Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 11/2014

I, Rosalinda Vincenza Clorinda FOGLIANI, State Coroner, having investigated the death of ***Michael John KING****, with an Inquest held at Perth Coroner's Court, Court 51, Central Law Courts Building, 501 Hay Street, Perth on 17 March 2014 find that the identity of the deceased person was* ***Michael John KING*** *and that death occurred on 15 March 2013 at Fremantle Hospital as a result of Ischaemic Heart Disease in association with Coronary Arteriosclerosis in the following circumstances -*

Counsel Appearing :

Sergeant Lyle Housiaux assisting the State Coroner
Ms Jennifer O'Meara (State Solicitors Office) appearing on behalf of the Department of Corrective Services
Mr Paul Gazia and **Mr Sarouche Razi** (Aboriginal Legal Service of Western Australia) appearing on behalf of the family of the deceased

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INTRODUCTION

1. Mr Michael John King (the deceased) died in Fremantle Hospital on 15 March 2013 from Ischaemic Heart Disease in association with Coronary Arteriosclerosis. He had significant pre-existing heart disease.

2. At the time of his death the deceased was a sentenced prisoner. Under section 16 of the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Accordingly immediately before death he was a "person held in care" within the meaning of subsection 22(1)(a) of the *Coroners Act 1996* (the Act) and his death was a reportable death.

3. In these circumstances, pursuant to subsection 22(1)(a) of the Act I must hold an inquest.

4. Further, pursuant to 25(3) of the Act, where the death is of a person held in care, I must comment on the quality of the supervision, treatment and care of the person while in that care.

5. I held an inquest into the deceased's death on 17 March 2014. The documentary evidence adduced at the inquest comprised:

   (a) two lever arch files of materials[1] containing reports into the circumstances of the deceased's death and of his treatment while in custody; the investigation report was prepared by First Class Constable Daniel Posavec of the Western Australian Police Service; the Death in Custody Review Report was prepared by Mr Richard Mudford of the Western Australian Department of Corrective Services;

   (b) the statement of Ms Barbara King, the deceased's sister, dated 14 March 2014[2],

   (c) the Department of Corrective Services Cardio-vascular Disease Care Plan for the deceased[3]; and

   (d) the Department of Corrective Services Diabetes Care Plan for the deceased[4].

6. First Class Constable Posavec and Mr Mudford gave oral evidence relating to their respective reports.

[1] Ex 1, Vol 1 and 2
[2] Ex 2
[3] Ex 3
[4] Ex 4

THE DECEASED

7. The deceased was a 48 year old Aboriginal man. At the time of his death he was obese and he had a complex medical history which included significant pre-existing heart disease.

Background

8. The deceased was born in Lismore, New South Wales on 18 June 1964, the second youngest of 10 children. His parents separated when he was four years old. He suffered poor living conditions and was exposed to violence from a young age. When he was 13 years old he was placed under the supervision of the Community Welfare Department[5]. He did not complete his schooling.

9. The deceased had sustained a severe head injury in a motor vehicle accident at the age of 15 years and subsequent IQ testing had indicated cognitive impairment[6].

10. Prior to his death the deceased's medical conditions included ischaemic heart disease, high cholesterol, asthma and diabetes. He was a smoker and had commenced abusing alcohol at a young age.

Incarceration

11. At the time of his death the deceased was a medium security prisoner at Hakea Prison having been

[5] T.12 to T.13.
[6] T.15

transferred there from Albany Regional Prison in August 2010[7].

12. The deceased had been sentenced in the Supreme Court of Western Australia at Perth on 17 July 1986 to strict security life imprisonment, in relation to wilful murder. On this date the deceased was also sentenced to concurrent terms of imprisonment for convictions of rape (ten years) and breaking and entering at night with intent (four years)[8].

13. On 15 August 1991 the deceased was sentenced in the District Court of Western Australia at Perth in relation to two further six month concurrent terms of imprisonment in respect of escaping legal custody and assaulting a police officer[9].

14. The deceased had a back dated sentence start date of 17 July 1986 and an initial sentence review date of 16 July 2006.

15. At the deceased's most recent sentence review, prior to his death in May 2012, the Parole Review Board, based on the reports and information presented to it, made the recommendation not to release the deceased to parole at that time. That recommendation was endorsed by the Attorney General[10].

16. The deceased's next sentence review date had been scheduled for 15 May 2015[11].

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[7] Ex 1 Vol 1, Tabs 2 and 41
[8] Ex 1 Vol 1 Tab 41
[9] Ex 1 Vol 1 Tab 41
[10] T.10
[11] T.10

Overview of medical conditions

17. The deceased had suffered an acute myocardial infarction in November 1998 and although he had been prescribed cardiac medications, he was frequently non-compliant despite encouragement and counsel by medical staff with taking his medications. He also had numerous episodes of angina (chest pain) which were investigated and also managed with medication. However the deceased was then often non-compliant with follow-up medical management or otherwise refused to attend hospital or the health centre for treatment and monitoring when suffering chest pain[12].

18. The deceased had a history of a renal cyst and haematuria (blood in urine) starting from 2001. This was monitored but by March 2004, the deceased refused to have further scans.

19. On 1 March 2007 the deceased was commenced on a Diabetes Care Plan,[13] but this was difficult to complete due to his ongoing refusal to have certain tests and examinations performed.

