[2023] WACOR 8

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Rosalinda Vincenza Clorinda Fogliani, State Coroner
HEARD	**:**	4 - 8 APRIL 2022
DELIVERED	**:**	31 JANUARY 2023
FILE NO/S	**:**	CORC 265 of 2017
DECEASED	**:**	GRAHAM, CALLY

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr C Beetham assisted the State Coroner
Mr J Berson and Ms J Buller (State Solicitor's Office) appeared on behalf of the Department of Justice, the Commissioner of Police and South Metropolitan Health Services
Mr S Vandongen SC and Mr J Deptula (Minter Ellison) appeared on behalf of Sodexo
Ms R Young and Mr E Panetta (Panetta McGrath) appeared on behalf of Aspen Medical and Nurse Ann-Marie Brennan
Ms B Burke (ANF) appeared on behalf of Nurse Doreen Mwendapole

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of ***Cally GRAHAM*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, Perth, on 4 April 2022 - 8 April 2022, find that the identity of the deceased person was* ***Cally GRAHAM*** *and that death occurred on 26 February 2017 at Fiona Stanley Hospital from hypoxic ischaemic encephalopathy, bronchopneumonia and myocardial ischaemia complicating a cardiorespiratory arrest in association with probable Takotsubo cardiomyopathy and methylamphetamine effect in the following circumstances:*

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INTRODUCTION

1. At approximately midday on 20 February 2017, Cally GRAHAM (Cally) arrived at the Melaleuca Remand and Reintegration Facility (Melaleuca Prison) having been arrested by police on 19 February 2017 and detained overnight at the Perth Watch House.[1]

2. Cally had initially come to the attention of police on 19 February 2017 due to her erratic driving. Police stopped her vehicle, and when they spoke with Cally, she appeared drowsy. It was clear that she was not capable of driving safely. Initially she gave police a false name. Further inquiry by police established her correct name and that she was driving whilst disqualified to do so.[2]

3. Police also established that Cally had outstanding warrants of commitment for unpaid fines totalling approximately $11,400. It was calculated that her warrants of commitment equated to six days in custody. Cally was imprisoned under those warrants in order to "*cut out*" her fines, under the former provisions of s 53 of the *Fines, Penalties and Infringement Notices Enforcement Act* 1994. It was Cally's first time in prison.[3]

4. At approximately midnight on 20 February 2017, just under 12 hours after her arrival at Melaleuca Prison, Cally was rushed to Fiona Stanley Hospital in an ambulance. She had collapsed in her cell and first aid efforts carried out within Melaleuca Prison had managed to achieve a return of circulation for her. She was unconscious and intubated on her way to the hospital.[4]

5. Cally was cared for by physicians in the intensive care unit at Fiona Stanley Hospital, but tragically she never regained consciousness. She was pronounced dead at 2.56 am on 26 February 2017. She was 31 years old.[5]

6. Cally would have been discharged to freedom on 24 February 2017, but at that time she remained unconscious, in hospital.

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[1] Exhibit 1 tab 11; Exhibit 2, tab A.

[2] Exhibit 1, tab 11.

[3] Ibid.

[4] Exhibit 1, tabs 47 and 54; Exhibit 2, tab A.

[5] Exhibit 1, tabs 1 and 6.

CALLY GRAHAM

7. Cally Graham was born on 23 June 1985 into a large and loving family. Together with her parents, she had two sisters with whom she was close, and a caring extended family. At the time of her death she was in a relationship with her partner.

8. Cally's mother described her as a beautiful girl who loved animals and children. She was gentle by nature, but she suffered from anxiety to a degree that affected her choices and her progression through life. Sadly, she started taking drugs and this caused problems for her personally, and at times in her interactions with others.[6]

9. Cally had a strong personality, and she could be wilful. She was loyal and her family always stood by her. Her mother had not known of her fines, or of her detention and conveyance to Melaleuca Prison. At that stage, Cally had elected not to inform her. Had Cally's mother known, she would have sought to see Cally, and endeavoured to address her fines, if possible.[7]

10. Cally's mother felt the experience of her detention at Melaleuca Prison might have been the impetus for her to move away from her drug taking and change her life around. Cally had a lot of potential. Her academic ability had been extremely good, and she had dreams of achieving a career.[8]

11. Her death leaves a family in mourning and is a loss to the community as a whole.

THE INQUEST

12. Cally's death was a reportable death within the meaning of s 3 of the *Coroners Act* 1996 (the Act) and it was reported to the coroner as required by the Act.

13. By reason of s 19(1) of the Act I have jurisdiction to investigate Cally's death. The holding of an inquest, as part of the investigation into her death, is mandated by reason of s 22(1)(a) of the Act. This is because immediately before death she was a "*person held in care*" by reason of

[6] ts 391.
[7] ts 392.
[8] ts 391 to 392.

being under the control, care or custody of the CEO of the Department of Justice – Corrective Services (then known as the Department of Corrective Services) in accordance with the *Prisons Act* 1981.

14. Whilst Cally would have been discharged to freedom on 24 February 2017, there were no material changes to her circumstances in between that time and the time of her death in Fiona Stanley Hospital on 26 February 2017. Her deterioration, directly resulting in her death, commenced at Melaleuca Prison, while she was under the control, care or custody of Prisons.

15. I held an inquest into Cally's death and heard evidence from 16 witnesses between 4 and 8 April 2022. At the commencement of the inquest, I received three exhibits into evidence, comprising of a total of 111 tabs. Between that time and 28 April 2022, I received exhibits 4 to 12 into evidence.

16. The inquest was attended by Cally's mother, who gave evidence on the final day of hearing and her two sisters.[9]

17. My primary function has been to investigate Cally's death. It is a fact-finding function. Pursuant to s 25(1)(b) and (c) of the Act, I must find if possible, how Cally's death occurred and the cause of her death.

18. Pursuant to s 25(2) of the Act, in this finding I may comment on any matter connected with Cally's death including public health, safety or the administration of justice. This is the ancillary function.

19. Pursuant to s 25(3) of the Act, as Cally was a person held in care, in this finding I must comment on the quality of her supervision, treatment and care. This obligation reflects the community's concern about the treatment of those who are deprived of their liberty.

20. Section 25(5) of the Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

[9] ts 390 to 392.

21. Pursuant to s 44(2) of the Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

22. After the evidence was taken at the inquest, submissions were provided to me for the purposes of s 44(2) of the Act, and in connection with possible recommendations, between 3 and 26 May 2022.

23. In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

24. My findings appear below.

MELALEUCA REMAND AND REINTEGRATION FACILITY

25. Melaleuca Prison opened in December 2016. It was designed to be a 254-bed remand and reintegration facility for female prisoners. When Cally was admitted to Melaleuca Prison it had only recently been opened and was very much in its infancy. Some of the practices and procedures were still being developed, and some staffing issues were still being worked out.[10]

26. Melaleuca Prison has several discrete areas: secure gatehouse, visitors' centre, reception, healthcare centre, prisoner accommodation, administration, kitchen and maintenance storage.[11]

27. Prisoner accommodation is provided within two units, 11 and 12, which are in turn split into two wings, A and B. Within the wings are the cells. During her time at Melaleuca Prison, Cally was assigned to unit 12, wing A, cell A01.[12]

28. From December 2016 to July 2020, Melaleuca was privately managed by Sodexo Australia Pty Ltd (Sodexo) pursuant to a services agreement it had executed with the Chief Executive Officer of the (then) Department of Corrective Services. The Services Agreement outlined the responsibilities of Sodexo in connection with the management,

[10] Exhibit 2, tab A.2; Exhibit 7.
[11] Exhibit 7.
[12] Exhibit 2, tab 14.

control and security of Melaleuca Prison and the welfare of the prisoners.[13]

29. Sodexo in turn entered into a subcontract agreement with Aspen Medical Pty Ltd (Aspen) for the provision of healthcare services at Melaleuca Prison, and the establishment and maintenance of medical records. The provision of healthcare services included the implementation of an emergency health response, with the use of appropriate resuscitation techniques, including the use of emergency care equipment and automated external defibrillators. Aspen was responsible for ensuring that first aid kits were appropriately stocked and located throughout Melaleuca Prison.[14]

30. The contractual arrangements involving Sodexo and Aspen were in place at the time of Cally's death. In July 2020, management of Melaleuca Prison returned to the Department of Justice, where it presently remains. The reasons for the return of the management to the Department of Justice are outside the scope of the inquest.

CALLY'S ARREST

31. Shortly after 8.00 pm on 19 February 2017, Cally was driving along Leach Highway in Cloverdale when she was stopped by police. She was driving an older model Ford that initially caught the police's attention due to the likelihood of mechanical defects.[15]

32. Police quickly saw that she was drifting across the lanes and swerving to correct the drift. She was the only occupant of the vehicle. They formed the view that the manner of Cally's driving was suggestive of intoxication, and they activated emergency lights and sirens to call upon her to pull over. After some initial apparent hesitation, she pulled over.[16]

33. Police officers conducted a preliminary breath test, which returned nil for alcohol, and which therefore failed to explain her erratic manner of driving. Cally was placed under a *Road Traffic Act* 1974 (Road Traffic Act) requirement to provide a sample of her blood, due to her apparent state of intoxication. Cally was compliant throughout this process but

[13] Exhibit 3 tab 2.

[14] Exhibit 3, tab 1.

[15] Exhibit 1, tab 11.

[16] Ibid.

appeared drowsy, with slurred speech and delayed verbal responses. Drug use was suspected.[17]

34. Cally had initially given police officers a false name, but when challenged, gave her actual name. Upon further questioning, Cally told police officers that she had recently used Lyrica and Rohypnol, and that she was not feeling well after taking the tablets.[18]

35. Lyrica is the brand name for the drug pregabalin, a medication used for neuropathic pain and occasionally as an adjunct therapy for partial seizures, a particular form of epilepsy.

36. Rohypnol is the brand name for a flunitrazepam, a benzodiazepine drug, a sedative that slows down the central nervous system.

37. As they were questioning Cally, the attending police officers also became aware that she was subject to 15 outstanding Warrants of Commitment for unpaid fines, and she was arrested in respect of these. The Warrant with the longest period was for six days' imprisonment.[19]

38. As a consequence, Cally was conveyed to the Cannington Police Station where officers collected Road Traffic Act blood kits, before taking her to the Perth Watch House, in Northbridge. She declined the offer by police to call a family member or a friend.[20]

CALLY'S ADMISSION TO PERTH WATCH HOUSE

39. Cally arrived at the Perth Watch House at approximately 9.00 pm on 19 February 2017, under arrest. She was taken to see the nurse, who attempted to obtain a sample of her blood. The nurse could not achieve this due to Cally having collapsed veins and scarring, most likely due to her previous drug use. The nurse observed that Cally was sufficiently coherent to understand her questions but that she appeared drowsy.[21]

40. Cally told the Watch House nurse that she had epilepsy, and that she had been prescribed Lyrica but had not taken her dose that day. She said she had no medication left. The Watch House nurse told the

[17] Ibid.
[18] Ibid.
[19] Exhibit 1, tab 11.
[20] Ibid.
[21] Exhibit 1 tab 15.

attending police that Cally would need to be taken to hospital to be assessed for epilepsy. She would also need to have her Road Traffic Act blood sample taken at hospital. At approximately 9.30 pm, the Watch House nurse completed a medical treatment report, requesting medical staff at Royal Perth Hospital take bloods and give prescribed medication.[22]

41. Cally was therefore not formally admitted to the Perth Watch House at this point. Upon the recommendation of the Watch House nurse, the attending police conveyed Cally to Royal Perth Hospital for blood tests and medical assessment. Towards midnight on 19 February 2017, a sample of blood was taken from Cally by the ED Registrar at Royal Perth Hospital under ultrasound guidance.[23]

42. Also at Royal Perth Hospital, Cally sought and received a prescription for a small number of Lyrica (pregabalin) 50 mg tablets, stating that she had run out of her epilepsy medication. The attending doctor could find no documented history of Cally having been prescribed Lyrica (pregabalin) previously. Nor was there a documented history of epilepsy for her. These facts were subsequently confirmed by Pharmaceutical Benefits Scheme records and materials produced by other healthcare providers.[24]

43. However, on that night, following a discussion between the attending doctor and a senior medical colleague, it was considered safe to prescribe the Lyrica (pregabalin) for Cally. A small number of tablets were provided in a brown cylindrical vial, labelled with Cally's details, to cover the next few days. The instruction was to take two 25 mg tablets once per day.[25]

44. A medical treatment report in respect of the custodial care for Cally was completed and handed to attending police. The attending doctor at Royal Perth Hospital noted that Cally's medical observations were stable, that she was sleepy, and that she had no complaints. It was also noted that there was no further treatment required for Cally while in police custody.[26]

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[22] Exhibit 1 tabs 15 and 17.

