JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Michael Andrew Gliddon Jenkin, Coroner
HEARD	**:**	28 MAY 2025
DELIVERED	**:**	12 JUNE 2025
FILE NO/S	**:**	CORC 3150 of 2023
DECEASED	**:**	BUTLER, GRAHAM JOHN

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Sergeant C. Martin assisted the coroner.

Ms T. C. Loo (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 ***Graham John BUTLER*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 28 May 2025, find that the identity of the deceased person was* ***Graham John BUTLER*** *and that death occurred on 22 October 2023 at St John Of God Midland Public Hospital, 1 Clayton Street, Midland, from out-of-hospital cardiac arrest in a man with coronary artery atherosclerosis and background history of diabetes mellitus in the following circumstances:*

Table of Contents

INTRODUCTION

1. Graham John Butler (Mr Butler) died at St John of God Midland Public Hospital (SJOG) on 22 October 2023, after experiencing an out of hospital cardiac arrest.[1,2,3,4,5,6,7,8]

2. At the time of his death, Mr Butler was a sentenced prisoner at Acacia Prison (Acacia), and he was thereby in the custody of the Chief Executive Officer of the Department of Justice (the Department).[9] This means that immediately before his death Mr Butler was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA), and further that his death was a "*reportable death*".[10]

3. In such circumstances, a coronial inquest is mandatory. 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 whilst in that care.[11]

4. I held an inquest into Mr Butler's death in Perth on 28 May 2025, which was attended by a member of his family. The documentary evidence adduced at the inquest comprised one volume, and the following departmental witnesses gave evidence:

a. Dr C Gunson, (Dep. Director, Health and Wellbeing Service);[12] and

b. Ms C Ziino, (Review Officer).[13]

5. The inquest focused on the supervision, treatment and care provided to Mr Butler while he was in custody, and the circumstances of his death.

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[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (23.10.23)
[2] Exhibit 1, Vol. 1, Tab 4, P98 - Mortuary Admission Form (22.10.23)
[3] Exhibit 1, Vol. 1, Tab 5, Death in Hospital form (22.10.23)
[4] Exhibit 1, Vol. 1, Tab 6, P92 - Identification of Deceased: Other than by Visual Means (06.11.23)
[5] Exhibit 1, Vol. 1, Tab 6.1, Affidavit - Sen. Const. C Heinz (06.11.23)
[6] Exhibit 1, Vol. 1, Tab 6.2, Affidavit - Sen. Const. W Chandler (06.11.23)
[7] Exhibit 1, Vol. 1, Tab 6.3, Coronial Identification Report (06.11.23)
[8] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (03.01.24)
[9] Section 16, *Prisons Act 1981* (WA)
[10] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[11] Section 25, *Coroners Act 1996* (WA)
[12] ts 28.05.25 (Gunson), pp4-12
[13] ts 28.05.25 (Ziino), pp12-15

MR BUTLER

Background[14,15,16]

6. Mr Butler was born in Fremantle on 11 October 1947, and he was 76 years of age when he died on 22 October 2023. Mr Butler had completed his schooling to the equivalent of Year 8, and during his working life, he was employed in various roles including: farm worker, service station attendant, dozer driver, bus driver, and supervisor.

7. Mr Butler had three children from his first marriage, which ended in divorce. After he remarried, Mr Butler had two children with his second wife. Mr Butler and his family relocated to Tasmania in 1992, and he had two stepsisters in Perth.

Offending history[17,18,19,20]

8. On 2 July 2021 in the District Court of Western Australia, Mr Butler was sentenced to a term of six years' imprisonment, following his conviction in relation to six child sexual offences. Mr Butler was made eligible for parole, and his earliest eligibility date for release was calculated as being 24 June 2027.

Medical history[21,22,23]

9. Mr Butler's medical history included: type 2 diabetes, ischaemic heart disease, angina, high blood pressure, high cholesterol, diverticulitis (following bowel surgery in 1994), gastro-oesophageal reflux disease, chronic low back pain, depression, anxiety, and recurrent urinary tract infections (UTI).

10. Mr Butler had experienced a cerebrovascular accident ("stroke") in 2003, a myocardial infarction ("heart attack") in 2013, and a transient ischaemic attack in 2015.

