Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 27/13

I, Dominic Hugh MULLIGAN, Coroner, having investigated the death of ***Bac Lam BANH****, with an Inquest held at Perth Coroners Court on* ***25 June 2013,*** *find that the identity of the deceased person was* ***Bac Lam BANH*** *and that death occurred on* ***5 September 2012,*** *at* ***Albany Regional Hospital****, as a result of* ***early Bronchopneumonia complicating Subarachnoid Haemorrhage due to a Ruptured Berry Aneurysm,*** *in the following circumstances:*

Appearances:

Sergeant Lyle Housiaux assisted the Coroner
Mr David Anderson (Office of the State Solicitor) appeared on behalf of the Department of Corrective Services

Table of Contents

3 – 5 September 2012

1. Mr Bac Lam Banh (the deceased) died in the Albany Regional Hospital on 5 September 2012.

2. At the time of his death Mr Banh was a sentenced prisoner serving his sentence at the Walpole Work Camp operated by the Department of Corrective Services.

3. During the evening of 3 September 2012, the deceased played badminton in the local community hall. The deceased was normally a very good player however on this occasion his play was noticeably weak.

4. Upon his return to the work camp the deceased made a telephone call to his partner. The deceased complained of a headache.

5. It is uncertain, but possible, that the deceased's headache and poor play were the first signs of bleeding from a berry aneurysm on an artery in the deceased's brain, which led to his death two days later.

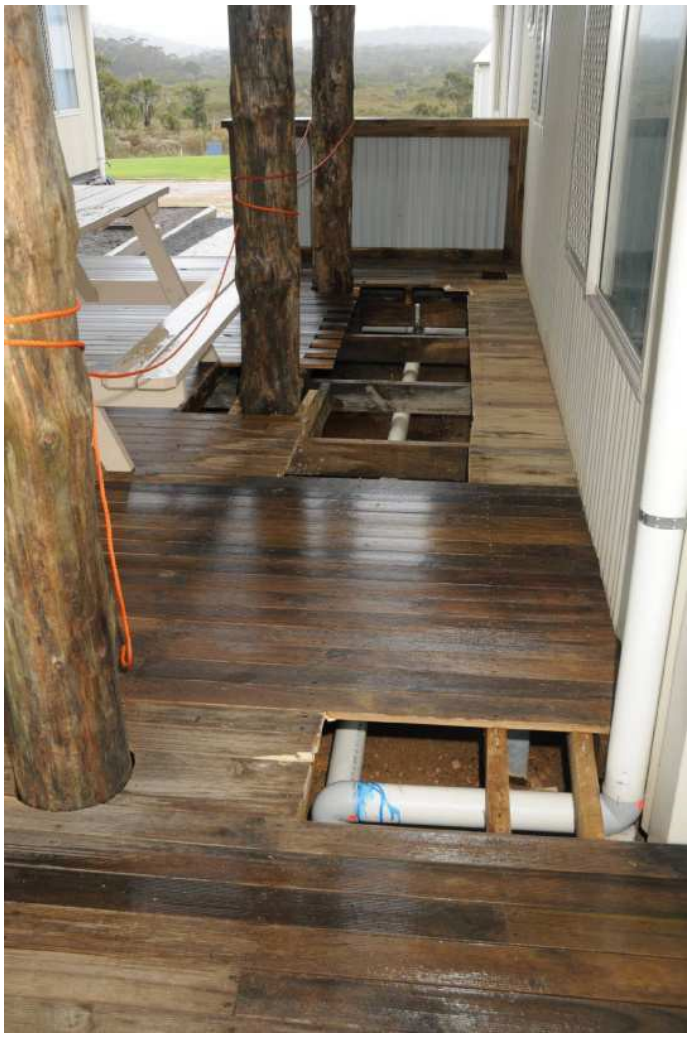
6. The following morning, 4 September 2012, the deceased awoke and undertook his normal morning regime of bathing, getting dressed, having breakfast and preparing for the day's work.

7. The deceased appeared to be in good health and spirits. He was not complaining of any particular ailment and he did not make reference, either to other inmates or prison officers, about having a headache.

8. The weather was poor and it was raining.

9. At about 8:15am that morning the deceased was tasked with repairing a faulty drainpipe connection which lay under decking outside one of the accommodation units. The work could only be undertaken on a rainy day when rain water would run through the pipes and any leaks would be apparent.

