Coroners, Act 1996

[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION OF DEATH

Ref No: 18/10

I, Evelyn Felicia VICKER, Deputy State Coroner, having investigated the death of ***Alan EGAN*** *with an inquest, held at the* ***Perth Coroner's Court, Court 58, CLC Building, 501 Hay Street, Perth*** *on* ***22-23 June 2010*** *find the identity of the deceased person was* ***Alan EGAN*** *and that death occurred on* ***2 March 2008*** *at* ***Fremantle Hospital*** *as a result of* ***Complications of Disseminated Malignancy*** *in the following circumstances:*

Counsel Appearing :

Mr Scott Schaudin assisted the Deputy State Coroner
Mr Michael Jenkin (State Solicitors Office) appeared on behalf of the Department of Corrective Services
Ms D Huxtable (Aboriginal Legal Service) appeared on behalf of the family

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INTRODUCTION

Alan Egan (the deceased) was a sentenced prisoner at Roebourne Regional Prison (RRP). In November 2007 he was diagnosed with a small cell lung cancer of the right upper lobe, with brain metastases, and after treatment was transferred to Casuarina Prison Infirmary for Palliative care. On 27 February 2008 he was transferred to Fremantle Hospital where he died on 2 March 2008. He was 63 years old.

Section 25(ss3) of the *Coroners Act 1996* requires a coroner investigating a death in care to comment on the quality of the supervision, treatment and care of the person while in that care.

BACKGROUND

The deceased was born on either 14 January or February 1945 in Carnarvon. He was adopted by the Egans and brought up by them on Mooloo Downs Station. He had one sister in that family, and a brother and two sisters in his family of origin. He went to school at the Church of Christ Mission and spent his holidays at Mooloo Downs.

He left school when he was 13 years of age and had regular employment as a station hand until he was injured and lost the use of one eye in 1977, when he was 33 years old.

Since that time he had found it difficult to find employment although he was otherwise fit and healthy.[1]

The deceased had four children of his own to two mothers, Lena Fishhook and Yvonne Williams. All children were fostered and the deceased had little contact with them. Ms Fishhook died in a motor vehicle accident and the deceased separated from Ms Williams in 1976. He generally lived alone and did not appear to have familial support.

The deceased's first conviction occurred in 1958 in the Carnarvon Children's Court and was for an unlawful and indecent assault. In 1968 in the Roebourne Court of Petty Sessions he was sentenced to 12 months imprisonment for the unlawful assault of a female child with a recommendation he receive psychiatric treatment. His offending was consistently drink related and included assaults of various kinds. In 1997 he was convicted for interfering with an eight month old baby girl, followed in 1978 and 1979 with attempts to have anal intercourse with six year old boys. He spent time in custody in both regional and metropolitan prisons. He was generally considered a model prisoner.

LATEST TERM OF IMPRISONMENT

In 1986 the deceased was convicted of aggravated sexual penetration and sentenced to six years imprisonment. The female child was three years of age and was injured in the

[1] Exhibit 2 Annexure 1

course of the assault. When sentencing the deceased the Judge also directed he be detained at the Governor's Pleasure on completion of his finite term of imprisonment. Once detained at the Governor's Pleasure in 1990 his detention became a matter for executive review At the time his indefinite sentence was imposed there was limited case law on the criteria to be applied when imposing such a term.

The legislation provided for annual review of detention by the Parole Board (now Prisoner Review Board). One of the criterion used for assessment was a detainee's compliance with programs designed to address their offending behaviour. Unfortunately there are aspects to these, not unreasonable requirements, which may affect a prisoner's attitude to the completion of these courses.

At the time of the introduction of prisoner programs to address various types of offending behaviour there were limited programs and limited places on programs. As a result they are not offered to new prisoners and places are reversed for those approaching a release date. By that time there may be a number of reasons affecting a prisoner's attitude to compliance with a program, over and above a refusal to acknowledge aspects of their offending behaviour.

