Coroners Act, 1996

[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION OF DEATH

Ref No: 14/12

I, Evelyn Felicia VICKER, Deputy State Coroner, having investigated the death of ***Tjantju JAMIESON (known as SANDY)*** *with an inquest, held at the* ***Perth Coroners Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on 22 - 24 May 2012 & 9 July 2012 find the identity of the deceased person was* ***Tjantju JAMIESON*** *and that death occurred on* ***19 January 2010 in Cell 1A, Unit 1, Albany Regional Prison,*** *and was* ***Consistent with Epileptic Seizure*** in *the following circumstances:*

Counsel Appearing :

Ms Melanie Smith assisted the Deputy State Coroner
Mr Paul Gazia (instructed by ALS WA) on behalf of the family
Ms Kate Pederson (State Solicitors Office) on behalf of Department Corrective Services (DCS)
Ms Fiona Vernon (Avant Law Pty) on behalf of Dr Juniper

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INTRODUCTION

The deceased, Tjantju Jamieson, known as Sandy, (Mr Jamieson) was a sentenced prisoner, expecting to be released in less than a month after the event of his death. He had a history of epileptic type seizures and alcohol abuse.

Following morning unlock on 19 January 2010 he was located deceased in his bed in Cell 1A Albany Regional Prison (ARP).

He was 41 years of age.

Pursuant to Section 22 of the *Coroners Act 1996*, Mr Jamieson was a person held in care for the purposes of the Act, and as such an inquest into the circumstances of his death is mandated. Further under s25(3) I am required to comment on the quality of the supervision, treatment and care of Mr Jamieson while he was in that care.

BACKGROUND

Mr Jamieson was born at Cundeelee Mission on 22 September 1968, and had lived in the Coonana Aboriginal Community, as well as various other communities in the Goldfields and South Australia.

He attended school until 14 years of age, but was illiterate when he was first incarcerated in 1987/88. This occurred as the result of his having run over a woman with a stolen car. It was during his first period of incarceration he learned to read and write. Mr Jamieson claimed alcohol abuse was the reason

for his offending and that he gave up drinking when he was convicted of murder in 1988. His criminal convictions since that date would indicate this was not correct. He was incarcerated a further three times for mostly violent offences.

Prior to his last incarceration Mr Jamieson lived at Tjuntjurra Aboriginal Community with his wife. They did not have any children, although it is possible Mr Jamieson had a son by another woman. At the time of his last period of imprisonment he was serving a sentence for aggravated unlawful wounding and other offences, for which he had received a total term of imprisonment of 18 months. He had been denied parole on 13 May 2009 and transferred to ARP from Casuarina in September 2009. His earliest date of release (EDR) was 14 February 2010.

MEDICAL HISTORY

Early reports from Mr Jamieson's community clinic indicate he suffered epileptic type seizures as early as 1979, when he was 11 years of age. He was not assessed and it was considered possible the seizures were related to a penicillin allergy.

He was definitively diagnosed with epilepsy during his first term of imprisonment in 1988, with a recorded grand mal seizure in 1996. He was referred for an EEG, carried out on 30 April 1996, while imprisoned in Canning Vale Prison. The report recorded *"abnormal resting record with generalized bilateral epileptic activity on a normal background"*. He is also recorded as suffering from asthma.

CURRENT TERM OF IMPRISONMENT

Mr Jamieson was sentenced to 18 months imprisonment for a series of offences related to violence, and giving false information, on 15 August 2008 at the Kalgoorlie Magistrates Court. He had a TOMS medic alert of epilepsy, for which he was medicated with Epilim (sodium valproate) and Tegretol (Carbamazepine).

There are various reports in his files of non-compliance with his medication while in the community, and some of non-compliance while in custody. Careful reference to the records would seem to indicate he was mainly compliant with his anti-epileptic medication during his last term of imprisonment, especially after transfer to ARP.

He was transferred to ARP in September 2009 for muster management purposes and an Individual Management Plan (IMP) was completed by Casuarina Prison in preparation for his transfer. An IMP is intended to outline the management of the prisoner and provide information with respect to his welfare and security, including re-habilitation and re-integration issues. While he was considered to be eligible for a number of programs, none of those were available to him in time for his EDR (14 February 2010).

A classification review for ARP altered his security rating from maximum to medium security and he was housed in Unit 1,

subject to a standard supervision regime. His unit officers reported he was a quiet prisoner, kept to himself and maintained an acceptable level of hygiene and cleanliness. He was not viewed as a management problem, and it was accepted he was isolated from family and friends due to the remoteness of his placement from their community.

Mr Jamieson was to be transferred to Casuarina Prison on 2 February 2010 from where it was intended he go to the Eastern Goldfields Regional Prison on 8 February 2010 pending his release on 14 February 2010.