20. On 31 January 2008 the deceased was commenced on a Cardiovascular Disease Care Plan[14].

21. In the course of both Care Plans the deceased received advice to stop smoking, lose weight and increase his exercise, but he was largely non-compliant with this advice.

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[12] T.10
[13] Ex 4
[14] Ex 3. See also Ex 1, Vol 1, Tabs 11 and 12

22. In 2008 the deceased was commenced on anti-depressant therapy[15].

23. Overall, the deceased's medical condition in the period leading up to his death was poor and this was exacerbated by his non-compliance with medical and management plans, which made treatment of his diabetes and ischaemic heart disease difficult.

EVENTS LEADING TO DEATH

24. On 15 March 2013, the date of his death, the deceased had attended at the Hakea Prison Visit Centre for a visit by his friend. At approximately 2:30pm the deceased was in the process of getting changed when he became unsteady on his feet and grabbed the change room door[16].

25. The deceased told a Prison Officer that he was a bit dizzy but he also said that he wanted to carry on with his visit. The deceased was told he would first need to be seen by a medical officer. The deceased continued to appear unwell and a Code Red Medical Alert was initiated by the Prison Officer. The deceased was taken to the rear of the Visits Area and sat down on the bench[17].

26. The deceased appeared to be sweating and breathing heavily. He stated that he felt ill but he did not know why. Medical staff, nurses and doctors, promptly

[15] T.10
[16] T.6
[17] T.10 and Ex 1, Vol 2, Tab 16

attended upon the deceased at the Visits Area and started medical observations. The deceased appeared to be confused and unsteady in his sitting position. His condition deteriorated. He was placed on a flat surface and given oxygen. After he became unresponsive, cardiopulmonary respiration (CPR) was commenced[18].

27. By this stage a Priority One ambulance had been called and resuscitation attempts continued until the arrival of the ambulance[19].

28. The St John Ambulance with paramedics (SJA), arrived at approximately 3pm and continued resuscitation attempts upon the deceased including the administration of adrenaline. SJA took the deceased to Fremantle Hospital, leaving Hakea Prison at 3:40pm. The deceased arrived at Fremantle Hospital Emergency Department shortly after 4pm[20].

29. Prior to the deceased's arrival at Fremantle Hospital, Emergency Department staff had been notified and they had already assembled the resuscitation teams. The deceased was brought into Fremantle Hospital asystole, CPR continued and further adrenaline was administered but the deceased remained asystole. The deceased was pronounced dead at approximately 4:18pm at Fremantle Hospital[21].

[18] Ex 1, Vol 2, Tab 16 and Tab 17
[19] T.10 and Ex 1 Vol 1,Tab 48, SJA received the call at 2.52pm and departed immediately
[20] Ex 1 Vol 1, tab 19
[21] T.7 and Ex 1 Vol 1, Tab 5 and Ex 1, Vol 2, Tab 19

30. At that stage, a principal clinical diagnosis of cardiovascular disease with dysrhythmia and cardiac arrest was recorded[22].

31. Incident Description Reports by the Hakea Prison Officers that attended upon the deceased consistent with the facts outlined above form part of the brief of evidence[23] before me. The reports are consistent with the Department of Corrective Services' requirements regarding the reporting of Incidents[24].

32. Emergency care and treatment by Hakea Prison Officers and medical staff was properly provided to the deceased and was consistent with the Department of Corrective Service's Health Services Policy requirements[25].

POST MORTEM EXAMINATION

33. Chief Forensic Pathologist, Dr C T Cooke, made a post mortem examination of the deceased on 19 March 2013 at the State Mortuary[26].

34. Dr Cooke's examination found enlargement of the heart with some thickening of the heart muscle. There was extensive scarring of the heart muscle in the rear wall of the left ventricle. The arteries on the surface of the heart showed significant arteriosclerotic hardening and narrowing. The lungs were congested, a non specific change which may be seen with

[22] Ex 1 Vol 1 Tab 48 and Ex 1, Vol 2, Tab 19
[23] Ex 1 Vol 1, Tab 16 to 30 and Ex 1, Vol 2, Tab 16
[24] Ex 1, Vol 2, Tab 17 and 22
[25] Ex 1, Vol 2, Tab 21
[26] Ex 1 Vol 1, Tab 6

malfunction of the heart. The body organs appeared to be otherwise healthy. Microscopic examination confirmed these changes, also showing some fatty change in the liver.

35. Dr Cooke stated that it appears that the deceased has died of a "heart attack" (cardiac arrhythmia), arising on the basis of significant pre-existing heart disease.

36. Dr Cooke's conclusion is that the cause of death was Ischaemic Heart Disease in association with Coronary Arteriosclerosis[27]. I accept this conclusion as the cause of death.

SUPERVISION, TREATMENT AND CARE

37. Pursuant to section 25(3) of the Act I have assessed the quality of supervision, treatment and care of the deceased while he was under the custody of Chief Executive Officer of the Department of Corrective Services.

38. The deceased had been in custody in Western Australia since 4 November 1985, a total of 27 years and approximately 4 months. The deceased escaped from custody on 6 September 1990 and was recaptured the next day.

39. During the time that the deceased was in custody in Western Australia he was transferred between Fremantle Prison, Casuarina Prison, Canning Vale Prison, Albany and Bunbury Regional Prisons and

[27] Ex 1, Vol 1 tab 6

most recently Hakea Prison. In some instances he was transferred to or from those prisons on more than one occasion.

