Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 43 /16

I, Sarah Helen Linton, Coroner, having investigated the death of ***Barry Matt STUART (formerly known as Barrymore Keith CRUTCH)*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***24 November 2016*** *find that the identity of the deceased person was* ***Barry Matt STUART*** *and that death occurred on* ***16 November 2013*** *at* ***Hakea Prison*** *as a result of* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisting the Coroner.
Mr D Harrop (State Solicitor's Office) appearing on behalf of the Department of Corrective Services.

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INTRODUCTION

1. Barry Matt Stuart (the deceased) died on 16 November 2013 at Hakea Prison. At that time he was a sentenced prisoner. As the deceased was a prisoner under the *Prisons Act 1981* (WA) at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1] I held an inquest at the Perth Coroner's Court on 24 November 2016.

2. The documentary evidence included two comprehensive reports of the death prepared independently by the Western Australia Police and by the Department of Corrective Services (the Department), together comprising two volumes.[2] The authors of both reports were also called as witnesses at the inquest.

3. Guided by the results of the investigations, the inquest focused primarily on the medical care provided to the deceased in prison prior to his death, as well as an issue that arose with his resuscitation by paramedics in consultation with a doctor at Fremantle Hospital.

THE DECEASED

4. The deceased was born on 27 November 1963 in New South Wales. He was named Barrymore Keith Crutch at birth, but later legally changed his name. The deceased's older sister, Donna Harding, reported that their mother had experienced a number of tragedies when the children were small, which affected her ability to care for them. She eventually abandoned her children, which led to the deceased and his sister being taken into care when the deceased was about one year old.[3] The deceased went to live with a foster family while his sister went to different carers, although they kept in contact for a number of years.[4]

5. The deceased reported that he suffered sexual abuse between the ages of five and nine years, which ended with the death of his abuser when he was about ten years old.[5]

6. The deceased attended primary school and progressed to high school but eventually left school in Year 10 without completing his leaving certificate examination.[6] After leaving school he worked in a variety of jobs, including as a strapper at the Randwick race course, a forklift driver and a machine operator.[7]

7. The deceased never married nor had any children of his own. He was in three significant relationships throughout his lifetime. His third and final

[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibits 1 and 2.
[3] Exhibit 1, Tab 8.
[4] Exhibit 2, Directed Review, p. 5.
[5] Exhibit 2, Directed Review, p. 5.
[6] Exhibit 2, Directed Review, p. 5.
[7] Exhibit 2, Directed Review, p. 6.

relationship lasted approximately a decade. His last partner had four sons and the deceased felt that he been a father figure to them. On 4 January 2007 the deceased changed his surname from Crutch to Stuart, the same as his partner, to signify their partnership. However, the relationship eventually ended. The deceased believed they had simply 'drifted apart' and he was hopeful that they would reunite at some stage.[8]

8. The deceased managed to re-establish contact with his biological family and moved to Western Australia to reunite with them. In particular, he formed a good relationship with his sister Donna. She provided support to him and accommodation when he was not in custody.[9]

9. The deceased had a long history of drug use and alcohol abuse (although he eventually gave up alcohol in 1998), which contributed to a pattern of criminal offending.[10] When using speed he was also known to become paranoid and believed people were following him, including when he was driving.[11]

OFFENDING HISTORY

10. The deceased's criminal history began in New South Wales in 1982, when he was approximately 19 years old. His convictions included armed robbery, burglary and possession of heroin.[12] He moved to Western Australian in 1994 and his criminal history records convictions the following year for robbery and deprivation of liberty, for which he received a total term of three years and six months' imprisonment.[13]

11. He continued to reoffend after being released from prison and was sentenced to a further lengthy prison term in February 1998 for a large number of armed robberies and other offences.[14] After release on parole the deceased appears to have managed to largely refrain from drug use and further offending, perhaps due to his stable relationship with his partner. He found work as a scaffolder after release but gradually started socialising with old friends and ended up back using amphetamines again. After a couple of years he stopped working.[15]

12. As his social situation deteriorated the deceased lapsed back into offending. In 2012 and 2013 he committed some traffic offences involving driving recklessly to escape police, which resulted in him being taken into custody in mid-2013. The circumstances suggested he was affected by drugs at the time. The deceased was eventually sentenced to a term of six months' imprisonment on 6 August 2013.[16]

[8] Exhibit 2, Directed Review, p. 6.
[9] Exhibit 2, Directed Review, Tab 1, p. 2.
[10] EcHO notes, Vol 3, 02.10.2013.
[11] Exhibit 1, Tab 24.
[12] Exhibit 2, Directed Review, p. 6.
[13] Exhibit 1, Tab 35.
[14] Exhibit 1, Tab 35.
[15] EcHO Notes, Vol 3, 02.10.2013.
[16] Exhibit 1, Tab 35; Exhibit 2, Directed Review, p. 6.

13. On 14 October 2013 the deceased appeared in the Perth Supreme Court and was sentenced to a further term of 14 months' imprisonment for an offence of armed robbery. This extended his earliest eligibility date for parole to 22 April 2014.

14. The last conviction came about as a result of the deceased's voluntary disclosure of the offence to police on 23 January 2013. He had committed the offence on 6 November 1994, so a long period of time had elapsed. The deceased later told a prison nurse that he had heard the police were looking for him and this led him to voluntarily hand himself into the police and admit to the offending.[17] The deceased had previously spoken to a friend and indicated that he had an ongoing concern that he would be picked up by police for armed robberies he had done in the past, and was also depressed because of debts he owed and issues with his ex-partner. The friend believed the deceased may have handed himself in to get away from his ex-partner and his debt problems.[18] The friend was also aware that the deceased had ongoing concerns that he might be extradited back to New South Wales in relation to outstanding matters, and this is also apparent from the contents of correspondence with the deceased's sister.[19]

GENERAL MANAGEMENT OF THE DECEASED DURING LAST PRISON TERM

15. The deceased was received into Hakea Prison on 15 July 2013. A standard Reception Intake Assessment was completed. The deceased disclosed significant health issues, a recent self-harm attempt and protection concerns. For those reasons, he was placed onto the 'At Risk Management System' (ARMS) and housed in the Crisis Care Unit overnight, with six hourly observations. Following an assessment by the Prison Counsellor the following day he was then placed into Unit 6 as a protection prisoner. He was initially held as a remand prisoner, before being sentenced on 6 August 2013.[20]

16. Within five days of his sentencing a Management and Placement checklist was completed to determine his initial security rating, and a further one was completed when he was sentenced again on 14 October 2013. Active Alerts were recorded for the deceased in relation to protection issues (he had reported issues with several Aboriginal families) and a history of self-harm (including his overdose attempt three weeks prior to going into custody). He indicated that at the time of his last attempt he had been sober and made a deliberate decision to take an overdose as he was stressed at his current life situation.[21]

17. After being placed in Unit 6 the deceased remained in that unit but moved cells a number of times. He was in shared cells for the majority of the time,

[17] EcHO notes, Vol 3, 02.10.2013; Exhibit 1, Tab 2 and Tab 36.
[18] Exhibit 1, Tab 24.
[19] Exhibit 1, Tab 24 and Tab 28.
[20] Exhibit 2, Directed Review, p. 6 and Tab 4.
[21] Exhibit 2, Directed Review, p. 7.

until moving to a single occupancy cell on 4 October 2013, where he remained until his death approximately six weeks later.[22]

18. There were no incidents or charges recorded against the deceased while in Unit 6. He was assessed and recommended for inclusion in a number of basic education and short term employment related courses. He also expressed an interest in participating in a substance abuse program, and was recommended accordingly. He gained employment within the prison laundry, where he received favourable reports regarding his work. Within a short space of time he was promoted up two gratuity levels on the basis of his good work performance.

