Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 19/ 19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Robin David MACARTNEY*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***14 May 2019*** *find that the identity of the deceased person was* ***Robin David MACARTNEY*** *and that death occurred on* ***13 July 2016*** *at* ***Bethesda Hospital****, from* ***bronchopneumonia in a man receiving terminal palliative care for metastatic carcinoma of the colon*** *in the following circumstances:-*

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner

Ms E Cavanagh (State Solicitor's Office) appeared on behalf of the Department of Justice

Table of Contents

INTRODUCTION[1]

1. Robin David Macartney (the deceased) died at Bethesda Hospital on 13 July 2016 as a result of bronchopneumonia on a background of metastatic colon cancer.

2. At the time of his death the deceased was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Corrective Services, as it then was.[2]

3. Accordingly, immediately before his death, the deceased was a "person held in care" within the meaning of the *Coroners Act 1996* (WA) (Coroners Act) and his death was a "reportable death".[3]

4. In such circumstances, a coronial inquest is mandatory.[4]

5. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[5]

6. I held an inquest into the deceased's death on 14 May 2019.

7. The documentary evidence adduced at the inquest included independent reports of the deceased's death prepared by the Western Australia Police[6] and by the Department of Justice[7] respectively, which together comprised two volumes.

8. Mr Richard Mudford, a senior review officer employed by the Department of Justice and the author of the Death in Custody review was called as a witness at the inquest.

9. The inquest focused on the care provided to the deceased while he was a prisoner, as well as on the circumstances of his death.

---

[1] Exhibit 1, Tab 2, Police Investigation Report
[2] Section 16, *Prisons Act 1981* (WA)
[3] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[4] Section 22(1)(a), *Coroners Act 1996* (WA)
[5] Section 25(3) *Coroners Act 1996* (WA)
[6] Exhibit 1, Vol. 1, Tab 2, Report - Police Investigation
[7] Exhibit 1, Vol. 2, Death in Custody Review

THE DECEASED

Background[8,9]

10. The deceased was born in New Zealand on 22 August 1953 and had two siblings. At the time of his death he was 62-years of age.

11. The deceased's parents separated when he was 3-years of age and he reported an unhappy childhood and that his mother struggled with mental health issues. The deceased left the family home at 15-years of age and travelled to Auckland where he worked in jobs driving, mechanical and maintenance type of work.

12. The deceased reportedly came to Western Australia in 1989 and worked in the mining industry until a back injury 1993 led to him giving up work.

13. The deceased is said to have fathered six children - two from an early relationship, one from his first marriage and three from his second marriage.

14. Although the deceased denied any history of substance abuse, he acknowledged that alcohol use had become problematic for him, especially following the breakdown of his first marriage and his apparent disillusionment with a worker's compensation payout for his 1993 back injury.

Offending History[10,11]

15. The deceased had two convictions relating to traffic offences in 1995 (driving under the influence) and 1996 (no driver's licence) respectively. Fines and disqualifications from driving were applied in each case.

16. It also appears that the deceased had a criminal record in New Zealand which included 20 convictions for wilful damage, three for theft and convictions for common assault, false pretences and dangerous driving.

---

[8] Exhibit 1, Vol. 2, Death in Custody Review, pp5-6 and ts 14.05.19 (Mudford), p8
[9] Exhibit 1, Vol. 1, Tab 2, Report - Police Investigation
[10] Exhibit 1, Vol. 2, Death in Custody Review, p6
[11] Exhibit 1, Vol. 2, Tab 1, Criminal History

17. On 8 December 1999, the deceased was arrested and subsequently charged with the murder of a young woman on 5 December 1999 at Cape Burney, near Greenough, Western Australia.[12]

18. The circumstances were that the young woman had been at the beach with friends when she was abducted by the deceased, sexually assaulted and murdered.[13]

19. On 7 August 2001 in the Supreme Court of Western Australia, the deceased was convicted of murder.[14] On 14 September 2001 in the Supreme Court of Western Australia, the deceased was sentenced to life imprisonment with a minimum term fixed at 14 years. His term was backdated to 8 December 1999, being the date of his arrest.[15,16]

20. The deceased's appeals against his conviction in 2001 and 2006 were unsuccessful.[17]

Application for Parole[18]

21. In decisions dated 1 August 2007, 3 February 2012, and 4 October 2013, the Prisoners Review Board of Western Australia (PRB) refused the deceased's applications for parole. The PRB's decision in 2013 was based on the deceased's unmet treatment needs, his risk of re-offending and his continued denials with respect to the offence.

