CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Melville Schrader
Hearing dates:	24 and 25 August 2023
Date of findings:	4 October 2023
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a man in lawful custody – requests for medical treatment – was response of the JH Network appropriate – would a more timely response have altered the outcome.
File number:	2019/252231
Representation:	Counsel Assisting: J Harris of Counsel i/b Solicitors, NSW Coroners Court Justice Health and Forensic Mental Health Network: B Bradley of Counsel i/b Makinson D'Apice Lawyers Commissioner of Corrective Services NSW: J de Castro Lopo, Department of Communities and Justice, Legal Melville Schrader's family: J Pender, Aboriginal Legal Service

Findings:	**Identity** The person who died is Melville Schrader. **Date of death**: Melville Schrader died on 13 August 2019. **Place of death**: Melville Schrader died at Long Bay Correctional Centre Hospital, Malabar, Sydney NSW. **Cause of death:** Melville Schrader died from small bowel obstruction in the setting of terminal metastatic neuro-endocrine tumour. **Manner of death:** Melville Schrader died as a result of natural causes, while he was in lawful custody.

1. Section 81(1) of the *Coroners Act 2009* (NSW) [the Act] requires that when an inquest is held, the coroner must record in writing their findings as to various aspects of the death.

2. Section 27(1)(b) of the Act requires that there be an inquest when a person dies in lawful custody.

3. These are the findings of the inquest held into the circumstances of Melville Schrader's death.

Introduction

4. On 13 August 2019 Melville Ernest George Schrader aged 76 years died at Long Bay Correctional Centre Hospital.

5. Mr Schrader's family has asked that in these findings he be referred to as 'Megs' (the initials of his full name), which was how he was known to his friends and his family.

6. Megs had been in prison since 2014. In January 2018 he was diagnosed with metastatic neuro-endocrine cancer. Although he received hospital treatment, it was not able to prevent the spread of his disease.

7. By May 2019 Megs had become very frail, and a decision was made to cease active medical treatment and to provide him with comfort care. On the morning of 13 August 2019 Megs was found deceased, sitting in his wheelchair.

8. An autopsy examination was performed by forensic pathologist Dr Elsie Burger. Dr Burger recorded the cause of Megs' death as small bowel obstruction in the setting of terminal metastatic neuro-endocrine tumour. Dr Burger commented that Megs was very emaciated. His liver was enlarged and it showed multiple tumour infiltrates, in keeping with his diagnosis of metastasised neuro-endocrine cancer.

9. A CT scan also identified a groin hernia, but it was not possible to determine if this had developed as a result of the tumours. Dr Burger observed that had Megs' hernia been diagnosed before his death, surgery to address it would probably not have been recommended given his poor condition.

Megs' life

10. Megs was born on 4 July 1943. He spent much of his adult life working in the town of Tweed Heads in northern NSW, where he also played rugby league for local teams. He married Pamela Pearce, who was a registered nurse, and they had four children: Steven, Rodney, Christine and Joan.

11. Megs and Pamela separated in 1985 and were divorced in 1996. However Pamela remained a loyal friend to Megs, and was his greatest support in his final years. After he was imprisoned Megs and Pamela spoke on the phone most days, and when he became seriously ill she worked hard to have him released to early parole so that he could die amongst his family. However her efforts were not successful.

12. Pamela Pearce attended the inquest by means of AVL, as she lives in Queensland. At the close of the evidence, her daughter Christine prepared a statement on behalf of the family, which was read to the court by their legal representative Mr Pender.

13. Christine wrote that she had only recently learnt that her father's life had not been easy. Megs was a First Nations man, whose father had been removed from his own First Nations family when he was a child. Megs' father had served in the Second World War, and he suffered lasting trauma as a result. Now Christine and her family are searching for the family from whom their grandfather was taken many years ago.

14. It was moving to hear Christine's memories of Megs spending happy times with his children, taking them out on the Tweed River and for trips to the beautiful beaches of northern NSW. Christine paid tribute to her mother too, describing Pamela as Megs' rock throughout his hard times.

Background

15. Megs was charged with criminal offences in 2014. He was granted bail and was allowed to move to Queensland to live in Pamela's home. Later that year he pleaded guilty to the charges and was sentenced to a significant period of imprisonment. He would not be eligible for parole until 5 December 2019.