40. The deceased's sister, Ms Barbara King has expressed concern about the number of times he was transferred between prisons and queried whether his medication was not kept up given the constant moving[28]. I have considered this matter as part of my overall assessment of the deceased's supervision, treatment and care.

41. The deceased's prison placement history is as follows [29]

CW Campbell Remand Centre	4 November 1985 to 18 December 1985	44 days
Fremantle Prison	18 December 1985 to 24 December 1985	6 days
CW Campbell Remand Centre	24 December 1985 to 3 January 1986	10 days
Fremantle Prison	3 January 1986 to 3 April 1986	90 days
CW Campbell Remand Centre	3 April 1986 t 17 July 1986	105 days
Fremantle Prison	17 July 1986 to 6 September 1990	1512 days
At Large	6 September 1990 to 7 September 1990	1 day
Fremantle Prison	7 September 1990 to 23 September 1991	381 days
Casuarina Prison	23 September 1991 to 22 July 1994	1033 days
Canning Vale Prison	22 July 1994 to 26 October 1994	96 days
Casuarina Prison	26 October 1994 to 7 August 1996	651 days
Canning Vale Prison	7 August 1996 to 17 August 1999	1105 days
Albany Regional Prison	17 August 1999 to 10 March 2000	206 days
Casuarina Prison	10 March 2000 to 22 December 2000	287 days
Albany Regional Prison	22 December 2000 to 7 December 2006	2176 days
Bunbury Regional Prison	7 December 2006 to 31 January 2007	55 days
Hakea Prison	31 January 2007 to 6 February 2007	6 days
Albany Regional Prison	6 February 2007 to 4 August 2010	1275 days
Hakea Prison	4 August 2010 to 15 March 2013	954 days

[28] Ex 2
[29] Ex 1, Vol 2, Death in Custody Review Report

My assessment of the quality of the deceased's supervision, treatment and care from late 1985 onwards is by reference to the treatment of his mental health and his physical health whilst in custody over various identified periods as set out below :

(a) CW Campbell Remand Centre and Fremantle Prison (November 1985 – September 1991)

42. On 4 November 1985, upon being taken into custody, as required the deceased underwent routine medical screening upon reception at Fremantle Prison. This medical screening revealed no acute or chronic medical conditions at that time[30].

(i) Mental Health Matters

38. The deceased's state of mental health was addressed at an early stage during his incarceration. He was assessed on numerous occasions over this period, and he was not found to be suffering from a mental illness.

39. On 18 December 1985 and whilst on remand, the deceased was transported to Graylands Hospital for psychiatric assessment[31].

40. The Psychiatrist Superintendent of Graylands Hospital by letter dated 24 December 1985 advised the Aboriginal Legal Service of WA (Inc) that the deceased arrived at Graylands Hospital on 18 December 1985 without prior warning or written information as to why he was referred. The deceased was assessed on 18 December 1985 as not

[30] Ex 1, Vol 2 : Death in Custody Review Report and T.15
[31] Ex 1, Vol 2 tab 5

being in need of any immediate psychiatric treatment. In view of his history of severe violence to females and his propensity to attempt to escape and there being no overt, current psychiatric symptoms, the deceased was returned to the Court. It was noted that a detailed psychiatric assessment could take place in safety in the Canning Vale Remand Centre by the visiting consultant psychiatrist [32].

41. A psychiatric assessment of the deceased was in fact undertaken on 9 January 1986 at Fremantle Prison by a consultant psychiatrist from Graylands Hospital[33]. On that assessment there was no indication of an ongoing psychiatric condition.

42. On 13 January 1987 the Fremantle Prison Psychologist reviewed the deceased at the request of the Superintendent of the Fremantle Prison in relation to the deceased's ongoing behavioural issues. The psychologist noted the deceased had been exposed to violence in early childhood, that he had almost certainly suffered some degree of brain damage and that he was of "borderline normal intelligence". He noted that the deceased had been a problem in management for many years. The psychologist found no basis for protecting the deceased from the consequences of his misbehaviour and stated that no evidence emerged from the deceased's social history and medical reports of previous years to indicate any form of mental illness[34].

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[32] Ex 1, Vol 2 tab 5
[33] Ex 1, Vol 2 tab 6
[34] Ex 1, Vol 2 tab 7 – The Fremantle Prison Psychologist did not consider it likely that the car

43. In early September 1990 the deceased was referred to the Psychiatrist after he expressed suicidal thoughts. Following psychiatric review, no recommendations were made, the deceased having indicated that his utterances were designed to irritate staff and were not statements of intent to commit suicide.

44. Over this period the deceased was also intermittently treated for anxiety and difficulties associated with sleeping.

(ii) Physical Health Matters

43. Over the relevant period of time Medical Progress Notes recorded each contact the deceased had with prison health services where he received treatment and medications. At this stage they included general health issues and it is clear that his complaints of chest pain and episodes of collapse were investigated.

44. However, some of the deceased's medical treatment was also as a result of injuries arising from altercations with other prisoners.

45. Casualty Records dated January and April 1986 confirm the deceased was treated for a sprain and facial contusions following altercations with other prisoners.

46. Casualty Records in February, April and June 1989 confirmed minor injuries relating to specific events, and one of them was in relation to minor facial abrasions

accident sustained by the deceased at the age of 15 years further contributed to his brain damage.

following an altercation with another prisoner. The deceased was treated by medical staff on each occasion.

47. Over this period the deceased commenced to experience chest pain. Medical Progress Notes reflect that the deceased complained of chest pain in November 1987 and in July 1988 but on each occasion, no adverse diagnosis was noted.

