JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART
HEARD	**:**	6 JULY 2021
DELIVERED	**:**	6 SEPTEMBER 2021
FILE NO/S	**:**	CORC 29 of 2017
DECEASED	**:**	EDGILL, MARSHALL RUBEN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Ms R Collins assisted the Coroner.
Ms A Lachal and Ms R Belton (Aboriginal Legal Services) appeared on behalf of the family.
Ms E Cavanagh (State Solicitor's Office) appeared on behalf of the Department of Justice (Corrective).

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Marshall Ruben EDGILL*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 6 July 2021, find that the identity of the deceased person was* ***Marshall Ruben EDGILL*** *and that death occurred on 7 May 2017 at Albany Health Campus, Warden Avenue, Spencer Park, from combined effects of acute-on-chronic respiratory disease and cardiomegaly in the following circumstances:*

Contents

INTRODUCTION

1 The deceased (Mr Edgill) died on 7 May 2017 at Albany Health Campus (AHC), Spencer Park, from the combined effects of acute-on-chronic respiratory disease and cardiomegaly. At the time of his death, Mr Edgill was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Corrective Services (the Department), as the Department was known at the relevant time.[1]

2 Accordingly, immediately before his death Mr Edgill was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[2] In such circumstances, a coronial inquest is mandatory.[3]

3 I held an inquest into Mr Edgill's death at Perth on 6 July 2021. The following witnesses gave oral evidence at the inquest:

i) Dr Scott Claxton (Consultant Sleep and Respiratory Physician);

ii) Dr Rhian Moss (General Practitioner and ex-Prison Medical Officer with the Department);

iii) Dr Joy Rowland (Director of Medical Services with the Department); and

iv) Ms Toni Palmer (Senior Review Officer with the Department).

4 The documentary evidence produced at the inquest comprised of two volumes which were tendered as exhibit 1. An additional three exhibits were tendered during the inquest (exhibits 2-5) and another five exhibits were provided after the inquest, at my request, by the Department (exhibits 6-10).

5 The inquest focused on the medical care provided to Mr Edgill while he was a prisoner, with an emphasis upon the treatment of his suspected obstructive sleep apnoea (OSA).

THE DECEASED

Background [4]

6 Mr Edgill was born on 2 February 1979 and was 38 years of age when he died on 7 May 2017. His parents separated shortly after he was born, and he was raised by

[1] Section 16, *Prisons Act 1981* (WA)
[2] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[3] Section 25(3), *Coroners Act 1996* (WA)
[4] Exhibit 1, Volume 2, Tab 0, Death in Custody Report by Richard Mudford dated 2 October 2019

his maternal grandmother until her death. Thereafter, Mr Edgill resided with extended family members.

7 Mr Edgill attended school until he was 14 years old, when he left part-way through year 9. Apart from working as a labourer in 2006 and short periods of employment with a Community Development Employment Program, he relied solely on Centrelink benefits.

8 Mr Edgill had a long-term de-facto relationship with his partner that existed for more than 20 years. He and his partner had five children, one of whom (their eldest daughter) died in 2007 from a brain tumour, when she was just 11 years old.

Offending history [5] [6]

9 Mr Edgill had an entrenched record of criminal and traffic-related convictions. His first court appearance was as a 10-year-old, in the Albany Children's Court. As a juvenile, he predominantly had convictions for dishonesty.

10 As an adult, he continued to commit offences of dishonesty and added a number of serious assault convictions. He also had a long list of traffic convictions. Sadly, much of Mr Edgill's violent offending was against his partner and their children.

11 On 9 October 1997, as an 18-year-old, Mr Edgill was first sentenced to an adult term of imprisonment. Thereafter, he was repeatedly sentenced to immediate terms of imprisonment. He had a poor response to community supervision, with only one of several orders made successfully completed, with all others breached by non-compliance or re-offending. From 31 March 2009 until his death, Mr Edgill was imprisoned on six separate occasions for periods ranging from two months to 17 months.

12 Mr Edgill had a long and established history of alcohol and drug dependency. He had disclosed using alcohol and cannabis from the age of 14 years, followed by methylamphetamine use from when he was 21 years old. The correlation between Mr Edgill's alcohol and illicit drug use, and his violent offending was readily apparent. Despite his engagement over many years in programs within the prison setting and in the community that addressed his alcohol and drug use, any benefits from these therapeutic interventions were always short-lived.

[5] Exhibit 1, Volume 2, Tab 0, Death in Custody Report by Richard Mudford dated 2 October 2019
[6] Exhibit 1, Volume 2, Tab 1, Mr Edgill's WA Court History – Criminal and Traffic

Circumstances of final imprisonment [7]

13 On 10 January 2017, Mr Edgill was sentenced by the Albany Magistrates Court to 9 months' imprisonment, back dated to 9 September 2016. Those offences comprised of fraud, burglary, possession of stolen property and breach of bail. He was made eligible for parole.

14 On 22 January 2017, he was released to short-term parole. On 2 February 2017, less than two weeks later, his parole was suspended due to non-compliance with his parole order conditions. On 4 February 2017, Mr Edgill was apprehended by police and taken to Hakea Prison on the following day. On 9 February 2017, his parole order was cancelled, which required him to serve the 122 days owing for breaching his parole. His maximum release date was 10 June 2017.