[23] Exhibit 1 tabs 16 and 17.

[24] Exhibit 1, tabs 17, 45 and 49 to 53; ts 218.

[25] Ibid.

[26] Exhibit 1, tab 17.

45. At approximately 12.30 am on 20 February 2017, Cally was returned by police to the Perth Watch House, where the Watch House nurse noted and signed her acknowledgement on the medical treatment report. At this point, Cally was admitted into the Perth Watch House, with responsibility for her being transferred from police to this entity.[27]

46. A custody handover summary was completed at the Perth Watch House. In the section addressing details of health and welfare status, Cally's answers were recorded as follows: an answer of "*yes*" next to the question of: "*Do you suffer fits*?", along with the comment "*suffers unknown seizures, has been to hospital and administered medication*."[28]

47. During this process Cally also disclosed that she had taken heroin, indicating that the last time had been the previous day. Cally was then allocated a cell, in the Perth Watch House and was the subject of hourly overnight checks, all without incident.[29]

48. Cally's Lyrica (pregabalin) medication was brought to the attention of the Watch House nurse. This nurse provided the brown cylindrical vial to the Perth Watch House property officer who sealed and labelled it. However, for reasons which are not clear, the existence of the medication was not recorded. At the material time, it was the role of the property officer to make this record on the custody management documentation. After this incident, by way of improvement, an additional obligation was imposed upon the Watch House nurse to make a separate entry regarding medication, as a failsafe process.[30]

49. Nonetheless, at approximately 6.45 am on the morning of 20 February 2017, at the Perth Watch House, Cally was administered her daily dose of Lyrica (pregabalin) according to the dosage prescribed on the bottle, that is, two 25 mg tablets, by the Watch House nurse. Notes made by this nurse record that the medication was then returned to "*property*".[31]

50. For reasons outlined later in this finding under the heading: *Did Cally have epilepsy*, I have determined that Cally did not have epilepsy. It follows that, in relation to the particulars of Cally's cause of death, nothing turns on the question of why the existence of the Lyrica

[27] Exhibit 1, tab 26.

[28] Ibid.

[29] Ibid.

[30] Exhibit 1, tabs 15, 16 and 26.

[31] Exhibit 1, tabs 23 and 26.

(pregabalin) was not recorded on the custody management documentation. It does however serve to highlight the importance of complying with procedures.

51. Again, for reasons that are outlined later, it is likely that Cally was using the Lyrica for its potentially sedative effects.

52. At approximately 10.40 am on 20 February 2017, Cally was released into the custody of Serco Group Pty Ltd (Serco, the prison contractor) for transport to Melaleuca Prison, for the purpose of "*cutting out*" her fines by time spent in that prison, under the Warrants of Commitment.[32]

53. Serco officers were provided with a print-out of the Perth Watch House Custody Handover Summary Report, a copy of the (incomplete) property receipt, and a sealed bag of Cally's property. Consistent with Serco policy, the bag remained sealed and upon arrival it was handed to the staff at Melaleuca Prison. Serco did not inspect the contents of the sealed bag and were not expected to do so.[33]

CALLY'S ADMISSION TO MELALEUCA

Arrival at Melaleuca

54. Cally arrived at the recently opened Melaleuca Prison at approximately midday on 20 February 2017. The prison included a healthcare centre, but not an infirmary. The healthcare centre was staffed by medical officers and nurses engaged by Aspen (the prison's healthcare service provider).[34]

55. Cally's admission to Melaleuca Prison was undertaken on 20 February 2017 by a prison custodial officer employed by Sodexo (the prison's private manager), though due to workload someone else processed her property. Her date of discharge to freedom would have been 24 February 2017 (which made up a total of six days in custody between time spent in the custody of police, at the Perth Watch House and at Melaleuca Prison).[35]

[32] Exhibit 1, tabs 24, 26 and 28.
[33] Ibid.
[34] Exhibit 2, tab A
[35] Exhibit 1, tab 32.

56. Property records show that the Lyrica (pregabalin) dispensed to Cally at Royal Perth Hospital was received at Melaleuca Prison, but it was not documented within the prison records until the afternoon of the following day, that is, after Cally had been conveyed to hospital by ambulance.[36]

57. Turning back to the admissions process, Cally underwent an "*At-Risk Offender Intake Assessment*" with the prison custodial officer in the reception area of Melaleuca Prison. Cally told the custodial officer that after she was arrested, she had been to Royal Perth Hospital for medication for epilepsy, that she was withdrawing from heroin, and that she felt sick. These statements were recorded by the prison custodial officer in Cally's electronic admission records.[37]

58. There are sections in the "*At Risk Assessment*" questions to be asked of the prisoner (Part A) which ask the following relevant questions:

(a) "*Do you have any serious health issues that need immediate attention*?". The custodial officer recorded Cally's response: "*Yes I'm coming down off heroin and I suffer epilepsy*".

(b) "*Are you on any prescribed medication*?". The custodial officer recorded that Cally disclosed the following sedatives: Serapax, Royhpnol and Valium. There is no mention of Cally having referred to Lyrica or pregabalin, though she came to the prison with this medication in a sealed bag.[38]

59. There is a section in the "*At Risk Assessment*" to be completed by the custodial officer (Part B) which asks: "*In your opinion were there any visible immediate health issues presented by the prisoner*?". The custodial officer's response was: "*Yes she is coming down off heroin and feels sick*".[39]

60. The custodial officer's general impression was that Cally was either under the influence of drugs or she was coming down "*off something*" (most likely heroin). Her descriptions indicate that Cally was, to her mind intoxicated: "….*she was continually on the nod*."[40]

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[36] Exhibit 2, tabs A and 7.

[37] Exhibit 1, tabs 32 and 42; Exhibit 2, tab A.

[38] Exhibit 1, tab 42.

[39] Exhibit 1, tab 42.

[40] Exhibit 1, tab 32.

61. Because Cally reported to the custodial officer during the admissions process that she was feeling sick, the nursing staff from the healthcare centre were called to conduct a welfare check in reception. Cally had indicated she felt like vomiting. Two nurses arrived and were involved in that welfare check at reception, one of whom, Nurse Brennan, gave evidence at the inquest to the following effect:

(a) she was based in the healthcare centre of the prison, and she attended the welfare check with her Nurse Manager;

(b) the Nurse Manager had received the call from reception to attend, and Nurse Brennan's understanding was that they were asked to attend the reception area because Cally was feeling "*tired*";

(c) the Nurse Manager performed the welfare check and spoke with Cally, while Nurse Brennan recorded Cally's observations, which were stable; and

(d) upon being questioned by the nurses, Cally said she was "*absolutely fine*", and she did not say anything about feeling sick.[41]

62. At the material time these early welfare checks were generally done at the request of the custodial officer if, for example, there was reason to believe that a new prisoner may have an immediate health need. On this occasion, none was identified and as a result, Cally's intake continued through the reception area.

63. Cally remained in the reception area, with some breaks, until approximately 2.30 pm. At approximately 2.40 pm, in accordance with the required processes, Cally attended Melaleuca Prison's healthcare centre to undergo an initial health screen assessment with Nurse Brennan. This was separate from and in addition to the nurses' welfare check for Cally in the reception area, described above.[42]

64. The information given by Cally during the reception intake and recorded by the custodial officer on the At-Risk Offender Intake Assessment showed that she claimed to have epilepsy. This information

[41] Exhibit 1 tab 45 t; ts 14 to 16.

[42] Exhibit 1 tab 45.

was entered by the custodial officer on Cally's Total Offender Management System (TOMS) records.[43]

65. At the material time however, the At-Risk Offender Intake Assessment form was not copied to Nurse Brennan, who subsequently conducted the initial health screen assessment. Nor did Nurse Brennan have complete electronic access to TOMS. Consequently, Nurse Brennan did not have information before her to indicate that Cally had claimed to have epilepsy, and that she had been to Royal Perth Hospital for medication for epilepsy.[44]

Initial health screen assessment at Melaleuca Prison

66. Nurse Brennan conducted Cally's initial health screen assessment at the healthcare centre, guided by an electronic version of Departmental form AMR1012 (*Heath Services Initial Health Screen*) into which information about a patient is entered in accordance with responses to questions asked by the assessing nurse. Nurse Brennan's evidence was that this assessment normally takes about 20 to 30 minutes. Once entered, data from the electronic AMR1012 form was saved by the nurse to the Departmental health records system known as Electronic Health On-Line (EcHO).[45]

67. During Cally's initial health screen assessment, her observations were again taken, and Nurse Brennan found them all to be within normal limits. This included blood pressure, heart rate, respiratory rate, and blood sugar levels. Nurse Brennan's view, drawn in part from Cally's demeanour and manner of responding, was that Cally was under the influence of drugs.[46]

68. Nurse Brennan recorded Cally's responses next to questions posed by the AMR1012. Relevantly, she recorded that Cally responded "*no*" to questions about whether she was feeling unwell, and whether she had epilepsy (which is the opposite of what Cally told the custodial officer).[47]

[43] Exhibit 2, tab A.
[44] Exhibit 1, tab 33.
[45] Exhibit 1, tab 45; ts 21; ts 43.
[46] Exhibit 1, tab 45; Exhibit 2, tab A; ts 19.
[47] Exhibit 1, tab 45.

69. In response to the nurse's question about her medications, Cally made reference to Valium (diazepam) and methadone, but did not refer to Lyrica (or pregabalin), though she had earlier told the custodial officer that she had been seen at Royal Perth Hospital for "*medication for epilepsy*."[48]

70. Therefore, unfortunately Cally's EcHO medical file did not record or reference her attendance at Royal Perth Hospital for epilepsy medication or that she claimed to suffer from epilepsy/seizures.[49]

71. One of the consequences of nursing staff not being aware of Cally's claim to have epilepsy was that when allocated to her cell, she was placed in the top bunk. Normally, a patient with epilepsy would be placed on the bottom bunk due to risk of seizure, with a record that the placement is under medical supervision. This did not occur in Cally's case.[50]

72. As part of her initial health screen assessment, Cally signed a form M031 request for release of medical information, addressed to a general practice which had previously treated her. Relevantly, and consistently with the information recorded on the AMR1012 and stored in EcHO, this document narrates: "*Patient states she takes methadone (not taken for 5 days) and Valium 25mg prn. Please can you provide history*". There is no mention in this document of Lyrica (pregabalin), or of epilepsy.[51]

73. Nurse Brennan formed the view that Cally required medications for her withdrawal from heroin. Cally had told the nurse that she could not remember if she had last used heroin on Friday or Saturday, and that her last dose of methadone was five days ago.[52]

74. At approximately 3.30 pm an e-consult request was lodged by Nurse Brennan with Melaleuca Prison's on-call doctor, requesting a prescription for opiate withdrawal medications. The doctor prescribed metoclopramide (for nausea and vomiting) loperamide (for diarrhoea) and a tapering regime of the benzodiazepine diazepam. The requested

[48] Exhibit 1, tab 45; Exhibit 2, tab A.

[49] Exhibit 2, tab A.

[50] Exhibit 2, tab A.

[51] Exhibit 1 tab 45.