48. In August and September 1989 Medical Progress Notes record the deceased complaining of sharp chest pain. He was reassured on the first occasion and on the second occasion, no adverse diagnosis was made.

49. On at least three occasions in 1990 (and apparently a number of years before that) the deceased experienced intermittent episodes of collapse. The deceased was referred to the Neurology Clinic at Fremantle Hospital and reviewed by the Neurology Registrar on 23 August 1990 [35].

50. The Neurology Registrar undertook further investigations, namely a cranial Computed Tomography (CT) scan and an Electroencephalogram (EEG) in September 1990. The objective was to ascertain whether the deceased's collapses were epileptic in nature. The results showed there was no evidence of epileptiform activity[36].

51. The Neurology Registrar suggested there may be a cardiovascular cause for the transient episodes of loss of consciousness, leaving any further investigation to prison health authorities.

[35] Ex 1 Vol 2 tab 8
[36] Ex 1, Vol 2 tab 8

(b) Casuarina and Canning Vale Prisons (1991-1994)[37]

(i) Mental Health Matters

50. Over this period of time the deceased received treatment in respect of mental health matters. In early February 1991 after receiving news that his father had passed away the deceased was offered placement in the Observation Unit overnight and provided with sedation to assist him with sleep.

51. A Casualty Report records that in July 1991 the deceased was moved by emergency response staff to a medical observation cell after barricading himself in his cell. He was not injured and he was medically sedated.

52. In December 1992 after placement in a punishment cell for an infraction the deceased attempted suicide by hanging with a bed sheet. He was received counselling from the Prison Psychologist and he was discharged back to his punishment cell.

53. In August 1993 Medical Progress Notes record the deceased as having deeply held paranoid beliefs of a dangerous and self-harming nature and that he appeared chronically depressed. The deceased was monitored and reviewed by the visiting Psychiatrist and was intermittently prescribed anti-psychotic medications.

(ii) Physical Health Matters

54. The deceased complained of chest pain, and these instances were investigated.

[37] Ex 1, Vol 2, Death in Custody Review Report

55. In early January 1992 the deceased complained of chest pains and on examination was treated for strains and muscular pain in that area.

56. In June 1992 the deceased complained of left sided chest pain when lying down and occasionally when taking deep breaths. He was diagnosed with intercostal pain.

57. In July 1992 nursing staff saw the deceased in relation to pain in his chest over a two month period. No adverse diagnosis was revealed and his pain was assessed as being musculoskeletal in nature.

58. In March 1993 the deceased complained of sharp left sided chest pain and an Electrocardiogram (ECG) was performed in conjunction with weekly blood pressure testing. The deceased was advised to undertake half an hour exercise on a daily basis and to lose weight.

59. There was other medical treatment of the deceased, not related to his chest pain over this period. In January 1992 the deceased was treated for an aching neck, lower skull and left shoulder as a result of hitting a wall with his right hand after he was disciplined by staff.

60. In March 1992 the deceased sustained bruising and swelling to his left hand after dropping a concrete slab on it. He was treated with an ice pack and bandaging and his hand was later X-rayed.

(c) Casuarina and Canning Vale Prisons (1994-1999)[38]

(i) Mental Health Matters

61. The deceased continued to be assessed as not suffering from a mental illness. His difficult behaviour escalated, reaching a crisis point. He engaged in some instances of self-harm.

62. In early May 1996, whilst under the influence of what is described as "home brew alcohol" the deceased obtained a knife and held staff at bay for approximately three hours during which time he inflicted multiple stab wounds to himself. When the situation was resolved, the deceased was treated in hospital and then followed up in the prison's medical observation unit.

63. Shortly after the incident where the deceased held staff at bay, he was reviewed by the Visiting Psychiatrist who highlighted his history of a major head injury, poor impulse control and violent behaviour but found no evidence of mental health illness or major psychiatric illness. Accordingly no specific psychiatric recommendations were made.

64. Casualty Reports for August and September 1996 record that on two occasions the deceased vented his frustration by head butting and punching a brick wall. On both occasions he sustained minor injuries which were treated including in the latter case by X-rays in hospital. There were no fractures though there was bruising.

[38] Ex 1, Vol 2, Death in Custody Review

(ii) Physical Health Matters

65. Over this period the deceased's cardiovascular condition emerged, culminating in a myocardial infarction in November 1998, for which he was treated. After that further instances of chest pain were carefully monitored.

66. In August 1995 the deceased complained of centralised chest pain radiating to his left side. An ECG was performed and the deceased was reviewed by the Prison Doctor who prescribed Mylanta for him. In addition a cardiac medical alert was recorded for him. As a result of medical testing it was identified that the deceased had raised levels of cholesterol and triglycerides.

67. Between March 1995 and May 1996, in relation to episodes of intermittent chest pain the deceased was prescribed blood thinning medications.

68. In July 1997 following particular symptoms the deceased attended hospital for an intravenous pyelogram procedure, but no appreciable disease was noted.

69. On 9 November 1998 the deceased collapsed and it was suspected that it was due to heat exhaustion. He was transferred to Royal Perth Hospital for assessment after complaining of chest pain. He was diagnosed with having had a myocardial infarction with hyperlipidaemia. He was admitted as an inpatient and underwent a Coronary Angiogram.