Overview of Medical Conditions[19]

22. The deceased's medical history included high blood pressure, alcohol abuse, asthma and depression. Prison records show that on numerous occasions during his incarceration, the deceased attended the medical centres of the prisons he was housed in for treatment of various medical issues.[20]

---

[12] Exhibit 1, Vol. 1, Tab 49, Transcript of Proceedings - Supreme Court of WA (07.08.01), p692
[13] Exhibit 1, Vol. 1, Tab 49, Transcript of Proceedings - Supreme Court of WA (14.09.01)
[14] Exhibit 1, Vol. 1, Tab 49, Transcript of Proceedings - Supreme Court of WA (07.08.01), p675
[15] Exhibit 1, Vol. 1, Tab 49, Transcript of Proceedings - Supreme Court of WA (07.08.01), p692
[16] Exhibit 1, Vol. 2, Tab 1, Criminal History
[17] Exhibit 1, Vol. 2, Death in Custody Review, p6
[18] Exhibit 1, Vol. 2, Tab 5, Decisions - Prisoner Review Board of Western Australia
[19] Exhibit 1, Vol. 2, Death in Custody Review, pp8-9
[20] Exhibit 1, Vol. 2, Tab 10, Offender Health Appointments

23. In 2002, the deceased complained of altered bowel habits and said he thought he had seen spots of blood in his stools. He asked for Metamucil which was prescribed. No further gastrointestinal issues appear to have been reported until late 2006, when the deceased complained of rectal bleeding. As discussed later in this Finding, investigations at that time found the deceased had metastatic colon cancer.[21]

PRISON HISTORY[22,23]

24. During his incarceration, the deceased was the subject of several notifications in the Total Offender Management System (TOMS), namely:[24]

    i. Special travel requirements (to carry Ventolin, not be placed in lower limb shackles due to childhood trauma) and no undue delays duly transfers (possible incontinence);

    ii. Falls risk (related to medication); and

    iii. Unfit for upper bunk and work (back/medical issues) and unfit for sport (recent surgery).

25. The deceased was first registered as a terminally ill prisoner in accordance with departmental policy on 14 April 2013. The policy categorises terminal prisoners as Stage I, II, III or IV terminally ill depending on prognosis.

26. The deceased was escalated to Stage IV terminally ill (meaning that his death was regarded as imminent) on 16 January 2016 and he remained at this category until his death (with the exception of a 2 week period in May 2016, when he was "de-escalated" to Stage III).[25]

27. In accordance with departmental policy, terminally ill prisoners may be considered for early release pursuant to the grant of a pardon in the exercise of the Royal Prerogative of Mercy.[26]

---

[21] Exhibit 1, Vol. 1, Tab 14, Report - Professor Moroz, p1, heading 1
[22] Exhibit 1, Vol. 2, Death in Custody Review, pp6-8
[23] Exhibit 1, Vol. 2, Tab 6, Individual Management Plans
[24] Exhibit 1, Vol. 2, Death in Custody Review, p9
[25] Exhibit 1, Vol. 2, Tab 12, TOMS Terminally Ill Module
[26] Exhibit 1, Vol. 2, Tab 11, Policy Directive 8 - Prisoners with a terminal medical condition

28. An application pursuant to that policy was not pursued because of the nature of the deceased's offending, his unmet treatment needs and the fact he had limited support in the community.[27,28]

29. With the exception of a 3-day placement at Bunbury Regional Prison in August 2008, the deceased remained at Casuarina Prison from 19 September 2001 to 1 July 2016 when he was transferred to Fiona Stanley Hospital.

30. The deceased's placement in prison was the subject of individual management plans (IMP). The IMP contain information about the deceased including his security rating, program interventions, behaviour, well-being and employment status. These IMPs appear to have initially been completed annually but subsequently became biannual.[29]

31. The earliest IMP in the Brief is dated 30 October 2001. It records the deceased's security rating within the prion as "*maximum*", a rating that was subsequently reduced to "*medium*" on 30 October 2004. The deceased's IMP for 2003 also noted that he was a protection prisoner and that:

> "*Staff state that he is a quiet prisoner who does not cause any problems within the unit. He maintains a low profile and associates with a small group of prisoners. He is respectful to staff and complies with rules and directions given to him.*"[30]

32. Entries in similar terms appear with respect to the deceased's IMPs from 2003 – 2016.[31] The deceased was convicted of several prison misconduct offences. The first of these occurred in 2003 and the last was in 2013. The offences related to failing to comply with directions and possession of unauthorised items.[32]