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[14] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneham (10.02.25), pp3-4
[15] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), p5
[16] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), p7
[17] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), p7
[18] Exhibit 1, Vol. 1, Tab 10.1, Transcript of Proceedings - District Court of WA (02.07.21)
[19] Exhibit 1, Vol. 1, Tab 10.2, History for Court - Criminal and Traffic
[20] Exhibit 1, Vol. 1, Tab 10.3, Sentence Summary - Offender
[21] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp4-5
[22] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneham (10.02.25), pp3 & 6-8
[23] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), p8

11. Mr Butler also experienced right-sided weakness following poliomyelitis as a child, and he mobilised using a walker due to back pain. Mr Butler had hearing and visual impairment and used hearing aids and reading glasses.

Prison history[24,25,26]

12. Mr Butler was received at Hakea Prison (Hakea) on 25 June 2021, and he remained there until 22 November 2021, when he was transferred to the assisted care unit at Acacia Prison (Acacia). Although Mr Butler was incarcerated at Acacia until his death, he had a period of convalescence at the infirmary at Casuarina Prison (Casuarina) between 12 - 20 September 2023, following an eight-day admission to hospital.

13. When Mr Butler was first received at Hakea, he underwent various assessments including an At Risk Management System (ARMS) assessment with a reception officer to evaluate his risk of self-harm and suicide. ARMS is the Department's primary suicide prevention strategy and aims to provide staff with guidelines to assist with the identification of prisoners deemed to be at risk.[27]

14. During the ARMS assessment interview Mr Butler denied any self-harm or suicidal ideation, and he told the reception officer he had a supportive family. However, Mr Butler did express concern about "*being at risk in prison due to the nature of his offending*".[28] At the conclusion of the ARMS assessment, the reception officer concluded that Mr Butler had no acute self-harm or suicide risks, noting:

> This is the prisoner's first time in prison. The prisoner did not present as a risk in my interview. There were no statements of ideation made referring to Self-Harm at the time of interview. The Prisoner was cooperative and answered all questions during my interview. The prisoner had made good eye contact and was very focused and had clear plans for his future. Nil recommendations.[29,30]

[24] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp3-4
[25] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), pp4-17 and ts 28.05.25 (Ziino), pp12-15
[26] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneham (10.02.25), p3
[27] ARMS Manual (2019), pp2-13
[28] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), p8
[29] Exhibit 1, Vol. 1, Tab 10.4, ARMS Reception Intake Assessment (25.06.23)
[30] Exhibit 1, Vol. 1, Tab 10.7, PHS Intake File Note (06.07.21)

15. Following reception procedures, Mr Butler was transferred to the Crisis Care Unit at Hakea for several days before being transferred to the Protection Unit.[31] Following a classification review on 12 July 2021, Mr Butler's security classification was reduced to "*medium*" and he was assessed as suitable for transfer to Acacia for the "*formulation of an Initial Individual Management Plan and to facilitate visits*".[32]

16. An Individual Management Plan created on 6 July 2022, said this about Mr Butler's behaviour at Acacia:

> Mr Butler resides in India Block (Protection) with an Earned level of supervision. Staff advise he is a well-mannered and respectful prisoner who is seen to socialise appropriately with his peers and he interacts well with officers. Mr Butler adheres to unit rules and regulations without issue, functioning well within India Block and maintaining his cell and personal hygiene to the required standard.[33,34]

17. Following a classification review on 27 June 2023, Mr Butler's security classification was reduced to "*minimum*", and by that stage Mr Butler was in the assisted care unit. The classification review report made the following comment about Mr Butler's conduct and general placement:

> Mr Butler attended interview, presenting in a friendly and positive manner. Mr Butler is extremely happy with his placement in Assisted Care, stating he is surrounded by good buddies and excellent supportive officers. He proudly confirmed his employment as storeman and advised he volunteers packing the sugar with several other prisoners to keep himself busy and active. Mr Butler was asked how his health is, as it is noted through emails from medical Mr Butler is currently undergoing assessment and medical appointments for health complaints relating to his Cardiac issues. He stated he is receiving good care and they are working through his Health issues and that many others were worse off than him. Mr Butler understands he is likely to remain at Acacia prison due to his health requirements and stated: "*No complaints here*".[35]

