Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 23/ 19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Malcolm Patrick O'DRISCOLL*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***30 May 2019*** *find that the identity of the deceased person was* ***Malcolm Patrick O'DRISCOLL*** *and that death occurred on* ***15 April 2017*** *at* ***Acacia Prison****, from* ***acute myocardial infarction on a background of atherosclerotic cardiovascular disease*** *in the following circumstances:-*

Counsel Appearing:

Sergeant L. Housiaux and Senior Constable C. Robertson assisted the Coroner

Ms L. Bultitude-Paull (State Solicitor's Office) appeared on behalf of the Department of Justice

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INTRODUCTION

1. Malcolm Patrick O'Driscoll (the deceased) died on 15 April 2017 at Acacia Prison, Great Eastern Highway, Wooroloo as a result of acute myocardial infarction on a background of atherosclerotic cardiovascular disease.

2. At the time of his death the deceased was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Corrective Services, as it then was.[1]

3. Accordingly, immediately before his death, the deceased was a "person held in care" within the meaning of the *Coroners Act 1996* (WA) and his death was a "reportable death".[2]

4. In such circumstances, a coronial inquest is mandatory.[3]

5. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[4]

6. I held an inquest into the deceased's death on 30 May 2019.

7. The documentary evidence adduced at the inquest included independent reports of the deceased's death prepared by the Western Australia Police[5] and by the Department of Justice[6] respectively, which together comprised two volumes.

8. Mr Richard Mudford, a Senior Systems Analyst employed by the Department of Justice and the author of the Death in Custody Review was called as a witness at the inquest.

9. The inquest focused on the care provided to the deceased while he was a prisoner, as well as on the circumstances of his death.

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[1] Section 16, *Prisons Act 1981 (WA)*
[2] Sections 3 & 22(1)(a), *Coroners Act 1996 (WA)*
[3] Section 22(1)(a), *Coroners Act 1996 (WA)*
[4] Section 25(3) *Coroners Act 1996 (WA)*
[5] Exhibit 1, Vol 1, Tab 2, Police Investigation Report
[6] Exhibit 1, Vol 2, Death in Custody Review

THE DECEASED

Background[7,8]

10. Although it is clear that the deceased was born in Myanmar (formerly Burma), his date of birth was the subject of some confusion. Information from the Department of Home Affairs (relating to the deceased's arrival in Australia) suggests that his date of birth is 23 March 1952.[9] However, when contacted, his sister was adamant the deceased's date of birth was 23 March 1953.[10] His criminal record lists several aliases and shows his date of birth as either: 23 March 1951, 23 March 1952 or 23 May 1951.[11] The deceased's prison records record his date of birth as 23 March 1951[12]

11. The Registrar of Births, Deaths and Marriages has confirmed that on the marriage registrations for his first marriage (26 May 1973) and his second marriage (15 January 1989), the deceased's date of birth is shown as 23 March 1951.[13]

12. On the basis of the evidence from the Registrar of Births, Deaths and Marriages, and noting that the deceased was alive when those registrations were made, I find that the deceased's date of birth is 23 March 1951. It follows that the time of his death, he was 66-years of age.

13. The deceased is said to have left school at 15-years of age and to have worked as a fridge mechanic and later as a postman. However, his employment history was described as "*inconsistent*".[14,15] The deceased was married twice and had two sons. It appears that the deceased had a significant history of alcohol abuse which is said to have impacted on his relationships. He smoked heavily and received the disability support pension from 1991.[16,17]

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[7] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p2
[8] Exhibit 1, Vol 2, Death in Custody Review, p5
[9] Email Department of Home Affairs (30.05.19)
[10] Email from Sgt Housiaux to Coroner Jenkin (04.06.19)
[11] Exhibit 1, Vol 2, Tab 1, Criminal History
[12] Exhibit 1, Vol 2, Tabs 4-8, Various Prison Reports and ts 30.05.19 (Mudford), p5
[13] Letter from Registrar of Births, Deaths and Marriages (17.06.19)
[14] Exhibit 1, Vol 2, Death in Custody Review, p5 and ts 30.05.19 (Mudford), pp6-7
[15] Exhibit 1, Vol 1, Tab 9, File Note - telephone conversation with deceased's sister (23.05.17)
[16] Exhibit 1, Vol 2, Death in Custody Review, p5 and ts 30.05.19 (Mudford), pp6-7
[17] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p2

