Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 16/11

I, Alastair Neil Hope, State Coroner, having investigated the death of ***Alan Murray TUCKER****, with an Inquest held at Perth Coroners Court on 28-29 June 2011 find that the identity of the deceased person was* ***Alan Murray TUCKER*** *and that death occurred on 19 or 20 September 2008 at Casuarina Prison, Orton Road, Casuarina, as a result of combined effects of atherosclerotic cardiovascular disease and pulmonary infarction due to pulmonary thromboemboli in the following circumstances -*

Counsel Appearing :

Mr Dominic Mulligan assisting the State Coroner
Mr Barry King (State Solicitors Office) for the Department of Justice
Ms W Hughes (ALS) for the family

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INTRODUCTION

Alan Murray Tucker (the deceased) was an Aboriginal male aged 25 years, born on 27 November 1982, he died while incarcerated at Casuarina Prison on the night of 19/20 September 2008.

A subsequent post mortem examination conducted by forensic pathologist, Dr Judith McCreath, revealed that the cause of death was combined effects of atherosclerotic cardiovascular disease and pulmonary infarction due to pulmonary thromboemboli.

The deceased had been ill for a significant period of time prior to his death and had he died in the community the death would not have been reported to a coroner. Section 22 of the *Coroners Act 1996*, however, provides that a Coroner does have jurisdiction to investigate and must hold an inquest where a death was a Western Australian death and the deceased was a person held in care. For the purposes of the Act the deceased was a person "held in care" (section 3).

Pursuant to section 25 of the Act as the death was of a person held in care, it was mandatory for a Coroner to comment on the quality of the supervision, treatment and care of the deceased while in care.

BACKGROUND

On 5 June 2004 the deceased was arrested and charged with two counts of Sexual Penetration of a Child Under the age of 13 years, a charge of Deprivation of Liberty and a charge of Assault Occasioning Bodily Harm. The complainant in these matters was a 6 year old male child.

The deceased was remanded in custody to Hakea Prison on 5 June 2004 and he entered a plea of guilty to all charges on 8 August 2004. On 31 August 2004 he was sentenced to a total period of 6 years imprisonment.

The deceased was returned to Hakea Prison after being sentenced and due to the nature of his offences he was placed in Protection Unit 6. On 18 July 2005 the deceased was transferred to Casuarina Prison where he remained until 29 November 2006. At that stage, as he had completed an intensive sexual offender treatment program, he was transferred to Acacia Prison as a medium security prisoner. He was placed in the protection unit, Juliet Block. The deceased received occasional visits from his mother who was serving a sentence at Bandyup Women's Prison and kept regular contact with his foster parents and grandmother.

On 18 December 2007 the deceased was discovered in his cell suffering from chest pain. Staff called for medical assistance and operated an oxy viva device. The deceased became unconscious and was transferred by ambulance to Swan District Hospital and later to Royal Perth Hospital.

The deceased was diagnosed with a collapsed or occluded coronary artery and having suffered a myocardial infarction. He underwent surgery to have a stent implanted but suffered another cardiac arrest while in the Intensive Care Unit and a second stent was implanted. He was placed on a cardiovascular treatment plan on 31 December 2007 and transferred to Casuarina Prison infirmary where he remained for three weeks before returning Acacia Prison.

On 6 February 2008 the deceased was found coughing up blood. He was asked to attend the Acacia Prison Medical Centre for an assessment. When he arrived nurses were issuing medications and he became impatient and walked out.

On 2 March 2008 a nurse from the medical centre observed a substantial amount of blood in the deceased's toilet bowl. The deceased was transferred to Swan District Hospital for treatment and was then returned to Acacia Prison on 7 March 2008.

During April and May 2008 the deceased was transferred on two occasions by ambulance to Swan District Hospital and Royal Perth Hospital after coughing up blood. On 22 May 2008 the deceased complained of leg pain and was assessed by a doctor at Acacia Prison following which he was transferred by ambulance to Swan District Hospital. He was diagnosed with deep vein thrombosis in his left leg and remained at Swan District Hospital until 6 June 2008 when he was returned to Acacia Prison.

The deceased was given warfarin for his blood clotting and was continued on that medication until his death.

The following day the deceased was again transferred by ambulance to Swan District Hospital due to coughing up blood and experiencing breathlessness. He returned to Acacia Prison on 10 June 2008.

On 30 June 2008 the deceased was transferred to Royal Perth Hospital after coughing up blood and was discharged on 25 July 2008 to Casuarina Prison. On 30 July 2008 he was again transferred from Casuarina Prison to Royal Perth Hospital where he was assessed by Dr Geoffrey Cope. A report prepared on 25 August 2008 indicated that the deceased had chronic heart failure.