70. Upon discharge from Royal Perth Hospital three days later, the deceased was transferred to Casuarina Prison's

Infirmary and further treated with medications. He was scheduled for a follow-up in six weeks time.

71. In the latter part of 1998 the deceased presented to medical staff with central chest pain symptoms resulting in further ECG's being performed. He was treated with Anginine and Glyceryl Trinitrate spray (GTN spray). Monthly blood pressure testing was commenced.

72. In early January 1999 the deceased was escorted to the Medical Centre with central chest pain and tingling radiating down one arm. He was clinically assessed and transferred to Royal Perth Hospital in an ambulance. He was discharged from hospital the same day after being diagnosed with angina.

(iii) Non-compliance with prescribed medication and medical advice

73. It was during the period at Canning Vale and Casuarina Prisons between 1994 to 1995 that the deceased began a pattern of behaviour characterised by erratic compliance and/or non-compliance with medical treatment and advice concerning his health.

74. In 1994 and 1995 the deceased failed to attend a number of medication parades. Mr Mudford's evidence of the usual procedure for medication parades was that prisoners are advised of times that medication parades take place but they are not (and cannot be) forced to attend medication parades[39].

[39] T.35

75. Throughout 1996 the deceased failed to attend a number of medication parades in respect of his prescribed blood thinning medications.

76. In July 1997 the deceased was reluctant to attend hospital for his intravenous pyelogram procedure. After an initial cancellation, the deceased managed to attend with counselling and support by nursing staff.

77. Following his discharge from Royal Perth Hospital in November 1998 and having been diagnosed with having had a myocardial infarction, medication charts for the deceased indicate erratic compliance and non-compliance with heart medications throughout November and December 1998.

78. Also following his discharge from Royal Perth Hospital in November 1998, the deceased was repeatedly counselled to take exercise, reduce his smoking and comply with his medications.

79. Medical notes for 1999 record the deceased's frequent non-compliance with essential medications, despite numerous episodes of central chest pain and/or angina symptoms. When the deceased agreed to be tested, his ECG results were faxed through to the hospital.

80. On a number of occasions over this relevant period the deceased refused to attend external cardiology appointments[40].

[40] These attendances were to have been undertaken in restraints because the deceased was a High Security Escort.

(d) Casuarina Prison, Albany and Bunbury Regional Prisons (1999-2007)[41]

81. Records over this period indicate the deceased received treatment in relation to chest pain complaints, but treatment was difficult to administer on occasion due to his non-compliance.

82. In July 2000 the deceased was transferred to Fremantle Hospital following chest pain and an abnormal ECG result, but he refused treatment. A myocardial infarction was not ruled out and his angina was assessed as being unstable due to ongoing non-compliance with essential medications.

83. In September 2000 the deceased was transferred to hospital after collapsing in his cell with severe chest pain.

84. In December 2000 the deceased was transferred to Albany Regional Prison where he remained for the next six years.

85. Whilst at Albany Regional Prison, the deceased continued to be a difficult patient in regards to attending external health appointments, but his overall compliance appeared to improve with continued encouragement by medical and custodial staff.

86. In September 2006 as a result of an Annual Nursing Assessment it was recorded that although suffering from haematuria over a number of years he had refused to attend hospital for further investigation.

87. Over this period, the deceased's Ischaemic Heart Disease was treated with GTN spray.

[41] Ex 1, Vol 2, Death in Custody Review

88. Again, the deceased was encouraged to address his obesity through exercise, appropriate diet and the cessation of his smoking.

(e) Albany Regional Prison (2008-2010)[42]

(i) Mental Health Matters

89. Over this period the deceased experienced episodes of depression and there was also an instance of self-harm. He was treated for the former and received medical attention in respect of the latter.

90. The deceased was commenced on anti-depressant medication (Zoloft) during 2008 and Medical Progress Notes at that stage record good results including a reduction in his aggressive outbursts.

91. By early 2009 the deceased was displaying positive behaviours and engagement.

92. However, it is noted that in February 2010 the deceased injured his hand after punching a wall in anger and he displayed other threatening behaviour a week later. The outbursts were attributed to a grief reaction in relation to the death of a friend and mental health support was provided to him as required.

93. In March 2010 after losing his temper with another inmate the deceased hit himself in the head with a dinner plate causing a six centimetre laceration to his forehead. No sutures were required and he declined an analgesia.

[42] Ex 1, Vol 2, Death in Custody Review

94. Towards the end of his stay at Albany Regional Prison in 2010 the deceased's aggressive behaviour and non-compliance in relation to attempts at medical treatment was exacerbated. In July 2010 the deceased was placed in the punishment section after assaulting another prisoner and over the next few days he displayed aggressive behaviour refusing all medications and treatment.

(ii) Physical Health Matters

95. Over this period there was some improvement in the symptoms of the deceased's cardiovascular condition and it coincides with an improvement in his compliance with taking essential medications.

96. During 2008 the deceased achieved some gains in relation to his efforts at weight reduction. He did not report chest pain nor is there a record of the use of GTN spray for over a year. In early 2008 a Cardiovascular Disease Care Plan was initiated for him.

97. The deceased's level of compliance with essential medications was recorded as being improved over this period.

98. However, by 2009 the deceased's Cardiovascular Care Plan still noted that weight management was a challenge for him and his eating habits had not improved[43].