14. It appears that one of the deceased's sons died in 2001 or 2002[18] and the deceased is also said to have had a third child with another partner. By May 2007, the deceased had been in a defacto relationship with a woman for a number of months, although he had known her for some years.[19]

Offending History

15. The deceased had an extensive criminal record and during the period from 1971 to 1981, was convicted of numerous driving, stealing and dishonesty offences.[20]

16. The deceased was first imprisoned in 1976 for the offences of false pretences and breaking and entering. He served further terms in 1978 (driving without a licence and escaping legal custody) and 1980 (reckless driving).[21]

17. In 1981, the deceased was sentenced to an aggregate term of 10 years imprisonment after being convicted in the Supreme Court of Western Australia of shooting to avoid arrest, unlawful wounding, deprivation of liberty and seven counts of armed robbery.[22]

18. Further terms of imprisonment followed in 1985 (escape legal custody) and 1988 (armed robbery). In the period 1991 – 1996, the deceased accumulated further convictions, mainly for driving offences, and he served a mandatory term of imprisonment in 1995 for driving without a licence.[23]

19. Between 1998 and 2002, the deceased was convicted on three occasions of public disorder offences and fined.[24] From 1976 until his death in 2017, the deceased had a total of 11 admissions to prisons in Western Australia.[25]

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[18] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p2, see also: ts 30.05.19 (Mudford), p7
[19] Exhibit 1, Vol 1,Tab 35, Sentencing Transcript (03.10.08), p676 & p689
[20] Exhibit 1, Vol 2, Tab 1, Criminal History
[21] Exhibit 1, Vol 2, Tab 1, Criminal History
[22] Exhibit 1, Vol 2, Tab 1, Criminal History
[23] Exhibit 1, Vol 2, Death in Custody Review, p3 and Exhibit 1, Vol 2, Tab 1, Criminal History
[24] Exhibit 1, Vol 2, Tab 1, Criminal History
[25] Exhibit 1, Vol 2, Death in Custody Review, p3

20. On 5 June 2008, following a trial in the Supreme Court of Western Australia at Perth, the deceased was convicted of the wilful murder of his defacto partner. On 3 October 2008, he was sentenced to life imprisonment and ordered to serve a minimum term of 19 years before being eligible for parole.[26] The sentence was backdated to 21 May 2007 and the deceased had a sentence review date of 20 May 2026.[27,28]

21. Although the deceased's appeal against his conviction was dismissed on 12 August 2011,[29] he continued to protest his innocence and pursue options through the Sellenger Centre Criminal Justice Review Project.[30]

Overview of Medical Conditions[31]

22. In addition to being diagnosed with anaemia and depression[32], the deceased had a complex medical history which included:

> "*severe, extensive atherosclerotic vasculopathy, requiring multiple stents, ischaemic heart disease with a quadruple bypass and a history of myocardial infarct, congestive heart failure, stable chronic renal failure with an atrophic left kidney, chronic obstructive airways disease, type-2 diabetes mellitus, with associated peripheral neuropathy, dyslipidaemia, a stroke, previous alcohol abuse and ongoing smoking (ten cigarettes per day)*".[33]

23. In May 2007, prior to his incarceration, the deceased was reportedly drinking two to three litres of cream sherry per day.[34,35] He self-reported continuing to smoke 20 cigarettes per day, despite repeated advice that he should stop.[36,37,38]