Mr Jamieson was visited by Aboriginal Visitors Scheme Staff on 13 January 2010 for general counseling when Mr Jamieson asked for that service to assist him in attempting to contact his son. He considered access was being blocked by his defacto partner. Aside from that issue Mr Jamieson was not recorded as having any problems or issues in early 2010 and seemed to be quite comfortable in his placing.

This was confirmed by his cell mate, Prisoner Jade De-Abreu.

Mr De-Abreu stated he doubled up with Mr Jamieson, by choice, due to disputes with his prior placement in Unit 2.

Mr De-Abreu considered Mr Jamieson to be a placid character, easy going, liked sport, was not short of friends, and was well respected by prison staff and inmates alike.[1]

[1] Exhibit 1, Tab 24

MEDICAL HISTORY WHILE AT ALBANY REGIONAL PRISON (ARP)

Mr Jamieson was medically assessed on his arrival at ARP on 7 September 2009 and found to have no significant medical problems, other than his epilepsy for which he took medication. He is also recorded as suffering from asthma.

He was medicated with Epilim (Sodium Valproate 500mg twice daily) Tegretol (Carbamazepine, 200mg twice daily) and short term Naprosyn, when required, for injuries.

Prisoner medications are dispensed by staff from a Webster pack which is generally prepared off-site by a pharmacist. In the case of short term medications, they are often packed separately in the Webster pack so they can be taken, or not, as determined by the on-site health practitioners.

His medical file since transfer to ARP indicated he had not had any known seizures, or complained of seizures, since his transfer to ARP. His last known seizure had been on 21 July 2009.

When initially transferred he occasionally did not attend for his medical reviews, but overall he seemed to be fairly compliant with medical issues.

On 22 October 2009 he had an abscess on his face incised and drained, and in November 2009 he was counseled for stress.

In December 2009 Mr Jamieson presented to the infirmary with an ear ache and at that time a nurse noted he should have his bloods taken for his Epilim level to check his blood plasma levels. This request is repeated on 29 December 2009 when the medical notes record *"requires Epilim level has not been done for a long time!."* The plan was *"for doctor to write up path form for bloods and test next week with follow-up after that".* This was done by Dr Wasium on 31 December 2009 as a request for a valproate level.

On 6 January 2010 Mr Jamieson presented at the infirmary for a blood test but his medication had not been withheld. The tests were rescheduled for the following week, with a note his medication was to be withheld that morning to enable an accurate assessment.

He was seen at the medical centre on 12 January 2010 as he had complained about some pain. His recorded observations were all normal and it was decided no further action was needed with respect to that issue.

On 13 January 2010 blood was taken for his Tegretol (Carbamazepine) levels and he was then issued with his medication. This had been requested by Nurse Whinnen.

There does not seem to be a recorded request for the Valproate level ordered by Dr Wasium.

When the results came in the Carbamazepine level was

recorded as 4mg/L (normal range by that laboratory 6-12 mg/L). Evidence at the inquest indicated this result was received by Nurse Whinnen's computer at 6:00am on 14 January 2010.[2] There was also an indication there were some volporate readings ordered, but not yet received. This would appear to relate to the earlier request for a volporate level. Nurse Whinnen's evidence was she only took note of results for her patients, although she took bloods from other patients for other practitioners.

On 14 January 2010 Mr Jamieson's Naprosyn medication was reviewed by Dr Juniper who, on information he believes must have come from a nurse, discontinued Mr Jamieson's Naprosyn. The Naprosyn had been prescribed short term for either his ear ache or a knee strain, more likely the knee strain, and evidence from Nurse Kerry Finigan, indicated the deceased had been refusing his Naprosyn medication which remained in the Webster pack.[3] As a result there was a request the script be discontinued to prevent further dispensing via a Webster pack from the pharmacist.

Dr Juniper does not believe he saw the carbamazepine or any valproate blood results at the time he reviewed the Naprosyn for Mr Jamieson. Nurse Whinnen confirmed Mr Jamieson was not one of her clients because his issue was not a blood borne disease, and while she may have taken the bloods, she would merely have transferred the information across to his file when she next opened her computer. She only reviewed the bloods

[2] Transcript 24.05,2012, pg 159
[3] Transcript 23.05.2012, pg 63

relevant to her own patients. She did not know when on 14 January 2010 she would have transferred results, but she would have done so.

