Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 19/16

I, Barry Paul King, Coroner, having investigated the death of ***Janene Devine*** *with an inquest held at* ***Perth Coroner's Court*** *on* ***1 June 2016****, find that the identity of the deceased person was* ***Janene Devine*** *and that death occurred on* ***16 March 2007*** *at* ***50 Sellars Way, Bull Creek,*** *from* ***malnutrition and sepsis on a background of end stage multiple sclerosis*** *in the following circumstances:*

Counsel Appearing:

Ms K E Ellson assisting the Coroner
Ms C J Thatcher (State Solicitor's Office) appearing for the Department of Health, Fremantle Hospital, Sir Charles Gairdner Hospital, Dr Gary Stein, Ms Kate Ballard, Ms Linda Freeman and Ms Renee Gilmore
Mr G C R Yin (D G Price & Co) appearing for Mr Andrew Devine

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INTRODUCTION

1. Janene Devine (**the deceased**) was 48 years old when she died. She lived in Bull Creek with her husband and their two sons.

2. The deceased had been a nurse. In 1999 she was diagnosed with multiple sclerosis (**MS**) with a poor prognosis. She continued to work at an aged-care facility until 2004 when she was no longer physically able to carry out her duties because of the debilitating progression of the MS.[1]

3. As the deceased's ability to look after herself declined, her husband Andrew Devine (**Mr Devine**) became her full time carer. Mr Devine was a psychiatric nurse who had stopped working in 2002 due to his own psychological problems, primarily a major depressive disorder. He received a disability pension and, later, a carer's pension.[2]

4. On 16 January 2004 the deceased attended Sir Charles Gairdner Hospital with an acute situational crisis from not coping with MS after she had stopped taking her antidepressant medication. She was admitted for six days and recommenced on the medication.[3]

5. On 21 April 2004 the deceased was again admitted to Sir Charles Gairdner Hospital, on this occasion with low mood and anxiety. She was seen by a consultant psychiatrist, who considered that there was a significant dysfunctional relationship between her and Mr Devine that was contributing to her problems.[4]

6. On 20 May 2005 the deceased was admitted to Sir Charles Gairdner Hospital for an extended stay after Mr Devine became incapable of caring for her due to his inability to cope. He had written a letter to the

[1] Exhibit 29
[2] Exhibit 29
[3] Exhibit 1, Volume 1, Tab 22
[4] Exhibit 1, Volume 1, Tab 22

deceased's mother indicating that he intended to gas the deceased and himself. He did not act on that intention at the time, but on 13 July 2005 he attempted to kill himself by carbon monoxide poisoning and was admitted to Fremantle Hospital overnight. [5]

7. The deceased was in Sir Charles Gairdner Hospital for seven months. She was diagnosed with MS with secondary progression and associated depression. When she discharged herself in early December 2005, medical and nursing staff were concerned that Mr Devine would not be capable of looking after her adequately. Efforts were made to find a residential placement, but the deceased wanted to return to the family home under Mr Devine's care.[6]

8. On 11 October 2006 Mr Devine took the deceased to the emergency department at Fremantle Hospital where she was admitted with rapidly progressing MS. The deceased was wheelchair-bound in a decreased conscious state and possibly starved. She had ceased taking medications nine months previously. On 16 October 2006 a percutaneous endoscopic gastronomy tube (**PEG tube**) was inserted to facilitate hydration and nutrition. Within days the deceased was mentally alert.[7]

9. On 1 November 2006 the deceased was discharged home. Mr Devine was provided with a number of items to aid in caring for and feeding the deceased and he was offered several in-home services, which he declined.[8]

10. The deceased's feeding regime through the PEG tube required four cans of prescribed food daily. Mr Devine was provided appropriate instructions and training in how to feed the deceased,[9] but he failed to comply with the instructions and the deceased again began to waste away.

[5] Exhibit 31
[6] Exhibit 1, Volume 2
[7] Exhibit 1, Volume 3
[8] Exhibit 1, Volume 1, Tab 23
[9] Exhibit 1, Volume 1, Tab 23

CIRCUMSTANCES OF THE DEATH

11. In the months leading up to the deceased's death, her sons were no longer living in the family home. They visited from time to time, but did not see the deceased's increasingly emaciated state because she was covered in blankets. Mr Devine discouraged them from going into her room so that she would not be overstimulated.[10]

12. Four days before the deceased died, her parents visited at Mr Devine's invitation. They sat with her on the veranda. She was unable to communicate and was obviously in a poor state of health, which the deceased's mother attributed to the MS.[11]

13. At about half past midnight on 16 March 2007 the deceased was still alive when Mr Devine checked on her. At 8.27 am that morning he called police after discovering her dead in her bed some time earlier.[12]

14. Police attended and observed the house to be in a state of squalor. Quantities of the canned food and all the components of the feeding system were intact and available for use close to the deceased.[13]

15. Forensic pathologist Dr J White conducted a post mortem examination of the deceased and found that she weighed only 30 kgs despite being 170 cms tall. When discharged from Fremantle Hospital on 1 November 2006, the deceased had weighed 43.2 kgs.[14] Dr White ultimately formed the opinion that the cause of the deceased's death was malnutrition in association with sepsis on a background of end stage multiple sclerosis.[15]

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[10] Exhibit 29
[11] Exhibit 29
[12] Exhibit 29
[13] Exhibit 29
[14] Exhibit 1, Volume 1, Tab 8
[15] Letter, Dr J White to Mr J Whalley (DPP) 11 February 2013