10. Whilst unattended the deceased lay on his stomach and examined the connection through a hole in the decking.



Photograph 1 - The deceased was working on the drainpipe depicted in the foreground

11. Whilst he was lying in that position a berry aneurysm in his brain ruptured and he began to suffer the effects of his severe subarachnoid haemorrhage. He collapsed and became unresponsive.

12. Very shortly after the deceased's collapse the prison officer who had tasked the deceased with the job of repairing the leak returned to where the deceased was working.

13. The officer spoke to the deceased, who did not reply. The officer initially believed the deceased to have been playing a joke on him and he thought the deceased was feigning unconsciousness.

14. The officer very quickly realised the deceased was very unwell and in need of immediate care and resuscitation.

15. The officer, assisted by two other prisoners tried to resuscitate the deceased. They performed expired air resuscitation (EAR; otherwise known as mouth-to-mouth resuscitation) and moved the deceased into the recovery position.

16. When circumstances permitted the officer left the deceased and called for the assistance of the Saint John Ambulance Service and the Police.

17. A nurse practitioner working for Walpole Silver Chain was also summonsed to assist Mr Banh. The nurse practitioner and two prison officers performed cardiopulmonary resuscitation (CPR), EAR and used an Oxy Viva in order to maintain the deceased's respiration.

18. Ambulance officers arrived shortly after being summonsed.

19. Shortly after their arrival the ambulance officers transferred the deceased by ambulance to the Walpole Health Clinic.

20. The doctor working at the health clinic was awaiting the deceased's arrival. The doctor examined the deceased who she found to have sustained a very severe brain injury. The deceased's pupils were both fixed and dilated, although his heart was still beating. The doctor injected the deceased with adrenaline and also inserted a laryngeal mask in order to further support in the deceased's breathing. The deceased was then transferred to the Albany Regional Hospital by ambulance. The doctor accompanied the deceased to the hospital.

21. The deceased arrived at the Albany Regional Hospital at about 11:15am. The deceased was treated and stabilised in the Emergency Department before being transferred into the High Dependency Unit.

22. Whilst in hospital the deceased's head was examined by a CT scan, which showed he had sustained an extensive grade IV subarachnoid haemorrhage.

23. A CXR scan was performed on the deceased's chest. The scan showed the deceased to have developed aspiration pneumonia.

24. The images were sent to neurosurgeons based in Perth, who concluded the deceased's condition was not survivable. The subarachnoid haemorrhage was too extensive to be successfully revised by surgery.

25. The deceased was supported by life-support systems until his family and partner had an opportunity to see him.

26. The deceased's life-support systems were then turned off and as a consequence he died. The deceased was certified to be life extinct by one of his treating doctors at 5:30am on 5 September 2012.

27. A toxicological analysis of samples of the deceased's blood detected only a quantity of Phenytoin (8 mg/L); a commonly used antiepileptic medication. The use of the medication was consistent with the deceased's proper hospital care.

28. A neuropathologist performed an examination on 13 September 2012. The neuropathologist detected a ruptured berry aneurysm and associated widespread subarachnoid haemorrhage.

29. A berry aneurysm is a small, sack-like out-pouching of a blood vessel in the brain. It is known as a berry aneurysm because of its appearance, which is similar to a berry.

30. During the inquest into the death inquest of Grantley Ross Winmar (a prisoner in Accacia Prison) I had the benefit of receiving an opinion from Professor Bryant Stokes, Professor of Neurosurgery, who gave his opinion about berry aneurysms. In my finding in that case I adopted the evidence of Professor Stokes.

31. In summary Professor Stokes said[1] a berry aneurysm is a congenital condition that was most likely present since the deceased's teenage years. As a person ages the berry aneurysm usually increases in size, especially if the person is hypertensive and also a smoker. Most people

[1] Inquest into the death of Grantley Ross Winmar, Exhibit 1, Volume 5, Tab 4-Email from Professor Bryant Stokes

with a berry aneurysm will remain asymptomatic until an acute bleed occurs.

32. A berry aneurysm can rupture without notice and a rupture is usually described as a thunder clap headache, meaning the instantaneous onset of a severe headache, sometimes with loss of consciousness, together with vomiting.

33. On 10 September 2012, a post-mortem examination was performed on the deceased by a forensic pathologist who, after receiving the results of further investigations on 31 October 2012, determined the cause of death to be '*early bronchopneumonia complicating subarachnoid haemorrhage due to a ruptured berry aneurysm'*.

