STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Keith Howlett
Hearing dates:	29 August 2016-1 September 2016, 20 December 2016
Date of findings:	31 March 2017
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	Coronial Law, -Death in custody, Cancer treatment in a custodial setting, Palliative care in a custodial setting,
File number:	2013/162787
Representation:	Mr Stephen Kelly – Coronial Advocate assisting Mr De Mars, solicitor Legal Aid Commission of NSW for Liza Turner (Next of kin) Ms T Berberian of counsel, instructed by K. Cook for Dr Baguley and the GEO Group Ms L Boyd, solicitor, Crown Solicitor's Office for Justice Health and Forensic Mental Health Network Ms Benish Haider, solicitor, Office of General Counsel for the Commissioner of Corrective Services

Findings:	On the balance of probabilities, I find that Keith Howlett died on 24 May 2013. He died at Junee Correctional Centre. The medical cause of his death was complications of non-small cell carcinoma of the lung. Keith Howlett's death was the result of natural disease.
Non Publication Orders	Pursuant to S. 74 (i)(b) 1. No publication of 6 DVD Discs (Volume 3, Tab 2) 2. No publication of any persons contact details (specifically contained in the Corrective Services Records - Volume 3). Pursuant to S. 65(4) Sections 13.1, 13.2, and 13.8 of the Corrective Services NSW Operating Procedure Manual must not be supplied except by express direction of the Coroner as it may contain information the disclosure of which could interfere with the safe management of a correctional centre.
Recommendations	**To The NSW Minister for Corrections** **The NSW Minister for Health** **The Chief Executive Officer of GEO Group** I recommend that 1. Consideration be given to developing and implementing a palliative care training package for all nursing and medical staff within Justice Health, and including all other providers of medical services contracted to

	Corrective Services. In particular training should address the early recognition of palliative care intervention for all inmates diagnosed with serious and life threatening illnesses and/or illnesses that may require opiate/analgesic relief. 2. Immediate consideration be given to creating a designated position and central location to resource and support medical staff across NSW in relation to palliative care options for inmates. 3. Immediate consideration be given to mandating that all inmates identified with cancer be given the option of being reviewed by the Cancer Care Nurse (who shall be provided access to the necessary medical information and support systems) within an appropriate and fixed time frame. 4. A brochure is developed for inmates in relation to the palliative care and cancer support services available within the NSW custodial system, (including the part of that system which is privately operated). 5. Annual auditing of GEO Health Services (or any similar contract providers) include a face-to-face interview component with a percentage of randomly selected inmates currently receiving health services. 6. Annual auditing of GEO Health Services (or any similar providers) should include mandatory checking of compliance with tools such as the Chronic Disease Screen.

IN THE STATE CORONER'S COURT
GLEBE
NSW
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

This inquest concerns the death of Keith Howlett

Introduction

1. Keith Howlett was 49 years of age at the time of his death. He was serving a term of imprisonment at Junee Correctional Centre. That gaol is privately operated by the GEO Group, through a contractual agreement with the Commissioner of Corrective Services. Junee is a medium/minimum security prison located about 40 kilometres from Wagga Wagga in Southern NSW.

2. Mr Howlett had entered custody on 18 April 2013, having been sentenced by the NSW District Court, sitting at Wagga Wagga. His earliest release date was 17 April 2015. He had indicated that he wished to appeal his sentence and was apparently awaiting a Supreme Court Bail application at the time of his death.

3. Mr Howlett was married to Lisa Marie Howlett (Liza Turner). He kept in close contact with her during his incarceration. Mr Howlett had numerous health issues, which had been taken into account at the time of his sentence. He had been recently treated for lung cancer in the community and was HIV positive.

4. On the morning of 24 May 2013 Mr Howlett began coughing up blood and sought help from other inmates. He collapsed and appeared unresponsive. Officers immediately called for medical back-up. Around 9.37 medical staff arrived, but resuscitation was not commenced and Mr Howlett was pronounced dead at the scene.

