JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	10 AUGUST 2021
DELIVERED	**:**	5 JANUARY 2022
FILE NO/S	**:**	CORC 1560 of 2018
DECEASED	**:**	WELLS, TERRENCE ALEXANDER PENMAN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Sergeant A Becker assisted the Coroner
Ms M Hemsley (State Solicitor's Office) appeared on behalf of the Department of Justice (Corrective Services)

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 ***Terrence Alexander Penman WELLS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 10 August 2021, find that the death of* ***Terrence Alexander Penman WELLS*** *occurred on 12 December 2018 at Fiona Stanley Hospital, Murdoch, from metastatic oesophageal neuroendocrine carcinoma in the following circumstances:*

Contents

INTRODUCTION

1 The decreased (Mr Wells) died on 12 December 2018 at Fiona Stanley Hospital (FSH), Murdoch, from metastatic oesophageal neuroendocrine carcinoma. At the time of his death, Mr Wells was a sentenced prisoner in the custody of the Chief Executive Officer (CEO) 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 Wells 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 Wells' death at Perth on 10 August 2021. The following witnesses gave oral evidence at the inquest:

i. Toni Palmer (Senior Review Officer with the Department);

ii. Dr Joy Rowland (Director of Medical Services with the Department).

4 The documentary evidence at the inquest comprised of three volumes which were tendered as exhibit 1. An additional exhibit was tendered during the inquest (exhibit 2) and another exhibit was provided after the inquest, at my request, by the Department (exhibit 3).

5 The inquest focused on the medical care provided to Mr Wells while he was a prisoner, with an emphasis on the care provided to him after his oesophageal cancer was diagnosed in April 2018.

[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)

THE DECEASED

Background [4]

6 Mr Wells was born on 9 November 1957 at King Edward Hospital, Subiaco and was 61 years of age when he died. He was the eldest of three children.

7 Mr Wells had a transient childhood and he attended numerous primary schools until he was placed in foster care when he was 14 years old. He remained there for several months, before returning to the family home when his father separated from his mother. He left school before he completed Year 10 to obtain full-time employment in order to financially assist his mother.

8 Mr Wells did not obtain any formal qualifications; however, he was employed in various manual jobs; including furniture removals, roof plumbing, railway labouring, carpet laying, cycle repairs and rubbish collecting. His last employment was as a tow-truck driver, a position he held for about eight years.

9 Mr Wells married his first wife in 1975 and they had two sons together. That marriage ended in 1980 when he was imprisoned. He remarried in 1987.

Offending history [5]

10 Mr Wells began offending as a 14-year-old and he had a number of convictions for dishonesty in the Children's Court.

11 In May 1980, he was sentenced to 6 ½ years' imprisonment for breaking into the house of a 17-year-old girl in the early hours of 26 January 1980. The girl was in bed, and she resisted when Mr Wells began making unwelcomed sexual advances towards her. He produced a knife and threatened her and when she

[4] Pre-Sentence Report for Mr Wells dated 21 January 2005; Exhibit 1, Volume 1, Tab 11, File Note by Senior Constable Peter Smith dated 10 March 2019; Exhibit 1, Volume 3, Tab B, Death in Custody Report dated 23 January 2020
[5] Exhibit 1, Volume 3, Tab B, Death in Custody Report dated 23 January 2020; Exhibit 1, Volume 1, Tab 17, Court History for Mr Wells; Pre-Sentence Report for Mr Wells dated 21 January 2005

called out. Mr Wells then punched her before leaving. This was his only term of imprisonment before his final one.

Circumstances of final imprisonment [6]

12 On 10 February 2005 in the Perth Supreme Court of Western Australia, Mr Wells pleaded guilty to the wilful murder of an 18-year-old woman.

13 The victim of this offence was the partner of a young man that Mr Wells had befriended. After this friend had complained to Mr Wells about the behaviour of the victim, Mr Wells strangled her with a piece of rope on or about 2 February 2004. Her body was then wrapped in a sheet and disposed of in North Dandalup, where it remained until found by police on 26 May 2004.