16. In June 2014 Megs was transferred to the Metropolitan Special Programs Centre at Long Bay Correctional Centre in Sydney. He did not complain of any significant health concerns, until on 29 October 2015 he lodged a Patient Self-Referral form as follows:

'I'm in pain in the lower back and abdomen. I've had family members with bowel cancer and I haven't had a colonoscopy and the pain still consist.'

17. This form was the first of many which Megs was to submit, notifying that he was in pain and asking to see a doctor. But it was not until 6 November 2017, more than two years later, that he finally succeeded in getting a medical review for his symptoms. Within a few weeks it was confirmed that he was in the advanced stages of a rare form of cancer known as Neuro-endocrine Tumour.

The issues at the inquest

18. The primary issue examined at the inquest was the response which Megs received to his many requests for medical help while he was a prisoner.

19. It may be said from the outset that the response was very poor, and far below the standard expected for the medical care of inmates. At the inquest this fact was acknowledged by the agency which was responsible for Megs' health care, the Justice Health and Custodial Mental Health Network.

20. The other issues examined at the inquest were as follows:

- Is it likely that earlier referrals and investigations would have resulted in an earlier diagnosis and treatment of Megs' condition?
- If so, what effect would earlier treatment have had on Megs' prognosis and his quality of life?
- What changes have been made to the system of patient self-referral since Megs' death?

21. The evidence included statements from those who had been involved in Megs' health care, together with records and relevant policies of the Justice Health and Custodial Mental Health Network [the JH Network].

22. In addition the court was assisted with independent expert evidence from the following specialists:

- Dr Stephen Clarke, medical oncologist and senior staff specialist at Royal North Shore Hospital
- Dr Shirley Wong, senior consultant medical oncologist at the Medical Oncology and Oncology Research Department at Western Health

- Dr Hester Wilson, a General Practitioner clinician with over 30 years' experience in general practice,

23. By way of background to these issues, I will briefly describe the system by which inmates in NSW correctional centres can seek medical help.

The Patient Self Referral System

24. In most NSW correctional centres, inmates receive their health care from staff of the the JH Network.

25. At the inquest Shaun Connolly, who is Nurse Manager Operations in the JH Network, explained how an incarcerated patient is able to request access to medical or nursing care. This is pursuant to a policy titled *Patient Self-Referral for Health Assessment in the Adult Ambulatory Care Setting (Non Urgent Issues Only).*

26. Then, as now, the patient completed a Patient Self Referral form [a PSR form] setting out the reason why they were seeking medical care. Patients could deliver the form either to the prison health centre or nurse clinic, or place it in a locked box (to which only staff of the JH Network had access), located in accommodation areas.

27. The PSR forms are collected and triaged by registered nurses. Nurses then use the JH Network's Patient Administration System [PAS] to place the patient's name on an electronic wait list to see an appropriate clinician.

28. Each request must be given a clinical priority, by reference to the JH Network's *PAS Waiting List Priority Level Protocol*. An 'Urgent' priority requires that the patient be seen within 1 to 3 days. With a 'Semi-Urgent' priority the patient is required to be seen within 3 to 14 days.

29. As will be described, after lodging his request on 29 October 2015 Megs did not receive a review by a doctor for more than two years, despite repeated attempts to get an appointment using the Patient Self Referral system.

The review on 28 January 2016

30. When Megs submitted his PSR form on 29 October 2015 he waited three months to receive an appointment. In the meantime he submitted a second PSR form. In this form, which he submitted on 4 December 2015, he stated:

> *'I've been getting severe pains in my lower abdomen & lower back for some time now. I'm a bit worried as there is bowel cancer in the family. I've had a colonoscopy test as of yet. Thank you Mel.'*

31. On the form there is notation, presumably made by a staff member of the JH Network, that the PSR form had been received. In addition the words were handwritten: *'Already on the wait list'.*

32. Megs received an appointment on 28 January 2016 at the nurse clinic, where he was reviewed by Registered Nurse Muang Myint.

33. In the patient notes for Megs RN Myint recorded that he was suffering constipation, and wanted to have a bowel cancer screen test because of his family history of bowel cancer. RN Myint gave Megs Metamucil to assist with his constipation, and documented that he had placed him on the General Practitioner list *'for ? bowel cancer screening referral'.* RN Myint also documented that Megs would be reviewed '*in a week'*.

34. At the inquest RN Myint told the court that Megs' symptoms and family history of bowel cancer indicated that he should see a doctor, and that he had made the above notation for this purpose.

