JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	21 FEBRUARY 2023
DELIVERED	**:**	13 MARCH 2023
FILE NO/S	**:**	CORC 4 of 2021
DECEASED	**:**	ALBERT, FRANK

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sergeant A. Becker assisted the coroner.

Ms A. Westerside (State Solicitor's Office) appeared for the Department of Justice.

Ms E. Langoulant (Aboriginal Legal Service of WA Ltd) appeared for members of Mr Albert's family.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Frank ALBERT*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 21 February 2023, find that the identity of the deceased person was* ***Frank ALBERT*** *and that death occurred on 8 January 2021 at Derby Regional Hospital from atherosclerotic heart disease in the following circumstances:*

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SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make an Order under section 49(1)(b) of the *Coroners Act 1996* that there be no reporting or publication of the name of any prisoner (other than the deceased) housed at West Kimberley Regional Prison. Any such prisoner is to be referred to as "Prisoner [Initial]".

Order made by: MAG Jenkin, Coroner (21.02.23)

INTRODUCTION

1. Mr Frank Albert (Mr Albert) died on 8 January 2021 at Derby Regional Hospital (DRH) from atherosclerotic heart disease.[1,2,3,4] At thattime, he was a sentenced prisoner housed at West Kimberley Regional Prison (WKRP), and thereby in the custody of the Chief Executive Officer of the Department of Justice (DOJ).[5]

2. Accordingly, Mr Albert was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[6] In such circumstances, a coronial inquest is mandatory,[7] and I am required to comment on the quality of the supervision, treatment and care Mr Albert received.[8]

3. I held an inquest into Mr Albert's death in Perth on 21 February 2023, which members of his family attended by video-link from Broome. The inquest focused on the care, treatment and supervision provided to Mr Albert while he was in custody, as well as the circumstances of his death. The documentary evidence adduced at the inquest comprised two volumes, and Dr Catherine Gunson, (Acting Director, Medical Services, DOJ);[9] and Mr Tom Perrin, (Review Officer, DOJ) gave evidence.[10]

[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (12.03.21)
[2] Exhibit 1, Vol. 1, Tab 5, P92 - Identification of Deceased (08.01.21)
[3] Exhibit 1, Vol. 1, Tab 7, Death in Hospital form (08.01.21)
[4] Exhibit 1, Vol. 1, Tab 8.3, Confidential Report to the Coroner - Supplementary Post Mortem Report (30.09.21)
[5] Section 16, *Prisons Act 1981 (WA)*
[6] Sections 3 & 22(1)(a), *Coroners Act 1996 (WA)*
[7] Section 22(1)(a), *Coroners Act 1996 (WA)*
[8] Section 25(3) *Coroners Act 1996 (WA)*
[9] Exhibit 1, Vol. 2, Tab 29, Health Services Review (17.02.23) and ts 21.02.23 (Gunson), pp7-44
[10] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22) and ts 21.02.23 (Perrin), pp46-56

MR ALBERT

Background[11,12,13]

4. Mr Albert was born on 7 April 1974 in Derby, and was 46-years of age when he died. Mr Albert's family lived in the Djarindjin Community about 220 km north of Broome, and after completing his schooling, Mr Albert worked on cattle stations. It seems that Mr Albert damaged his hips and back in a workplace accident, and eventually he was unable to work and received a Centrelink pension.

5. Mr Albert had four children and one grandchild, and was described as a "*happy bloke*" who enjoyed fishing and crabbing. In her very moving letter to the Court, Ms Naomi Johnson (Mr Albert's aunt) refers to past trauma inflicted on family members, and the extraordinary contribution made to the wider community by a number of Mr Albert's relatives.[14]

Medical history[15]

6. After Mr Albert's death, DOJ completed a review of his medical care (Health Review), which noted his medical history included: abnormal liver test results, high cholesterol and type-2 diabetes. Although he had reportedly ceased smoking cigarettes in 1992, Mr Albert had a history of polysubstance use including methylamphetamine, cannabis, and alcohol. He carried an Epi-pen because of a severe allergy to rockmelon, and his family history of cardiac disease, high blood pressure and diabetes was noted as early as 2009.

Offending history[16,17,18]

7. Mr Albert had an extensive criminal history and he accumulated 112 convictions for offences including: burglary, grievous bodily harm, disorderly conduct, and breaches of violence restraining orders. In relation to some of these offences, Mr Albert served various terms of imprisonment between 1992 and 2019.

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[11] Exhibit 1, Vol. 1, Tab 2.2, Report - Det. Sen. Const. J Wilkinson (04.03.22), pp3-4
[12] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), p8
[13] ts 21.02.23 (Langoulant), p60
[14] Letter to Court - Ms N Johnson (01.03.23), pp1-2
[15] Exhibit 1, Vol. 2, Tab 29, Health Services Review (17.02.23), pp3-4
[16] Exhibit 1, Vol. 1, Tab 22, List of Criminal Court Outcomes
[17] Exhibit 1, Vol. 2, Tab 23.2, History for Court - Criminal & Traffic
[18] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), p8

RECEPTION AT WEST KIMBERLEY REGIONAL PRISON

Circumstances of most recent incarceration[19,20,21,22]

8. On 17 October 2019, Mr Albert was remanded in custody to Broome Regional Prison (BRP) in relation to two charges of burglary, and one charge of possessing cannabis. He was transferred to WKRP on 21 November 2019.

9. On 13 January 2020, in the Magistrates Court of Western Australia at Broome, Mr Albert was sentenced to 18-months' imprisonment in relation to the burglary charges. The possession of cannabis charge was disposed of by reference to the time Mr Albert had already served in custody. His earliest eligibility date for parole was 16 July 2020.

At Risk Management System and initial assessment[23]

10. When a prisoner is received at prison they are interviewed by a reception officer who conducts a risk assessment to determine whether the prisoner needs to be managed under the At Risk Management System (ARMS). ARMS is DOJ's primary suicide prevention strategy and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide.[24]

11. Mr Albert underwent an ARMS risk assessment at BRP on 17 October 2019. He was identified as a returning prisoner, and he told the reception officer he expected his family would be supportive. Mr Albert denied any self-harm or suicidal ideation and disclosed daily consumption of alcohol and cannabis. He also said he was on medication for diabetes, but otherwise had no serious medical issues. At the conclusion of the ARMS assessment, the reception officer noted:

> Writer does not consider the Prisoner to be at risk of self-harm or suicide at time of interview. Prisoner showed alert and timely responses to all questions asked.[25]

[19] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), pp8 & 9
[20] Exhibit 1, Vol. 1, Tab 19.1, Warrant of Commitment (13.01.20)
[21] Exhibit 1, Vol. 1, Tab 20, Transcript of Proceedings, Broome Magistrates Court (13.01.20)
[22] Exhibit 1, Vol. 2, Tab 23.3, Sentence Summary Offender
[23] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), p9
[24] ARMS Manual (2019), pp2-13 & 21-24
[25] Exhibit 1, Vol. 2, Tab 23.5, ARMS Reception Intake Assessment (17.10.19), p6

MANAGEMENT IN CUSTODY

Supervision issues[26]

12. A management and placement report (MAP) dated 18 October 2019, noted that Mr Albert's security rating had been reduced to "*medium*". As mentioned, Mr Albert remained at BRP until 21 November 2019, when he was transferred to WKRP.[27,28] When he arrived at WKRP, it was noted that Mr Albert had a relative at the facility and because he was "*off Country*", he was referred to the Prison Support Officer.[29]

13. A MAP performed on 15 January 2020, noted that Mr Albert preferred to stay at WKRP so he could maintain contact with his family and Countrymen. However, at his request, he was transferred to BRP on 19 November 2020 to attend a family funeral the following day. Mr Albert was returned to WKRP on 3 December 2020 after the funeral, and he remained there until his death.[30,31,32,33,34]

14. A parole review report completed on 6 May 2020 recommended that Mr Albert be denied parole on the basis that he had no viable release plan, and his accommodation and employment options were unconfirmed. In addition, there were no protective strategies in place to prevent reoffending, and Mr Albert had "*unmet treatment needs*" and a history of breaching community orders.[35]

15. On 16 June 2020, the Prisoner Review Board (PRB) wrote to Mr Albert to tell him he had been denied release on parole. The PRB considered Mr Albert was likely to breach a parole order because of: unmet treatment needs relating to his polysubstance use, his extensive criminal record, his poor response to previous community/suspended imprisonment orders, and his lack of a viable parole plan.[36]