It was apparent from the EcHo screen for Mr Jamieson the system produces a triangle with alerts for problems specific to the prisoner whose medical file is under review. By the time Dr Juniper gave evidence at the inquest he was unable to recall whether or not the triangle with an exclamation mark on the problem screen indicated a significant issue for the prisoner, for example they required epilim, or it meant a new result with respect to epilim had been received on the file. He was confident that at the time he observed an alert as a part of his working in the system, even as an outside practitioner, he would have understood the significance of the alert. By the time of the inquest he could no longer recall the difference between the two options. If, on 14 January 2010 he had looked at the result for Mr Jamieson's carbamazepine level, he would not have taken steps to review Mr Jamieson because there were no reports and no evidence Mr Jamieson's epilepsy was not being controlled by his medication levels.

Review of the signing sheet for the deceased's Webster pack, current at the time of his death, indicated he was compliant with his medication for epilepsy. While he had not been taking his Naprosyn, he had mostly been signed off, twice a day, for both his epilim and tegretol. The only date for which there is an apparent *"non-compliance"* was the evening before his death.

Nurse Finigan explained it was frequently very hard to assess whether or not a patient had his medication during the course of the medication rounds. Generally, the fact a prisoner had not attended would not be understood until a return to the medical centre and a collation undertaken of the Webster packs.

Nurse Finigan described how the medication round was performed by a nurse, with a trolley with the files and Webster packs. The nurse was accompanied around the Units by prison officers. Part of the prison officer's function was to escort the nurse, call prisoners to the medication round, and ensure prisoners requiring oral medication consumed it when dispensed. When a prisoner presented to the trolley the nurse would select the appropriate file and Webster pack, dispense the medication, and sign the medication as having been taken. The fact a particular prisoner had not attended at that time could be missed until the round was completed. At the time of Mr Jamieson's death there were approximately 80 prisoners requiring medications from the trolley on the medication rounds.

The signing pages were supposed to be marked 'A' for absent or 'R' for refusal depending on the circumstances. Sometimes the collation could not take place at the conclusion of a round, although this was the preference.

Nurse Finigan said it was not until after the deceased's death,

when she returned to the medical centre to check his file, she found the medications for the evening of 18 January 2010 were still present in the Webster pack.[4] She then put an 'A' in the appropriate signing slot of the Webster pack signing sheet. The Webster pack and sheet were seized by police for the purposes of the investigation. That was the explanation for why the doctor reviewing Mr Jamieson's file for the Department of Corrective Services was under the misapprehension Mr Jamieson had been non-compliant with his medication for the period 9-19 January 2010. The signing off sheet was in the custody of the police after being handed to them by Nurse Finigan on the date of his death.[5] The level of carbamazepine for the bloods taken on 13 January 2010, although recorded as low by that laboratory as to the normal therapeutic range, is however, consistent with the fact the deceased was compliant with his medications, or at least his tegretol, at that time.

It is apparent the deceased had missed his epilim and tegretol for the evening of 18 January 2010. Other than that he had been compliant for the prior ten days.

At the time of his death the only complete blood results for Mr Jamieson's anti-epileptic medication were those for 24 November 2008, when his valproic acid had been 15m/L (therapeutic range 50-100) and carbamazepine 4mg/L, (therapeutic range 6-11), this was while on the same dosage he was receiving at the time of his death.

[4] Transcript 23.05.2012, pg 80
[5] Exhibit 1, Tab 3

The only other reading is that for 13 January 2010, which was for carbamazepine alone and recorded as 4mg/L (therapeutic range 6-12) with no result for valproic acid at that time.

The deceased had recorded an epileptic fit on 21 August 2008, after which he had his levels checked in November 2008. He had presented in June 2009 at Casuarina Prison with an indication he *"felt like he was going to have a fit,* however, he was not recorded as actually having one. The records for Casuarina indicate he was non-compliant with his epilim at that time. That incident was followed by an epileptic seizure on 21 July 2009, but no blood levels were taken.

Therefore at the time of his death at ARP the deceased had not had an epileptic fit while in Albany, nor had he had his bloods properly reviewed for his medication levels, but he had been compliant with his medications.

There was no management plan in place for his epilepsy, nor do there appear to have been epilepsy care management plans generally in the Corrective Services Health System in 2010, despite it being considered a chronic disease and the general health care policy being chronic diseases needed specific management plans. Nor had he had a comprehensive annual general health care review taking into account he suffered from epilepsy.

THE INCIDENT

Mr De-Abreu stated Mr Jamieson was well on the evening of 18 January 2010. Mr De-Abreu realised Mr Jamieson took medication but he does not remember, or know, what he took medication for. His memory of the evening of 18 January was the two of them had been watching television up until about 10:30pm - 11:00pm but there was nothing on. Mr De-Abreu was in the top bunk and he recalled seeing Mr Jamieson lying in the bunk below with his legs uncovered. Later discussion with another prisoner by prison officers revealed Mr Jamieson had drunk two cups of *"home brew"* during the evening of 18 January 2010. There is no evidence as to what was in the home brew.

