



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 7th, 9th and 11th days of September 2020, the 15th day of January 2021 and the 9th day of February 2022, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Michael Anthony Curran.

The said Court finds that Michael Anthony Curran aged 62 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at Northfield, South Australia on the 24th day of November 2015 as a result of metastatic hepatocellular carcinoma. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

- 1.1. Michael Anthony Curran, who was then 62 years of age, died on 24 November 2015 at the Queen Elizabeth Hospital (QEH). At the time of his death Mr Curran was serving a sentence of imprisonment for an offence of murder for which he had been convicted in the Supreme Court of South Australia on 18 December 2006. A mandatory sentence of life imprisonment with a non-parole period of 24 years and 4 months was imposed. This sentence was backdated to 13 November 2006 which was the date on which Mr Curran's home detention bail had been revoked and when, as a result, he was remanded in custody. Mr Curran was held in Department for Correctional Services (DCS) custody from 13 November 2006 to the date of his death. His custody was lawful.
- 1.2. Mr Curran's death was a death in custody in respect of which an inquest into the cause and circumstances of that death was mandatory pursuant to the provisions of the Coroners Act 2003. These are the findings of that inquest.

- 1.3. After Mr Curran was sentenced he was transferred between Port Augusta Prison and Yatala Labour Prison (YLP) on a number of occasions, in the main related to medical need. In April 2014 Mr Curran was transferred to Mobilong Prison where he remained until he was returned to YLP in October 2015. He remained at YLP until he was transferred into palliative care at the QEH shortly before his death.
- 1.4. Mr Curran's death was from a natural cause. An autopsy was not necessary. Rather, his case files from the QEH and the Royal Adelaide Hospital (RAH) were examined and evaluated in the course of a pathology review conducted by medical practitioners at Forensic Science South Australia. Tendered in evidence was the pathology review report of Dr Iain McIntyre dated 26 November 2015.¹ It is evident from the report that Dr McIntyre evaluated Mr Curran's clinical history and circumstances and in doing so conferred with the forensic pathologist Dr Neil Langlois. The conclusion as to the cause of Mr Curran's death is expressed as '*metastatic hepatocellular carcinoma*'. I find that to have been the cause of Mr Curran's death. The cause of death can be simplified in lay terms to liver cancer that had spread to another part of his body, in this case, primarily his lungs.

2. Background

- 2.1. In 2005 blood tests revealed that Mr Curran was positive for hepatitis C. Following this diagnosis, and while Mr Curran was in the custody of DCS, Mr Curran was under the care of the South Australian Prison Health Service (SAPHS) as well as the Liver Clinic within the RAH.
- 2.2. Hepatitis C is a significant risk factor for the development of liver cancer to which Mr Curran would ultimately succumb in 2015. There is no doubt that there was a connection between his hepatitis C positivity and the development of liver cancer in his case.
- 2.3. The evidence also revealed that a hepatitis C infection can result in fibrosis forming within the liver. As well, it can result in the development of the more serious condition known as cirrhosis of the liver. Cirrhosis of the liver is a frequent precursor to the development of liver cancer. It is evident that this clinical progression had occurred in the case of Mr Curran. The only issue of substance that was examined in this inquest

¹ Exhibit C2a

was whether or not Mr Curran's medical care was optimal having regard to his custodial circumstances. The associated question is whether Mr Curran's death could have been prevented, or at least delayed, or whether there was any factor in his care that may have contributed to his death.

- 2.4. It is generally accepted, rightly, that prisoners should have available to them medical treatment that is of no less a standard than that provided to the general public within the public health system.
- 2.5. Mr Curran would not be diagnosed as suffering from liver cancer until 2015 when he complained to medical staff at Mobilong of worsening pain in his shoulder area. On 15 June 2015 Mr Curran also complained of aching in the area of his liver, kidney and spleen.
- 2.6. The existence of severe fibrosis in Mr Curran's liver had been apparent since 2007 when a liver biopsy had been performed. In the biopsy report there was also reference to the possibility of liver cirrhosis at that time. The significance of this reference in terms of Mr Curran's ongoing care was a matter that was the subject of discussion and debate during the course of this inquest. I think it is accurate to say, however, that the evidence did not reveal that there had been a serious clinical manifestation of Mr Curran's liver disease until 2015, not long before his death. Ultimately, an abdominal ultrasound performed on 21 October 2015 revealed a heterogeneous mass consistent with hepatocellular carcinoma. As well, CT scanning of his chest, abdomen and pelvis on the same day better defined the liver lesion and also revealed multiple lung lesions. Further investigation revealed that these lesions represented a primary hepatocellular carcinoma with lung metastases which would ultimately be the cause of the deceased's death.
- 2.7. The issue specifically ventilated in the inquest is whether the development of what became a fatal liver cancer, could have been arrested or ameliorated in a way that may have prevented Mr Curran's death or have prolonged his life.

