Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 18 /20

I, Sarah Helen Linton, Coroner, having investigated the death of ***Norman Alexander HAZELGROVE*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***18 February 2020*** *find that the identity of the deceased person was* ***Norman Alexander HAZELGROVE*** *and that death occurred on* ***18 September 2017*** *at* ***Bethesda Hospital*** *as a result of* ***metastatic carcinoma of the lung with palliation*** *in the following circumstances:*

Counsel Appearing:

Sgt L Houisaux assisting the Coroner.
Mr T Ledger (State Solicitor's Office) appearing on behalf of the Department of Justice.

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INTRODUCTION

1. Normal Hazelgrove had been a heavy smoker for many years when he died from metastatic carcinoma of the lung at Bethesda Hospital on 18 September 2017.

2. At the time of his death Mr Hazelgrove was a sentenced prisoner, having been sentenced in 2013 to a long term of imprisonment for historical sexual offences. He had been transferred to hospital from prison when it became apparent that his death was imminent and he required palliative care. He had been receiving palliative care for a couple of days before he died.

3. As Mr Hazelgrove 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]

4. I held an inquest at the Perth Coroner's Court on 18 February 2020. Separate investigations had been conducted into the death by the Western Australian Police Force and by the Department of Corrective Services (the Department) and reports were prepared.[2] The author of the Departmental Report was also called as a witness at the inquest. The inquest focused primarily on the gap in Mr Hazelgrove's medical while a prisoner, from the early suspicion of COPD to the later diagnosis of terminal lung cancer.

BACKGROUND

5. Mr Hazelgrove was born and raised in New South Wales. He worked for the NSW State Rail Authority for 43 years as a locomotive driver before retiring. He later moved to Perth, Western Australia. The course of offending that led to his imprisonment began in NSW and continued in Western Australia.[3]

6. On 21 June 2013 Mr Hazelgrove pleaded guilty to a number of offences, all committed against the same victim between 2003 and 2005 in Western Australia. He was sentenced on 20 August 2013 in the District Court of Western Australia to a total term of 9 years' 8 months' imprisonment.[4] At the time of his sentencing he was 69 years of age and had some cognitive deficits, but he did not have any other known major health conditions. However, given he was not eligible to be released on parole until 20 February 2021, at which time he would be in his late seventies, there was always some risk that his health would deteriorate while imprisoned.[5]

7. Mr Hazelgrove was described as a well-mannered and courteous prisoner who abided by the rules and regulations of the prison and interacted well with his peers. He had no disciplinary issues while in prison other than a loss of privileges on one occasion for smoking in his cell. He initially worked

[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibit 1.
[3] Exhibit 1, Tab 8.
[4] Exhibit 1, Tab 8.
[5] Exhibit 1, Tab 8.

and received gratuities, and when he became unable to work due to his health issues he was given still prison gratuities without being employed.[6]

EARLY SIGNS OF COPD

8. When Mr Hazelgrove was first admitted to prison, he had no major health concerns and was not taking any medications. Early health screens found he had elevated blood pressure and he was started on antihypertensive medication.[7]

9. On 13 September 2013, a few months after being imprisoned, Mr Hazelgrove was reviewed by a doctor and a chest examination revealed reduced breath sounds. When questioned, Mr Hazelgrove reported a smoker's cough and some shortness of breath, so he was encouraged to stop smoking and a chest x-ray was arranged. A chest x-ray performed on 29 October 2013 at RPH was reported as showing moderately severe hyperinflation with diffuse peribronchial thickening compatible with Chronic Obstructive Pulmonary Disease (COPD).[8] However, a diagnosis of COPD was not added to his problem list despite the x-ray being noted by medical staff. Subsequently, Mr Hazelgrove did not have any specific treatment or monitoring for COPD, although he was repeatedly counselled to stop smoking.[9]

10. On 17 December 2013 Mr Hazelgrove was reviewed again by a doctor in relation to his high blood pressure and he was again encouraged to stop smoking. Nevertheless, it appears he continued to smoke and made it clear to health staff that he didn't want to stop smoking.[10] He continued to be monitored for his high blood pressure, as well as some other health issues, throughout 2014. From March 2015 Mr Hazelgrove's medical reviews reduced significantly and he did not have regular monitoring.[11]

11. As noted above, there was no follow-up of Mr Hazelgrove's COPD diagnosis until he experienced respiratory difficulties on 6 May 2017. It would appear he was not particularly symptomatic for his COPD over that time, despite the fact he continued to smoke.[12]

SJOG HOSPITAL ADMISSION 6 MAY 2017

12. On 6 May 2017 Mr Hazelgrove experienced difficulties breathing and low oxygen saturations. He was administered oxygen and taken to St John of God Hospital Midland by ambulance.[13]

[6] Exhibit 1, Tab 18; Exhibit 2, Death in Custody Report, Executive Summary.
[7] Exhibit 1, Tab 36; Exhibit 2, Death in Custody Report, Executive Summary.
[8] Exhibit 1, Tab 36.
[9] Exhibit 2, Tab 22.
[10] Exhibit 1, Tab 36; Exhibit 2, Tab 22.
[11] Exhibit 2, Tab 22.
[12] Exhibit 1, Tab 34; Exhibit 2, Tab 22.
[13] Exhibit 1, Tab 34.