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[26] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), p9
[27] Exhibit 1, Vol. 2, Tab 23.6, Management and Placement Report (18.10.19)
[28] Exhibit 1, Vol. 2, Tab 23.7A, Decision slip (21.11.19)
[29] Exhibit 1, Vol. 2, Tab 23.9, Orientation Checklist - WKRP (21.11.19)
[30] Exhibit 1, Vol. 2, Tab 23.10, Management and Placement Report (15.01.20)
[31] Exhibit 1, Vol. 2, Tab 23.14, Funeral Application (30.10.20)
[32] Exhibit 1, Vol. 2, Tab 23.15, Temporary Placement History
[33] Exhibit 1, Vol. 2, Tab 23.16, Orientation Checklist - BRP (20.11.20)
[34] Exhibit 1, Vol. 2, Tab 23.17, Decision slip (02.12.20)
[35] Exhibit 1, Vol. 2, Tab 23.11, Parole Review Report (06.05.20)
[36] Exhibit 1, Vol. 1, Tab 19.2, Letter - Prisoner Review Board to Mr Albert (16.06.20)

16. Whilst at WKRP, Mr Albert was employed as a unit worker, and was considered to be a polite person who interacted well with others. He kept his cell to "*an acceptable standard*" and records show he was the subject of random substance use tests and cell searches, all of which were negative. Mr Albert received regular visits from his family and friends, and he made numerous phone calls.[37,38,39,40,41,42]

17. Whilst incarcerated, Mr Albert was convicted of two offences against the *Prison Act 1981* (WA). The first related to gambling, and the second to disobeying a local order. In respect of each offence, Mr Albert lost gratuities for four days. His conduct in prison was otherwise unremarkable.[43]

Management of medical issues[44,45]

18. On 20 October 2019 at BRP, Mr Albert underwent a general assessment by a prison nurse. It was noted that Mr Albert had refused diabetes medication whilst in the community because he believed it made him "*heavy in the chest*". On 30 October 2019, Mr Albert was reviewed by a prison medical officer (PMO) and although his blood pressure was normal, his albumin-to-creatinine ratio was raised possibly indicating early kidney disease. The following day, an electrocardiogram (ECG) following day to check Mr Albert's heart function was reported as "*normal*".

19. Mr Albert was seen by a prison nurse on various occasions during November 2019, but remained adamant he did not want to restart his diabetes medication. Mr Albert said that instead, he would manage his condition by "*healthy eating*". He was given education on healthy eating for diabetes on multiple occasions, as well as an information booklet. A diabetes care plan was completed on 11 December 2019, and Mr Albert's blood sugar level (BSL) was regularly monitored.

[37] Exhibit 1, Vol. 2, Tab 23.12, Individual Management Plan (03.07.20)
[38] Exhibit 1, Vol. 2, Tab 23.35, Substance Use Test Results - Offender
[39] ts 21.02.23 (Perrin), p47
[40] Exhibit 1, Vol. 2, Tab 23.41, Visits History - Offender
[41] Exhibit 1, Vol. 2, Tab 23.42, Cell Searches - Offender
[42] Exhibit 1, Vol. 2, Tab 23.44, Recorded Call Report
[43] Exhibit 1, Vol. 2, Tab 23.36, Charge History - Prisoner
[44] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), pp9-14
[45] Exhibit 1, Vol. 2, Tab 29, Health Services Review (17.02.23), pp6-12 and ts 21.02.23 (Gunson), pp8-44

20. On 28 February 2020, Mr Albert saw a prison nurse and said he had experienced chest pains when taking diabetes medication in the past. Mr Albert's BSL and blood pressure continued to be regularly checked, and on 3 March 2020, his BSL was noted to be very high. Mr Albert was seen by a PMO who recommended Mr Albert take diabetes medication, but he refused and he signed a "*Release from Medical Responsibility*" form. Mr Albert received ongoing advice about diet and exercise, and twice daily BSL checks were started on 4 March 2020.

21. When Mr Albert was reviewed by a PMO on 27 July 2020, he continued to refuse diabetes medication. Further, although the PMO wanted him to undergo an exercise stress test to check his heart function, Mr Albert declined the referral. However, on 25 September 2020, Mr Albert saw a physician and agreed to trial a low dose of metformin (diabetic medication). A further review was planned in four months.

22. By 3 November 2020, Mr Albert's diabetes indicators had worsened, and a PMO increased his metformin dose and introduced another diabetes medication (empagliflozin), as well as the cholesterol lowering medication, Atorvastatin.

23. On 15 December 2020, Mr Albert's diabetes management plan was reviewed by a prison nurse, who noted that his BSL readings remained high. Mr Albert was again counselled about his diet and exercise regimes and although he was scheduled for a review by a PMO, Mr Albert died before the review could occur.

Review by an Aboriginal Health Worker[46]

24. The Health Review identified that Mr Albert was never seen by an Aboriginal Health Worker (AHW) during the time he was at WKRP. I am aware that AHWs offer a range of valuable services including advocacy, support, and culturally appropriate health promotion and education. At the relevant time, there were no AHW at WKRP, and regrettably, that unsatisfactory position persists to this day.[47]

[46] Exhibit 1, Vol. 2, Tab 29, Health Services Review (17.02.23), p12 and ts 21.02.23 (Gunson), pp29-30
[47] Attachment to Email from Ms A Westerside to Sgt A Becker (08.03.23)

25. As I have explained, Mr Albert repeatedly declined to resume taking diabetes tablets because of his erroneous assumption that the medication caused chest pain. Further, after complaining of chest pain, he refused a stress test. If Mr Albert had been seen by an AHW, there is at least a possibility that he might have agreed to resume taking diabetes and/or lipid medication at an earlier stage, and/or that he might have agreed to a stress test. Mr Albert may also have been encouraged to consume a diabetic diet, especially if culturally appropriate food choices had been proactively offered to him.

26. At the inquest, Dr Gunson (Acting Director of Medical Services, DOJ) agreed with Ms Langoulant's assertion that some Aboriginal prisoners distrust Western medical practices, and that this may affect a person's willingness to take prescribed medications and/or undergo recommended investigations.[48] In this context, an AHW may have been able to provide Mr Albert with relevant information in a culturally appropriate way. In my view, the fact that Mr Albert was not seen by an AHW whilst he was at WKRP was a missed opportunity to have potentially improved his health outcomes.

27. At the inquest it was suggested that all Aboriginal prisoners (especially those with chronic health issues like Mr Albert) should be reviewed by an AHW. In my view this is a very sensible suggestion given the obvious potential benefits, and I note with approval the following exchange at the inquest:

> *Ms Langoulant:* Would you be supportive of some change in how the health service is provided at the prison so that perhaps appointments with an Aboriginal Health Worker is offered as a matter of course and especially for a prisoner with chronic health (conditions) like Mr Albert?
>
> *Dr Gunson:* I think that would be an excellent idea.[49]

28. Mr Albert had a number of chronic health conditions, and it would clearly have been appropriate for him to have been offered the opportunity to be reviewed by an AHW.

[48] ts 21.02.23 (Gunson), pp29-30
[49] ts 21.02.23 (Gunson), p30

29. However, in a response to the Court provided on 8 March 2023, DOJ pointed to the difficulties in recruiting AHW, especially in regional areas. Despite the fact that are no AHW at WKRP, there are currently two AHW at Melaleuca Women's Prison, and two AHW at Eastern Goldfields Regional Prison. DOJ also noted that:

> Many of the Department's staff have experience in working within Aboriginal Medical Services, and some staff work part-time in Aboriginal Medical Services and part-time with the Department. Some staff have been recruited directly from Aboriginal Medical Services. Nevertheless, the gap that isn't resolved is the Department's limited number of Aboriginal Health Workers, which is primarily because the Department is not yet funded for this across all facilities.[50]

30. DOJ referred to the challenges it has faced in filling AHW roles, and noted that it had attempted to attract graduates from Marr Mooditj Training, a registered training organisation that provides training and assessment services to Aboriginal and Torres Strait Islander people.[51] I accept that DOJ has a finite budget and must make difficult choices about the allocation of resources. I also accept that recruiting staff in regional areas can be challenging, and I have addressed this issue in previous inquests I have presided over.[52]

31. Nevertheless, given the incidence of chronic medical conditions amongst the Aboriginal prisoner cohort, it would appropriate for DOJ to redouble its efforts to recruit AHW, especially for regional prisons. This is especially relevant at WKRP, whose website states: "*West Kimberley Regional Prison (WKRP) is a purpose built facility designed to support Aboriginal culture, kinship and connection to country, housing male and female prisoners, remand and sentenced*".[53]

32. I have therefore recommended that DOJ consider the feasibility of recruiting additional AHW so that all Aboriginal prisoners may be reviewed by an AHW on their admission to prison, and thereafter as appropriate.