The deceased was reviewed by the hospital's heart transplant team but was not recommended as a suitable

candidate for a transplant due to poor compliance with his medications. He was discharged from Royal Perth Hospital on 31 August 2008 and returned to the Casuarina Prison infirmary.

On 3 September 2008 the deceased returned to his cell in Unit 6, Cell B08. It appears that the deceased wished to be with his uncle, prisoner Dexter Williams.

The Progress Notes in the deceased's Medical File contain a final note on 11 September 2008 at which time he had provided a sample of blood for a blood test and results were sent to pathology. This appears to be the last occasion on which he received medical treatment prior to his death.

DISCOVERY OF DEATH

At about 7:33am on 20 September 2008 Prison Officers Martin Stokes and Paul Cheong commenced to unlock the cells in Unit 6. The first cell they opened on B Wing was number 8 which was occupied by the deceased and his uncle.

Prison Officer Stokes unlocked the door and looked through the observation hatch. He could see the deceased lying on his back on the lower bunk with his uncle lying on a mattress on the floor of the cell. The prison officer

knocked on the door to wake them up and asked them to move as was the usual practice.

The deceased's uncle woke and sat up. He was asked by the prison officer to give the deceased a nudge to wake him up and he shook the mattress on the deceased's bunk.

Prison Officer Stokes entered the cell to wake the deceased, but on touching his leg found him to be cold and unresponsive.

Prison Officer Cheong called for assistance from other staff which included Clinical Nurse Andrew Hain who was in the unit ready to dispense the morning's medications to prisoners. Nurse Hain examined the deceased and found that there were no signs of life. Clinical Nurse Janice Tyler who had been at the infirmary arrived shortly afterwards and also checked the deceased. She confirmed the conclusion that he had passed away.

The prison doctor was advised that there was a deceased prisoner in Unit 6 and his attendance was required. At about 9:15am he examined the deceased and confirmed death.

POLICE ATTENDANCE

Police attended and officers from the Major Crime Squad conducted an investigation.

The deceased's uncle was interviewed and a statement obtained from him. Prisoners from adjacent and opposite cells were also interviewed and statements obtained from them. There was nothing of concern in the statements of any of the prisoners.

An appropriate forensic examination was conducted by officers from the Crime Scene Investigation Unit.

Subsequently an investigation was conducted by officers of the Custodial Standards and Review Branch, Professional Standards Division, Department of Corrective Services. That review addressed systemic issues arising from the incident.

CONCLUSION

The deceased was a 25 year old Aboriginal incarcerated prisoner who died at Casuarina Prison as a result of combined effects of atherosclerotic cardiovascular disease and pulmonary infarction due to pulmonary thromboemboli.

The deceased had been very unwell for a significant period prior to his death and his medical history included ischaemic heart disease with stents in his coronary arteries, anticoagulation therapy, hypercholesterolaemia and haemoptysis (coughing up blood).

I find that the death arose by way of Natural Causes.

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

The quality of the supervision, treatment and care of the deceased while he was incarcerated appears to have been generally satisfactory.

The deceased had been appropriately placed in protection units in the context of his past offending and considerable efforts had been made to ensure that he received ongoing medical treatment.

Only two potential issues relating to the quality of his treatment and care were raised during the inquest hearing.

1. THE SIZE OF THE CELL IN WHICH THE DECEASED WAS HELD

While the size of the cell had no bearing on the deceased's death, it is noted that the cell did not comply with the Department of Corrective Services current design standards[1].

The deceased was sharing a cell with his uncle, the cell floor area was approximately 9 square metres. This is the appropriate minimum size for a single occupancy cell. The guidelines dictate that a double occupancy cell should be 13.5 square metres.

While the cell was small, it is noted that the inquest was informed that many prisoners at Hakea Prison are considerably worse off than the deceased and that prisoners there share cells with a floor area of 5.09 square metres.

It appears that the prison muster for Casuarina Prison has increased faster than the ability to provide new cells. This has resulted in prisoners sharing cells designed for single prisoner occupancy.

[1] Design Guidelines for Western Australian Correctional Facilities, Government of Western Australia, Department of Corrective Services

Casuarina Prison at the time of the death had a designed capacity for 397 prisoners, at the time of the death the muster was 628.

It should, however, be noted that it appears that the deceased and his uncle wished to share a cell.

While I recognise that provision of suitable cells depends on infrastructure available, which in turn depends on government funding, questions relating to prioritisation of funding are not a matter for my consideration and I am required to comment on the quality of care provided to the deceased.

In the context of the above evidence and information I make the following recommendation.