[52] Exhibit 1, tab 45.

prescriptions were issued by the doctor at approximately 7.00 pm, with the medications to be administered by the night nurse as scripted.[53]

75. A task referral was made for Cally to see the prison doctor within 28 days, or earlier if required.[54]

Inconsistencies concerning Cally's health status

76. As outlined above, there were some early inconsistencies regarding Cally's health status.

77. The primary inconsistency concerns the different responses recorded regarding epilepsy - whether Cally had it and whether she took medication for it:

(a) Cally informed the Perth Watch House nurse and the doctors at Royal Perth Hospital that she had seizures and/or epilepsy. She requested her medication, Lyrica (pregabalin), and it was dispensed to her, but removed from her possession;

(b) During her reception intake at Melaleuca Prison, Cally also informed the custodial officer that she had epilepsy. Cally would later give the same information to her cellmate. Cally's Lyrica (pregabalin) medication (being part of her property) was not processed during her reception intake; and

(c) On the other hand, Cally denied having epilepsy during her initial health screen assessment with the nurse at the healthcare centre of Melaleuca Prison and made no reference to Lyrica or pregabalin when asked in that consult about her medications.[55]

78. There is no obvious reason for these inconsistent responses from Cally. They may be attributable to her confused mental state, and it is noted that during Cally's admission the custodial officer kept helping her to focus, prompting her to provide answers to most of the questions being asked.[56]

[53] Ibid

[54] Exhibit 1 Tab 45; Exhibit 2, tab A.

[55] Exhibit 1 tabs 32, 42, 45 and 45A; ts 36 and 43.

[56] Exhibit 1, tab 32.

79. The situation was not assisted by Cally being separately processed by the custodial officer, and then the nurse (save for the welfare check). As specified above, medical information provided by Cally to the custodial officer during her intake was not passed on to the nurse at the healthcare centre. This was due to processes not being fully implemented, or well understood, at this early stage of the opening of Melaleuca Prison. The matter has subsequently been rectified through a number of avenues, including the provision of copies of the reception intake forms to the healthcare centre, and improved access to computer systems.[57]

80. The confusion regarding Cally's medications (and potentially her claim to have epilepsy) would have been avoided had the custodial officer (during Cally's admission) dealt with Cally's property, which included the brown cylindrical vial containing a few days' worth of Lyrica (pregabalin) tablets. The custodial officer cited reasons related to excessive workload and unavailability of staff for not being able to deal with Cally's property. As referred to above, Cally's medication (Lyrica) was registered and stored with Cally's prisoner property the next day, after she had had her cardiac arrest and been taken to hospital.[58]

81. The Department subsequently reported to the coroner on the outcome of its review into Cally's death. On the matter of the staff access to information on computers, the Department reported that at the material time, healthcare staff did not all have full access to TOMS, and/or that access was intermittent. The evidence at the inquest was that there were problems with the computer systems at the time, in that the screens occasionally froze, and/or the data was unable to be saved.[59]

82. Aspen reported to the coroner that while each of their healthcare staff members had a State issued log in to access EcHO and TOMS, supply of the logins to the staff was often protracted.[60]

83. There was evidence given by two of the prison custodial officers that when they prepared their incident reports regarding Cally's death on TOMS, they had to use other officers' logins because their own logins were not yet available, which is unsatisfactory, and reflects upon the

[57] Exhibit 2, tab A.
[58] Exhibit 1, tabs 32 and 45; Exhibit 2, tab A.
[59] Ibid.
[60] Exhibit 1, tab 56.

fact that Melaleuca Prison had only recently opened, and its computer systems were not fully ready.[61]

84. Another consequence of the nursing staff not being aware of Cally's claim to have epilepsy was that this information was not able to be entered into the TOMS medical status model by the nurse, as would ordinarily have been required, so that relevant information about health status could be properly shared amongst those who have responsibility for the supervision, care and treatment of prisoners.[62]

85. While Cally's observations of vital signs may have been within normal limits, Cally was not "*absolutely fine*" during her admission to Melaleuca Prison. Her movements were slow, and she appeared confused, with signs of delayed reactions.

86. Cally gave different responses as to how she was feeling. Her demeanour, her confusion and her intermittent claims of ill health, were attributed by the custodial staff and the nurses to drug withdrawal. This was not unreasonable given the history that Cally gave them about her heroin use, and her statements to the effect that she was withdrawing from heroin.

87. It is known that just under 12 hours later, Cally had a cardiac arrest and was conveyed to hospital, where she did not regain consciousness, and she subsequently died.

88. I am satisfied that there were no clinical indications, at this stage, of Cally having a more serious underlying health condition, that warranted further medical investigation.

89. This is on the basis that I have found, for the reasons outlined later in this finding under the heading: *Did Cally have epilepsy*, that Cally did not have epilepsy.

Cally's allocation to a cell at Melaleuca

90. After Cally's intake was completed, on the afternoon of 20 February 2017 she was allocated to a cell at Melaleuca Prison. Ultimately that was within Unit 12, Wing A, cell A01. Cally had a cellmate who, as the

[61] ts 53; ts 112 to 113.
[62] Ibid.

facts will show, played a very important part in the efforts to save her. Cally was allocated the top bunk.[63]

EVENTS LEADING TO DEATH

Cally's cardiac arrest

91. Cally's cardiac arrest occurred later that night on 20 February 2017, shortly before 11.00 pm. This was after she had been placed in her cell, and after she had been seen for the administration of her medications, as prescribed by the on-call doctor. Her cellmate, who happened to be an enrolled nurse, heard and observed Cally at the time of her collapse, and described Cally as having a "*seizure*".[64]

92. Initially at approximately 6.00 pm Cally had been given paracetamol and ibuprofen for "*bodyache*". At about 6.40 pm, muster and lockdown of Unit 12 prisoners occurred.[65]

93. At approximately 8.10 pm the Senior Prison Custody Officer and the Night Nurse entered Unit 12 to undertake a "*medication run*" where a number of prisoners, including Cally, were seen to.[66]

94. At approximately 9.00 pm that evening, Cally made a cell call, which was answered by Prison Custody Officer Kirsty Turner (Officer Turner), the sole nightshift officer rostered for unit 12 that evening.[67]

95. In that call, Cally stated:

> *Hey, it's Cally Graham. I brought some epilepsy tablets with me from Royal Perth Hospital. I never got them tonight.*

96. In response, Officer Turner says:

> *Okay, I've got the nurse coming down in just a moment. I'll pop to your cell. I can't quite hear you properly over this. Just a sec.*

97. Officer Turner telephoned Cally's request through to the Night Nurse at the Melaleuca Prison healthcare centre and assumed that the Night Nurse (Nurse Doreen Mwendapole, Aspen employee/contractor)

[63] Exhibit 2, tabs A, 13 and 14.
[64] Exhibit 1, tab 31; Exhibit 2, tab A.
[65] Exhibit 2, tab A.
[66] Ibid.
[67] Exhibit 1, tab 36; Exhibit 2, tab 15.

together with the Senior Prison Custody Officer (Officer Glenda Mitchell, Sodexo employee/contractor) attended at Cally's cell to discuss her epilepsy medication with her. As is now known, Cally's Lyrica (pregabalin) medication had not been registered with her property at that stage, and neither Nurse Mwendapole nor Officer Mitchell knew of its existence.[68]

98. However, there was an attendance upon Cally at her cell as a result of the cell call that she made at 9.00 pm. At approximately 10.00 pm, Nurse Mwendapole attended Cally's cell and, while she was unable to specifically recall her attendance, I am satisfied that Officer Mitchell attended as well (as would have been the normal practice for her).[69]

99. Nurse Mwendapole's shift had begun at 7.00 pm, and Officer Mitchell was the Senior Prison Custody Officer at Melaleuca Prison that night. During her handover, Nurse Mwendapole had been informed that Cally was a "*heavy drug user*" and that she was to administer her withdrawal medications at around 10.00 pm. Officer Mitchell was not provided with any information about Cally during her handover; it was her first overnight shift.[70]

100. During the 10.00 pm attendance upon Cally at her cell, Nurse Mwendapole administered Cally's opiate withdrawal medication, in accordance with the on-call doctor's prescription. Had Cally's Lyrica (pregabalin) been registered with her property, the process would have been for the nurse to record it, and then arrange an e-consult with the prison doctor to have it charted, because the prison nurses would not ordinarily unilaterally administer a medication that has been prescribed by another facility. In any event, Cally had been given her daily dose of Lyrica (pregabalin) earlier that day at the Perth Watch House.[71]

101. At this stage at Melaleuca Prison there was nothing to indicate an imminent and catastrophic deterioration in Cally's condition, though she was unwell and had been vomiting intermittently. Prison officers had been made aware of her nausea and vomiting. This was still being attributed to drug withdrawal.[72]

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[68] Exhibit 1, tab 36; Exhibit 2, tab 15; ts 163.
[69] Exhibit 1, tabs 37 and 38; ts 115.
[70] Exhibit 1, tabs 37 and 38.
[71] Exhibit 1 tabs 38 and 45; ts 163 to 168.
[72] Exhibit 1, tab 31.

102. Less than an hour later, whilst lying on her bunk in her cell Cally made a gurgling sound and became unresponsive. Her cellmate, who had been worried about her due to her vomiting, and who had been listening to her breathing, immediately became aware of the emergency. It sounded to her like someone was trying to breathe through a seizure.[73]

103. At 10.50 pm and 25 seconds Cally's cellmate made an urgent cell call to Officer Turner:

> Officer Turner: *Name and medical emergency?*
> Cellmate: *She's having a seizure.*
> Officer Turner: *Carly* [sic] *is having a seizure did you say?*
> Cellmate: *She's having a seizure.*
> Officer Turner: *Hold on, I'll get the nurse out* [?] *straight away, thank you.*[74]

104. Cally's cellmate, who as indicated had previously worked as an enrolled nurse, promptly commenced unprotected CPR on Cally, on her bunk. Cally had stopped breathing and she commenced giving Cally Expired Air Resuscitation (mouth to mouth rescue breaths). Initially the cellmate found Cally to have an irregular pulse, but after about three to four breath cycles, the cellmate could no longer feel a pulse and she commenced CPR at a ratio of seven compressions to two breaths.[75]

Melaleuca Prison's resuscitation attempts

105. Upon being informed of the seizure, Officer Turner immediately called a "*Code Amber*" medical emergency alert over the prison radio: *Code Amber, Code Amber, unit 12, I have a medical emergency please.*[76]

106. Officer Turner then ran to Cally's cell to observe from the cell door. She saw the cellmate performing CPR, and it became apparent to her that Cally was having breathing difficulties.[77]

107. Within a matter of moments, Officer Turner upgraded the medical emergency alert to a *"Code Red*", which was confirmed over the radio by Officer Mitchell, followed a few seconds later by a further

[73] Exhibit 1, tabs 31 and 38.
[74] Exhibit 2, tabs A and 15.
[75] Exhibit 1 Tab 31.
[76] Exhibit 2, tab 15.
[77] Exhibit 1, tab 36; Exhibit 2, tab 15.

transmission from Officer Turner confirming she needed "*medical*", and that it was for "*breathing issues*":

> Officer Turner: *Can I increase that to a Code Red please. Code Red unit 12.*
> Officer Mitchell: *Confirming medical Code Red.*
> Officer Turner: *That's medical please, uh, breathing issues.*[78]

108. At approximately 10.55 pm, Nurse Mwendapole arrived at Cally's cell, together with Officer Mitchell, Officer Turner and Prison Custodial Officer Neil Whatcott (Officer Whatcott), in response to the Code Red. Officer Whatcott had been stationed in the crisis care unit that night, near to the healthcare centre, and had also responded to the Code Red medical emergency.[79]

109. Officer Mitchell had collected Nurse Mwendapole from the healthcare centre. Nurse Mwendapole was reliant upon Officer Mitchell having the key to open Cally's cell. At the material time, clinical staff were not able to enter the cells without a Senior Prison Custodial Officer being present, who would be responsible for unlocking the cell door.[80]

110. Within a matter of seconds after arriving at Cally's cell, the door was unlocked by Officer Mitchell and Nurse Mwendapole and Officers Turner and Whatcott entered the cell. Therefore, the time it took for them to get to Cally was about 4 minutes and 50 seconds after the cellmate made the cell call raising the alarm about Cally having a seizure. At this point Cally's cellmate was still performing CPR on Cally, on the top bunk where she lay, unresponsive.[81]

111. The officers lifted Cally down from the top bunk to the floor, and took over the chest compressions, on rotation. The cellmate continued to deliver the rescue breaths, and she was unprotected (meaning she did not have a protective mask). A defibrillator was applied, and four shocks were delivered. An attempt was made to give oxygen to Cally from a medical device, but this was unsuccessful.[82]

112. At the inquest I heard evidence to the effect that the oxygen tank brought to the cell was empty, and also conflicting evidence, to the

[78] Ibid.
[79] Exhibit 2, tabs A and 36; ts 82 to 84.
[80] Ibid.
[81] Exhibit 2, tabs 13, 16 and 37A.
[82] Exhibit 1, tabs 35 and 37A; Exhibit 2, tab A.

effect that there was no oxygen tank brought to the cell by Nurse Mwendapole. This was in the context of a lot of rushing around in a highly charged environment and is addressed later in this finding under the heading: *The response to the medical emergency*.