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[50] Attachment to Email from Ms A Westerside to Sgt A Becker (08.03.23)
[51] See: www.marrmooditj.com.au
[52] See: Report of Investigation into Death: Mr J Williams [2022] WACOR 16, published 25.02.22, paras 187-193
[53] See: www.wa.gov.au/organisation/department-of-justice/corrective-services/west-kimberley-regional-prison

Mr Albert's collapse on 8 January 2021[54,55,56,57,58,59,60,61,62,63,64,65,66,67]

33. Dealing now with the events at WKRP, at about 9.04 am, a prisoner approached Officer Tompsett who was in the Unit 2 office at WKRP and said Mr Albert "*was having a heart attack or something*". Officer Tompsett asked where Mr Albert was located and was told he was in House 1 in Unit 2. Officer Tompsett made a medical emergency radio call (Code Red), and he and Officer Prouse made their way to House 1 where they were met by Officers Miles and Van Brussel who were responding to the Code Red.

34. The officers found Mr Albert in his cell "*propping himself up on his bed*" with his hand on his chest. Officer Van Brussel asked where his pain was, and Mr Albert touched his chest and said he felt he was he was "*blacking out*". Mr Albert was reassured that medical staff were on their way, and Officer Miles opened an access door to enable Nurse Ahuriri and Nurse Bavoillot (accompanied by Officer Goodchild and Senior Officer Marino) to enter House 1.

35. Mr Albert was experiencing heavy central chest pain, jaw stiffness and left arm pain. He was also restless, nauseated and clammy. He was given aspirin, and two doses of glyceryl trinitrate spray (GTN), used to treat angina, and Nurse Ahuriri's initial assessment was: "*cardiac involvement requiring emergency medical intervention*".

36. A short time later, Senior Officer Maurer arrived and took control of the scene. Staff who had responded to the Code Red and who were not required were stood down, and at 9.15 am (at the request of Nurse Ahuriri) Senior Officer Maurer ordered the prison officer on duty at the front gate (the Gate Officer) to call an ambulance.

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[54] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), pp14-18
[55] Exhibit 1, Vol. 2, Tab 23.20, Incident Description Report - Officer J Tompsett (08.01.21)
[56] Exhibit 1, Vol. 2, Tab 23.22, Incident Description Report - Officer A Van Brussel (08.01.21)
[57] Exhibit 1, Vol. 2, Tab 23.23, Incident Description Report - Officer T Prouse (08.01.21)
[58] Exhibit 1, Vol. 2, Tab 23.24, Incident Description Report - Officer B Miles (08.01.21)
[59] Exhibit 1, Vol. 2, Tab 23.25, Incident Description Report - Nurse T Ahuriri (08.01.21)
[60] Exhibit 1, Vol. 2, Tab 23.26, Incident Description Report - Officer K Goodchild (08.01.21)
[61] Exhibit 1, Vol. 2, Tab 23.27, Incident Description Report - Sen. Officer T Maurer (08.01.21)
[62] Exhibit 1, Vol. 2, Tab 23.28, Incident Description Report - Officer J Katonivualiku (08.01.21)
[63] Exhibit 1, Vol. 2, Tab 23.29, Incident Events Log (08.01.21)
[64] Exhibit 1, Vol. 2, Tab 23.30, Incident Description Report - Officer B Beer (08.01.21)
[65] Exhibit 1, Vol. 1, Tab 18, WA Country Health Service (Kimberley) Ambulance Care Record (08.01.21)
[66] Exhibit 1, Vol. 2, Tab 26, WKRP Local Emergency Management Plan
[67] Exhibit 1, Vol. 2, Tab 29, Health Services Review (17.02.23), pp6-12 and ts 21.02.23 (Gunson), pp22-26

Call for an ambulance[68,69,70,71,72]

37. In several centres in Western Australia (including Derby where WKRP is located) St John Ambulance WA (SJA) does not provide ambulance services. In these locations, when a caller contacts emergency services (i.e.: 000) relevant details are passed on "*to the appropriate agency as outlined in the country call out guidelines*". In Derby, the "*appropriate agency*" was DRH. Where the relevant agency cannot respond to the call, SJA arranges for the closest "*SJA resource*" to attend.[73]

38. The Gate Officer's call to emergency services requesting an ambulance lasted just under five minutes. On receiving the Gate Officer's call, SJA rang DRH at about 9.25 am to request an ambulance. The ambulance departed DRH at 9.30 am, and arrived at WKRP at 9.43 am, some 28 minutes after WKRP's initial call.

39. In regional centres which do not have SJA ambulance services, response times will vary. That is because in some centres ambulance services are provided by volunteers who may not always be immediately available. In this case, given that the emergency services operator (the Operator) had to relay the information provided by WKRP to DRH, the timeline does not seem unreasonable. In any event, in the period prior to the ambulance's arrival at WKRP, Mr Albert was being cared for by nursing staff, and there is no evidence that his clinical journey would necessarily have been different if he had arrived at DRH earlier.[74]

40. Nevertheless, I am concerned about the quality of the information initially provided to the Operator by the Gate Officer. This is especially because the Gate Officer was unable to give any detail about Mr Albert's condition, other than the fact that he had chest pain. The Gate Officer was also unable to advise Mr Albert's age, and more importantly, whether he was awake and/or breathing.

[68] Exhibit 1, Vol. 2, Tab 25.1, SJA Operational Guidelines CTY007 - Country Crew Availability - Notification
[69] Exhibit 1, Vol. 2, Tab 25.2, SJA Emergency Call Out Guidelines - Derby
[70] Exhibit 1, Vol. 1, Tab 18, WA Country Health Service Kimberley Ambulance Care Record (08.01.21)
[71] Exhibit 1, Vol. 2, Tab 28.1, "000" call: WKRP to Emergency Services (08.01.21)
[72] Exhibit 1, Vol. 2, Tab 28.2, "000" call: SJA to DRH (08.01.21)
[73] Exhibit 1, Vol. 2, Tab 25.1, SJA Operational Guidelines CTY007 - Country Crew Availability - Notification
[74] ts 21.02.23 (Gunson), pp25-26 & 27

41. As the Operator explained to the Gate Officer during the emergency call, this information is required so that the appropriate level of response can be determined, including the number of ambulances that need to be despatched. Having listened to the emergency call, it is my view that the Operator displayed extraordinary patience as she pressed the Gate Officer for further information.

42. Eventually, the Gate Officer used a radio to contact prison staff who were with Mr Albert, and was thereby able to confirm that Mr Albert was awake and breathing. It is astonishing that this process took two minutes and 28 seconds![75] Frankly, it beggars belief that any prison officer would call an emergency services operator without being in possession of such basic information as whether the patient is awake and/or breathing.

43. It is certainly possible that the quality of the Gate Officer's call to the Operator was an aberration, and that appropriate information is routinely provided to emergency services. However, it is notable that although the "*All calls to 000*" table in WKRP's Local Emergency Plan (the Table) includes a requirement that the caller provide the patient's gender and age, there is no requirement to advise an emergency operator whether the patient is awake and/or breathing.[76]

44. The critical importance of conveying accurate information in emergency situations cannot be overemphasised. I have therefore recommended that DOJ issue a state-wide bulletin reminding staff that when requesting an ambulance, they should be able to advise emergency services: the prisoner's name, age and ethnicity (where relevant); the nature of the emergency; and whether the prisoner is awake and/or breathing. I have also recommended that the Table be appropriately amended.

45. Another suggestion explored briefly at the inquest was that clinical staff carry mobile phones for use in emergency situations. I accept there may be logistical and security issues to resolve, but in my view this suggestion has considerable merit and should be further explored.[77]

[75] Exhibit 1, Vol. 2, Tab 28.1, "000" call from WKRP to Emergency Services (08.01.21), 1.00 - 3.28 min. mark
[76] Exhibit 1, Vol. 2, Tab 26, WKRP Local Emergency Management Plan, p220 of 284
[77] ts 21.02.23 (Gunson), pp22-25; ts 21.02.23 (Perrin), pp52-53 and ts 21.02.23 (Langoulant), p61

Transfer to Derby Regional Hospital[78,79,80,81,82,83]

46. Meanwhile at about 9.32 am at WKRP, Officers Miles and Van Brussel were sent to the front gate to facilitate the ambulance's entry into the prison. When the ambulance arrived at WKRP, Officers Miles and Van Brussel escorted the nurses manning the ambulance to House 1, where Mr Albert was located.

47. The WACHS Ambulance Care record for this attendance states:

> INITIAL COMPLAINT: Chest pain, no other details provided to SJA. PRE-HOSPITAL ASSESSMENT: lengthy delay attending (patient) as he was not at clinic but in a separate building with driving through footpaths (required) to get to (patient).[84]

48. When assessed by the ambulance nurse, Mr Albert was alert but was also anxious, sweaty and pale. His respiration rate was elevated and an ECG was "*abnormal*". Mr Albert left WKRP for DRH in the ambulance at about 9.50 am. On the way to DRH, Officer Katonivualiku removed plasti-cuffs from Mr Albert's wrists so that the ambulance nurse could insert an intravenous line, and Mr Albert was given anti-nausea medication and morphine "*with good effect*". The ambulance arrived at DRH at 10.05 am.