19. The deceased had very limited social contact during this last prison term. He did not receive any social visits, had four official visits and made ten telephone calls to his sister.[23] He also corresponded with his sister by mail.[24]

THE DECEASED'S MEDICAL MANAGEMENT

20. The deceased had a known history of depression, drug induced psychosis, hepatitis C and previous attempts of self-harm. He also had a documented history of variable compliance with medications for the treatment of psychosis and depression.[25]

21. During his earlier prison terms in Western Australia the deceased received ongoing therapy and psychiatric input. He was prescribed antidepressants and anticonvulsants, as well as a night time sedative. He was also managed for muskoskeletal pain and issues related to his smoking, as well as investigations and treatment in relation to hepatitis C.[26]

22. Medical records show that the deceased voluntarily presented to the Emergency Department of Armadale Hospital multiple times during December 2012 and January 2013, and was admitted for three periods of between three and nine days. His presentations were largely around his expressed concern regarding suicidal ideation, hallucinations and paranoia with an admission of ongoing use of intravenous amphetamines. His principal diagnosis was of drug induced psychosis with antisocial personality traits. On each admission he made a good recovery on the ward.[27]

23. When the deceased was incarcerated on 24 January 2013 he admitted to ongoing drug abuse, particularly amphetamines, and advised that he was under the care of community mental health services. He also reported he had been voluntarily admitted to Armadale Hospital one week prior for drug induced psychosis. He told the Clinical Nurse on admission that he has suicidal thoughts when under the influence and asks to be taken to hospital when he has these thoughts. He denied ever having suicidal thoughts when

[22] Exhibit 2, Directed Review, p. 7.
[23] Exhibit 2, Directed Review, p. 7.
[24] Exhibit 1, Tab 28.
[25] Exhibit 2, Directed Review, p. 9.
[26] Exhibit 2, Tab 1, p. 3.
[27] Exhibit 1, Tab 29; Exhibit 2, Tab 1, p. 6 - 7.

not affected by drugs. He guaranteed that he would ask for help if he needed. He was given some olanzapine (an atypical antipsychotic), as that is what he had been prescribed on hospital discharge, and was referred to see the psychiatrist.[28]

24. The deceased was seen by a consultant psychiatrist, Dr Schineanu, the following day. He told Dr Schineanu that he was feeling depressed and paranoid but was coherent and showed no signs of disordered thought. Dr Schineanu formed the impression the deceased did not have a functional psychosis but might have episodic, drug related psychosis. He was not feeling suicidal during the review. He told Dr Schineanu he had not been compliant with his olanzapine in the community but was happy to continue treatment. Dr Schineanu prescribed desvenlafaxine (Pristiq), which is an antidepressant, and also olanzapine, as he had been in prison less than 48 hours and had admitted to using amphetamines recently.[29] Dr Schineanu noted that he should be reviewed in a couple of weeks to see whether he needed to continue with the antipsychotics, but he was released before this could occur. He was compliant with his medication until he was released on 6 February 2013.

25. When the deceased returned to prison on 28 March 2013 he indicated he had not taken his medications since leaving Hakea and had been using amphetamines intravenously every two days. Nevertheless, he was prescribed a continuation of his medications. He was released less than two weeks later without apparently having seen a doctor.[30]

26. On 17 June 2013 the deceased was admitted to Armadale Hospital again after being brought in by police for assessment due to his paranoid behaviour. He admitted amphetamine use and acknowledged he had an upcoming court appearance. He was diagnosed with drug induced psychosis and was discharged after his symptoms resolved on olanzapine and desvenlafaxine and an inhaler.[31]

27. Just prior to his last reception to prison the deceased attempted suicide by overdosing on his olanzapine medication. He was admitted to Royal Perth Hospital (RPH) on 2 July 2013. This event apparently occurred one day after he had been discharged from Armadale Hospital. The deceased told doctors at RPH that he had been experiencing low mood for the last 12 months following the breakdown of his relationship. His symptoms had been worsening over time and he had been experiencing low self-esteem, repeated suicidal thoughts, decreased motivation and poor concentration. He also reported paranoid symptoms, believing "everyone wants to get me" and an internal voice telling him to kill himself.[32] He admitted using amphetamines regularly, although he reported that he had "cut down" to only using every two weeks.[33] He was diagnosed with a drug indicated psychosis with mixed anxiety/depression overlying antisocial personality disorder.[34]

[28] EcHO Notes Vol 3, 24.01.2013; Exhibit 2, Tab 1, p. 4.
[29] EcHO Notes Vol 3, 25.01.2013.
[30] EcHO Notes Vol 3, 28.3.2013 & 9.4.2013; Exhibit 2, Tab 1, p. 5 – released on 4.4.2013.
[31] Exhibit 1, Tab 29.
[32] EcHO Notes Vol 3, Correspondence, RPH Inpatient Discharge Letter 12.7.2013.
[33] EcHO Notes Vol 3, Correspondence, RPH Inpatient Discharge Letter 12.7.2013.
[34] Exhibit 2, Tab 1, p. 5.

28. The deceased was admitted for psychiatric care and his medications were reviewed. His dose of desvenlafaxine was increased to 100 mg and he was trialled on Risperidone (another antipsychotic) but he did not tolerate it well so he was recommenced on olanzapine. The deceased was noted to be at high risk of overdose so he was only provided with a one week supply of his medications when he was discharged on 12 July 2013. The plan was for him to follow up on more medication from Mirrabooka Mental Health Services the following week.[35]

29. Before the deceased could attend Mirrabooka Mental Health Services he returned to custody. The deceased was received at Hakea from court on 15 July 2013. He was assessed by a clinical nurse that afternoon. The deceased informed the nurse of his recent admission to RPH following an olanzapine overdose. He stated that he was still extremely depressed but denied any current thoughts of suicide or self harm. As noted above, he was placed onto ARMS and housed in the Crisis Care Unit with six hourly observations. Arrangements were made for a doctor to prescribe olanzapine and desvenlafaxine. He was prescribed a six month supply of desvenlafaxine and a 28 day supply of olanzapine. The short supply of olanzapine was in response to his recent overdose on that medication and because he had no formal diagnosis of psychosis (only drug induced episodes). He was scheduled for review with a psychiatrist.[36]

30. The deceased was seen by a mental health nurse the next day and noted to be pleasant and appropriate in presentation. He reported that he had generally not been taking his prescribed medication while in the community. He denied any current suicidal ideation. His medical notes were reviewed by a doctor the following day and his case was discussed at the Mental Health Team meeting on 22 July 2013, which included Consultant Psychiatrist Dr Mark Hall. He remained on low ARMS (12 hourly observations) and the plan for psychiatric review remained.[37]