15 Upon his reception to Hakea Prison, Mr Edgill said he felt stressed and stated an intent to self-harm as his partner was unwell and in hospital. He was placed on the At Risk Management System (ARMS), with an initial two-hourly observation schedule, before being assessed by the prison's mental health staff. Those observations were reduced to a four-hourly schedule before Mr Edgill was transferred to unit 6 for orientation. He was then placed with the mainstream population. Mr Edgill remained subject to ARMS until he was removed from the system on 14 February 2017.

16 At his request, Mr Edgill was transferred to Albany Regional Prison (ARP) on 18 February 2017, as his family resided in Albany. He subsequently remained at ARP until his death.

17 I am satisfied as to the supervision, treatment, and care Mr Edgill received from the Department during his 13 days at Hakea Prison.

OVERVIEW OF MEDICAL CONDITIONS AND TREATMENT IN HOSPITAL AND PRISON

18 Mr Edgill had numerous interactions with hospital and prison health services throughout his adult life. He had a history of asthma, obesity, and hypertension. He also had issues with anxiety and depression during his various periods of incarceration. Other issues included proteinuria, dyslipidaemia, and drug and alcohol misuse. It is clear he had poor compliance with treatment and lifestyle advice provided to him by hospital and prison medical staff.

[7] Exhibit 1, Volume 2, Tab 0, Death in Custody Report by Richard Mudford dated 2 October 2019

Albany Health Campus [8]

19 An examination of Mr Edgill's medical records from AHC shows he had many admissions and presentations to that hospital over a number of years. Although these admissions and presentations were mainly for asthma related issues and chest infections, these records also refer to OSA.

20 The first reference to OSA occurred during an admission in August 2000 when Mr Edgill was noted to have sleep apnoea overnight.

21 During an overnight admission in 2010 it was noted that he experienced apnoeic periods during his sleep. Mr Edgill's general practitioner was advised to arrange a sleep study and an echocardiogram (ECG).

22 Apnoeic episodes were again recorded by nurses when he was admitted to Albany Hospital in January 2011. On 17 January 2011, a referral was sent to a doctor at a sleep apnoea clinic for the consideration of acquiring a CPAP machine for Mr Edgill.[9]

23 During a three-day admission to AHC in July 2011, another diagnosis of likely sleep apnoea was made, and Mr Edgill was advised to get a referral to a sleep clinic.

24 During another hospital admission in September 2015, it was noted that Mr Edgill had OSA but was not using a CPAP machine. It was also noted that the frequency of apnoea and the degree of Mr Edgill's de-saturations was suggestive of "*VERY SEVERE OBSTRUCTIVE SLEEP APNOEA*". Mr Edgill's discharge summary on this occasion stated that he had missed several referrals for sleep studies and his general practitioner was asked to re-refer.

25 During an over-night stay at AHC in April 2016, Mr Edgill was noted to have severe sleep apnoea while lying on his back.

26 It is not in dispute that Mr Edgill did not attend a sleep clinic on any of these occasions.

[8] Albany Health Campus medical records for Mr Edgill

[9] A CPAP machine treats sleep apnoea by delivering a stream of oxygenated air into the wearer's airways, through a mask and a tube. This is to prevent a collapse of the upper airway during sleep.

Albany Regional Prison [10]

27 There were also several references to OSA in Mr Edgill's prison medical file. However, this was also never formally diagnosed by a sleep study during his time in prison.

28 The earliest prison medical record referring to OSA was in 2002, when Mr Edgill said he had been diagnosed with OSA when he was in hospital the previous year. On 30 October 2003, it was again documented that Mr Edgill had OSA. On that occasion, he was advised that he needed to lose 20 kg in weight.

29 On 3 June 2008, there was a further reference to OSA, indicated by snoring, breath-holding and daytime tiredness. An ECG was ordered, and weight loss was again recommended. An ECG on 5 June 2008 was within normal limits.

30 On 13 April 2010, Mr Edgill was seen by a prison nurse. At this time, he weighed 133.2 kg and he indicated to the nurse that he planned to lose weight once he was released in four months' time. During this consultation, Mr Edgill requested a referral to a sleep apnoea clinic as he was snoring and had stopped breathing regularly at night.

31 On 22 April 2010, Mr Edgill was seen by the prison medical officer who noted that he was "*snoring with sleep apnoea*" and the assessment concluded "*obese, asthmatic wished referral for outside post discharge*". Mr Edgill was subsequently referred to the local sleep clinic in Albany. However, there is no record that Mr Edgill went to a sleep clinic following his discharge from prison on 7 September 2010.

32 Mr Edgill served another term of imprisonment, commencing on 3 December 2012. On 12 February 2013, he was seen by the prison medical officer for an admission assessment. It was noted during that assessment that he had "*some sleep apnoea*".