14 Mr Wells was sentenced to strict security life imprisonment, with a non-parole period of 23 years. His earliest date for release on parole was 2 June 2027.

Prison history [7]

15 Mr Well had the following prison placements and transfers for this offence:

a. Hakea Prison: 4 June 2004 – 25 June 2005 (386 days)
b. Casuarina Prison: 25 June – 28 June 2005 (3 days)
c. Hakea Prison: 28 June 2005 – 26 October 2006 (485 days)
d. Acacia Prison: 26 October 2006 – 28 June 2015 (3,197 days)
e. Bunbury Regional Prison: 28 July 2015 – 23 April 2018 (1,000 days)
f. Casuarina Prison: 23 April 2018 – 29 May 2018 (36 days)
g. Bunbury Regional Prison: 29 May 2018 – 13 November 2018 (168 days)
h. Casuarina Prison: 13 November 2018 – 12 December 2018 (29 days)

[6] Pre-Sentence Report for Mr Wells dated 21 January 2005; Exhibit 1, Volume 1, Tab 20, Supreme Court sentencing transcript dated 10 February 2005; Exhibit 1, Volume 3, Tab B, Death in Custody Report dated 23 January 2020
[7] Exhibit 1, Volume 3, Tab B, Death in Custody Report dated 23 January 2020

16 Throughout his 14 years of incarceration, Mr Wells was reported to be a likeable prisoner, who kept his cell clean and his personal hygiene to a high standard. He was known to be a hard worker who consistently interacted well with prison staff and other prisoners. He was never a management issue and was not the subject of any formal prison charges or loss of privileges. He had regular visits from family and friends, alongside frequent telephone contact and writing letters to them.

OVERVIEW OF MR WELLS' MEDICAL CONDITIONS AND TREATMENT IN PRISON AND IN HOSPITAL [8]

From June 2004 to January 2018

17 On admission to Hakea Prison on 4 June 2004, Mr Wells was assessed by a nurse and then, on the following day, by a doctor. He reported a past medical history of ulcers and chronic lower back pain. Mr Wells also said he was not taking any regular medications and he denied any substance abuse issues or thoughts of self-harm. A lump on his testicle was thought to be a sebaceous cyst for which he was prescribed antibiotics.

18 On 11 June 2004, he was seen by the prison's counselling service and was assessed as not being at risk of self-harm or suicide. He received a Hepatitis-B shot and sought medical attention for minor ailments.

19 On 21 June 2005, Mr Wells complained of chest pain to a prison nurse and an electrocardiogram (ECG) was found to be abnormal. He was transferred by ambulance to Fremantle Hospital, where he was diagnosed with an inferior myocardial infarction (heart attack). He was discharged from hospital on

[8] Exhibit 1, Volume 1, Tab 21, Health Services Summary into the Death in Custody dated June 2021; Department of Corrective Services' EcHO records for Mr Wells; Fiona Stanley medical records

25 June 2005, and he was commenced on medical management for ischaemic heart disease.

20 On 12 July 2005, a prison doctor diagnosed Mr Wells with Type 2 diabetes. For the balance of his imprisonment there were periods when Mr Wells had very poor blood sugar control. However, this was largely due to his resistance for a long period to have insulin injections.

21 Mr Wells was also a regular smoker and he was frequently advised to quit smoking by prison health service providers. He was occasionally able to quit smoking during his term of imprisonment; however, never permanently.

22 On 8 December 2011, Mr Wells was diagnosed with bi-lateral sensorineural hearing loss and tinnitus. Hearing aids were discussed as an option.

23 At an annual health screen on 17 September 2014, Mr Wells stated he was managing prison life well and was happy with how his current health problems were being managed. Although his blood sugar control from his diabetes was not being effectively controlled by tablets, he continued to refuse insulin injections.

24 Late in September 2016, after continuing poor blood sugar control, Mr Wells agreed to commence insulin injections to better manage his diabetes.