5. An autopsy was conducted which identified Mr Howlett's cause of death as complications of non-small cell carcinoma of the lung. The examination revealed a destructive lesion in

the upper lobe of the right lung, which appeared to have eroded into the trachea and right bronchus. The haemoptysis Mr Howlett suffered was massive and unexpected. While Mr Howlett had recorded in his diary that he had coughed up "a piece of lung cancer" on 17 May 2013, there is no record which indicates this event had been specifically reported to Dr Baguley or medical staff at the Junee clinic.

The role of the coroner

6. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[2]

7. In this case there is no dispute in relation to the identity of Mr Howlett, or to the date and place of his death. For this reason the inquest focussed on the manner and medical cause of Mr Howlett's death. It was also necessary to consider whether or not his death was in any way avoidable and if so what mechanisms, if any, could be put in place to help prevent such a situation recurring. Issues relating to the manner of his death, touching upon his level of comfort and the adequacy of his care in the lead up to his death were also considered.

8. Where a person dies in custody, it is mandatory that an inquest is held.[3] The inquest must be conducted by a senior coroner.[4] When a person is detained in custody the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice, it is especially important that the care they receive is of an appropriate standard. Even where the death appears to have been naturally caused, it is essential that any medical treatment provided is reviewed independently and that its quality is carefully assessed.

9. The legal representative for the family noted that it has been said "you can judge a society by how well it treats its prisoners". There is undoubtedly great truth in that statement.

[1] Section 81 *Coroners Act* 2009(NSW)
[2] Section 82 *Coroners Act* 2009(NSW)
[3] Section 27 *Coroners Act* 2009(NSW)
[4] Section 23 *Coroners Act* 2009(NSW)

While there are recognised challenges in delivering quality health care services across the range of custodial institutions that exist throughout regional NSW we must nevertheless strive to maintain high standards for those incarcerated and thus unable to choose their own care. Notwithstanding the recognised difficulties, in compliance with NSW Health and Justice Health policy and procedure, the GEO Group are required to provide a standard of care comparable to that provided in the public health system, with special regard to the unique health needs of patients who are inmates.[5] In other words, at the time of his death Mr Howlett's level of care should have resembled the care any citizen would expect within the public system in the community.

10. Section 81 (1) of the *Coroner's Act* (2009) NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Keith Howlett.

Scope of the inquest

11. A list of issues relevant to Mr Howlett's death was circulated prior to the inquest commencing. The following questions were posed:

- Did Mr Howlett have a terminal illness at the time of his incarceration?
- Did Mr Howlett receive appropriate medical treatment at Junee Correctional Centre?
- Was Mr Howlett exhibiting symptoms at Junee Correctional Centre consistent with the progression of his lung cancer?
- Should Mr Howlett have been referred for a palliative care assessment prior to his death whilst at Junee Correctional Centre?
- Did medical staff at Junee appropriately consult Mr Howlett's specialists in the treatment of his complex medical conditions?
- Should Mr Howlett have been transferred to a hospital facility to appropriately manage his serious medical conditions prior to his death?
- Did staff at Junee appropriately manage his level of anxiety and depression associated with his medical illness?

[5] Exhibit 1, Volume 4, Tab 12 Letter of Dr Roy Donnelly, Director of Medical Programs

- What type of palliative care services are provided to persons in custody with life limiting illnesses?

12. The inquest proceeded over four sitting days. A large number of statements were tendered, as were expert reports, medical records and policy documents. Oral evidence was also received, including from Mr Howlett's wife, and from medical and nursing practitioners involved in Mr Howlett's care both in the community and in custody.

13. Comprehensive submissions were received from all parties and oral submissions were taken. I was greatly assisted by the detailed summaries of the evidence provided to me and do not intend to restate those chronologies in detail. I have considered all the material and the questions initially posed very carefully but a hearing can tend to crystallize the issues and I intend to distil my reasons fairly briefly under a small number of very broad headings.

Background

14. When Mr Howlett entered custody on 18 April 2013 he had a complex medical history. He had been diagnosed with lung cancer in May 2012 and was still being monitored after initial treatment. Mr Howlett also had a number of chronic and long standing conditions which had previously been documented by Justice Health for his sentencing proceedings.[6] These conditions included HIV, peripheral vascular disease, chronic nausea, depression, anxiety, insomnia, gastro-oesophageal disease, hypercholesteromia.