33 During a visit to a prison nurse on 19 September 2013, Mr Edgill stated that he wanted to get a machine for sleep apnoea and asked whether it could be funded. The nurse provided him with a list of devices that were available from a pharmacy and Mr Edgill was recorded as saying he was happy to read the list and get back to

[10] Department of Justice medical records for Mr Edgill

the nurse. There is no record of any further conversation Mr Edgill had with prison medical staff regarding his sleep apnoea prior to his release on 7 April 2014.

34 Although Mr Edgill had another four periods of incarceration, there were no further references to sleep apnoea in his prison medical records.

35 Mr Edgill was last seen by prison medical staff for a routine appointment on 1 May 2017. His only complaints during that appointment were that he had a toothache and a head cold.

EVENTS LEADING TO DEATH [11]

36 Mr Edgill gave no indication that he was feeling unwell in the days prior to his death, or on the day itself. He had a telephone conversation with his partner at about 2.00 pm on 7 May 2017 during which he "*seemed fine*" and did not say anything about feeing unwell. Similarly, his cellmate (who was also his cousin), had lunch with Mr Edgill at about 11.30 am and noted that Mr Edgill was "*alright*". After lunch, Mr Edgill's cellmate returned to the cell, whilst Mr Edgill went for a walk before he also returned to the cell and laid on his bunk.

37 At about 2.50 pm, Mr Edgill left the cell to watch some prisoners play football. He was last sighted on CCTV cameras re-entering his cell at 3.07 pm. At about the same time, Mr Edgill's cellmate left the cell to visit some other prisoners. When he returned to the cell at 3.35 pm, he found Mr Edgill laying on his bunk. He yelled out to Mr Edgill to get up for muster, but he did not answer. When he saw that Mr Edgill was not breathing, he immediately yelled out to prison officers to attend.

38 Three prison officers entered the cell and attempted to wake Mr Edgill up. When they did not get a response, a Code Red medical emergency was called over the radio. The prison officers then lifted Mr Edgill from the top bunk and placed him in the recovery position on the cell floor. After failing again to get a response from Mr Edgill, he was moved out from the cell to provide room to commence CPR.

39 Within minutes, prison medical staff attended and took over the resuscitation efforts. A Guedel airway was inserted into Mr Edgill's mouth and a defibrillator was attached at 3.38 pm, with compressions continuing during these interventions.

40 At 3.41 pm, a call was made for an ambulance to attend. At 3.44 pm, an intravenous line was inserted, and two doses of adrenaline were given. Prison

[11] Exhibit 1, Volume 1, Tabs 7-31, various witness statements and incident description reports

medical staff contacted AHC and an emergency department consultant gave instructions over the telephone to continue with CPR. Compressions continued until the defibrillator authorised a shock at 3.50 pm. Ambulance officers arrived at 3.55 pm and Mr Edgill was intubated at 4.05 pm. At 4.11 pm, the ambulance left the prison to convey Mr Edgill to AHC. Five doses of adrenaline were given to Mr Edgill on the way to the hospital. The ambulance arrived at AHC at 4.24 pm. Once at the hospital, resuscitation efforts continued, however Mr Edgill remained in asystole (without a heartbeat) throughout those efforts. Resuscitation efforts were ceased and Mr Edgill was certified as deceased at 4.36 pm.[12]

CAUSE AND MANNER OF DEATH [13]

41 On 12 May 2017, Dr Judith McCreath, a forensic pathologist, conducted a post mortem examination on Mr Edgill's body.

42 That examination noted that Mr Edgill weighed 125 kg and was 1.72 m in height. His BMI (body mass index) was 42.3. It was also noted that Mr Edgill had an enlarged heart, excess fluid in his lungs and gallstones were evident. He had also sustained rib and sternal fractures that were consistent with resuscitation attempts.

43 A microscopic examination of lung tissue showed pneumonia and asthmatic changes within both lungs. Neuropathological examination of Mr Edgill's brain showed no significant abnormalities. Toxicological analysis of blood samples was negative for alcohol and common drugs.

44 At the conclusion of her investigations, Dr McCreath expressed the opinion that the cause of death was combined effects of acute-on-chronic respiratory disease and cardiomegaly.

45 I accept and adopt the conclusion expressed by Dr McCreath as to the cause of Mr Edgill's death.

46 I find that his death occurred by way of natural causes.

ISSUES RAISED BY THE EVIDENCE

47 Some "*lost opportunities*"[14] were identified regarding the medical care provided to Mr Edgill during his periods of incarceration. It is an undeniable fact that he had

[12] Exhibit 1, Volume 1, Tab 4, Life Extinct Form
[13] Exhibit 1, Volume 1, Tab 5A & 5B, Post Mortem Supplementary Report and Post Mortem Report dated 12 May 2017 from Dr Judith McCreath; Exhibit 1, Volume 1, Tab 6, Toxicology Report dated 23 May 2017
[14] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021, p.15

multiple comorbidities. He also had some complex psycho-social stressors and his risks were also increased as he was an Indigenous man.[15]

48 Mr Edgill's compliance with treatment regimes and attendance at healthcare appointments, both within the prison and the community, varied. Although he generally had a positive family life, which provided motivation for him, his six periods of imprisonment from 2009 were interspersed with relapses back into methylamphetamine and alcohol dependency. During that period, he was rarely able to achieve a weight below 120 kg.

