Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 27/18

I, Rosalinda Vincenza Clorinda FOGLIANI, State Coroner, having investigated the death of ***Colin George GRAHAM*** *with an inquest held at the Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth on 21 August 2018 find that the identity of the deceased person was* ***Colin George GRAHAM*** *and that death occurred on 24 January 2016 at St John of God Hospice, Murdoch Drive, Murdoch as a result of disseminated malignancy – known non-small cell carcinoma of lung in the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the State Coroner.
Ms E O'Keefe (State Solicitor's Office) appearing on behalf of the Department of Justice.

TABLE OF CONTENTS

Introduction 2
The Deceased 3
Prison History 4
Medical History 8
Cause and Manner of Death 10
Quality of Supervision, Treatment and Care 11
Conclusion 12

INTRODUCTION

1. Colin George Graham (the deceased) was a 56 year old Aboriginal man who died at St John of God Hospice in Murdoch on 24 January 2016 while receiving palliative care for advanced metastatic lung cancer.

2. At the time of his death he was a sentenced prisoner, serving his sentence at Casuarina Prison. Under s 16 of the *Prisons Act* 1981 he was deemed to be under the custody of the Chief Executive Officer of the Department of Corrective Services (as it then was). This made him a "*person held in care*" within the meaning of s 3 of the *Coroners Act* 1996 (the Coroners Act) with the result that his death was reportable, and an inquest into his death (as part of the investigation into his death) was mandated by reason of s 22(1)(a) of the Coroners Act.

3. Under s 19(1) of the Coroners Act I have jurisdiction to investigate the deceased's death. I held an inquest into his death on 21 August 2018. I heard from one witness and received two Exhibits into evidence containing a total of 50 tabs.

4. My primary function has been to investigate the deceased's death. It is a fact-finding function. Under s 25(1)(b) and (c) of the Coroners Act, I must find, if possible, how the deceased's death occurred and the cause of his death.

5. Under s 25(2) of the Coroners Act, in this finding I may comment on any matter connected with the deceased's death including public health, safety or the administration of justice. This is the ancillary function.

6. Pursuant to s 25(3) of the Coroners Act, because the deceased was a person held in care, I must comment on the quality of his supervision, treatment and care while in that care. This obligation reflects the community's concern about the treatment of those who are deprived of their liberty.

7. The deceased had a troubled background, and an extensive criminal history. He was a heavy smoker and had developed severe emphysema and chronic obstructive pulmonary disease (COPD). In 2012 he was diagnosed with lung cancer.

8. The inquest focussed on the deceased's treatment care and supervision while he was held in care, in the period leading up to his lung cancer diagnosis, and throughout his treatment for that condition, leading up to his death.

9. My findings appear below.

THE DECEASED

10. The deceased was born on 15 March 1959 in Melbourne, Victoria, the second of six children. He was of Aboriginal descent on his mother's side.

11. The deceased's parents separated when he was six years old, and he resided with members of his mother's extended family until he was 11 years old. He returned to live with his father for a short period of time, but this did not work out and he sadly ended up living a transient existence, seeking refuge, residing on the streets, and spending time in youth training centres from a relatively young age.[1]

12. The deceased's childhood was marred by instances of abuse, and he often lacked the basic necessities of life, reporting that much of his carer's finances were spent on alcohol. He had a very troubled and unstable childhood, and he suffered from neglect. He did not complete his primary school education, though he was able to teach himself basic reading skills. His life would have been very different had he lived in a sufficiently stable and nurturing environment.[2]

13. Unfortunately, the deceased sought to cope with his trauma by abusing alcohol during his teens, and this only served to exacerbate his problems. He compounded the damage by abusing methylated spirits, and it was posited that he developed cognitive impairment secondary to his substance abuse. He had a history of memory loss while intoxicated. He became estranged from his family, and over time he denied knowledge of his family, and of his cultural background.[3]

14. The deceased spent most of his adult life incarcerated, or on the streets. He had an extensive criminal history over numerous decades, spanning a number of States. His adult offending included manslaughter, burglary, armed robbery, malicious wounding and assault occasioning bodily harm. In 2001 he was convicted and sentenced to an indefinite imprisonment order, with a minimum term of 11 years, in respect of two violent sexual assaults. In prison, he declined to participate in treatment programs (such as the Intensive Sex Offender Treatment Program). He expressed the view that he wished to remain in prison, as he did not have family, friends or other supports in the community. He refused to nominate a next of kin.[4]