25 On 10 July 2017, Mr Wells complained of dental pain to a prison nurse. On 25 July 2017 he was seen by a dentist who diagnosed generalised severe periodontitis (severe gum infection). It was arranged that his remaining upper teeth were to be extracted and this process began on 22 August 2017, with no complications.

26 As part of a continuing dental plan, all of Mr Wells' remaining teeth were extracted on 3 and 17 October 2017. Mr Wells was placed on a waiting list for dentures to be made.

27 On 26 November 2017, the process of supplying Mr Wells with hearing aids was commenced. On 8 January 2018, a referral was made to Australian Hearing for a hearing aid.

Events leading to the diagnosis of oesophageal cancer [9]

28 On 2 April 2018, Mr Wells complained to a prison nurse of gastric (upper abdomen) discomfort over the past week when he was eating and drinking. He reported to the nurse that he had not been eating well as he did not have any teeth and was awaiting dentures.[10] The nurse recorded that Mr Wells was already on the antacid medication, pantoprazole, and that he was to be reviewed once he could eat more effectively. It was noted "*for review if symptoms continue*".

29 On 11 April 2018, Mr Wells saw a prison nurse after returning from work duties early due to back pain. He also had an issue with his eyes, which he thought may be due to his eating problems and low blood sugar levels. Mr Wells told the nurse he was unable to eat solid food as it was making him vomit and he still had no teeth. He stated it felt like he had a knot in his stomach.

30 Mr Wells' back pain had already been addressed by a prison doctor at an earlier appointment and he had been commenced on pregabalin, a medication for neuropathic pain. The nurse forwarded a high-priority task for the prison doctor to review Mr Wells' abdominal pain.

[9] Department of Corrective Services' EcHO records for Mr Wells; Fiona Stanley Hospital medical records
[10] On 23 January 2018, a dentist made preliminary impressions for dentures for Mr Wells and on 6 March 2018, final impressions were taken

31 On 13 April 2013, Mr Wells was reviewed by a prison doctor. He reported a five week history of difficulty swallowing and a feeling of things being blocked. He stated that the symptoms were getting worse and he was having difficulty if he drank too fast. His weight had dropped from 85 kg to 77.5 kg. Although an examination of his abdomen was normal, the prison doctor spoke with the surgical registrar at Bunbury Regional Hospital (BRH), who agreed to review Mr Wells the following day. A liquid nutritional supplement was charted and Mr Wells was advised that his symptoms may be due to something serious. The prison doctor recorded that the diagnosis may possibly be cancer of the oesophagus.

32 As planned, Mr Wells was admitted to BRH on 14 April 2018 where he was seen in the emergency department. A computerised tomography (CT) scan revealed a distal (i.e. closer to stomach) oesophageal malignancy with extensive lymph nodes and multiple liver metastases. The tumour was also seen on a gastroscopy and biopsies were taken. A nasogastric and central line were inserted for feeding and Mr Wells was transferred to FSH.

33 Results of the biopsies were, "*Neuroendocrine carcinoma (NEC) large cell type, grade 3; Ki - 67 proliferation index 58%"*.

34 At FSH, a stent was placed into Mr Wells' oesophagus to allow food to enter his stomach and pass the blockage caused by the cancer. At a multidisciplinary meeting, the medical team discussed Mr Wells' case and it was noted that the stent and chemotherapy (with possible radiotherapy) were for palliation and not aimed at a cure, due to the cancer's progression. Chemotherapy was to commence at BRH when Mr Wells returned to Bunbury Regional Prison. He was also referred to an oncologist in Bunbury.

35 On 25 April 2018, Mr Wells was discharged to Casuarina Prison where he was reviewed by a doctor on the following day. Mr Wells was reported to be unaware of the extent of his cancer. On 1 May 2018, he was added to the Department's Terminally Ill List because of his oesophageal cancer and was classified at Stage 3. He was reviewed twice-daily by prison nursing staff, and the prison doctor as required.