13. Mr Hazelgrove was initially diagnosed with pneumonia/COPD. Upon further investigation, a chest x-ray revealed a right pleural effusion and a chest CT scan showed a large tumour in the right lung with collapse of the middle and right lower lobes. A pleural fluid tap confirmed metastatic adenocarcinoma and Mr Hazelgrove was diagnosed with lung cancer.[14]

14. On 13 May 2017 a Medical Emergency Team (MET) call was made for increasing respiratory rate and oxygen requirements. Testing confirmed multiple segmental pulmonary emboli and Mr Hazelgrove was commenced on anticoagulation medication injections.[15]

15. The ceiling of medical care was discussed with Mr Hazelgrove, who agreed to medical management and he signed an Advanced Health Directive that he was not for CPR/intubation/dialysis.[16]

16. Mr Hazelgrove was eventually discharged back to prison on 18 May 2017 with an outpatient appointment arranged for follow-up in one to two weeks.[17] He was placed on the Department's Terminally Ill Prisoner Register.[18]

BACK AT ACACIA PRISON

17. On return to Acacia Prison Mr Hazelgrove was prescribed a number of medications, including nicotine patches to help him cease smoking. His diagnosis was noted and a plan was put in place to monitor his oxygen saturations twice daily.[19]

18. Mr Hazelgrove was initially reluctant to attend his follow-up appointment with the oncologist, stating that he had three to eight months to live and he wanted to enjoy this time in relatively good health, without undergoing palliative chemotherapy. He signed a refusal to attend a medical appointment form for his oncology appointment on 8 June 2017.[20]

19. He was seen by a Medical Officer on 13 June 2017 and after a discussion about the importance of attending the oncology appointment, Mr Hazelgrove eventually agreed to attend another appointment. However, on 23 June 2017 he signed another refusal to attend a medical appointment form.[21]

20. Finally, on 2 August 2017, Mr Hazelgrove was reviewed in the SJOG Midland Hospital Oncology Clinic and palliative chemotherapy was discussed. He declined treatment and no further follow up was arranged.

21. Mr Hazelgrove's condition gradually deteriorated over the next few weeks and by 17 August 2017 he had difficulty breathing, was coughing up white

[14] Exhibit 1, Tab 34.
[15] Exhibit 1, Tab 34.
[16] Exhibit 1, Tab 34; Exhibit 2, Tab 1.
[17] Exhibit 2, Death in Custody Report, Executive Summary.
[18] Exhibit 2, Death in Custody Report, Executive Summary.
[19] Exhibit 2, Tab 22.
[20] Exhibit 2, Tab 22.
[21] Exhibit 2, Tab 22.

sputum and had low oxygen saturations. On 22 August 2017 a Code Blue was called after he coughed up blood. He was administered antibiotics and oxygen and his condition appeared to improve.

TRANSFER TO CASUARINA INFIRMARY

22. On 24 August 2017 Mr Hazelgrove's medical status was changed to Stage 3 Terminally Ill on the Department of Corrective Services' TOMS system and an end of life care plan was discussed with his nominated next of kin. On 25 August 2017 he was transferred to the Casuarina Prison Infirmary.[22]

23. On 28 August 2017 Mr Hazelgrove was reviewed by the Medical Officer and he confirmed he did not want any active treatment. His clexane (anticoagulant) dose was reduced based on his recent weight loss. He was also reviewed by the Mental Health Team to ensure he had the mental capacity to refuse treatment and a request was made for Mr Hazelgrove to be assessed by the Metropolitan Palliative Care Consultancy Service.[23]

24. The Palliative Care Service assessed Mr Hazelgrove on 7 September 2017. He had shortness of breath and a cough but denied any pain. He was happy to trial morphine for pain relief on an 'as needed' basis. He also reported he was happy at Casuarina and felt well looked after. The Palliative Care Service suggested a medication regime to manage his pain, cough and constipation.[24]

25. On 13 September 2017 Mr Hazelgrove was reviewed again by the Palliative Care Service and he was commenced on more regular morphine for pain relief. A plan was made to transfer him to Bethesda Hospital Palliative Care Unit once a bed became available.[25]

26. On 16 September 2017 Mr Hazelgrove reported feeling acutely unwell and very short of breath. His oxygen saturations were very low and he was coughing and cyanotic. He was given oxygen and transferred to Fiona Stanley Hospital, where he remained until a palliative care bed became available at Bethesda Hospital.[26]

FINAL DAYS

27. Mr Hazelgrove was admitted to the Palliative Care Unit of Bethesda Hospital on the morning of 17 September 2017. He was commenced on a subcutaneous pump of morphine and midazolam for end of life care. He was reported to have struggled with breathing in the afternoon and required haloperidol for agitation and glycopyrolate for excessive secretions. He required regular doses of morphine to manage breakthrough pain and the dose of medications in his pump were increased accordingly.