Management at Derby Regional Hospital[85,86,87,88]

49. Mr Albert was taken to the emergency department at DRH, where clinical staff took over his management. Officer Mugwagwa arrived at DRH at about 10.30 am to assist with Mr Albert's supervision. He and Officer Katonivualiku were told that Mr Albert was to be transferred to Perth by the Royal Flying Doctor Service for further management, and as a result, Mr Albert's leg restraints were removed at 10.48 am.

[78] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), pp14-18
[79] Exhibit 1, Vol. 2, Tab 23.22, Incident Description Report - Officer A Van Brussel (08.01.21)
[80] Exhibit 1, Vol. 2, Tab 23.24, Incident Description Report - Officer B Miles (08.01.21)
[81] Exhibit 1, Vol. 2, Tab 23.25, Incident Description Report - Nurse T Ahuriri (08.01.21)
[82] Exhibit 1, Vol. 2, Tab 23.28, Incident Description Report - Officer J Katonivualiku (08.01.21)
[83] Exhibit 1, Vol. 2, Tab 23.29, Incident Events Log (08.01.21)
[84] Exhibit 1, Vol. 1, Tab 18, WA Country Health Service Kimberley Ambulance Care Record (08.01.21)
[85] Derby Hospital - Emergency Department Notes UIRN B8012335 (08.01.2021)
[86] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), pp14-18
[87] Exhibit 1, Vol. 2, Tab 23.28, Incident Description Report - Officer J Katonivualiku (08.01.21)
[88] Exhibit 1, Vol. 2, Tab 23.30, Incident Description Report - Officer B Beer (08.01.21)

50. At about 11.15 am, Mr Albert told DRH nursing staff he had "*smoked a pill*" the previous night. As I will explain later in this finding, this was a quetiapine tablet which Mr Albert had obtained illicitly from another prisoner. At about 11.30 am, Mr Albert told Officer Katonivualiku: "*If anything happens to me, let my family know I love them, especially the grandkids*". A short time later Officer Beer arrived to relieve Officer Katonivualiku who was preparing to accompany Mr Albert to Perth.

51. At about 11.45 am, Mr Albert's condition suddenly deteriorated and he was intubated. At about 12.00 pm, he went into cardiac arrest and hospital staff started CPR, with help from Officers Mugwagwa and Beer. Despite resuscitation efforts, Mr Albert could not be revived and he was declared deceased at 12.32 pm.[89,90]

CAUSE AND MANNER OF DEATH

52. On 15 January 2021, a forensic pathologist (Dr Nina Vagaja) conducted a post mortem examination of Mr Albert's body at the State Mortuary. Dr Vagaja found Mr Albert had widespread severe narrowing of the arteries supplying his heart (coronary artery atherosclerosis).[91,92,93]

53. Microscopic examination of tissues confirmed the presence of severe coronary artery disease, and also identified degenerative changes in the heart along with widespread scarring (myocardial fibrosis). Dr Vagaja noted that this scarring in the heart muscle:

> [A]cted as a substrate for a cardiac arrhythmia and predisposed (Mr Albert) to a sudden cardiac death.[94]

54. Dr Vagaja found no evidence of pneumonia or other lung injury, and no other significant abnormalities were noted in tissue samples. Mr Albert's epiglottis was not swollen, making it unlikely he had experienced any sort of anaphylactic reaction.

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[89] Exhibit 1, Vol. 1, Tab 7, Death in Hospital form (08.01.21)
[90] Derby Hospital - Emergency Department Continuation Notes, UIRN B8012335 (08.01.2021)
[91] Exhibit 1, Vol. 1, Tab 8.2, Confidential Report to the Coroner -Post Mortem Report (15.01.21)
[92] Exhibit 1, Vol. 1, Tab 8.3, Confidential Report to the Coroner - Supplementary Post Mortem Report (30.09.21)
[93] Exhibit 1, Vol. 1, Tab 8.4, Histopathology Report (05.04.21)
[94] Exhibit 1, Vol. 1, Tab 8.3, Confidential Report to the Coroner - Supplementary Post Mortem Report (30.09.21), p1

55. Although blood tests established that Mr Albert's recent diabetes control had been poor, there was no evidence of kidney dysfunction. Toxicological analysis found quetiapine, fentanyl, metoclopramide, midazolam, and salicylic acid (aspirin) in Mr Albert's system, along with several medications typically used during resuscitation attempts, namely atropine, ondansetron, and morphine. Alcohol, cannabis, and other common drugs were not detected.[95,96]

56. Dr Vagaja stated it was most likely that Mr Albert had died from an abnormal beating rhythm of his heart (heart attack), caused by his atherosclerotic heart disease and associated heart damage. Dr Vagaja said there was no evidence that quetiapine toxicity had contributed to Mr Albert's death.

57. However, Dr Vagaja noted that quetiapine was inadvisable in individuals at risk of cardiac arrhythmias because it may interfere with the conduction of the electrical signal in the heart (i.e.: cause prolongation of the QT interval). From other inquests I have presided over, I am aware that QT prolongation may place a person at serious risk of developing a cardiac arrhythmia.[97,98] Dr Vagaja reviewed the DRH notes relating to Mr Albert's presentation on 8 January 2021, and observed that:

> [T]he heart trace (ECG) showed changes to indicate insufficient blood flow to the heart muscle (ischaemia) **but no prolongation of the QT interval**.[99] [Emphasis added].

58. At the conclusion of her post mortem examination, Dr Vagaja expressed the opinion that the cause of Mr Albert's death was atherosclerotic heart disease.

59. On the basis of Dr Vagaja's report, I find that Mr Albert died from atherosclerotic heart disease. Further, in view of all of the circumstances, I find that his death occurred by way of natural causes.

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[95] Exhibit 1, Vol. 1, Tab 9.2, Final Toxicology Report (25.02.21)
[96] Exhibit 1, Vol. 1, Tab 18, WA Country Health Service Kimberley Ambulance Care Record (08.01.21)
[97] [2021] WACOR 24, published 30.07.21, paras 104-109
[98] See also: Exhibit 1, Vol. 2, Tab 29, Health Services Review (17.02.23), pp13-14
[99] Exhibit 1, Vol. 1, Tab 8.3, Confidential Report to the Coroner - Supplementary Post Mortem Report (30.09.21)

Quetiapine in Mr Albert's system

60. As noted, toxicological analysis confirmed that Mr Albert had quetiapine in his system when he died.[100] Quetiapine is used to decrease psychotic symptoms in illnesses such as schizophrenia, and as a mood stabiliser for patients with Bipolar 1 disorder. The medication is only available in tablet form and can affect heart function and cause type-2 diabetes.[101]

61. As I have explained, one way quetiapine may affect the heart is by prolonging the QT interval thereby placing the person at increased risk of developing a fatal arrhythmia. In addition to this acute effect, quetiapine may also have a longer term effect and cause metabolic syndrome and weight gain, making the patient more susceptible to developing diabetes, and in turn heart disease.[102]

62. There is some evidence that Mr Albert had been using quetiapine illicitly on a regular basis for 18 months. Dr Gunson said that if this was true, it was a possible explanation for why Mr Albert's diabetes was not under effective control. Just as quetiapine can cause diabetes, it can also exacerbate the condition.[103]

63. Mr Perrin (a review officer with DOJ) conducted a review of the circumstances of Mr Albert's death to identify any "*systemic issues and operational risks that may need to be addressed to prevent similar deaths from happening in the future*".[104]

64. Mr Perrin's findings are set out in a document entitled "*Review of Death in Custody*" (DIC Review). The DIC Review noted that a police investigation had confirmed that all quetiapine tablets at WKRP had been accounted for and that "*standard operating procedures*" for dispensing medication at WKRP had been followed.[105] However, the question of how Mr Albert came to have quetiapine in his system was not explored in the DIC Review. In my view this was a serious omission, and this issue should have been addressed.

[100] Exhibit 1, Vol. 1, Tab 9.2, Final Toxicology Report (25.02.21)
[101] ts 21.02.23 (Gunson), pp8-10 & 37
[102] ts 21.02.23 (Gunson), pp8-9 & 32-35
[103] ts 21.02.23 (Gunson), p34
[104] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), p4 and ts 21.02.23 (Perrin), p46
[105] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), p6

65. As I will explain, evidence from some of the inmates at WKRP was that at the relevant time, the practice of secreting quetiapine was common and security procedures at medication parades were routinely circumvented.

66. It should have been patently obvious that the issue of whether or not medication parades at WKRP were secure, squarely raised the question of whether there were "*systemic issues and operational risks that may need to be addressed to prevent similar deaths from happening in the future*" which the DIC Review proudly proclaims as its primary purpose.[106]

67. Apart from the issue of business improvements, the trafficking of prescription medication is obviously a serious problem for other reasons. First, the prisoner secreting the medication and giving it to others is not receiving their prescribed dose and may thereby be exposed to adverse health outcomes. Second, trafficking may involve stand over tactics, as is alleged to have occurred in this case, and this can adversely affect prison security and safety. Third, those prisoners illicitly taking prescription medication may be exposed to adverse health outcomes.[107]

68. So, given that Mr Albert was not prescribed quetiapine, the obvious question that should have been addressed in the DIC Review was where did he get it from?