15. The inquest received detailed evidence in relation to Mr Howlett's lung cancer status and diagnosis.[7] I do not intend to restate each of the expert opinions. In my view it is established that Mr Howlett had a potentially life threatening disease which had been treated initially in the community with curative intent. There were indications that radiotherapy had produced some positive effect and the tumour which had been identified had shrunk in size to some degree. Whether or not Mr Howlett had active disease on 18 April 2013, cannot be definitively established at this point. However, in my view it is most likely. It is clear that Mr Howlett had a disease which had the capacity to recur and may have already been progressing from the time just prior or just after his

[6] Letter of Dr Jacques Ette, Staff specialist, Justice Health. Exhibit 1, Volume 2, page 43
[7] For a summary of his previous treatment see the report of Dr Sullivan Vol 4, Tab 7

entry into custody. Mr Howlett certainly had some physical symptoms which were at least consistent with the possibility of ongoing or recurrent disease.[8] I accept Professor Chye's view that there were concerning symptoms which needed further investigation.[9]

16. Various opinions were given as to Mr Howlett's projected life expectancy and real chance of survival. It is important to note that such predictions are inherently unreliable, particularly for individuals like Mr Howlett who have other complex health risks. Dr Yap estimated a patient in Mr Howlett's condition in the community would, at the time he entered custody, have had a 1 in 6 chance of survival after 5 years.[10] Dr Sullivan who had treated Mr Howlett in the community, was of the view that on the information available to her that "given there had been some response to treatment, and more importantly no progression, his prognosis would have been measured in years with a median survival of approximately 1.5-2 years."[11]

17. Whatever the case, Mr Howlett believed that his disease was incurable. This certainly appears to have been the way it was presented to the court at his sentencing proceedings on 18 April 2013. Her Honour Judge English remarked that it is "not an easy task to send a dying man to gaol"[12] It was also Dr Baguley's evidence that at the first consultation Mr Howlett specifically stated that "his cancer was not cured and that he would die from it". Further Dr Baguley said that Mr Howlett had clearly told him "that there was no further treatment options."[13] In contrast, Mr Howlett's wife had an understanding that prior to him going into custody Keith had been told "there may be another bout of radiation and chemo; however, that wasn't actually documented. It was just, it, it was, a day by day, see how he's going sort of basis".[14]

Mr Howlett's entry into custody and his relationship with Dr Baguley

18. On his entry into custody, Mr Howlett was seen by Nurse Blight who completed the "Reception Screening Tool".[15] It was immediately clear that Mr Howlett was "seriously ill"

[8] There was considerable discussion of this issue. While some of the symptoms were relatively "non-specific", symptoms such as increasing body pain, weakness and increasing nausea were described. Later there was also the possibility that a small volume haemoptysis had occurred, which was described as "coughing up" a 1 cm piece of lung cancer.
[9] See for example discussion of this issue in Dr Chye's report, Vo1 1, Tab 7, page 3 5.3.2
[10] Report of Dr Yap, Exhibit 1, Volume 1, Tab 9, page 11
[11] Report of Dr Sullivan, Volume 4, Tab 7, page 2
[12] Transcript of Remarks on Sentence. Her Honour Judge English, District Court of NSW 18 April 2013,page 13. Exhibit 1, Volume 4, Tab 11, page 13
[13] Evidence of Dr Baguley, Transcript 29 August 2016, page 22, line 35 onwards.
[14] Evidence of Lisa Marie Howlett, Transcript 1 September 2016, page 51, line 35 onwards
[15] Exhibit 1, Vol 4

and a review with the doctor was organised for the following day. Mr Howlett spent that night in the medical unit.

19. Mr Howlett saw Dr Baguley for the first time 19 April 2016. A very brief record exists of this consultation .[16] Dr Baguley notes the lung cancer and that Mr Howlett's treatment was "not curative". He notes the HIV and severe PVD and writes "to be weaned off opiates as appropriate". He ordered a chest X-ray. I am struck by the brevity of the note and the lack of detail recorded. When questioned about the need to obtain further information about Mr Howlett's treatment options and prognosis from his medical practitioners in the community rather than just accepting Mr Howlett's assessment, Dr Baguley reported that the nurses would have sent out a number of letters, "that's done automatically on admission to the gaol".[17] Dr Baguley suggested that there was no real point in directly contacting the practitioners now that Mr Howlett was in custody, it seemed that it was his practise to start again and if necessary use local specialists.