Mr De-Abreu described that over night Mr Jamieson had been alive because he was awoken at approximately midnight by Mr Jamieson snoring loudly. He stated Mr Jamieson did not usually snore quite so loudly and he leaned over the bunk and called *"Oi Sandy"* which caused Mr Jamieson to snore less.[6]

Mr De-Abreu recalled some cell checks and stated he put his hand up on one occasion to show movement.

The Department of Corrective Services Death in Custody Review (Review)[7] indicated Unit 1's Reports and Occurrences log confirmed there had been three muster checks on the morning of Tuesday 19 January 2010. They had been at

[6] Exhibit 1, Tab 5
[7] Exhibit 2, Tab B

2:55am, 5:25am and 6:20am. The nightly muster checks are a body count and do not require movement.[8] The fact nightly muster checks no longer require movement is the result of prisoners complaining to the Ombudsman the checks, which required they showed movement, disturbed their sleep. As a result DCS policy directed the nightly checks were purely a body count to ensure the correct number of prisoners were present in each cell. Movement was not required for muster checks during normal sleeping hours.

At 6:20am there was a change of shift and the night prison officers handed over to the prison officers coming on duty. For Unit 1 that was Officers Marino, Goatley, Dore, Collins, Stephens, Van der Schaaf, Beet, Elliott, Probationary Officer Peglar, plus Senior Officers Scott and Robinson.[9]

The unlock and muster check was then performed at 7:55am. Prison Officer Goatley was the officer who unlocked the cell in which Mr Jamieson and Mr De-Abreu were located.

ARP Standing order A9 s110 and 111 required that at unlock prisoners were to be roused and brought out of sleep or inactivity and the officer was to ensure a positive response from the prisoner.

Mr Goatley described his procedure at the unlock and muster check. He acknowledged he was not only unlocking the cell doors, but observing movement from each prisoner present

[8] Transcript 23.05.2012, pg 106
[9] Exhibit 2, Tab B

when unlocked. This is a quite different check from the night random muster body counts.

Mr Goatley recalled when he unlocked the cell he observed Mr De-Abreu, he believed putting on an item of clothing, and he also believed when he looked at Mr Jamieson he observed his shoulder move after he had specifically requested movement.[10] As a result of being satisfied the prisoners in the cell were moving Mr Goatley moved on with the unlock.

Prisoner De-Abreu recalled the unlock, which he thought was 7:30am, and indicated he sat up in bed, looked over, and saw Mr Jamieson lying in the same position he had been in the night before. Mr De-Abreu then got up from his bunk and made his way down to the floor, where he was when another prisoner came to visit.

Mr De-Abreu, believing Mr Jamieson was having a lie-in, told his visitor to be quiet and he would sort out the issue later. That prisoner then left the cell and Mr De-Abreu combed his hair and went to have breakfast with some of the others.

The fact Mr De-Abreu recalled another prisoner coming in at unlock, whilst he was still getting up, may reflect a distraction at the time of the unlock of Cell 1A.

After breakfast Mr De-Abreu returned to the cell ready for a work party muster. He thought it was unusual Mr Jamieson

[10] Transcript 23.05.2012, pg 111-112

was not up, but was not concerned, and did not believe there was any need to disturb him.

For the work muster check prisoners are expected to stand at the doorway to the cell. Mr De-Abreu recalled the work party muster commenced as he walked back to his cell from breakfast. He stood by the door and was asked by one of the prison officers to rouse Mr Jamieson because he had not come to the door.

It was when he went to pull him on the leg Mr De-Abreu realised Mr Jamieson felt cold. He backed out of the cell and asked one of the officers to check on Mr Jamieson. Mr De Abreu had thought Mr Jamieson was alive but *"mucking around"*. It was when the prison officer went into the cell and then told Mr De-Abreu to go he realised there was some sort of problem.

The prison officer entering the cell and realising there was a problem with Mr Jamieson was Kerry-Lee Stephens. She had been standing at the door to Cell A1 while Mr Goatley completed the work party muster by walking down to Cell A12. After Mr De-Abreu had failed to rouse Mr Jamieson and explained to Ms Stephens he was cold, Ms Stephens recalled Mr Goatley. He went into the cell while Ms Stephens stood outside.

Mr Goatley attempted to rouse Mr Jamieson and realised fairly quickly all was not well. He called Senior Officer Robinson

over and they discussed the fact Mr Jamieson appeared to be deceased.

Senior Officer Robinson checked Mr Jamieson before exiting the cell and calling the other Senior Officer Scott. As a result a lock down was ordered for the yard and the medical centre asked to attend.