[31] Exhibit 1, Vol. 1, Tab 10.5, Cell Placement History (25.06.23 - 06.07.23)
[32] Exhibit 1, Vol. 1, Tab 10.6, Management and Placement Checklist - Sentenced (12.07.21)
[33] Exhibit 1, Vol. 1, Tab 10.8, Individual Management Plan (06.07.22), p1
[34] See also: Exhibit 1, Vol. 1, Tab 10.9, Classification Review (07.07.22), p1
[35] Exhibit 1, Vol. 1, Tab 10.10, Classification Review (27.06.23), p3

18. At the time of his death, Mr Butler was the subject of six alerts on the computer system the Department uses for prisoner management, namely the Total Offender Management Solution system (TOMS). These alerts related to family violence restraining orders, restricted visits, post sentence supervision, protection, and high risk sex offender status.

19. Mr Butler had periods of employment at Acacia as a general worker, and he had 33 social visits from family members and a friend, and a total of eight official visits from his lawyer, and a Justice of the Peace. Mr Butler sent 42 items of mail to various family members and friends, and he regularly called them using the Prisoner Telephone System.[36,37,38]

20. Mr Butler did not commit any prison offences during his incarceration, and he was the subject of random drug and alcohol tests, all of which returned negative results. Mr Butler's cell was searched on 19 occasions, but nothing untoward was ever located.[39,40,41]

MANAGEMENT OF HEALTH ISSUES[42,43]

21. While Mr Butler was at Acacia he regularly attended the medical centre for treatment of various medical issues. Mr Butler was reviewed by various specialists and allied health professionals (including a physiotherapist, a podiatrist, a dentist, and an optometrist. Mr Butler also attended a number of external medical appointments for reviews and assessments.[44,45]

22. Key aspects of Mr Butler's medical management in the period leading up to his death include:

a. *13 July 2022*: Mr Butler presented to the medical centre with a history of chest pain for a few weeks. An electrocardiogram was normal, as were blood tests to check troponin levels;

[36] Exhibit 1, Vol. 1, Tab 10.22, Visits history report
[37] Exhibit 1, Vol. 1, Tab 10.23, Prisoner mail history report
[38] Exhibit 1, Vol. 1, Tab 10.24, Work history report
[39] Exhibit 1, Vol. 1, Tab 10.25, Substance use test results
[40] Exhibit 1, Vol. 1, Tab 10.26, Cell search history report
[41] Exhibit 1, Vol. 1, Tab 10.27, Charge history report
[42] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp6-17 and ts 28.05.25 (Gunson), pp4-12
[43] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), pp8-12
[44] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp20-21
[45] See for example: Exhibit 1, Vol. 1, Tab 10.13, Temporary Placement History (27.08.21 - 17.10.23)

b. *22 July 2022*: Mr Butler's condition was reviewed and his treatment plan was "*further testing, reviews and relevant referrals conducted and identified*";[46]

c. *11 December 2022*: Mr Butler was taken to SJOG by ambulance after attending the medical centre complaining of dizziness, nausea, and dry-retching. Mr Butler was transferred back to Acacia on 13 December 2022, and following overnight observation in the medical centre, he returned to his unit the following day;[47,48]

d. *20 December 2022*: Mr Butler was diagnosed with a urinary tract infection and prescribed medication. I note that Mr Butler had an indwelling catheter;

e. *7 February 2023*: a Code Blue Medical Emergency[49] was initiated after Mr Butler told prison officer he felt unwell. Following a nursing assessment in his cell, Mr Butler was taken to SJOG by ambulance, where he was diagnosed with sepsis caused by a UTI (urosepsis). After treatment, he was returned to Acacia on 11 February 2023, where he was monitored by clinical staff;[50,51,52]

f. *14 March 2023*: Mr Butler expressed concerns about his catheter and reported a sharp pain in his lower abdomen and a burning sensation. His urine was a dark rose colour, and when he was reviewed on 16 March 2023, a small amount of blood staining was noted in his urine. A UTI was confirmed and antibiotics were given. Mr Butler had several skin cancers removed on 24 March 2023;[53,54]

g. *19 April 2023*: Mr Butler had a new catheter inserted and it was noted that surgical sites from the removal of some skin cancers were healing well;

h. *June 2023*: Mr Butler had review appointments with a podiatrist, an optometrist and a physiotherapist. He was also reviewed by a dietician who gave him advice on weight management;[55]

i. *August 2023*: Mr Butler was reviewed by a physiotherapist for ongoing back pain, and he presented with signs of a UTI. Mr Butler was reviewed by a dietician and it was noted he was no longer losing weight;[56]