The deceased consistently refused to undertake any programs directed towards sexual offending for a number of reasons, including the fact delivery of a program was to be

by a non-aboriginal female. He remained an otherwise model prisoner until the time his refusal to participate in programs was undeniably the reason for his lack of release by the Parole Board.

The deceased was transferred to Greenough Regional Prison (GRP) from Canning Vale and took part in an *"Ending Offending"* alcohol program. He began to exhibit disciplinary problems and initially agreed to be transferred to the metropolitan region to attend a Sex Offenders Treatment Program (SOTP) followed by a pre-release programme at Burringurrah Community.

On 15 November 1991 he wrote a letter to the Superintendent at GRP stating he did not want to be sent south to do the SOTP. He stated he had served five years in prison and had been promised the previous year he would be released. He asked that instead of going south he be sent north to be nearer family in Carnarvon to allow for visits.

The following Christmas the deceased was transferred to Casuarina Prison for assessment for a SOTP. He was co-operative with assessment but stated he would not participate in group treatment, or co-operate if there were female staff involved.

At that time those conditions effectively precluded his inclusion in any program. Later, when other options

became available and were discussed with the deceased by Aboriginal Visitors Scheme (AVS) members, he refused to consider any form of SOTP and it seems as though the earlier hope of co-operation was lost. By that time there is a distinct probability the deceased was to some extent institutionalised and his consistent refusal to co-operate with plans directed towards release may have been more complex than mere denial of offending behaviour.

The deceased spent periods of time at both Roebourne Regional Prison (RRP) and GRP. AVS members in both locations attempted to persuade the deceased to be more cooperative with prison management in an effort to promote his reviews with the Parole Board and the possibility of release.

In 1996 a Clinical Psychologist suggested it would benefit both GRP and the deceased if he could be transferred to RRP and continue with input from AVS members with whom he had developed a raporté.

The deceased was transferred, but did not receive family visits, although AVS attempted to facilitate contact between the deceased and family members. AVS in Roebourne also regularly spoke with the deceased but was unable to persuade him to engage in any SOTP despite the fact this affected his ability to persuade the Parole Board he was suitable for release back into the community.

The deceased did complete a *"skills training for aggression control"* while at RRP in May 1997. Due to the fact his sexual offending behaviours always related to periods of intoxication it is quite likely the deceased believed the courses he was prepared to undertake should have been enough to satisfy the Parole Board, in view of his perceived cultural obligations.

Over time the Department of Corrective Services continued to develop refinements to their SOTP. One was an aboriginal specific SOTP and would have enabled the deceased to progress to the more intensive programs needed for the purposes of satisfying Parole Board requirements. The deceased refused to co-operate with the assessment process, which was conducted by a non-aboriginal female, and was then reported to have exhibited behaviours needing intensive intervention. Consequently, on his annual review by the Parole Board he still failed to meet any criteria of completing required programs due to his refusal to consider any form of assessment for SOTP.

At the turn of the century the Parole Board became increasingly concerned the deceased was not participating in programs and began to defer consideration of his parole rather than refusing it out right. He still declined to co-operate and the Parole Board continued to defer consideration of his applications.

By July 2003 the deceased informed a Senior Community Corrections Officer he was resigned to dying in prison. There is no indication he intended to precipitate death in custody, rather he recognised there was an impasse between his lack of preparedness to conform and his need to conform with pre-release programs to enable his release to be considered.

In April 2005 the deceased was recommended for participation in a cognitive skills program at RRP. It is not exactly clear what happened next but it seems the program was cancelled until 2006. By then the deceased was no longer prepared to participate in either that program or any other. The Parole Board maintained its postion he would not be considered for release until he completed relevant SOTP.

By June 2007 the Parole Board was asking the Aboriginal Legal Service (ALS) be involved in the deceased's circumstances in an attempt to explore an alternative to obtaining an assessment of his risk of re-offending. A Petition for Clemency was prepared for the Attorney General to consider release of the deceased. However, the Attorney General ultimately responded he did not intend to send the deceased's case for review until he met the requirement of the Parole Board to accept appropriate treatment intervention to suit his needs and provide an acceptable pre-release plan.