At the same time the Code Red medical emergency for 'A' yard was called, Officers Goatley and Robinson moved Mr Jamieson onto the floor to determine whether CPR should be conducted. Ms Stephens told Mr De-Abreu to sit down on a chair between cells A1 and A2 before he was placed in another cell for support.

Registered Nurse Kerry Anne Finigan was on duty that morning as Clinical Nurse at ARP. She was Acting Clinical Nurse Manager at the time. RN Finigan recalls the medic alert being called at approximately 8:27am and she attended the Code Red emergency in Unit 1.

RN Finigan could detect no signs of life for Mr Jamieson. He had no pulse, his pupils were clouded and non-reactive and there was no evidence of any cardiac output. She noted he was cold to touch and rigor mortis was evident.

Mr Goatley also advised the court it was his belief the deceased was stiff by the time he attempted to place him on the floor. He realised then it was likely he had been mistaken

when he believed he observed movement from Mr Jamieson approximately half an hour earlier.[11]

RN Finigan applied oxygen and the defibrillator to Mr Jamieson but there was no cardiac rhythm and she instructed CPR should not be conducted as there was no prospect of Mr Jamieson being revived.

Dr Clark Wasium attended the prison to review Mr Jamieson and certified his life extinct at approximately 9:15am.

It was then RN Finigan recalled she did not believe she had seen Mr Jamieson the night before for his medication round. In her view Mr Jamieson was a very compliant patient and it was unusual for him to miss his medication. It was at that stage she returned to the medical centre and checked his Webster pack. She located the medication for the night before still present. She marked an 'A' as Absent on the signing sheet and handed the blister pack to the police for their investigation.

The cell was then sealed to allow the police investigation to proceed.

A week after the death of Mr Jamieson prison officers located a bag of *"home brew"* under his bunk. It was not analyzed. There is no evidence of its contents, either at the time of Mr Jamieson's death, or at the time it was located. The only

[11] Transcript 23.05.2012, pg 115

evidence it was present at the time of his death is the information supplied by another prisoner, Mr Jamieson had drunk some on the night before his death, and the fact the cell was sealed after his death until its search by police and then the prison officers.[12] It was apparently not located by police at the time of their investigation.[13]

POST MORTEM REPORT[14]

The post mortem (PM) examination was performed by Dr Clive Cooke, Chief Forensic Pathologist on 22 January 2010.

Dr Cooke found increased fluid in the lungs, finely scarred kidneys and early arteriosclerotic hardening of the arteries with mild coronary arteriosclerosis. There was no other pathology observable. Histology confirmed the presence of some coronary arteriosclerosis and focal scarring of part of the heart muscle, congestion of the lungs with *"agonal aspiration of vomit into some of the smaller airways".*

Mr Jamieson's PM toxicology[15] showed a therapeutic blood level of Carbamazepine at 3mg/L and a sub-therapeutic blood level of Valproic Acid (70mg/L). The chemistry centre uses its own state references for therapeutic levels and this is demonstrative of different laboratories having different therapeutic ranges depending upon their accreditation and laboratory techniques. The PM result are indicative of whole blood

[12] Transcript 23.05,2012, pg 98
[13] Transcript 09.07.2012, pg 197
[14] Exhibit 1, Tab 34
[15] Exhibit 1, Tab 35

levels, while those taken for clinical purposes are serum levels[16]

The post mortem results indicate Mr Jamieson was generally complaint with his medication because he is still recording detectable levels of his medication despite missing the medical round on the evening of 18 January 2010. Toxicology did not reveal any alcohol in Mr Jamieson's system, despite the alleged consumption of *"home brew"*.

Neuropathology[17] indicated no *"significant abnormalities"* which renders the cause of death as one of exclusion. No cause of death is evident for Mr Jamieson other than the indicators his death was consistent with his epilepsy from his history, in a man who had early arteriosclerosis, from post mortem examination.

Dr Cooke clarified[18] this due to some dispute from Dr Carbon, Director Health Services within DCS.[19]

"Consistent with epileptic seizure is based on the exclusion of other causes. As Professor Kamien indicates, it is the same as SUDEP (Sudden Unexpected Death in Epilepsy)" and is analogous with SIDS in that no precise cause or mechanism has been found at post mortem examination. The presumed mechanism of death is a cardiac arrhythmia which is why

[16] Transcript 09.12.2012, pg 202
[17] Exhibit 1, Tab 35
[18] E-mail correspondence on 18 July 2012 between counsel assisting the Coroner and Dr Cooke provided to Dr Carbon
[19] Transcript 09.07.2012, pg 221

Dr Cooke included the fact of focal coronary arteriosclerosis as a background to the death, in that it may become important in worsening a cardiac arrhythmia once it starts.