113. There is some evidence that the cellmate was asked to stand aside and to stop delivering the unprotected rescue breaths when Cally was positioned on the floor and the prison officers took over the compressions. The cellmate was a trained nurse, and I am satisfied that she bravely continued to deliver the rescue breaths because it was clear to her that the oxygen was not otherwise available.[83]

114. Nurse Mwendapole and Officer Mitchell had to make a hasty return to the healthcare centre to retrieve a functioning oxygen tank. About eight minutes elapsed while the oxygen tank was obtained, from the time they left, until they returned to Cally's cell. Meanwhile, the prison officers continued the compressions and the cellmate continued giving rescue breaths.[84]

St John Ambulance paramedics resuscitation attempts

115. At approximately 10.58 pm, very shortly after the Prison Custodial Officer radioed the Control Room, an emergency call was made by Melaleuca Prison to St John Ambulance. Records reflect that the St John Ambulance paramedics departed promptly and that they arrived at the prison at 11.19 pm.[85]

116. This first ambulance crew reported some difficulty initially accessing Cally's cell due to security measures at Melaleuca Prison (some of the gates and doors needed to be unlocked to allow for entry). After arrival at Melaleuca Prison, they estimated it took approximately five minutes for them to access Cally's cell.[86]

117. Officer Mitchell went to the Melaleuca Prison gatehouse to escort the paramedics to Cally's cell, but she reported feeling unprepared for this function because she was not exactly sure where the emergency gate was located. Again, this reflects upon Melaleuca Prison having been

[83] Exhibit 1, tabs 31, 37 and 38; Exhibit 2, tab A.
[84] Exhibit 1, tabs 31, 35 to 38.
[85] Exhibit 1, tab 47.
[86] Ibid.

recently opened, and systems and processes (including training) not being fully implemented.[87]

118. St John Ambulance records reflect that upon arrival at Cally's cell the paramedics observed that good compressions and rescue breaths were being performed. The paramedics took over the resuscitation efforts. Cally was initially found to be in a state of pulseless electrical activity. However, with ongoing compressions and ventilation by the paramedics with a bag valve mask, the paramedics achieved a return of circulation for Cally.[88]

119. The paramedics were unable to obtain intravenous access and a bone gun was used to administer intravenous fluids. They intubated Cally and adjusted the endotracheal tube when they noted it had moved. In the meantime, following an earlier follow up call another St John Ambulance crew arrived and they assisted with taking Cally out of Melaleuca Prison and conveying her to Fiona Stanley Hospital.[89]

120. This other crew had also experienced some difficulty getting to Cally. In their case they had trouble finding the entry to Melaleuca Prison, arriving first at Hakea Prison, due to the entrance signage not being visible from the road. Like the first crew, they also experienced some delays going through security once they got to Melaleuca Prison.[90]

121. It should be noted that at around the time Cally was being attended to, at approximately 10.56 pm a Code Green emergency was called by the nightshift officer in unit 11, who reported that a prisoner had fallen from her bed and had possibly broken her arm. This also undoubtedly placed a further burden on the Melaleuca Prison staff that were available to deal with emergencies that night.[91]

122. At approximately midnight, the St John Ambulance with Cally on board departed Melaleuca Prison for Fiona Stanley Hospital, arriving at approximately nine minutes past midnight on the morning of Tuesday, 21 February 2017.[92]

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[87] Exhibit 1, tab 37.
[88] Exhibit 1, tab 47; Exhibit 2, tab A.
[89] Ibid.
[90] Ibid.
[91] Exhibit 2, tabs A and tab 15.
[92] Exhibit 1, tabs 47 and 54; Exhibit 2, tab A.

Treatment at Fiona Stanley Hospital

123. Cally presented to the Emergency Department of Fiona Stanley Hospital following an out of hospital cardiac arrest. She was hypoxic on the way to the hospital. Her oxygen saturations were at 47% upon arrival, which was very low, but recovered to greater than 92% with the repositioning of the endotracheal tube that had been placed in the right main bronchus.[93]

124. Cally was admitted to the ICU for further investigations and management. Overnight she experienced multiple seizures, and she was commenced on medication to control them. An EEG performed on 21 February 2017 showed findings in keeping with severe diffuse encephalopathy. However, there was no evidence of ongoing seizures. A CT head scan showed no acute intracranial pathology.[94]

125. Cally remained in the ICU. A coronary angiogram performed on 23 February 2017 showed normal coronary arteries. However, the angiogram report noted that there was severe impairment of systolic function of the left ventricle, which was considered to possibly be due to Takotsubo cardiomyopathy or a metabolic cause (hypoxia/acidosis) such as an out of hospital cardiac arrest.[95]

126. On 24 February 2017 Cally was still on a respirator, treatment was continued, and sedation was withdrawn. On 25 February 2017 doctors noted that Cally had made no neurological improvement and her expected prognosis was poor. The extent of Cally's hypoxic brain injury was discussed with her family and arrangements were made to undergo a withdrawal of care.[96]

127. Cally was therefore commenced on a morphine infusion, and she was extubated at 5.00 pm on 25 February 2017. She was pronounced dead at 2.56 am on 26 February 2017.[97]

128. At Fiona Stanley Hospital, Cally had remained under Serco guard until the expiry of her sentence, being 24 February 2017. Serco officers ceased their hospital site duties at one minute past midnight. The

[93] Exhibit 1, tab 54.
[94] Ibid.
[95] Ibid.
[96] Ibid.
[97] Exhibit 1, tabs 6 and 54.

TOMS database recorded Cally's discharge date and time as 24 February 2017 at 7.54 am.[98]

129. Notwithstanding, I am satisfied that at the time of her death, Cally was a person held in care, due to there being no material change to her condition following her discharge date and time.

CAUSE OF DEATH

Post mortem examination findings

130. On 1 March 2017 the forensic pathologist Dr J. White (Dr White) made a post mortem examination at the State Mortuary on Cally's body. At the examination Dr White noted that the lungs were heavy with fluid with likely underlying infection. There was an evident fibrinous pericarditis with enlargement of the heart and a recent subendocardial infarction (heart attack).[99]

131. Dr White was not able to form an opinion on the cause of death at the conclusion of the examination on 1 March 2017 and ordered further investigations, including toxicology, microbiology, histology and recommended that neuropathology be performed.[100]

132. Those further investigations took place and on 29 December 2018 Dr White reported on them as follows:

(a) Toxicology showed multiple medications in keeping with Cally's known history and hospital care; alcohol was not detected in the ante mortem samples; in an ante mortem sample taken on 21 February 2017 (when Cally was initially conveyed to Fiona Stanley Hospital) pregabalin was not detected, but methylamphetamine was detected at a level of 0.11mg/L, and amphetamine at 0.03mg/L (the amphetamine represents the metabolic derivation from the methylamphetamine); in an earlier ante mortem sample taken on 19 February 2017 close to midnight (when Cally had been conveyed to Royal Perth Hospital for testing of a blood sample under the Road Traffic Act) a higher level of methylamphetamine was detected, being at a level of 0.30mg/L, and amphetamine at 0.04mg/L;

[98] Exhibit 2, tab A.
[99] Exhibit 7A.
[100] Ibid.

(b) Microbiology studies did not contribute any relevant information;

(c) Histology confirmed the findings upon examination, including an acute evolving bronchopneumonia, an evident chronic active hepatitis and a diffuse subendocardial infarction (heart attack);

(d) DNA studies showed there was no inherited cardiac condition;

(e) Gross neuropathology of the brain was completed, showing no significant abnormalities; microscopy of the brain confirmed global cerebral ischemia; and

(f) Hospital notes showed an echocardiogram in keeping with Takotsubo cardiomyopathy.[101]

133. On 29 December 2018 Dr White formed the opinion that the cause of death was hypoxic ischaemic encephalopathy and bronchopneumonia complicating a cardiorespiratory arrest in association with probable Takotsubo cardiomyopathy and methylamphetamine effect.[102]

134. The references to "*Takotsubo cardiomyopathy*" and "*methylamphetamine effect*" were further explored at the inquest and I was assisted by reports from various experts, that are referred to under the relevant headings immediately below.

135. After the inquest, with the availability of further information, on 3 May 2022 Dr White amended her opinion on cause of death to add a reference in her recitation to "*myocardial ischaemia*." Dr White explained that adding this element aids in the understanding of the complications subsequent to Cally's collapse leading to her death.[103]

136. I accept and adopt the opinion on cause of death that Dr White formulated on 3 May 2022. **I find that the cause of Cally's death was hypoxic ischaemic encephalopathy, bronchopneumonia and myocardial ischaemia complicating a cardiorespiratory arrest in association with probable Takotsubo cardiomyopathy and methylamphetamine effect.**

[101] Exhibit 1, tabs 7 to 9.
[102] Exhibit 1, tab 7.
[103] Ibid.

The role of Takotsubo cardiomyopathy

137. Takotsubo cardiomyopathy (broken heart syndrome) is a potentially reversible heart condition whereby the contractility (pump function) of the left ventricle is impaired, with apical ballooning. Often there is psychological stress involved.[104]

138. It is thought that it occurs primarily in persons with increased susceptibility of the coronary microcirculation and of cardiac myocytes to the stress hormones leading to prolonged but transient left ventricular dysfunction with secondary myocardial inflammation.[105]

139. Questions were raised as to whether Cally had Takotsubo cardiomyopathy. It will be seen, under the below heading: "*The role of methylamphetamine*" that Takotsubo cardiomyopathy is a recognised consequence of the use of methylamphetamine. In her opinion on cause of death, Dr White referred to Cally having "*probable Takotsubo cardiomyopathy*."

140. Further specialist opinions on the question of whether Cally had Takotsubo cardiomyopathy were obtained from the following:

(a) Dr Adrian Regli (Dr Regli), who was involved in Cally's care at Fiona Stanley Hospital ICU, confirmed that Cally had been diagnosed with Takotsubo cardiomyopathy while being treated in the ICU, and noted that the subendocardial myocardial infarction found at post mortem examination did not negate the clinical diagnosis of Takotsubo cardiomyopathy, pointing to the following:

A. Cally had echocardiogram findings compatible with Takotsubo cardiomyopathy with normal coronary arteries, basal dysfunction with apical ballooning, a raised troponin and non-specific ECG changes;

B. Methylamphetamine could be contributory or cause Takotsubo by increasing a person's sympathomimetic drive;

C. However, a separate non-methylamphetamine related cardiorespiratory arrest could also lead to a surge in

[104] Exhibit 1, tab 54.
[105] Exhibit 1, tab 7.

catecholamines and thereby cause Takotsubo cardiomyopathy.[106]

(b) Dr Johan Janssen (Dr Janssen) Cardiologist, Western Cardiology, disagreed with the diagnosis of Takotsubo cardiomyopathy, pointing to the following:

A. Takotsubo cardiomyopathy is usually found in elderly women and when treated carries an excellent, prognosis;

B. Noting that Cally was younger and under the influence of illicit drugs, he opined that she probably had a cardiac arrythmia that caused hypoxia of the inner lining of the heart which reduced the pump function and caused the abnormal echocardiogram.[107]

141. Dr White carefully considered the various opinions and maintained her opinion to the effect that Cally did have a probable Takotsubo cardiomyopathy, and I accept that, noting that this is also supported by the hospital specialist involved in her case.