69. At the relevant time, only three prisoners at WKRP were prescribed quetiapine. One of them (Mr TS) was taking one 400 mg slow-release quetiapine tablet daily.

70. Apart from certain medications which may be given to prisoners to self-administer (e.g.: blood pressure tablets) at WKRP prescription medication is dispensed to prisoners at regular "medication parades" conducted by a nurse and a prison officer known as the medical duty officer (Medical DO). Because of the risk of it being trafficked, quetiapine is never issued to prisoners to self-administer.[108]

[106] Exhibit 1, Vol. 2, Tab 23, Death in Custody Review (22.11.22), p4 and ts 21.02.23 (Perrin), pp47-51
[107] ts 21.02.23 (Gunson), pp11-13
[108] ts 21.02.23 (Gunson), pp14-15

71. DOJ policy provides that prisoners are not to attend medication parades carrying any additional items, and only disposable cups and water provided by the nurse are to be used. The requirements for checking that a prisoner has consumed medication they have been given are as follows:

a) Observe prisoner swallow medication and drink from cup provided.

b) Check prisoner's open mouth and underside of tongue, also both hands.

c) Observe empty cup being discarded.[109]

72. In his statement, Mr Perrin said he had contacted a clinical nurse based at WKRP (Nurse Ahuriri) and she had provided the following additional detail about how medication is administered at WKRP:

a) The prisoner receives their medication at the Unit Office which is dispensed by a nurse;

b) The prisoner is required to swallow their medication with at least ½ a cup of water; and

c) The prisoner's mouth is then checked (tongue up and down) by a custodial officer to ensure the tablet/s have been ingested.[110]

73. In her statement, Nurse O'Brien confirmed that: "*The Medical DO checks the prisoner's mouth to make sure they have swallowed the medication prior to walking away*". This makes sense given that the Medical DO is usually standing next to the prisoner, whilst the nurse is concentrating on ensuring that the correct medication and dose is being administered to the prisoner.[111]

74. In relation to Mr Albert, an inmate at WKRP (Mr TC) says Mr Albert smoked "*a lot of*" quetiapine in the morning and at night. Mr TC said Mr Albert crushed the quetiapine tablets up and smoked them with tobacco twice a day, two days per week. Mr TC said he didn't know where Mr Albert obtained the quetiapine from, and that when Mr Albert smoked it he became "*lazy*" and "*mellows out*".[112]

[109] Exhibit 1, Vol. 2, Tab 24.2, WKRP: Standing Order 6.1 Access to Health Care and Medication (09.04.21), p8
[110] Exhibit 1, Vol. 2, Tab 24.1, Statement - Mr T Perrin (19.01.23), paras 7-9
[111] Exhibit 1, Vol. 1, Tab 16, Statement - Nurse K O'Brien (25.1.21), para 21
[112] Exhibit 1, Vol. 1, Tab 13, Statement - Mr TC (undated), paras 24-40

75. Mr LS (an inmate at WKRP) claimed that Mr Albert would make him obtain quetiapine, and that Mr Albert smoked it "*almost daily*". Mr LS says that the night before Mr Albert died, he asked Mr LS to speak to Mr TS and obtain some quetiapine. According to Mr LS, Mr TS initially denied having any quetiapine, but when Mr Albert produced some cigarettes, Mr TS "*pulled the pill out from his pocket*".[113]

76. Mr LS says he would go to Mr TS's cell and Mr TS would give him the quetiapine tablet which he (Mr LS) would hand to Mr Albert. Mr LS says that apart from quetiapine, he never saw Mr Albert smoke anything other than tobacco.[114] Mr LS explained that he obtained quetiapine for Mr Albert because if he didn't, Mr Albert became aggressive. Mr LS said: "(Mr Albert) *would get angry and always order me around. It was like he was forcing me to do it*".[115]

77. Another inmate at WKRP (Mr HC) said he was a close friend of Mr Albert and had been telling him to stop smoking quetiapine for 18 months. In reply, Mr Albert had told Mr HC to "*roll with himself*", which Mr HC understood to mean that he should mind his own business. Mr HC also said that although he had never seen Mr TS supply quetiapine to Mr Albert: "*It's common knowledge throughout the prison that Mr TS supplies (quetiapine)*".[116]

78. Between 5.00 pm and 5.15 pm on 7 January 2021, Nurse O'Brien conducted a medication parade in Unit 2 at WKRP. During that parade she administered a quetiapine tablet to Mr TS. After checking the medication, Nurse O'Brien placed the tablet into a transparent plastic cup which was handed to Mr TS, who was required to consume the tablet in the presence of Nurse O'Brien and the Medical DO.[117]

79. Following Mr Albert's death, Mr TS was interviewed by police and he admitted giving Mr Albert part of a quetiapine tablet during the evening of 7 January 2021, that he (Mr TS) had "*chipped off*" after being given the medication by a nurse.[118]

[113] Exhibit 1, Vol. 1, Tab 14, Statement - Mr LS (08.02.21), paras 15-28
[114] Exhibit 1, Vol. 1, Tab 14, Statement - Mr LS (08.02.21), paras 30-33
[115] Exhibit 1, Vol. 1, Tab 14, Statement - Mr LS (08.02.21), para 29
[116] Exhibit 1, Vol. 1, Tab 15, Statement - Mr HC (08.02.21), paras 12-24
[117] Exhibit 1, Vol. 1, Tab 16, Statement - Nurse K O'Brien (25.01.21), paras 23-39
[118] Exhibit 1, Vol. 2, Tab 27, Audio recording of Police interview - Mr TS, (10.01.21), 26 min 20 sec onwards

80. Although Mr TS denied having previously supplied Mr Albert with quetiapine, he said everyone knew Mr Albert was taking it, and that eight other prisoners had also asked for the medication.[119]

81. It is perhaps unsurprising that Mr TS should deny previously supplying Mr Albert with quetiapine during his interview with police. After all, Mr TS was aware he was being investigated for the illicit supply of quetiapine, and he was no doubt concerned about whether this was in any way linked to Mr Albert's death. As it happens, on 10 March 2021, in the Magistrates Court at Derby, Mr TS was convicted of supplying quetiapine to Mr Albert.[120]

82. In his statement to the Court, Mr Perrin advised that he had contacted the superintendent of WKRP (Ms Murchie) and she had advised that:

> [F]rom a custodial perspective, **the dispensing and sharing of medication at WKRP is not an issue**. She (Ms Murchie) advised that there have only been two incidences of secretion since 2021, one in February 2022 and another in August 2022.[121] [Emphasis added]

83. Although Ms Murchie's statement is superficially reassuring, if the evidence of Messrs. TC, LS, HC and TS is to be believed, then the system of administering medication at WKRP clearly was (and may still be) subject to abuse.

84. In any event, the evidence of these prisoners suggests that the practice of secreting medication is far more widespread at WKRP than Ms Murchie's comments would suggest.

85. The fact that only two secretion episodes have been detected since 2021 says nothing about how many incidents there may have been in that time that went unnoticed. It is not possible to blithely ignore the evidence of prisoners at WKRP merely because only two secretion incidents (plus the incident involving Mr Albert) have been identified.

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[119] Exhibit 1, Vol. 2, Tab 27, Audio recording of Police interview - Mr TS, (10.01.21), 26 min 20 sec onwards
[120] Exhibit 1, Vol. 1, Tab 2.2, Report - Det. Sen. Const. J Wilkinson (04.03.22), p13
[121] Exhibit 1, Vol. 2, Tab 24.1, Statement - Mr T Perrin (19.01.23), para 10

Preventing the trafficking of prescription medication

86. The available evidence unequivocally establishes that prior to his death, Mr Albert consumed a piece of a quetiapine tablet he obtained illicitly from another prisoner (Mr TS). The fact that Mr Albert was able to do so was a serious breach of security at WKRP and raises the question of what can be done to prevent similar situations in the future?

87. At the inquest, Dr Gunson confirmed that for staff conducting medication parades "*there's a huge time pressure*" to complete the parades promptly. Clearly, the number of prisoners requiring medication stretches available staff resources to the limit and in that context, mistakes can (and clearly do) occur.[122]

88. I am troubled by the possibility that checks by the Medical DO at medication parades may have a tendency to become perfunctory, precisely because of the time pressures Dr Gunson referred to. In any case, as the Health Review noted:

> Unfortunately, while all health and custodial staff are aware of and are on the alert for diversion of medication, sometimes prisoners are able to evade detection. This is an ongoing problem, but staff continue to be vigilant.[123]

89. I am aware that night times in prison are a busy time with dinner, recreation, muster checks and the night time lockup all having to be attended to. In that context, I agree with Dr Gunson's observation that it may be possible to reduce secretion incidents at medication parades if additional nurses and Medical DOs were made available. This would allow simultaneous medication parades with fewer prisoners, and additional time for checking that medication had been consumed.[124]

90. Another benefit of additional staff at medication parades would be that separate parades could be conducted for more desirable or trafficable medications. Additional scrutiny would then be possible, and the time pressures referred to by Dr Gunson could be managed more effectively.