49 A majority of Mr Edgill's time in jail was at ARP. It is evident from his prison health records that prison health care staff made repeated efforts to provide education regarding the management of his health. That management focused on three main areas: namely Mr Edgill's weight issues, hypertension, and asthma. I accept the evidence of Dr Moss that the Department's treatment of these three conditions was of a reasonable standard.[16] However, following Mr Edgill's death, the lost opportunities identified concerned how the Department addressed the consequences of these conditions[17]

50 In making my findings with respect to those missed opportunities I must apply the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J), which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

51 I am also mindful not to insert hindsight bias into my assessment of the actions by the Department's staff in their dealings with, and treatment of, Mr Edgill.[18]

Mr Edgill's sleep apnoea

52 Although it was never formally diagnosed by a sleep study, the evidence before me suggests it was almost inevitable that Mr Edgill had OSA. As outlined above, there were several references to OSA in his prison medical file. The question that arises is whether the Department had any responsibility for the failure of Mr Edgill to participate in a sleep study to have his OSA formally diagnosed and then to have it potentially treated with a CPAP machine.

[15] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021
[16] ts 6.7.21 (Dr Moss), pp.40-41, 44
[17] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021, p.15
[18] Hindsight bias is the tendency, after the events, to assume the events are more predictable or foreseeable than they really were: Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

53 I accept Dr Claxton's opinion that OSA may have contributed to Mr Edgill's death, in that it could have contributed, over time, to cardiac failure.[19] Dr Claxton further stated:[20]

> Obstructive sleep apnoea would not have directly caused his death but rather been a risk factor for what sounds like acute pulmonary oedema due to left ventricular dysfunction. Previous initiation of CPAP therapy and control of his sleep apnoea may have prevented his death at this time. This would depend on his cardiac state at the time at which CPAP was commenced.

54 As Dr Claxton said at the inquest, CPAP therapy was "*the gold standard for treatment*" for OSA.[21] He also identified that the main risk factor for OSA is obesity[22] and that an enlarged heart can be one of the consequences of untreated OSA.[23]

55 In her evidence at the inquest, Dr Rowland pointed out several factors that prison medical staff at the Department were not aware of regarding Mr Edgill's OSA. First, there was no indication from his prison medical notes that his sleep apnoea was particularly severe:[24]

> So, looking through his notes, looking for signs of the severity of the sleep apnoea and how much it bothered him, he wasn't presenting frequently saying that he was tired or saying that he had headaches or saying that he was snoring. He wasn't requesting changes in his cell because his cellmate was complaining about him. He wasn't requesting a single cell because he was always in trouble for snoring. So those markers that may have assisted people in understanding how bad it was for him weren't there. And, because he didn't mention it consistently, it was probably easy to overlook in comparison to the need to work on his weight and the need to work on his asthma, which was far more prominent to staff caring for him.

56 Second, Dr Rowland correctly noted that the AHC had the best opportunity to confirm the existence of OSA and to monitor its severity:[25]

> It was the hospital that saw him overnight on monitoring with him on a pulse oximeter, so the hospital would have had the best indication of the severity and the existence. And the hospitals can refer to a specialist. That happens all the time. So, every time he had a hospital admission and they were concerned about sleep

[19] Exhibit 1, Volume 1, Tab 40A, Report of Dr Scott Claxton dated 19 October 2020, p.2
[20] Exhibit 1, Volume 1, Tab 40A, Report of Dr Scott Claxton dated 19 October 2020, p.2
[21] ts 6.7.21 (Dr Claxton), p.8
[22] ts 6.7.21 (Dr Claxton), p.7
[23] ts 6.7.21 (Dr Claxton), p.16
[24] ts 6.7.21 (Dr Rowland), pp.72-73
[25] ts 6.7.21 (Dr Rowland), p.75

> apnoea, they had an opportunity to refer him, and I believe on at least one occasion they've referenced that they've asked his local community GP to make a referral, and there's reference to him missing multiple appointments in the community after that referral was made.

57 The third factor was that although Mr Edgill had repeated admissions to AHC since 2010 and had been diagnosed with suspected OSA on five of those occasions, every time that he was imprisoned after these admissions he answered "*no*" to the question asked during his prison health screening process whether he had been in hospital.[26] On one of those occasions in May 2016, he had only been admitted to hospital less than one month earlier. Hence, the prison medical staff did not have the opportunity of requesting relevant medical files from AHC for any of these admissions. As Dr Moss said at the inquest, "*They would only request from the hospital if Mr Edgill had told them he had been in hospital, otherwise they would request from the GP.*"[27] However, Mr Edgill's doctor never placed OSA on the list of medical conditions sent to ARP.[28]

58 As to the prison nurse's note on 19 September 2013 that Mr Edgill wanted to get "*a machine for sleep apnoea*" and asked if it could be funded, Dr Rowland made the pertinent point it was not known what was the extent of the discussions between the nurse and Mr Edgill regarding that matter. For example, whether the nurse talked to Mr Edgill about how much money his family might have and whether his community might assist him with the cost.[29] Such conversations would not necessarily be recorded.

