JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA

ACT : CORONERS ACT 1996

CORONER : MICHAEL ANDREW GLIDDON JENKIN, CORONER

HEARD : 4 APRIL 2024

DELIVERED : 10 APRIL 2024

FILE NO/S : CORC 1608 of 2022

DECEASED : RATCLIFF, ALAN DAVID

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Prisons Act 1981 (WA)

Counsel Appearing:

Acting Sergeant C Robertson assisted the coroner.

Ms N Worthy (State Solicitor's Office) appeared for the Department of Justice.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of **Alan David RATCLIFF** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 4 April 2024, find that the identity of the deceased person was **Alan David RATCLIFF** and that death occurred on 20 June 2022 at Sir Charles Gairdner Hospital, Hospital Avenue, Nedlands, from complications of intracranial haemorrhage, with terminal palliative care in the following circumstances:*

Table of Contents

INTRODUCTION **3**
MR RATCLIFF **4**
Background and medical history 4
Offending history 4
MANAGEMENT IN PRISON **5**
Supervision issues 5
Management of medical issues 5
Mr Ratcliff's collapse on 12 June 2022 7
The terminally ill register 9
CAUSE AND MANNER OF DEATH **10**
QUALITY OF SUPERVISION, TREATMENT AND CARE **11**
CONCLUSION **12**

INTRODUCTION

1. Alan David Ratcliff (Mr Ratcliff) died on 20 June 2022 at Sir Charles Gairdner Hospital from complications of an intracranial haemorrhage.[1,2,3,4,5,6,7] At the time of his death, Mr Ratcliff was a sentenced prisoner at Acacia Prison (Acacia) and thereby in the custody of the Chief Executive Officer of the Department of Justice (the Department).[8]

2. Accordingly, immediately before his death, Mr Ratcliff was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[9] In such circumstances, a coronial inquest is mandatory,[10] and where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[11]

3. I held an inquest into Mr Ratcliff's death at Perth on 4 April 2024, which focused on the care, treatment and supervision provided to Mr Ratcliff while he was in custody, as well as the circumstances of his death.

4. The documentary evidence adduced at the inquest comprised one volume and included separate reviews by the Department of both Mr Ratcliff's management in custody, and health care he received while incarcerated.

5. The following witnesses gave evidence at the inquest:

a. Dr Catherine Gunson, (Acting Director Medical Services, DOJ);[12,13] and
b. Ms Toni Palmer, (Senior Review Officer, DOJ).[14]

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[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (29.03.23)
[2] Exhibit 1, Vol. 1, Tab 4, Death in Hospital form (20.06.22)
[3] Exhibit 1, Vol. 1, Tab 5.1, P92 - Identification of deceased person other than by visual means (23.06.22)
[4] Exhibit 1, Vol. 1, Tab 5.2, Affidavit - Sen. Const. C Heinz (22.06.22)
[5] Exhibit 1, Vol. 1, Tab 5.3, Affidavit - Sen. Const. W Pugh (23.06.22)
[6] Exhibit 1, Vol. 1, Tab 5.4, Coronial Identification Report (23.06.22)
[7] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (14.03.23)
[8] Section 16, *Prisons Act 1981* (WA)
[9] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[10] Section 22(1)(a), *Coroners Act 1996* (WA)
[11] Section 25(3) *Coroners Act 1996* (WA)
[12] Exhibit 1, Vol. 1, Tab 15.1, Acacia Health Services Review (21.06.22)
[13] Exhibit 1, Vol. 1, Tab 15.2, Dept. of Justice Health Services Review (07.03.24) and ts 04.04.24 (Gunson), pp4-11
[14] Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24) and ts 04.04.24 (Palmer), pp15-19

MR RATCLIFF

Background and medical history[15,16,17]

6. Mr Ratcliff had what was described as "*an unhappy childhood*" and after leaving school in Year 8 he is said to have served in the Australian Army for three years, and to have worked intermittently in the mining and construction sectors.[18] Mr Ratcliff is known to have had a son from a previous relationship, and more recently was said to have been in a relationship with a woman who lived in Malaysia.