Some Preliminary Matters of Law

34. The inquest into the death of the deceased was held in accordance with the *Coroners Act 1996* (WA) (the Act). Pursuant to section 25 (1) of the Act the coroner must find, if possible-

a) The identity of the deceased;
b) How death occurred;
c) The cause of death; and
d) The particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1998.

35. The obligation to determine the manner of death also arises as part of the enquiry as to how the deceased died pursuant to section 25 (1)(b) of the Act. In this context Buss JA noted that '*in my opinion s 25 (1)(b) confers on the coroner the jurisdiction and obligation to find, if possible, the manner in which the deceased happened to die*.' ***Re The State Coroner; Ex Parte the Minister for Health*** [2009] WASCA 165 [42].

36. Pursuant to the *Births, Deaths and Marriages Registration Act 1998* (WA) the coroner must find, if possible, the manner of death. The manner of death is registrable information under section 49 (2) of that Act and is information that is captured on a BDM204 form which a coroner, or delegate, must provide to the Registrar of Births, Deaths and Marriages.

37. Section 25 (2) of the Act provides that a coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

38. Section 25 (3) of the Act makes it mandatory for the coroner to comment on the quality of the supervision, treatment and care the prisoner received whilst in custody.

39. When making findings or comment a coroner needs to be mindful of section 25 (5) of the Act, which places the only statutory limitation upon how a comment or finding may be framed. Section 25 (5) of the Act provides:

> A coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

40. The analogous provision within the South Australian legislation was considered by the Supreme Court of South Australia in ***Perre v Chivell*** No. SCGRG-99-1218 [2000] SASC 279 (24 August 2000) when considering the appropriateness of a finding that had been made by the South Australian State Coroner in the following terms:

> Accordingly, I find, pursuant to section 25 (1) of the Coroners Act 1975, that the circumstances of the death of Detective Sergeant Geoffrey Leigh Bowen were that he died when he opened a parcel bomb, sent to him by Domenic Perre, and the bomb exploded in his hands.

41. After concluding that the finding didn't appear to determine any question of civil or criminal liability, His Honour considered whether or not the finding offended against the Act as '*suggesting*' that Mr Perre was guilty of a criminal offence or liable in a civil context. At paragraph 57 of the judgment His Honour Nyland J stated:

> As I have already mentioned, section 26 (3)[2] refers not only to findings of criminal or civil liability, but also any "suggestion" thereof. The addition of the word "suggestion" is liable to cause confusion as it might be argued that the mere finding of certain facts can, in cases such as the present, suggest or hint at criminal or civil liability and hence breach the section. This is due to the fact that certain acts, such as, in this case, sending a bomb, appear to have no possible legal justification. However, I do not think that section 26 (3) should be read in such a way. The mere recital of relevant facts cannot truly be said, of itself, to hint at criminal or civil liability. Even though some acts may not seem to be legally justifiable, they may often turn out to be just that. For example a shooting or stabbing will, in some circumstances, be justified as lawful self-defence. As I have stated, criminal or civil liability can only be determined through the application of the relevant law to the facts, and it is only the legal conclusions as to liability flowing from this process which are prohibited by section 26 (3). Thus, the word "suggestion" in this section should properly be read as prohibiting the coroner from making statements such as "upon the evidence before me X may be guilty of murder" or "X may have an action in tort against Y" or statements such as "it appears that X shot Y without legal justification". In other words, the term "suggestion" in section 26 (3) prohibits speculation by the coroner as to criminal or civil liability. In the present case, the coroner has neither found nor suggested that Perre is criminally or civilly liable for his acts.

42. Section 41 of the Act provides that a coroner holding an inquest is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit. This section provides a coroner with latitude as to the types of evidence that can be

[2] *Analogous to s25 (5) Coroners Act 1996 (WA)*

considered by the coroner and allows a relaxing of the normal rules of evidence.

43. Section 41 does not allow a coroner to disregard the rules of natural justice or fairness developed in a series of cases beginning with ***Annetts v McCann*** (190) 170 CLR 596 FC 90/057 (20 December 1990).

44. It is trite to say the standard of proof in a coronial matter is the civil standard; on the balance of the probabilities.

45. Caution does need to be taken in circumstances where a finding or comment may be adverse to a person involved in the inquest process.