31. The deceased also participated in a prison counselling session that day, during which he expressed concerns about his placement as he had ongoing issues with some Aboriginal families who had family members in Hakea. He acknowledged feelings of disappointment and sadness at his present situation and still had current thoughts of self harm and suicide, although they were greatly reduced from his feelings when he overdosed a few weeks earlier. It was recommended that he remain on ARMS and be placed in the protection unit (Unit 6).[38]

32. The deceased underwent a full medical assessment by a prison medical officer, Dr Kelly, on 29 July 2013. At this time he reported that he was settled and 'happy on olanzapine,' with no further paranoid thoughts and no thoughts of self harm or suicide. At that time he expected to be released

[35] EcHO Notes Vol 3, Correspondence, RPH Inpatient Discharge Letter 12.7.2013.
[36] EcHO Notes Vol 3, 15.07.2013; Exhibit 2, Tab 1, p. 5.
[37] EcHO Notes Vol 3, 17.07.2013 & 22.7.2013; Exhibit 2, Tab 1, p. 5.
[38] Exhibit 1, Tab 37.

from prison in early August. General medical tests were ordered at the end of the medical review.[39]

33. On 29 July 2013 it was noted that the deceased was not attending the morning medication round for his antidepressant, desvenlafaxine. On review with a mental health nurse the following day the deceased indicated that he "was great and has been good since being in prison because he can sleep on his olanzapine and it keeps the voices away."[40] Significantly, given what occurred later, the deceased specifically expressed concern that the mental health nurse might stop the olanzapine. Given the ongoing prescription of olanzapine was an issue, the mental health nurse booked a non-urgent appointment with a psychiatrist.[41]

34. On 30 July 2013 the deceased participated in a counselling session with a prison counsellor. He fully participated in the interview and showed no evidence of anxiety or distress. He indicated that he was feeling happy in Unit 6 and was happy with his medication regime (particularly the olanzapine). He was enjoying increased appetite and good quality of sleep with no heightened anxiety. He cited his employment in the laundry as a substantial protective factor. He strongly refuted any current suicidal thoughts or emotions, which appeared to the counsellor to be genuine denials. After this interview, and taking into account that no acute risk issues had been identified during his mental health assessment the previous day, he was removed from ARMS.[42]

35. The deceased continued to be non-compliant with his antidepressant, prompting counselling by a nurse on 2 August 2013. The deceased indicated he hadn't been taking it as he didn't like it.[43] He was scripted a further 28 days of olanzapine by a doctor without a face to face medical appointment on 8 August 2013, still pending psychiatric review.[44]

36. When seen again by a doctor on 26 August 2013 for review of his hepatitis tests, the deceased was given a further 28 day prescription for olanzapine. It was noted that he was still awaiting psychiatric review in relation to his medications. The deceased claimed at that time he was coping well and "doing easy jail."[45]

37. The deceased continued to be non-compliant with his antidepressant and he was spoken to by a nurse on 2 September 2013 about the issue. The deceased expressed his view that he didn't need to take it and was happy just with olanzapine at night. It was noted that he was booked to see a psychiatrist at the end of the month and formal cessation of his antidepressant could be discussed at that time.[46]

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[39] EcHO Notes Vol 3, 29.07.2013; Exhibit 2, Tab 1, p. 5.
[40] EcHO Notes Vol 3, 30.07.2013; Exhibit 2, Tab 1, p. 5.
[41] EcHO Notes Vol 3, 30.07.2013; Exhibit 2, Tab 1, p. 5.
[42] Exhibit 1, Tab 37.
[43] EcHO Notes Vol 3, 02.08.2013; Exhibit 2, Tab 1, p. 5.
[44] EcHO Notes Vol 3, 06.08.2013; Exhibit 2, Tab 1, p. 5.
[45] EcHO Notes Vol 3, 26.08.2013; Exhibit 2, Tab 1, p. 5.
[46] EcHO Notes Vol 3, 02.09.2013; Exhibit 2, Tab 1, p. 5 - 6.

38. On 27 September 2013 the deceased was reviewed by a senior comorbidity/mental health nurse about his refusal to take his antidepressant. It was noted that his olanzapine script had run out at that time and the deceased stated he didn't see the point of taking the antidepressant when his olanzapine had ceased. It appears his scheduled psychiatric review had been postponed, as the nurse noted that the deceased wasn't booked to see a psychiatrist until 21 November 2013 due to demand and limited clinics. The nurse arranged for a further one month prescription of olanzapine to be issued for the deceased by a medical officer.[47]

39. The same nurse saw the deceased again on 2 October 2013 as the deceased was still not taking his antidepressant. The deceased told her that he didn't feel he needed to take the antidepressant anymore as he hadn't taken it for a fortnight and was feeling good. He indicated that initially he had felt depressed on coming back to prison but he now felt "at home" and prison gave him structure and security. He denied experiencing any depressive symptoms and showed no evidence of suicidal intent or ideation, although he did admit to paranoia and being overly sensitive about other people. He found those symptoms were mild when he was on olanzapine but they were increasing while he was off it. His sleep had also been poor while off olanzapine as he lay awake at night with an overactive mind. He indicated that he would like to stay on olanzapine but it is recorded he told the nurse "he understands if [they] don't prescribe it for him."[48] The nurse noted the psychiatric review was scheduled for 21 November 2013 and indicated consideration should be given at that time to ceasing his antidepressant but a further prescription of olanzapine should be considered.[49]

40. The deceased had some other medical appointments in October and November for other issues and it was noted that he continued to decline to take his antidepressant. He failed to attend a GP appointment on 30 October 2013, for reasons unknown, and his appointment was rescheduled for 18 November 2013 (two days after he died).[50] On 5 November 2013 a note was made that his psychiatric appointment was now scheduled for 25 November 2013, although it is not clear why the appointment date was changed.[51]

41. On 12 November 2013 the mental health nurse who had reviewed the deceased at the time his olanzapine prescription expired in October, made an administrative note that the deceased's olanzapine script had expired again. She noted that he required rescripting but made a comment that he may be better served by awaiting the pending psychiatry appointment two weeks later.[52]

42. Three days later, on 15 November 2013, a prison nurse noted that the deceased was requesting a medication review. She referred to the note by the previous nurse and noted that he had an appointment scheduled with the prison psychiatrist, Dr Hall, on 25 November 2013. The nurse also noted

[47] EcHO Notes Vol 3, 27.09.2013; Exhibit 2, Tab 1, p. 5 - 6.
[48] EcHO Notes Vol 3, 02.10.2013; Exhibit 2, Tab 1, p. 6.
[49] EcHO Notes Vol 3, 02.10.2013; Exhibit 2, Tab 1, p. 6.
[50] Exhibit 1, Tab 33.
[51] EcHO Notes Vol 3, 05.11.2013; Exhibit 2, Tab 1, p. 6.
[52] EcHO Notes Vol 3, 12.11.2013; Exhibit 2, Tab 1, p. 6.

that there were no earlier appointments available with Dr Hall. No other steps were taken to obtain another prescription of olanzapine for the deceased and he died the following day.[53]