[43] Ex 3 Entry dated 16 September 2009

(f) Hakea Prison (August 2010 – March 2013)[44]

(i) Physical health Matters and Escalating Non-Compliance with Medical Advice

99. On arrival at Hakea Prison medical staff assessed the deceased as being very overweight, diabetic, suffering from Ischaemic Heart Disease and hyperlipidaemia and therefore of high risk of a cardiovascular event. Arrangements were made for him to attend medication parades.

100. During this relevant period the deceased reverted to an increasingly non-compliant attitude towards taking his essential medications. Encouragement and counselling from medical staff appears to have been of limited effect and the deceased did not attend doctors' and nurses' reviews. The deceased was recorded as doing "nothing about lifestyle improvement" (specifically in respect to weight management)[45].

101. The deceased's non-compliance was reflected in his refusal to attend for particular surgery at Royal Perth Hospital (not related to his cardiovascular condition) in March 2011, which had been rescheduled due to his transfer from Albany Regional Prison.

102. The deceased's non-compliance was amplified in August 2011 when, following erratic compliance with essential medications, he presented to medical staff complaining of feeling generally unwell and dizzy. The deceased had high blood pressure, an irregular pulse rate and

[44] Ex 41, Vol 2 Death in Custody Review and T.16 to 19
[45] T.17

shortness of breath. Due to significant changes in the deceased's ECG results a decision was made to transfer him to hospital as an emergency patient. However, following the arrival of the ambulance the deceased became aggressive and threatening, refusing to be transferred. The deceased also refused to remain in the medical observation unit and was eventually escorted back to his unit under guard.

103. A Management Plan was initiated given those refusals and the deceased remained in his unit and was seen twice daily in the medical centre for an ECG and baseline observations, with night checks through the cell observation hatch being conducted as well.

104. Medical Progress Notes record that after this period the deceased developed chest soreness and a persistent cough (acute bronchitis) over a number of weeks and was scripted with antibiotics. The deceased's erratic compliance with medications and non-attendance or refusals to attend the medical centre continued.

105. In June 2012, following continued erratic compliance with medications and treatment a more vigorous approach was taken with respect to encouraging the deceased to continue with essential medications, but it was to no avail.

106. In July 2012 blood tests confirmed the onset of diabetes and the deceased was again encouraged to exercise to address his obesity.

107. On 14 September 2012 a Code Red Medical Alert was initiated when the deceased was found unconscious in his cell. This was the deceased's second episode of fainting in a number of days and he had been coughing prior to collapse on each occasion. The deceased had been treated for a cough over the previous four weeks. Clinical observations were made, an ECG was performed at the medical centre and the deceased was transferred to Royal Perth Hospital to assess his fainting. There the deceased was diagnosed with bronchitis. No cardiac component was identified and he was discharged from hospital the same day.

108. Two days later the deceased was brought to the medical centre for assessment because he had again lost consciousness the previous night following an episode of coughing. The ECG revealed no new changes. At this stage, the deceased received asthma advice, he was scripted with a Ventolin inhaler and a plan was made to assist him in reducing his smoking with nicotine patches[46].

109. Whilst there was a brief improvement in the deceased's compliance with essential medications, about one month before his death, his level of compliance declined considerably with frequent refusals of medications or failures to attend medication parades being recorded.

[46] It was noted he had been a heavy cigarette smoker for the past 30 years, but that he had reduced his smoking. However, in due course he became non-compliant with the patches and resumed smoking.

110. In the week leading up to the date of the deceased's death, records show he received essential daily medications on four occasions.

111. I am satisfied that over this period pro-active and reasonable attempts were made by prison medical staff to encourage the deceased to take his medications and to explain the likely consequences of failing to take them to him.

(g) Overview of Management of the Deceased during his Incarceration

112. This section is divided into three areas:

(i) Management of the deceased;

(ii) Support programs offered to the deceased; and

(iii) The deceased's applications for Interstate Transfers.

(i) Management of the deceased

113. Throughout most of the deceased's period of incarceration, he was frequently identified as a difficult prisoner to manage and on the evidence before me I accept this to be the case. The deceased often came to the attention of prison authorities when he displayed aggressive behaviours towards other prisoners. On other occasions, other prisoners displayed aggressive behaviours towards the deceased.

114. In April 1986 the deceased was assaulted by other inmates and a message came to the attention of prison authorities to the effect that the deceased faced an

unacceptable risk unless action was taken to exclude him from a certain part of the prison[47].

115. In September 1990 during an escort to Fremantle Hospital the deceased escaped legal custody and was apprehended by police the following morning. In August 1991 the deceased was subsequently convicted in Court of the escape and of assaulting a public officer. He was sentenced to concurrent terms of imprisonment[48].

116. The deceased's Sentence Planning Report records that between 1986 and 1991 the deceased was the subject of a total of 35 separate prison charges against him relating to threatening behaviours and/or misconduct generally, but also including two assault charges against him[49].

117. By April 1994 the deceased had become the subject of a further six prison charges against him including possessing a weapon, using or possessing alcohol as well as offences involving acts of insubordination[50].

118. In October 1994 the deceased was identified as being involved in an attempted escape[51] and was subsequently transferred from Canning Vale Prison to Casuarina Prison's Special Handling Unit.

119. As has been described above, the deceased's misbehaviour reached a critical point in early May 1996, where shortly after one of his applications for an interstate transfer was refused, he held prison officers at

[47] T.20
[48] Ex 1, Vol 1, Tab 41
[49] Ex 1, Vol 2, Tab 10 and T.20 to 21
[50] T.20
[51] Ex 1, Vol 2, Tab 11

bay for three hours with a knife. During this incident the deceased inflicted multiple wounds to himself requiring hospitalisation[52]. It transpired the deceased had consumed "home brew alcohol".

