Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 22/15

I, Sarah Helen Linton, Coroner, having investigated the death of ***John MAJINSKI*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth****, on* ***29 June 2015****, find that the identity of the deceased person was* ***John MAJINSKI*** *and that death occurred on* ***16 June 2013*** *at* ***Royal Perth Hospital*** *as a result of* ***complications of fibrosing alveolitis*** *in the following circumstances:*

Counsel Appearing:

Sgt Housiaux assisting the Coroner
Mr W Fitt (State Solicitor's Office) appearing on behalf of the Department of Corrective Services

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INTRODUCTION

1. John Majinski died in the early hours of the morning on 16 June 2013 at Royal Perth Hospital (RPH). At the time of his death, the deceased was serving a term of imprisonment imposed on 13 December 2011.

2. As the deceased was a sentenced prisoner under the *Prisons Act 1981* (WA) at the time of his death, he was a 'person held in care' as defined in section 3 of the *Coroner's Act 1996* (WA).

3. Pursuant to section 22(1)(a) of the *Coroner's Act*, where a person was held in care immediately before his or her death in Western Australia, an inquest is required to be held. Accordingly, I held an inquest at the Perth Coroner's Court on 29 June 2015.

4. Section 25(3) of the *Coroner's Act* specifies that where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care. Accordingly, the reports of the investigating police officer, First Class Constable Posavec, and Senior Review Officer from the Department of Corrective Services (the Department), Mr Richard Mudford, provided detailed information about the deceased's medical care, general care and supervision in the prison, to assist me in that regard.[1]

5. At the conclusion of the inquest, an internal medical review prepared by a prison medical officer, Dr Thomas O'Gorman, was also provided to the court to assist in an examination of the deceased's medical care while he was in custody.[2]

[1] Exhibits 1 and 2.
[2] Medical Report of Dr Thomas O'Gorman dated 8 July 2014 provided by Mr Watt to the Coroner's Court on 29.6.14.

BACKGROUND OF THE DECEASED

6. The deceased was born on 24 September 1957 in Serbia (formerly Yugoslavia). He moved to the east coast of Australia with his family when he was approximately 13 years old. He briefly attended school on arrival in Australia but was reportedly victimised by his peers due to his lack of proficiency in English and stopped attending school after only a few months. Shortly after, he commenced employment in a series of unskilled roles in factories. He became an Australian citizen in 1974.[3]

7. The deceased was married twice and had three children from his two marriages.[4]

8. The deceased moved to Perth with his wife and family in the early 1990s with the hope of gaining work in the mining industry. That work did not eventuate and he obtained work as a cleaner instead. It was around this time that the deceased appears to have been diagnosed with lupus and a near fatal bout of pneumonia.[5] As a result, his health deteriorated to the point that he could no longer work and he was granted a disability pension.[6]

9. After the deceased's second marriage ended, he lived alone in a Homeswest unit, leading a relatively quiet lifestyle due to his numerous health issues, particularly his lupus-related lung disease, fibrosing alveolitis.[7]

10. Until the offences in November 2009, the deceased had a relatively minor record of offending, apart from a conviction for wilful exposure in 1996, for which he was fined.[8]

[3] Exhibit 1, Tab 2, 1 and Exhibit 2, Tab 2.
[4] Exhibit 2, Tab 2, 3.
[5] Exhibit 2, Tab 2, 3.
[6] Exhibit 2, Tab 2, 2.
[7] Exhibit 2, Tab 2, 2 – 3, Dr O'Gorman's Report, 2.
[8] Exhibit 2, Tab 3.

SENTENCE OF IMPRISONMENT

11. On 28 November 2009, the deceased went to an aquatic centre in Inglewood, where he committed sexual offences against a 12 year old boy who was unknown to him.[9]

12. In 2011, the deceased was convicted after trial of one count of indecent dealing and one count of sexual penetration of a child under 13 years. On 13 December 2011, he was sentenced to a total of four years' imprisonment with eligibility for parole, which was backdated to commence on 20 October 2011.[10] As a result, his earliest eligibility date for parole was 18 October 2013.[11]

13. The deceased continued to deny culpability for the offences while serving his prison term.[12]

MEDICAL HISTORY

14. At the time the deceased was sentenced he was a 54 year old with a history of multiple medical problems, including:

- Fibrosing Alveolitis;
- Severe pulmonary hypertension;
- Diabetes;
- Pericarditis;
- Asthma;
- Autoimmune disease;
- Panic attacks and depression;
- Recurrent pneumonia;
- Vitamin D deficiency;
- Recurrent gastrointestinal bleeding causing life-threatening anaemia; and
- Colonic polyps.

[9] Exhibit 1, Tab 11.
[10] Exhibit 1, Tab 11.
[11] Exhibit 1, Tab A, 3.
[12] Exhibit 1, Tab A, 3.