The role of methylamphetamine

142. At the request of the coroner, Professor D.A. Joyce (Professor Joyce), Head of Clinical Pharmacology and Toxicology at QEII Medical Centre, reported on the relationship between Cally's drug exposure and her death, and he also gave evidence at the inquest.[108]

143. Professor Joyce analysed the methylamphetamine levels detected in Cally's blood samples and I refer to two aspects of this analysis. The first addresses the question of whether Cally used methylamphetamine at any stage while she was held in custody. The second addresses the potential contribution of the methylamphetamine to Cally's death.

144. Methylamphetamine was detected at a level of 0.11mg/L after Cally presented to Fiona Stanley Hospital on 21 February 2017 because of her cardiac arrest. This level was detected after she had been held in

[106] Exhibit 1, tabs 7 and 54; Exhibits 7 and 9.
[107] Exhibit 1, tabs 7 and 55.
[108] Exhibit 2, tab 31; ts 209 to 219.

custody since approximately 8.00 pm on 19 February 2017 (just over 24 hours) and is still quite high.[109]

145. The methylamphetamine initially detected at a level of 0.30mg/L after Cally's arrest on 19 February 2017 was even higher. In Professor Joyce's opinion this level is fairly typical of a person who is using the drug regularly in, at least, moderate doses.[110]

146. Professor Joyce informed the court that the levels detected after Cally presented to Fiona Stanley Hospital correspond to a half-life for methylamphetamine of approximately 16 hours. It is within the known range for the half-life of methylamphetamine in adults.[111]

147. I am therefore satisfied that Cally did not use methylamphetamine after she came into custody.

148. For completion, after Cally's death, a trace of methylamphetamine was detected in the post mortem blood sample taken at the time of her mortuary admission.[112]

149. I turn now to the role of methylamphetamine in Cally's death. Having regard to a number of studies, Professor Joyce informed the court that there is a well known, but low, incidence of sudden death occurring in stimulant users hours or even days after drug use. The cause has generally been taken to be a sudden disturbance in heart rhythm (arrythmia), similar to what may be produced by the intravenous administration of adrenaline, but not occurring immediately.[113]

150. Studies have shown that methylamphetamine can also cause constriction of the coronary arteries supplying blood to the heart (similar to an injection of adrenaline). This obstruction to the heart's blood supply can predispose to rhythm disturbances or completed myocardial infarction.[114]

[109] Exhibit 2, tab 31.
[110] Ibid.
[111] Ibid.
[112] Exhibit 1, tab 8.
[113] Ibid.
[114] Ibid.

151. Professor Joyce also noted that a more recent study has recognised methylamphetamine intoxication as a cause of acute dysfunction of the left ventricle of the heart (Takotsubo cardiomyopathy).[115]

152. It is known that in 2014, Cally had been admitted to Royal Perth Hospital with an out of hospital cardiac arrest and she recovered. Professor Joyce had regard to this previous and similar episode. In his opinion, the evidence falls short of proving that methylamphetamine caused the death, but it was a contributing factor. The reasons are outlined below.[116]

153. Factors referred to by Professor Joyce as supporting a causative effect from the methylamphetamine are as follows:

(a) Methylamphetamine was present;

(b) A tachyarrhythmia was present at around the time of Cally's collapse (as judged from the automatic defibrillator's decision to deliver a shock on four occasions);

(c) The post mortem examination showed acute myocardial infarction (an acknowledged consequence of methylamphetamine cardiotoxicity); and

(d) Myocardial infarction under these circumstances, when it does occur, is taken to be a consequence of the methylamphetamine induced spasm of coronary arteries.

154. However, factors referred to by Professor Joyce as uncertainties as to whether there was a causative effect from the methylamphetamine are as follows:

(a) Cally had tolerated higher concentrations of methylamphetamine without experiencing lethal coronary hypoperfusion, for example the previous day;

(b) Previous cases where direct methylamphetamine poisoning has caused cardiac death have had appreciably higher concentrations of the drug (though there is limited information in this area);

[115] Ibid.
[116] Exhibit 1, tab 54; Exhibit 2, tab 31.

(c) An alternative explanation for the myocardial infarction is the failure of cardiac tissue blood perfusion due to the cardiac arrest itself;

(d) Seizures can occur during methylamphetamine toxicity, but seem to be restricted to intoxication that is severe enough to cause confusion and delirium, rather than a phenomenon occurring more than a day after the last dose.[117]

155. Professor Joyce opined that on the balance of probabilities methylamphetamine should be considered as a contributor to Cally's death (but not the cause of it).[118]

156. Dr White referred to medical literature recognising that methylamphetamine has significant acute and chronic effects on the heart, all of which lead to a reduction of the heart's blood supply leading to myocardial irritation predisposing to rhythm disturbances and extending to a completed myocardial infarction.[119]

157. Dr White opined that Takotsubo cardiomyopathy and endocardium myocardial infarction are both recognised consequences of the use of methylamphetamine and referred to Professor Joyce's opinion on this point.[120]

158. Having regard to its known and deleterious effects on heart rhythm and coronary arteries, I am satisfied that while Cally's death was not caused by methylamphetamine toxicity, the methylamphetamine contributed to her death.

159. Dr White referred to "*methylamphetamine effect*" as part of the recitation of her opinion on Cally's cause of death (referred to earlier in this finding) thereby noting its contributory effect.[121]

MANNER OF DEATH

160. Were it not for the methylamphetamine effect, the manner of Cally's death would have been by way of Natural Causes.

[117] Exhibit 2, tab 31.
[118] Ibid.
[119] Exhibit 1, tab 7.
[120] Ibid.
[121] Ibid.

161. However, as I am satisfied that the methylamphetamine has contributed to her death, most likely by precipitating a tachyarrhythmia that gave rise to the cascade of events leading to her death, **I find that Cally's death was by way of Accident.**

WAS CALLY'S DEATH PREVENTABLE?

162. In considering whether Cally's death was preventable I have had regard to the following:

(a) Whether Cally had epilepsy;

(b) The quality of the response to the medical emergency;

(c) The role of an oxygen supply for Cally; and

(e) Cally's prospects of survival.

Did Cally have epilepsy?

163. A question arose on the evidence as to whether or not Cally had epilepsy. In determining that Cally did not have epilepsy, I took account of the following factors:

(a) Cally sought and received a few days' supply of Lyrica (pregabalin) at Royal Perth Hospital, having stated that she had epilepsy;

(b) As outlined earlier in this finding, Cally gave inconsistent responses at different stages of her intake and health assessment at Melaleuca Prison, when asked whether she had epilepsy;

(c) There is no prior medical record of Cally having been diagnosed with epilepsy; at the inquest Professor Joyce explained the process of diagnosis that includes a history from the patient, information from observers, and he referred to varying degrees of monitoring by electroencephalograph (to see if signs of epilepsy appear in the electrical activity of the brain);

(d) Save for the Lyrica (pregabalin) given to Cally at Royal Perth Hospital at approximately midnight on 19 February 2017, there is no medical record of Cally having ever been prescribed medication for epilepsy;

(e) In his report and at the inquest Professor Joyce explained that the main therapeutic use of pregabalin is in managing neuropathic pain. It is also used, though uncommonly, as an add-on drug for the treatment of patients who have a particular form of epilepsy who continue to have regular seizures despite optimised therapy with other anti-epileptic drugs;

(f) Professor Joyce referred to the sedative qualities of pregabalin, and its attraction as a drug of abuse for this reason. It is not perceived as having the same addictive potential as benzodiazepine drugs or opiate drugs and may be considered easier to prescribe. It is noted that Cally had told her cellmate that she was "*coming down from heroin and Lyrica*" and one inference that may be drawn from this comment alone is that Cally was using pregabalin for its sedative qualities;

(g) Professor Joyce explained that when people who are abusing pregabalin are forced to stop, they can experience a withdrawal state, with malaise, low mood and sometimes symptoms like nausea and diarrhoea. If the pregabalin has been used to treat epilepsy, seizures may recur if it is stopped suddenly;

(h) Other than as part of the cardiac event in 2014 and the cardiac event in 2017 resulting in her death, there is no record of Cally experiencing seizures; and

(i) The seizure activity described by Cally's cellmate in connection with her collapse on 20 February 2017 is likely to be explicable, in Dr Janssen and Dr White's opinions, by hypoxia of the brain caused by ventricular fibrillation:

A. Dr Janssen referred to an arrythmia, probably ventricular fibrillation, that caused not only subendocardial hypoxaemia of the heart, but also hypoxia of the brain, hence the epileptiform insult that she had; and

B. Dr White referred to the seizure activity being likely related to cerebral hypoxia due to the preceding cardiac events, in both 2014 and 2017, noting that seizures can occur in individuals in cardiac arrest who have never had a seizure before.[122]

[122] Exhibit 1, tabs 7, 31 and 55; Exhibit 2, tab 31; ts 214 to 215.

164. I am satisfied, to the requisite standard that:

(a) Cally did not have epilepsy;

(b) Cally used Lyrica (pregabalin) for its sedative qualities;

(c) There is no evidence to indicate that Cally had a seizure on 20 February 2017 due to a potentially missed dose of Lyrica (pregabalin); and

(d) The cause of the seizure activity that Cally's cellmate witnessed was due to cerebral hypoxia after her cardiac event.

The response to the medical emergency

165. There were two aspects of potential concern regarding Melaleuca Prison's in-house response to Cally's medical emergency, and there was conflicting evidence in respect of both aspects:

(a) The first concerns the interactions between Nurse Mwendapole and Officer Mitchell when the Code Red medical emergency was called;

(b) The second concerns the availability of a functioning oxygen tank to assist in the CPR performed on Cally.

Interactions between Night Nurse and Senior Prison Custody Officer

166. Nurse Mwendapole was the only nurse on night-shift on 20 February 2017, and she was involved in Cally's resuscitation.

167. A question arose on the evidence as to what Nurse Mwendapole was doing at the time the Code Amber and Code Red alerts were called by Officer Turner. There were conflicting accounts in the evidence given by Officer Mitchell and Nurse Mwendapole at the inquest, and these are outlined below.[123]

168. Procedures required Officer Mitchell to escort the night nurse to the cell, unlock doors as required, and let her in (this officer was the only

[123] ts 117 to 119; ts 170 to 177.

person with all the keys for this purpose). Officer Mitchell's evidence was that upon her arrival at the healthcare centre to urgently collect Nurse Mwendapole to go to Cally's cell, the Code Red had already been called.[124]

169. Upon arrival, it appeared to Officer Mitchell that Nurse Mwendapole was watching something on the computer screen, unrelated to the emergency, and that the nurse either did not have her radio earpiece in, or the radio earpiece was unplugged, though she did not recall which it was. When the earpiece is unplugged the sound (such as a Code Red) comes through the radio.[125]

170. Officer Mitchell testified that she yelled to Nurse Mwendapole that she needed her assistance, and the nurse quickly moved and grabbed what looked like an emergency response bag, and within 15 to 20 seconds they were on their way to the cell. Officer Whatcott was also in attendance (though not a party to the interactions between Officer Mitchell and Nurse Mwendapole at this point). Officer Turner, who had called the Code Red, was waiting for them outside Cally's cell.[126]

171. At the inquest Nurse Mwendapole disputed some aspects of Senior Officer Mitchell's evidence. Nurse Mwendapole denied being seated and watching an unrelated matter on her computer screen at the time that Officer Mitchell arrived to collect her and testified that she had heard the Code Red and had already collected the emergency response bag and was standing waiting at the door when Officer Mitchell arrived to collect her.[127]

172. Nurse Mwendapole testified that she had heard the Code Red while she was on the way to the dispensary to collect medications for Cally, because Officer Turner had previously telephoned her to inform her that Cally was having a seizure. When she heard the Code Red, she doubled back and rushed to collect the emergency response bag.[128]

173. The two accounts are quite distinct and cannot easily be reconciled. However, in light of the fact that, it is not disputed that only 15 to 20 seconds passed from the time that Officer Mitchell arrived before they

[124] ts 118.
[125] ts 117 to 118.
[126] ts 118 to 119.
[127] ts 172 to 174.
[128] ts 170 to 171.

made their way to Cally's cell, I have determined that it is not necessary for me to prefer one account over the other.