THE DECEASED'S BEHAVIOUR IN WEEKS PRIOR TO DEATH

43. Robert Cummins, a prison inmate who had known the deceased for two or three years, spoke to the deceased daily during his last prison term. He was aware that the deceased had some 'girlfriend issues' and knew the deceased had tried to put his ex-partner on his prison phone list but the deceased's ex-partner did not accept the request. Mr Cummins was also aware that the deceased had had some issues with continuing his prescription for a medication to help him sleep (presumably olanzapine) and he had recently seen the deceased in the laundry and had a discussion with him about the issue. The deceased had said, "How could my script run out?" Mr Cummins had encouraged the deceased to speak to a prison officer who had helped him to get a repeat prescription previously. He was unsure whether the deceased followed his advice.[54] Mr Cummins had also heard that the deceased had asked another inmate in the laundry, "What do you think it would be like on the other side?"[55]

44. Mr Cummins had also noted that the deceased had recently been sitting by himself at the back of his prison unit to smoke, rather than sitting with everyone else. This perhaps indicated he was withdrawing from others to some extent.[56]

45. Another prison inmate who was a long-term friend of the deceased, William Ralph, saw the deceased in the laundry on the Thursday before he died. They stopped and talked to each other and the deceased seemed happy. Mr Ralph had seen the deceased outside the prison and thought he was a totally different person then, as the deceased seemed a lot happier in prison. He was aware that the deceased had mental health issues related to drug use, although he was not aware of his previous suicide attempts. He was also aware that the deceased had split up with his partner sometime before coming back into prison. He thought the deceased seemed well and the deceased made no mention of suicide.[57]

46. Another prison inmate, Neil Wright, had met the deceased during this last prison term. Normally the deceased and he would wave at each other as they passed, and usually the deceased would be the first to wave, but Mr Wright recalled that in the last week he would have to instigate the wave instead. He also observed the deceased appeared to be withdrawing a bit from others. Nevertheless, the deceased appeared to always be smiling and was funny and jovial. The deceased did not say anything to Mr Wright to suggest he

[53] EcHO Notes Vol 3, 15.11.2013; Exhibit 2, Tab 1, p. 6.
[54] Exhibit 1, Tab 25.
[55] Exhibit 1, Tab 25.
[56] Exhibit 1, Tab 25.
[57] Exhibit 1, Tab 26.

was having problems and Mr Wright described his later death as "unexpected."[58]

EVENTS ON 16 – 17 NOVEMBER 2013

47. The reports and occurrence logs show there were no issues with standard musters throughout the day on 16 November 2013.

48. The deceased was seen by his friend, Mr Cummins, playing volleyball between 1.00 pm and 3.00 pm that day and he had seemed fine at that time. The deceased said to a few people, "See you on the flip side" but this was not considered unusual as he often used this phrase.[59]

49. The deceased was locked into his single cell, N12, that evening at the usual time of 6.30 pm.[60] He was the sole occupant of the cell from that time. The cell was a standard prison cell and had been 3-point ligature minimised (window bars, light fittings and shelving brackets removed). Nevertheless, there were numerous ligature points remaining in the cell, as is the case in most prison cells in Western Australia other than in the Crisis Care Unit.

50. No cell calls from the deceased requesting assistance were recorded by the prison that night.[61]

51. At approximately 8.00 pm Prison Officer Nelson conducted the first lock and muster check of N wing in Unit 6. During the check he lifted the observation hatch of the deceased's cell and observed the deceased lying on the floor of his cell. The officer's vision was restricted, so he could only see the deceased's legs with his feet pointing upwards. Officer Nelson called out to the deceased, asking him if he was alright, and kicked the cell door to get his attention. He received no response from the deceased and detected no movement. Officer Nelson observed what appeared to be water on the cell floor and thought it was possible the deceased had slipped and knocked himself unconscious.[62]

52. In order to open (or breach) the deceased's cell after hours Officer Nelson required the attendance of the Officer in Charge of the prison, who at that time was Senior Prison Officer Gary Hawthorn.[63] Officer Nelson radioed Senior Officer Hawthorn and requested his attendance. A number of prison officers, who formed the Night Recovery Team, attended together with Senior Officer Hawthorn. Senior Officer Hawthorn looked through the observation hatch of the deceased's cell and recognised that the liquid on the floor was actually phlegm and vomit. He immediately used a key to unlock and open the deceased's cell door. Upon entering the cell he saw the deceased was sitting in a half upright seated position and had an electrical cable tied

[58] Exhibit 1, Tab 27 [13].
[59] Exhibit 1, Tab 25.
[60] Exhibit 2, Tab 8.
[61] T 9.
[62] Exhibit 1, Tab 21; Exhibit 2, Tab 10.
[63] Exhibit 1, Tab 23.

around his neck, with the other end tied around the sink and attached to a tap.[64]

53. Senior Officer Hawthorn immediately radioed a Code Red (medical emergency) and requested the attendance of the medical team and an ambulance 'Priority 1'. The call was recorded to be made at 8.05 pm. He then used a Hoffman knife to cut the ligature and removed the cord from around the deceased's neck. Prison officers commenced CPR before moving the deceased into the unit corridor to allow better access for medical treatment. All of the responding officers held qualifications in CPR. Prison medical staff arrived minutes later and relieved the prison officers, continuing CPR with the use of a defibrillator. The defibrillator showed a continuous flat line. A clinical nurse made an assessment of the deceased and noted he was cyanotic, his pupils were fixed and dilated and he showed no pulse or respirations. Attempts to deliver oxygen were unsuccessful due to possible internal neck trauma causing obstruction.[65]

54. At approximately 8.25 pm an ambulance arrived at the prison and paramedics attended the unit. They took over resuscitation management, using a medical compression unit. At approximately 8.49 pm the defibrillator was switched off as the deceased had not responded to continuous resuscitation attempts for twenty minutes and it was expected that resuscitation efforts would soon be ceased after a final examination of the deceased. However, at 8.50 pm a paramedic announced, "I have a pulse."[66] This return of spontaneous circulation occurred approximately one minute prior to the time when the St John Ambulance guidelines indicated termination of the resuscitation efforts.[67]

DECISION TO CEASE RESUSCITATION

55. At approximately 9.00 pm the deceased was removed from Unit 6 on a stretcher and loaded into the rear of the ambulance. It was intended that he would be taken by ambulance to Fremantle Hospital. The ambulance crew indicated to prison staff at that time that it was likely that the deceased would die either in transit to hospital or soon after arrival.[68]

56. During the delay exiting the prison due to security procedures, an ambulance officer contacted the Fremantle Hospital Emergency Department to inform them of the estimated time of arrival of the ambulance. This is customary for all seriously ill or injured patients. While this was occurring the deceased went into cardiac arrest again, with intermittent return of spontaneous circulation following administration of adrenaline.[69]

[64] Exhibit 1, Tab 23.
[65] T 10; Exhibit 2, Tabs 10 and 11; Echo Notes, Vol 3, 16.11.2013.
[66] Exhibit 2, Directed Review, p. 8.
[67] Exhibit 1, Tab 31, p. 1.
[68] Exhibit 2, Directed Review p. 8.
[69] Exhibit 1, Tab 31.

57. The ambulance officer spoke to Dr Curry at Fremantle Hospital. Doctor Curry advised them that they should not continue with resuscitation nor transport the deceased to the hospital.[70]

58. As a result of that conversation with Dr Curry, the ambulance crew decided to return to the prison medical centre. At approximately 9.10 pm the ambulance returned from the front gate to the prison medical centre and the deceased was transferred to the medical centre's internal waiting room. The ambulance crew asked for the assistance of prison staff as to what to do next. The area manager telephoned the hospital again to discuss the matter. Dr Curry gave the same instruction to the area manager. As a result, resuscitation efforts were terminated by ambulance officers at 9.48 pm.[71] The prison's on-call GP later attended and after examining the deceased he then completed the certificate certifying him life extinct at 10.15 pm.