36 Nursing records noted that it was Mr Wells' preference to return to Bunbury Regional Prison as his partner and friends were lived nearby. He was subsequently transferred to that prison on 29 May 2018.

37 On 14 June 2018, Mr Wells had an appointment with an oncologist at BRH where he was advised that he had a high grade tumour and that such tumours tended to be aggressive. Mr Wells was keen to commence chemotherapy and a regime of carboplatin and etoposide was recommended. Mr Wells was advised by the oncologist that it was unlikely he would survive the nine years before his scheduled release from prison. Mr Wells' chemotherapy treatment began on 18 June 2018.

38 On 1 July 2018, Mr Wells collapsed while getting up to go to the toilet during the night. He was taken to BRH and was diagnosed with pancytopenia (low amount of red and white blood cells and platelets) due to his chemotherapy treatment. Mr Wells was given a blood transfusion and discharged from hospital on 2 July 2018. The prison doctor subsequently recommended weekly blood tests to monitor Mr Wells' blood count while he was receiving chemotherapy.

39 On 23 July 2018, Mr Wells was again admitted to BRH as he was anaemic, with a haemoglobin of 76 g/L. He was given another blood transfusion and was discharged the following day. Again, the anaemia was noted to be caused by the

chemotherapy treatment. BRH's discharge summary noted that Mr Wells declined to be relocated to Perth.

40 On 31 July 2018, Mr Wells' dentures were inserted by the prison dentist.

41 On 1 August 2018, Mr Wells had another appointment with the oncologist. A plan was made for him to proceed with his third cycle of chemotherapy, with a review to be conducted after three weeks. At his next appointment with the oncologist on 22 August 2018, it was noted he was tolerating the chemotherapy well, had put on weight and his swallowing had improved. His fourth round of chemotherapy was then scheduled, with imaging to take place after that.

42 On 4 September 2018, Mr Wells attended the prison medical centre complaining of fatigue and not feeling well. The prison nurses decided he should be taken to the emergency department at BRH. Mr Wells was subsequently diagnosed with neutropenic sepsis (a serious infection due to a low white blood cell count) and was commenced on antibiotics for pneumonia. He required a blood transfusion for his anaemia. Mr Wells remained at BRH until 9 September 2018.

43 On 10 October 2018, Mr Wells had another scheduled appointment with the oncologist. A CT scan had shown improvement of his cancer. His last cycle of chemotherapy was to be given that day, with a follow up scan and review planned for six weeks' time.

44 On 27 October 2018, Mr Wells complained of dizziness, headache and tiredness. Following an e-consult with a doctor, he was taken to BRH where he was diagnosed as being anaemic with a haemoglobin of 76 g/L. He was given a blood transfusion and returned to prison that same day.

45 From 4 - 6 November 2018, Mr Wells presented to prison nursing staff and then the prison doctor for back pain and increased difficulty in swallowing. The prison doctor commenced a treatment with anti-fungal for oral thrush.

46 On 9 November 2018, a CT scan showed that the cancer had progressed. There was an enlargement of the oesophageal tumour into Mr Wells' stomach and the previously placed stent. There was also an enlargement of the mediastinal and upper abdominal lymph nodes. A new nodule on the surface of Mr Wells' spleen and an enlargement of the liver metastases were also seen.

47 Over the following days, prison nursing notes recorded increasing concerns about Mr Wells' deteriorating health. A liquid diet was obtained from the prison kitchen, along with icy poles, to assist with his fluid intake.

EVENTS LEADING TO MR WELLS' DEATH [11]

48 On 12 November 2018, Mr Wells was admitted to the emergency department of BRH. The following day, he was transferred to FSH where dehydration secondary to dysphagia was diagnosed. A smaller stent was inserted and investigations revealed the growth of the primary tumour as well as metastatic lesions. He was discharged from FSH to Casuarina Prison on 16 November 2018.

49 On 17 November 2018, Mr Wells was taken back to the emergency department of FSH as there were insufficient medications provided by the hospital for the prison medical centre to treat him over the weekend. He was returned to Casuarina Prison that day.