35. But for reasons which are not clear, Megs' name was not entered onto PAS to see a GP. Instead of recording a booking on the doctor wait list, PAS recorded that Megs was to be reviewed in a week by a nurse. To add to the confusion, the clinical priority recorded onto PAS was '*Non Urgent'*, meaning that Megs was to be seen within a period of 14 days to three months, instead of within a week.

36. At the inquest RN Myint was unable to explain why this had happened, except to say that he himself had probably made an error by selecting the nurse wait list rather than the GP wait list.

37. Following this appointment on 28 January 2016, Megs did not see a GP as RN Myint had intended. Nor did the review which was to occur in a week take place.

38. Worse still, this was only the first of many errors and oversights which afflicted Megs' care over the next twenty months.

The subsequent requests

39. Megs' next appointment was on 7 March 2016, when he was seen by another nurse. According to the records, Megs again reported constipation and was given Metamucil. The PAS record again recorded that Megs was to be reviewed '*in a week'*. But for reasons which are unknown, no such review was in fact booked.

40. On 10 April 2016 Megs submitted his third PSF form. He wrote:

> *'I am constantly going to the toilet up to 8 times a day to use my bowels as bowel cancer is in my family I think I may have polyps in my bowels, I have not had a colonoscopy.'*

41. This form was received on 12 April 2016. Handwritten onto it were the words: *'Added to* p*rimary health waiting list'.*

42. But in fact Megs' name was not on the wait list for an appointment with any health clinician. It must be assumed that the JH Network staff member who

placed the above notation on Megs' April PSR form failed to check the PAS system to confirm this information.

43. Seven months passed, and Megs completed a fourth PSF form. On this form dated 30 November 2016 he wrote:

'I have severe pain just under my right rib cage'.

44. A copy of this form was provided by Pamela Pearce, as there are no records from the JH Network that it was received by their staff.

45. Meg's fifth Self-Referral From was submitted three months later, on 23 February 2017. He wrote:

'I am concerned about my health. I am 74 years old. I lodged my self-referral form 1.12.16 – no action. I have pain across lower chest, persistent slight vomiting & diarrhoea. Lack of appetite and inability to sleep. This is affecting my work and well being. Please may I see the doctor?'

46. On this form the words were handwritten: *'Mr Schrader, I have placed you on the Dr wait list for rev 23/3/17'.*

47. It is inexplicable why these words were written. No appointment of any kind was booked for Megs, no review was booked for 23 March 2017, and once again Megs' request for medical help met with no effective response.

48. On 8 May 2017 Megs received a flu vaccine at the health clinic.

49. Megs' next appointment was on 27 May 2017. This time Megs presented himself at the health centre, and he was seen by an agency nurse. Megs told the nurse that he had been vomiting and that his family had a history of bowel cancer. The nurse gave him Metamucil and Gastrogel, advised him to keep hydrated, and told him that he was on the wait list to see the GP and to be referred for a bowel cancer screening test. An entry was made that Megs was *'awaiting bowel cancer screening referral'.*

50. But again, this was incorrect. Megs' name was not on the PAS wait list to see a GP or to have a bowel screening test.

51. Mr Connolly was unable to explain this omission. However at the inquest RN Myint speculated that it may have occurred because the nurse who saw Megs on 27 May 2017 was an agency nurse. At that time agency nurses were not authorised to access the PAS system. Instead they were required to forward to the Nursing Unit Manager any requests for placement onto it.

52. It is now impossible to know if the agency nurse failed to forward this request to the Nursing Unit Manager, or indeed if they did forward the request but it was not actioned. Whatever the reason, no appointment for a GP was made.

53. On 29 October 2017, exactly two years after he had submitted his first PSF form, Megs submitted his sixth one. This time he wrote:

'I am very concerned about my health. I put in a form in to see a doctor in November last year, and several form since then with no doctor seen yet. I've lost 11-12 kg in weight in the last eleven months. I suffer from stomach-bowel pain daily and have several attacks of diarrhoea every day. My sleep has been disturbed every night. Its been over three years since my last blood test. I was promised a bowel cancer scan last November but have yet to receive it'.

54. Around the same time Megs told Pamela in one of their regular phone conversations that he had lost weight, was suffering stomach cramps and diarrhoea, and had been feeling ill for almost two years.

The diagnosis

55. On 3 November 2017 a correctives officer on his own initiative brought Megs into the health clinic, as Megs was suffering abdominal pain with alternating constipation and diarrhoea.