46. Dixon J in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336 at pp 362 - 3 articulated the concern a tribunal of fact should have when dealing with cases, which could potentially have serious consequences for one or more parties involved in the inquest:

> Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from the particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the Tribunal. In such matters reasonable satisfaction should not be produced by inexact proofs, indefinite testimony, or indirect inferences… when in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is, according to the better opinion, the same as upon of the civil issues… but consistently with this opinion weight is given to the presumption of innocence and exactness of proof is expected.

47. I take the comments of Dixon J in ***Briginshaw*** to encourage a more cautious approach, than that represented by the normal standard of persuasion, in circumstances where an adverse finding is under consideration

48. It is with that statutory and legal background that the inquest into the death of Mr Bac Lam Banh has been held and this finding delivered.

Comments Relating to the Quality of Supervision, Treatment and Care of the Deceased Whilst Incarcerated.

56. Because the deceased was in custody at the time of his death I must, pursuant to section 25(3) of the Act, comment on the quality of the supervision, treatment and care the deceased received while he was in custody.

57. For the last 918 days of the deceased's incarceration he was held at the Pardelup Prison Farm and the Walpole Work Camp. The Pardelup Prison Farm is responsible for the management of the Walpole Work Camp.

58. The Pardelup Prison Farm is located in the Plantagenet Shire. It is 386 km South West of Perth. It is about 27 km from Mount Barker and 80 km north of Albany.

59. The Pardelup Prison Farm was established in 1927 as an open, fence-free, rural location with a focus on positive farm-based work.

60. In 2009 the government further invested in Pardelup Prison Farm's accommodation and amenities which allowed prisoner numbers to rise from 20 in 2002 to 84 in March 2010.

61. According to the Office of the Inspector of Custodial Services[3], which conducted an unannounced inspection of Pardelup Prison Farm in May 2012, the prison farm has proved to be a secure and safe facility. Careful prisoner selection, a zero tolerance approach to bullying and misbehaviour, positive staff/prisoner relations, and the incentive of having a single cell accommodation in a pleasant setting have been key ingredients of this success.

62. According to the Office of the Inspector of Custodial Services, both staff and prisoners reported having a stronger sense of personal safety than at other prisons. In addition, extensive community-based work and

[3] Exhibit 1 volume 3 Tab 8

recreation activities have been successful, safe and warmly embraced by the community.

63. Prisoners typically spend some time working and training at the Pardelup Prison Farm before they are considered eligible to transfer to the Walpole Work Camp.

64. Walpole Work Camp has a capacity of 12 prisoners.

65. The Walpole Work Camp is located approximately 140 km to the south west of Pardelup Prison Farm, and 120 km west of Albany. It is an open prison, without any mechanism for containing prisoners within its bounds.

66. The 12 prisoners are housed in two accommodation blocks. The accommodation blocks contain individual bedrooms for each prisoner together with other amenities such as a kitchen, common room, bathroom et cetera. The accommodation blocks are distinctly more home-like than prison-like.

67. The deceased had his own room, which was of a good size and had been made very comfortable by the deceased. The room had two large windows, without bars, which allowed a significant quantity of natural light to permeate the room. It was also fitted with an electric oil heater which provided effective heat during the cooler months.

Photograph 2 - The Entry to the deceased's bedroom

68. The deceased decorated his room with two rugs on the floor and numerous photographs. He also had a variety of electronic goods to entertain himself. He had a computer, DVD player, video recorder and flatscreen monitor. His room also contained his other possessions such as his clothes, toiletries, personal effects, food items and sports equipment (badminton racquet and fishing rod).

69. By the standards of those who live in the community the deceased's accommodation was of a reasonable standard. By the standard of prisoners in other institutions within Western Australia the deceased's accommodation was of the highest standard.

Photograph 3 - A view inside the deceased's bedroom

70. Prisoners at the Walpole Work Camp lived a life far more akin to life in the community than in a higher security correctional institution. The inmates were largely responsible for their own domestic circumstances. They were also responsible for keeping their accommodation clean and tidy. They were responsible for waking up in the morning, performing their own ablutions, preparing their own meals and the presenting themselves for their daily work.

71. The inmates work from Monday to Friday either on projects within the confines of the work camp or on community-based projects in the Walpole area. They worked with either minimal supervision or in some circumstances with no supervision at all. Their labour has been of significant assistance to the local community.