OTHER INFORMATION

59. When the medical team had taken over care of the deceased Senior Officer Hawthorn had a brief opportunity to look around the deceased's cell. He could not see any suicide note or anything that appeared to be suspicious.[72]

60. As part of standard procedure for a death in custody, Major Crime Squad was notified and Detective Sergeants Williams and Thompson of Major Crime Squad attended Hakea. They examined the scene and obtained statements from witnesses before determining that there was no criminality associated with the deceased's death.[73]

CAUSE AND MANNER OF DEATH

61. On 22 November 2013 Dr D. Moss, a Forensic Pathologist, made a post-mortem examination of the body of the deceased. The post mortem examination revealed faint small abrasions to the anterior neck, though no definite ligature mark. There was a fracture to part of the larynx (left superior thyroid horn) and there were pinpoint haemorrhages in the eyes (conjunctival petechiae). An area of subcutaneous bruising was noted to the right wrist and coronary artery atherosclerosis was also noted. Toxicological analysis was performed and no alcohol or other common drugs were detected, which is consistent with the deceased not having taken any prescribed medications in the days prior to his death.

62. At the conclusion of the examination Dr Moss formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging). I accept and adopt the conclusion of Dr Moss as to the cause of death.

[70] Exhibit 1, Tab 31.
[71] Exhibit 1, Tab 31.
[72] Exhibit 1, Tab 23.
[73] T 6.

63. Taking into account the cause of death in the context that the deceased's body was discovered locked in his single occupancy cell, and the conclusion of the experienced police coronial investigator, Detective Sergeant Simmonds (now Sergeant Simmonds), that there was no evidence of the unlawful involvement of another person in the death of the deceased, I find that the manner of death was by way of suicide.[74]

QUALITY OF SUPERVISION, TREATMENT AND CARE

64. Under s 25(3) of the *Coroners Act 1996*, 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.

65. The investigation found that the deceased had used a television electrical cable as a ligature in this instance. The Department has a Ligature Point Reduction Program, which acknowledges that television electrical cables are at risk of being used as a ligature, but there are practical difficulties with removing such items from standard cells. At present, the approach of the Department has been to focus upon managing the risk of such cables in safe cells, by keeping all such cords to a minimum length and performing a risk assessment of a prisoner's risk of self-harm before allocating such an item to a prisoner. However, in standard cells the need to provide a certain level of amenity to prisoners, and an acknowledgment that all ligature points and risks can never be removed from a cell while still maintaining some level of comfort for prisoners, means that there will always be the opportunity for prisoners housed in standard cells to fashion a ligature where they are committed to that purpose. I understand the need for a practical approach in these circumstances.

66. The Department's internal review found that the emergency response by custodial and prison medical staff was prompt and well-coordinated.[75] I agree with that conclusion.

67. What arises from the evidence as the primary area of concern in the case of the deceased's supervision, treatment and care, was his access to psychiatric review and cessation of medications without that review.

Review by Dr Fitzclarence

68. The Deputy Director of Prison Health Services, Dr Cherelle Fitzclarence, prepared a report for the Department reviewing the deceased's medical care in custody.[76] Dr Fitzclarence noted that the deceased had been repeatedly scripted olanzapine during his last period of incarceration, although there was no confirmed indication for the continued prescription of the atypical antipsychotic. His only confirmed diagnosis was of depression, for which he had a long-term script for an antidepressant that he routinely declined to

[74] T 16 – 17.
[75] Exhibit 1, Tab 21, p. 2.
[76] Exhibit 2, Tab 1 – NB: The report was largely prepared by the then Director of Prison Health Services, Dr Roslyn Carbon, but Dr Carbon left the Department before the report was finalised so Dr Fitzclarence finalised and signed the report.

take.[77] There was a suggestion of drug-induced psychosis only, that would resolve on ceasing illicit drugs. Dr Fitzclarence observed that ongoing antipsychotics are not normally indicated for this condition.[78]

69. Dr Fitzclarence went on to explain that community standards dictate that antipsychotics can be prescribed by general practitioners for certain indications (under the Pharmaceutical Benefits Scheme) if the patient is suffering from psychosis. However, it would be expected that a Consultant Psychiatrist would at some point be involved in the care and would be expected to confirm or establish the diagnosis.[79]

70. In the prison setting, Dr Fitzclarence advised that due to previous issues with general practitioners allegedly being 'stood over' by prisoners for drugs, second generation antipsychotics (also known as atypical antipsychotics) such as olanzapine were deemed to be the province of Consultant Psychiatrists and required consultant opinion and diagnosis for prescription. The difficulty is that there has been a lack of availability of psychiatrists within the Department. This has meant that general practitioners have at times been required to give long-term prescriptions without the benefit of psychiatric assessment, which has created issues with dependency on medication for which there may be no ongoing clinical indication. However, the policy within the Department (formulated in response to previous coroner's reports and best practice) is not to cease psychotropic medication for psychiatric indication without formal review.[80]

71. During 2013 there was a particular crisis in the supply of Consultant Forensic Psychiatrists to the Department. Despite an established Service Level Agreement with the State Forensic Mental Health Service (North Metropolitan Health Service) which was to supply 1.3 FTE of psychiatry service across all metropolitan prisons, in practice this service resulted in only 0.2 to 0.4 FTE at any one time. Modelling of health care needs at Hakea indicate there was a requirement for a minimum of a half time to full-time psychiatrist on site. Through the direct employment from June 2013 of a single psychiatrist (at 0.7 FTE) across the metro areas, the Department was able to provide limited cover at Hakea. However, access to psychiatry input remained severely limited.[81]

72. Additional pressure on psychiatry services, both at Hakea and other prisons was, and continues to be, created by the lack of forensic psychiatry beds at the Frankland Centre, with up to ten inmates awaiting urgent psychiatric admission under the *Mental Health Act* at any one time. The need to prioritise the management of these seriously mentally ill, high care, patients means the management of less unwell, 'non urgent' patients in the prison system is delayed. They must be placed on waiting lists to see a psychiatrist.[82]

[77] Exhibit 2, Tab 1, p. 7.
[78] Exhibit 2, Tab 1, p. 7.
[79] Exhibit 2, Tab 1, p. 7.
[80] Exhibit 2, Tab 1, p. 7.
[81] Exhibit 2, Tab 1, p. 7.
[82] Exhibit 2, Tab 1, p. 8.