15. The deceased did not receive any social visits and did not make any telephone calls or send or receive any mail during his periods of incarceration. He had become institutionalised and did not believe in his ability to cope or even survive in the community. Sadly, the only stability he had ever known came from his experiences with incarceration. As at the time of his death, he was not eligible for parole and was still serving his 2011 sentence of indefinite imprisonment.[5]

---

[1] Exhibit 1, tab 2; Exhibit 2, tabs A and 1.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.

16. He was registered as a terminally ill prisoner at Acacia Prison in November 2013, and transferred to Casuarina Prison's infirmary in May 2015. From there he had numerous hospital attendances as his illness progressed, and he died in custody, whilst under palliative care at St John of God Murdoch Community Hospice on 24 January 2016.

PRISON HISTORY

17. Prior to the deceased's admission to custody at Canning Vale Prison on 22 June 2000 he was living on the streets, and prone to substance abuse. He was in receipt of a disability pension due to respiratory problems occasioned by his long term heavy smoking. On the day of his admission to custody he was assessed as being of high risk of self-harm due to his unstable presentation, absence of community supports, previous suicide attempts and stated suicidal ideation. He was placed in the crisis care unit overnight, made subject to the at risk management system (ARMS) and referred to the mental health nurse.[6]

18. The next day, 23 June 2000, he was transferred to Casuarina Prison, where he remained for just under seven years (until 5 March 2007). Upon arrival at Casuarina Prison he was housed in their crisis care unit and made subject to regular observations, for his safety. The electronic records from the total offender management system (TOMS) reflect that a number of alerts were noted for him, relating to his substance abuse, risk of self-harm, and his fears due to a previous prison assault.[7]

19. Shortly after the deceased's admission to Casuarina Prison's crisis care unit in June 2000, the deceased was transferred to the Frankland Centre at Graylands Hospital for a two week period for psychiatric assessment after concerns developed about his suicidal thoughts and risk of self-harm. He was treated, discharged and returned to the unit. Following the imposition of an indefinite imprisonment order at his sentencing in June 2001, an individual management plan was identified for him. As a maximum security protection prisoner he remained at Casuarina Prison and additional related alerts were added to his TOMS records.[8]

20. Early in his prison term the deceased had frequent contact with mental health services. These included the Prison Counselling Services, psychologists, visiting psychiatrists and other mental health workers. These early interventions can be credited with helping him develop some empathy for his victims and accept a measure of responsibility for his offending. Whilst the deceased accessed the intensive psychology input in the early years, in 2004 he withdrew from such treatment, claiming he no longer wished to be released into the community.[9]

[6] Exhibit 2, tab A; ts 8 to 9.
[7] Exhibit 2, tab 8; ts 7 to 8.
[8] Exhibit 2, tab A; ts 8 to 9.
[9] Exhibit 2, tab A; ts 9 to 10.

21. Nonetheless, efforts continued to encourage his participation in psychological counselling and relevant programs (educational, vocational, cognitive skills and substance abuse). It was considered that he would best benefit from an initial legal and social awareness (Pathways) program, as a prerequisite to the cognitive skills program. Unfortunately, the deceased chose not to participate, and by 2005 the Pathways program was deferred.[10]

22. The plan had been for the individual psychology input to lead him to participate in an Intensive Sex Offender Treatment Program. The deceased expressed his disinclination to participate in this program. His explanation was that he feared it would improve his prospects of release, and his expressed preference was to remain incarcerated. As a consequence, it was determined that his risk of reoffending remained high. Over this period he was also assessed as remaining at risk of suicide whether in prison or the community. He remained a long-term resident in Casuarina Prison's protection unit.[11]

23. The deceased was a willing worker in the Casuarina Prison garden, and was found to require minimal supervision to complete his tasks. In 2006 his security rating was reduced to medium. However, to facilitate program participation and in light of his mental health, he remained at Casuarina Prison. A January 2007 review of his individual management plan again confirmed his refusal to participate in any individual or group prison programs. On 5 March 2007 he was transferred to Acacia Prison as a medium security prisoner, which was apparently his preference.[12]