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[122] ts 21.02.23 (Gunson), pp11-12
[123] Exhibit 1, Vol. 2, Tab 29, Health Services Review (17.02.23), p14
[124] ts 21.02.23 (Gunson), pp12-14

91. As mentioned, at the relevant time, only three prisoners at WKRP were prescribed quetiapine, which begs the question of whether additional scrutiny may have been possible within the resources available at the time. I accept that providing additional staff for medication parades may be challenging from a resource perspective. I also accept that it may not be possible to start the parades earlier given that most medications have to be given within set timeframes. Nevertheless, other remedies suggest themselves.

92. Two such remedies are already in place. The first relates to a conscious effort to reduce the prescription of certain desirable medications (e.g.: opioid pain medications, and medications which affect a person's mental state, such as quetiapine). At the inquest, Dr Gunson confirmed that the Director Medical Services (Dr Joy Rowland ACM) had implemented a policy whereby quetiapine is only prescribed on the recommendation of a psychiatrist. Opioid medications are similarly restricted.[125]

93. The other strategy employed by DOJ to reduce secretion events is to identify whether less trafficable forms of the medication, such as syrups or dissolvable wafers are available. Unfortunately, as I have mentioned, quetiapine is only available in tablet form.[126]

94. The current medication parade procedure requires the Medical DO to inspect the prisoner's mouth after they have consumed their medication, and at WKRP the prisoner is required to lift their tongue. This is fine as far as it goes, but leaves open the possibility that a prisoner might secrete all or part of a tablet between their gums and the inside of their lips.[127]

95. I accept that it would be inappropriate for the Medical DO to insert their finger into a prisoner's mouth to check that dispensed medication has not been secreted in the manner described above. Apart from the fact that this would constitute an assault, the practice is clearly unhygienic and would potentially expose the Medical DO to serious injury.

[125] ts 21.02.23 (Gunson), pp13-14
[126] ts 21.02.23 (Gunson), pp16 & 37
[127] ts 21.02.23 (Gunson), pp39-40

96. Nevertheless, I am concerned that current medication parade procedures are potentially open to abuse. Notwithstanding the fact that Mr Albert's death was not related to quetiapine toxicity, the trafficking of prescription medication is clearly of serious concern. In my view DOJ should closely examine current medication dispensing policies and the resources allocated to these parades, to determine whether there are any measures which can be taken to ensure that medication given to prisoners is actually consumed by them.

97. Dr Gunson agreed that additional checks could be considered, particularly in the case of more trafficable medications, such as quetiapine. Heightened vigilance is clearly warranted for these types of medications and additional checks might include (but would not be limited to) having the prisoner run their tongue and/or finger between the gums and lips, and the use of flashlights and/or tongue depressors to give the Medical DO greater visibility into the prisoner's mouth.[128]

CONCERNS RAISED BY MR ALBERT'S FAMILY

98. On 15 February 2023, Ms Eloise Langoulant[129] sent an email to the Court outlining five concerns Mr Albert's family had raised with her:

a. *What is the availability of PMOs (doctors) at WKRP?*[130]

At the inquest, Dr Gunson confirmed that a PMO is on duty at WKRP three days per week during office hours. One day is spent at BRP and the PMO is not rostered on duty on Fridays, or over the weekends. Nursing staff are not available at WKRP overnight either. In an emergency, prison officers call emergency services to request an ambulance.

Mr Albert's collapse occurred on a Friday when there was no PMO at the WKRP. Nevertheless, before the ambulance arrived at WKRP, Mr Albert was attended to by nurses and he was given aspirin and GTN. Dr Gunson confirmed that Mr Albert's management would not have been any different had a PMO been present, and therefore that the absence of a PMO had made no material difference to Mr Albert's management.

[128] ts 21.02.23 (Gunson), p40
[129] Ms Langoulant is a lawyer with the Aboriginal Legal Service of WA Ltd. who acts for Mr Albert's family
[130] ts 21.02.23 (Gunson), pp26-27

b. *Are prisoners provided with medication to self-administer?*

The departmental policy *COPP 6.4 Officers issuing medication* (the Policy) provides that: "*No prisoner shall be issued a prescription medication, including on-person-medication, without the approval of Health Services*". The Policy permits prison officers to issue over-the-counter medication (e.g.: Panadol) to prisoners "*for the treatment of a minor medical condition after hours and without prior approval*".[131] As noted, in some cases, prisoners are issued with certain prescription medications (e.g.: blood pressure medication).[132] However, as noted, at the inquest, Dr Gunson confirmed that trafficable medications, such as quetiapine, are never issued to prisoners for self-administration.[133]

c. *Mr Albert's family are aware of rumours suggesting he was involved in an altercation with another prisoner before his death and sustained facial injuries (bumps/bruises). Does DOJ have evidence of this occurring?*

According to Mr Perrin, there is no record of Mr Albert being involved in an altercation, or being assaulted by another prisoner prior to his death.[134] Further, the post mortem report does not refer to any injuries suggestive of an assault, although it does refer to medical intervention involving Mr Albert's face. This included the presence of nasal prongs and an endotracheal tube secured to Mr Albert's face by tape "*which runs across the angles of the mouth and lower cheeks, onto the sides and back of the neck, with associated indentation of the skin*".[135] In the absence of any evidence of an assault, it seems more likely that the "*bumps or bruises*" Mr Albert's family noticed on his face after his death were related to this medical intervention;

d. *Does DOJ provide culturally appropriate food options to Aboriginal prisoners?*

The evidence establishes that up until 22 September 2020, Mr Albert had persistently refused to take diabetes medication, preferring instead to manage his condition with diet and exercise. Although Mr Albert was repeatedly counselled about his diet and exercise regimes and eventually agreed to take diabetes medication, his BSL remained high.

[131] Exhibit 1, Vol. 2, Tab 24.3, COPP 6.4 Officers Issuing Medication, p3, para 2
[132] [2022] WACOR 30, published 21.06.22, para 45
[133] ts 21.02.23 (Gunson), pp14-15
[134] ts 21.02.23 (Perrin), p53
[135] Exhibit 1, Vol. 1, Tab 8.2, Confidential Report to the Coroner -Post Mortem Report (15.01.21)

At the inquest, the question of whether Mr Albert had ever been offered a diabetic diet was raised. Ms Westerside referred to an entry in Mr Albert's EcHO health record on 9 March 2020, which states: "*Will send email to kitchen to see if we can arrange a diabetic diet for him as he is unable to move units and cook his own food*".[136] Although this entry records an effort to provide Mr Albert with a diabetic diet, it is unclear whether it was eventually offered and if so, whether Mr Albert regularly consumed it.

In terms of the availability of dietary options for Aboriginal prisoners, a departmental policy known as "*COPP 4.2 Aboriginal Prisoners*" (COPP 4.2) introduced on 11 October 2021, provides:

> 3.4.1 Superintendents shall ensure, where possible and practicable, Aboriginal prisoners are offered foods that meet their cultural needs.
>
> 3.4.2 The Superintendent (or delegate) shall ensure liaison with Aboriginal prisoners, staff and elders to develop appropriate menus.
>
> 3.4.3 Cultural events, ceremonies or Aboriginal specific programs may be catered for in accordance with the Department's RAP and at the discretion of the Superintendent.
>
> 3.4.4 The Superintendent, in consultation with Aboriginal staff, may give approval for traditional food to be brought into a prison for significant cultural events or Aboriginal specific programs.[137]

At the inquest, Mr Perrin advised that his enquiries had determined that prisoners in Units 1 and 2 at WKRP (where Mr Albert was housed) self-cater, and may order foods which suit them. Kangaroo meat is available one day per week, and at certain key times of the year (e.g.: NAIDOC Week), kangaroo tails are provided.[138]

Although COPP 4.2 deals with the availability of culturally appropriate food, it does not deal specifically with the issue of culturally appropriate food for Aboriginal prisoners with diabetes. This issue was the subject of a recommendation in December 2010 by the then State Coroner, following an inquest into the death of an incarcerated Aboriginal man with diabetes.

On the morning of the inquest, Ms Langoulant alerted the Court to this matter, and provided a copy of the finding.