---

[27] Exhibit 1, Vol. 2, Tab 14, Terminally Ill Case file (13 Jun 16) and ts 14.05.19 (Mudford), p7
[28] Exhibit 1, Vol. 2, Death in Custody Review, p3
[29] ts 14.05.19 (Mudford), p14
[30] Exhibit 1, Vol. 2, Tab 6, Individual Management Plan (30.10.01)
[31] Exhibit 1, Vol. 2, Tab 6, Individual Management Plans
[32] Exhibit 1, Vol. 2, Tab 7, Charge History

33. The deceased's IMP for 2003 notes his employment in prison as a painter and later as a gardener. In 2008, the deceased had ceased working as a result of his medical condition, but he resumed work as a painter in 2010 and this continued until 2016.[33]

34. The deceased's use of the Prisoner Counselling Service (PCS) "*as required*" is noted in his IMPs from 2004 onwards. In 2008, his IMP noted he was an active client with PCS, and was seeing a counsellor on a weekly basis.[34]

35. On six occasions, the deceased was managed on the At Risk Management System (ARMS). ARMS is the Department's primary suicide prevention framework and aims to provide staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide.[35]

36. Depending on the perceived level of risk, prisoners on ARMS are observed at either high (one-hourly), moderate (three-hourly) or low (six-hourly) intervals. Prisoners on ARMS are managed by the Prisoner Risk Assessment Group (PRAG), which meets in each prison regularly.[36]

37. On the occasions he was managed on ARMS, the deceased denied self-harm ideation and it appears that his placement on ARMS was for short periods related to his court appearances (both for sentencing and as a result of his appeals against conviction).[37]

38. The deceased's IMPs record that during his incarceration, he received visits from friends and at times his family (e.g.: November 2015). He maintained phone contact with friends and occasionally sent mail.[38,39]

[33] Exhibit 1, Vol. 2, Tab 6, Individual Management Plans
[34] Exhibit 1, Vol. 2, Tab 6, Individual Management Plans
[35] ts 14.05.19 (Mudford), p13
[36] ts 14.05.19 (Mudford), p13
[37] Exhibit 1, Vol. 2, Death in Custody Review, p7
[38] Exhibit 1, Vol. 2, Death in Custody Review, p7
[39] Exhibit 1, Vol. 2, Tab 6, Individual Management Plans

DIAGNOSIS & SUBSEQUENT MANAGEMENT[40]

39. In late November 2006, the deceased complained of rectal bleeding. On 12 December 2006, following a colonoscopy at Royal Perth Hospital, the deceased was diagnosed with metastatic sigmoid colon cancer.

40. Following his diagnosis, the deceased attended numerous appointments with specialists in the fields of radiology, surgery, dermatology, gastroenterology and thoracic and respiratory medicine.[41]

41. It was recommended that the deceased undergo surgery to remove the tumour in his colon. However, on 18 February 2007, the deceased refused to undergo surgery. He said he believed God would cure him.[42]

42. The deceased signed a "medical escort waiver" on 19 February 2007 declining to attend an appointment at Royal Perth Hospital for treatment. The reason stated for the refusal was: "*on religiouse* (sic) *grounds*".[43]

43. Despite reviews by the medical officer at Casuarina Prison, the deceased continued to refuse surgery. When seen by Mr Salama (consultant surgeon) at Royal Perth Hospital on 26 February 2007, the deceased said his God had taken his cancer away from him and given to those who were responsible for putting him in jail. The deceased said his symptoms of bowel obstruction had resolved and that he felt he was cured.[44]

44. Mr Salama gave the deceased a detailed explanation of the risks of not proceeding with surgery. Those risks included: bowel obstruction; failing to provide a cure; and a higher risk of death. Mr Salama told the deceased he had three options: do nothing; have further tests to see if the tumour was still present; or have surgery. The deceased declined the offer of further tests and refused a follow-up appointment.[45]

---

[40] Exhibit 1, Vol. 2, Death in Custody Review, pp9-11 & Deceased's Prison/Hospital Medical Records
[41] Exhibit 1, Vol. 2, Tab 10, Offender Health Appointments
[42] Exhibit 1, Vol. 1, Tab 14, Report - Professor Moroz, p2, heading 1
[43] Exhibit 1, Vol. 1, Tab 50, Medical Escort Waiver
[44] Deceased's medical records: F-009-16-88, Vol. 3: Letter - Mr P Salama (26.02.07), p1
[45] Deceased's medical records: F-009-16-88, Vol. 3: Letter - Mr P Salama (26.02.07), p1