It was in November 2007 the deceased was diagnosed with terminal lung cancer with metastases in the brain.

Thereafter a request to exercise the *"Royal Prerogative for Mercy"* in the deceased's case was also declined.

The deceased's offences had always involved aboriginal children and it was likely he would come into contact with aboriginal children if released.

MEDICAL CIRCUMSTANCES

The deceased had lost an eye in 1977 which resulted in some depression for which he was treated in 1978. By the time of his final incarceration in 1986 he seemed to have found ways to cope with that loss and indeed became well known in RRP for his fine art work during his last term of imprisonment.

The deceased's medical file outlines various medical interventions over the years covering gastro-intestinal problems, some cardiac concerns, asthma and a persistent cough which developed to chronic obstructive airways disease. [2]

On 31 October 2007 the deceased was discovered in his cell slumped forward with blood in his mouth. He was assessed and found to have laboured breathing and an inability to respond appropriately to direction. This improved after the

[2] Exhibit 1, annexure 15

administration of oxygen and he complained of a severe headache. He was transferred to Nickol Bay Hospital in Karratha and from there to Royal Perth Hospital (RPH).

Investigations at RPH revealed multiple cerebral, cerebrular, pancreatic and gastric metateses from untreatable small cell carcinoma of the lungs. His Oncologist advised he could only be treated palliatively and he was commenced on radiotherapy and oral chemotherapy.

The deceased was transferred to Casuarina Infirmary on 28 November 2007 for ongoing palliative care. He suffered side effects from the treatment and was returned to RPH on those occasions the infirmary could not adequately care for him.

The Prisoners Review Board (PRB) indicated it wished for more input with respect to considering a release program for the deceased and Alan Parke, Manager of release planning for the Department of Corrective Services, and a member of the PRB, contacted Sally Wade, a Senior Community Corrections Officer based in Casuarina Prison, to enquire into the deceased's circumstances for the PRB. Mr Parke later advised Ms Wade the Attorney General had not approved the deceased's application for *"Royal Prerogative for Mercy"* and the PRB were most concerned the situation for the deceased be progressed.[3]

[3] Exhibit 6

Ms Wade continued to search for ways to engage the deceased. Culturally appropriate people were asked for their input and Ms Wade was in contact with AVS in Roebourne to assist with family contact. None of those approaches were successful nor was obtaining the cooperation of the deceased's family with attempts to engage the deceased, or find an appropriate residence for him if released.

RPH Oncology had by this time advised the PRB the prognosis for the deceased was very limited. The deceased himself was visited by a doctor in the company of the Casuarina Infirmary Clinical Nurse Manager, and Peer Support Officer, Winston Jackson. The deceased made it clear he wanted to be actively treated. This indicated a will to live and differed from his attitude when first diagnosed with cancer at which time he did not want his family involved with his circumstances. Ms Wade continued to try and find community and family support for the deceased if he were to be released.

On 20 February 2008 Ms Wade understood the PRB were satisfied with the medical information provided and it only remained for a proper parole plan to be prepared for his release. They wished to review an appropriate plan on 8 April 2008.

Ms Wade again attempted to find family members in Carnarvon to assist with the deceased, whilst also

attempting to clarify the medical facilities available for treatment of the deceased when in Carnarvon. The aged care assessment team was to help with this after assessing the deceased and his medical needs.

None of the deceased's family responded to contact through AVS.

The deceased was advised on 27 February 2008 his case was to be reviewed by the PRB on 8 April 2008. Unfortunately this corresponded with a definite deterioration in the deceased's neurological status and he was transferred to Fremantle Hospital on 27 February 2008. His prognosis was only a few days and it became clear a suitable facility would not be found in Carnarvon.

Ms Wade's input changed to try and contact family members to come to the metropolitan area to spend time with the deceased. He was still in custody, all appeals for Clemency having been rejected, and so had to remain under guard while in hospital.

The Superintendent of Casuarina Prison provided some funds for relatives to visit the deceased from Carnarvon and the hospital offered to assist with some accommodation.