Dr Cooke indicated forensic pathology prefers to use the term *"consistent with epileptic seizure"*, rather than the clinical SUDEP. From a coronial perspective it is more easily understood by families and carers than a technical acronym which to a lay person appears to be a condition all of its own.

Dr Cooke further indicated these types of death are not rare in the context of those with a known history of seizures and frequently do not leave the symptoms Dr Carbon believed were *"evidence"* of seizures resulting in death.

I intend to use the term 'Consistent with epileptic seizure' because it is likely Mr Jamieson's family and friends will understand the context of his death more readily.

CONCLUSION AS TO THE DEATH OF MR JAMIESON

I am satisfied Mr Jamieson was a 41 year old sentenced prisoner at ARP due for release from custody on 14 February 2010. He was expecting transfer to the metropolitan region, pending transfer to the Goldfields in early February.

Mr Jamieson's time in ARP had been reasonably uneventful, both from the prison management and medical perspective. Whatever his earlier compliance record whilst in custody, or even in the community, it is clear that once in Albany, after

initially being resistant to medication, he settled well and was mostly compliant with his medication.

He was not a stranger to the medical centre, but was not subject to any reviews specifically considering his history of epilepsy. There are no management care plans for epilepsy in Prison Health Services and as such there does not appear to have been reliable review to specifically consider whether or not he was:

- compliant with his medication; and
- whether that level of medication was controlling his seizure activity.

There is very little information about his epilepsy in his prison file other than the fact he suffered epilepsy, confirmed by EEG on 30 April 1996, and his belief he *"felt a seizure coming on"* in June 2009 when not medication compliant. There is no record as to whether or not he *"felt a seizure coming on"* when actually experiencing one in July 2009, or what his plasma medication levels were at that time. There is no way of knowing whether it was always apparent he had had a seizure if un-witnessed. Consequently while it was possible to determine he appeared to be medication compliant it was not possible to actually know whether it was effective in controlling his epilepsy. All we know is he was not complaining of seizure activity.

The only time bloods were taken at ARP for a review of his medication/blood serum levels was on 13 January 2010. The

result from that test indicated a carbamazepine level of 4mg/L, considered to be low by that laboratory whose reference range is 6-12mg/L. However a valproate level had not been received at the same time, nor was there any record of epileptic seizure. As such he was not reviewed with respect to his epilepsy, even to ascertain how he believed he was feeling.

Dr Juniper, when asked to review Mr Jamieson's file for the purposes of discontinuing Naprosyn, did not consider Mr Jamieson needed review for his epilepsy urgently. If Dr Juniper had seen the Carbamazepine results he would have believed there was still Valproate outstanding. Pending that result there was no indication Mr Jamieson's medication needed to be considered. He was not suffering known seizure activity and the indicators were whatever he was doing was effective.

Dr Juniper indicated he did not appreciate that discontinuance of Naprosyn could make a difference to a patient's valproate levels, not recorded in any event, and consequently discontinued the Naprosyn because his information was Mr Jamieson was not taking it, possibly because of a side effect. Dr Juniper explained Naprosyn frequently has a gut reaction which causes patients some discomfort. The Naprosyn had only been prescribed short term on 7 January 2010 as an anti-inflammatory, if required, and he had no hesitation in discontinuing the prescription in view of the fact Mr Jamieson was not taking it. There was no

reason Dr Juniper could see which indicated Mr Jamison needed to be counselled about Naprosyn specifically.

Consequently when Dr Juniper discontinued the prescription for Naprosyn at the request of the medical centre he did not consider a need to review Mr Jamieson, and did not ask Mr Jamieson be booked for an appointment. If Dr Juniper was aware of the results and had believed there was a requirement Mr Jamieson be reviewed specifically with respect to the blood test results, he would have asked Mr Jamieson be provided with an appointment.

Mr Jamieson had given no indication he considered his medication was not effective and it was not realised until after his death he had not taken his medication on the evening before his death.

The fact his carbamazepine, which was the medication recorded as low on 13 January 2010, was considered to be within the therapeutic range at post mortem (on blood levels) would indicate Mr Jamieson was compliant with his medication. The general censuses is there is more concern with checking carbamazepine levels because carbamazepine can cause toxicity if the levels are too high[20].

There is controversy over the implications for fluctuating levels of valproate. The issue with his valproate level is less clear. It had been considered low when taken in November 2008

[20] Transcript 09.07.2012, pg 184

following a seizure in August 2008 and was low at post mortem (different techniques). There were two recorded epileptic seizures prior to his move to ARP but there are no recorded serum levels relevant to the seizure in July 2009 to assist with the valproate levels considered to be effective in Mr Jamieson's case.