50 On 18 November 2018, a prison nurse prepared a referral to the Metropolitan Palliative Care Consultancy Service. At a prison doctor review on

[11] Exhibit 1, Volume 1, Tab 21, Health Services Summary into the Death in Custody dated June 2020; Bunbury Regional Hospital medical records; Fiona Stanley Hospital medical records

19 November 2018, Mr Wells stated that he was eager to return to Bunbury Regional Prison. However, due to his very frail state, a decision was made that he was to remain at Casuarina Prison in order to assess his ability to manage daily activities.

51 On 21 November 2018, Mr Wells was reviewed by the Metropolitan Palliative Care Consultancy Service. Mr Wells was provided with advice about analgesia and it was recommended that a further CT scan of Mr Wells' back and head should be performed, together with testing of his cognitive ability, as he had seemed confused during the review. He was also requiring assistance with mobility and was using a wheelchair for longer distances. Blood tests on the same day showed an increased white cell count, indicating an infection. On the following day, Mr Wells was reviewed by the prison doctor who could find no obvious source of the infection and Mr Wells was commenced on antibiotics for a week.

52 On 30 November 2018, Mr Wells complained of back pain to the prison doctor. The following day, when that pain couldn't be controlled, he was referred to the emergency department of FSH for pain management. He was returned to prison later that day. A prison nurse noted that Mr Wells was pale, confused and still in pain.

53 On 2 December 2018, Mr Wells was taken to the emergency department of FSH. He was admitted under the acute medical team and changes were made to his analgesia regime. On 5 December 2018, there was a MET (medical emergency team call) as Mr Wells had low blood pressure. Although his blood pressure responded to fluid resuscitation, it was noted that he was not for further MET calls or resuscitation in the event of deterioration. It was initially planned for Mr Wells to return to Casuarina Prison; however, it became apparent that the prison medical services would be unable to accommodate his care needs. There

was also some confusion about a transfer to Bethesda Hospice. It was noted that a referral to this hospice had not actually been completed and therefore a bed was not available. As a result, Mr Wells remained at FSH.

54 On 10 December 2018, Mr Wells was upgraded to Stage 4 on the Department's Terminally Ill List, after a discussion with his treating doctors at FSH.

55 The hospital palliative care team then held discussions with Mr Wells and his family, including his partner who had attended FSH to see him. It was explained that Mr Wells had advanced cancer and all treatment options had been exhausted. Consent was obtained from the Department for the removal of Mr Wells' restraints. Palliative care was provided, including a subcutaneous syringe driver. Mr Wells died at 2.35 am on 12 December 2018.[12]

CAUSE AND MANNER OF DEATH [13]

56 A forensic pathologist (Dr Dan Moss) conducted an external post mortem examination of Mr Wells' body on 19 December 2018. Dr Moss was of the view that an examination of the FSH medical records would allow a cause of death to be given without a full internal post mortem examination.

57 An external post mortem examination revealed that Mr Wells had low body weight and evidence of palliative medical care. A toxicological analysis showed the presence of prescribed type medications, including morphine, in keeping with the palliative medical care provided to Mr Wells.

58 At the conclusion of the external post mortem examination, and after reviewing the results of the toxicological analysis, Dr Moss expressed the opinion that the

[12] Fiona Stanley Hospital Death in Hospital Form signed by Dr Andrew Chen
[13] Exhibit 1, Volume 1, Tab 7A and 7B Supplementary Post Mortem Report by Dr Moss dated 19 December 2018; Forensic Consultation Post Mortem Report by Dr Moss dated 19 December 2018; Toxicology Report dated 7 February 2019

cause of Mr Wells' death was metastatic oesophageal neuroendocrine carcinoma.

59 I accept and adopt that conclusion expressed by Dr Moss and I find that Mr Wells' death occurred by way of natural causes.

What are neuroendocrine and oesophageal cancers?