56. Megs was reviewed by a clinic nurse, who confirmed that despite a record that he had been referred for a bowel screening test, none had taken place. The nurse recorded that Megs looked emaciated, and identified a large tender mass in his abdomen. Megs was promptly booked for a GP review *'as a matter of urgency',* and was also placed on the wait list to see the cancer coordinator.

57. Megs was finally reviewed by a doctor three days later, at the Long Bay Hospital outpatient clinic. Two long years had passed since RN Myint first determined that he needed to see a doctor.

58. The medical review was performed by staff specialist Dr Gary Nicholls. Dr Nicholls took Megs' history, then examined him and noted his enlarged liver. He ordered urgent blood tests and an abdominal CT scan.

59. When the CT scan was performed at the Prince of Wales Hospital, it revealed an enlarged liver with multiple lesions. Further hospital tests suggested that Megs had cancer of the colon with possible metastases to his liver.

60. This diagnosis was given to Megs in a consultation on 8 December 2017. The progress notes recorded that Megs appeared '*calm and cooperative'*. A further note recorded that he had found the diagnosis a shock, but that he *'knew he had cancer as his mother had lost a lot of weight before she died'.*

61. On 19 December 2017 Megs was brought into the Prince of Wales Hospital oncology unit for a series of medical investigations. He underwent a further CT scan, a liver biopsy and a colonoscopy to determine the cancer's nature and its degree of spread.

62. These tests confirmed that Megs was suffering a rare form of cancer known as Neuro-endocrine Tumour [NET]. The primary cancer site was not able to be identified, but it was evident that it had already spread to Megs' liver.

63. Dr Siobhan O'Neill was the oncologist assigned to Megs' care at the Prince of Wales Hospital. In a report dated 18 January 2018 she commented:

'I am concerned about the delayed diagnosis given that he was reporting symptoms over the 12 months'.

The treatment

64. Megs commenced receiving lutate treatment, a targeted form of radiotherapy used to treat NETs when there has been progression of the disease. He also received a type of drug known as a somastatin analogue, to help control his symptoms of diarrhoea and to slow his weight loss.

65. Unfortunately Megs' condition gradually deteriorated. In February 2019 he was moved to live in the Long Bay Correctional Centre Hospital. Three months later Megs had a meeting with Dr O'Neill, in which she explained to him that further anti-cancer treatment was unlikely to benefit him. She considered that the ongoing focus of his care should be on comfort. Dr O'Neill commented that:

'*Mr Schrader showed good insight and understanding and agreed with the purely palliative approach'.*

66. By 8 August 2019 Megs was so frail that he needed full care and assistance. On the morning of 13 August 2019 he was reviewed by nursing staff on several occasions, and his pain levels assessed. He told his nurse that he wanted to remain in his wheelchair rather than return to bed. At 11.40am he was again assessed, and was found sitting in his wheelchair, unresponsive. He was pronounced deceased shortly afterwards.

67. I turn now to the issues examined at the inquest.

The adequacy of care: October 2015 to October 2017

68. I will note at this point that there was no significant criticism of Megs' medical treatment once his NET had been diagnosed. In his expert report Dr Stephen Clarke generally approved of his post-diagnosis management, with a few exceptions which I do not need to address. This is because Dr Clarke acknowledged that the measures which he identified as missing would not have made a significant difference in outcome:

' … *unless they had been introduced at much earlier timepoints which was clearly not possible due to the delayed diagnosis'.*

69. A report was sought from GP specialist Dr Hester Wilson as to the adequacy of Megs' medical care during the period October 2015 to November 2017.

70. In her report Dr Wilson noted that bowel cancer is the second most common cancer in Australia, and has high mortality without treatment.

71. Having reviewed Megs' health records, Dr Wilson was critical of the lack of response he had received to his requests for help. She observed that *'failures in administrative processes and the notification system'* appeared to prevented proper follow up. In her opinion Megs would have been referred for colonoscopy, had he seen a GP in the community with complaints of abdominal symptoms and with a family history of bowel polyps. She commented that:

' … further investigations would likely include blood tests and potentially a CT scan or other imaging investigations'.

72. At the inquest Dr Wilson said that it was likely Megs had been very unwell since at least October 2015. By the time of his diagnosis more than two years later he was frail and emaciated, and she expressed surprise that he had sought medical help so infrequently, and had *'put up with that for so long'*.