73. At the time of the deceased's final prescription for olanzapine ending the nurse made a decision that the olanzapine should be ceased to await the planned psychiatry appointment, which she was aware was not scheduled until nearly two weeks' time. This was contrary to the usual practice, which would be to seek a script from a GP in the interim. It is not clear why the mental health nurse deviated from the normal practice in this instance. It is relevant that the decision was made in the absence of appropriate psychiatric resources within the prison health system at that time.[83] At the time of the deceased's death general practitioners and nurses continued to believe psychiatric assessment was imminent, but did not have access to accurate clinic timing.[84]

74. It is Dr Fitzclarence's view that the deceased should have been granted a continued supply of olanzapine until his eventual review by a psychiatrist, or at the very least until a formal consultation by the mental health nurse with the deceased could have been done, with a verifiable reason to cease supply being made and documented thereafter.[85] However, Dr Fitzclarence expressed the opinion that it "is not possible to determine whether the provision of a further olanzapine script would have altered the final outcome."[86] Dr Fitzclarence also indicated that it is not possible to determine what effect the deceased's continued refusal to take his antidepressant medication had on the final outcome.[87]

75. At the conclusion of her medical review Dr Fitzclarence made a number of recommendations. Of particular relevance to this inquest, Dr Fitzclarence recommended that mental health nurses within the Department should not make decisions about ongoing medication requirements without medical officer advice either from a prison medical officer (GP) or psychiatrist. Following on from Dr Fitzclarence's report, it was acknowledged in the Department's Management Review Report that the mental health nurse did not follow the required practice at the time. The Department's "Prescribing, Reviewing of Medications, Medical Effectiveness Policy MM02" requires that a medical practitioner appointment is made before expiry of a current prescription for the purpose of reviewing the prisoner's need for the medication and renewing the prescription, if required.[88] However, the decision was made "in the absence of appropriate resources within the health system and high workload."[89]

76. Dr Fitzclarence also recommended that when GP's are prescribing antipsychotics *prior to* psychiatric review of a patient, they should record a working diagnosis and the medication should be continued until psychiatric review unless there is good indication to cease the medication. In such case, Dr Fitzclarence indicated the documentation should be meticulous. The Department's Management Review Report noted that at the time of the deceased's death the Department already had a policy in place at time requiring the Chief Medical Officer to authorise prescriptions of

[83] Exhibit 2, Tab 1, p. 8.
[84] Exhibit 2, Tab 1, p. 9.
[85] Exhibit 2, Tab 1, p. 9.
[86] Exhibit 2, Tab 1, p. 8.
[87] Exhibit 2, Tab 1, p. 8.
[88] Exhibit 2, Tab 21, p .3 and Tab 21A.
[89] Exhibit 2, Tab 1, p. 2.

antipsychotics by GP's and indicating prescriptions may then be continued until a psychiatric review has been conducted. Since the death of the deceased in 2013, documentation of the reasons for prescribing medications and the process of authorisation have improved, with all prescriptions detailed on a prisoner's progress notes and medication section in EcHO.[90]

77. Further, Dr Fitzclarence recommended that the Department should develop and initiate a "missed medication' policy that provides a formal process to follow when a patient is refusing medication. In June 2015 the Department implemented the "Refusal of Medication Policy MM09," which provides medical staff with clear procedures to follow when a prisoner refuses medication.[91]

78. Finally, Dr Fitzclarence recommended that the GP's engaged with prison health services should be encouraged to undertake extended mental health skill training, and the Department should facilitate this where possible, and steps should be taken in conjunction with the Department of Health to deliver the full FTE consultant psychiatry required to provide appropriate psychiatry cover to prisoners. The Department's Management Review Report acknowledged this recommendation and indicated that half of the Department's 18 GP's have undertaken extended mental health skills training at their own costs and there is a MOU between the Department and the Department of Health for the provision of health services to prisoners, but it is still to be implemented. In the meantime, it was acknowledged that the level of clinician availability will remain inadequate.[92]

79. Dr Fitzclarence concluded that the deceased was a man with a history of repeated attempts on his own life who had spent much of his adult life in prison. He had significant risk factors for self harm, which had been noted and addressed both in prison and in the community. He had a variable record of coping within the prison system, but he did not have a recorded episode of self harm or suicide attempt while in custody (as he confirmed during his ARMS intake assessment on 15 July 2013).[93] During his last period of incarceration the deceased did not exhibit any specific risk factors that might have alerted medical staff or prison staff that he was at acute risk of suicide.[94] Dr Fitzclarence noted that the deceased had repeated encounters with the Department's health services but his medical management was fragmented. She acknowledged that the "ongoing and significant shortage of forensic psychiatry services within the prisons, coupled with a system lacking cohesion at that time, contributed to the final outcome for this man."[95] I agree with that observation, in the sense that the lack of availability of psychiatric review, with proper consideration being given to continuation or cessation of olanzapine by a psychiatrist, left the deceased in an uncertain position that clearly preyed upon his mind.

[90] Exhibit 2, Tab 1 and Tab 21, p. 3.
[91] Exhibit 2, Tab 1 and Tab 21, p. 5 and Tab 21B.
[92] Exhibit 1, Tab 21, p. 5.
[93] Exhibit 2, Tab 1, p. 9 and Tab 4, 6.3.2.
[94] Exhibit 2, Tab 1.
[95] Exhibit 2, Tab 1, p. 10.

Review by Dr De Felice

80. As part of the coronial investigation, Dr C. Nick De Felice, a Consultant Psychiatrist, was asked to review the medical care provided to the deceased. After reviewing the relevant medical records and other materials Dr De Felice provided a report to the court. Dr De Felice indicated there is no doubt from the records that the deceased had the problem of polysubstance abuse, as well as exhibiting some antisocial personality traits. He also noted the documented history of repeated suicide attempts as far back as 1998. Given the deceased's early background of traumatic life experiences and reported family history of depression, Dr De Felice thought it reasonable to conclude that the deceased had a significant genetic and developmental predisposition to depression, which supported a diagnosis of recurrent major depressive disorder.[96]

81. Dr De Felice also acknowledged that there was no question the deceased suffered from recurrent psychotic symptoms. However, he noted the question arises as to the force driving such symptoms, namely whether the symptoms were fuelled only by illicit stimulant drugs or whether the psychotic symptoms were indicative of an underlying psychotic disorder such as schizophrenia, albeit worsened by his use of illicit substances. After reviewing the deceased's reported history of late onset of psychotic symptoms, in his late forties, as well as the rapid settling of his psychotic symptoms in hospital and the lack of psychotic symptoms reported when gaoled, Dr De Felice observed that these considerations made him lean towards a diagnosis of drug-induced psychosis rather than an underlying process such as schizophrenia.[97]

82. Having reached that conclusion, Dr De Felice states that even back in January 2013 when Dr Schineanu reviewed the deceased, considerations should have been given as to whether he still needed to continue antipsychotics. Dr De Felice went on to explain,

> *That is, in the absence of a clear functional illness such as schizophrenia, with the expectation that any psychosis precipitated by amphetamine use was likely to be contained in prison by no (or less) access to amphetamines, and thinking that any psychosis might be observed sooner rather than later, the ongoing use of a medication such as Olanzapine would be of concern. Although Olanzapine is a very appropriate drug to assist with psychotic symptoms, it is associated with very significant weight gain, and an increased risk of diabetes and raised cholesterol, namely the metabolic syndrome. Accordingly, in the absence of the need for such treatment one would at least reconsider its use and the onus would be on it being clearly required for it to be continued rather than any question be raised should it be ceased.*[98]

83. Dr De Felice noted that there appeared to be periods before the deceased was in prison, and even after he was in prison from 15 July 2013, when he was not taking olanzapine. Not all such times were documented as being