174. This is within the context of it having taken just under five minutes in total (specifically four minutes and 50 seconds) for them all to reach and enter Cally's cell after the cellmate made the emergency call to advise of Cally having a seizure.

175. However, the general rushing around might have an impact upon the aspect addressed immediately below, which concerns the conflicting evidence about the availability of a functioning oxygen tank to assist in the CPR performed on Cally.

The availability of a functioning oxygen tank

176. Ordinarily, in the course of performing CPR on a person in Cally's position, the airway will be maintained, and ventilation will be given. For this purpose, an entity such Melaleuca Prison had an oxygen tank, as part of an Oxy Viva resuscitation kit, that formed part of the emergency response equipment in the emergency bag. Ordinarily CPR will be performed by staff in a prison environment until paramedics arrive, who will usually take over the resuscitation efforts.[129]

177. At the material time, the nurses and officers were not issued with masks for the purposes of providing rescue breaths, and the only way to provide ventilation was through the Oxy Viva resuscitation kit, which ought to have had a functioning oxygen tank available for attachment. The kit did not come with a bag valve mask.[130]

178. In Cally's case, pending the arrival of the St John Ambulance paramedics, Cally was ventilated primarily by the unprotected rescue breaths given by her cellmate, who happened to be a qualified enrolled nurse. By all accounts the cellmate competently performed the rescue breaths and should be commended for that.[131]

179. However, this is not how ventilation or oxygen is to be ordinarily given to a prisoner who has collapsed, and there should be no expectation that other prisoners will perform this function (irrespective of their

[129] Exhibit 1, tabs 35 to 38; Exhibit 1, tab 47.
[130] Exhibit 1, tab 38.
[131] Exhibit 1, tabs 31 and 35 to 38; Exhibit 1, tab 47.

qualifications). Ordinarily a prison will be resourced to provide resuscitation that includes the devices needed for ventilation, and relevant staff will be trained.[132]

180. I turn back to the availability of a functioning oxygen tank at Melaleuca Prison, as the delivery of oxygen was its responsibility.

181. By the time the Code Red was called it was known that Cally had "*breathing issues.*" Specifically, Officer Turner had escalated the emergency to a Code Red because she became aware that there was a problem with Cally's breathing.[133]

182. As outlined previously in this finding, there are conflicting accounts in the evidence as to whether an empty oxygen tank was initially brought to Cally's cell, or whether no oxygen tank was brought at all.

183. However, be it one or the other, the evidence is consistent to the extent that, in the middle of the resuscitation efforts, Nurse Mwendapole, accompanied by Officer Mitchell had to rush back to the healthcare centre to get a functioning oxygen tank for the Oxy Viva kit, and then return with that tank to Cally's cell. During this time Officer Whatcott and Officer Turner, on rotation, continued to perform chest compressions on Cally, and the cellmate continued to provide rescue breaths.[134]

184. Nurse Mwendapole gave evidence about the general procedures concerning the oxygen tank, and her role in Cally's resuscitation.

185. The general procedure was that the Oxy Viva resuscitation kit and functioning oxygen tank was kept in the emergency bag, which Nurse Mwendapole described as being very big. She explained that oxygen would be delivered to a patient by means of a mask, connected to a tube that is in turn connected to the oxygen tank. In an emergency the nurse is responsible for connecting the parts.[135]

186. Nurse Mwendapole also explained that the clinical nurse manager had put in a standard procedure for the nurses to check the emergency bags

[132] Ibid.
[133] Exhibit 1, tab 36.
[134] Exhibit 1, tabs 31 and 35 to 38.
[135] ts 177 to 179.

on certain days, and also on the occasions when they had used the emergency bag (in order to replace everything that was used).[136]

187. If a nurse had previously used the existing oxygen tank on a patient, the procedure was as follows:

(a) If after the event was complete, the oxygen tank was empty, the nurse was to place a fresh oxygen tank in the emergency bag; and

(b) If after the event was complete the oxygen tank was not empty, the amount of oxygen left in the tank was to be ascertained and documented by the nurse in an emergency check book that was kept at the nurses' station.[137]

188. In Nurse Mwendapole's experience the emergency bag was always sealed and, in an emergency, she would pick up the bag and go. There would be no time to check what was in the emergency bag, and it was her expectation that everything that was required would be in the bag.[138]

189. On the night that Nurse Mwendapole went to attend to Cally, she had collected the emergency bag. Her recollection was that after she placed the defibrillator pads onto Cally, she sought to apply the oxygen. She turned on the oxygen tank, looked at the gauge and realised that the cylinder was empty.[139]

190. Consequently, Nurse Mwendapole, escorted by Officer Mitchell, ran back to the healthcare centre to collect a full oxygen tank. When they returned to Cally's cell, Nurse Mwendapole had to put the Oxy Viva equipment together. She then sought to put the oxygen on again, but by that stage to her recollection the paramedics arrived, and they took over the resuscitation efforts. The cellmate had continued to deliver the rescue breaths. Therefore, Melaleuca Prison's oxygen tank attached to the Oxy Viva resuscitation kit was ultimately not utilised to deliver oxygen to Cally.[140]

191. Cally's cellmate reported to the coroner that she recalled placing an oxygen mask on Cally, from the equipment initially brought to the cell by Nurse Mwendapole. She recalled that when the oxygen was turned

[136] ts 179.
[137] ts 179 to 180.
[138] ts 180.
[139] Exhibit 1, tab 38; ts 182.
[140] Exhibit 1, tab 38; ts 182 to 187.

on, there was not enough pressure, and the gauge showed the tank was near empty. She continued to perform rescue breaths, now utilising a protective face mask from the emergency bag.[141]

192. Officer Mitchell's evidence was consistent with that of Nurse Mwendapole to the extent that she escorted Nurse Mwendapole back to the healthcare centre to "*uplift*" the oxygen. She recalled this being at Nurse Mwendapole's request. Shortly afterwards she was summoned to the gatehouse to go and let the ambulance on site.[142]

193. Officer Turner was performing compressions and while she recalled there being an "*issue*" with the oxygen tank, and that someone may have gone to get one, her focus was on the compressions.[143]

194. However, Officer Whatcott, who was doing the compressions, and involved in applying the defibrillator, recalled that that the oxygen "*wasn't there*" and he called for someone to go and get it. He did not recall there being an empty oxygen tank brought to the cell before the staff went back to obtain a functioning oxygen tank.[144]

195. This raises the question of whether an oxygen tank, albeit empty, was in the emergency bag at all, and reflects upon the adequacy of the emergency and first aid procedures at Melaleuca Prison. As indicated, at the material time the relevant staff were not issued with masks in order to provide protected rescue breaths.

196. I am satisfied that the cellmate, the nurse and all the prison custodial officers who attended upon Cally that night worked assiduously and to the best of their ability to endeavour to revive her. They had all been trained in performing CPR. There was a fair amount of rushing around. It was a difficult and stressful environment, and for some of them it was the first time they had performed CPR. They were all deeply affected by the event.

197. This environment may account for the differences in recall as to whether there was, at first, an empty oxygen tank, or no oxygen tank at all.

[141] Exhibit 1, tab 31.
[142] Exhibit 1, tab 37; ts 120.
[143] Exhibit 1, tab 36; ts 61.
[144] ts 89 and 101.

198. I note that the cellmate obtained and used a face mask from the emergency bag initially brought by Nurse Mwendapole, to continue performing rescue breaths, and she recalled the tank being empty. Nurse Mwendapole gave clear evidence about the tank being brought by her when she first attended and found to be empty.

199. I am satisfied to the requisite standard that there was an empty oxygen tank, in the emergency bag and that the events concerning the oxygen tank unfolded as described by Nurse Mwendapole.

200. The evidence is consistent on the matter of Nurse Mwendapole, escorted by Officer Mitchell, having to rush back to the healthcare centre to retrieve a functioning oxygen tank, and I accept that.

201. Either way, the result for Cally was that there was a period of approximately 13 minutes (comprising four minutes 50 seconds for the response time, and a further eight minutes to obtain oxygen from the healthcare centre) during which oxygen from a medical device was not supplied. During this time, though, Cally was given rescue breaths by the cellmate.

202. The subsequent improvements in the availability of oxygen at Melaleuca Prison, as part of a resuscitation kit, to ventilate a prisoner who is not breathing, or struggling to breathe, is addressed under the heading *Improvements*, later in this finding.

The role of an oxygen supply for Cally

203. I was assisted by evidence from the following two expert witnesses, in considering the role of an oxygen supply on Cally's prospects of survival:

(a) Dr Janssen, Cardiologist, Western Cardiology; and

(b) Dr Regli, Intensive Care Consultant, who was involved in Cally's care at Fiona Stanley Hospital ICU.[145]

204. It is understood that Cally's cellmate competently provided Expired Air Resuscitation (rescue breaths) to the best of her ability throughout the incident and her efforts deserve praise.

[145] Exhibit 1, tabs 54 and 55; ts 227 to 229; ts 256 to 257.

205. Self-evidently however, reliance cannot be placed upon cellmates generally being capable and willing to perform rescue breaths. Melaleuca Prison had an oxygen tank for the purpose of delivering oxygen, and it was supposed to be functional.

206. Therefore, I have also considered whether ventilation for Cally may have been more effectively delivered by means of an oxygen tank (as opposed to rescue breaths), and whether that may have affected Cally's prospects of survival.

207. Dr Janssen was asked for his views on this issue having regard to:

(a) A four minute and 50 second time period between the cell alarm being raised by Cally's cellmate and the prison officers reaching Cally to perform CPR; and

(b) A further eight minute period to obtain the functioning oxygen tank.[146]

208. Within the context of CPR, Dr Janssen referred to the primary importance of chest compressions: "*start pumping*." He explained that blood is 98 per cent to 99 per cent oxygenated, meaning that compressions will circulate that oxygenated blood. With the benefit of his knowledge and experience he opined as follows:

> *"….if we can make the blood circulate without breathing, as we're sitting here, we can sustain life with a functioning brain for at least five minutes before we're really going to need additional oxygen".*[147]

209. In other words, with effective and continuing compressions, and assuming the blood's usual oxygen saturations, there is a five minute window (approximately) before oxygen needs to be separately given (be it by rescue breaths or by means of a medical device such as an oxygen tank).

210. Dr Regli agreed with Dr Janssen, that "*uninterrupted chest compressions*" are "*much, much more important than oxygen*", though

[146] ts 227.
[147] ts 227 to 228.

added that comparisons have shown that survivability is better when rescue breaths are given (together with the chest compressions).[148]

211. Chest compressions are of primary importance. However, after a certain time, ventilation, with or without supplemental oxygen (for example from an oxygen tank) also becomes important, for better prospects of survivability. This period of time is counted in minutes and referred to below as the "*cut-off time*" for requiring oxygen (in addition to chest compressions) for better survivability. The number of minutes referred to below is approximate.