72. Prisoners are also free to exercise during their spare time and are allowed to enter into community based activities such as those provided by sports or social clubs. The deceased play badminton on a weekly basis in a community-based environment.

73. The 12 men incarcerated in the Walpole Work Camp enjoy amongst the best accommodation, the most freedom and most meaningful work of any prisoners within the West Australian prison system.

Health Care

74. The standard of health care provided by the Department of Corrective Services to prisoners is set out in a policy document known as '*Health Services Policy PM00'*. The relevant portion of the policy provides:

> Every person in custody will have appropriate and timely access to evidence-based health care provided by competent, registered health professionals who will provide safe quality health care equivalent to that in the general community.

75. The Walpole Work Camp houses just 12 prisoners. For that reason it is not economically viable for the Department of Corrective Services to provide a dedicated medical capability equivalent to that available in large prisons.

76. A nurse practitioner employed at the Pardelup Prison Farm provides an informal shared-care arrangement with the Walpole Silver Chain Health Centre. The nurse practitioner essentially had three roles:

    i. To arrange for prisoners to be returned to the Pardelup Prison Farm, in the event an inmate required dental care or other forms of care beyond the capacity of local healthcare facilities;

ii. To act as an advocate for the prisoner with the medical staff at the Walpole Silver Chain medical centre; and,

iii. To provide support to inmates in the Walpole Work Camp by providing services such as processing prescriptions for medication, updating and maintaining the prisoners electronic medical files on the Department's EcHO system, diarising and following up on all medical appointments to ensure the prisoner receives appropriate medical care.

77. Walpole Work Camp prisoners receive their immediate health care from the Walpole community's Silver Chain Health Centre.

78. The Silver Chain service[4] employs two doctors who travel from Denmark in order to consult with local patients. One doctor visits two and a half days per week. The doctor has consults for a full day Mondays and Thursdays. On Tuesdays the doctor consults for half a day. The other doctor works at the health centre for a whole day, every second Wednesday.

79. The Walpole Health Centre employs two nurses; a registered nurse who is available to respond to emergencies at all hours of the day and another practitioner who works as a child health nurse and project officer. The child health nurse does not respond to emergencies.

80. The health centre also received visits from Allied health professionals.

81. In the event of an emergency a person calling *'000'* has their call answered by the Saint John Ambulance Service who dispatch ambulance staff to the location of the person requiring their service.

82. A person calling the health centre after hours will be redirected to Health Direct, a national telephone-based triage service, who will refer the caller to the '*000*' service in the event of an emergency or direct the call to the registered nurse working at Walpole Health Centre who will respond as appropriate.

[4] Statement of Nurse Helen Joy Rollins, Exhibit 1 Volume 1 Tab 11

83. The police and the Saint John Ambulance Service have the registered nurses telephone number and are able to contact her at all hours of the day and night.

84. Dr Matt Merefield, an inspections and research officer at the Office of the Inspector of Custodial Services, who inspected the Walpole Work Camp in January 2013 provided a report[5] outlining the health care options available to inmates at the work camp.

85. Dr Merefield noted high prisoner satisfaction levels with the quality of the health services they received whilst being held at Walpole Work Camp and at Pardelup Prison Farm. According to Dr Merefield a survey of the prisoners, performed in 2012 found 81% of inmates felt their general health care services were 'mostly good' a result which is considerably higher than the state average of 54%. Similarly, 71% of inmates were happy with their access to health services, a result higher than the state average of 56%.

Hypertension

86. The deceased suffered from mild hypertension. This is significant as raised blood pressure can provide the impetus for a berry aneurysm to rupture.

87. The deceased's medical advisers were aware he suffered from hypertension before his death. It was not known the deceased had a berry aneurysm.

88. The National Heart Foundation grade blood pressure into a number of classifications which define the threat a patient's blood pressure poses to his or her health.

[5] Exhibit 1 Volume 3 Tab 10

CATEGORY	SYSTOLIC (millimetres of mercury)	DIASTOLIC (millimetres of mercury)
Normal	<120	<80
High – Normal	120 – 139	80 – 89
Grade 1 (mild)	140 – 159	90 – 99
Grade 2 (moderate)	160 – 179	100 – 109
Grade 3 (severe)	>= 180	>= 110
Isolated Systolic	>= 140	<90

Table 1 - National Heart Foundation Hypertension Categories

89. The Department of Corrective Services use a slightly different scale to classify hypertension. They adopt a classification in which blood pressure of <135/85 is considered normal and greater than that figure is considered hypertensive.

