including offences of a sexual and alcohol related nature. He was first detained as a juvenile and was also incarcerated on a number of brief occasions as a young adult. In 1986, Mr Egan was convicted of a serious sexual offence, the Aggravated Sexual Penetration of a three year old female, and sentenced in the Perth Supreme Court to a finite term of six years imprisonment. He was detained at the Governor's Pleasure. Whilst incarcerated, Mr Egan was regularly reviewed for release by the Parole Board (now the Prisoner Review Board); however, his release to parole was repeatedly deferred due to his refusal to undergo a psychological risk assessment and to participate in programs to address his offending. Mr Egan died in Fremantle Hospital at approximately 2016 hours on 2 March 2008.

Finding

The Deputy State Coroner found that Mr Egan died as a result of Complications of Disseminated Malignancy and that death arose by way of Natural Causes (Page 15 of the Deputy State Coroner's Report refers).

Comments on the Supervision, Treatment and Care of the Deceased

The Deputy State Coroner noted that "one of the people approached by the ALS in late 2007 in an attempt to engage the deceased when requested to do so by the Parole Board was an Aboriginal Psychologist, Mr Darryl Henry... Evidence from Mr Henry during the inquest indicated he believed he would have been able to properly engage the deceased in an appropriate and relevant therapy to progress a pre-release program. Mr Henry also believed the deceased had become resigned to not leaving prison and was to a considerable extent institutionalised" (pages 16 and 17).

The Deputy State Coroner went on to say that "the very fact he [Mr Egan] would at least speak with Mr Henry, as he had with the AVS members at Roebourne, may indicate a more culturally appropriate approach could be successful with people such as the deceased at a much earlier stage of their prison life. It may suggest rapid inclusion in appropriate programs would be more successful in engaging indigenous men, in particular, in addressing behavioural problems, before they become lost in a cycle of hopelessness" (page 17).

The Deputy State Coroner acknowledged that "...in more recent times, the prison system has very much attempted to provide appropriate treatment programs for a number of offending behaviours, using various assessment methods" (page 17). The Deputy State Coroner also accepted that "...it is essential offenders cooperate with the assessment process to enable an appropriate understanding of the programs which will best build on an individual's needs and



circumstances to work towards a positive achievement ultimately for the appropriate program" (page 18).

In again referring to the evidence of Mr Henry, the Deputy State Coroner stated, "Mr Henry believes there are ways indigenous prisoners can be appropriately engaged in rehabilitative programs which address an offender's criminogenic needs. These need to consider skilled workers rather than professionally or tertiary qualified workers. Mr Ellis agreed more recently he believed this was an appropriate matter for the prison system to consider" (page 19). In response to Mr Henry's suggestion, the Deputy State Coroner indicated, "I am also concerned better engagement of indigenous prisoners while in the prison system will improve general health expectations... I am satisfied it would be beneficial to the prison system to consider more wide spread use of appropriately skilled aboriginal health care workers in an attempt to engage the disproportionate number of indigenous prisoners in the system" (page 19).

The Deputy State Coroner made the following recommendation in relation to this issue:

Recommendation: I recommend that there be serious consideration given to the appointment of skilled Indigenous Health Workers to co-ordinate and assist AVS members in engaging indigenous prisoners in ways considered appropriate to achieve outcomes which will satisfy general community goals.

DCS Response: The Department of Corrective Services supports this recommendation in principle and acknowledges the similar previous recommendation (dated 14 January 2005) following the inquest into the death of Mr Garlett. The Department can advise it has been working with the Western Australian Country Health Service (WACHS) and Area Health to address aboriginal health in prisons.

This initiative is dependent on COAG funding and is directed by the WA Department of Health as the lead agency. The Department's role remains that of a partner by offering training and practicum placements for aboriginal health workers within corrections as part of this initiative.

Background information in relation to this issue

As part of the COAG funding process the Department submitted several general proposals (as requested) to WACHS in January 2010 and then reworked them through March and April 2010. The three proposals were:

1. A 1800 number to facilitate the exchange of information when an offender is released (dependent upon consent) via one point of contact for any health practitioner wanting to follow up on a person's medical care whilst in custody. (The decision has since been made to fund this from within the Department and the proposal has been fully developed and is due for implementation in the near future);
2. Re-entry services emphasising health throughcare - an extension of the existing re-entry services across the state; and
3. Practicum placements for Aboriginal health workers.