[96] Exhibit 1, Tab 34.
[97] Exhibit 1, Tab 34.
[98] Exhibit 1, Tab 34, p. 3.

associated with a recurrence of psychosis. There was reference to the deceased having poor sleep and an overactive mind (with some paranoia) on 2 October 2013 after a week off olanzapine, but Dr De Felice concluded there was not enough information in the documentation to conclude that there was a relapse of psychosis at this time.[99]

84. Dr De Felice found it unclear from the notes when the deceased received his last dose of olanzapine. From the available information he concluded the deceased's olanzapine dose most likely ceased in late October.[100] A review of the "Webster-pak" medication chart indicates the deceased last received a dose of olanzapine on 28 October 2013, so Dr De Felice's assumption was correct.[101]

85. Dr De Felice noted that even in people with a clear history and diagnosis of schizophrenia, the worsening of psychotic symptoms after cessation of medication usually takes a few weeks to emerge, sometimes even months, depending on the severity of the illness. Therefore, even if it was the case that the deceased did have an emerging psychotic disorder (and not simply psychotic symptoms precipitated by the use of amphetamines), in Dr De Felice's opinion the cessation of olanzapine for one to three weeks would not have been "such as to lead to a marked worsening of any underlying psychotic disorder that was by that time emerging."[102] Accordingly, Dr De Felice expressed the opinion that he did not think it likely that a recurrence of psychosis led to the deceased's suicide, and therefore, the cessation of olanzapine was unlikely to have been relevant to his suicide.[103] Dr De Felice also noted in this regard that there is no evidence that olanzapine has an "anti-suicide" effect.

86. From the available information Dr De Felice also did not think that the deceased's suicide was prompted by a recurrence of depression.[104]

87. The only possible link that Dr De Felice found to the cessation of the deceased's medications was that the deceased told the mental health nurse on 2 October 2013 that without the sedative effect of olanzapine his sleep was poor and he was "lying awake with an overactive mind." Dr De Felice acknowledged that it was possible that in this context the ceasing of olanzapine led to some discomfort for the deceased and it is possible his musings at night when he could not sleep led to consideration of suicide and planning of this act. Dr De Felice acknowledged that this link was speculative, but still commented that it would have been wise to consider the use of other sedative medication in those circumstances, at least until formal psychiatric review.[105]

[99] Exhibit 1, Tab 34, p. 4.
[100] Exhibit 1, Tab 34, p. 4.
[101] EcHO notes, Vol 3, Charts, Webster pak chart started 26.10.2013.
[102] Exhibit 1, Tab 34, p. 4.
[103] Exhibit 1, Tab 34, p. 4 - 5.
[104] Exhibit 1, Tab 34, p. 4.
[105] Exhibit 1, Tab 34, p. 5.

The cessation of olanzapine

88. What is apparent from the reviews by both Dr Fitzclarence and Dr De Felice is that there was no clear medical indication for the deceased to be prescribed olanzapine on an ongoing basis. There was little evidence that he had an underlying psychotic disorder, but rather his psychotic symptoms were most likely associated with his amphetamine use. While in prison, with limited access to such a drug, his psychotic symptoms were not likely to re-emerge and there was no evidence that they had done so at the time of his death. In Dr De Felice's opinion, if the deceased had been reviewed by a psychiatrist, it is most likely in those circumstances that his prescription for olanzapine would have been ceased as the side effects were not justifiable where the medication was not needed to manage an ongoing psychotic condition. However, cessation of the deceased's olanzapine, without a review by a psychiatrist, was not recommended.

89. The difficulty in this case was that the opportunity for psychiatric review was limited, given the lack of psychiatric services available to prisoners at Hakea at that time (and even today) and the lack of urgency associated with the deceased's case, where he was not acutely psychiatrically unwell. The need for the deceased to undergo psychiatric review was well known and well documented, and yet at the time of his death many months had still elapsed without it occurring. Looking at the history of events, I cannot be confident that if the deceased had not taken his life he would have seen a psychiatrist in the oncoming weeks, despite an appointment being scheduled for approximately two weeks' time.

90. What happened, as a result of the delay, is that a mental health nurse ultimately made a decision not to take action to obtain yet another prescription for the deceased's olanzapine, presumably with the expectation that it would not be renewed when he finally underwent psychiatric review. That assumption was most likely correct, given the opinion of Dr De Felice. However, what the nurse did not take into account was that the deceased's expressed desire to continue the medication appears from the evidence to have related to the mental benefits he gained from the sedative effect of the olanzapine, which allowed him to sleep at night and avoid ruminating at night when alone in his cell. It may well be that a psychiatrist might have ceased the deceased's olanzapine, but replaced it with another sedative medication with less side effects, to assist him to sleep at night. This is the opinion of Dr De Felice, which I accept.

91. The decision to allow the deceased's prescription for olanzapine to cease without arranging medical review, even by a GP if no psychiatric review was possible, was an error in clinical judgment given the available history, which showed the deceased was psychologically dependent upon the medication, whether or not it was psychiatrically indicated. However, I understand that the decision occurred in a context where the deceased had been given numerous repeats of a medication that was not clearly indicated for his condition and with the knowledge that he had gone periods without it in the past without incident. The deceased had also indicated to the nurse some understanding of the likelihood of the prescription being ceased.

92. The events that followed showed that the deceased reacted negatively to the cessation of the olanzapine, at least in the sense that the issue preyed upon his mind. He took some action to remedy the situation, by seeking a medication review, but it appears that the nurse whom he approached felt bound to await the scheduled psychiatric review. Before that could occur, the deceased made what appears to have been an impulsive decision to take his own life. I accept the opinion of Dr Fitzclarence that the deceased's decision to do so was, at least in part, due to the cessation of olanzapine, but in the context that I have explained above. That is, it does not appear to have been prompted by a re-emergence of psychosis, but rather due to the absence of the sedative effect of the medication, which had a psychological benefit for the deceased.

93. In another inquest I conducted recently into a death of a young man who had been a prisoner at Hakea and then Casuarina prison prior to his death in 2013 issues were also raised about a lack of access to psychiatric review and medication issues. I heard evidence from Dr Mark Hall, who was involved in the care of the deceased in this case, and Dr Adam Brett, who are both consultant psychiatrists who have worked extensively in Western Australian prisons.[106] During that inquest Dr Hall gave evidence that there had been an increase in the level of availability of psychiatrists in Casuarina and Dr Hall is now permanently employed by the Department to provide services at Hakea.[107] Dr Brett acknowledged that there has been some increase in psychiatric services for prisoner since 2013, but described the increase as "just managing the tip of the iceberg."[108] Dr Brett expressed the view that there is a need for a complete review of forensic mental health within the Department.[109] I address that issue more closely in the finding related to that other matter, give the evidence arose in that inquest.

94. However, I find in this case that the psychiatric care provided to the deceased in this case was less than the standard one would expect to be provided for a prisoner, who is unable to independently access such care and is dependent upon the Department to make that service available. In that context, the evidence I have heard in a previous inquest from psychiatrists actively involved in providing psychiatric care on behalf of the Department is directly relevant.

95. I made a recommendation in the other matter, that I largely replicate in this matter, given very similar issues arose.