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[26] Exhibit 1, Vol 1,Tab 35B, Sentencing Transcript (03.10.08), p655 & p691
[27] Exhibit 1, Vol 2, Tab 2, Sentence Summary
[28] Exhibit 1, Vol 2, Death in Custody Review, p6 and ts 30.05.19 (Mudford), p8
[29] Exhibit 1, Vol 2, Tab 9, TOMS offender notes (13.08.11)
[30] Exhibit 1, Vol 2, Death in Custody Review, p12 & see also: https://www.ecu.edu.au/schools/arts-and-humanities/research-and-creative-activity/sellenger-centre-for-research-in-law-justice-and-social-change/criminal-justice-review-project/overview
[31] Exhibit 1, Vol 2, Death in Custody Review, pp6-8
[32] Exhibit 1, Vol 2, Death in Custody Review, p7
[33] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17), p1
[34] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, p2
[35] Exhibit 1, Vol 1,Tab 35B, Sentencing Transcript (03.10.08), p685 & p689
[36] Deceased's medical records (D075-22-59), Letter - Dr L Okiwelu (date stamped 20.12.11)
[37] Deceased's medical records (D075-22-59), Letter Dr M Sharif (date stamped 07.03.12)
[38] Deceased's medical records (D075-22-59), Letter Dr V Jayaraman (date stamped 13.08.14)

24. On 12 April 2009, the deceased complained of "*chest pains and a tingling sensation in his right arm*". He was seen at the medical centre at Acacia Prison and then taken to the emergency department at Swan District Hospital (SDH) by ambulance. He was returned to Acacia Prison after he signed a waiver and discharged himself. He remained in the prison medical centre for observation overnight before returning to his cell the following day.[39]

25. On 24 July 2009, the deceased complained of "*chest pains and pain down his arms*". He was taken to Acacia Prison's medical centre and from there to the emergency department at SDH by ambulance.[40] On admission, he was diagnosed with a myocardial infarction (heart attack).[41] Tests showed he was not a suitable candidate for a stent and he was referred for coronary bypass graft surgery (CABG).[42] He was admitted to Sir Charles Gairdner Hospital (SCGH) on 23 August 2009 and underwent CABG surgery on 1 September 2009.[43,44]

26. The deceased remained at SCGH until 15 September 2009 when he was transferred to the infirmary at Casuarina Prison for post-operative care before returning to Acacia Prison on 21 September 2009.[45,46]

27. In 2011 and 2014, the deceased had a number of stents inserted into various arteries in his body on account of his extensive atherosclerotic vasculopathy.[47,48]

28. Prison medical centre records show that between 12 July 2007 and his death, the deceased attended the prison medical centre on over 300 occasions for treatment of various issues.[49] In that period he also attended over 50 appointments at SCGH and Royal Perth Hospital (RPH) with specialists in radiology, vascular surgery, cardiology, radiology, ophthalmology and nephrology.[50]

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[39] Exhibit 1, Vol 2, Tab 10, Incident Description Report - Officer Rosin (12.04.09)
[40] Exhibit 1, Vol 2, Tab 12, Incident description report - Officer Jones (24.07.09)
[41] Deceased's medical records (D075-22-59) SCGH discharge summary (28.07.09)
[42] Deceased's medical records (D075-22-59) SCGH discharge summary (28.07.09)
[43] Deceased's medical records (D075-22-59) SCGH discharge summary (15.09.09)
[44] Exhibit 1, Vol 2, Death in custody review, pp11-12
[45] Deceased's medical records (D075-22-59) SCGH discharge summary (15.09.09)
[46] Exhibit 1, Vol 2, Death in custody review, pp11-12
[47] Deceased's medical records (D075-22-59) SCGH discharge summary (22.12.11)
[48] Deceased's medical records (D075-22-59) SCGH discharge summary (25.06.14)
[49] Exhibit 1, Vol 2, Tab 3, Offender health appointments - internal & external
[50] Exhibit 1, Vol 2, Tab 3, Offender health appointments - internal & external

29. The deceased was also seen on numerous occasions with respect to his extensive atherosclerotic vasculopathy,[51,52,53] admitted for day procedures on four occasions and taken to emergency departments on four occasions.[54,55]

30. The deceased sometimes refused to attend specialist appointments and annual health assessments.[56,57] His reasons varied. Sometimes he said he was unwell,[58] or that the particular appointment was unnecessary.[59] On other occasions, his refusal related to his dislike of certain hospitals[60] or because he said he was stressed by long waiting times.[61]

31. After considering all of the evidence, I am satisfied that the deceased's medical needs were appropriately addressed during his incarceration.

32. In coming to that conclusion, I note the deceased's complex medical needs, his periodic refusal to attend specialist appointments and his refusal to stop smoking, despite repeated advice that he should do so.