7. Mr Ratcliff's medical history included high blood pressure, high cholesterol, asthma, and migraines with sensory disturbances (aura). When Mr Ratcliff was remanded in custody at Eastern Goldfields Regional Prison (EGRP) on 21 March 2021, he told the reception officer he had a heart murmur, arthritis, and asthma for which he was prescribed medication. Mr Ratcliff also disclosed he was a smoker, and records showed he had a history of alcohol misuse.

Offending history[19,20,21,22,23]

8. Mr Ratcliff had an extensive criminal record with convictions in Tasmania, New South Wales, Northern Territory, South Australia, Queensland and Western Australia. Mr Ratcliff's criminal history included periods of imprisonment for various offences including sexual penetration of a child, and indecent dealings with a child.

9. On 2 November 2021, Mr Ratcliff was imprisoned for 15-months by the Magistrates Court at Perth. On 12 November 2021, Mr Ratcliff was made the subject of a high risk and serious offender interim detention order by the Supreme Court of Western Australia (Supreme Court). The effect of that order was that Mr Ratcliff was not to be released until further direction from the Supreme Court.

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[15] Exhibit 1, Vol. 1, Tab 2, Investigation report - Det. Sgt. J Binder (29.03.23), p4
[16] Exhibit 1, Vol. 1, Tab 15.1, Acacia Health Services Review (21.06.22) and ts 04.04.24 (Gunson), pp6-7
[17] Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24), p7
[18] Exhibit 1, Vol. 1, Tab 17, Sentencing submissions, District Court of Western Australia (24.03.20), p13
[19] Exhibit 1, Vol. 1, Tab 2, Investigation report - Det. Sgt. J Binder (29.03.23), p3
[20] Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24), p7
[21] Exhibit 1, Vol. 1, Tab 16.3, Criminal Histories: New South Wales, Northern Territory, Tasmania, South Australia & Queensland
[22] Exhibit 1, Vol. 1, Tab 16.4, History for Court - Traffic and Criminal (Western Australia)
[23] Exhibit 1, Vol. 1, Tab 16.5, Sentence Summary - Offender

MANAGEMENT IN PRISON

Supervision issues[24]

10. On 24 March 2021, Mr Ratcliff was transferred from EGRP, where he had been incarcerated for three days, to Hakea Prison (Hakea). He remained at Hakea for 366 days, and on 25 March 2022, Mr Ratcliff was transferred to Acacia Prison (Acacia), where he remained until his death (87 days).

11. Mr Ratcliff was assessed as requiring a lower bunk because of hip, knee and shoulder issues, and it was noted that he had requested that his family not visit him in prison due to concerns relating to the COVID-19 pandemic. Mr Ratcliff's security rating was "*medium*" and he was scheduled for transfer to Acacia under an individual management plan.[25]

12. At the time of his death, Mr Ratcliff was the subject of several alerts on TOMS[26] relating to his offending behaviour. He received a number of official visits between March 2021 and June 2022, and sent 32 items of mail during that period.[27,28] Mr Ratcliff was the subject of one random substance use test which was negative, and his work history shows he was employed as a unit worker on various occasions.[29,30]

Management of medical issues[31,32,33,34,35]

13. Whilst Mr Ratcliff was at Hakea, he was seen in the prison medical centre and received treatment for various minor ailments. He also underwent an electrocardiogram to investigate his heart murmur. On 20 May 2021, Mr Ratcliff was examined by an optometrist after he complained of double vision.

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[24] Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24), pp4-13
[25] Exhibit 1, Vol. 1, Tab 16.9, Management and placement plan (21.12.21)
[26] Total Offender Management Solution, the computer system the Department uses for prisoner management
[27] Exhibit 1, Vol. 1, Tab 16.26, Alert history - Offender
[28] Exhibit 1, Vol. 1, Tab 16.27, Prisoner mail and visits history
[29] Exhibit 1, Vol. 1, Tab 16.28, Substance use test results - Offender
[30] Exhibit 1, Vol. 1, Tab 16.29, Work history - Offender
[31] Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24), pp9-10
[32] Exhibit 1, Vol. 1, Tab 12, EcHO Medical records
[33] Exhibit 1, Vol. 1, Tab 15.1, Acacia Health Services Review (21.06.22)
[34] Exhibit 1, Vol. 1, Tab 15.2, Dept. of Justice Health Services Review (07.03.24)
[35] Exhibit 1, Vol. 1, Tab 10, SCGH Discharge Summary (20.06.22)

14. On 22 June 2021, Mr Ratcliff was placed in the Crisis Care Unit after he was assaulted by another prisoner when he refused to hand over cigarettes. He sustained minor injuries and bruises to his forehead and right temple but did not require hospital admission.