120. After this incident there was during the following three years, an improvement in the deceased's behaviour in that there were no further prison charges against him from May 1996 through to June 1999.

121. However, I note that in August 1996 the deceased was transferred from Casuarina Prison to Canning Vale Prison due to the intimidatory effect he had on staff at Casuarina Prison. This followed a series of threatening and aggressive acts by the deceased against staff and other persons at Casuarina Prison[53].

122. The deceased remained at Canning Vale Prison for the next three years (August 1996 to August 1999) and was then incarcerated at Albany Regional Prison from August 1999 to March 2000. However, in March 2000 the deceased was transferred back to Casuarina Prison because of concerns regarding the safety and security of others.

123. Offender in Custody files record considerable unrest between the deceased and other Casuarina Prison inmates[54].

[52] T. 21 to T. 22
[53] Ex 1, Vol 2, Tab 12.
[54] T.22

124. As a result security staff assessed the situation and concluded that for security reasons the deceased ought to be transferred from Casuarina Prison[55].

125. On 22 December 2000 the deceased was transferred to Albany Regional Prison.

126. The deceased was incarcerated at Albany Regional Prison from December 2000 to December 2006 and again from February 2007 to August 2010.

127. Once again at Albany Regional Prison there was an initial marked improvement in the deceased's behaviour, he performed his tasks, attended the education centre and gained further skills. At this point the deceased was not considered a management problem.

128. In October 2002 the deceased's security rating was reduced to medium.

129. However, during the latter part of his incarceration at Albany Regional Prison the deceased's misconduct began to escalate, and it involved acts of aggression against staff and other prisoners[56].

130. Given this deterioration in the deceased's behaviour it was considered the deceased had become a threat to the good order and safety of persons at the Albany Regional Prison and a decision was made to transfer him to Hakea Prison on 4 August 2010[57].

131. Ms King, the deceased's sister, has expressed concern about the deceased having been transferred at least 16

[55] T.23
[56] T.44
[57] T.25

times in the period of his incarceration and has queried the effect of this upon the treatment of his medical condition[58].

132. Under cross-examination by legal representatives for the deceased's family, Mr Mudford explained the Department of Corrective Services' procedure that bears upon the continuity of medical treatment for prisoners when they are transferred from one prison to another[59].

133. Mr Mudford stated that when a prisoner is transferred, their medical files and Care Plans go with them and that predominantly the Electronic Health Online (ECHO) system is used by doctors and nurses, which is interfaced with Total Offender Management System (TOMS), used by custodial staff.

134. I am satisfied that there was a proper process in place for the continuity of the deceased's medical treatment in the event of his transfers. The evidence of his medical treatment that I have described above at the various prisons is consistent with the adoption of the procedure that is described by Mr Mudford.

135. Mr Mudford was cross-examined by legal representatives for the deceased's family in connection with the number of times the deceased was transferred between prisons.

136. Mr Mudford stated that the deceased was transferred between prisons for a range of reasons that included

[58] Ex 3
[59] T.37 and T.38

health reasons, program participation and security reasons[60].

137. Mr Mudford's evidence was that, noting the cost of moving prisoners, a full assessment needs to be taken, including a consideration of financial factors and what is best for the prisoner.

138. On the evidence before me there is nothing to suggest that the deceased's transfers between prisons were as a result of anything other than properly considered decisions. Some of them were necessitated by the deceased's own problematic behaviours[61].

(ii) Overview of support programs offered to the deceased[62]

139. A range of support programs were offered to the deceased over the period of his incarceration.

140. In February 1996 the deceased was psychologically assessed for inclusion in the Sex Offenders Treatment Program (SOTP) but was deemed unsuitable due to his denial stance.

141. The deceased was considered suitable for an anger management programme, but his participation was deferred until a male tutor could be arranged due to his perceived risk to female staff.

142. In April 1999 the deceased was assessed for inclusion in the Violent Offender Treatment Program (VOTP). However, the deceased refused to attend based on his

[60] T.32-34
[61] T.46
[62] T.21 to T.26

denial stance. Consequently he was not recommended for participation in the VOTP.

143. In February 2002 the deceased commenced the Cognitive Skills Program but he withdrew from the program due to his inability to work within a group setting[63]. This program was seen as a pre-requisite for more intensive intervention. To address the deceased's needs, individual counselling with the prison's Clinical Psychologist was commenced in January 2005 and in the circumstances he underwent a VOTP, delivered to him individually.

144. The deceased participated in this individual counselling until December 2005 and his VOTP Treatment Report[64] indicates that gains were made. The Report recommended further individual counselling for the deceased in the form of an individual sex offender program.

145. The deceased was scheduled to participate in the SOTP conducted at the Bunbury Regional Prison in early 2007 and was transferred there from Albany Regional Prison in December 2006 to facilitate his integration into this program. The intention was that upon completion of the SOTP, the deceased would be required to complete the group based VOTP.

146. In January 2007, shortly after his transfer to the Bunbury Regional Prison the deceased was deemed unsuitable to participate in a group based SOTP by the Clinical Supervisor as he had not met the pre-requisites

[63] T.24
[64] Ex 1, Vol 2, Tab 13

for meaningful participation. The deceased was subsequently transferred back to Albany Regional Prison, via Hakea Prison, for reassessment of his specific treatment needs.