60 Neuroendocrine cancers are tumours that begin in specialised cells called neuroendocrine cells. These cells have traits similar to nerve and hormone-producing cells. They can occur at many sites within the body, most commonly in the lungs, appendix, small bowel, rectum and pancreas. Some neuroendocrine cancers produce excess hormones which can cause symptoms such as skin flushing, diarrhoea and skin rashes. Other symptoms may be related to the physical size and location of the growing cancer. Neuroendocrine tumours can be slow growing or aggressive, with rapid growth. They are a relatively rare form of cancer.

61 Some neuroendocrine tumours are associated with inherited genetic syndromes. Treatment depends on the location, stage and type of neuroendocrine tumour.

62 Symptoms of oesophageal cancers can include difficultly swallowing, vomiting, loss of appetite and weight loss, hoarseness and blood loss. Oesophageal cancers often present late with advanced disease at the time of diagnosis.

63 Most oesophageal cancers are either squamous cell carcinomas or adenocarcinomas. Risk factors for developing these cancers include alcohol and/or tobacco use and chronic irritation or inflammation of the oesophagus.

ISSUES RAISED BY THE EVIDENCE

11 January 2018: Report by Mr Wells of ongoing neck issues [14]

64 On 11 January 2018, Mr Wells saw a prison nurse. He complained of "*on-going neck issues*", when lying on his side in bed at night. He said that he would roll from side to side to relieve the symptoms. He also reported that the "*problem is not new but the symptoms are more frequent*". Upon examination by the nurse there was normal movement, colour, warmth and sensation of Mr Wells' neck. The matter was tasked for a prison doctor review.

65 It is accepted by the Department that, with the benefit of hindsight, it is possible that the problems Mr Wells had in January 2018 were symptoms of the oesophageal cancer.

66 Dr Joy Rowland, Director of Health Services for the Department, was of the view that it was reasonable for Mr Wells not to be sent for cancer testing in January 2018. Her explanation for this opinion was:[15]

> I think if you look at each of those incidents, he was presenting with different symptoms over that period of time … each of which he related to either a previous problem he had had the same as or an explanation which was very reasonable to be accepted at face value. There was no sign that he was repeatedly presenting with any symptoms that were ignored or that were not reasonable at the time, and this is just the nature of oesophageal cancer is that it can be very subtle and slow in its onset and if patients are confident about what's causing their symptoms, staff are inclined to accept the patient's word because they know their body best.

67 The first presentation of Mr Wells with symptoms specific to swallowing was on 2 April 2018. However, he blamed this on his absence of teeth and so a dental review was arranged. When Mr Wells indicated that these symptoms had worsened on 11 April 2018, where he reported that he was unable to eat, he was referred by the nurse to the prison doctor. When he saw the prison doctor two

[14] Exhibit 1, Volume 1, Tab 21, Health Services Summary into the Death in Custody dated June 2021
[15] ts 10.8.21 (Dr Rowland), p.18

days later, on 13 April 2018, an arrangement was immediately made for an emergency review at BRH the next day.

68 Given all the circumstances, and being careful not to insert hindsight bias, I am satisfied that the Department did not fail in its duty of care by the fact Mr Wells' oesophageal cancer was not picked up in January 2018. I accept the explanations provided by Dr Rowland and I note the speed with which Mr Wells was taken to BRH once he reported his worsening difficulty in swallowing in April 2018.

Medication error [16]

69 On 10 August 2018, a prison doctor noted that a medication error had occurred on 20 June 2018 when Mr Wells was given two different types of cholesterol lowering medications in his prison medication pack for a six-week period. One of those medications was ceased and a blood test to check muscle breakdown (creatinine kinase) was ordered.

70 This error was not reported as a clinical incident and it was therefore not investigated. An investigation was only undertaken in March 2021, which identified multiple contributing factors, mostly around non-compliance with the Department's Health Services Policies and Procedures.