24. The deceased remained at Acacia Prison for just over eight years, until 7 May 2015 (other than a few days in Casuarina Prison infirmary in 2011, for medical reasons). There he again gained employment and received positive work and behaviour reports. He did attend a Motivation to Change induction program shortly after his admission to Acacia Prison, but refused to participate in all other programs recommended by the psychologist. He consistently expressed a reluctance to be out in the community.[13]

25. From 2009, the deceased resided in the Assisted Care Unit at Acacia Prison, due to his deteriorating health. He had been a long term heavy smoker and developed severe COPD. As described above, for a few days in November 2011 the deceased was transferred to Casuarina Prison infirmary, after suffering complications of a collapsed right lung (pneumothorax) following a bronchoscopy at Royal Perth Hospital. On 24 November 2011, being deemed medically fit, he was returned to Acacia Prison.[14]

26. By 2011, the matter of the deceased's parole was coming up for assessment at Acacia. The attempts to assess him for parole suitability were hampered by his reluctance to engage in that assessment. In keeping with his ongoing expressed wishes not to be out in the community, the deceased signed waivers excluding him from all prison treatment programs. He made a written request

[10] Exhibit 2, tab A.
[11] Ibid.
[12] Ibid.
[13] Exhibit 2, tabs A, 9 and 10.
[14] Exhibit 2, tabs A, 9 and 10; ts 11 to 12.

to the effect that parole or participation in a Re-Socialisation Program be denied.[15]

27. His decisions not to participate in treatment programs were reviewed by the clinical psychologist and the senior forensic consultant at the material time, in January 2011. A number of assessments had already been undertaken to determine his treatment needs prior to the first statutory review for his parole. Following his interview with the clinicians at Acacia Prison on 19 January 2011, his mental status was found to be in the normal range. He made it clear to the clinicians that he did not propose to participate in the Intensive Sex Offender Treatment Program (and the other identified programs). It was noted he had maintained the same stance for many years.[16]

28. The deceased's stance appeared to be based upon his view that it was an appropriate punishment for him to remain incarcerated, and that out in the community he had no stable accommodation, would be drinking heavily, and had no familial supports. He envisaged living out the remainder of his life incarcerated, but denied the need to participate in programs in order not to reoffend. In the circumstances, the clinical psychologist and the senior forensic consultant did not conduct a full assessment of his suitability for a re-socialisation program on 19 January 2011. His attitude suggested that should he be released, he may be unprepared for life in the community, and may re-offend for the purposes of being incarcerated for longer.[17]

29. The deceased had regular medical assessments during his incarceration, and on 6 November 2013 (at Acacia Prison), he was assessed as no longer fit for work, and he was identified as a terminally ill prisoner due to his severe underlying lung disease and carcinoma of the right lung.[18]

30. In accordance with the departmental policy directive concerning procedures for prisoners with a terminal medical condition, the deceased was notified and made subject to regular health assessments. On 14 February 2014, a medical assessment deemed him to remain as a phase one terminally ill prisoner, and it was noted his cancer was relatively slow growing. This was based on the medical opinion that he was unlikely to die within 12 months.[19]

31. Regular assessments followed as required under the policy, and on 8 July 2014, a medical assessment deemed the deceased to remain as a phase two terminally ill prisoner, due to his locally advancing right lower lobe cancer and severe COPD secondary to emphysema. This was based upon the medical opinion that he was likely to die within 12 months, but unlikely to die within three months.[20]

[15] Exhibit 2, tabs A, 9 and 10; ts 12 to 13.
[16] Exhibit 2, tab 10; ts 9 to 11.
[17] Ibid.
[18] Exhibit 2, tabs A and 14.
[19] Exhibit 2, tabs A and 14; ts 5.
[20] Ibid.