147. In cross-examination Mr Mudford conceded that technically the transfer from Albany Regional Prison to Bunbury Prison in December 2006 was "probably unnecessary". He explained that transfer as follows:

> "His transfer was in good faith to get him down there for a program participation. The assessment later on determined he wasn't suitable" [65].

148. In September 2007 the deceased commenced the eight week Think First program but his placement was terminated approximately three weeks into the course after it was established that he did not meet the program criteria due to the specific nature of his offences.

149. In February 2008 the deceased completed a Personal Development Behavioural Change – Responsibility course with Albany Regional Counselling and Mentoring Services.

150. Material tendered into evidence[66] records that a Treatment Needs Update Report dated 19 May 2011 concluded that the deceased's chronic issues related to violent and sexual offending, alcohol use and volatility and that they were compounded by his intellectual deficit and psychopathic traits. He was deemed unsuitable to engage in group therapeutic treatment. It was considered

[65] T.44
[66] Ex 1, Vol 2 Tab 2 document dated 19 March 2012 and T.42 to 43

that his volatility and limited behavioural control could negatively impact on other participants in a group therapy situation. At this stage he was not considered suitable for inclusion in individual therapeutic treatment. Instead, strict supervision and monitoring to provide external controls to assist the deceased in managing his behaviour was recommended.

151. Based on this information, in May 2012 the Parole Review Board did not recommend the deceased's release to parole and his next sentence review date was set for a date in May 2015[67].

152. The deceased remained at Hakea Prison as a medium security prisoner and his Individual Management Plan was reviewed in accordance with six monthly timeframes. The deceased was not scheduled to complete any further prison-based program intervention.

153. I find that the deceased was provided with adequate and reasonable opportunities to participate in programs to address his treatment needs. Further, that individual counselling was made available to him in an effort to address his unique treatment needs in circumstances where his negative behaviour made other forms of treatment unworkable. As a result of his volatility and/or denial stance, the deceased missed some opportunities for treatment despite the Department's efforts to include him. I note, however, that gains were achieved as a result

[67] T.26

of the individual counselling and those counselling efforts are to be commended.

(ii) The Deceased's applications for interstate transfers

154. The deceased made separate applications (1998, 1993 and 1994) to transfer his sentence to the Eastern States[68] to be closer to his family members, who resided there, particularly his sisters, who were supportive of him. The deceased withdrew his second application some months after applying and the other two applications were unsuccessful.

155. In 1996 he made a further application for Interstate Transfer to New South Wales. However, when he was advised that New South Wales sentencing laws precluded a statutory review of his Western Australian life sentence he deferred action on his application to seek legal advice. In the circumstances, this application was unsuccessful[69].

156. In 2007 the deceased made a further application to transfer his sentence to New South Wales. That and subsequent applications to the ACT and NSW to transfer his sentence were also unsuccessful.

CONCLUSION AS TO QUALITY OF SUPERVISION, TREATMENT AND CARE

157. The deceased was a difficult prisoner to supervise and to treat. Having regard to the evidence of the deceased's

[68] Prisoners (Interstate Transfer) Act 1983
[69] T.21

supervision, treatment and care at each of the prisons, as I have described above, I find that he was properly supervised and that medical care was properly arranged and/or provided to him. He was encouraged and counselled to comply with attending medical appointments and taking his essential medications. The quality of the deceased's supervision, treatment and care was appropriate and reasonable in the circumstances.

CONCLUSION AS TO HOW DEATH OCCURRED

158. The deceased had been diagnosed with heart disease and there was a Cardiovascular Disease Care Plan in place for him. He had been diagnosed with diabetes and there was a Diabetes Care Plan in place for him.

159. The deceased was frequently non-compliant with his medications and on occasion refused to attend medical appointments. Proper and reasonable efforts were made to counsel him as to the possible consequences to his health and to encourage him to take his medications and attend medical appointments and medication parades. In the week prior to his death he received essential daily medications on four occasions.

160. I am satisfied that despite his intellectual deficit, the deceased understood there was a need to take his medications, for the sake of his health, but that on many occasions he made an informed decision not to take them.

161. There is no indication of a mental illness that precluded the deceased from making an informed decision in this regard.

162. At about 2:30pm on 15 May 2013 the deceased was preparing for a visit at the Hakea Prison Visitors Centre when he became suddenly dizzy and unstable on his feet. He was noted to be red in the face and sweating profusely. A Code Red Medical Alert was properly initiated. The deceased became unresponsive and CPR was commenced in accordance with the Department's Health Services Policy. At approximately 3pm SJA paramedics arrived and conveyed the deceased to Fremantle Hospital arriving shortly after 4pm.

163. When the ambulance officers arrived at Hakea Prison to attend to the deceased, he was in ventricular fibrillation. Resuscitation attempts were continued by SJA including the administration of adrenaline. However, the deceased went into pulseless electrical activity and became asystole. At Fremantle Hospital CPR was continued for a further period and further adrenaline was administered but the deceased could not be resuscitated and he was pronounced dead at Fremantle Hospital at 4.18pm.

CONCLUSION AS TO CAUSE OF DEATH

164. The deceased died of a heart attack arising on the basis of significant pre-existing heart disease.

165. The cause of death is Ischaemic Heart Disease in association with Coronary Arteriosclerosis.

166. The manner of death is Natural Causes.

R V C FOGLIANI
STATE CORONER
10 July 2014