71 Although this incident was unlikely to have impacted upon Mr Wells' overall outcome, the Department accepted it may have possibly been a contributary factor to his hospital admission on 1 July 2018.[17]

72 The Department's investigation in March 2021 led to improvements being made to its EcHo medical records. To avoid prison doctors having too many individual patient records open at the same time, the settings on the EcHo

[16] Exhibit 1, Volume 1, Tab 21, Health Services Summary into the Death in Custody dated June 2021
[17] ts 10.8.21 (Dr Rowland), p.16

electronic medical record have been modified to limit the number of individual patient records that can be opened at any one time to just two.

73 I am satisfied that these recent changes will significantly reduce a prison doctor inadvertently allocating drugs to the wrong prisoner in the way that it apparently occurred when Mr Wells was allocated an incorrect medication.

Royal Prerogative of Mercy not considered by the Department

74 As already noted, Mr Wells was classified at Stage 3 of the Department's Terminal Ill List on 1 May 2018. On 10 December 2018, two days before his death, that was upgraded to Stage 4.

75 The relevance of these notifications is that a prisoner who has reached Stages 3 or 4 can be considered for release by the Governor on compassionate grounds. The Department had a policy and procedure in place at the time of Mr Wells' classifications governing what was to occur in these circumstances (the Policy).[18]

76 A terminally ill prisoner is classified at Stage 3 if the Department's Director of Health Services is of the opinion that the prisoner, "*is likely to die within three months*" and/or "*has one or more medical conditions which may increase the potential for sudden death*".[19] A terminally-ill prisoner is to be classified as Stage 4 if the prisoner's death is imminent.[20]

77 The Policy requires certain tasks to be undertaken once a prisoner is classified as Stage 3. One of those is that the Manager, Sentence Management (or their delegate) shall, within seven working days of the notification of the classification, "*prepare a briefing note for the Minister for Corrective Services*

[18] Exhibit 2, Policy Directive 8 – Prisoners with a Terminal Medical Condition – Procedures dated 8 December 2014
[19] Exhibit 2, Policy Directive 8 – Prisoners with a Terminal Medical Condition – Procedures dated 8 December 2014, p.3
[20] Exhibit 2, Policy Directive 8 – Prisoners with a Terminal Medical Condition – Procedures dated 8 December 2014, p.5

which notifies the Minister of the prisoner's medical situation and life expectancy, the likelihood of the prisoner dying in custody and any other relevant information".[21]

78 A similar briefing note is to be prepared when a prisoner is classified as being at Stage 4.[22] These briefing notes commence the process for the exercise of the Royal Prerogative of Mercy which allows a prisoner to be released on compassionate grounds before the expiration of their term of imprisonment.

79 Unfortunately, a briefing note was not prepared for Mr Wells when he was classified at Stage 3 or at Stage 4. Ms Toni Palmer, the Senior Review Officer at the Department, was able to provide an explanation for this oversight at the inquest. At the time the Department of Corrective Services became part of the Department of Justice, Department employees were permitted to apply for redundancy. As Ms Palmer explained:[23]

> The person that was responsible and in the role that did the briefing note for the RPOM[24] process took redundancy and the position, therefore, became vacant, and under the rules at the time once the person went, the position went as well. So there was nobody. The role didn't move to somebody else.

80 This unsatisfactory position remained for about 18 months.[25] Ms Palmer was able to assure the court that a person was definitely occupying this role now. However, about seven or eight prisoners (including Mr Wells) who were classified at either Stage 3 or Stage 4 during that 18 month hiatus were effected.[26]

81 I was troubled to hear this. Although a prisoner who has been classified as a Stage 3 or Stage 4 terminally-ill prisoner (and/or their family) may write to the

[21] Exhibit 2, Policy Directive 8 – Prisoners with a Terminal Medical Condition – Procedures dated 8 December 2014, p.4
[22] Exhibit 2, Policy Directive 8 – Prisoners with a Terminal Medical Condition – Procedures dated 8 December 2014, p.5
[23] ts 10.8.21 (Palmer), p.10
[24] Acronym for Royal Prerogative of Mercy
[25] ts 10.8.21 (Palmer), p.11
[26] ts 10.8.21 (Palmer), p.11

Minister and request a Royal Prerogative of Mercy,[27] there is always a very real possibility that the prisoner, or their family, may not be aware of this process. In those circumstances, the procedure that the Department has for the preparation of the briefing note becomes very relevant.