3. The course of Mr Curran's illness

- 3.1. The circumstances of Mr Curran's illness and medical picture prior to his death is explained in the statements and oral evidence of Dr Daniel Pronk who is the Medical Director of SAPHS.² Dr Pronk holds a Bachelor of Medicine and a Bachelor of Surgery

² Exhibit C19 and C19h

from Flinders University. As well, he is a Fellow of the Royal Australian College of General Practitioners. He has a Master of Business Administration conferred by the University of South Australia. He is an Associate Fellow of the Royal Australian College of Medical Administrators. Dr Pronk has worked in various medical environments around Australia, including in the Army. He has occupied the role of Medical Director of SAPHS since September 2017. Dr Pronk was not involved in the treatment or management of Mr Curran and did not work for SAPHS at any stage during Mr Curran's incarceration. Dr Pronk spoke of Mr Curran's treatment, history and management by reference to his clinical records both within the SAPHS as well as the RAH. Those records were tendered as exhibits in the inquest.³

- 3.2. It is not necessary to recite every aspect of Mr Curran's illness and treatment prior to his ultimate death in 2015. I will mention some of the salient features insofar as it is necessary to explain and deal with the issue at hand. That issue can be condensed into a consideration as to whether Mr Curran's liver cancer could and should have been diagnosed at an earlier point in time, the associated issue being whether the cirrhosis of his liver, a precursor of liver cancer, could and should have been identified at an earlier point in time and the appropriate treatment then instituted. Central to those issues was whether or not Mr Curran should have been subjected to regular liver screening that would have involved ultrasound examination that is normally undertaken on a six monthly basis in circumstances where cirrhosis of a person's liver has been identified. Such screening not only includes liver ultrasound but may also include blood tests. It did not take place in Mr Curran's case. It was said during the inquest that such screening is the '*gold standard*' in cases in which cirrhosis is identified. On one view of the matter regarding Mr Curran's medical history and what was known about his liver disease, and for reasons I will explain, these regular examinations should have taken place. As things transpired in his case, cirrhosis of his liver was not diagnosed with complete certainty at any stage during the course of Mr Curran's medical history while in prison and, as indicated elsewhere in these findings, his liver cancer was only diagnosed at a very late point in time and in circumstances that did not enable him to receive meaningful treatment.
- 3.3. Following Mr Curran's diagnosis of hepatitis C, he was offered a treatment for this infection and was referred to the Liver Clinic at the RAH. Mr Curran's treatment which

³ Exhibit C14, Exhibit C15 and Exhibit C16

consisted of twice daily ribavirin tablets and weekly self-administered interferon subcutaneous injections, which is standard treatment for hepatitis C, took place in 2008. However, in February 2009 testing showed a positive result for hepatitis C which indicated that the course of treatment had failed. Mr Curran would undergo a second course of the same treatment which also failed. This second failure was established in February 2012.

- 3.4. I have previously mentioned the fact that Mr Curran underwent a liver biopsy. This occurred in November 2007. The analysis of this biopsy was conducted by Dr Penelope Cohen, a pathologist. The pathological diagnosis as expressed in Dr Cohen's report is '*chronic hepatitis with severe fibrosis and architectural disturbance, irregular cirrhosis is not excluded, histological activity A=2*'.⁴ The report also contains reference to the liver pathology under two classifications known as the Scheuer and the Metavir classifications. Under the Scheuer classification it is stated in Dr Cohen's report:

'Fibrosis:
4 – probable or definite cirrhosis'

Under the Metavir classification it is recorded as follows:

'Fibrosis:
F3 – F4 numerous septa, possible cirrhosis'⁵

During the inquest there was considerable debate about the interpretation of this pathology report and in respect of its significance in terms of the clinical management of Mr Curran's condition from that point forward. On 15 January 2008 a letter⁶ was written by Dr Zakary, a liver registrar within the RAH Department of Gastroenterology and Hepatology, to the '*Medical Officer*' at the YLP informing that the liver biopsy showed '*severe fibrosis and architectural disturbance with irregular cirrhosis which is not excluded*'. This not exactly what the biopsy report stated. The report did not state that the biopsy demonstrated severe fibrosis and architectural disturbance '*with*' irregular cirrhosis. In any event the only advice tendered to the YLP medical officer at that time was that Mr Curran needed to be started on '*treatment*' which, as I understood the evidence, consisted of the first failed ribavirin and interferon course which, it had been hoped, would treat the hepatitis C infection. However, on 16 April 2008 the same registrar wrote this time to the '*Medical Officer*' at the Port Augusta Prison saying

⁴ Exhibit C15, volume 2, pages 146-147

⁵ Exhibit C15

⁶ Exhibit C14, volume 1, page 320

among other things that *'the GP in Pt Augusta jail could do a follow up for his hepatitis C with a blood test in the form of liver function test and CBC and ultrasound every three months'*.

- 3.5. In the event, the 2007 liver biopsy would be the only liver biopsy conducted until November 2015 when Mr Curran was more or less in extremis. The only liver ultrasound performed during the intervening period occurred in July 2010 at which time the liver texture was reported as homogenous and normal with no focal finding. I am not certain how that result sat comfortably with the earlier biopsy result. Some might say the ultrasound was reassuring. But the fact remained that the biopsy had reported significant disease within the liver. I have accepted the evidence, that I will discuss, that the biopsy report was accurate insofar as it established the presence of significant disease. The evidence failed to establish why further regular ultrasound was not conducted in spite of the hospital's suggestion to the prison health authorities that among other things it should be conducted.
- 3.6. The review conducted in the Liver Clinic in October 2010 resulted in the decision for Mr Curran to undergo the failed second round of treatment for hepatitis C that I have already referred to. At the time at which this treatment was being contemplated, a RAH gastroenterology registrar, Dr Sweelin Chen Yi Mei, wrote to Dr Peter Frost care of the Port Augusta Prison advising of the proposed treatment. Dr Frost was at that time the Medical Director of SAPHS, a predecessor of Dr Pronk. The letter refers to a recent liver ultrasound that *'you organised'* but in respect of which the registrar did not have the results. I know of no ultrasound other than that referred to in the preceding paragraph which was unremarkable. The letter also referred to them following up Mr Curran *'by the usual process as he is a current prisoner'*. Dr Sweelin Chen Yi Mei provided a statement to the inquest dated 10 December 2020.⁷ Although it is unsurprising that the doctor asserts that she has no recollection of Mr Curran, she states that her understanding at the time would have been that because Mr Curran was a prisoner he would be monitored by the healthcare professionals within the prison, with a review at the hospital at the conclusion of his proposed course of treatment. If this involved a further assumption that the SAPHS would monitor each and every aspect of Mr Curran's liver disease and treatment from that point forward, as things were to

⁷ Exhibit C20

transpire this may have been an assumption too far. In any event, as seen already, the second course of treatment would fail.

- 3.7. Ultimately, Mr Curran's fatal condition would be diagnosed in 2015 by way of deteriorating liver function tests and an abdominal ultrasound followed by CT scanning of his chest, abdomen and pelvis.
- 3.8. In Dr Pronk's original witness statement compiled in April 2020 he stated as follows:

'It would appear from my review of the deceased's notes that despite knowing he was cirrhotic that he was not monitored in accordance with the gold standard practice of 6-monthly abdominal ultrasounds. It does appear that there was a degree of ongoing awareness of his positive hepatitis C status and some effort was made to monitor his liver function tests as an indicator of potential disease progression. Of note is the fact that the deceased had undergone two courses of the contemporary hepatitis C treatment of the day and both had failed, and his death occurred in the time period prior to the refinement and wide scale introduction of the newer Direct Acting Antivirals (DAA) that we now have to treat hepatitis C. My interpretation of the health records is there was an impression that further courses of the interferon treatment may have been futile and that the best course of action was to wait for the newer treatments to become available. None of this excuses the failure to adequately monitor the patient for development of hepatocellular carcinoma in the context of known cirrhosis and ongoing active hepatitis C infection. This case predates my time with SAPHS and as such I cannot speak with authority as to why the deceased was not monitored with 6-monthly ultrasound scans. As an observation it is noted that the deceased moved prisons multiple times throughout his incarceration, thus changing his treating health team on each occasion and adding complexity to continuity of his care. There may have also existed the impression that as he was well known to the specialist hepatitis team from the Royal Adelaide Hospital that some degree of responsibility for his ongoing monitoring may have rested with them. Further complicating his continuity of care and routine follow up monitoring was the absence of an electronic medical record that would have allowed for an alert to be set as a reminder for surveillance to be performed periodically. To this date, despite ongoing efforts, SAPHS is yet to introduce an electronic medical record due to issues including the appropriateness of available systems for the prison system, financial constraints, and the complexity of working within the Department for Correctional Services information technology firewalls.'⁸