20. Mr Howlett was kept on the medical ward for the first few days of his incarceration. However, there was confusion about the reason for this. While Dr Baguley suggested at some point that it may have been a "suicide watch", there is no firm documentary evidence that supports this contention. In evidence Dr Baguley suggested that it was due to Mr Howlett's vomiting and "to get a handle on how sick he was" as well as his "risk of self-harm". RN Workman's evidence was that he was kept to monitor his physical health. Unfortunately very little appears to have been done in this respect. Formal observations were not recorded or only in a partial or sketchy manner. The reason for his release back to the unit is not recorded.

21. Mr Howlett saw Dr Baguley again on 26 April 2013 and 10 May 2013. At the inquest Dr Baguley had no clear recollection of whether he had seen any material from any of the treating specialists during these later consultations. The appointment on 10 May 2013 was organised in response to Mr Howlett informing the nursing staff that he had been vomiting. Dr Baguley recorded "vomiting ++ on and off still" and changed his medication. At the inquest Dr Baguley expressed the view that this vomiting was likely to have been

[16] Medical Notes, Exhibit 1, Volume 2, Tab 1, page 13
[17] Evidence of Dr Baguley, 29 August 2016, page 22, line 40 onwards.

caused by anxiety. He stated that Mr Howlett "did not look ill"[18] and suggested that Mr Howlett's diary entries in relation to this matter may have been exaggerated.

22. While Dr Baguley saw Mr Howlett on three occasions, it is in my view quite clear that a meaningful therapeutic relationship did not develop between doctor and patient. There appears to have been no reassurance given that contact would or had been made with relevant specialists. As far as any plan was made by Dr Baguley for Mr Howlett's future it consisted of him seeing Mr Howlett on a monthly basis and responding to health problems that he was specifically alerted to. It is difficult to understand why further investigations were not put in train. The review of the chest X-ray obtained was cursory at best and involved no comparison to past scans or reports. While Mr Howlett's HIV needs were seen to by an outside specialist, there was in my view no systematic or appropriate review of his lung cancer.

23. Mr Howlett was certainly concerned about the lack of care he was receiving. When he saw Dr Bourne on 17 May 2013, by video link in relation to his HIV[19], he took the opportunity to state that he was not happy with the health services he had been provided with. He expressed concern that he was "missing the next round of therapy" for his lung cancer. This seems completely at odds with Dr Baguley's contention that he had been told "nothing could be done".

24. I am of the view that the transfer of care for Mr Howlett from the community to the custodial setting was well below best practice. He was known to have complex medical conditions and had established therapeutic relationships with medical providers in the community. Sending off form letter requests to providers was not enough. Dr Baguley's approach seemed to be to "take things as they came". According to the process that should have been followed, a Comprehensive Health Assessment Plan (CHAP) should have been created. Dr Baguley believed this was the nurse's responsibility and appeared quite unconcerned about it. It did not appear to have been a useful document to him. For a patient known to have anxiety, this lack of a coordinated approach must have been very stressful.

[18] Evidence of Dr Baguley, 29 August 2016, page 35, line 34 onwards.
[19] It is noted that Mr Howlett's access to HIV medication was interrupted for a short period on his entry to custody, without apparent ill effect.