82 Although I accept that a Royal Prerogative of Mercy is very rarely granted,[28] and it was very unlikely Mr Wells would have received one given he still had nine years to serve before being eligible for parole, he was nevertheless deprived of the opportunity of being considered for release into the community before his death. It is my view that the Department ought to have ensured there was an employee responsible for preparing these briefing notes a lot earlier than the roughly 18 months that it took.

QUALITY OF THE DEPARTMENT'S SUPERVISION, TREATMENT AND CARE

83 Having carefully assessed the documents tendered into evidence and the evidence of Dr Rowland at the inquest, I am satisfied that Mr Wells' various medical conditions, including his oesophageal neuroendocrine carcinoma, were appropriately managed and the standard of supervision, treatment and care he received whilst he was in custody (including when he was hospitalised), was appropriate. I agree with the following assessment made by the Department:[29]

> Mr Wells had comprehensive multidisciplinary care for many years, including diabetes and cardiovascular care plan visits, screening, prevention, lifestyle advice and management of existing conditions to therapeutic goals in discussion with the patient.
>
> Mr Wells was a smoker with multiple documented attempts and temporary success in quitting. He was provided with many instances of education and advice about quitting during his period of incarceration.

[27] ts 10.8.21 (Palmer), pp.11-12
[28] Ms Palmer was unaware of any prisoner receiving a Royal Prerogative of Mercy: ts 10.8.21 (Palmer), p.13
[29] Exhibit 1, Volume 1, Tab 21, Health Services Summary into the Death in Custody dated June 2021, p.22

> His diagnosis of oesophageal cancer was made quickly once he reported specific symptoms and he was immediately transferred for specialist care and received full treatment thereafter.

84 On the available evidence before me, the only deficiency in the Department's care of Mr Wells was its oversight in not preparing a briefing note to the Minister for Corrective Services when he was classified at Stage 3 of the Department's Terminally Ill List.[30] Had it done so, the process for a Royal Prerogative of Mercy for Mr Wells would have been commenced. That should have occurred, notwithstanding the low prospect of Mr Wells being released from prison before his death.

CONCLUSION

85 Although convicted of a heinous crime committed in February 2004, throughout the 14 years he was imprisoned, Mr Wells always maintained a high level of behaviour and work ethic. He was promoted to an earned work supervision level and he had a good rapport with prison staff and prisoners alike. He was never recorded as a management issue and he was, by all accounts, an exemplary prisoner. His prison work history included periods of employment as a cleaner, vegetable processing, general worker, small motors general worker, grounds leading hand and maintenance worker.[31] He often had contact with family and friends via the telephone and had regular social visits and letter correspondence.[32]

86 Unfortunately, Mr Wells developed a rapidly progressing oesophageal cancer that was diagnosed in April 2018. Although he was quickly taken to hospital once he advised prison health staff of his difficultly in swallowing (a known

[30] I do not make the same observation with respect to the Department's failure to prepare a briefing note after Mr Wells was classified at Stage 4, as this classification only occurred two days before his death.
[31] Exhibit 1, Volume 3, Tab B, Death in Custody Report dated 23 January 2020, p.9
[32] Exhibit 1, Volume 3, Tab B, Death in Custody Report dated 23 January 2020, p.9

symptom of oesophageal cancer),[33] it was too advanced for him to be cured and he died on 12 December 2018.

87 I am satisfied that the medical care and treatment provided by the Department to Mr Wells in the eight months before he died, and by the hospitals that cared for him during this period, were of the same standard that a person living in the general community would expect to receive. Accordingly, I have found that the medical care and treatment Mr Wells received from the Department was appropriate.

88 I convey my condolences to Mr Wells' partner and his family for their loss.

PJ Urquhart
Coroner
5 January 2022

[33] ts 10.8.21 (Dr Rowland), p.19