In his oral evidence Dr Pronk resiled somewhat from that stated position. In essence Dr Pronk's oral evidence is that the original biopsy report to which I have referred did not demonstrate any positive diagnosis of cirrhosis of the liver. In addition, he asserts that certain blood results over the course of Mr Curran's clinical management, from which results a score known as an APRI score can be calculated, were consistent with Mr Curran not having developed cirrhosis at any significant or identifiable point in

⁸ Exhibit C19

time. Dr Pronk now believes that the biopsy report has been misinterpreted, not least to begin with by himself.

3.9. It is as well here to refer to the reports of the independent expert who was engaged to examine and evaluate Mr Curran's treatment and management for hepatitis C. Professor Geoff McCaughan is the AW Morrow Professor of Medicine (gastroenterology and hepatology) at the Royal Prince Alfred Hospital and University of Sydney. Professor McCaughan is a Fellow of the Royal Australian College of Physicians and is a Doctor of Philosophy. He is also the Director of the Australian Liver Transplant Unit. Professor McCaughan has provided the Court with three reports. His initial report⁹ dated 16 October 2019, refers to issues of a general nature regarding Mr Curran's treatment. The second report was commissioned in the light of Dr Pronk's statement to which I have referred.¹⁰ The third report¹¹ of Professor McCaughan is dated 22 September 2020 and was commissioned in light of the issues ventilated in the inquest.

3.10. In his first report Professor McCaughan expressed an opinion regarding the management of Mr Curran. Professor McCaughan reported as follows:

'The only issue is that Mr Curran had documented cirrhosis with his active hepatitis C infection. The hepatitis C cirrhosis normally would have been managed by at least six monthly visits with six monthly ultrasounds and serum alpha-fetoproteins. The aim would be to detect early hepatocellular cancer. By the time he actually presented in October 2015 when there was some weight loss, he had quite advanced hepatocellular cancer and this was proven on liver biopsy (4th November 2015) and he deceased on 24th November 2015. **So, the only issue really, regarding management, is could the hepatocellular cancer have been detected earlier?? The answer to this is YES, provided 6 monthly liver ultrasounds and blood tests were performed. Following his second course of Interferon and Ribavirin there is no evidence that this was undertaken.**'¹² (The emboldening is in Dr McCaughan's report).

3.11. It is apparent from the reproduced passages above that in the first instance there was consistency between the views of Dr Pronk and Professor McCaughan regarding the need for six monthly liver screening. I will deal with the oral evidence of Dr Pronk and the contents of Professor McCaughan's subsequent reports in a moment. Firstly, I

⁹ Exhibit C13

¹⁰ Exhibit C13a

¹¹ Exhibit C13b

¹² Exhibit C13

should describe what Dr Cohen, the pathologist who compiled the 2007 biopsy report, has to say about her report's proper interpretation.