25. As the evidence emerged, it was clear that there was room for improvement in the transfer of care for inmate patients such as Mr Howlett, with a cancer diagnosis. There appeared to be some recognition of this issue within Justice Health. Dr Donnelly, the Director of Medical Programs within Justice Health and the Forensic Mental Health Network, gave evidence in relation to the establishment of a new position in July 2016 within Justice Health, the Cancer Care Coordinator. With the increase in the prison population, there is of course a corresponding increase in the number of patients with cancer. Dr Donnelly explained the new role as,

> "a person with clinical expertise in management of cancer patients and their main role is to be aware of all patients who have a diagnosis of cancer in custody, to assist in coordination of their care, such as…chasing up previous medical reports and make sure that that information is available to the relevant clinicians, and to assist in coordinating getting acute care to that patient if they require, for example further surgery, chemotherapy or radiotherapy. They also will have a role in transition to palliative care for appropriate patients with cancer"[20]

26. Dr Donnelly spoke of this position as an improvement to make sure "no-one slips through the cracks". My understanding of the position is that it would involve co-ordination for inmates in a GEO run prison in the same way as in a prison where Justice Health administered the health service. In my view this position is a positive step which may improve care for patients such as Mr Howlett.

Planning for future patient care

27. The Inquest heard that the medical management of patients in NSW gaols is "nurse led".[21] Doctors are not on site 24 hours in all correctional centres. The system is designed so that nurses provide ongoing care and refer to medical staff when required, firstly to a general practitioner or to specialist nursing staff such as a mental health nurse or drug

[20] Evidence at Inquest, Dr Donnelly 1/9/16 Page 19, line 20 onwards
[21] Dr Donnelly Evidence at Inquest 1/9/16, Page 4, line 38 onwards

and alcohol nurse. Referral can apparently also be made to a specialist if circumstances require.

28. At the time of Mr Howlett's incarceration, nurses had responsibility for gathering information and completing the Comprehensive Health Assessment Plans within 30 days. No CHAP was completed in relation to Mr Howlett by the time of his death.[22] Counsel for GEO pointed out that it was by then only days late of the target time-frame. This is correct, but what seems of greater interest is the lack of concern this caused. It may be that practitioners felt the document was of little value. Dr Baguley showed little familiarity with it and RN Phillips seemed unsurprised that it was late. It appeared to be the type of task which fell to the bottom of a priority list. One can only wonder at its value for treatment in these circumstances. Certainly Mr Howlett would have benefitted from knowing that there was a plan in place, but it does not appear to have been remotely important to Dr Baguley.

29. In any event the document has now been replaced with the Chronic Disease Screen. It is important that tools such as this, if required, are undertaken in accordance with the guidelines in place. Failures to meet formal deadline requirements of this nature should not be easily dismissed. It is important that there are meaningful ways to measure compliance in a complex health system reliant on well-known policies and standards. More comprehensive auditing may be necessary to see if targets are being systematically met. If they are not, it may be that further compliance checks are needed. On the other hand if the non-compliance occurs because the tools do not gather useful information, then revision is certainly called for. The evidence of Dr Donnelly demonstrated that the number of files actually audited each year is very few.[23]

Mental Health

30. Mr Howlett saw nurses on a number of occasions. On 6 May he undertook a mental health assessment with RN Workman.[24] She noted that he had a history of Chronic PTSD and anxiety. He described chronic pain, nausea and vomiting. He had reduced appetite, fatigue and insomnia. He told RN Workman that he was "entitled to better care".

[22] It is noted that the Justice Health had assured Mr Howlett's sentencing court that this comprehensive risk assessment would be undertaken upon his entry into custody.
[23] For example when one reviews the documentation of the 2015 audit, only 3 out of some 700-800 files appears to have been reviewed.
[24] Mental Health Assessment, Exhibit 1, Volume 2, pages 20-27

Shockingly, it appears she did not know more than that he had a "serious medical condition". She gave evidence that at some stage after this assessment she discussed Mr Howlett's mental health with a visiting psychiatrist Dr Matthew Jones and it was decided that they would continue to "monitor" Mr Howlett.[25] Unfortunately, even with his known issues, Mr Howlett was never seen by a psychiatrist.

31. Mr Howlett also saw a psychologist employed by Corrective Services on one occasion. It was recorded that he was "coping as well as possible in the circumstances". Dr Donnelly described an historical arrangement whereby Justice Health employed only psychiatrists and mental health nurses and the Department of Corrective Services employed psychologists. He was unable to comment on the scope of psychology services the Department offered. It is well beyond the scope of this inquest, but this arbitrary division between mental health professionals seems unhelpful.