73. As I have noted, when Dr O'Neill commenced treating Megs in January 2018 she too expressed concern at the lack of response he had received to his requests for help. In her opinion, the symptoms he had been reporting for more than twelve months were a red flag for '*significant underlying disease'.* These included:

' … *15kgs of unintentional weight loss associated with abdominal pain, erratic bowel habit and tenesmus (a sensation of incomplete emptying of your bowel after passing stool)'*.

74. In their reports, oncologists Dr Shirley Wong and Dr Stephen Clarke agreed. Dr Clarke stated:

'I found the lack of care provided to Mr Schrader in the prison medical system to be distressing. He repeatedly asked for help for significant symptoms and was unable to get access to a Medical Practitioner. While this was occurring he lost 20% of his bodyweight'.

75. Few would disagree with Dr Clarke's conclusion that:

'.. a sick incarcerated person should be able to easily receive medical review'.

76. The evidence leaves no room for doubt that the prison health care which Megs received during the period October 2015 to October 2017 was seriously deficient. This fact was fully acknowledged by the JH Network, as will be further described below.

Would an earlier referral have led to earlier diagnosis and treatment?

77. This was a question of great importance to Megs' family. Might the outcome have been different for Megs, if he had received a prompt response to his requests for help?

78. According to Dr Clarke Megs' initial symptoms were non specific, which is one of the reasons why a diagnosis of NET is commonly delayed. Nevertheless both he and fellow oncologist Dr Wong were clear that had the JH Network responded appropriately to Megs' symptoms, his condition would have been capable of diagnosis and treatment at an earlier stage.

79. Commenting that Megs first complained of abdominal pain and diarrhoea in December 2015, Dr Wong stated:

'Assuming a colonoscopy was performed at that time, the non-cancerous colon polyp was found, further testing would likely have continued to investigate the abdominal pain and diarrhea. The CT scan would be the next investigation and so the liver metastases would be found at that time'.

80. Dr Clarke agreed. Megs' persisting symptoms and especially his loss of body weight and nocturnal diarrhoea:

' … *should have prompted referral to a gastroenterologist for review and endoscopic evaluation'*.

81. He concurred with the opinion of Dr Wong that Megs could reasonably have been diagnosed in December 2015:

'*Investigations undertaken on all occasions of complaint from October 2015 would have permitted an earlier diagnosis of his metastatic neuroendocrine tumour.'*

82. I accept the opinions of Dr Wong and Dr Clarke in this regard. Both are highly qualified oncologists with extensive experience treating cancer patients. No evidence was adduced in contradiction of their opinion.

83. The evidence establishes that due to a multitude of errors and oversights on the part of the JH Network, Megs lost the opportunity for an earlier diagnosis and treatment of the illness which took his life.

84. These criticisms were accepted by the JH Network. It was properly conceded on behalf of the JH Network that unacceptable delays had prevented an earlier diagnosis and treatment of Megs' illness.

Would earlier diagnosis and treatment have made a difference?

85. In Dr Wong's opinion, Meg's disease was almost certainly metastatic by the time he noticed symptoms of abdominal pain and diarrhoea, which Dr Wong described as indicative of '*disseminated disease'*.

86. It was for this reason that she expressed the view, with which Dr Clarke and Dr O'Neill did not agree, that Megs' life expectancy at the time he was actually diagnosed was not very different to what it would have been, had his disease been diagnosed in a timely manner.

87. Dr Clarke concurred with Dr Wong's opinion that Megs' disease *' ..was metastatic at all possible times of potential diagnosis'.*

88. In his words, by the time Megs was diagnosed he was '*a very frail and wasted man who had very advanced malignancy .. who wasn't well enough for other more intensive investigations or therapies …'.*

89. However Dr Clarke disagreed with Dr Wong that earlier diagnosis would not have altered Megs' period of survival. In his view, had Megs had the chance to commence treatment at an earlier stage:

' .. *he would not have had cancer cachexia syndrome and would have been in a better condition to tolerate multi-modality treatment … '*

90. As Dr Clarke went on to explain:

'Overall, I think it is likely that earlier use of therapies when Mr Schrader was less cachectic and better able to tolerate the treatment of all kinds would have enabled more protracted disease control and longer survival and maintained quality of life with delayed development of the cancer cachexia syndrome. This might have added substantially to the quality and duration of his survival'.