- 3.12. As indicated earlier, Dr Penelope Cohen is a pathologist. She received her original medical degrees in 1980 from the University of Cape Town in South Africa. She has been a Fellow of the Royal College of Pathologists of Australasia since 1991. She was employed by the Institute of Medical and Veterinary Science (IMVS) between 1991 and 2008. She has been employed by the Central Adelaide Local Health Network (CALHN) Incorporated since 2008 when IMVS became SA Pathology. Dr Cohen provided to the inquest an affidavit dated 5 November 2020. In that affidavit she confirms that she is the Dr Cohen who was the author of the liver biopsy of Mr Curran of November 2007. The topic of Dr Cohen's affidavit is the manner in which her biopsy report should be interpreted.
- 3.13. In her affidavit Dr Cohen states that when she reported that '*irregular cirrhosis is not excluded*' she meant that she did not have sufficient evidence within Mr Curran's liver biopsy to confirm that he definitely had cirrhosis of the liver, but that she could not exclude cirrhosis either. The liver biopsy contained a small sample of liver tissue from which she could identify that Mr Curran had severe fibrosis and an architectural disturbance, but she could not confirm from the particular sample of liver that Mr Curran had cirrhosis. This is due to the fact that she did not see complete nodules surrounded by fibrosis. Dr Cohen did add that it was possible that a sample of a different part of the liver could have led her to a different conclusion. This explains her assertion in the biopsy report that cirrhosis is not excluded. Dr Cohen also states that it is possible to identify that a patient does have cirrhosis of the liver if the liver nodules are of a size to be encompassed in the biopsy sample provided and are completely surrounded by fibrosis. However, while she is able to indicate in a pathological diagnosis section of a report like Mr Curran's that a patient's liver biopsy showed cirrhosis, that was not the case in respect of Mr Curran's particular liver biopsy. I accept all of that evidence.
- 3.14. Dr Cohen's report also deals with the Scheuer and Metavir classifications as set out in her report. I must confess that I am not certain of the significance of those classifications as they might apply to Mr Curran. Dr Cohen states in her affidavit that she understood such scores as meaning probable or definite cirrhosis on the Scheuer classification and possible cirrhosis on the Metavir classification. However, it is clear

from Dr Cohen's report as well as her affidavit that she did not identify any cirrhotic tissue. But the fact remains that Mr Curran's liver exhibited severe fibrosis and architectural disturbance. The report of Dr Cohen left open the possibility that irregular cirrhosis may have existed in his liver and that it may have been identified by further biopsy of a sample of a different part of the liver. One would have thought that such an interpretation would have been available to liver specialists employed within a tertiary hospital such as the RAH. One matter seems to be reasonably clear and that is that even if on further sampling no cirrhosis was identified, this is not to say that Mr Curran would not develop cirrhosis at some point in the future.

- 3.15. Properly considered, Dr Cohen's report is consistent with Dr Pronk's assertion in his oral evidence that the biopsy report did not in fact positively describe cirrhosis of the liver. It is also correct, I think, as Dr Pronk asserts in his affidavit dated 12 November 2020, that Mr Curran was never formally diagnosed with cirrhosis of the liver. So, on that basis Dr Pronk argues that six monthly ultrasounds of Mr Curran's liver, the undoubted internationally accepted gold standard for monitoring of cirrhotic patients, were not indicated. However, as I will explain below, in my opinion Mr Curran in any event should have been managed on the basis that he probably had developed cirrhosis, or at the very least that at some point in the future he would develop cirrhosis, and that on either scenario he should have been subjected to regular screening for cirrhosis.
- 3.16. In his second report Professor McCaughan confirms that the international and national practice guidelines indicate that patients with cirrhosis should undergo screening for liver cancer every six months. The screening recommendation includes liver ultrasound plus or minus a blood test. Professor McCaughan states that in his opinion the fact that these measures were not undertaken in Mr Curran's case was a failure of medical management. He goes on to assert that if hepatocellular carcinoma had been detected earlier, and if Mr Curran was '*in the community*', then he could have received liver surgery, liver transplantation or local ablative therapies depending on the size of the cancer and the extent of his underlying liver disease. However, he could not comment on whether access to all of these would have been possible whilst he was in prison. I would note, however, that it is axiomatic that such treatment should be made available to prisoners. There could be no reason why such treatment could legitimately be withheld from a person simply because that person was undergoing a sentence of imprisonment.