32. It is apparent and unfortunate that no positive rapport was developed between Mr Howlett and any mental health practitioner. While an assessment took place, little else was achieved. It is unfortunate that a man with known mental health fragilities was not seen by a psychiatrist within the five weeks he was at Junee.

What was Mr Howlett's quality of life in the period leading up to his death?

33. In my view there is overwhelming evidence that Mr Howlett was suffering greatly in the lead up to his death. He had discussed his vomiting with nursing staff and with Dr Baguley. He had told Dr Bourne about it. There is ample evidence that his vomiting and diarrhoea was also well known to custodial officers. He was seen vomiting as he returned to the unit after morning medication.[26] Other inmates had complained about his constant diarrhoea and the smell of faeces in the cell.[27] He had trouble attending for his medication. He spoke to his wife and mother-in –law about it and recorded the extent of it in his diary.

34. GEO submitted that Dr Baguley treated Mr Howlett's nausea in an appropriate manner and drew the Court's attention to Dr Baguley's evidence that Mr Howlett's appearance was not consistent with vomiting at the level he described in his diary. Nevertheless I am

[25] See Statement of Janice Workman, Volume 4, Tab 13, Paragraph 18
[26] Case note
[27] DCS memo

persuaded by the weight of the evidence that there was a significant problem with nausea and diarrhoea and that it required further attention. In addition, Mr Howlett described being in pain. The breakthrough pain medication he had been prescribed in the community was not made available to him in custody. There appears to have been no clear reason for this decision, except that Dr Baguley thought he was already "getting enough".

35. There is evidence that Mr Howlett was very thin and not coping with the prison diet. He was fatigued and found moving around the gaol difficult. All of these issues should have been explored by a practioner skilled in recognising palliative care needs. The issues needed to be explored by a practitioner capable and open to developing rapport with a seriously ill patient.

36. Dr Baguley's approach appears to have been that when Mr Howlett "began to deteriorate" he would be sent to Sydney. Dr Donnelly explained that in Sydney, inmates could be treated at the Long Bay Prison Hospital or treated at the secure ward at Prince of Wales. What Dr Baguley did not seem to entertain was that palliative care strategies could have been commenced and planned for while Mr Howlett was still at Junee.

The need for palliative care

37. Palliative care is a multi-faceted approach that aims to improve the quality of life of patients facing the various problems that can be associated with life limiting or life threatening illness. It can involve a focus on pain relief and symptom management, as well as psychological care and support.[28]

38. The palliative care needs of prisoners are currently managed in a variety of ways within the NSW Correctional system.[29] Patients may be admitted to Long Bay Prison Hospital[30] and managed in the Medical Sub-Acute Unit, or more rarely in the Aged Care Rehabilitation Unit. Those with higher clinical needs are transferred for care to Prince of Wales Hospital. However, this is apparently rare. Palliative care provided at Long Bay is by arrangement with the Sacred Heart Hospice and involves assessment if necessary by visiting staff from that institution.

[28] See Exhibit 10, The NSW Government plan to increase access to Palliative Care 2012-2016, page 6
[29] For discussion of this issue see Dr Donnelly's correspondance to the Court. Exhibit 1, Volume 4, Tab 12.
[30] Dr Donnelly estimated about 25 palliative care patients have been admitted to

39. Importantly Dr Donnelly stressed that palliative care patients may also be managed in other correctional facilities by local clinical staff. In cross-examination he identified the importance of treating patients close to their families and avoiding acute admissions where possible. He explained that the thrust of the Ministry's policy direction in this area is to educate all primary health providers. He stated

> "For us to pick up on that would be to continue educating our GPs and nurses in appropriate recognition and pain management in the peripheral facilities and only escalate acute palliative care for particular patients…I think the resources are better spent continuing with the education of GPs rather than trying to set up a network of palliative care consultation across the state."[31]

40. Dr Donnelly gave evidence of a session on palliative care at the 2014 Annual General Practitioners conference, which had been attended by Dr Baguley and others who work in the country and rural areas. There was also evidence that Professor Chye had given training on palliative care to nurses around August 2016.[32] There was no evidence of a co-ordinated or comprehensive training package which had been regularly or systematically rolled out.