91. In his supplementary report dated 26 May 2023 Dr Clarke maintained the view that earlier treatment:

' … may have permitted more intense investigation and therapies that may have resulted in better quality and quantity of life'.

92. Megs' treating oncologist Dr O'Neill agreed it was likely that the delay in diagnosis and treatment had adversely affected his survival period. By the time of his diagnosis Megs had:

' … extensive symptomatic hepatic tumour burden …. indicating his prognosis was likely poorer than patients with limited burden of disease'.

93. There is therefore a difference of opinion amongst the expert oncologists (among whom I include Dr O'Neill) as to whether earlier diagnosis and treatment would have prolonged Megs' period of survival. I accept there is inevitably an element of speculation in this analysis. It is fair to say however that there is evidence that earlier treatment '*may'* have lengthened Megs' life.

94. But Dr Wong was in no doubt that the delayed diagnosis had caused Megs a greater level of suffering from his symptoms, and impaired his quality of life. This too was the opinion of Dr Clarke. The impact for Megs was described by

his daughter Christine, who visited him a few weeks before his death and found him *'exhausted'* and in great discomfort. '*This was the one and only time I ever saw my father cry'*, she wrote.

95. The evidence leaves no room for doubt that over the period October 2015 to October 2017 Megs tried repeatedly to get medical care for his painful and debilitating symptoms. The response from the JH Network was seriously inadequate. Human errors on the part of JH Network staff were compounded by administrative failures, leaving Megs with a very serious illness which remained undiagnosed and untreated for almost two years.

96. The evidence compels the finding that had the JH Network responded appropriately, Megs' illness would have been diagnosed and treated at an earlier stage. While an earlier response would not have resulted in a cure for Megs, it may have prolonged his survival period and would most certainly have improved the quality of his life by reducing his physical suffering.

97. I have no difficulty endorsing Dr Clarke's conclusion that:

' … the protracted delay in providing medical attention to Mr Schrader in the prison system was deleterious to his situation and avoidable'.

98. These failings were fully acknowledged by the JH Network, as I will now describe.

The response of the JH Network

99. In closing submissions, Mr Bradley on behalf of the JH Network told the court that his client acknowledged the failures which had unreasonably delayed Megs' diagnosis and treatment. The JH Network accepted that Megs was denied the opportunity of an earlier diagnosis, which may have given him an increased period of survival. It was fully acknowledged that at the least, an earlier diagnosis would have given him a better quality of life.

100. On behalf of the JH Network, Mr Bradley also acknowledged that the failure to diagnose Megs' condition at an earlier stage, and the pain he had endured, must have added greatly to his family's grief at his passing.

101. It is appropriate that the JH Network made this acknowledgement to Megs' family and to the court. I also endorse their acknowledgement of the distress that Pamela and her children must have felt, knowing that Megs had been unable to get the medical treatment he needed to relieve his painful and debilitating symptoms.

102. The statements provided by individual managers within the JH Network also acknowledged that errors and omissions had afflicted the response to Megs' requests for medical help. Mr Gary Forrest, Chief Executive of the JH Network, wrote to Pamela Pearce on 28 December 2017, apologising to her on behalf of the JH Network. With some understatement he acknowledged that:

‘ .. on review, there have been delays in having Mr Schrader reviewed and screened/tested for bowel cancer without any apparent reason.’

103. In similar vein Ms Natalie Lyall, Regional Nurse Manager for South East Region at JH Network, also acknowledged:

‘ …there were multiple issues regarding the waitlisting and triaging of his requests which resulted in Mr Schrader’s diagnosis of bowel cancer being delayed’.

104. Ms Lyall noted that Megs had made:

‘ … *numerous requests to clinic nursing staff via direct requests and patient self-referral forms seeking medical attention for his gastrointestinal symptoms. He also requested a colonoscopy because of his family’s history of bowel cancer’.*

105. She acknowledged that given his symptoms and family history, Megs ought to have been reviewed following his self-referral on 29 October 2015, and that his care ought then to have been escalated to the GP and cancer care nurse.

Changes to the Patient Self Referral system.

106. At the inquest Mr Connolly frankly acknowledged that the JH Network’s Patient Self Referral system had failed Megs, and had been ‘*not fit for purpose’*. He told the court of work that was currently underway to improve patients’ access to health care.