Professor Kamien, Provost of the WA Faculty of the College of General Practitioners and Emeritus Professor UWA, noted Mr Jamieson's recorded grand mal fits in the late 1990s all occurred at times he was known not to be taking his anti-epileptic medications.[21] Issues recorded during Mr Jamieson's latest term of imprisonment seem to relate to periods of non-compliance with his medication, but it is not entirely clear whether or not that is true for the seizure on 21 July 2009 which only makes reference to the fact he was *"known"* to be non-compliant.

At the time of Mr Jamieson's death he only appears to have missed medication on the evening before his death and his post mortem toxicology results make it unlikely this was overly significant in the occurrence of a seizure, other than a potential to elevate a risk. There is nothing in the post mortem toxicology screen to indicate the composition of the *"home brew"*.

Other than his non attendance at the medication round on the evening of 18 January 2010 there is nothing of note in

[21] Transcript 09.07.2012, pg 174

Mr Jamieson's behaviour preceding the morning of 19 January 2010 which would indicate he was in danger of a fatal seizure.

Following Mr Jamieson's alleged consumption of two cups of *"home brew"*, sometime on the evening of 18 January 2010, he re-acted perfectly normally and went to sleep. He was heard to be snoring, more loudly than usual, around midnight. On the muster checks in the early morning he was observed to be in his bed and Mr De-Abreu confirms Mr Jamieson was in the same position at unlock as he had been when he last leaned over the bunk and told him to quieten down.

Prison Officer Goatley agreed he must have been mistaken when he believed he saw movement from Mr Jamieson at 7:55am on the morning of 19 January 2010.

I am satisfied Mr Jamieson was deceased by that time and Prison Officer Goatley was mistaken when he thought he saw movement. Further, I am satisfied had Prison Officer Goatly realised Mr Jamieson was deceased at that stage he would still not have been able to revive Mr Jamieson. All the evidence indicates Mr Jamieson had died sometime previously and it would not have been possible to resuscitate him. Rigor mortis was well established and it is likely he died prior to 6.20am.

I have no concern RN Finigan did not commence resuscitation, indeed I think it would have been disrespectful. She was

certain he was deceased and it would not have been appropriate.

I am further satisfied that whatever the *"home brew"* contained it does not appear to have been alcoholic enough to have promoted a seizure due to there being no trace of alcohol in Mr Jamieson's system at post mortem examination, nor other questionable substances.

In view of the investigations conducted and the fact Mr Jamieson had both carbamazepine and valproate in his system at post mortem examination, it is clear he was mostly compliant with his medication, despite his omission to attend the medication round the night before. There is no explanation for his death, other than his history of epileptic seizure.

I find death arose by way of Natural Causes.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF MR JAMIESON

There are a number of issues which warrant mention, however, the management of prisoners with epilepsy is probably the most significant. I do not believe a lack of supervision, treatment and care with respect to his epilepsy resulted in Mr Jamieson's death. I do however, believe his epilepsy could and should have been more transparently managed.

CARE PLANS

Department of Corrective Services, Health Services Directorate policy requires care management plans be provided for known chronic conditions or illnesses. Dr Carbon agreed epilepsy was a chronic condition but did not agree it needed a specific management plan despite policy.[22]

In 2010 there was not a plan for prisoners suffering from epilepsy and it seems there were not many prisoners recorded with epilepsy.

There are many different forms of epilepsy and seizure activity may have different signatures. It would appear from Mr Jamieson's first diagnosis he was accepted as suffering seizure activity and recorded as epileptic without any further investigation. From the post mortem neuropathology it is unlikely there would have been any specific organic basis for his epilepsy, and there is no reliable information as to whether or not he was aware of seizure activity before it happened, or only became aware of it after it happened, or indeed whether or not he was ever aware of it without input from other observers. The one reference to his belief he felt a seizure coming on does not indicate whether this was usual for Mr Jamieson.

I can find no review of his instances of known epileptic seizure which would provide a guide for future reference. The only

[22] Transcript 09.07.2012, pg 224

references in his medical file are to a lack of compliance with medication.

I understand plasma levels of both carbamazepine and valproic acid can vary greatly within an individual with known or altered dosages and the most significant matter from a general practitioner's view is whether or not the epilepsy is being controlled. However, with review in a consistent format, with clinical consciousness as to a potential for seizure, it may become possible to ascertain a particular individual's response to medication. Further, where there is an issue in the prison system with prisoners with chronic conditions being noncompliant with their medication, there is no baseline, without review, for the level of concern a practitioner needs to be aware of with respect to non-compliance.

It would be preferable prisoners such as Mr Jamieson had their seizure activity investigated and recorded in an attempt to determine their plasma levels of medication at the time of a seizure and their plasma levels at the time of no apparent seizure activity. To achieve this it would be necessary for there to be review with plasma levels of relevant medication at the time of a known seizure and some follow up when a particular individual was considered to be stable. I am not suggesting a change in medication levels without meaningful indicators is necessary. Whether a patient was always aware of seizure activity would also be an important factor to determine, as well as the existence of possible triggers other than medication.