15. After recurrent issues with migraine headaches and double vision, Mr Ratcliff was referred for a CT scan at Fiona Stanley Hospital (FSH). The scan was performed on 2 September 2021, which at the time, was probably earlier than would have been the case had he been in the community.[36] The CT scan indicated Mr Ratcliff may have posterior reversible encephalopathy syndrome, which is characterised by headaches and vision issues.

16. On 16 September 2021, a prison doctor reviewed Mr Ratcliff and referred him to a neurologist. On 1 October 2021, the doctor was advised that the referral to FSH had been accepted, and that Mr Ratcliff would be advised of his appointment 30 days prior to the scheduled date. However, prison records indicate that no neurology review appointment was made prior to Mr Ratcliff's death.[37]

17. At the inquest, Dr Gunson said that had the neurological review occurred, it may have led to an MRI scan which in turn may have detected issues that required further attention. For example, an MRI scan may have identified an aneurysm (a weakness in an artery in the brain) which could then have been monitored, or if large enough surgically "*clipped*".[38]

18. However, I accept that Dr Gunson's observations are entirely speculative, and that given Mr Ratcliff's presenting issue was recurrent migraines, the neurology referral had not been identified as urgent. Nevertheless, it is clearly unfortunate Mr Ratcliff was not seen by a neurologist before his death.

[36] ts 04.04.24 (Gunson), p13
[37] Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24), pp9-10 & 12-13
[38] ts 04.04.24 (Gunson), pp7-9

19. However, having made that observation, I have to say that on the basis of the available evidence, I am unable to make any findings, to the relevant standard, about whether the failure to have Mr Ratcliff reviewed by a neurologist had any impact on his death.

20. Mr Ratcliff was transferred to Acacia on 25 March 2022, and although he was up to date with his vaccinations, on 31 May 2022 he returned a positive test for COVID-19 and was placed in medical isolation for 10 days. On 10 June 2022, Mr Ratcliff was negative for COVID-19 on a RAT test, and was returned to his mainstream unit.

21. At the inquest Dr Gunson said that based on her research, it seemed unlikely that Mr Ratcliff's COVID-19 infection was related to the intracranial haemorrhage he experienced on 12 June 2022.[39] However, Dr Gunson also said:

> I suspect that in this case (Mr Ratcliff's intracranial bleeding) was not a complication of his COVID infection. But possibly in a more general sense, maybe the inflammation that likely occurred, despite him being asymptomatic, might have contributed to the susceptibility to developing the bleed. But that's very conjectural and I couldn't really say that. I'm not a neurologist or an infectious diseases specialist.[40]

Mr Ratcliff's collapse on 12 June 2022[41,42,43]

22. Shortly after 4.25 pm on 12 June 2022, prison officers responded to an emergency call from Mr Ratcliff's cellmate who said Mr Ratcliff was disorientated. Prison officers found Mr Ratcliff on the floor of his cell unable to answer basic questions and suspected he was having a stroke.

23. Mr Ratcliff was taken to the prison medical centre and was found to have a left-sided facial droop and left-sided weakness. He also tested positive for COVID-19.

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[39] ts 04.04.24 (Gunson), pp11-12
[40] ts 04.04.24 (Gunson), p11
[41] Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24), pp11-12
[42] Exhibit 1, Vol. 1, Tab 13.2, SJA Patient Care Record MUN21D2 (12.06.22)
[43] Exhibit 1, Vol. 1, Tab 10, SCGH Discharge Summary (20.06.22)

24. An ECG detected no abnormal activity and Mr Ratcliff's vital signs were stable, but emergency services were called and ambulance officers arrived to take Mr Ratcliff to St John of God Midland Hospital (SJOG) for assessment.

25. On the way to SJOG, Mr Ratcliff's condition deteriorated, and the ambulance was diverted to SCGH, where tests confirmed he had experienced a haemorrhagic stroke. Mr Ratcliff was assessed as being an unsuitable candidate for surgery, and he was treated palliatively.