32. Again regular assessments followed as required under the policy, and on 18 November 2014, a medical assessment deemed him to be a phase three terminally ill prisoner, due to conditions that included lung cancer, malnutrition and weight loss, severe COPD and recurrent chest infections. He was noted to be very frail and given a prognosis of three to six months.[21]

33. Again regular assessments followed as required under the policy, and on 17 August 2014, a medical assessment deemed him to be a phase four terminally ill prisoner due to his continued deterioration and recent exacerbation of very severe lung disease (COPD). His prognosis was grave, and it was noted he had weeks to months, or that he could die at any moment. This was based upon the medical opinion that his death was imminent.[22]

34. The escalation of the severity of the condition through the phases one to four guides the frequency of monitoring and clinical reviews and the modification, if necessary, of the more routine management decisions to take account of the medical condition. The increase in severity of the condition also precipitates a number of notifications as to whether the prisoner is likely to die in custody. A phase three status generates a consideration of whether a recommendation ought to be made as to the suitability of a prisoner's release into the community.[23]

35. By 7 May 2015 the deceased was transferred to Casuarina Prison infirmary due to his compromised health, and he continued to reside at the infirmary for additional treatment and care. By November 2015, following regular assessments, it was noted that the deceased displayed new symptoms suggestive of brain metastases. This was confirmed with CT scanning in hospital. In early January 2016, the deceased was diagnosed with renal metastases. Over this period he was frequently transferred to hospital for treatment. After continued deterioration, the deceased died at St John of God Hospice in Murdoch on 24 January 2016.[24]

36. It is noted that between November 2014 and September 2015, early release under Royal Prerogative of Mercy provisions was considered in accordance with the policy, but not recommended due to the nature of the deceased's offending, lack of community supports, refusal to participate in programmatic assessment and re-socialisation programs and his refusal to be released from prison. He therefore died in custody.[25]

37. The details concerning his medical history and treatment while in custody are referred to immediately below.

[21] Ibid.
[22] Ibid.
[23] Exhibit 2, tab 14.
[24] Exhibit 2, tabs A and 14.
[25] Exhibit 2, tab 14.

MEDICAL HISTORY

38. As described above, the deceased was a long term heavy smoker and he had developed severe COPD. In prison, he underwent diagnostic testing (spirometry), was prescribed inhalers and administered preventative measures (yearly influenza vaccinations and pneumonia vaccination). Infective exacerbations of COPD were treated with steroids and antibiotics.[26]

39. In prison, attempts were made to address the deceased's smoking habit. He was prescribed medication to assist with smoking cessation from July 2003, and this later included nicotine replacement patches. His smoking status and readiness to quit was regularly addressed at medical reviews. A chest x-ray performed in April 2006 was normal.[27]

40. In October 2011, in the course of being treated for an infective exacerbation of COPD by the prison doctors, a chest x-ray was performed and it showed suspicious right upper lobe changes. As a consequence, the deceased was referred to Royal Perth Hospital for a CT of his chest, and related investigations. In November 2011 he was seen at the respiratory clinic at Royal Perth Hospital, where a bronchoscopy returned without evidence of malignancy. The procedure was complicated by a pneumothorax (collapsed lung) that required a short admission to hospital.[28]

41. In February 2012, a repeat CT scan of the deceased's chest at Royal Perth Hospital showed the above lesions appeared to have resolved, and it was considered that they may be inflammatory changes. However, a further repeat CT scan of his chest in September 2012 showed changes in the right lower lobe suggestive of malignancy. A repeat bronchoscopy was performed soon afterwards, and the results were highly suspicious for poorly differentiated squamous cell carcinoma.[29]

42. The thoracic oncology multidisciplinary team discussed the case in October 2012 and determined by consensus that the deceased would not be a suitable candidate for radical treatment (including palliative radiation) given his poor lung function and general condition. Given the risk of damage to any remaining functional lung tissue, it was determined his symptoms would best be treated with supportive and palliative care.[30]

43. In November 2013 the deceased was again seen at the respiratory clinic at Royal Perth Hospital due to being short of breath on minimal exertion. Spirometry testing showed further decrease in lung functions. A chest x-ray showed no new lung nodules, and the respiratory specialist formed the view that the new symptoms were related to his airways disease and not his early

[26] Exhibit 2, tab A and 1.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] Ibid.

stage lung cancer. The deceased's medication was reviewed and changed, and a repeat CT scan and review was arranged for three months' time.[31]

44. The deceased was duly seen at the respiratory clinic in February 2014, and whilst his breathing was a little improved, the CT scan showed the right lobe lesion to have grown in size. It was explained to the deceased that his right lung cancer was incurable and that he did not have significant lung reserve to tolerate treatment. The deceased was treated for pain relief and in March 2014, a further CT scan showed clear progression of the right lung mass. His case was discussed by the Radiation Oncology team and it was determined that there were no changes required to his treatment and medication.[32]