The deceased was visited by some family members over the weekend and died in Fremantle Hospital on Sunday 2 March 2008.

POST MORTEM EXAMINATION

The post Mortem examination was carried out on 5 March 2008 by Dr J White of Pathwest, Forensic Pathology.

Dr White indicated medical examination of the deceased showed evidence of disseminated malignancy thought to be from a primary lung tumour with involvement of the right lung, mediastinum, multiple lymph nodes, stomach, right adrenal, pancreas and brain. There were changes in his lungs consistent with emphysema and possible infection. Tumour nodules within his stomach had caused a recent gastro intestinal bleed.

It was concluded the deceased had died of complications of disseminated malignancy.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 63 year old Aboriginal male who had been in the prison system continuously from 1986 when he was sentenced to a six year prison term followed by an indefinite sentence where he was held at the Governor's Pleasure.

Once held at the Governor's Pleasure he was subject to annual review by the Parole Board (which later became PRB), but was consistently denied release to the community

due to his intransigence with respect to participation in any form of SOTP and the seriousness of his original offending.

I accept the prison system attempted to engage the deceased in appropriate programs. Originally they were not available to a prisoner such as the deceased due to their restricted placements. As, over time, they became refined, so the deceased's attitude towards any behaviour changes became entrenched.

No progress was made with engaging the deceased in any SOTP program which was a PRB requirement.

Over time he became recognised as an accomplished artist in the prison community and gained great respect for his art work and age.

While accepting the department was attempting to find ways to accommodate the deceased it is also the fact, from the deceased's perspective, there was no ability to compromise over the terms of any appropriate SOTP. Whatever was suggested never closed all his objections and so provided the deceased with a reason to decline to engage. There is no doubt he processed the cognitive ability to engage if he so chose. It also seems obtuse from a psychological perspective to require aboriginal males be assessed by females, of whatever ethnicity, when considering indigenous appropriate SOTPs.

Unfortunately the deceased became extremely unwell and was diagnosed with terminal cancer. Plans for both release and Clemency were rejected without some input from the deceased with respect to attempts to address any perceived danger to the community into which he was released.

Efforts were made to re-engage the deceased, however, he became severely unwell before it was possible to determine whether or not he would eventually follow through with a culturally appropriate management and behaviour modification plan. The deceased had at times acknowledged he had an alcohol problem and it seems all of his offending had occurred at times when he was severely intoxicated. He appears not to have seen his sexual offending behaviour as separate from his intoxication. He had addressed his alcohol consumption with respect to a healthier lifestyle. It is possible, regardless of the purpose of the alcohol education, his desire to remain alcohol free would have prevented his sexual offending.

The Parole Board followed by the PRB consistently required full SOTP involvement rather than the alcohol or cognitive behaviour therapies.

The deceased died of his disease in Fremantle Hospital on 2 March 2008 before being engaged in any management plan.

I find death arose by way of Natural Causes.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED WHILE IN CUSTODY

Community policies, as reflected by the executive and judicial attitudes, have changed since 1986 when the indefinite term of imprisonment was imposed on the deceased. In 1986 a Judge could impose an indefinite sentence without hearing expert evidence as to a prognosis for the offender's future offending behaviour. Case law after that time developed a system whereby the prosecution would make such an application to the judge and the defence would be warned of such an application and both sides would attempt to provide expert input for the benefit of the Judge then imposing an indefinite sentence.

Once the indefinite sentence was imposed, and there had been no appeal over-turning the sentence, then the detainee subject to an indefinite sentence would be annually reviewed as to their circumstances, once into the indefinite term. This occurred with the deceased and it was at those annual reviews the subject of his willingness, or lack thereof, to engage in relevant SOTPs arose. They were relatively new and unsophisticated initially.

One of the people approached by the ALS in late 2007 in an attempt to engage the deceased when requested to do so by the Parole Board was an Aboriginal Psychologist, Mr Darryl Henry. He is the author of the Aboriginal Cognitive Skills Program used in WA prisons at that time

Evidence from Mr Henry during the inquest indicated he believed he would have been able to properly engage the deceased in an appropriate and relevant therapy to progress a pre-release program. Mr Henry also believed the deceased had become resigned to not leaving prison and was to a considerable extent institutionalised.