15. On admission to prison the deceased was on a large number of medications to manage his various medical conditions, namely:

- Mirtazapine for depression/anxiety;
- Gliclazide and metformin for diabetes;
- Cholecalciferol for vitamin D deficiency;
- Micardis for hypertension;
- Simvastatin for high cholesterol; and
- Salbutamol inhaler for lung disease.

MANAGEMENT IN PRISON

16. The deceased was received for the first time into Hakea Prison on 20 October 2011. No welfare concerns, self-harm or suicidal ideation were identified during the reception process. However, he disclosed significant health issues and anxieties about being in prison for the first time. He was seen by a prison nurse on the day he was admitted for a nursing assessment and was housed in the Crisis Care Unit overnight.[13]

17. The deceased was placed in Unit 6 as a protection prisoner the following day and was reviewed by a prison doctor, Dr Philip Hames.[14] After the review, the deceased was rescripted essential medications and sent for a full blood count. He signed a 'Release of Information' to facilitate communication with his regular general practitioner about his medical history and was scheduled for a medical review in two weeks' time.[15] He was also issued with a medical certificate exempting him from work for the next six months although he was permitted to perform light duties at his discretion.[16]

[13] Exhibit 2, Tab A, 5.
[14] Exhibit 2, Tab A, 5.
[15] Exhibit 2, Tab A, 6.
[16] Exhibit 2, Tab A, 6.

18. Prior to his next scheduled doctor's appointment, the deceased attended the prison medical centre on two occasions in relation to respiratory chest pain.[17]

19. The deceased was reviewed again by a prison doctor on 11 November 2011 and he was found to be stable in his presentation.[18] As expected, his pathology testing showed abnormal levels, in particular cholesterol and blood sugar levels. Cardiac and Diabetic Care Plans were commenced.[19] Some paracetamol was prescribed for his chest pain, deemed to be secondary to his fibrosing alveolitis. A referral was also made for the deceased to have his colonoscopy follow-up at Sir Charles Gairdner Hospital (SCGH).[20]

20. On 16 December 2011, the deceased was reviewed by a prison doctor after he reported chest tightness. He was diagnosed with a chest infection and commenced on antibiotics.[21] He was reviewed again three days later and his diabetic and hypertensive medications were increased in light of his worsening blood sugar control and hypertension.[22]

21. Over the next few months, the deceased initiated regular contact with the prison medical centre, complaining of episodes of anxiety, panic attacks, heart palpitations and difficulty sleeping. Investigations by ECG were unremarkable and the symptoms eventually settled towards the end of January 2012 after the deceased was commenced on the beta-blocker propranolol at night for his anxiety.[23]

22. On 3 February 2012, repeat blood tests showed that the deceased's triglyceride and blood sugar levels had improved but his "good" cholesterol levels remained low.

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[17] Exhibit 2, Tab A, 6.
[18] Dr O'Gorman's Report, 2.
[19] Exhibit 2, Tab A, 6.
[20] Dr O'Gorman's Report, 2.
[21] Dr O'Gorman's Report, 2.
[22] Dr O'Gorman's Report, 2.
[23] Dr O'Gorman's Report, 2.

23. On 9 February 2012, the deceased reported chest pain to custodial staff resulting in a medical emergency being called. Responding medical staff assessed the deceased and noted his clinical observations were normal and his colour was good. His complaint related primarily to sleeplessness and anxiety and he was told to wait and see the doctor on a scheduled appointment.[24]

24. The deceased was transferred to Casuarina Prison on 11 February 2012.[25] Upon receival, he was seen by the nursing staff and he advised that he had not slept for four days and was very anxious about his recent placement. A recent ECG was unremarkable and his standard clinical observations were normal, with no shortness of breath observed throughout the consultation. An e-Consult with a doctor was made and the deceased was scripted with Valium to ease his anxiety.[26]

25. The deceased was reviewed by a prison doctor on 13 February 2012. He was assessed as mildly depressed and anxious but was not considered at risk of suicide or self-harm. His anti-depressant medication was increased and he was scripted a new medication for anxiety and sleeplessness.[27] During a blood pressure check a few days later, the deceased told the nursing staff he was feeling much more settled as a result of the recent change to his medications.[28]

26. However, on 21 February 2012, the deceased again complained of trouble sleeping, shortness of breath and chest tightness, necessitating a visit by nursing staff to his cell. He was transferred to the Infirmary where an ECG was normal. Although offered a bed in the infirmary overnight, he decided to return to his unit.[29]

[24] Exhibit 2, Tab A, 6.
[25] Exhibit 2, Tab A, 4.
[26] Exhibit 2, Tab A, 6.
[27] Exhibit 2, Tab A, 6.
[28] Exhibit 2, Tab A, 6.
[29] Exhibit 2, Tab A, 6.