90. The deceased's average blood pressure for the eight years preceding his death was 149/95 which, according to the National Heart Foundation categorisation, indicates he suffered from mild hypertension.

91. The deceased's blood pressure was recorded during his incarceration at a figure equal to or greater than 135/85 on 18 occasions.

92. The Department of Corrective Services recorded the deceased's BP on his admission into Hakea Prison on to October 2003. At that time his BP was 158/88. The deceased's elevated systolic blood pressure may in part have been caused by the stress of his incarceration.

93. When the deceased returned to Hakea Prison on 6 June 2007 his BP was 180/102.

94. The deceased's BP was recorded on a number of occasions on 10 September 2007 and the highest reading was 130/90.

95. On 5 September 2011 the deceased's blood pressure was recorded at its highest known level; 192/110 indicating, according to the National

Heart Foundation categorisation table, the deceased had severe hypertension.

96. The deceased's blood pressure was labile and from 11 October 2011 until the time of his death, it was significantly lower than that recorded on 5 September 2011.

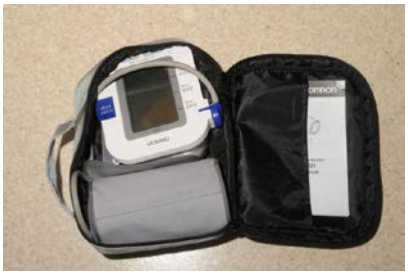
DATE	BLOOD PRESSURE	CATEGORISATION OF BLOOD PRESSURE
5 September 2011	192/110	Severe Hypertension
11 October 2011	135/110	Severe Hypertension
17 October 2011	130/90	Mild Hypertension
6 February 2012	125/90	Mild Hypertension
21 June 2012	145/91 & 153/91	Mild Hypertension
23 July 2012	135/85	High – Normal BP

Table 2 - The deceased's BP recorded by the Walpole Health Centre during the 12 months preceding his death.

97. In the 12 months prior to the deceased's death, with the exception of the two readings on 21 June 2012, the deceased's blood pressure was gradually declining from a situation where he had severe hypertension to a situation where his blood pressure was in the high-normal range.

98. The deceased's blood pressure was regularly monitored by his physicians, who did not consider he required hypertensive medication.

99. The deceased was provided with a Sphygmomanometer in order to monitor and record his own blood pressure.



Photograph 4 - The Deceased's Sphygmomanometer

100. The Department of Corrective Services asked Prof Max Kamien to review the medical care provided to the deceased during the course of his incarceration.

101. According to a later analysis undertaken by Prof Kamien the deceased's measurements of his own blood pressure occurred on many more occasions than feature in his medical records. Prof Kamien noted[6] '*most of these are reported as having been normal or mildly elevated'*.

102. Obesity, smoking and a lack of exercise are all linked to hypertension.

103. The deceased was advised to quit smoking, exercise more and lose weight.

104. The deceased took his doctor's advice and stopped smoking and regularly exercised. He also made changes to his diet so he would reduce weight.

105. The Department of Corrective Services recorded the deceased's weight on his admission into Hakea Prison on 2 October 2003. At that time the deceased weighed 88 kg.

106. When the deceased returned to Hakea Prison on 6 June 2007's weight was recorded as being 88 kg.

107. At the time of death the deceased was recorded as weighing 90 kg and being 170 cm tall. The deceased's body mass index (BMI) was 31.1 meaning he was obese.

108. Prof Kamien drafted a report[7] relating to the deceased's care, in which he made a number of points:

    i. The deceased made few demands upon the Corrective Services Medical System. Prof Kamien believes '*the treatments that he was given were compassionate and correct'*.