45. Mr Salama felt the deceased demonstrated sufficient intellectual understanding and did not demonstrate any evidence of psychosis. Mr Salama felt the deceased's mental state was "*ok*" and that the deceased was competent to make the decision to refuse treatment.[46]

46. On 4 April 2007, the deceased was reviewed by a psychiatrist who determined he (the deceased) was competent to make decisions about his medical treatment and the deceased was not affected by mental illness or cognitive impairment.[47]

47. By the end of 2008, tests showed that the deceased's cancer had progressed but the deceased indicated he would refuse surgery unless he could be assured that he would not be required to wear leg restraints.[48]

48. On 6 March 2009, the deceased was advised that he would not be required to wear leg restraints during any hospital admission relating to his cancer surgery.[49]

49. On 30 April 2009, the deceased underwent surgery to remove his colon cancer at Royal Perth Hospital.[50] Following surgery, the deceased was seen by numerous specialists and in 2010, metastases (secondary tumours) were detected in his lungs. These were treated with good effect by radiotherapy.[51]

50. A lesion was found in the deceased's liver and this was treated successfully by chemotherapy in July 2015.[52]

51. On 5 January 2016, the deceased was admitted to Royal Perth Hospital with falls and confusion. Tests showed he had metastases in his brain. The deceased underwent brain surgery for tumour removal.[53]

---

[46] Deceased's medical records: F-009-16-88, Vol. 3: Letter - Mr P Salama (26.02.07), p2
[47] Deceased's medical records: F-009-16-88, Vol. 3: Medical Notes - Dr Morton (04.04.07)
[48] Medical records: F-009-16-88, Vol. 4: PCS File Note (06.03.09)
[49] Medical records: F-009-16-88, Vol. 4: PCS File Note (06.03.09)
[50] Medical records: F-009-16-88, Vol. 1: Letter - Dr Van Hagen (17.08.09)
[51] Medical records: F-009-16-88, Vol. 1: Letter - Dr Leong (14.06.11)
[52] Medical records: F-009-16-88, Vol. 1: Letter - Fiona Stanley Hospital (05.08.15)
[53] Medical records: F-009-16-88, Vol. 2: Discharge Summary - Fiona Stanley Hospital (08.01.16)

52. On 25 May 2016, the deceased was admitted to Fiona Stanley Hospital with confusion. A CT scan of his brain showed that his brain was swollen and that further brain metastases, identified in March 2016, had progressed. After treatment with steroids, he was transferred to St John of God Murdoch Community Hospice on 3 June 2016.[54]

53. When admitted to the Hospice, the deceased showed no signs of confusion and instead was described as "*alert and orientated*". He was assessed as having minimal symptom requirements and was noted to mobilise confidently and independently without aids. The deceased's falls risk was assessed as "*low*".[55]

54. Whilst at the Hospice, the deceased was thought to be engaging in inconsistent symptom reporting/behaviour. For example, although the deceased reported neuropathic pain in his right arm, he only displayed symptoms of discomfort when medical or nursing staff were present.[56]

55. In another example, the deceased reportedly slumped in bed and slurred his speech when offered his morning medication. After swallowing the medication (with apparent difficulty and discomfort), he consumed breakfast with "*great enthusiasm*". He then complained to staff (without slurred speech) that the breakfast was too small.[57]

56. On the basis that he did not presently require hospice care, the deceased was returned to the infirmary at Casuarina Prison on 9 June 2016.[58]

57. In the month before his death, the deceased fell in the infirmary at Casuarina Prison on 15 June, 22 June and 27 June 2016. In response to the deceased's increasingly unsteady gait, he was reviewed daily by medical staff and encouraged to call for help when he needed to get out of bed.[59]

---

[54] Exhibit 1, Vol.1, Tab 16, FSH Discharge Summary (03.06.16)
[55] Exhibit 1, Vol.1, Tab 23, SJGH Discharge Summary (09.06.16), p1 and ts 14.05.19 (Mudford), p12
[56] Exhibit 1, Vol.1, Tab 23, SJGH Discharge Summary (09.06.16), p2
[57] Exhibit 1, Vol.1, SJGH Discharge Summary (09.06.16), p2
[58] Exhibit 1, Vol.1, SJGH Discharge Summary (09.06.16),
[59] Exhibit 1, Vol. 2, Death in Custody Review, p10 and ts 14.05.19 (Mudford), pp9-10

58. The deceased was also provided with a wheelchair and walker for mobility, an electric bed (which could be raised and lowered), a bedside commode and a call alert bell (to seek help from nursing staff).[60]

59. On 1 July 2016, the deceased was found in the corner of his room in the infirmary. It appears he had got out of bed to go to the toilet and fallen. He complained of pain in his right elbow and was taken to Fiona Stanley Hospital.[61]

60. On admission, he was found to have fractured his right humerus (upper arm bone). After treatment, he was admitted to the hospice at Bethesda Hospital later that day. He remained in the hospice until his death on 13 July 2016 at about 6.20 am.[62,63]

CAUSE AND MANNER OF DEATH[64]

61. A forensic pathologist (Dr Cooke) conducted a post mortem of the deceased's body on 15 July 2016. Dr Cooke found metastatic cancer in both of the deceased's lungs, his liver and his right humerus (upper arm bone).