16. The sepsis to which Dr White referred was a result of infected bedsores.[16]

17. Evidence obtained from a neurologist who had treated the deceased in 2004 established that the cause of the deceased's emaciation was Mr Devine's failure to feed her the required amount of food through the PEG tube. It was later established that he had been feeding her only a fraction of what she required. Had he fed her properly, she would have gained weight and would have been expected to live another six or seven years.[17]

THE INITIAL INQUEST

18. The State Coroner was notified of the deceased's death on 16 March 2007. On 3 December 2007 the State Coroner instructed that further inquiries be undertaken before the issue of whether an inquest should be held could be considered. For reasons that are not apparent from the records available to me, those inquiries met with substantial delay. An inquest was eventually held before Coroner Mulligan on 22, 23, 24, 25, 26 and 30 October 2012 at the Perth Coroner's Court.

19. On 26 October 2012 Coroner Mulligan made an order under, I infer, section 49 of the *Coroners Act 1996* (**the Act**) prohibiting the reporting of Mr Devine's evidence at the inquest.[18]

REFERRAL TO THE DIRECTOR OF PUBLIC PROSECUTIONS

20. Following the taking of evidence and before delivering a record of investigation, on 10 December 2012 Coroner Mulligan wrote to the Director of Public Prosecutions, Mr Joseph McGrath SC, to report under section 27(5) of the Act his opinion that Mr Devine had committed an

[16] Exhibit 1, Volume 1, Tab 8; Exhibit 29
[17] Exhibit 29
[18] Exhibit 28 pp. 522 - 528; Suppression Order Report, Exhibit 28, Volume 2

indictable offence under the Criminal Code by starving the deceased to death. Coroner Mulligan arranged for copies of the exhibits and the transcript from the inquest to be provided to Mr McGrath SC.

21. Coroner Mulligan also made an order suppressing the reporting of the evidence adduced at the inquest.

22. By letter of 13 March 2013, the Deputy Director of Public Prosecutions, Mr Bruno Fiannaca SC, informed the Coroners Court that the Director of Public Prosecutions had reached the view that there was sufficient evidence to establish that Mr Devine had committed an indictable offence in respect of the death of the deceased. However, further investigation would be required by the Western Australia Police to compile evidence in an appropriate form, and the police would need to charge Mr Devine in the first instance.

23. Under section 53(1)(b) of the Act, where a coroner has commenced an inquest and is informed that a person has been charged with an offence in which the question whether the accused person caused a death is in issue, the coroner is to adjourn the inquest until the proceedings in respect of the offence have concluded.

MR DEVINE PLEADS GUILTY

24. Mr Devine was charged with wilful murder by way of a prosecution notice dated 31 July 2013.[19]

25. On 25 February 2014 Mr Devine's legal representatives sent the Director of Public Prosecutions his offer to plead guilty to the charge of manslaughter on the basis of his failure to provide the deceased with the necessaries of life, which caused her death. The Director of Public Prosecutions accepted that offer on 4 April 2014.[20]

[19] Exhibit 30, p. 11
[20] Exhibit 30, pp. 11-12

26. On 12 August 2014 Mr Devine was arraigned on the charge of manslaughter before Simmonds J in the Supreme Court of Western Australia in Perth. He pleaded guilty and was duly convicted.[21] On 14 August 2014 Simmons J sentenced Mr Devine to one year imprisonment.[22]

THE RECENT INQUEST

27. As Coroner Mulligan was no longer appointed as a coroner in Western Australia, on 1 June 2016 I held another inquest into the death of the deceased. The evidence adduced at the inquest was:

    a. the exhibits[23] and the transcript of oral evidence before Coroner Mulligan;[24]

    b. the judgment of Simmonds J, *The State of Western Australia v Devine* [2014] WASCSR 156;[25]

    c. the transcript of sentencing proceedings before Simmons J on 12 August 2012;[26]

    d. a psychiatric report dated 25 May 2014 by Dr Victoria Pascu, psychiatrist, with respect to Mr Devine;[27]

    e. a psychologist's report dated 8 August 2014 by Helen Fowler, clinical psychologist, with respect to Mr Devine;[28] and

    f. a neuropsychological report dated 3 September 2013 by Mandy Vidovich, clinical neuropsychologist, with respect to Mr Devine.[29]

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[21] Exhibit 30, p. 13
[22] Exhibit 29
[23] Exhibit 1, Volumes 1 – 3; Exhibits 2 - 27
[24] Exhibit 28 pp. 1 - 636
[25] Exhibit 29
[26] Exhibit 30
[27] Exhibit 31
[28] Exhibit 32
[29] Exhibit 33

28. No oral evidence was adduced and counsel made no submissions.[30]

HOW DEATH OCCURRED AND THE CAUSE OF THE DEATH

29. On the basis of the information available to me, I am satisfied that, while the deceased was incapacitated with end stage multiple sclerosis, Mr Devine provided her with a level of nutrition and care that was so inadequate as to lead to malnutrition and sepsis, which caused her death.

30. Under section 53(2) of the Act, the finding of the coroner on an inquest must not be inconsistent with the result of any earlier proceedings where a person has been charged on indictment in which the question whether the accused person caused the death is in issue.

31. Consistent with section 53(2) of the Act, I find that death occurred by way of unlawful homicide.

32. I find that the cause of death was malnutrition in association with sepsis on a background of end stage multiple sclerosis.

B P King
Coroner
30 September 2016

[30] Exhibit 28 pp. 637 - 641