26. Contrary to departmental policy, an external risk assessment on 12 June 2022, and an initial assessment by Ventia (the company the Department uses to supervise prisoners during hospital admissions), determined that Mr Ratcliff required three-point restraints at all times.[44,45] Mr Ratcliff's supervision was taken over by Ventia at 7.00 pm on 14 June 2022.[46]

27. In light of Mr Ratcliff's status as a palliative patient, Ventia raised the issue of whether he should be restrained. At 8.50 pm on 14 June 2022, Acacia confirmed that Mr Ratcliff's restraints could be removed, and they were.[47,48,49,50]

28. The inappropriate use of restraints during the hospitalisation of elderly, terminally ill, and/or palliative patients has been the subject of comment by the Court in a number of previous inquests.[51]

29. At the inquest, Ms Palmer confirmed that departmental policies and procedures had been updated, and that she was confident that in the absence of human error, it was unlikely that a prisoner such as Mr Ratcliff would be restrained if admitted to hospital today.[52]

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[44] Exhibit 1, Vol. 1, Tab 16.12, External movement risk assessment (12.06.22)
[45] Exhibit 1, Vol. 1, Tab 16.15.1, Ventia risk assessment (2.31 pm, 14.06.22)
[46] Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24), pp11-13
[47] Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24), pp11-13 and ts 04.04.24 (Palmer), pp16-17
[48] Exhibit 1, Vol. 1, Tab 16.15, Ventia risk assessment (8.50 pm, 14.06.22)
[49] Exhibit 1, Vol. 1, Tab 16.16, Ventia PIC Escort Record 308615-308634 (14-17.06.22)
[50] Exhibit 1, Vol. 1, Tab 16.17, Ventia PIC Escort Record 308635-308652 (18-20.06.22)
[51] See for example: Investigation into Death of Frank Kenneth Major [2023] WACOR 23, (25.07.23), paras 30-52
[52] ts 04.04.24 (Palmer), pp17-18

30. On 17 June 2022, Acacia gave approval for Mr Ratcliff to be visited by his son,[53] and Mr Ratcliff was kept comfortable as his condition slowly deteriorated. At 6.25 am on 20 June 2022, Ventia officers noticed that Mr Ratcliff appeared to have stopped breathing, and following an assessment clinical staff declared Mr Ratcliff deceased at 6.57 am on 20 June 2022.[54,55,56,57,58,59]

The terminally ill register[60,61]

31. Prisoners with a terminal illness[62] are managed in accordance with a departmental policy known as *COPP 6.2 Prisoners with a Terminal Medical Condition* (COPP 6.2). Once a prisoner is identified as having a terminal illness, a note is made in the terminally ill module of TOMS. Prisoners in the terminally ill module of TOMS are identified as either Stage 1, 2, 3 or 4 prisoners depending on their expected lifespan. Stage 3 prisoners are expected to die within three months, whereas at Stage 4, the prisoner's death is regarded as imminent. On 13 June 2022, Mr Ratcliff was identified as a Stage 4 terminally ill prisoner.[63]

32. From previous inquests I have conducted, I am aware that departmental policy provides that Stage 3 and 4 sentenced prisoners may be considered for early release pursuant to the Royal Prerogative of Mercy (RPOM).

33. In this case, a briefing note was sent to the Minister for Corrective Services on 15 June 2022, regarding Mr Ratcliff's release pursuant to the RPOM. Although Mr Ratcliff's prison term expired on 20 June 2022, he was not recommended for release because he was the subject of a high risk and serious offender interim detention order. As noted, any determination about Mr Ratcliff's release from custody would have to be made by the Supreme Court.

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53 Exhibit 1, Vol. 1, Tab 16.20, Email Acacia Prison to Ventia (17.06.22)
54 Exhibit 1, Vol. 1, Tab 4, Death in Hospital form (20.06.22)
55 Exhibit 1, Vol. 1, Tab 10, SCGH Discharge Summary (20.06.22)
56 Exhibit 1, Vol. 1, Tab 16.18, Ventia notifiable incidents report (20.06.22)
57 Exhibit 1, Vol. 1, Tab 16.19, Ventia incidents reports (20.06.22)
58 Exhibit 1, Vol. 1, Tab 16.21, Ventia initial incident advice checklist (20.06.22)
59 Exhibit 1, Vol. 1, Tab 16.22, Ventia death in custody initial details checklist (20.06.22)
60 Exhibit 1, Vol. 1, Tab 16, Death in Custody Review (01.02.24), pp11-12 and ts 04.04.24 (Palmer), pp16-18
61 Department policy: COPP 6.2 - Prisoners with a Terminal Medical Condition, pp4-6
62 One or more conditions that on their own or as a group, significantly increase the likelihood of a prisoner's death
63 Exhibit 1, Vol. 1, Tab 16.13, Terminally Ill Health Advice (13.06.22)