The Department understood these proposals would be sent through to the various Aboriginal Regional Forums for consideration.

On 22 November 2010 the Department obtained an update from WACHS, to ascertain the current status of the proposals. The following information was provided to COAG by WACHS:

- The funding is to support throughcare of prisoners and opportunities to increase the capacity of Aboriginal health professionals working within the prison system;



- Regional planning forums have all engaged a representative from the regional prison and each planning forum has submitted a plan for use of the funding in specific regions; and
- There is no linkage with the funds held by the Mental Health Commission - \$22.4M - which is to be used to establish a specialist mental health service for Aboriginal people.

In relation to the last dot point the Department is in discussions with the Mental Health Commission in respect to this initiative and its relevance to offenders.

The Department has been involved in discussion with WACHS in relation to the development for an extended period of time. Given the most recent contact with WACHS indicates that the state-wide proposals are reaching conclusion, the Department is confident that the funding will soon translate into increased state-wide health services for prisoners.

The 'Assessment of Clinical Service Provision of Health Services of the Western Australian Department of Corrective Services' report which was released on 22 November 2010, identified the need to actively identify agencies that can provide clinical services for Aboriginal offenders.

In concluding her findings, the Deputy State Coroner indicated her acceptance that "...the treatment, supervision and care of the deceased was a work in progress which was being addressed as adequately as was possible in the current state of custodial services. It was not possible to engage him at a time which would probably have been most beneficial to him and the community" (page 20).

Preparation of this Report

This report was prepared by Shana Eusebio (Coordinator Coronial Inquests) with input from the Health Services Directorate (Offender Management and Professional Development Division).

Eusebio

Shana Eusebio
Coordinator Coronial Inquests

8 December 2010

Endorsed: 
Deputy Commissioner
Adult Custodial

10.12.10

Endorsed: 
Deputy Commissioner
Offender Management & Professional Development

8.12.10

Endorsed: 
Assistant Commissioner
Professional Standards

13.12.10



Deaths Referred to the Coroners Court 1 July 2009 – 30 June 2010

A total of 2,580 deaths were referred to the coronial system during the year.

Of these deaths, in 720 cases death certificates were ultimately issued by doctors. In many cases there were initial problems experienced in locating a treating doctor or a treating doctor had initial reservations about signing a certificate which were ultimately resolved.

In the Perth area there were 1,360 Coroner's cases and in the country regions there were 500 Coroner's cases a total of 1,860 cases.

Coroner's cases are 'reportable deaths' as defined in section 3 of the *Coroners Act 1996*. In every Coroner's case the body is in the possession of the Coroner until released for burial or cremation. In all Coroner's cases an investigation takes place and either on the basis of that investigation or following an Inquest subsequent to the investigation, a Coroner completes findings as to the identity of the deceased, how the death occurred and the cause of death.

Statistics relating to the manner and cause of deaths referred to the Coroner for investigation are detailed below. In a number of cases a Finding by a Coroner had not been made at the time of compilation of the statistics, but an apparent manner and cause of death has been provisionally determined from the circumstances in which the body was found and from other information available.

There remains 133 cases which are still under investigation and have not been completed by way of finding by a Coroner.



**Deaths referred to a Coroner for investigation for the
Metropolitan area which have been completed
and signed by a Coroner**

1 July, 2009 - 30 June, 2010

Natural	680
Suicides	200
Accidents	238
Traffic	89
Homicide	11
Open	21
Misadventure	2
Possible Inquest	11
Incompleted cases	108
TOTAL	1360

**Deaths referred to a Coroner for investigation for the
Country area which have been completed
and signed by a Coroner**

1 July, 2009 - 30 June, 2010

Natural	239
Suicides	61
Accidents	64
Traffic	79
Homicide	5
Open	17
Misadventure	3
Possible Inquest	7
Incompleted cases	25
TOTAL	500