[6] Exhibit 1 Volume 1 Tab 32 Sub Tab 7 Page 2
[7] Exhibit 1 Volume 1 Tab 32 Sub Tab 7

ii. Prof Kamien believes in cases where it is uncertain as to whether a patient suffers from a particular condition, such as high blood pressure, a retrospective analysis of past blood pressure readings may provide a more clear guide as to whether hypertensive therapy should be instituted.

iii. Prof Kamien suggested that had a retrospective analysis of the deceased's blood pressure been undertaken, the results would have indicated the deceased suffered from mild hypertension which required treatment. In this context the deceased's blood pressure was recorded above 135/90 on 18 occasions and he had an average blood pressure of 149/95 in the eight years preceding his death.

iv. Prof Kamien believes a reasonable GP aware of the pattern of the deceased's blood pressure during his incarceration and his average blood pressure during the preceding eight years, would have initiated therapy for the deceased's hypertension especially as he had a family history of stroke.

v. Prof Kamien acknowledges it is a counsel of excellence to ask GPs to retrospectively reconsider all of the patient's data in order to detect patterns and averages. Prof Kamien said it was an axiom of good medical practice that '*when one is not sure of what is going on with a patient, then read their medical record*'.

vi. Prof Kamien also said it would be speculative to suggest that hypertensive therapy would prevent the rupture of the deceased's berry aneurysm. In this context Prof Kamien stated:

> I understand that a post mortem examination showed that his subarachnoid haemorrhage arose from a ruptured cerebral artery aneurysm. The moderately raised BP would have had some contributory effect on the time of the rupture. But some 2% of the population have cranial artery aneurysms and half of them die from their rupture. It is a common cause of sudden, unexpected death.

109. Dr Carbon, the Director Health Services with the Department of Corrective Services, is recorded[8] as believing the Department's partial medical governance has the potential to provide a level of medical care to prisoners at Walpole Work Camp inconsistent with what can be provided in mainstream prisons.

110. There would be significant cost implications for the Department should it choose to provide its own health service to 12 inmates in such an isolated location.

111. I note copies of the notes made by clinicians at the Walpole Health Clinic are forwarded to the Department of Corrective Services, who digitise the record and place it on with the inmate's EcHO file.

112. The Department may be able to improve the quality of governance and medical care provided to inmates at the Walpole Work Camp by developing a system of regular reviews of each inmate's EcHO file by a doctor employed by the Department but located elsewhere.

113. The Department's doctors may be able to review the inmate's medical records and determine whether an unwelcome pattern has developed which invites further investigation or treatment.

114. This form of review may provide not only the outcome sought by Prof Kamien, but also the cost efficiencies sought by the Exchequer.

115. The Department should also consider whether it would be appropriate to provide a paper copy of the inmate's EcHO file to the Walpole Health Clinic. The relevant portion of the inmate's EcHO file would set out his medical circumstances before arriving at the Walpole Work Camp.

116. The provision of the inmate's EcHO file to the Walpole Health Clinic would place an inmate in the same position as any other person moving into the area who is seeking continuity of medical care.

[8] Exhibit 1 Volume 1 Tab 31

117. The inmate's EcHO file could be given to the Walpole Health Clinic with the written permission of the inmate.

Recommendation No. 1

I recommend the Commissioner of the Department of Corrective Services consider implementing changes to the healthcare arrangements of prisoners at the Walpole Work Farm, so they can provide written permission for a hard copy of their EcHO file to be provided to their local, community based physician.

Recommendation No. 2

I recommend the Commissioner of the Department of Corrective Services consider implementing changes to the healthcare arrangements of prisoners at the Walpole Work Farm, so their EcHO file is regularly reviewed by a physician employed by the Department, with a view to determining whether an unwelcome pattern of ill-health has developed which invites further medical investigation or treatment.

Conclusion

118. In general terms I believe the quality of the supervision, treatment and care given to the deceased by the Department of Corrective Services was good and he was provided with meaningful work, excellent accommodation, significant opportunities to engage with the community and an ability to maintain and enhance his sense of independence and self-dependence.

119. On the evidence available to me I am satisfied the deceased had access to quality health services which was at least equal to that available to members of the Walpole community.

120. The deceased unfortunately had a berry aneurysm. The aneurysm was undetected and unknown to his medical advisors. This is not unusual as most people with a berry aneurysm are unaware of its existence until it ruptures.

121. The rupture of the berry aneurysm could have occurred at any time with little or no warning. Its rupture was likely to be fatal irrespective of where the deceased was.

122. In my opinion the deceased's prospects of recovery from the ruptured berry aneurysm were not negatively affected by the fact of his incarceration.

123. He was given prompt medical attention and he was transferred to the Albany Regional Hospital with a doctor in attendance. The nature and the extent of the subarachnoid haemorrhage, together with the development of early bronchopneumonia meant his condition was not survivable.

124. I find death arose by way of natural causes.

DH Mulligan
Coroner
3 July 2013