PRISON HISTORY

33. From 22 May 2007 until his death, the deceased was incarcerated for 3,526 days (just over 9.5 years) at: Hakea Prison (22.05.07 - 12.01.09); Acacia Prison (12.01.09 - 26.08.09); Casuarina Prison (26.08.09 - 21.09.09); and finally Acacia Prison (21.09.09 – 15.04.17).[62]

34. When admitted at Hakea Prison on 22 May 2007, the deceased denied suicidal or self-harm ideation and illicit drug use. He said his health was "*good*" but said he would be applying for protected prisoner status, because he "*may have enemies in prison*".[63]

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[51] Exhibit 1, Vol 2, Death in custody review, p7
[52] Exhibit 1, Vol 2, Tab 3, Offender health appointments - internal & external
[53] Exhibit 1, Vol 1, Tab 40, Letter - Dr Yin (SCGH) re deceased's numerous specialist appointments
[54] Exhibit 1, Vol 2, Death in custody review, p7
[55] Exhibit 1, Vol 2, Tab 3, Offender health appointments - internal & external
[56] Exhibit 1, Vol 2, Death in Custody Review, p7
[57] Exhibit 1, Vol 2, Tab 3, Offender health appointments - internal & external
[58] Example: Deceased's medical records (D075-22-59) Refusal to attend appointment (23.07.14)
[59] Example: Deceased's medical records (D075-22-59) Refusal to attend appointment (04.07.14)
[60] Example: Deceased's medical records (D075-22-59) Refusal to attend appointment (16.12.13)
[61] Example: Deceased's medical records (D075-22-59) Refusal to attend appointment (21.05.13)
[62] Exhibit 1, Vol 2, Death in Custody Review, pp9-13
[63] Exhibit 1, Vol 2, Tab 4, Reception At Risk Checklist(22.05.07)

35. The deceased was accorded "protected prisoner" status for the first five years of his incarceration.[64] His security rating was reduced from high to medium on 31 December 2008.[65]

36. The deceased consistently denied responsibility for the death of his defacto partner and declined to participate in a number of prison-based programs.[66,67] He did, however, complete a creative writing course from November 2009 to March 2010.[68]

37. The deceased was described as a quietly spoken, polite and respectful prisoner who complied with prison rules. He interacted well with other prisoners and kept his cell clean and tidy.[69]

38. The deceased's individual management plan for 2011 notes he received occasional visits from friends and occasionally sent and received mail.[70] He also regularly spoke to friends on the telephone.[71]

39. The deceased was initially employed in the prison laundry, then as a cleaner and later as a gardener in the assisted care unit at Acacia Prison. He was in that role for over 5 years and was reported to have performed his duties to a high standard with minimal supervision.[72,73]

[64] Exhibit 1, Vol 2, Death in Custody Review, p8
[65] Exhibit 1, Vol 2, Death in Custody Review, p10
[66] Exhibit 1, Vol 2, Tab 5, Education and vocational training checklist (17.10.08)
[67] Exhibit 1, Vol 2, Tab 6, Cognitive skills - initial assessment (08.12.08)
[68] Exhibit 1, Vol 2, Death in Custody Review, p8 & p12
[69] Exhibit 1, Vol 2, Tab 15, Individual Management Plan (24.10.10)
[70] Exhibit 1, Vol 2, Tab 15, Individual Management Plan (24.10.10)
[71] Exhibit 1, Vol 2, Tab 39, Telephone records
[72] Exhibit 1, Vol 2, Death in Custody Review, p10
[73] Exhibit 1, Vol 2, Tab 15, Individual Management Plan (24.10.10)

EVENTS LEADING TO DEATH

The events leading up to 15 April 2017

40. On 4 April 2017, the deceased was taken to St John of God Hospital, Midland (SJOGHM) following two episodes of painless haematuria (blood in the urine).[74]

41. Blood tests performed before the deceased was admitted to hospital showed that his haemoglobin levels (used to check for anaemia) and kidney function were normal. Urine tests showed a high white cell count, suggestive of infection.[75]

42. A CT urogram at SJOGHM found critical stenosis of his left single main renal artery and renal atrophy. There was also moderate to severe stenosis in his right main renal artery and accessory upper pole vessel. The scan found a blood clot in his bladder but no causes for the clot were identified in his bladder or kidneys.[76,77]