[136] Exhibit 1, Vol. 2, Tab 30, EcHO Health Record (09.03.20), p37
[137] Exhibit 1, Vol. 2, Tab 31.5, COPP 4.2 Aboriginal Prisoners (11.10.21), p5
[138] ts 21.02.23 (Perrin), pp53-54

Amongst other things, the then State Coroner recommended:

> (DOJ) liaise with appropriate Aboriginal organisations and Aboriginal health care workers with a view to designing diets which, while compliant with the requirements of a diabetic diet, would be reasonably appealing to Aboriginal prisoners.[139]

By way of an email to the Court dated 8 March 2023, Ms Westerside advised that this recommendation had not been supported by DOJ, and that the following response had been sent to the Court at the time:

> Whilst the Department acknowledges the comments of the Coroner it is deemed that we are already providing a low fat health diet across the board for all prisoners. Please note that a dietary review of custodial facilities in Western Australia was undertaken in conjunction with the Department of Health in 2003 and the current prison diet was adapted from the outcome of this review. All prisoners however have a choice to purchase snacks whether healthy or unhealthy from the prison canteens and have the unrestricted option to consume snacks deemed unhealthy which are available in the prison units throughout the day. The Health Service Directorate will continue to educate all prisoners with diabetes on healthy eating as part of their ongoing health education.[140]

Policy Directive 15 (PD 15) headed: "*Catering Services and Dietary and Nutritional Requirements*" provides in part:

> 5.1 Prisoners must be provided with sufficient nutritious and healthy food and fresh drinking water to maintain health and well-being.
>
> 5.2 Special dietary food must be provided where it is established that such food is medically prescribed for health reasons.
>
> 5.3 Where it is requested to meet established cultural, religious or other special needs and is in accordance with the Department's Special Meals Guidelines, special dietary food should be provided where practicable.[141]

The "*Special Meals Guidelines*" (the Guidelines)[142] referred to in PD 15 contain a section headed "*Dietary Recommendations for Diabetes*" which sets out the goals of dietary management in diabetes.

[139] Report of Investigation into Death, Mr Hector Cedric Green, 33/10, delivered 20.10.10, p29
[140] Exhibit 1, Vol. 2, Tab 31.1, Endorsed Response Template - Mr H Green (03.02.11)
[141] Exhibit 1, Vol. 2, Tab 31.2, Policy Directive 15: Catering Services and Dietary and Nutritional Requirements (09.12.13)
[142] Exhibit 1, Vol. 2, Tab 31.3, Special Meals Guidelines (Dec 2010), pp13-15

The section also provides information about various macronutrients and suggested food choices appropriate for prisoners with diabetes are listed. Other sections in the Guidelines deal with diet suggestions for prisoners with type-1 or type-2 diabetes, but there is nothing in the Guidelines that deals with culturally appropriate food choices for Aboriginal prisoners with diabetes. The version of the Guidelines provided to the Court was updated in December 2010 and in my view, it would be appropriate for DOJ to consider inserting a section into the Guidelines dealing specifically with culturally appropriate diet choices for Aboriginal prisoners with diabetes.

In terms of how a prisoner goes about accessing a special diet, "*COPP 6.3 Prisoner Food and Nutrition*" (COPP 6.3) provides:

> 4.1.1 Where it is requested to meet established cultural, religious or other special needs, the Superintendent may authorise the provision of such foods where practicable (refer to COPP 4.2 - Aboriginal Prisoners and COPP 9.1 - Cultural, Religious and Spiritual Services).
>
> 4.1.2 Prisoners who have specific dietary requirements are required to complete Special/ Religious/ Cultural Meal Request Form.
>
> 4.1.3 Forms will need to be provided to the Chef Supervisor as soon as practicable to ensure the prisoner's needs are catered for in a timely manner.[143]

The word "*diabetes*" appears once in COPP 6.3 as an example of a "*medical diet*" which may be assessed and approved in accordance with another departmental policy, "*PM 17 Special Diet, Dietary Supplements and Obesity Management*" (PM 17), approved on 23 January 2023. PM17 states:

> Ordering special diets will be completed by a Registered Nurse (RN) or a Medical Practitioner using a medical certificate when there is a medical indication. The medical certificate will identify the type of dietary requirements and the duration of the diet. The RN or Medical Practitioner is to record the commencement of (the) special dietary requirement and the duration of the diet in the patient's EcHO medical record.[144]

On the evidence before me, it is unclear whether Aboriginal prisoners with diabetes are proactively followed up and encouraged to take advantage of any diabetic meal options which may be available.

[143] Exhibit 1, Vol. 2, Tab 31.4, COPP 6.3 Prisoner Food and Nutrition (11.10.21), p4
[144] Exhibit 1, Vol. 2, Tab 31.6, PM 17 Special Diet, Dietary Supplements and Obesity Management (23.01.23), p4

In Mr Albert's case, although there is evidence that he was regularly given education about healthy eating and exercise, there is only one reference to him being specifically referred for a diabetic diet. In any case, as laudable as DOJ's polices relating to special diets may be, as I have noted, none of them specifically addresses the issue of providing culturally appropriate food choices to Aboriginal prisoners with diabetes. It is a great pity that DOJ rejected the sensible recommendation made by this Court on this issue in 2010. I urge DOJ to reconsider its position and specifically address the availability of culturally appropriate diet options for Aboriginal prisoners with diabetes.

I accept that prisoners with chronic health conditions cannot be forced to comply with specific dietary or exercise regimes. I also accept that prisoners have access to snacks and beverages at prison canteens which may or may not be "*healthy*". However, what can be done is to provide culturally appropriate diet choices along with appropriate education, support and encouragement. This again highlights the importance of AHWs and the crucial role they might play in addressing the type-2 diabetes epidemic.

I am aware of a study led by Ngarrindjeri Elders in South Australia in association with Flinders University (the Study) which will examine whether a "*traditional*" diet low in carbohydrates and high in fats can help drive type-2 diabetes remission in Aboriginal people. An ABC News report states:

> Boandik, Ngarrindjeri, Narungga and Kaurna woman and RMCLHN director of Aboriginal health Sharon Wingard said the study provided an opportunity for Aboriginal people to learn from their ancestors for better health outcomes. She (Ms Wingard) said the typical diet of Ngarrindjeri people, which included hunted meat and fish and bush tucker such as saltbush, was typically low in carbohydrates and high in fats.[145]

It is expected that the Study will begin in 2024 and at the inquest, Dr Gunson said she intended to reach out to the study's authors with a view to collaborating in their research. If the Study did identify favourable outcomes, it may be possible to introduce a local version of the "*ketogenic*" diet into Western Australian prisons for Aboriginal prisoners with uncontrolled type-2 diabetes.[146]

[145] See: www.abc.net.au/news/2023-02-15/diabetes-study-indigenous-australians-ketogenic-diet/101975598
[146] ts 21.02.23 (Gunson), pp18-19 & 31

e. *Is there a link between quetiapine and a "heart attack"?*

In relation to this issue, the Health Services Review relevantly states:

> It is known that quetiapine can cause a cardiac conduction abnormality which can then result in an arrhythmia; the particular abnormality is prolongation of the QTc interval on the electrocardiogram, which is then a well-documented risk factor for the arrhythmia known as Torsade de Pointes, which can then precipitate sudden cardiac death.
>
> Other cardiac effects documented in the literature may possibly also include myocarditis and/or cardiomyopathy. However, the latter two effects would be more likely to be associated with ongoing regular administration of quetiapine; Mr Albert was not prescribed it and had obtained it illicitly; it is therefore likely (although not certain) that he would not have been using it daily.[147]

Mr Albert had "*severe multifocal coronary artery atherosclerosis*" and his illicit use of quetiapine was a highly risky endeavour - although he was no doubt unaware of this at the time. As Dr Vagaja explained, there was no evidence of QT prolongation in Mr Albert's case and the abnormal beating rhythm of his heart he experienced was likely due to insufficient blood flow caused by his atherosclerotic heart disease and associated heart damage.[148]

In her letter to the Court Ms Naomi Johnson referred to the prevalence of quetiapine abuse, and the widespread view amongst inmates "*that it helps with sleep*".[149]

As I have explained, quetiapine toxicity was not relevant in Mr Albert's case. However, he was able to obtain a potentially dangerous medication that he was not prescribed. This should not have occurred, and highlights the importance of stamping out the trafficking of prescription medication within the prison estate.

[147] Exhibit 1, Vol. 2, Tab 29, Health Services Review (17.02.23), pp13-14
[148] Exhibit 1, Vol. 1, Tab 8.3, Confidential Report to the Coroner - Supplementary Post Mortem Report (30.09.21)
[149] Letter to Court - Ms N Johnson (01.03.23), p4

RECOMMENDATIONS

99. In view of the observations I have made in this finding, I make the following recommendations:

Recommendation No. 1
I recommend that the Department of Justice issue a state-wide bulletin reminding staff that whenever they contact emergency services (i.e.: 000) to request an ambulance, they should be able to state the relevant prisoner's name, age (and where relevant) ethnicity, as well as the nature of the emergency, and whether the prisoner is awake and/or breathing.