CAUSE AND MANNER OF DEATH[64,65]

34. A forensic pathologist (Dr J Ong) conducted a post mortem examination of Mr Ratcliff's body on 5 July 2022 and found early thickening and narrowing of the vessels supplying the heart (coronary artery atherosclerosis). The kidneys were scarred and the lungs were congested, which is considered a non-specific finding.

35. A post mortem CT scan showed evidence of an intracranial haemorrhage, but no evidence of recent skeletal injury. Microscopic examination of tissues showed changes in the lungs consistent with early bronchopneumonia, and confirmed the presence of coronary artery atherosclerosis.

36. No significant viral infection was detected in the lungs or the heart, and specialist examination of the brain showed "*abundant recent haemorrhage within the mid-brain and pons extending into the aqueduct and lateral ventricles*".

37. Dr Ong said that although the cause of the haemorrhage in Mr Ratcliff's brain was not apparent on microscopic examination, the distribution of the haemorrhage favoured "*a hypertensive haemorrhage*".

38. Toxicological analysis detected various medications in Mr Ratcliff's system that were consistent with his recent medical care.[66]

39. At the conclusion of the post mortem examination, Dr Ong expressed the opinion that the cause of Mr Ratcliff's death was complications of intracranial haemorrhage, with terminal palliative care.

40. I accept and adopt Dr Ong's conclusion as my finding in relation to the cause of Mr Ratcliff's death, and I find that Mr Ratcliff's death occurred by way of natural causes.

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[64] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (14.03.23)
[65] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (05.07.22)
[66] Exhibit 1, Vol. 1, Tab 7.2, Final Toxicology Report (27.09.22)

QUALITY OF SUPERVISION, TREATMENT AND CARE

41. In relation to the care and treatment Mr Ratcliff received whilst he was in custody, the Acacia Health Review made the following observation:

> Mr Ratcliff did have an outstanding referral to neurology in regards to his migraines with aura. Mr Ratcliff had just completed his isolation period from being diagnosed with Covid. Mr Ratcliff received a high level of care during the code blue.[67,68] He was a fit and healthy man, who didn't require much medical interventions during his short time at Acacia. All care provided to Mr Ratcliff during his incarceration was appropriate and timely.[69]

42. In its Health Review, the Department made the following observation:

> Mr Ratcliff received patient-centric comprehensive multidisciplinary care throughout his time in custody, with good access to services and continuity of care inclusive of preventative health care, screening, management of acute presentations and chronic conditions. The care he received was of a high standard.[70]

43. At the inquest, Dr Gunson agreed that with the exception of Mr Ratcliff's outstanding neurology referral, the care and treatment provided to Mr Ratcliff whilst he was incarcerated was commensurate with the care he would have received in the community.[71]

44. Having carefully considered the available evidence, I am satisfied that the supervision, treatment and care that Mr Ratcliff received whilst he was incarcerated was of an acceptable standard. In particular, I accept Dr Gunson's opinion about the medical care Mr Ratcliff received while he was in custody.

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[67] Unlike other prisons, Acacia still uses the term "*Code Blue*" rather than "*Code Red*" to designate a medical emergency
[68] ts 04.04.24 (Palmer), p18
[69] Exhibit 1, Vol. 1, Tab 15.1, Acacia Health Services Review (21.06.22), p7
[70] Exhibit 1, Vol. 1, Tab 15.2, Dept. of Justice Health Services Review (07.03.24), pp8-9
[71] ts 04.04.24 (Gunson), pp8-9

CONCLUSION

45. Mr Ratcliff was 65-years of age when he died at SCGH on 20 June 2022 from complications of an intracranial haemorrhage. On behalf of the Court, I wish to extend to Mr Ratcliff's family my condolences for their loss.

MAG Jenkin
Coroner
10 April 2024