43. The deceased was transferred to RPH on 5 April 2017. Following bladder washouts and treatment with antibiotics, the deceased was discharged to the medical centre at Acacia Prison on 7 April 2017.[78]

44. The deceased's haemoglobin levels were stable at this time and he was referred for a flexible cystoscopy (a camera check of his bladder) to further investigate the source of his bleeding.[79,80]

45. The deceased was reviewed in medical centre at Acacia Prison on 8 April 2017. He seemed well and was keen to return to return to his cell.[81] After consulting with a medical officer, a nurse cleared the deceased to return to his cell. The plan was that he be reviewed by the medical officer on 10 April 2017.[82]

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[74] Exhibit 1, Vol 1, Tab 41, SJOG-M Discharge summary (05.04.17)
[75] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17), p2
[76] Exhibit 1, Vol 1, Tab 41, SJOG-M Discharge summary (05.04.17)
[77] Exhibit 1, Vol 1, Tab 42, RPH Discharge summary (07.04.17)
[78] Exhibit 1, Vol 1, Tab 42, RPH Discharge summary (07.04.17)
[79] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17)
[80] Exhibit 1, Vol 1, Tab 42, RPH Discharge summary (07.04.17)
[81] Deceased's medical records (D075-22-59) Acacia medical centre records, (08.04.17)
[82] Deceased's medical records (D075-22-59) Acacia medical centre records, (08.04.17)

46. When reviewed by the medical officer on 10 April 2017, the deceased said he felt well but said he was still getting some blood in his urine although it was: *not as thick as before*". He had no fever and no stinging or burning when urinating. The plan was for the deceased to finish his course of antibiotics and have further tests and investigations in one week.[83]

47. On 11 April 2017, Officer Murray (who knew the deceased well) asked him if he was able to complete his gardening duties. He said he was "*OK*" and watered the gardens of the assisted care wing as usual.[84]

48. On 12 April 2017, Officer Murray noticed the deceased's face looked "*puffy*" and he seemed "*jaundiced*". She and Officer Underdown (the unit manager), spoke with the deceased but he said he was OK but there was still some blood in his urine.[85]

The events of 15 April 2017

49. On 15 April 2017, the deceased was housed in cell 12 on the assisted care unit at Acacia Prison (Foxtrot block). Foxtrot block has two wings, designated "self-care" and assisted care" respectively. There are 20 single occupancy cells on the assisted care wing.[86]

50. Prisoners in the assisted care wing have been assessed as being unable to cope in mainstream cells and receive extra help. They are typically elderly or physically or mentally unwell.[87]

51. Regular checks known as "*arms and welfare*" checks are conducted by custodial staff to assess prisoner welfare. During the check, the officer asks the prisoner to respond and the prisoner raises their hand above their head to indicate they are well. At night, the officer will either shine a torch into the prison cell or switch on one of the cell lights in order to observe movement.[88,89]

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[83] Deceased's medical records (D075-22-59) Acacia medical centre records, (10.04.17)
[84] Exhibit 1, Vol 1, Tab 11, Statement - Officer Murray, paras 65-67
[85] Exhibit 1, Vol 1, Tab 11, Statement - Officer Murray, paras 61-63
[86] Exhibit 1, Vol 1, Tab 11, Statement - Officer Murray, paras 6
[87] Exhibit 1, Vol 1, Tab 11, Statement - Officer Murray, paras 4-5
[88] Exhibit 1, Vol 1, Tab 10, Statement - Officer Gengler, paras 4-5
[89] Exhibit 1, Vol 1, Tab 11, Statement - Officer Murray, paras 17-18

52. At 12.55 am on 15 April 2017, Officer Gengler was conducting an arms and welfare check in the assisted care unit. The deceased was getting into bed in his cell and raised his arm to indicate he was fine when asked to do so by Officer Gengler.[90]

53. At the 4.15 am check, the deceased was sitting on the toilet in his cell. When Officer Gengler asked if he was "OK", the deceased nodded his head. Officer Gengler said the deceased's state of health at that time appeared "*normal*".[91]