RECOMMENDATION

I recommend that the Department of Corrective Services, when planning what future changes are to be made to the mental health services it provides to prisoners, should invest significantly more resources in ensuring that prisoners are

[106] Inquest into the death of Jayden Stafford Bennell, 29.8.2016 – 1.9.2016.
[107] Inquest into the death of Jayden Stafford Bennell, 29.8.2016 – 1.9.2016, T 336, 389.
[108] Inquest into the death of Jayden Stafford Bennell, 29.8.2016 – 1.9.2016, T 394.
[109] Inquest into the death of Jayden Stafford Bennell, 29.8.2016 – 1.9.2016, T 394 – 396.

given regular access to psychiatrists and that overall an emphasis be placed on providing a more holistic approach to mental health care.

Decision to Cease Resuscitation

96. Following the death of the deceased, the incident involving the communications between the ambulance crew and Dr Curry at Fremantle Hospital's Emergency Department was raised as a clinical incident and reported by St John Ambulance as a Sentinel Adverse Event to the Department of Health Western Australia.

97. Dr Chris Curry, who is a senior consultant emergency physician, provided a report in relation to this incident. Dr Curry was the senior consultant on duty in the Emergency Department at Fremantle Hospital on the night the deceased died and recalls that he took the ambulance priority telephone call at 9.30 pm. Dr Curry was advised by the ambulance officer that the deceased had been found without signs of life at 7.25 pm and at the time of the call was in asystole (no cardiac electrical activity) and the estimated time of arrival of the ambulance at the hospital would be 10.05 pm. Dr Curry asked for more information and was told that the deceased appeared to have sustained severe deforming injury to his hyoid bone in the front of his neck and that his airway was compromised. He was also told that after nearly 20 minutes of paramedic resuscitation the crew had been going to terminate resuscitation efforts when a return of cardiac electrical activity was noted, which lasted for approximately five minutes before the deceased was asystole again. Because there had been a return of spontaneous circulation, albeit briefly, the ambulance crew member explained to Dr Curry that their protocol required them to transport the deceased to hospital.[110]

98. Dr Curry suggested that the deceased was dead at that time and the ambulance officer agreed, but was concerned about the nature and location of the incident. Dr Curry then spoke to the ambulance commander and explained that from what he had been told the patient was dead and any further resuscitation efforts would be futile. If he was brought to hospital Dr Curry anticipated his only task would be to declare the patient dead. It was then agreed between Dr Curry and the ambulance crew that resuscitation could be terminated.[111]

99. Since that time the Emergency Department at Fremantle Hospital has been closed so it is not relevant to explore whether the hospital has a protocol for such situations.[112]

100. A full investigation was completed in accordance with the St John Ambulance Clinical Governance framework. The outcome of the investigation was then discussed at the St John Ambulance Clinical Safety and Quality Committee meeting in January 2014. After reviewing the evidence the

[110] Exhibit 1, Tab 55.
[111] Exhibit 1, Tab 55.
[112] Exhibit 1, Tab 55.

committee found that the crew member who made the phone call to the Emergency Department did not fully understand that the purpose of making the phone call was to provide pre-arrival notification to the Emergency Department, not to seek advice or authority for transport. Due to this misunderstanding, the St John Ambulance Clinical Practice Guidelines were not followed. The guidelines directed that the crew should have transported the deceased to the hospital regardless of the on-phone discussion with Dr Curry.[113] The committee took into account that the deceased had been in cardiac arrest for close to two hours at this stage, and as such had a very poor probability of survival, as well as the pressures that the crew were under at the time. The committee recommended that the crews involved receive remedial counselling on the Clinical Practice Guidelines, and also recommended wider communication to the ambulance service as a whole on this issue. This action was then undertaken.[114]

101. Overall, the evidence indicates the deceased had died at the time that the conversation took place between Dr Curry and the ambulance crew member, and was beyond recovery. As a result, the decision not to transport him to the hospital did not influence the outcome, in the sense that the deceased could not have been saved if he had been transported to the hospital. The decision to follow the advice of Dr Curry not to transport him to hospital did not comply with St John Ambulance protocol, but I note that the service has its own Ambulance Service Medical Advisors who could have made the same decision, if they had been contacted by the ambulance crew.

102. It was apparent from the reaction of the deceased's sister at the inquest that this information has caused her great distress. I can certainly understand her reaction, given the possible interpretation that not everything possible was done to try to save her brother. In particular, I acknowledge how distressing this information must seem to the deceased's family, when expressed as a "refusal" by Dr Curry to allow the deceased to be brought to the hospital.[115] However, having reviewed all of the material, I am satisfied that at the stage when the ambulance crew had the telephone conversation with Dr Curry, there was no chance that the deceased could be saved and it was on this basis that Dr Curry expressed the opinion that a lengthy transporation of the deceased to hospital would be futile. The deceased had gone a significant length of time without any spontaneous circulation and the effect on his brain from the lack of oxygen was irretrievable. If he had been taken by ambulance to the hospital (as per usual protocol) all that would have occurred is that a different doctor would have certified his death.[116] I am satisfied that the decision-making process was not, in any way, based upon the fact that the deceased was a prisoner, but rather based upon the known clinical information about how long he had been without spontaneous circulation and that he was, to all effects and purposes, already dead at the time the ambulance crew were waiting at the prison gate to leave.

[113] Exhibit 1, Tab 31.
[114] Exhibit 1, Tab 31.
[115] T 10.
[116] T 10.

CONCLUSION

103. The deceased was a sentenced prisoner at the time of his death at Hakea in November 2013. He had been to prison before so he was familiar with the environment. The evidence suggests that after an initially difficult transition back to prison life, the deceased had settled back in to the routine and was generally coping well.

104. However, one of the deceased's coping mechanisms was the use of a medication, namely olanzapine. He had been prescribed it to treat psychotic symptoms he had experienced in the past, but it appears a significant secondary benefit the deceased gained from it was that it helped him to sleep, which enabled him to avoid dwelling on negative thoughts when he was locked in his cell at night. From a medical perspective, there was some doubt as to whether the deceased should be taking the medication, given he had no formal diagnosis of an underlying psychotic disorder. Accordingly, a concern about whether the prescribing of this medication would continue was an ongoing theme in the deceased's records for his last period of imprisonment.

105. The ultimate decision as to whether the deceased should remain on olanzapine was dependent upon the deceased being reviewed by a psychiatrist. The difficulty was that in 2013 there was a severe shortage of psychiatric appointments at Hakea prison, as well as other prisons in Western Australia. As a result, the deceased went several months without seeing a psychiatrist. His olanzapine prescription was renewed a number of times, while awaiting a psychiatric appointment, but eventually at the end of October 2013 it was allowed to expire without renewal. The evidence indicates this caused the deceased some concern, as he lost the psychological benefit of the sedative effects of the medication without any form of sedative medication replacement being explored by medical staff.

106. After approximately two weeks without his olanzapine medication, and in the context of finding out his ex-partner did not want to renew contact with him, the deceased made an impulsive decision to take his life. He then took steps to hang himself from a sink in his cell after being locked in for the evening. By the time he was discovered by a prison officer, it was too late to save him despite the best efforts of prison staff and attending ambulance officers.

107. I find that the lack of psychiatric review in a reasonable time period contributed to the deceased's decision to take his life, in the sense that more prompt psychiatric review and considered thought about his medication regime might have prevented his suicide.

S H Linton
Coroner
March 2017