45. In between the above hospital appointments the deceased was regularly reviewed by prison nurses, and by the prison doctors as needed. From late in 2013, he had weekly welfare checks with the prison nurse. In April 2014 he was reviewed at Acacia Prison by the palliative care consultant, and prescribed pain control medications. After transfer from Acacia Prison to the Casuarina Prison infirmary in May 2015, the deceased was reviewed on a daily basis by the nursing staff there.[33]

46. In late 2015 the deceased's condition deteriorated markedly. In between November 2015 and January 2016 he had a number of admissions to Fiona Stanley Hospital. On each occasion he was conveyed there from the Casuarina Prison infirmary, treated in the hospital, and returned to the infirmary, until his transfer to the hospice in late January 2016 for terminal palliative care.[34]

47. On 16 November 2015 the deceased was conveyed to the Fiona Stanley Hospital emergency department with a neurological event, namely a facial droop and left-sided weakness. A CT scan of his head showed predominantly right-sided brain metastases. He was offered admission for consideration of radiotherapy or chemotherapy palliative treatment, but he declined admission expressing a wish for hospice care and palliation only. He accepted steroid medication to reduce the effect of swelling around the tumour in the brain. He was medically assessed as having the capacity to decline other treatment. His medication was reviewed and he was returned to the prison infirmary, where he was advised that hospital admission could be arranged whenever it was needed.[35]

48. The deceased also requested that restraints not be used for hospital transfer, and this was supported by the prison doctors, who made recommendations to that effect. He was briefly admitted to Fiona Stanley Hospital between 19 and 20 November 2015, and again between 25 and 30 November 2015 to optimise pain relief.

49. He was returned to the Casuarina Prison infirmary, and on 9 to 10 January 2016, he was again briefly admitted to Fiona Stanley Hospital under the

[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Ibid.
[35] Ibid.

medical team for palliative care involvement, due to increasing pain and complications related to his condition. A CT scan of his abdomen and pelvis revealed metastatic tumour deposits in his kidneys. His pain settled and he was returned to the Casuarina Prison infirmary, but nursing staff at the prison expressed concerns about the availability of pain relief for him. Consequently, he was re-admitted to Fiona Stanley Hospital on 11 January 2016 for palliative care, and he remained there until 20 January 2016, where his pain was more effectively able to be managed.[36]

50. Permission for removal of his restraints had been granted on 12 January 2016. On 20 January 2016 the deceased was conveyed to St John of God Murdoch Community Hospice for terminal palliative care, and he died there at 10.51 am on 24 January 2016.[37]

CAUSE AND MANNER OF DEATH

51. The forensic pathologist Dr G. A. Cadden made a post mortem examination on the body of the deceased at the State Mortuary on 3 February 2016. Dr Cadden noted disseminated malignancy to be evident widely in both lungs and also in both kidneys. On that date Dr Cadden formed the opinion that the cause of death was disseminated malignancy – known non-small cell carcinoma of lung.[38]

52. Neuropathology results subsequently became available to Dr Cadden. A macroscopic examination of the deceased's brain by neuropathologist Dr V. A. Fabian showed multiple cerebral and cerebellar tumour deposits, and this report became available on 18 February 2016. A microscopic examination of the deceased's brain by anatomical pathologist Dr J. M. Dyke showed metastatic poorly differentiated squamous cell carcinoma with focal glandular differentiation and this report became available on 9 June 2016.[39]

53. Toxicological analysis was ordered and became available on 13 June 2016. The results were consistent with terminal palliation.[40]

54. The forensic pathologist reviewed the further investigations; his opinion on cause of death remained the same.[41]

55. I accept and adopt Dr Cadden's opinion on cause of death. **I find that the cause of the deceased's death was disseminated malignancy – known non-small cell carcinoma of lung**.

56. **I find that the manner of the deceased's death was natural causes**.

---

[36] Ibid.
[37] Exhibit 2, tab A and 1; ts 15.
[38] Exhibit 1, tab 6.
[39] Exhibit 1, tab 7.
[40] Exhibit 1, tab 8.
[41] Exhibit 1, tab 6.