RECOMMENDATION NO. 1

THE DEPARTMENT OF CORRECTIVE SERVICES TAKE ACTION TO ENSURE THAT AS SOON AS PRACTICABLE PRISONERS ARE NOT HOUSED IN CELLS WHICH FAIL TO MEET THE DEPARTMENT'S DESIGN GUIDELINES.

2. Policy Directive 08 – Prisoners with a Terminal Illness

A question was raised at the inquest as to whether in the context of the deceased's poor health, he should have been considered for early release in accordance with the Department of Corrective Services Policy Directive 08.

Policy Directive 08 addresses treatment of prisoners with terminal illness and provides for a two phase approach.

Phase I provides as follows –

> A "terminally ill" prisoner is identified by the prison's health service provider as suffering from an illness where there is a high probability of death. Once identified, the condition will be continuously monitored. An initial Phase 1 "terminally ill prisoner" form will be provided by the health service provider to the Manager Sentence Management. A prisoner identified as terminally ill is to be asked by the prison's health service provider to consent to the release of medial information for purposes associated with this Policy Directive. Confidential health care information obtained in accordance with Section 39(e) of the Prisons Act 1981 may be provided to others to assist in the routine management of the prisoner.
>
> The health service provider will advise the Superintendent of the holding prison that a "terminally ill" prisoner has been identified.
>
> Upon being notified of the health status of the prisoner, the Superintendent shall ensure that all routine management decisions have regard to the prisoner's notified status.
>
> The health service provider is responsible for the verification of medical reports and will prepare a Phase I "terminally ill prisoner" form notifying the Manager Sentence Management of the prisoner's medical condition/prognosis.

Phase II deals with the situation where the death of a prisoner is imminent and the relevant section of the directive provides –

> In those cases where a prisoner's condition becomes end stage, the health service provider will prepare a Phase II "terminally ill prisoner" form notifying the Manager Sentence Management.
>
> The Manager Sentence Management will arrange for correspondence detailing the circumstances of the case to be prepared for urgent submission to the Minister through the Executive Director, Prisons. This will be a briefing note which will report on –
>
> - Sentence details;
> - Criminal history;
> - Judges sentencing remarks (where applicable);
> - Victim issues;
> - Prison conduct reports;
> - Most recent Parole Board decisions (where applicable);
> - Programme performance;
> - Community supports;
> - Health status; and
> - Recommendation – Phase II

It was a matter of concern at the inquest that doctors involved in the treatment of the deceased employed by the Department of Corrective Services were unaware of Policy Directive 08 and appeared to be unaware of how that policy directive should be applied.

It was also a concern that there was confusion as to the identity of the "health service provider" who was required to complete the "terminally ill prisoner" form.

Dr Joseph Diaz, who had extensive dealings with the deceased, believed that he was the "health service provider" while Dr Fraser Moss, the Acting Director, Health Services, considered that the "health service provider" was either the Director or the Health Service Directorate.

Dr Moss explained that ideally the policy should provide for the treating doctor to contact him when it was determined that a prisoner was terminally ill and then it would be for him to contact the Manager, Sentence Management, to ensure that there would be ongoing management of the case and that appropriate action would be taken prior to a prisoner's death becoming imminent.

While there was some potential for confusion as to the stage at which the deceased had reached prior to his death in the context of Policy Directive 08 case, particularly in a context where his heart failure was described as "end stage", it appears that this reference was intended to communicate the fact that the deceased's heart failure was irreversible, but did not necessarily mean that death was imminent.

In my view the deceased's condition should have resulted in his being identified as a "terminally ill" prisoner whose condition needed to be continually monitored (Phase I). He had not reached the stage where death was

imminent, even though it was recognised that he could die at any time.

The deceased's condition, therefore, had not reached the stage where it would have been appropriate to refer his case to the Minister for consideration as to whether early release would have been appropriate and the failure did not have any significant bearing on his management.

In the above context, however, it appears clear that the Policy Directive 08 requires amendment and clarification.

RECOMMENDATION NO. 2

I RECOMMEND THAT THE DEPARTMENT OF CORRECTIVE SERVICES TAKE STEPS TO FORMULATE A CLEAR AND UNAMBIGUOUS POLICY TO REPLACE POLICY DIRECTIVE 08 WHICH SETS OUT PRECISELY HOW A TERMINALLY ILL PRISONER IS TO BE IDENTIFIED AND MANAGED AND DETAILS THE STEPS WHICH SHOULD BE IN PLACE TO REFER THE CASE TO THE MINISTER FOR A CONSIDERATION FOR CLEMENCY.

A N HOPE
STATE CORONER
20 July 2011