Working with the deceased would involve allowing him respect for the positives in his life and using that as a basis for addressing the negative aspects of his behaviour. Unfortunately, Mr Henry did not have the opportunity to progress his plan for the deceased and see whether or not he could really be engaged in the way Mr Henry hoped.

However, the very fact he would at least speak with Mr Henry, as he had with the AVS members at Roebourne, may indicate a more culturally appropriate approach could be successful with people such as the deceased at a much earlier stage of their prison life. It may suggest rapid inclusion in appropriate programs would be more successful in engaging indigenous men, in particular, in addressing behavioural problems, before they become lost in a cycle of hopelessness.

Evidence from both Mr Parke and Mr Ellis at the inquest indicated, in more recent times, the prison system has very much attempted to provide appropriate treatment programs for a number of offending behaviours, using various assessment methods.

It is essential offenders cooperate with the assessment process to enable an appropriate understanding of the programs which will best build on an individual's needs and circumstances to work towards a positive achievement ultimately for the appropriate program. This has not always been the case and certainly it is fair to say that when the deceased commenced his prison term programs addressing criminogenic needs, whether they be by way of mental health or behavioural issues, were very much more basic than the systems now available. It is entirely possible the deceased became disillusioned and non receptive to attempts to engage with him before prison services had reached a level at which they could suitably deal with him. His offences were serious and the system needed to consider broader community issues.

I am persuaded, as time has progressed, there is becoming available to the prison system a number of options it would be beneficial to consider. Mr Ellis indicated changes in the expectation of workers in the prison system has altered over time. Originally there were no specific requirements for relevant qualifications. This changed in 2001 when it became mandatory for people employed in various counselling and program delivery programs in the system to be relevantly qualified.

This probably precluded satisfactory input in a number of minority groups and includes the indigenous community.

Mr Henry believes there are ways indigenous prisoners can be appropriately engaged in rehabilitative programs which address an offender's criminogenic needs. These need to consider skilled workers rather than professionally or tertiary qualified workers. Mr Ellis agreed more recently he believed this was an appropriate matter for the prison system to consider.

I am also concerned better engagement of indigenous prisoners while in the prison system will improve general health expectations. While the deceased does appear to have been prepared to accept medical treatment I note he appears to have made no compliant leading to earlier diagnosis of his cancer condition, until discovered unconscious.

I am satisfied it would be beneficial to the prison system to consider more wide spread use of appropriately skilled aboriginal health care workers in an attempt to engage the disproportionate number of indigenous prisoners in the system. As Mr Ellis indicated addressing criminogenic needs is ultimately cost effective. Any strategy which would work towards encouraging offenders to accept some sort of responsibility for their offending behaviour and address it is a benefit to the community as a whole. Generally a community which respects itself finds it easier to respect others and differences in culture are more appropriately resolved and effective compromise obtained.

I accept the treatment, supervision and care of the deceased was a work in progress which was being addressed as adequately as was possible in the current state of custodial services. It was not possible to engage him at a time which would probably have been most beneficial to him and the community.

I note there are a number of long time prisoners in the prison system subject to indefinite sentences imposed after relatively short finite terms. This indicates the initiating offence itself is less of a problem than the concern as to the on-going behaviour of the offender. (This was not the case for the deceased who's offences had been serious).

I hope the sorts of individual therapeutic strategies considered at the end of his life for the deceased may be utilised and refined for the benefit of some of those still incarcerated.

I accept some of those serving indefinite sentences are, and will always remain, a danger to the community as a whole due to matters wholly individual to themselves.

I RECOMMEND

There be serious consideration given to the appointment of skilled Indigenous Health Workers to co-ordinate and assist AVS members in engaging indigenous prisoners in ways considered appropriate to achieve outcomes which will satisfy general community goals.

Evelyn Vicker

EF Vicker
DEPUTY STATE CORONER

2 September 2010