27. He continued to experience further anxiety attacks while at Casuarina, resulting in an increase in his doses of Valium and propranolol and a change to his anti-depressant medication, as well as a referral to the prisoner counselling service and the visiting psychiatrist or senior psychologist.[30]

28. On 24 April 2012, the deceased was transferred to Karnet Prison Farm. Medical progress notes record no reports of panic attacks requiring medication after the deceased's arrival at Karnet.[31] He was seen by a psychiatrist in May 2012 who reported that the deceased's anxiety was improving.

29. Due to his long-term illness and limited mobility, the deceased only held short-term employment at Karnet Prison Farm. Unit staff described him as a polite person and a courteous prisoner who always followed directions and maintained a high level of hygiene.[32]

30. The deceased only received a small number of social visits during his incarceration, but he maintained regular contact with family and friends via telephone and, on occasion, he also corresponded by mail.[33]

31. On 26 September 2012, the deceased was reported by the RPH Respiratory Clinic as having a reduced total lung capacity but his pulmonary fibrosis appeared to be relatively static.[34]

32. The deceased's blood sugar levels, on the other hand, continued to be labile and insulin was eventually added to his diabetic management regime.[35]

33. The deceased was taken to Armadale Kelmscott Memorial Hospital (AKMH) on 22 November 2012 and

[30] Exhibit 2, Tab A, 7 and Dr O'Gorman's Report, 3.
[31] Exhibit 2, Tab A, 7.
[32] Exhibit 2, Tab A, 5.
[33] Exhibit 2, Tab A, 5.
[34] Dr O'Gorman's Report, 3.
[35] Exhibit 2, Tab A, 8.

28 November 2012 owing to chest infections and shortness of breath. On the second occasion he was admitted for five days and given IV antibiotics before being discharged on 2 December 2012.[36]

34. In September 2012, the deceased was referred to specialists for a routine colonoscopy, which eventually took place on 7 December 2012 at SCGH.[37] A small polyp was removed and mild diverticular disease and haemorrhoids were noted.[38]

35. The deceased was returned to and from hospital to the Casuarina Prison Infirmary and then returned to Karnet. This was usual for his hospital admissions.

36. On 20 December 2012, the deceased consulted with dermatologists at Fremantle Hospital in relation to a photosensitive eruption on his cheeks.[39]

37. On 6 February 2013, the deceased was admitted to RPH with a diagnosis of infective exacerbation of pulmonary fibrosis. He was given antibiotics and discharged on 11 February 2013.[40]

38. On 17 February 2013, the deceased was taken to AKMH after complaining of chest pain. He was diagnosed with pericarditis and treated at Fremantle Hospital before being discharged on 18 February 2013.

39. On 22 February 2013, the deceased returned to AKMH with further chest pains secondary to his pericarditis. His pericarditis management was optimised and once his pain had improved he was discharged on 1 March 2013.[41]

40. On 19 March 2013, the deceased experienced a further episode of shortness of breath and was taken to AKMH

[36] Dr O'Gorman's Report, 3.
[37] Dr O'Gorman's Report, 3.
[38] Dr O'Gorman's Report, 3.
[39] Dr O'Gorman's report, 4.
[40] Dr O'Gorman's report, 4.
[41] Dr O'Gorman's report, 4.

and then Fremantle Hospital. He was again diagnosed with pericarditis and underwent an angiogram, which showed no significant coronary artery disease. He was discharged to the Casuarina Prison Infirmary the next day and after his clinical picture improved he returned to Karnet on 9 April 2013.[42]

41. On 15 April 2013, the deceased was again taken to AKMH due to further episodes of shortness of breath and chest pain. He was diagnosed with a pulmonary embolus and pneumonia and admitted for treatment. He was discharged to the Casuarina Prison Infirmary on 24 April 2013. He remained in the infirmary, which provides 24 hour nursing care, and received daily oxygen therapy.[43]

LAST ADMISSION TO HOSPITAL

42. On 9 May 2013, the deceased complained to nursing staff of feeling acutely short of breath while on continuous supplementary oxygen. He was transferred by ambulance to RPH and was admitted to the ward with specialist respiratory team input.[44]

43. The deceased was reviewed by Dr Lavender, the consultant in charge of the Advanced Lung Team. Dr Lavender felt that the deceased's pulmonary hypertension was due to his interstitial lung disease and, as such, would not respond to treatments for pulmonary hypertension. The mainstay of treatment was steroid and steroid sparing agents in order to try to halt the progression of the lung disease and improve the deceased's lung function. It was explained to the deceased that his functioning may not return to previous levels.[45]

[42] Dr O'Gorman's report, 4.
[43] Dr O'Gorman's report, 4.
[44] Dr O'Gorman's report, 5.
[45] Exhibit 1, Tab 16, Inpatient Case Notes, 15.5.2013 and 16.5.2013

44. On 13 May 2013, the deceased was registered as a '*Phase 1'* (high probability of death) on the Department's terminally ill prisoner register.[46]

45. While in hospital, the deceased continued to be regularly reviewed and adjustments were made to his diabetic medication regime as well as ongoing review of his respiratory diseases.