59 I accept that the Department, through no fault of its own, was not kept fully apprised of the severity of Mr Edgill's OSA. Although Dr Rowland in her evidence at the inquest made the following concession, I accept this was a concession made with the benefit of hindsight:[30]

> However, I think that it certainly would have helped if the sleep apnoea, which was a provisional diagnosis until proven, had been added to his active problem list, which is our summary list of major problems that we're dealing with. And, although it's mentioned by doctors in the notes on admission and by a nurse, no one actually adds it to that target list of items that we're dealing with, which is the major risk in things

[26] Exhibit 9, Copies of Admissions Checklists for Mr Edgill (1996-2017) with summary page
[27] ts 6.7.21 (Dr Moss), p.51
[28] ts 6.7.21 (Dr Rowland), p.83
[29] ts 6.7.21 (Dr Rowland), pp.81-82
[30] ts 6.7.21 (Dr Rowland), p.73

> not following through for continuity of care, because that's your summary of what we're dealing with.

60 After carefully considering all the evidence, and for the reasons I have outlined above, I am satisfied that no adverse comment should be made against the Department regarding its treatment of Mr Edgill's OSA.

Cardiac symptoms

61 Dr Moss identified three occasions when Mr Edgill presented to prison health staff with cardiac symptoms.[31] The first occasion was on 12 February 2013 when he was seen by the prison medical officer during his medical assessment following admission. On that occasion, Mr Edgill complained of a "*missing heartbeat*". The second occasion was on 12 January 2014 when Mr Edgill presented to the prison medical centre with "*tightness in chest*". The third occasion was on 12 October 2014, when, during a review by a prison nurse, Mr Edgill presented with "*splutters in chest*" and it was recorded that he was describing palpitations.

62 Dr Moss noted that no ECG was performed regarding any of these events and no consideration was made to any further investigation or a specialist assessment. Dr Moss also observed that on two of these occasions, Mr Edgill was only seen by a clinical nurse and the event was not reviewed by the prison medical officer.[32]

63 Dr Moss gave evidence at the inquest that it was her view that "*a bit more could have been done*" and gave the examples that if Mr Edgill had presented to a GP in the community with these symptoms, he may have been referred on for an ECG or a halter monitor, or some other formal investigation.[33]

64 At the completion of the inquest, Dr Rowland was provided with the opportunity of responding to Dr Moss's observations once she had the opportunity of re-reading the material from the Me Edgill's prison medical file. The subsequent review by Dr Rowland was undertaken in consultation with several general practitioners, who were currently practicing both within the prison setting and in private practice. The report from this review became exhibit 8.[34]

[31] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021
[32] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021, p.15
[33] ts 6.7.21 (Dr Moss), p.50
[34] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.3

65 As to the disclosure of a "*missing heartbeat*" on 12 February 2013, Dr Rowland noted that an ECG was done in June 2013 and was normal.[35] Although Dr Rowland accepted that, "*Ideally the doctor will have recorded more details regarding the patient's experience…*", she also noted that, "*It is typical to write brief notes of salient points only, especially during comprehensive admissions.*"[36] Dr Rowland's concluding observations were that, "*In the absence of further detail we have no indication for an urgent ECG but the lack of detail also provides for the possibility that further investigation or referral could have been justified*",[37] and that a referral to Cardiology for a halter monitor would have been warranted, if the symptoms were "*recurrent or concerning*".[38]

66 As to the presentation of "*tightness in chest*" during Mr Edgill's visit to the clinical nurse on 12 January 2014, Dr Rowland clarified that Mr Edgill did see the prison medical officer on 22 January 2014. However, when he was seen on that occasion, the notes were brief and, "*there is no mention of chest pain or acute symptoms*".[39] Dr Rowland was of the view that if Mr Edgill's complaint was "*describing an acute cardiac symptom*", then a chest pain assessment, including an ECG, would have been required.[40]

67 As to the complaint of "*splutters in his chest*" to the nurse on 12 October 2014, Dr Rowland was satisfied that the nurse had conducted an appropriate assessment and recorded that Mr Edgill had a normal heart rate and rhythm, with no symptoms indicating an acute cardiac event or current arrythmia.[41] In those circumstances, Dr Rowland was of the view that an ECG would not have been urgent. However, Dr Rowland also accepted that a further ECG done on this day would have been of benefit to the doctor conducting the scheduled appointment on 15 October 2014. This would have ensured the prison medical officer was alerted to this symptom

[35] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.4
[36] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.4
[37] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.4
[38] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.5
[39] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.6
[40] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.5
[41] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.6

and addressed it specifically during the appointment.[42] At that appointment there was no reference to further complaints by Mr Edgill regarding his heart, however, the prison medical officer made no mention of the notes from 12 October 2014. A review of such notes would have been an expected course of action.[43]

68 Dr Rowland identified a fourth occasion when Mr Edgill had self-presented, complaining of feeling dizzy the day before. This self-presentation occurred on 12 November 2014 when he was seen by a prison nurse. Dizziness can be caused by a number of conditions, including arrythmia.[44] Although there were no further complaints of dizziness by Mr Edgill, Dr Rowland was of the view, "*Further details should have been recorded by the nurse on that day regarding the nature, duration, severity and associated symptoms with the dizziness, any prior episodes and why it worried him sufficiently to present to the clinic.*"[45] According to Dr Rowland, these details were necessary and it may have warranted a more urgent escalation to the prison medical officer than the consultation that took place two weeks later.[46]