QUALITY OF SUPERVISION, TREATMENT AND CARE

57. By reason of s 25(3) of the Coroners Act, I must comment on the quality of the deceased's supervision, treatment and care while in custody. The deceased died while receiving palliative care for advanced metastatic lung cancer, and while serving his indefinite sentence of imprisonment.

58. The deceased received ongoing and appropriate mental health treatment during his incarceration. In the early stages he displayed symptoms of suicidal ideation and intent to self-harm, and his treatment was intensified and directed to those concerns. It included a period of hospitalisation. Once he stabilised, he received ongoing psychology input for a number of years, to address his cognitive impairment and prepare him for participation in an Intensive Sex Offender Program.

59. Unfortunately after a time the deceased refused the psychology input. He expressed a wish to remain incarcerated, and a refusal to take part in any programs which would improve his chances of release. I am satisfied that the department did not take those refusals at face value but, properly, explored them through appropriately qualified clinicians, to better understand his reasoning and his capacity for decision making.

60. The deceased was provided with numerous and ongoing opportunities to review his position and elect to participate in available psychological counselling and programs to address his educational needs, vocational needs, social awareness, cognitive skills and substance abuse. He refused to participate, and I am satisfied he had capacity to make that decision and understand the likely consequences. He did not commence the Intensive Sex Offender Program.

61. The deceased received ongoing medical treatment of a high quality during his incarceration. His COPD was appropriately treated by a care plan in consultation with respiratory specialists, and regular attempts were made to encourage him to cease smoking (including by means of medication). From the time the chest x-ray showed suspicious right upper lobe lung changes in October 2011, his health was carefully monitored, he was reviewed at the respiratory clinic at Royal Perth Hospital, and had follow up investigations there as needed.

62. In 2012 he was diagnosed with lung cancer. The type of cancer he had was not confirmed as it was considered that invasive diagnostic tests would be too risky in light of his poor underlying lung function. His clinicians assessed him as suitable for symptom management only. This was an appropriate course of action and it was explained to the deceased. His illness continued to be appropriately managed in prison and regularly reviewed in accordance with the departmental procedures concerning prisoners with a terminal medical condition. In 2013 he was registered as a terminally ill prisoner, and the severity was appropriately escalated through stages one to four, following regular reviews. He was kept fully informed, and his wishes concerning his treatments were respected.

63. Between 2013 and 2015 his condition remained relatively stable, but his lung cancer continued to progress. In late 2015 medical tests revealed brain metastases and he later developed renal metastases. In January 2016 he was transferred to Fiona Stanley Hospital following further deterioration in his condition. There he was provided with palliative care and then transferred to St John of God Hospice in Murdoch, where he died of natural causes on 24 January 2016.

64. At the time the deceased was admitted to custody in connection with his last prison term in June 2000 he presented with significantly compromised health and respiratory issues, and substance abuse problems. I accept the clinician's opinion expressed in the department's medicolegal report, upon a review of the deceased's medical treatment while incarcerated: "*The deceased had regular contact with health professionals and had seen specialists in a tertiary hospital when it was necessary in a timely manner. It is without doubt the medical care provided to the deceased was way above community standards. It is because of the regular and comprehensive care provided, his life was prolonged.*"[42]

65. I am satisfied that the quality of the deceased's supervision, treatment and care while incarcerated was of a high standard and equal to or better than he would have received in the community, particularly having regard to the careful monitoring and regular reviews, that prompted the escalation of his care. He had the capacity and understanding to refuse some treatments and elect pain relief, and his wishes were respected.

CONCLUSION

66. The deceased was born into difficult circumstances and experienced a traumatic childhood. He had become estranged from his family and had no community supports. He committed serious and violent crimes and had spent a large portion of his life incarcerated. In the latter part of his life he had reached the stage where he no longer felt able to survive in the community and expressed a preference for incarceration. This was explored with him by suitably qualified clinicians on a number of occasions, with a view to encouraging his participation in pre-release programs. He did not wish to engage in programs offered. His mental and physical health needs were managed and treated to a high standard and he died at St John of God Hospice, Murdoch after a long illness.

R V C FOGLIANI
State Coroner

31 May 2019

[42] Exhibit 2, tab 12.