46. On 20 May 2013, blood tests were performed with a view to referral for possible lung transplant, but the deceased's hepatitis B serology results showed active infection and he was deemed unsuitable for lung transplantation.[47] It was explained to the deceased that a trial of CPAP and IV methylprednisolone would go ahead but that if he continued to deteriorate he could only be managed symptomatically.[48] The deceased did not tolerate the CPAP and a "not for cardiopulmonary resuscitation" form was completed on 22 May 2013 by Dr Teng.[49] The deceased's family was informed of his poor prognosis.

47. While the deceased remained under constant supervision by SERCO guards during his hospital admission, from 22 May 2013 he was permitted to be unrestrained on the recommendation of his doctor, due to his extremely poor health.[50]

48. The deceased's status was escalated to '*Phase 2*' (death imminent) on 24 May 2013.[51] In view of a lack of community support or suitable accommodation early release by way of Royal Prerogative of Mercy was not considered appropriate.[52]

49. At around 2.35 am on 16 June 2013, the deceased was found by a nurse slumped on the side of his bed, incontinent of urine and faeces. He was given high flow

[46] Exhibit 2, Tab A, 3.
[47] Exhibit 1, Tab 16, Inpatient Case Notes, 20.5.2013 09.30 and 22.5.2013 09.30.
[48] Exhibit 1, Tab 16, Inpatient Case Notes, 22.5.2013 09.30.
[49] Exhibit 1, Tab 16.
[50] Exhibit 1, Tab 2, 2, Exhibit 2, Tab 9.
[51] Exhibit 2, Tab A, 3.
[52] Exhibit 2, Tab A, 3.

nasal prong oxygen but was noted to be cyanotic and gasping for breath. By 2.40 am his pupils had become fixed and dilated and he was certified deceased at 2.56am by Dr Yang.[53]

CAUSE AND MANNER OF DEATH

Post Mortem Report

50. On 18 June 2013, Dr D Moss, a forensic pathologist, conducted a post mortem examination of the deceased. The examination revealed severely fibrotic lungs, consistent with the deceased's medical history. Microscopic examination confirmed the presence of severe pulmonary fibrosis with features in keeping with usual interstitial pneumonia. There was no evidence of acute blood clots in the lungs or calves.[54]

51. Toxicological analysis showed medications consistent with the deceased's medical treatment. Alcohol and other common drugs were not detected.[55]

52. At the conclusion of all investigations, Dr Moss formed the opinion that the cause of death was complications of fibrosing alveolitis.[56]

53. I accept and adopt the opinion of Dr Moss as to the cause of death.

54. It follows from that conclusion that the manner of death was by way of natural causes.

[53] Exhibit 1, Tab 16, Inpatient Case Notes, 16.6.2013.
[54] Exhibit 1, Tab 6.
[55] Exhibit 1, Tab 6 and Tab 7.
[56] Exhibit 1, Tab 6.

QUALITY OF SUPERVISION, TREATMENT AND CARE

55. At the time he was sentenced to serve a finite term of imprisonment, the deceased already had a long history of multiple medical problems, including diabetes and severe pulmonary fibrosis.

56. The deceased's medical records show that throughout his term of incarceration he became increasingly unwell. Nevertheless, the medical notes reveal the deceased's medical conditions were intensively managed by the prison medical staff in conjunction with a multitude of specialists and allied health professionals.

57. He was appropriately transferred to hospital emergency departments whenever his condition worsened.

58. The medical care the deceased received in prison and in hospital was of a high standard. When his severe lung condition deteriorated significantly, he was considered for lung transplantation but was deemed unsuitable due to his recent diagnosis of active hepatitis B. When there were no other treatments that could be offered, he was provided with palliative care until he died.

59. While little could be done in terms of early release, the deceased was treated compassionately, in terms of removal of unnecessary restraints when he became terminally ill and contact with his family was facilitated.

60. No concerns have been raised by the deceased's family or other members of the community in relation to the deceased's supervision, treatment or care while in the custody of the Department leading up to his death.

CONCLUSION

61. At the time of his incarceration the deceased had a large number of serious medical problems, including long-standing severe lung disease. Despite appropriate

medical treatment, the deceased's health deteriorated further while in custody, until he died on 16 June 2013.

62. The deceased was in the custody and care of the Department immediately before he died. I am satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death.

S H Linton
Coroner
2 July 2015