Once there had been instituted a method of review for an individual it would then be possible to review less frequently provided there was no evidence of further seizure activity. I considered Professor Kamien's annual review with a consciousness on the part of the reviewer to address the patient's general health from a perspective directed towards a potential for seizure activity appropriate.

The fact general practitioners reviewing the deceased did not alter his medication in response to apparently low blood levels, when there had been no apparent issue of seizure activity would seem to be entirely acceptable. However, it would be preferable that was done against a background of knowledge of his medication plasma levels and specific enquiry into his awareness of seizure activity.

I believe, where a prisoner is identified by the prison system as suffering a chronic disease/condition which benefits from preventative medications an individual prisoner care plan should be implemented to review and monitor relevant/significant signs with respect to each condition suffered by the prisoner and its medication.

In the case of epilepsy the prisoner care plan should initially include six monthly annual reviews to assess seizure control, preceded by relevant blood plasma levels, with results, to establish compliance and monitor general well being with any relevant interactions. Once there is a base line the review may

be annual. I am not referring to separate care plans for each condition but an individual prisoner care plan, including all conditions for that prisoner.

The issue of the home brew Mr Jamieson is alleged to have consumed the evening before his death is of some interest. Whatever the home brew comprised by the time it was located on 25 January 2010 it was not alcoholic at the time Mr Jamieson consumed it. Post mortem toxicology reveals no alcohol which could have induced a seizure. The fact the mixture was discovered under the bed when the cell was cleared by prison staff after the forensic examination of the cell by police is of some concern. It seems the forensic police did not locate the *"home brew"* the prison officers located some days later. Testing at the time of Mr Jamieson's death may have shed some light on its composition, largely lost six days later, when it was still not analyzed.

I question, firstly, the ability of prisoners to be confident they can secrete home brew in a prison environment, and secondly, the lack of police detection of the home brew at the time of Mr Jamieson's death. We will never know whether or not it had the potential to be relevant to seizure activity, despite the post mortem results.

With respect to the specific issues raised as questions with respect to this matter I am satisfied Mr Jamieson was already deceased at the time Prison Officer Goatley performed unlock, and that he was mistaken in his perception he saw movement

from Mr Jamieson. In the circumstances of this case I do not believe that to have been significant with respect to Mr Jamieson's supervision, treatment or care.

As to the issue of monitoring of Mr Jamieson's plasma levels for his anti-epileptic medication I doubt monitoring, without prior input and proper review of his prior seizures would have revealed a need to change his medication. He had not suffered a known seizure since he had been in ARP, nor had he given any indication he was experiencing any concerns despite fairly regular contact with medical staff.

Mr Jamieson was mostly compliant with his medication and his post mortem toxicology confirmed this. There may be some relevance of the fact he had not had his medication the night before and it is unfortunate the tracking of the dispensing of regular medications in a timely manner is so difficult at ARP.

I appreciate the difficulty for nurses on the medication round in understanding an individual prisoner has missed his medication until review of the Webster packs sometime after the conclusion of the round. It would be preferable the relevant prisoner was contacted while the trolley was still in the Unit to remind them to attend, or ascertain whether it is an active refusal which may require some further input.

It is essential prisoners actively refusing medication are noted as such so they can be reviewed and counselled. I do not

know how difficult it would be for nursing staff to compile a list by Unit of prisoners requiring regular medication on a round because it was not canvassed. The prisoner could then be marked off the list at the same time as their medication was dispensed. Those missing at the conclusion of the round in that Unit could be contacted prior to moving to the next Unit.

ARP is an old facility and as with most prisons generally runs with an over-capacity muster. I understand from Dr Carbon's evidence the provision of medical services is difficult in the conditions at ARP and it would seem EcHo, although a relatively recent system in the prison, is not as user friendly as is desirable. I do not know whether a different system would have assisted competent review of Mr Jamieson's epilepsy, but I do consider proper prisoner health care planning would have made his management more transparent.

I recommend:-

1. All prisoners have annual health reviews to ensure all chronic conditions relevant to that prisoner are being appropriately managed, with a prescribed plan for those conditions requiring more regular and specific review, embedded within the overall health management plan for each prisoner.

2. Improved health care facilities for ARP to support clinically appropriate health services especially the dispensing of medication.

3. Suitable custodial support for the provision of clinically appropriate health services.

4. Funding to facilitate identification, acquisition and implementation of a suitable electronic medical records system which will properly assist in the provision of comprehensive and workable health care plans and services in the prison system.

EF VICKER
Deputy State Coroner

31 August 2012