212. While Dr Janssen considered the cut-off time was five minutes, Dr Regli considered the cut-off was somewhere between six and eight minutes. There is a difference of some minutes, but I am satisfied that their evidence on this point is sufficiently consistent.

213. In either case, it took a further eight minutes for a functioning oxygen tank to become available after the nurse and custodial officers entered Cally's cell, and this was too long. It was an unnecessary delay. It was some 11 minutes after the Code Red was called (due to Cally having breathing issues) and some 13 minutes after the cellmate made the emergency telephone call.[149]

214. In his evidence Dr Regli drew attention to the Australian Resuscitation Council's recommendation that laypersons give rescue breaths, within the context of basic life support. He distinguished this from advanced life support within a hospital setting, where he said that oxygen would be given if available (and it is my expectation that hospitals would have oxygen available for the administration of CPR on a patient who is not breathing).[150]

215. Cally's CPR ought to have been carried out with the benefit of a functioning oxygen tank available at the time that Nurse Mwendapole and Officers Turner and Whatcott entered her cell, at approximately 10.55 pm on 20 February 2017.

[148] ts 255.
[149] ts 227 to 228; ts 255 to 256.
[150] Exhibit 8; ts 256.

Cally's prospects of survival

216. At the inquest Dr Janssen described Cally's prosects of survival, after her collapse, as "*very slim*". He took account of the significant loss of her heart function, having regard to his review of the post mortem report, and the cellmate's reported description of Cally gurgling when she collapsed.[151]

217. By reason of Dr Janssen's opinion, and of the matters outlined above in this part, under the heading: *Was Cally's death preventable*, I am satisfied that Cally's prospects of survival were indeed very slim, but they were not wholly absent. After taking over CPR the paramedics were able to achieve a return of circulation for her. Sadly, however her condition did not improve, and she died five days later.

218. The CPR given at Melaleuca Prison prior to the arrival of the paramedics, including ventilation with her cellmate's rescue breaths, was performed to an appropriate standard.

219. However, were it not for the cellmate's rescue breaths, I would have concluded that the CPR given at Melaleuca Prison prior to the arrival of the paramedics was not performed to an appropriate standard, and an important opportunity was missed to save her life.

220. The CPR given by the St John Ambulance paramedics was of a very high standard.

221. In the circumstances, I am satisfied that Cally was afforded an appropriate opportunity for lifesaving CPR.

QUALITY OF SUPERVISION, TREATMENT AND CARE

222. Under s 25(3) of the Coroners Act, I must comment on the quality of Cally's supervision, treatment and care while in the care of the CEO of the Department of Justice – Corrective Services.

[151] ts 227.

Quality of response to medical emergency

Time taken to reach Cally's cell

223. I am satisfied that the time taken for the night nurse and prison custodial officers to reach Cally's cell, being four minutes and 50 seconds from the time the cellmate made the emergency call, was reasonable in the circumstances.

224. At the inquest Dr Janssen described it as a "*good effort*", especially for a non-hospital setting, and he suggested that in some circumstances, it was equal to, or better than, the time that would be taken for a hospital to mount a response.[152]

The lack of a functioning oxygen tank

225. As indicated earlier in this finding, if Cally's cell mate had not performed the rescue breaths, I would have found that an important opportunity to perform effective CPR on Cally following her collapse was missed, and further that it potentially had an adverse impact upon her prospects of survival (which were very slim but not wholly absent).

226. Even so, within a prison setting, the appropriate source of oxygen in similar circumstances is by way of a medical device (such as an Oxy Viva resuscitation kit with an oxygen tank, or a bag valve mask), potentially from a trained staff member's rescue breaths with the protection of an appropriate mask, but not from a cellmate's rescue breaths (unprotected or otherwise).

227. At the material time staff members had not been issued with masks for the purpose of providing protected rescue breaths. The only rational inference is that if ventilation was required at Melaleuca Prison, it was to be delivered by means of the oxygen tank.

228. In considering the quality of Melaleuca Prison's response to the medical emergency, I have had regard to the evidence of Dr Janssen and Dr Regli as outlined under the above heading: *The role of an oxygen supply for Cally*, and also to the following:

[152] ts 227 to 228.

(a) Dr Janssen's evidence, given in the context of a lack of oxygen for eight to 12 minutes, where he opined that by that stage: "….*the majority of the damage would probably have been done*"; and

(b) Dr Regli's evidence to the effect that rescue breaths are "*better than nothing*."[153]

229. In the normal course oxygen delivered through an oxygen tank gives a more stable supply and avoids the risk of exhaustion, and/or intermittent pauses on the part of the person delivering the rescue breaths.

230. There is some evidence before me about the cellmate being asked to stand aside, to stop providing the rescue breaths to Cally. Undoubtedly it was a difficult situation, but in reality, there was no other means of effectively providing ventilation for Cally at that stage.[154]

231. The cellmate informed the custodial officers that she had been an emergency room nurse and knew what she was doing and continued providing the rescue breaths. The custodial officers who were present formed the view that the cellmate was capable, and willing to continue the rescue breaths.[155]

232. As outlined earlier in this finding, a functioning oxygen tank for the Oxy Viva resuscitation kit was not available for Cally for at least 11 minutes after the Code Red was called, and it is to be borne in mind that the Code Red was called due to Cally having evident breathing difficulties.

233. Also as outlined earlier I am satisfied that it is more likely than not, that there was an empty oxygen tank, in the emergency bag. If I am wrong in that, the situation is not improved by there being no oxygen tank at all in the emergency bag.

234. At the inquest, in commenting on this issue, Dr Janssen considered that the resuscitation trolley should be checked every day on the start of the shift and that it is "*not excusable*" to have an empty oxygen cylinder, or no oxygen, available on the resuscitation trolley.[156]

[153] ts 227 to 228.
[154] Exhibit 1, tabs 31, 36 and 38.
[155] Ibid.
[156] ts 227.

235. A functioning oxygen tank should have been available at the time that the nurse and prison custodial officers entered Cally's cell, being four minutes and 50 seconds after the cellmate made the emergency call.

236. I am satisfied that Melaleuca Prison's standards of care fell below what should ordinarily be expected in delivering CPR for Cally, by reason of not having a functioning oxygen tank when the staff entered Cally's cell, as a consequence of which it took a further eight minutes to make one available.

Availability of procedures for staff

Reception intake procedures

237. Cally's intake at Melaleuca Prison on 20 February 2017 had four distinct aspects, the last of which occurred after she was conveyed to Fiona Stanley Hospital in the early hours of 21 February 2017:

(a) First, Cally's admission was undertaken and processed by a prison custodial officer who completed the "*At Risk Assessment*" module on TOMS.

(b) Secondly, part way through her intake, Cally underwent a welfare check by nursing staff at the request of the prison custodial officer performing the intake. That check was carried out within the reception area, but separately to the reception intake. The results of that nursing welfare check were recorded by the nurse on EcHO.

(c) Thirdly, after the reception intake had concluded, Cally underwent an initial health screen assessment at Melaleuca Prison's healthcare centre. The results of that assessment were recorded on the Departmental form AMR1012 (*Heath Services Initial Health Screen*) and saved on EcHO.

(d) Fourthly, Cally's property, including the Lyrica (pregabalin) prescribed at Royal Perth Hospital, was processed and inputted into TOMS, but not until the afternoon of the following day, after Cally had been conveyed to Fiona Stanley Hospital.[157]

[157] Exhibit 1, tabs 42 and 45; Exhibit 2, tab 7.

238. Self-evidently the Lyrica (pregabalin), being part of Cally's property, should have been processed during Cally's intake at the Melaleuca Prison reception area, and this appears not to have been done due to workload issues being experienced by the prison custodial officer.[158]

239. There ought to have been a process for conveying the information obtained by the prison custodial officer during the reception intake and inputted to TOMS, to the nurse who conducted the initial health screen assessment. This lack of information was compounded by the separate and late processing of Cally's property, with the result that the nurse did not receive, nor have access to, any information about Cally having Lyrica (pregabalin) in her possession upon admission. [159]

240. At the inquest Nurse Brennan who performed that initial health screen assessment gave evidence that, if she had been given the information obtained by the prison custodial officer during the reception intake (and inputted into TOMS), including that Cally had said that she had epilepsy, Nurse Brennan would have:

(a) Still asked all the required questions to get her own answers;

(b) Questioned Cally further about epilepsy and her medications; and

(c) Told the on-call doctor that Cally was "*epileptic*" and outlined any medications she was taking.[160]

241. Consequently, Cally's EcHO medical file did not record or reference that she suffered from epilepsy and/or seizures. If the nurse had been aware of the Lyrica (pregabalin) it would likely have led to further questions being asked, and an understanding gained that Cally had attended at Royal Perth Hospital for the epilepsy medication (and this would also likely have been added to Cally's EcHO medical file by the nurse).

242. At the material time, Sodexo's operating manual for the Reception Process at Melaleuca Prison (Reception Policy) outlined a reception process that would be operated through a team of dedicated reception officers supported by a range of other facility staff. It was envisaged

[158] Exhibit 1, tab 32.
[159] Exhibit 2, tab A; ts 26.
[160] ts 27.

that nursing staff and intake officers would work together as part of the intake process.[161]

243. Specifically, the Reception Policy provided for a member of the healthcare staff to participate in the reception process and review any prisoner in possession of prescription medication against Melaleuca Prison's procedures regarding in-possession medication. Continuity of community prescribed medication would be facilitated through a consult with the on-call doctor.[162]

244. The Reception Policy also provided for all of a prisoner's in-possession and stored property to be recorded on the prisoner's property card, which would be signed by the prisoner and counter-signed by the prison custodial officer at reception.[163]

245. In Cally's case, this did not occur. This was not as a result of individual behaviour. Rather, the processes, staff resourcing and monitoring that would have been needed to ensure this would occur, were not fully clarified and/or implemented. Regard is to be had to the fact that Melaleuca Prison had only recently opened, and the extent to which the Reception Policy had been promulgated, with training for all affected staff, remains unclear. Numerus witnesses expressed levels of doubt about procedures, and/or concerns about staffing levels.

246. While neither a cause nor contributor to Cally's death, this fragmentation of relevant medical information (as between custodial officers, inputting into TOMS, and the nursing staff, inputting into EcHO) could potentially lead to a failure to communicate important medical information. It is important that a policy such as the Reception Policy, designed to provide a safe, well-controlled and welcoming reception environment be clarified, implemented and monitored.[164]

247. The concerns around compliance with the Reception Policy were identified by the Department of Justice as part of its Death in Custody Report to the coroner. The Department reported that its review found that the prisoner intake assessment controls relating to Cally's reception at Melaleuca Prison on 20 February 2017 were inadequate and drew attention to Cally's separate processing by custodial and health staff.

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[161] Exhibit 2, tab 6.
[162] Ibid.
[163] Ibid.
[164] Ibid.

248. This became the subject of an internal Departmental recommendation referred to in its 23 November 2017 report, in the following terms:

> "*A Notice is issued to relevant MRRF staff to highlight the importance of compliance with current reception policies and procedures and promote the value of a* ***dual custodial and health approach*** *to prisoner admission.*"[165] [emphasis added]

249. At the inquest the Departmental witness agreed that the Department's notice (immediately above) does not identify exactly what staff need to comply with, referring to a need for it to be more "*pointed*."[166]

250. On 1 March 2018, a notice in similar terms was issued by Sodexo to all staff, referring to the following:

> "*Highlight to all staff the importance of* ***joint working between custodial and medical staff*** *during the prisoner reception process. The focus on this is the assessment of each prisoner and the delivery of appropriate care and referral within supportive processes*."[167] [emphasis added]

251. Phrases such as "*dual custodial and health approach*" and "*joint working between custodial and medical staff*" do not fully and clearly address the requirement for there to be a proper and complete handover of relevant medical information from the custodial staff to the nursing staff.

252. The custodial and nursing staff should know exactly what they need to comply with, in the context of "*dual*" or "*joint*" working arrangements.