[46] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), p10
[47] Exhibit 1, Vol. 1, Tab 10.11, Incident Reports - Various Officers (11.12.22)
[48] Exhibit 1, Vol. 1, Tab 10.11, Incident Report Minutes (11.12.22)
[49] At every other prison in WA the term used is "*Code Red*". In my view Acacia's use of term "*Code Blue*" is inappropriate.
[50] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp6-7
[51] Exhibit 1, Vol. 1, Tab 10.12, Incident Reports - Various Officers (07.02.23)
[52] Exhibit 1, Vol. 1, Tab 10.12, Incident Report Minutes (07.02.23)
[53] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), p7
[54] Exhibit 1, Vol. 1, Tab 10.13, Temporary Placement History (27.08.21 - 17.10.23), p2
[55] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), p8
[56] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), p8

j. *4 September 2023*: a Code Blue Medical Emergency[57] was initiated after a prisoner alerted prison officers to the fact that Mr Butler was gasping for air. Following a nursing assessment, Mr Butler was taken to SJOG by ambulance, where he tested positive for the COVID-19 virus during his admission. Following treatment Mr Butler was transferred to the infirmary at Casuarina on 12 September 2023. Following a period of convalescence, Mr Butler was returned to Acacia on 20 September 2023;[58,59,60]

k. *22 September 2023*: Mr Buter attended Fremantle Hospital for a cystoscopy, where an instrument was inserted into his bladder. It was planned that Mr Butler's catheter would be removed for a "*trial of void*", with the catheter to be reinserted if the trial failed;[61]

l. *October 2023*: Mr Butler's catheter was removed on 4 October 2023. He had reviews by a podiatrist and at the Ophthalmology Clinic at Fremantle Hospital. Mr Butler's blood sugar levels were noted to be elevated and were monitored; and

m. *2 - 7 October 2023*: Mr Butler had ongoing incontinence issues with his catheter, and he had a series of bladder scans. Mr Butler was noted to be refusing to drink water, saying he did not like the taste. Despite encouragement to increase his water intake, Mr Butler: "*remained adamant that he would not drink water*".[62,63]

Mr Butler found unresponsive[64,65,66,67,68,69,70,71]

23. At about 6.15 pm on 22 October 2023, Mr Butler was standing outside his cell door for the routine nighttime lockdown count. He appeared to be his usual self, and prison officers did not report any concerns for his welfare at that time.

24. During a routine cell check just before 7.00 pm, prison officers noted that Mr Butler was lying on his bed, leaning against the wall with his chin tucked against his chest.

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[57] At every other prison in WA the term used is "*Code Red*". In my view Acacia's use of term "*Code Blue*" is inappropriate.
[58] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp8-10
[59] Exhibit 1, Vol. 1, Tab 10.14, Incident Reports - Various Officers (04.09.23)
[60] Exhibit 1, Vol. 1, Tab 10.14, Incident Report Minutes (04.09.23)
[61] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp10-11
[62] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp11-13
[63] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), p12
[64] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp12-17 & 34-38
[65] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), pp12-13
[66] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigator R Fyneham (10.02.25), pp1-2
[67] Exhibit 1, Vol. 1, Tab 3, Memorandum - Sen. Const. K Cooper (02.11.23)
[68] Exhibit 1, Vol. 1, Tab 10.17, Incident Summary Report (22.10.23)
[69] Exhibit 1, Vol. 1, Tab 10.17, Incident Description Reports - Various Officers (22.10.23)
[70] Exhibit 1, Vol. 1, Tab 10. 17, Incident Report Minutes (22.10.23)
[71] Exhibit 1, Vol. 1, Tab 10.19, Serco Post Incident Review (14.11.23), pp6-7

25. Mr Butler was a person with a heavy build, and prison officers called out to him as they were concerned that the position he was lying in may be affecting his breathing (i.e.: positional asphyxia).