- 3.17. As to whether Mr Curran's death could have been prevented if Mr Curran's cancer had been diagnosed earlier, Professor McCaughan indicates that the overall chance of survival is much greater for patients who receive the treatment of a kind I have just described than it is for those who present with advanced and incurable disease which was the case with Mr Curran. The professor adds that overall Mr Curran's chances of survival would have been improved although he adds the rider that some patients still present with advanced liver cancer even with regular screening.
- 3.18. In the light of the issues that unfolded in the course of this inquest, a third report was obtained from Professor McCaughan.¹³ In that report Professor McCaughan passes comment on a number of matters raised for the most part by Dr Pronk in his oral evidence. As well, Professor McCaughan refers to certain aspects of Dr Cohen's biopsy report. Professor McCaughan indicates that he, being a liver specialist, would have interpreted the biopsy result as describing probable cirrhosis in Mr Curran and, accordingly, the best practice guidelines indicated that six monthly screening for liver cancer should have taken place.
- 3.19. Professor McCaughan's third report is of critical importance. In preparation for this third report, Professor McCaughan was asked by counsel assisting to consider whether patients with biopsy results which indicate that irregular cirrhosis could not be excluded, but who are hepatitis C positive as well, should be managed by six monthly ultrasounds plus or minus a blood test. To this question Professor McCaughan reiterates that he would have interpreted the biopsy report as showing probable cirrhosis and that, therefore, the six monthly screening was indicated in Mr Curran's case.
- 3.20. In his third report Professor McCaughan refers to the APRI scores calculated from blood results that in Dr Pronk's opinion were not consistent with cirrhosis. Professor McCaughan again reiterates that he believes that when assessing the 2007 biopsy, Mr Curran had probable cirrhosis in the November of that year. As well, Mr Curran had a diagnosed ongoing hepatitis C infection with expected continuing liver damage following that. This would have suggested that it was likely that within a few years Mr Curran's condition was going to evolve into cirrhosis and that is so even if it had not been present in 2007. He therefore states that taking into account the 2007 biopsy result, the APRI scores referred to by Dr Pronk would not have been robust

¹³ Exhibit C13b

enough to exclude cirrhosis. Professor McCaughan asserts that in respect of a patient displaying the November 2007 liver biopsy result, he would view with a high degree of scepticism the APRI scores that Dr Pronk insists are significant. In relation to the issue of the significance of the APRI scores, I accept the evidence of Professor McCaughan and prefer it to the evidence of Dr Pronk. Professor McCaughan is a specialist gastroenterologist and hepatologist and is an undoubted expert in that particular field of medicine. Dr Pronk is not. Indeed, Dr Pronk acknowledged that even taking into account Mr Curran's calculated APRI score blood results, a biopsy that could not exclude cirrhosis would warrant further investigation. Dr Pronk said '*I do accept that, yes*'.¹⁴

- 3.21. It is worthwhile observing that when Dr Pronk gave oral evidence and was cross-examined by Ms Giles of counsel assisting, Dr Pronk appeared to acknowledge that where cirrhosis had not been excluded, although positively not identified, there should still be six monthly liver screening, although he added that the issue involved a '*grey area*'.¹⁵ He suggested that this would involve '*a situation where I would ask the opinion of a specialist*'.¹⁶ Dr Pronk also acknowledged that he would defer to Professor McCaughan's opinion that a patient diagnosed with severe fibrosis where cirrhosis could not be excluded, should be referred for six monthly ultrasounds.¹⁷ Dr Pronk's attention was also drawn by counsel assisting to a medical text that asserts that if there is a concern about the accuracy of liver fibrosis assessment, referral to a specialist with experience in assessing liver disease severity and managing patients with advanced liver disease for further assessment for the presence of cirrhosis is recommended. Dr Pronk agreed with that assertion. Professor McCaughan is such a specialist. The professor's view is that Mr Curran should have been subjected to six monthly screening. I agree with that assessment and so find.
- 3.22. I must say that I did sympathise with Dr Pronk's position to a certain extent. He was approaching the case of Mr Curran from the perspective of general practitioners working for the SAPHS and not from that of specialist hepatologists working in a liver clinic within a major public hospital. It is to be acknowledged in my view that specialists within the RAH were in a much better position than medical practitioners within the SAPHS to determine what was appropriate liver screening for Mr Curran.

¹⁴ Transcript, page 95

¹⁵ Transcript, page 70

¹⁶ Transcript, page 71

¹⁷ Transcript, page 103

In his oral evidence Dr Pronk made the point that the SAPHS provides within the prison system a community equivalent general practice. There would be no expectation that one of the SAPHS doctors would be able to interpret a specialist liver biopsy compiled by a pathologist and intended for a hepatologist to review and interpret. He points out that the SAPHS was not the entity that had ordered the liver biopsy in the first instance. He added:

'So, the doctor who has ordered this is the one who has the responsibility, and presumably the specialist training to interpret this result into something meaningful, as opposed to a general practitioner in a prison system.'¹⁸

I can understand Dr Pronk's assertions in this regard. But the fact remains that the RAH liver registrar had written to the SAPHS putting it on notice that regular liver ultrasound examination was indicated.