253. Even if the nursing staff are present during a dual or joint custodial intake (or part of it), the nursing staff would still continue to separately address the matters as required on Departmental form AMR1012 (*Heath Services Initial Health Screen*) and saved on EcHO.

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[165] Exhibit 2, tab A.
[166] ts 320.
[167] Exhibit 2, tab A.2.

254. The reception intake processes at Melaleuca Prison concerning prisoner intake and property processing were not fully clear nor completely followed in Cally's case.[168]

255. It will be readily apparent that if Cally did have epilepsy (which she did not) and if Cally had suffered a seizure on 20 February 2017 due to epilepsy (again, which she did not) then the consequences of the nursing staff not having access to this information, despite it being in the possession of custodial staff, would have been magnified.

Resuscitation Procedures

256. As at 26 February 2017, the Department of Justice had a Corrective Services procedure titled "*Medical Emergency and Resuscitation of Prisoner*" which set out a procedure for responding to a Code Red medical emergency. Amongst other things, the policy required the registered nurse on duty to:

(a) attend the location of the medical emergency;

(b) take the emergency bag and defibrillator;

(c) assess the patient and the situation; and

(d) provide emergency care and necessary interventions that are within their professional scope of practice and competency.[169]

257. Aspen, who was subcontracted to provide the healthcare services at Melaleuca Prison, had a number of documented procedures addressing CPR standards or guidelines, in force between December 2016 and December 2019 (together referred to as the Aspen Procedures) as follows:

(a) A document in flowchart format titled "*Correctional Healthcare Solutions - Adult Cardiorespiratory Arrest Flowchart CPG*", that refers to "*Oxygen*" under the heading "*During CPR*";

(b) A document in flowchart format titled "*Correctional Healthcare Solutions - Basic Life Support CPG*", that, under the hearing "*Start CPR*" refers to "*30 compressions: two breaths*" and that

[168] Exhibit 2, tab A.
[169] Exhibit 10.

may or may not have been in the emergency bag at the material time;

(c) A document entitled "*Correctional Healthcare Solutions – Management of: Respiratory; Dyspnoea CPG*" that addresses shortness of breath and airway obstruction, and that refers amongst other things to the following: "*Oxygen is the treatment for hypoxia not breathlessness*", and it is known that Cally had stopped breathing (as opposed to feeling breathless).[170]

258. The CPR protocols in the Aspen Procedures were based upon standard industry guidelines and they referenced the Resuscitation Councils of each of Australia and New Zealand.[171]

259. I am satisfied those procedures were available at the material time, that they addressed the performance of CPR on an unresponsive prisoner, and all of them, as would be expected, refer to the need for oxygen in appropriate circumstances, with one of them referring to breaths.

260. Self-evidently prison custodial officers would not be required to provide unprotected breaths to an unresponsive prisoner. My expectation is that a functioning source of oxygen for use in the resuscitation equipment would be available for this purpose. In Cally's case a functioning source of oxygen was in fact on the premises at Melaleuca Prison, but it was not made available to her within a reasonable time.

261. The presence of the functioning oxygen tank at Melaleuca Prison at the material time presupposed its usage if required. Given its availability, it would not be prudent to dispense with it and revert to the practice of Expired Air rescue breaths.

262. Since the time of Cally's death there have been improvements in the clarity of the Department of Justice's procedures regarding CPR equipment, and these are addressed under the heading *Improvements*, later in this finding.

[170] Exhibit 11; ts 177 to 178.
[171] Exhibit 11.

Procedures for checking emergency bags

263. The importance of checking the emergency bags cannot be overstated. If the Departmental checking procedures that were in place in February 2017 had been followed, it is likely there would have been a functioning oxygen tank inside (or accompanying) the emergency bag that Nurse Mwendapole collected on her way to attend to Cally in her cell.

264. Specifically, as at 26 February 2017, the Department had a Corrective Services procedure titled "*Checking of Emergency Bags and Health Centre Defibrillator at Adult Health Centres*", which was reviewed shortly after Cally's death.[172]

265. There was a standardised checklist for emergency bags, which were to be used in conjunction with other first responder mobile equipment, referred to as an Oxy Viva, airway and breathing equipment and defibrillator. The emergency bags also contained an emergency drug pack and were to be located in an easily accessible yet secure area of the healthcare centres. The emergency bags were to contain only the items listed on the emergency bag checklist.[173]

266. Relevantly, the procedure stated that the contents of the emergency bag should be checked and documented on the checklist weekly. The clinical nurse manager was to organise auditing of compliance with conducting checks as per the checklist.[174]

267. Nurse Mwendapole's evidence concerning her knowledge of the procedures for checking the emergency bag is outlined earlier in this finding under the heading: *The response to the medical emergency* and is broadly consistent with the Departmental procedure.

268. However, Nurse Mwendapole's evidence was that this checking procedure may not have been complied with at the material time, due in part to staffing shortages. There are no checklist records available to show whether the procedure was being complied with in February 2017.[175]

[172] Exhibit 10.

[173] Exhibit 10.

[174] Ibid.

[175] ts 195 to 196;

269. That there was an empty oxygen tank in the emergency bag goes to show that checking procedures were not invariably being followed at the material time, which is unsatisfactory. On the other hand, if there was no oxygen tank at all, in or connected with, the emergency bag, that is equally unsatisfactory.

IMPROVEMENTS

270. Since the time of Cally's death, there have been improvements in the areas of computer access, handover of relevant medical information and staffing ratios. These represent the continual improvements that would be expected as Melaleuca Prison developed from a newly opened facility to a fully functional one.[176]

271. While none of the above issues caused or contributed to Cally's death, they ought to be regarded as lessons learnt for the future, and reflect upon the importance of testing systems, analysing resourcing, developing procedures, implementing training, and monitoring compliance, at the earliest possible stage.

272. The following two improvements, concerning oxygen equipment and entry signage, occurred after Cally's death, and specifically address areas of concern:

Oxygen Equipment

273. There have been improvements at Melaleuca Prison concerning the availability of oxygen resuscitator kits for use in emergency situations, in recognition of its importance, including in the area of CPR.

274. The Department of Justice reported to the coroner that the emergency bag, which was heavy, in a backpack style, has been replaced with a push-chair buggy that can be moved quickly and with ease.[177]

275. At the inquest the current Superintendent of Melaleuca Prison, Mr Wade Reid (Mr Reid), who commenced his role there in July 2020, informed the court that there are now three Oxy Viva resuscitation kits at the prison, one in the healthcare centre and one in each of units 11 and 12.

[176] Exhibit 1, tab 56; Exhibit 2, tabs A and 29.
[177] Exhibit 2, tab A.

The situation is now also the same for the defibrillators. Mr Reid informed the court that oxygen equipment is checked by health staff.[178]

276. Dr Rowland gave similar evidence, referring to the oxygen resuscitator at the healthcare centre as a portable OxiBoot kit, that is kept in the emergency bag (now the push-chair buggy). Its contents are maintained and checked through the clinical nurse manager. Dr Rowland informed the court that, in addition to this, Oxy-Viva resuscitation kits are kept on the prison units, and these are checked by the custodial staff.[179]

277. By reason of these improvements, which Dr Rowland said apply to government prisons in Western Australia, there is no need for me to make a recommendation regarding the availability and checking of functioning oxygen tanks for the emergency resuscitation of prisoners.

Signage for entry to Melaleuca

278. St John Ambulance Western Australia dispatched three ambulances to Melaleuca Prison in response to Cally's collapse. One of the ambulance crews reported difficulty in finding the entrance to Melaleuca Prison.[180]

279. The ambulance crew that had difficulty finding the entrance to Melaleuca Prison ended up at Hakea Prison, which is close by. The reason was that, at the material time, the signage for the entry at Melaleuca Prison was not readily visible from the road.[181]

280. At the inquest Officer Mitchell informed the court of her recollection that, at the time of Cally's collapse, the signage for Melaleuca Prison was at the pathway as you walk in, and that from the road, only the Hakea Prison signage was visible.[182]

281. Officer Mitchell recalled that, in prior emergency situations, clear instruction had had to be given to ambulance crews to come to Hakea

[178] ts 338.
[179] ts 146.
[180] Exhibit 1, tab 47.
[181] Exhibit 1, tab 47; ts 124.
[182] ts 124.

Prison then carry on up the road, and that Melaleuca Prison was at the end of that road.[183]

282. The Department of Justice reported to the coroner that, after the critical incident involving Cally, road signage for Melaleuca Prison is now in place. By reason of this improvement, there is no need for me to make a recommendation concerning signage and access.

RECOMMENDATION: POST INCIDENT CARE

283. As outlined throughout this finding, Cally's cellmate commenced CPR on Cally within the cell, and continued to provide rescue breaths after prison custodial officers and Nurse Mwendapole arrived. Those rescue breaths were in part provided without any protection, and for about 13 minutes were Cally's only source of ventilation.

284. There is some evidence to indicate that adequate post incident care was not provided to Cally's cellmate at Melaleuca Prison. Whilst an exhaustive exploration of this aspect is outside the scope of the inquest, I heard from Dr Joy Rowland (Dr Rowland), Director of Medical Services, Department of Justice (Corrective Services) about her expectations of the kind of care she would expect to be given to a prisoner in the cellmate's position and her evidence was as follows:

> "*A debrief. Sort of, a conversation to find out how they felt about everything, and in terms of safety, inquiring whether they would – whether they feel concerned about their exposure and then ask them what they think their exposure risk is and cover off any false beliefs or false concerns.* […] *You're very unlikely to catch HIV through – through giving breaths unless there was blood involved or you had sores on your mouth. You're very unlikely to catch Hepatitis C from that sort of engagement. You're not likely to catch hep B unless there was a lot of transmission of fluid or blood* […] *So fear is often greater than the real risk, so I would address that, and then if they needed further reassurance through testing or discussion, I would address what was required to – for their reassurance even if it wasn't actually medically indicated. You know, if their fear was greater than risk."*[184]

[183] Ibid.
[184] ts 157 to 158.

285. The cellmate was released to freedom shortly after this incident, and she made inquiries with Cally's partner about how Cally was going in hospital. She was subsequently informed that Cally had died, and she was understandably highly distressed and deeply affected by it. She met with members of Cally's family who thanked her for her role in performing the CPR.[185]

286. Support under these circumstances is vital. It is known that bystanders who participate in CPR, where the person subsequently dies, may have complex feelings about it. They ought to be reassured of the value of their efforts irrespective of the outcome, and of the high regard that the community has for bystanders who offer to assist with CPR.

287. I urge the Department of Justice to ensure that prisoners who assist in resuscitation incidents, or otherwise assist fellow prisoners in the course of a critical incident, receive adequate and reasonable support and care, including a debrief (of which records should be kept), and where appropriate, medical review. I therefore make the following recommendation:

Recommendation

I recommend that the Department of Justice give consideration to the development, adoption and promulgation of a post-incident care policy for prisoners involved in or affected by critical incidents.

CONCLUSION

288. Cally was imprisoned in February 2017 for the non-payment of her fines in accordance with an administrative process that had applied under the previous provisions of the *Fines Penalties and Infringement Notices Enforcement* Act 1994.

[185] Exhibit 1, tab 31.

289. This legislation was amended in 2020, to ensure that for future cases, only a Magistrate can order imprisonment for non-payment of fines. One of the applicable principles now is that imprisonment is an enforcement measure of last resort.

290. Cally was imprisoned for six days to cut out her fines, and it was her first time in prison. In the lead up to her collapse there were no clinical indications that ought to have alerted the nursing staff to an imminent and catastrophic deterioration in her condition.

291. Melaleuca Prison's custodial and nursing staff worked together to perform CPR. Melaleuca Prison ought to have had a functioning oxygen tank promptly available to assist with resuscitating Cally, but they did not. The humanity and quick thinking of her cellmate in commencing CPR and giving Cally rescue breaths until the paramedics arrived satisfies me that Cally was afforded an appropriate opportunity for lifesaving CPR.

R V C Fogliani

STATE CORONER

31 JANUARY 2023