[22] Exhibit 2, Death in Custody Report, Executive Summary.
[23] Exhibit 2, Tab 22.
[24] Exhibit 2, Tab 22.
[25] Exhibit 1, Tab 2.
[26] Exhibit 1, Tab 2.

28. Mr Hazelgrove was kept comfortable until he passed away peacefully just after midnight on 18 September 2017.[27]

CAUSE AND MANNER OF DEATH

29. An external post mortem examination was performed by Forensic Pathologist Dr Vicki Kueppers on 20 September 2017, which included a review of the medical records and limited toxicology analysis. The toxicology results were in keeping with terminal palliative medical care. Dr Kueppers formed the opinion the cause of death was metastatic carcinoma of the lung, with palliation, based upon the external examination only.[28]

30. I accept and adopt the opinion of Dr Kueppers as to the cause of death. The manner of death was by way of natural causes.

COMMENTS ON SUPERVISION, TREATMENT AND CARE

31. An internal health review summary was provided by the Department, dated December 2019. The document is a very helpful summary of Mr Hazelgrove's care while in prison, and the author of the document provided a very thoughtful and considered opinion on the level of care provided, which I have found very helpful.

32. Some issues were identified in the review in relation to Mr Hazelgrove's follow-up care for his possible COPD, and it was noted that there were missed opportunities during his annual health assessments and blood pressure reviews to follow this up. It was noted that the omission of the formal diagnosis, assessment and management of his COPD did not affect his later development of lung cancer, but did represent a "missed opportunity for optimal care and potentially earlier diagnosis of his lung cancer,"[29] although closer monitoring many not necessarily have identified the cancer or changed the outcome.

33. I note that Mr Hazelgrove was a known heavy smoker, which was the likely origin of his COPD and metastatic lung cancer, and even after diagnosis he did not quit smoking. When testing identified that he had developed metastatic lung cancer, there was no curative treatment available for him. He was offered chemotherapy but he declined this option, as was his right. His capacity to make that decision was properly investigated by mental health services, and it was concluded he had sufficient cognitive function to understand and make that choice. He was kept comfortable and provided with a high standard of care, including palliative treatment in a hospital setting in his final days. I am satisfied his medical care after diagnosis was of a high standard and comparable to the care expected in the community.

[27] Exhibit 1, Tab 2.
[28] Exhibit 1, Tab 6 and Tab 7.
[29] Exhibit 2, Tab 22, p. 9.

34. There was some consideration of releasing Mr Hazelgrove prior to his death via the Royal Prerogative of Mercy, but he didn't have any real prospect of finding a suitable place to stay if released and his offending behaviour was considered to be unaddressed. Mr Hazelgrove was interviewed about the possibility of early release and it seems he understood such an option was unlikely. I note he had reported to the external Palliative Care Service that he was happy at the Casuarina Infirmary and felt he was treated well there prior to his death.[30]

35. As to his medical care prior to the diagnosis of his lung cancer, I agree that there were missed opportunities to treat and monitor Mr Hazelgrove's COPD, although I note that he would have been aware he had the option to avail himself of medical review if he desired, and there is no evidence he requested such a review.

36. I am informed that since Mr Hazelgrove's death some improvements have been initiated to the prison health services to prompt more regular medical reviews with an emphasis on preventative health and identifying risk factors. Education has also been provided regarding appropriate response to abnormal observations through the Clinical Nurse

37. I am satisfied that the steps taken by the Department in reviewing Mr Hazelgrove's care and initiating improvements prior to the inquest, have satisfactorily addressed any concerns I have about his ongoing medical care and management prior to his diagnosis of lung cancer.

CONCLUSION

38. Mr Hazelgrove went to prison for the first time as an older man after being convicted of offences that had occurred some years before. Although he was in relatively good health at the time of admission to prison, given his age and the fact he had been a heavy smoker since he was a teenager, there was always some potential for him to develop a serious health condition while serving his sentence.

39. He began to exhibit respiratory symptoms not long after his admission to prison, but nothing so severe that it prompted regular follow-up or led him to seek medical assistance. In May 2017 Mr Hazelgrove had a significant medical event, that led him to be hospitalised and diagnosed with metastatic lung cancer. He was not a candidate for active treatment and he declined palliative chemotherapy. He was placed on the terminally ill prisoner register and regularly monitored. As his health declined, he was moved to the Casurina Infirmary and commenced on palliative care. In his final days, he was moved to hospital, where he was kept comfortable until he died. He received at least the standard of care one would expect in the community, if not more, and I am satisfied the Department discharged its duty of care.

[30] Exhibit 1, Tab 28; Exhibit 2, Death In Custody Report, Executive Summary.

S H Linton
Coroner
20 March 2020