69 Dr Rowland has properly acknowledged the shortcomings on those four occasions that Mr Edgill presented with potential cardiac symptoms, particularly regarding the recording of notes. However, I am not satisfied that these missed opportunities were so grave as to warrant any criticism. In so finding, I am mindful to not overlook the "*consideration of resources and time*"[47] and that, "*Prison health is essentially a boiling pot for everything. We get more of everything. You know, our chronic disease numbers of every disease are higher than the general population.*"[48]

Absence of an admission medical assessment by a prison medical officer

70 During his last two periods of incarceration, Mr Edgill was not seen by the prison medical officer for a medical assessment.[49] The first of these incarcerations was

[42] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.6
[43] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.7
[44] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.7
[45] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, p.8
[46] Exhibit 8, Health Services Follow-Up Supplementary Report into the Death in Custody dated August 2021, pp. 8-7
[47] ts 6.7.12 (Dr Rowland), p.94
[48] ts 6.7.12 (Dr Rowland), p.106
[49] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021, p.15

from 15 November 2016 to 22 January 2017. Although a prison medical officer review was scheduled, it never took place during the 11 weeks Mr Edgill was in prison on that occasion. As already outlined above, his final period of incarceration extended beyond three months.[50] Although an assessment had been requested, it had not been done.[51]

71 The Department's policy that existed at the time of Mr Edgill's last two periods of incarceration gave the prison nurse performing the admission and risk assessment for new prisoners the responsibility of "*making an appointment for the patient to be reviewed by a Prison Medical Officer (PMO) within 28 days of reception.*"[52]

72 Dr Rowland conceded that Mr Edgill should have been assessed by a prison medical officer on both of those occasions.[53] She agreed that the failure of those assessments taking place was a resource issue.[54]

73 With respect to this particular matter, I find that the Department had let Mr Edgill down. A prisoner with his array of comorbidities should not have been left without a medical assessment by a qualified doctor for the lengths of time that occurred on these two occasions. As Dr Moss pointed out, "*You want to be optimising this opportunity to improve people's health.*"[55]

Pneumovax immunisation

74 The Department had a policy on pneumovax immunisation that was implemented on 10 January 2011.[56] As at 2017, an Indigenous man with chronic lung disease should have been offered two doses of pneumococcal (pneumovax 23), five years apart, with a maximum of three life time doses.[57] Mr Edgill fell within that category, yet he was not offered a pneumovax immunisation.[58] As Dr Moss testified at the inquest, such an immunisation would have reduced Mr Edgill's risk of "*recurrent pneumonias and airway disease*".[59]

[50] This incarceration period also includes the 13 days Mr Edgill was initially held in Hakea Prison before his transfer to ARP
[51] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021, p.15
[52] Exhibit 10, Department of Corrective Services, Health Services Procedure: PM01 Adult Admission and Risk Assessment, Version 6, p.5
[53] ts 6.7.12 (Dr Rowland), p.102
[54] ts 6.7.12 (Dr Rowland), p.102
[55] ts 6.7.12 (Dr Moss), p.59
[56] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021, p.14
[57] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021, p.14
[58] Exhibit 1, Volume 1, Tab 41, Report of Dr Rhian Moss dated 29 January 2021, pp.14-15
[59] ts 6.7.21 (Dr Moss), p.47

75 It was unfortunate that Mr Edgill was never offered this immunisation. It is not in dispute that he should have been. Although, if he had had the immunisation, it would not have changed the outcome of his death.[60]

IMPROVEMENTS SINCE MR EDGILL'S DEATH

76 As would be expected of all governmental departments, the Department is on a pathway of continuous improvement. It was evident to me that the Department has made several improvements since Mr Edgill's death, which were outlined in Dr Rowland's first report.[61]

Sleep apnoea and CPAP machines

77 A specific template for assessing the severity of OSA was introduced by the Department in July 2020. If any prisoner is suspected of having OSA, a prison medical officer can quickly run a screening tool with an associated scoring system.[62] This is to aid not only the diagnosis, but also improve the quality of referrals to sleep clinics to facilitate an appropriate triage by the receiving clinic.[63]

78 A further improvement that has been made since Mr Edgill's death is the capacity for the Department to utilise Telehealth for prisoners suspected of having OSA. The Department has also explored the option of using overnight CPAP machines inside the prison setting to streamline the process for determining exactly which machine is the best one for the prisoner.[64] This process means that the sleep study need not take place within a hospital environment. As at the time of the inquest, it was shortly planned to undertake the first use of a sleep study in a prison setting at Bunbury Regional Prison.[65]

79 Dr Rowland's evidence at the inquest was that prison health staff now have the opportunity of being more proactive in determining if someone may have sleep apnoea, rather than the prisoner reporting what their problems might be.[66]

80 It was encouraging to hear of these improvements made by the Department with respect to the diagnosis and treatment of OSA within prisons. I agree with