41. Mr Howlett was clearly a candidate for a comprehensive palliative care assessment.

Was Mr Howlett's death predictable or expected ?

42. Mr Howlett was only in custody for about 5 weeks. His quality of life appeared to be deteriorating and he was initially reluctant to be transferred to Sydney, away from his wife. Whether there was ultimately anything that could have been done to prevent the fatal haemotysis, had staff been aware of an incident of prior haemotysis, is now pure

[31] Evidence at Inquest, Dr Donnelly 1/9/16, page 17, line 25 onwards.
[32] Evidence at Inquest, Dr Donnelly 1/9/16, page 19, line 5 onwards.

conjecture. I accept his cancer took a rapid and unexpected turn and that it would have been most unlikely that anyone could have accurately predicted the fatal events which caused his death. However, one can easily imagine that the enormous discomfort of his last days could have been eased somewhat by greater attention to his palliative care needs.

43. On the morning of his death Mr Howlett filled out a request to see a doctor. He wrote "Haven't been able to keep any food or liquid down for 28 days. I'm getting weaker by the day".[33] After his death, the autopsy showed the progress of his disease and indicated the way it was likely to have been affecting his day to day functions.

Conclusion

44. Mr Howlett's last weeks were full of despair and dissatisfaction in relation to his medical care. His palliative care needs had not been adequately assessed and no clear plan had been identified in relation to possible further treatment, palliative or otherwise. The lack of an appropriate therapeutic relationship with either nurse or doctor at Junee was particularly unfortunate.

45. The evidence does not support a clear finding that his death was caused or hastened by the treatment (or lack of treatment)he received. What is established is that the opportunity to properly assess some of his pressing needs was missed by those responsible for his care. This caused great discomfort and pain for Mr Howlett and his wife in what turned out to be the last days of his life.

Findings made pursuant to section 81 of the *Coroner's Act* 2009 (NSW)

46. On the balance of probabilities, I find that Keith Howlett died at on 24 May 2013.

47. He died at Junee Correctional Centre.

48. The medical cause of his death was complications of non-small cell carcinoma of the lung.

[33] Vol 1, Tab 1, paragraph 23

49. Keith Howlett's death was the result of natural disease.

Recommendations pursuant to section 82 of the *Coroner's Act* (NSW) 2009

50. Lessons can often be learnt from the close examination of a single death, and while it is prudent to acknowledge the limited scope of the inquiry, it is equally important to identify areas of possible improvement as they emerge.

51. A number of recommendations were circulated at the conclusion of the inquest for comment. It is fair to say they received little support from either Justice Health, the GEO Group or from the Commissioner of Corrective Services.[34] Mrs Howlett was largely supportive of the draft recommendations.

52. I note that Justice Health was of the view that no recommendations in relation to palliative care training were necessary. It was submitted that Justice Health can already access NSW Health's state wide program for development and training which includes relevant educational modules. It was also submitted that there had been a session on palliative care at a 2014 Justice Health Medical Officer conference, which GEO doctors were welcome to attend. Even though issues of training were directly addressed with Dr Donnelly in evidence, Justice Health appeared surprised that training was an area of concern for the Court. Given the importance of palliative care in the context of an aging prison population, it was somewhat disappointing that Justice Health did not embrace recommendations with the real potential to improve the quality of life for a growing group of prisoners.

53. The evidence established that Mr Howlett's last days were unnecessarily uncomfortable. The Court accepts his death was sudden and somewhat unpredictable. However, in the weeks preceding his death Mr Howlett was anxious and dispirited about his future care. There had been no real recognition of the urgent need to screen his palliative care requirements. His nausea and diarrhoea were inadequately controlled. He was fatigued and without breakthrough pain medication. He was without adequate mental health support and had not been provided with any information about when he may be seen by

[34] See written submission received from Justice Health, Commissioner of Corrective Services, GEO Group and on behalf of the family.

a lung cancer specialist for review. Dr Baguley and other medical staff appear to have been of the view that the need for a palliative care review had not yet arisen, notwithstanding the fact that Mr Howlett had already been receiving palliative care in the community. Given the facts of this case it appears quite obvious that further training for medical staff on the early recognition of a prisoner's palliative care needs would be an appropriate intervention. Similarly giving inmate patients more information about what might be available to them within the system makes sense.