- 3.23. It will be noted in Dr Pronk's original statement from the passage that I have set out above in paragraph 3.8, that he observed that the deceased had moved prisons multiple times throughout his incarceration with the result that his treating health team on each occasion was changed, adding to the complexity and continuity of Mr Curran's care. Further complicating continuity of care and routine follow up monitoring was the absence of an electronic medical record that would have allowed for an alert to be set as a reminder for surveillance to be performed periodically. He points out that despite ongoing efforts, the SAPHS is yet to introduce an electronic medical record system due to issues including the appropriateness of available systems for the prison environment, financial constraints, and the complexity of working within DCS information technology firewalls. Dr Pronk expanded on these matters in his oral evidence. Although it is patently absurd that the SAPHS should not be able to fully participate in SA Health electronic medical record systems such as OACIS and Sunrise, and I mean by that, SAPHS should be able to enter data onto those systems as well as have reading access to them, I am not certain that the lack of such participation in this case made any difference to the outcome. For instance, it is not as if the surveillance of Mr Curran's condition was interrupted either by a lack of access to electronic medical records within SAPHS or by his being moved from prison to prison. The fact of the matter was that meaningful surveillance which would have been afforded by six monthly reviews was never even commenced.

¹⁸ Transcript, pages 98-99

- 3.24. In the course of his oral testimony, Dr Pronk gave some detailed evidence about relatively new diagnostic and treatment modalities in relation to hepatitis and liver cancer that were not available prior to Mr Curran's death. I do not need to go into that evidence in great detail. Suffice it to say Dr Pronk made out a reasonable case for concluding that a repeat of the circumstances surrounding the death of Mr Curran would be significantly less likely now than it was in the years preceding 2015 when he died.

4. Conclusions

- 4.1. In conclusion, in my view Mr Curran should have been subjected to regular liver screening for the presence of cirrhosis in the years between 2007 and 2015. I so find. To the extent that this did not occur, there was a failure of medical management. As Professor McCaughan has said in his third report, it was likely that Mr Curran's condition would ultimately evolve into cirrhosis within a few years of 2007 if it had not evolved already at that stage. To my mind it is difficult to see how it could be assumed that the condition of Mr Curran's liver would remain stable. It was predictable that Mr Curran would develop cirrhosis of the liver meaning that further testing throughout the course of his illness should have been put in place with such an eventual probable diagnosis in mind. To my mind it is more probable than not that regular screening would also have detected the liver cancer at an earlier point in time. By the time it was diagnosed the cancer had developed and spread to the point where Mr Curran could not receive meaningful treatment.
- 4.2. It has not been possible to establish with precision why it was that regular liver screening of the kind suggested by the RAH liver registrar, Dr Zakary, was not put in place. The possibility that the RAH contemplated that the SAPHS would provide the impetus for this to take place but that the SAPHS contemplated the opposite, with the result that nothing ever happened, has not been excluded.
- 4.3. As to the preventability of Mr Curran's death, I have accepted Professor McCaughan's evidence on this topic. I have found that the chances of Mr Curran's overall survival, or at least the chances of his life being prolonged, would have been enhanced if an earlier diagnosis of his advanced liver disease had been made. However, it cannot be said with certainty that even in those circumstances his death would have been prevented or his life would have been prolonged. Much would have depended on the

state of Mr Curran's liver disease at the time it was revealed by whatever testing modality was employed.

5. **Recommendation**

5.1. In the inquest into the death of a DCS prisoner, Leonard Edward Dodson,¹⁹ this Court repeated an earlier recommendation that had been made in an inquest into the death of another prisoner Franklin Delano Miller.²⁰ That recommendation was directed to the issue of continuity of care within the prison health system. It was as follows:

'That the Medical Director of the South Australian Prison Health Service assign to a senior medical officer or officers within the Service the responsibility of maintaining oversight of the medical treatment and investigation of those prisoners within institutions operated by the Department for Correctional Services who are suspected of suffering from a serious or life threatening illness, especially in circumstances where the medical treatment and investigation of such prisoners is being conducted by medical practitioners who are not employees of the Service;'

The Court repeats that recommendation.

Key Words: Death in Custody; Prison; Natural Causes; Prison Medical Services

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 9th day of February, 2022.

Deputy State Coroner

Inquest Number 02/2019 (2136/2015)

¹⁹ Inquest 45/2016, Finding delivered 27 July 2017

²⁰ Inquest 32/2009, Finding delivered 13 February 2013