26. Mr Butler made no response when officers called his name, and a Code Blue Medical Emergency was initiated.[72] Prison staff, including a nurse, entered the cell and found Mr Butler was unresponsive and had no pulse. Mr Butler was moved to the floor of his cell, and CPR was commenced.

27. An automated defibrillator was attached to Mr Butler's chest and the first of several shocks was administered at 7.03 pm. Emergency services were called at 7.04 pm, and ambulance officers arrived at Acacia at 7.15 pm, and Mr Butler was taken to SJOG.

28. Despite further resuscitation efforts, Mr Butler could not be revived, and he was declared deceased at 8.20 pm on 22 October 2023.[73]

29. An External Movement Risk Assessment (EMRA) was completed, and although restraints were recommended, they were not applied to Mr Butler during his transfer to SJOG. The EMRA noted that restraints were: "*Non applied due to resuscitation efforts…Non responsive - resuscitation efforts at time of movement*".[74]

30. The fact that restraints were not applied to Mr Butler is entirely consistent with departmental policy, and the officers involved in making this decision are to be commended.[75]

31. On the basis of the evidence before me, the resuscitation efforts of prison officers, ambulance officers, and clinical staff at SJOG appear to have been timely and appropriate.[76,77,78]

[72] At every other prison in WA the term used is "*Code Red*". In my view Acacia's use of term "*Code Blue*" is inappropriate.
[73] Exhibit 1, Vol. 1, Tab 5, Death in Hospital form (22.10.23)
[74] Exhibit 1, Vol. 1, Tab 10.18, External Movement Risk Assessment (22.10.23), p3
[75] Departmental policy: COPP-12.3 *Conducting Escorts*
[76] Exhibit 1, Vol. 1, Tab 10.19, Serco Post Incident Review (14.11.23), p3
[77] Exhibit 1, Vol. 1, Tab 10.20, First Aid Certificates for prison staff responding to Mr Butler
[78] See also: ts 28.05.25 (Ziino), pp13-14

Management on the terminally ill register[79,80,81]

32. Prisoners with a terminal illness[82] are managed in accordance with a departmental policy known as *COPP 6.2 Prisoners with a Terminal Medical Condition*. Once a prisoner is identified as having a terminal illness, a note is made in the terminally ill module of TOMS.

33. Prisoners are identified as Stage 1, 2, 3 or 4, on the basis of their expected lifespan. Stage 3 prisoners are expected to die within three months, whereas for Stage 4 prisoners, death is expected imminently.

34. At about 7.30 pm on 22 October 2023, Mr Butler was identified as a Stage 4 terminally ill prisoner when the Department's Director Medical Services received advice that Mr Butler had collapsed and was receiving active resuscitation. Mr Butler was removed from the terminally ill module of TOMS on 23 October 2023, once advice of his death had been received.[83,84,85]

35. Although Stage 3 and 4 sentenced prisoners may be considered for early release pursuant to the Royal Prerogative of Mercy, Mr Butler died before any consideration could be given to this issue.

CAUSE AND MANNER OF DEATH[86]

36. A forensic pathologist (Dr Ong) conducted a post mortem examination of Mr Butler's body on 30 October 2023, and reviewed CT scans. Dr Ong noted that Mr Butler had: "*an enlarged heart with associated hardening, thickening and narrowing of the vessels supplying the heart muscle (coronary artery atherosclerosis)*". Mr Butler's kidneys were scarred, and his lungs were congested, which is a non-specific finding.[87]

[79] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), pp21 & 39-40
[80] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), p13
[81] Departmental policy: COPP 6.2 - Prisoners with a Terminal Medical Condition, pp4-6
[82] One or more conditions that on their own or as a group, significantly increase the likelihood of a prisoner's death
[83] Exhibit 1, Vol. 1, Tab 5, Death in Hospital form (22.10.23)
[84] Exhibit 1, Vol. 10.16, Terminally Ill Health Advice (22.10.23)
[85] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), p21
[86] Exhibit 1, Vol. 1, Tab 7, Post Mortem Report (30.10.23)
[87] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (03.01.24), p1