Recommendation No. 2
I recommend that the Department of Justice conduct a review of the "*All calls to 000*" table in the West Kimberley Regional Prison Local Emergency Plan to ensure that it lists the key information staff contacting emergency services (i.e.: 000) should provide the emergency services operator, including the relevant prisoner's name, age (and where relevant) ethnicity, as well as the nature of the emergency, and whether the prisoner is awake and/or breathing.

Recommendation No. 3
I recommend that the Department of Justice conduct a review of the time and staff resources allocated to medication parades in order to determine whether those resources are sufficient to prevent the illicit trafficking of prescription medication within the prison estate. The review should also consider whether there are any additional measures that could be implemented to assist in detecting medication secretion/diversion attempts by prisoners, particularly in relation to those medications which are more trafficable, such as quetiapine.

Recommendation No. 4
I recommend that the Department of Justice redouble its efforts to recruit Aboriginal health workers (AHW), especially for regional prisons, with a view to examining the feasibility of ensuring that all Aboriginal prisoners with chronic medical conditions are reviewed by an AHW on their initial admission, and thereafter as appropriate. The purpose of such reviews would include (but not be limited to) identifying any treatment gaps in the prisoner's care and providing culturally appropriate education about the potential benefits of recommended prescription medication and/or investigative procedures.

Recommendation No. 5
I recommend that the Department of Justice liaise with appropriate Aboriginal organisations and Aboriginal health workers with a view to developing culturally appropriate dietary options for Aboriginal prisoners with diabetes, and that these dietary options be proactively offered to those prisoners.

Comments relating to Recommendations

100. A draft of my proposed recommendations was forwarded to all counsel by Sergeant Alan Becker on 21 February 2023. Counsel were asked to forward any comments on the proposed recommendations to the Court by close of business on 3 March 2023.[150] DOJ requested an extension to the close of business on 8 March 2023, which I granted.[151,152]

Response to Recommendations - Mr Albert's family

101. In an email dated 1 March 2023, Ms Langoulant advised that Mr Albert's family were supportive of the proposed recommendations and wished to make the following additional comments:[153]

[150] Email - Sgt A Becker to counsel for parties appearing at the inquest (21.02.23)
[151] Email - Ms A Westerside (Counsel for DOJ) to Sgt A Becker (23.02.23)
[152] Email - Ms K Christie to Ms A Westerside (Counsel for DOJ) (24.02.23)
[153] Email - Ms E Langoulant (Counsel for Mr Albert's family) to Sgt A Becker (01.03.23)

a. Local Aboriginal health organisations, such as Broome Regional Aboriginal Medical Service, and Kimberley Aboriginal Medical Services should be consulted in the development of culturally-appropriate medical care at WKRP, given the high proportion of Aboriginal prisoners who are held there, and DOJ's stated aim that WKRP be a "*culturally safe*" prison for Aboriginal people; and

b. Better support in terms of housing, income support and ID[154] to prisoners being released into the community, could have a significant impact on their risk of repeated offending, and could help them get their lives back on track.

102. In her letter to the Court, Ms Naomi Johnson reiterated the importance of consultation with local Aboriginal groups when developing culturally appropriate diets for Aboriginal prisoners, and noted:

> There are Indigenous employees at many services such as Kimberley Aboriginal Medical Services (KAMS), Broome Regional Aboriginal Medical Services (BRAMS), Milliya Rumurra Aboriginal Rehabilitation Centre, Kimberley Interpreting Services, Health Consumer's Council etc, who could all assist the Prison with developing a more culturally appropriate diet/menu.[155]

103. I wholeheartedly endorse the family's comments, although I note that issues relating to the support provided to prisoners when they leave custody is outside of the scope of my inquest into Mr Albert's death.

Response to Recommendations - DOJ

104. By way of an email to the Court dated 8 March 2023, Ms A Westerside advised that DOJ's responses to my proposed recommendations were as follows:[156]

a. *Recommendation 1*: this recommendation is supported by DOJ and can be practically implemented;

b. *Recommendation 2*: this recommendation is supported by DOJ and can be practically implemented;

[154] In this context, "ID" refers to birth certificates, photo identification etc required to access income support
[155] Letter to Court - Ms N Johnson (01.03.23), p4
[156] Email and attachments - Ms A Westerside (Counsel for DOJ) to Sgt A Becker (08.03.23)

c. *Recommendation 3*: DOJ suggested an alternative recommendation framed in terms of a policy review aimed at improving medication parades with a focus on security, alternative methods of medication delivery, and a predetermined period of supervision. DOJ stated: "*[A]ny review into staff resources allocation would be extensive and a significant strain on current resources*", and referred to a number of security processes already in place to detect medication secretion.

Although I appreciate DOJ's position, the evidence before me is that medication parades are conducted under considerable time pressures and that additional time and staff resources would assist in making them more secure. I have therefore decided to persist with Recommendation 3 as originally drafted;

d. *Recommendation 4*: DOJ suggested an alternative recommendation to the effect of:

> The Department of Justice work with local Aboriginal Medical Services to invite them to enter into a formal agreement with the Department of Justice to provide Aboriginal Medical Services as and when required.

By way of explanation, DOJ reiterated the difficulties in recruiting AHW, especially in regional areas and stated that:

> [M]any of the Department's staff have experience in working within Aboriginal Medical Services, and some staff work part-time in Aboriginal Medical Services and part-time with the Department. Some staff have been recruited directly from Aboriginal Medical Services.
>
> The Department's Health Services aims to provide a model of care which is consistent with Aboriginal Medical Services and the templates for care are all matched to the Aboriginal health cycle of care and Medicare items specific to Aboriginal health. Health Services policies and procedures are consistent with the principles outlined in the WA Aboriginal Health and Wellbeing Framework 2015-2030.

Notwithstanding the difficulties DOJ has referred to with the recruitment of AHWs, it remains my view that the terms of Recommendation 4 as originally drafted are appropriate; and

e. *Recommendation 5*: in DOJ's view, the substance of this recommendation "*is supported by current practice*".

However, although "*diabetes*" is referred to in the Guidelines (and briefly in COPP 6.3), none of the policies I have reviewed specifically addresses the issue of providing culturally appropriate food choices for Aboriginal prisoners with diabetes. For that reason, it remains my view that the terms of Recommendation 5 are appropriate as drafted.

Further, after careful consideration, I have decided to add the words: "*and that these dietary options be proactively offered to those prisoners*" to Recommendation 5, to ensure that Aboriginal prisoners with diabetes are actively encouraged to consider consuming culturally appropriate dietary options.

QUALITY OF SUPERVISION, TREATMENT AND CARE

105. In relation to the medical care provided to Mr Albert, the Health Review relevantly states:

> After he was received into custody, (Mr Albert) was reviewed regularly and in a timely manner for all his health issues, including dental problems. He attended his Diabetes Care Plan visits, chronic disease monitoring and medical reviews, and was not noted to miss appointments.
>
> Despite his declining of medications, he remained engaged in his health care and was receptive to at least some of the health advice and education he was provided. He was referred to the appropriate allied health personnel as required, and also to a specialist when further evaluation was required. I am of the opinion that Mr Albert's health care whilst he was in custody was excellent, and was delivered to a much higher standard than he would have received in the community.[157]

106. Having carefully considered all of the available evidence, I am satisfied that the supervision, treatment and care provided to Mr Albert whilst he was incarcerated was of an appropriate standard.

[157] Exhibit 1, Vol. 2, Tab 29, Health Services Review (17.02.23), pp14-15

107. However, it is my view that the fact that Mr Albert accessed quetiapine, a medication not prescribed to him, was a **serious** breach of security at WKRP. In Mr Albert's case, quetiapine had the potential to cause a fatal arrythmia and the fact that this did not occur is beside the point. The security of the medication parade at WKRP on 7 January 2021 was seriously compromised, and on any reasonable view this is completely unacceptable.

CONCLUSION

108. It is deeply troubling that Mr Albert was able to access a potentially harmful medication which he was not prescribed. I have recommended that DOJ review its medication parade procedures and the adequacy of the resources currently allocated. The purpose of this recommendation is to strengthen efforts to eliminate the illicit trafficking of prescription medication within the prison system.

109. I have also made four other recommendations which deal with various issues arising from the evidence. It is my sincere hope that these recommendations will be implemented and that prisoner welfare and safety at WKRP may thereby be improved.

110. I cannot begin to imagine the grief and sadness that Mr Albert's family and friends have experienced since his death. As Ms Johnson's letter to the Court eloquently explains, Mr Albert was a dearly loved family member and his loss is keenly felt. As I did at the inquest, I wish to again extend to Mr Albert's loved ones on behalf of the Court, my very sincere condolences for their loss.

MAG Jenkin
Coroner
13 March 2023