54. At about 6.25 am, Officers Murray and Solomon began conducting the count required prior to the unlock procedure in Foxtrot block. They completed the count on the self-care wing of the block without incident and began the count on the assisted care wing.[92]

55. When Officer Murray looked into the deceased's cell, she saw him crouched on the floor between the left-hand side of the toilet and the wall. He was bent over with his face on the ground and did not respond when she called out to him.[93]

56. Officer Murray called out to Officer Solomon and they opened the deceased's cell. Officer Solomon told Officer Murray to call a "*code blue*" medical emergency (which she did).[94] Officer Solomon looked at his watch and saw that the time was 6.35 am. Officer Solomon stood by the wing door so that custodial and nursing staff responding to the code blue would have easy access.[95]

57. In response to the code blue, a number of custodial and nursing staff rushed to Foxtrot block. Officer McGreevy placed the deceased on his back so he could be assessed by nursing staff.[96] CPR was commended by Nurse Dockar and Officer McCulloch while Nurse Patrick attached defibrillator pads to the deceased's chest.[97]

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[90] Exhibit 1, Vol 1, Tab 10, Statement - Officer Gengler, paras 8-9
[91] Exhibit 1, Vol 1, Tab 10, Statement - Officer Gengler, paras 8-9
[92] Exhibit 1, Vol 1, Tab 11, Statement - Officer Murray, paras 13-14
[93] Exhibit 1, Vol 1, Tab 11, Statement - Officer Murray, paras 25-28
[94] Exhibit 1, Vol 1, Tab 12, Statement - Officer Solomon, paras 25-26
[95] Exhibit 1, Vol 1, Tab 11, Statement - Officer Murray, paras 30-34
[96] Exhibit 1, Vol 1, Tab 24, Incident description report - Officer Denis and ts 30.05.19 (Mudford), p9
[97] Exhibit 1, Vol 1, Tab 22, Incident description report - Officer Cook

58. Nurse Kinsey and Officer Holdman assisted with CPR[98] while Officer Denis covered the viewing windows of the other cells on the assisted care unit to prevent prisoners seeing what was happening.[99] Officer Dillon called emergency services at 6.43 am.[100]

59. Despite the efforts of custodial and nursing staff, the deceased could not be revived. St John Ambulance officers arrived on the scene at 6.55 am and declared the deceased had died at 7.03 am on 15 April 2017.[101]

Critical incident review

60. Following the deceased's death Acacia Prison conducted a critical incident review (the Review).[102] The Review identified several issues requiring attention including:

i. At the relevant time, nursing staff were unaware of the departmental policy requiring them to administer CPR until the prisoner had been declared deceased by an "*appropriate authority*"; and

ii. The door to the designated command suite or incident control facility (i.e.: the boardroom), where "*contingency material*"[103] was stored was secured with a PIN code lock and few staff had the code.

61. Following the deceased's death, nursing staff were briefed on the requirements of the policy relating to resuscitation efforts and the PIN code for the lock on the boardroom door was provided to the duty manager and radio control officer.[104,105,106] In any event, neither of these issues contributed to the deceased's death.

62. After reviewing all of the available evidence, I am satisfied that the resuscitation efforts by custodial and nursing staff were timely and appropriate.

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[98] Exhibit 1, Vol 1, Tab 34, Incident description report – Nurse Dockar
[99] Exhibit 1, Vol 1, Tab 24, Incident description report - Officer Denis
[100] Exhibit 1, Vol 1, Tab 25, Incident description report - Officer Dillon
[101] Exhibit 1, Vol 1, Tab 47, St John Ambulance patient care record and ts 30.05.19 (Mudford), p9
[102] Exhibit 1, Vol 2, Tab 16, Acacia Prison - Critical Incident Review, p8
[103] "*Contingency material*" consists of copies of instructions, checklists, plans etc. designed to assist in the management of a range of serious incidents, see: ts 20.05.19 (Mudford), p14 and Submissions, Department of Justice (14.06.19), para 3
[104] Exhibit 1, Vol 2, Tab 16, Acacia Prison - Critical Incident Review, p8
[105] Submissions, Department of Justice (1.06.19), para 3
[106] Exhibit 1, Vol 2, Tab 17, Acacia Prison - Internal recommendations update, point 7.2