54. The Court accepts that it may be that modules in relation to palliative care, already developed by the NSW Health Education and Training Institute, may be useful in developing programs for a custodial context, but particular issues arise for patients who are inmates. These require specific attention.

55. Justice Health could also see no benefit in allowing all prisoners with cancer the option of being reviewed by the Cancer Care nurse, a position recently created by Justice Health. The main difficulty appeared to be that those with lesser conditions such as skin cancer may cause too great a demand. It was an unhelpful response. Given that Justice Health has created a position of "Cancer Care Nurse", I am confident that the organisation would have the ability to manage the definitional issue appropriately. Overall I was surprised by the resistance displayed by Justice Health in this regard.

56. Equally disappointing was the response of the Commissioner of Corrective Services, who wanted any recommendations made limited to the Junee Correctional Centre. Dr Donnelly's evidence was helpful and wide ranging and I am of the view that wider opportunities for improvement emerged. There was nothing in the evidence to suggest that the care offered at Junee was below that offered in other regional settings or that the need for increased awareness of palliative care issues was only relevant to GEO staff. It is important that health care options are uniform for prisoners, whether their care is provided by a private operator or by Justice Health itself. Equally I was not persuaded by the Commissioner's arguments that strengthening the evaluation and audit process of providers such as GEO was unnecessary.

57. Submissions received by the GEO Group did not support any of the recommendations and appeared to express the view that each was largely unnecessary or did not fall within its area of responsibility.

58. Given the interwoven responsibilities for the provision of health services to prisoners, especially in a privately run correctional facility, consideration of implementing the recommendations will require ongoing cooperation between all of the agencies involved. A co-operative approach is required and for that reason, these recommendations will be addressed jointly to those with the capacity to drive change. Where there is a will to implement, the mechanics of service delivery will fall into place. Rather than quibble about exactly who has final responsibility for implementation, a more co-operative approach is called for. The over-arching policy framework must include commitment to equal health service whether an inmate finds him or herself in a custodial setting run by a private operator or a Government entity. Turf wars become irrelevant where there is a genuine motivation to improve current practise. Given that evidence received at this inquest suggested that palliative care for prisoners should and can be improved, it was disappointing that a more open and proactive approach was not adopted .

Recommendations pursuant to section 82 of the Coroner's Act (NSW) 2009

59. Arising from the evidence taken and for reasons set out in these findings I make the following recommendations. Clearly implementation will require co-operation and so I have taken the unusual course of directing each of the recommendations to the following persons for their joint consideration.

To

The NSW Minister for Corrections

The NSW Minister for Health

The Chief Executive Officer of GEO Group

I recommend that

60. Consideration be given to developing and implementing a palliative care training package for all nursing and medical staff within Justice Health, and including all other providers of medical services contracted to Corrective Services. In particular training should address the early recognition of palliative care intervention for all inmates diagnosed with serious and life threatening illnesses and/or illnesses that may require opiate/analgesic relief.

61. Immediate consideration be given to creating a designated position and central location to resource and support medical staff across NSW in relation to palliative care options for all inmates.

62. Immediate consideration be given to mandating that all inmates identified with cancer be given the option of being reviewed by the Cancer Care Nurse (who shall be provided access to the necessary medical information and support systems) within an appropriate and fixed time frame.

63. A brochure is developed for inmates in relation to the palliative care and cancer support services available within the NSW custodial system, (including the part of that system which is privately operated).

64. Annual auditing of GEO Health Services (or any similar contract providers) include a face-to-face interview component with a percentage of randomly selected inmates currently receiving health services.

65. Annual auditing of GEO Health Services (or any similar providers) should include mandatory checking compliance with tools such as the Chronic Disease Screen.

66. Finally, I offer my sincere condolences to Mrs Howlett. I thank her for her active participation in this process.

67. I direct the Registry to send a copy of these findings to the Chief Executive Officer of Justice Health and the Forensic Mental Health Network and to the NSW Commissioner for Corrective Services.

68. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
31 March 2017