[60] ts 6.7.21 (Dr Claxton), p.26
[6161] Exhibit 1, Volume 1, Tab 42, Health Services Supplementary Report into the Death in Custody dated April 2021
[62] ts 6.7.21 (Dr Rowland), p.87
[63] Exhibit 1, Volume 1, Tab 42, Health Services Supplementary Report into the Death in Custody dated April 2021, p.6
[64] ts 6.7.21 (Dr Rowland), p.78
[65] ts 6.7.21 (Dr Rowland), p.85
[66] ts 6.7.21 (Dr Rowland), p.87

Dr Rowland's evidence that the number of prisoners with OSA is likely to increase within the prison population, due to rising levels of obesity.[67]

81 I accept Dr Rowland's evidence that if somebody was presently in Mr Edgill's position within a prison environment, his OSA would be addressed in a better way.[68] It was also reassuring to hear Dr Rowland's evidence that she has not encountered a situation where a prisoner had been diagnosed with sleep apnoea and required a CPAP machine and the Department had not been able to get that prisoner a machine due to funding.[69]

Cardiac symptoms

82 There now exists an Admission Template for prison medical officers to use that has specific questions to be asked of new inmates, regarding symptoms of cardiac disease and a calculation of the prisoner's individual cardiovascular risk.[70] There are also questions as to whether they are under any specialists, and if they are waiting for any appointments with specialists. The purpose of such questions is to try and tease out this information from inmates who may not otherwise volunteer it without a specific inquiry.[71]

83 Education on cardiovascular risk and management is regularly provided to prison medical officers and a Chest Pain pathway has been developed and implemented for responding to presentations of chest pain.[72]

Immunisations

84 Prison nurses (provided they are qualified) can now give vaccinations without requiring a doctor's script. This procedure was introduced in 2019 and has increased efficiency during the immunisation process.[73]

85 When requesting medical details for an incoming prisoner from their treating GP, there is a specific item requesting the prisoner's immunisation history.[74] The

[67] ts 6.7.21 (Dr Rowland), p.85
[68] ts 6.7.21 (Dr Rowland), p.77
[69] ts 6.7.21 (Dr Rowland), p.108
[70] Exhibit 1, Volume 1, Tab 42, Health Services Supplementary Report into the Death in Custody dated April 2021, p.6
[71] ts 6.7.21 (Dr Rowland), p.76
[72] Exhibit 1, Volume 1, Tab 42, Health Services Supplementary Report into the Death in Custody dated April 2021, p.6
[73] ts 6.7.21 (Dr Rowland), p.111
[74] ts 6.7.21 (Dr Rowland), p.111

Doctor Admission template[75] and all the Department's Chronic Disease Care Plans now have prompts to review vaccination status and optimise opportunistic vaccination.[76]

Medical assessments for new inmates

86 Dr Rowland acknowledged that the policy existing at the time of Mr Edgill's death that required a medical assessment by a prison medical officer within 28 days of the prisoner's admission was "*unrealistic*".[77] A decision was then made to take away the target of 28 days and "*say that it was up to the nurse's discretion on reception whether or not they needed to see a doctor at all.*"[78] That led to some prisoners not even seeing a doctor. I am of the view that this policy (which existed for a year to 18 months) was entirely unsatisfactory. I note that Dr Rowland did not agree with it either.[79] Had this policy still existed at the time of the inquest, I would have certainly recommended that it be modified immediately.

87 However, changes have been made, and the current policy was introduced in May 2019. It stipulates that a comprehensive health assessment by a medical practitioner must be conducted within three months of reception.[80] However, the urgency of this assessment is determined by the nurse performing the initial health assessment (which must be undertaken within 24 hours of admission for adult prisoners).[81] The policy provides:[82]

> Patients with pre-existing conditions including any chronic diseases, or on medications or at high risk for chronic disease should be booked for review (Acute or Admission depending on appointment availability) within 7 days of arrival into prison.

88 Under the present policy, there would be an expectation that an incoming prisoner with Mr Edgill's comorbidities would be seen by a prison doctor within seven

[75] This template is used by prison medical officers when undertaking a new inmate's medical assessment.
[76] Exhibit 1, Volume 1, Tab 42, Health Services Supplementary Report into the Death in Custody dated April 2021, p.6
[77] ts 6.7.21 (Dr Rowland), p.99
[78] ts 6.7.21 (Dr Rowland), p.99
[79] ts 6.7.21 (Dr Rowland), p.99
[80] Exhibit 10, Department of Justice, Admission and Risk Assessment PM01 Policy and Procedure dated 31 May 2019, p.5
[81] Exhibit 10, Department of Justice, Admission and Risk Assessment PM01 Policy and Procedure dated 31 May 2019, p.8
[82] Exhibit 10, Department of Justice, Admission and Risk Assessment PM01 Policy and Procedure dated 31 May 2019, p.9

days, either through an Acute doctor consult (a 15 minute appointment booked to deal with urgent needs) or a full 30 minute Doctor Admission.[83]

My evaluation of the improvements made by the Department

89 I commend the changes that have made by the Department to its policies and procedures since Mr Edgill's death in May 2017. In light of the improvements, particularly in the diagnosing and treatment of OSA and the timeframes for medical assessments upon admission, I need not make any recommendations.