Comment about code blue medical emergency

63. When using hand-held radios, custodial staff employ code words and abbreviations to promote clear communication. At Acacia Prison, staff calling a medical emergency on the radio use the phrase "*code blue*". However, staff at other prisons (e.g.: Casuarina Prison) use the phrase "*code red*" to indicate a medical emergency.[107]

64. Mr Mudford was asked why different codes were used in different prisons and his response was:

> *"Essentially, that's what Acacia as a private prison have adopted. My understanding is it's very similar to the…Department of Health hospital coded calls. I'm not sure which one's right and which one's wrong but essentially, they are different and that's the first thing I came up with. I didn't know what a code blue was the first time I heard it. I inquired and essentially that's the coding system that they have decided upon."*[108]

65. I am concerned that this discrepancy exists. By definition, a medical emergency at a prison is a stressful event and it seems obvious that critical information should be conveyed in the most timely and accurate fashion possible.

66. In my view, having different codes for medical emergencies within the Western Australian prison system creates an unnecessary risk. Given that time is of the essence when responding to a medical emergency, anything which might hinder that response should be identified and resolved.

67. I do not think it matters whether a medical emergency is designated as a "*code red*" or a "*code blue*" (or indeed by some other phrase). The point is that medical emergencies should be designated in the same throughout all prisons in Western Australia regardless of whether they are publicly or privately managed.

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[107] ts 30.05.19 (Mudford), p10
[108] ts 30.05.19 (Mudford), p10

68. Mr Mudford confirmed that custodial staff do transfer between publicly and privately run prisons and that during the new staff orientation procedures at each prison, issues such as the correct codes to use on the radio are covered.[109] In submissions, the Department clarified that whilst it is common for staff to work across multiple public prisons, it is much less common for staff to transfer between public and private prisons.[110]

69. The Department also noted that whilst staff from publicly run prisons may visit a privately managed prison (like Acacia Prison) this would only be for a limited purpose such as collecting a prisoner being transferred or observing a planned emergency exercise.[111] The Department says staff attending a private prison in that capacity would "…*never be responsible for responding to an emergency* code".[112]

70. According to the Department, staff transferring between public prisons, or between public and private prisons (or vice-versa) receive "*re-orientation training specific to the new facility*".[113] Nevertheless, in order to avoid any possibility of doubt, introducing a standardised system of emergency codes seem to make obvious sense.

71. In submissions, the Department said it would need to examine the contracts for privately operated facilities to: "*determine whether a change to the code system could be imposed on the two private prisons*" and that it was unable to conclusively state "…*whether a recommendation for standardisation of medical codes is warranted or could be implemented*".[114]

72. There is no evidence that the response to the medical emergency in the deceased's case was anything other than timely and appropriate. Nevertheless, I strongly urge the Department to review and standardise its emergency procedures, especially with respect to the emergency radio codes used by staff in all prisons (whether public or private) in Western Australia.

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[109] ts 30.05.19 (Mudford), p10
[110] Submissions, Department of Justice (1.06.19), para 1
[111] Submissions, Department of Justice (1.06.19), para 1
[112] Submissions, Department of Justice (1.06.19), para 1
[113] Submissions, Department of Justice (1.06.19), para 1
[114] Submissions, Department of Justice (1.06.19), para 1

CAUSE AND MANNER OF DEATH

73. Forensic pathologists (Dr Kueppers and Dr Vagaja) conducted a post mortem on the deceased's body on 26 April 2017. They found extensive atherosclerotic disease of the arterial tree with thickening and calcification of the aorta and many of its branches, some of which contained metal stents.[115]

74. The deceased's heart was enlarged and showed thickening and scarring of its muscle as well as significant narrowing of its surface vessels (severe coronary atherosclerosis). The deceased had two heart by-pass grafts, both of which were patent and unremarkable.[116]

75. Microscopic examination of the deceased's heart demonstrated acute myocardial infarction (heart attack). Sections of the deceased's lung demonstrated long standing chronic lung disease and sections of his kidney were consistent with chronic kidney disease.[117]

76. There was calcified atherosclerotic narrowing of the arteries supplying the deceased's kidneys and both of his kidneys appeared scarred. There was also a small incidental tumour nodule on the surface of the deceased's left kidney but it was not connected to his urine drainage system and showed no evident bleeding.[118]