37. Microbiological testing noted several bacterial organisms in Mr Butler's lungs, but in the absence of evidence of pneumonia, Dr Ong stated: "*this likely represents post mortem contamination of the tissues*". A blood test to assess Mr Butler's blood sugar control over the previous three months showed "*a sub-optimal blood sugar control*".[88]

38. Toxicological analysis detected the following medications in Mr Butler's system: benzydamine, irbesartan, metoprolol, pantoprazole, paracetamol, sertraline, and frusemide. Mr Butler also had a urine alcohol level of 0.037%, but alcohol was not detected in his blood. Other common drugs were not detected.[89]

39. Dr Ong noted Mr Butler's significant pre-existing heart disease, and his diabetes "*which is a known risk factor for the development of cardiovascular disease*", and stated that: "*it appears most likely that Mr Butler suffered an out-of-hospital cardiac arrest*".[90]

40. At the conclusion of his post mortem examination, Dr Ong expressed the opinion that the cause of Mr Butler's death was "*out-of-hospital cardiac arrest in a man with coronary artery atherosclerosis and background history of diabetes mellitus*".[91]

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

[88] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (03.01.24), p2
[89] Exhibit 1, Vol. 1, Tab 8, Toxicology Report (15.11.23)
[90] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (03.01.24), p2
[91] Exhibit 1, Vol. 1, Tab 7.1, Supplementary Post Mortem Report (03.01.24), pp1-2

QUALITY OF SUPERVISION, TREATMENT AND CARE

42. Following Mr Butler's death, the Department investigated his management and supervision whilst he was incarcerated. The results of that review were published in a document entitled "*Death in Custody Review*", which made no business improvements, having concluded that:

> This review found Mr Butler's custodial management, supervision and care was in accordance with the Department's policy and procedures as listed in Appendix 1. Records indicate the response was prompt and lifesaving measures were conducted as soon as possible. Relevant death in custody procedures, including notifications and handover to WA Police were followed.[92]

43. Mr Butler's clinical care was also reviewed after his death by the Department (Health Review). In relation to the care and treatment Mr Butler received whilst he was in custody, the Health Review made the following observation, with which I agree:

> Health Services can confirm that during his time in custody, that (Mr Butler) received appropriate health care, of a standard equivalent to that which he would have received in the community. When (Mr Butler) presented with health concerns, support was always provided in a timely manner, and follow-up reviews were always put in place. He was referred to appropriate specialists when indicated, with communication well maintained for continuity of his care. Although some small issues in delivery of care were identified, it is highly unlikely that these affected the ultimate outcome for Mr Butler. In conclusion, the health care provided to Mr Butler was holistic and patient-centred, and overall, of a standard equivalent to or better than the standard of care he would have received in the community.[93]

44. Having carefully reviewed the available evidence, I am satisfied that the standard of supervision, treatment, and care Mr Butler received whilst he was incarcerated was of a very good standard. In my view Mr Butler's medical care was equal to or better than the care he would have received in the community.

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[92] Exhibit 1, Vol. 1, Tab 10, Death in Custody Review (06.01.25), p5
[93] Exhibit 1, Vol. 1, Tab 9, Health Services Review (26.05.25), p26 and see also: ts 28.05.25 (Gunson), pp9-11

CONCLUSION

45. Mr Butler was 76 years of age when he died at St John of God Midland Public Hospital on 22 October 2023. I found that the cause of Mr Butler's death was an out of hospital cardiac arrest in a man with coronary artery atherosclerosis and background history of diabetes mellitus, and that the manner of his death was natural causes.

46. After reviewing the available evidence, I concluded that the standard of supervision, treatment and care that Mr Butler received whilst he was incarcerated was very good. In my view, Mr Butler's medical care was equal to or better than the care he would have received in the community.

47. As I did at the conclusion of the inquest, I wish to again convey to Mr Butler's family and loved ones, on behalf of the Court, my sincere condolences for their loss.

MAG Jenkin
Coroner
12 June 2025