107. In 2018 there was a formal review of the Patient Self Referral system. Mr Connolly said that arising from this review:

‘ …the recommended option was for a Patient Self-Referral Call Centre staffed by four registered nurses. This option endorsed the use of the Offender Telephone System [OTS) to enable patients to self-refer health problems or concerns in real time as opposed to the current paper-based system.’

108. Unfortunately however:

‘Funding constraints prevented this recommendation being operationalised at the time’.

109. In better news, the project was revived in 2022 and renamed the Patient Health Enquiry and Self-Referral Project [PHES].

110. A PHES pilot scheme commenced in February 2023, whereby a dedicated call centre has been established to receive phone referrals from patients within six NSW correctional centres. The phone service is staffed by four nurses who are employed by the JH Network, and who triage calls and forward them to health care staff at the caller’s correctional centre. The triage nurses are able to access patients’ electronic medical records as they are speaking with them.

111. Mr Connolly advised that between the period February 2023 to June 2023, the new service received approximately 2,000 calls. He advised further that the JH Network intends to maintain the pilot scheme, and wishes to expand this model to cover all NSW correctional centres. This however cannot happen without an enlarged workforce and further funding.

112. Since Megs died the JH Network has also introduced an improved PSF paper form. There is also a proposal to enable patients to seek medical help digitally by using iPads.

113. Mr Connolly advised that in addition, agency nurses are now trained to operate the PAS system.

114. There reman two matters which were of concern to Megs' family. These were the vehicles which were used to transport Megs to his many hospital appointments, and the refusal to grant him an early release on compassionate grounds.

Transport and early release

115. Up until June 2019, Megs was transported to and from his hospital appointments in prison transport vehicles which caused him much pain and discomfort. On his behalf, the JH Network made requests in June 2018 and again in January 2019 for him to be transported in special transport rather than in the standard prison vehicle.

116. The evidence suggested that an alert was raised by staff of Corrective Services NSW that Megs needed to be transported in a more suitable vehicle. However it was unclear when this change was made for Megs.

117. At the inquest the court heard evidence that in June 2019 a special Medical Escort Unit was established, which is responsible for the transportation of inmates in the Sydney metropolitan and Cessnock areas to their medical and hospital appointments. This unit has available to it a range of vehicles which can better cater to the needs of infirm and frail inmates. I hope that this reform has the effect of reducing the pain and discomfort of such patients in the course of their medical treatment.

118. A further matter which saddened Megs' family was the failure of Pamela's attempts to secure early release for him on compassionate grounds. Pamela made a number of such requests to the State Parole Authority in 2018 and 2019, but each application was declined on the basis that the JH Network was able to provide him with the necessary medical treatment. Pamela's final application was made on 10 July 2019, but it was adjourned to 16 August 2019 for further medical reports. Megs did not survive until then.

119. It was beyond the scope of this inquest to examine the policies which guide members of the State Parole Authority, when considering applications for early release on compassionate grounds. There can be no doubt however that it was

saddening for Megs' family to know that he died alone in prison without their care and support.

Conclusion

120. Access to adequate medical care for imprisoned people is an undeniable obligation of a civilised society. This inquest into the circumstances of Megs' death exposed failures which denied Megs that right for an unacceptable length of time.

121. The court heard evidence of changes to the JH Network's system which are designed to improve patients' ability to ask for and to receive medical help. This is encouraging. However it was clear from Mr Connolly's evidence that these improvements cannot be implemented across NSW without further funding.

122. I endorse the closing submission of Counsel Assisting, that the facts in Megs' case illustrate the tragic consequences of systems failure. For this reason I intend to ensure that a copy of these findings is provided to the NSW Ministry of Health, and to invite the Minister to give the findings serious consideration in any application for funding for the PHES Project.

123. On behalf of everyone at the Coroners Court I offer sincere sympathy to Pamela and her family for the loss of Megs.

124. I also thank the Assisting team and the representatives for the interested parties, for their assistance in the conduct of this inquest.

Findings pursuant to section 81(1) of the Coroner's Act 2009

Identity
The person who died is Melville Schrader.

Date of death:
Melville Schrader died on 13 August 2019.

Place of death:
Melville Schrader died at Long Bay Correctional Centre Hospital, Malabar, Sydney NSW.

Cause of death:
Melville Schrader died from small bowel obstruction in the setting of terminal metastatic neuro-endocrine tumour.

Manner of death:
Melville Schrader died as a result of natural causes, while he was in lawful custody.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

Date 4 October 2023