62. There was evidence of a past stroke to the left side of the deceased's brain and there was arteriosclerotic hardening of the arteries and narrowing of the arteries of his heart (coronary artery arteriosclerosis). Microscopic analysis confirmed the above findings and also found bronchopneumonia. Toxicological analysis found a number of medications in the deceased's system consistent with his palliative medical care.[65]

63. Dr Cooke expressed the opinion that the cause of death was bronchopneumonia in a man receiving terminal palliative care for metastatic carcinoma of the colon. I accept and adopt that conclusion.

64. I find the deceased's death occurred by way of natural causes.

---

[60] Exhibit 1, Vol. 2, Death in Custody Review, p10 & ts 14.05.19 (Mudford), p10
[61] Exhibit 1, Vol. 2, Death in Custody Review, p10
[62] Exhibit 1, Vol. 2, Tab 14, Terminally Ill Case file
[63] Exhibit 1, Vol. 1, Tab 23, SJGH Discharge Summary (09.06.16)
[64] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[65] Exhibit 1, Vol. 1, Tab 7, Toxicological Report

QUALITY OF SUPERVISION, TREATMENT AND CARE

65. During his incarceration, the deceased was seen by prison medical and nursing staff on numerous occasions for various medical issues.[66] On a number of occasions he was managed on ARMS and he was seen regularly by PCS.

66. Following a colonoscopy in 2006, the deceased was diagnosed with metastatic colon cancer. He refused surgery on the basis that God would cure him and was assessed as psychiatrically competent to make that decision.

67. Although the deceased relented in 2009 and agreed to undergo surgery, radiotherapy and chemotherapy, by that stage, his colon tumour had metastasised and affected his lungs, liver and brain.

68. The deceased received treatment for these secondary cancers and when he could no longer be managed at the infirmary at Casuarina Prison, he was transferred to a hospice.

69. The deceased's medical care was reviewed by Professor Moroz, a general surgeon and surgical oncologist, who provided the Court with a report.[67]

70. Professor Moroz felt it was very unlikely that the deceased had colon cancer in 2002 when he complained of altered bowel habit and spots of blood in his stools. Professor Moroz felt those symptoms were more consistent with haemorrhoids and irritable bowel syndrome.[68]

71. With respect to the deceased's decision not to have surgery, Professor Moroz noted that the deceased had been assessed as psychiatrically competent and had:

> "*…simply made a bad decision in 2007 that may have prevented a cure*".[69]

[66] Exhibit 1, Vol. 2, Tab 10, Offender Health Appointments
[67] Exhibit 1, Vol. 1, Tab 14, Report - Professor Moroz
[68] Exhibit 1, Vol. 1, Tab 14, Report - Professor Moroz, p2, heading 1
[69] Exhibit 1, Vol. 1, Tab 14, Report - Professor Moroz, p2, heading 1

72. As to the quality of the care the deceased received, Professor Moroz said the deceased had:

> "*…received an excellent standard of care in the treatment of his sigmoid colon cancer and disease progression in the years afterwards. The fact that [he] survived almost 10 years from the time his tumour was discovered, and over 7 years from the time of his colonic resection reflects the quality of the care he received…*
>
> *I would go so far as to state that most patients in the non-custodial community would not have received such aggressive treatment; it is unlikely that a patient would have received a craniotomy with tumour excision from the brain in the presence of none, liver and lung metastases which Mr Macartney did in 2016.*[70]

73. In my view, appropriate regard was had to the deceased's early release pursuant to the grant of a pardon in the exercise of the Royal Prerogative of Mercy. The decision not to proceed with that application seems justified on the basis of the evidence.

74. Having regard to all of the circumstances of the deceased's incarceration, I am satisfied that the supervision, treatment and care provided to the deceased during his incarceration was reasonable and appropriate.

M A G Jenkin
Coroner
24 May 2019

[70] Exhibit 1, Vol. 1, Tab 14, Report - Professor Moroz, p2, heading 2