77. The deceased's bladder contained a blood clot weighing 160 grams, but there was no visible source of bleeding in his ureters or kidneys. The clot was examined microscopically but it showed no special features which might have identified its source. Microscopic examination of the deceased's prostate and bladder also failed to identify any source of blood loss.[119]

78. Examination of the deceased's body showed no evidence of any significant injury and although his lungs were congested, this is a non-specific finding.[120]

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[115] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report
[116] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report
[117] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17)
[118] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report
[119] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17)
[120] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report

79. Neuropathological analysis showed evidence of previous strokes involving the right parietal lobe and pons and found complicated cerebrovascular atherosclerosis. A new stroke was not seen and there was no evidence of recent traumatic brain injury.[121,122]

80. Biochemical analysis of the deceased's vitreous humour showed mildly elevated levels of glucose and suggested suboptimal management of his diabetes over the past two to three months. Markers indicating kidney dysfunction were also detected.[123] Other biochemical and microbiological testing was unremarkable and toxicological analysis found medications in the deceased's system, consistent with his medical care.[124]

81. The amount of blood the deceased lost as a consequence of his urinary bleed was said to be "*difficult to quantify*". Dr Kueppers and Dr Vagaja referred to the deceased's medical history, his haemoglobin level on discharge from hospital, his subsequent clinical improvement in the days leading to his death and the size of the clot found in his bladder before noting:

> "*…it would appear that the urinary bleed was not significant enough to cause Mr O'Driscoll's death on its own. However, this bleeding may have contributed to a decompensation of his already unstable chronic heart disease.*"[125]

82. Dr Kueppers and Dr Vagaja expressed the opinion that the cause of death was acute myocardial infarction on a background of atherosclerotic cardiovascular disease.[126] I accept and adopt that conclusion.

83. I find the deceased's death occurred by way of Natural Causes.

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[121] Exhibit 1, Vol 1, Tab 7, Neuropathology Report
[122] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17), p2
[123] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17), p3
[124] Exhibit 1, Vol 1, Tab 8, Toxicology Report
[125] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17), p3
[126] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report

QUALITY OF SUPERVISION, TREATMENT AND CARE

84. Dr Kueppers and Dr Vagaja expressed the opinion that the deceased: "*…had multiple and serious health conditions which predisposed him to a premature death*".[127]

85. During his incarceration, the deceased was seen by prison medical staff and external specialist on numerous occasions with respect to his complex medical issues.[128] As noted, the deceased received surgical treatment following his heart attack in 2009[129,130] and his severe vascular disease was treated with numerous stents in 2011 and 2014.[131,132]

86. During his incarceration the deceased declined to attend any prison-based treatment courses but he did attend a creative writing course and was described as an excellent student.[133] The deceased was gainfully employed initially in the laundry, then as a cleaner and subsequently, (for a period of over 5 years), as a gardener. He was regarded as an excellent worker and his prison conduct was unblemished by prison charges.[134]

87. The deceased was seen by a prison doctor on 10 April 2017 when he reported feeling well.[135] There is no evidence that in the days leading up to his death, the deceased had complained of feeling unwell and his death appears to have been unexpected.

88. Having regard to all of the circumstances of the deceased's incarceration, I am satisfied that the supervision, treatment and care provided to the deceased was reasonable and appropriate.

MAG Jenkin
Coroner
19 June 2019

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[127] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17), p3
[128] Exhibit 1, Vol 2, Tab 3, Offender health appointments - internal & external
[129] Deceased's medical records (D075-22-59) SCGH discharge summary (15.09.09)
[130] Exhibit 1, Vol 2, Death in Custody Review, pp11-12
[131] Deceased's medical records (D075-22-59) SCGH discharge summary (22.12.11)
[132] Deceased's medical records (D075-22-59) SCGH discharge summary (25.06.14)
[133] Exhibit 1, Vol 2, Death in Custody Review, p12
[134] Exhibit 1, Vol 2, Death in Custody Review, p10 & p12
[135] Exhibit 1, Vol 1, Tab 6, Letter - Dr Kueppers and Dr Vagaja (14.11.17)