90 One additional matter that did arise from the evidence was the placement of Mr Edgill in a cell with a smoker at the time of his death. Although Mr Edgill did not complain about this, such a placement would have had obvious consequences for his asthma. The prevalence of smoking within prisons is a major issue, given that 80% of prisoners smoke[84] and the scarcity of single occupancy cells available to the mainstream prison population.

91 I have decided not to make any recommendations to the Department regarding this vexed issue as it was brought to my attention during the inquest that the Office of the Inspector of Custodial Services was already undertaking a comprehensive review of smoking in Western Australian prisons. It is anticipated that the Inspector's report will be available to the public in November 2021.

QUALITY OF SUPERVISION, TREATMENT AND CARE

92 With one exception, I am satisfied that Mr Edgill's health needs were adequately addressed on all the occasions he was imprisoned as an adult. As identified at the commencement of my finding, I placed particular emphasis on the treatment of his suspected OSA. Although the treatment of his OSA within the prison environment could have been better, to now be critical of what was done would to be to insert hindsight bias. I also accept Dr Rowland's observation in her report that:[85]

> Since August 2015[86] Mr Edgill spent a maximum of only 3 months in custody on any one occasion and the majority of his time was spent living in the community and accessing community services. Even if attempts had been made to refer/re-refer him to the sleep clinics and access CPAP machines there would not have been sufficient time for the

[83] Exhibit 10, Department of Justice, Admission and Risk Assessment PM01 Policy and Procedure dated 31 May 2019, p.8
[84] ts 6.7.21 (Dr Rowland), p.117
[85] Exhibit 1, Volume 1, Tab 42, Health Services Supplementary Report into the Death in Custody dated April 2021, p.7
[86] This should more accurately read since 2 September 2015 as this was the date Mr Edgill was released after he was imprisoned for 12 months.

> necessary assessments to occur, due to community waitlist length, before he was released back to the community.

93 I also accept Dr Rowland's comment that whilst the Department's health services aim for a very high standard of care, it "*is limited by resourcing and the challenging nature of providing intermittent care to a mobile population with poor health literacy who have limited or unreliable engagement with community services when they have the freedom to do so.*"[87]

94 Unfortunately, a review of Mr Edgill's engagement with community health services illustrates that observation made by Dr Rowland.

95 The one exception I have identified when finding that the Department's supervision, treatment, and care of Mr Edgill was adequate, involved the failure of the Department to have Mr Edgill seen by a prison medical officer for a medical assessment during his last two periods of incarceration. This failure was acknowledged by the Department and I am satisfied that compliance with the policy now in existence will ensure that a prisoner with similar extensive comorbidities would not be placed in the same predicament as Mr Edgill.

CONCLUSION

96 Mr Edgill was a relatively young man at the time of his death. He had been returned to prison just two weeks after his release for breaching his parole order conditions. He was less than five weeks away from his release date when he was found unresponsive on his bed by a cellmate on 7 May 2017.

97 Although this event was promptly responded to by prison officers, and resuscitation was quickly undertaken by prison officers and prison medical staff before he was admitted to AHC, all resuscitative efforts were unsuccessful. Mr Edgill was later found to have died from the combined effects of acute-on-chronic respiratory disease and cardiomegaly.

98 Mr Edgill died over four years ago. Since then, the Department has introduced changes which should not just have prisoners with suspected OSA receiving better treatment and care, but it should also assist other prisoners with serious health conditions.

[87] Exhibit 1, Volume 1, Tab 42, Health Services Supplementary Report into the Death in Custody dated April 2021, p.7

99 Although I have not made any recommendations, I will make the following observation. I have considerable empathy for the predicament that Dr Rowland, as Director of Medical Services with the Department, finds herself in. The barriers she identified in her report that impact upon the Department's ability to deliver optimal health care to patients within a custodial environment are immense. They include the necessity of having adequate staff numbers, with appropriate qualifications, to deal with the multitude of health problems that arise in the prison environment and the need to provide a competitive recruitment package to attract experienced doctors to fill the roles of prison medical officers.[88]

100 In 2020, a positive initiative was made to employ Indigenous health workers at prison health centres. However, any long-term gains that such an initiative was bound to achieve have been extinguished as no additional funding has been provided.[89]

101 The allocation of resources is obviously a matter for the Government. Nevertheless, I fear that unless the shortcomings arising from the lack of resources in the health care of prisoners identified by Dr Rowland are addressed, the missed opportunities that existed in the treatment of Mr Edgill will be repeated with other prisoners who have significant comorbidities.

102 As the tyranny of distance prevented Mr Edgill's family from attending the inquest, I convey my condolences to his partner and his four children for their loss.

PJ Urquhart
Coroner
6 September 2021

[88] Exhibit 1, Volume 1, Tab 42, Health Services Supplementary Report into the Death in Custody dated April 2021, p.7
[89] Exhibit 1, Volume 1, Tab 42, Health Services Supplementary Report into the Death in Custody dated April 2021, p.7