QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Jay Maree Harmer**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2016/2668
DELIVERED ON:	10 August 2018
DELIVERED AT:	BRISBANE
HEARING DATE(s):	7 February 2018, 4 April 2018
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, palliative care in a correctional setting, Hepatitis C, prisoner carers, exceptional circumstances parole applications.

REPRESENTATION:

Counsel Assisting:	Ms Holly Ahern
Queensland Corrective Services:	Mr Dominic Robinson, Legal Advice and Advocacy, Department of Justice and Attorney-General

West Moreton HHS:	Mr Matthew Hickey, instructed by Minter Ellison Lawyers
Ms Wendy Panuve:	Ms Janice Crawford, instructed by Kilroy Callaghan Lawyers
Dr Graeme MacDonald:	Ms Jane Fitzgerald, instructed by Avant Law
Metro South HHS:	Ms Fiona Banwell

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Introduction

1. Jay Maree Harmer was 38 years of age when she died at the Brisbane Women's Correctional Centre (BWCC) at Wacol in early July 2016. Ms Harmer had a very complex medical history which included opioid dependence and advanced chronic liver disease due to Hepatitis C infection. Her health had deteriorated significantly in the years leading up to her death.

2. Ms Harmer had six recorded periods in custody. She had been discharged to parole in January 2013 but was returned to prison after a breach in January 2014 and remained in custody until her death. As she died while in custody an inquest into her death was mandatory.

3. Ms Harmer had been admitted to the Princess Alexandra Hospital's Secure Unit from 10 to 15 June 2016 for the investigation of the progressive deterioration in her liver function. Ms Harmer was admitted to the PAH again on 24 June 2016 after a doctor at the BWCC became concerned about Ms Harmer's increasing falls and progressive encephalopathy.

4. Ms Harmer was reviewed by a number of specialists at the PAH who agreed she should remain in hospital to manage her encephalopathy, with a view to transfer to a palliative care facility on parole. However, Ms Harmer wished to return to the BWCC against advice and was discharged on 28 June 2016. Although Ms Harmer had been eligible for parole since early 2015, an application for exceptional circumstances parole was not made until 24 June 2016.

5. On the morning of 2 July 2016, Ms Harmer was found deceased on her bed by her cell mate and carer, Amy Kemp.

The investigation

6. Plain Clothes Constable Jacob Andriolo from the Queensland Police Service Corrective Services Investigation Unit investigated the circumstances leading to Ms Harmer's death.

7. CSIU officers attended the WCC immediately after being notified of Mr Harmer's death. Her correctional records and her medical files from the BWCC and the Princess Alexandra Hospital (PAH) were obtained.

8. The investigation was informed by statements from Ms Harmer's cell mate, relevant custodial correctional officers, registered nurses at the prison, and treating medical officers.

9. The CSIU investigation concluded that Ms Harmer died as a result of natural causes, and that she was provided with adequate medical care. It also found that there were no suspicious circumstances associated with the death. I am satisfied that the CSIU investigation was professionally conducted and that all relevant material was accessed.

10. Dr Natalie MacCormick from the Queensland Health Clinical Forensic Medicine Unit (CFMU) also examined Ms Harmer's medical records and reported on them. Further information was obtained from the Queensland Parole Board in relation to its consideration of Ms Harmer's parole applications.

The inquest

11. An inquest into Ms Harmer's death was held on 4 April 2018. There were 55 exhibits tendered the inquest. At the pre-inquest conference a number of draft issues were identified for exploration at the inquest and those granted leave to appear were provided with the opportunity to make submissions concerning the proposed issues. The issues settled for investigation at the inquest were:

    - The findings required by s. 45 (2) of *Coroners Act* 2003; namely the identity of the deceased, when, where and how she died and what caused her death;
    - The appropriateness of the facilities available to inmates with chronic or terminal illness at the Brisbane Women's Correctional Centre;
    - The adequacy of the health and palliative care received by Ms Harmer from Queensland Corrective Services and their in-prison health providers; and
    - The process by which Ms Harmer's application for special circumstances parole was considered in June 2016 and whether the process for the consideration of applications for such parole from prisoners requiring palliative care, could be enhanced.

12. Five witnesses were called to give evidence at the inquest:

    - Dr Graeme MacDonald, Senior Staff Specialist, Department of Gastroenterology and Hepatology, Metro South Hospital and Health Service;
    - Dr Natalie MacCormick, CFMU;
    - Ms Kate Holman, General Manager, Brisbane Women's Correctional Centre;
    - Ms Marie Finlay, Director of Operations/ Nursing Director Prison Health, West Moreton Hospital and Health Service (West Moreton HHS); and
    - Mr Peter Shields, Deputy President, Parole Board Queensland.

Personal and Medical History

13. Ms Harmer was the oldest of seven children. She had three younger sisters and three younger brothers. She also had three children of her own. In a statement provided to the inquest, Ms Harmer's mother, Wendy Panuve, said that Jay's early live was stable and happy, and she was an excellent student at both primary and high school. Jay had hoped to join the police service and become a detective and senior officer. Unfortunately, she developed a severe drug addiction after year 10 when she joined the "wrong crowd" of young people.[1]

[1] Exhibit B16.

14. Ms Panuve said that she did not condone Jay's criminal activity, and this strained their relationship greatly. She had told Jay that if she went back to prison she would not be able to visit her. Notwithstanding, Ms Panuve indicated that if she been advised that her daughter was close to death; she would have "needed to visit her to say goodbyes". Ms Panuve would also have agreed to have Jay paroled to her home. (Ms Panuve was employed as a disability/mental health support worker for twenty years.) It is clear that Ms Harmer was loved by her family and friends and is missed by them. I extend my condolences to them.

15. Ms Harmer had a history of opioid dependency from her teenage years. At the time of her death, she was on opiate replacement therapy with suboxone, which was administered at the prison.

16. Ms Harmer's liver disease was attributed to Hepatitis C (genotype 1a) infection and obesity related injury, diagnosed in July 2013. This was complicated by cirrhosis (irreversible liver damage). Ms Harmer had a Child Pugh score of B, with a model for end stage liver disease (MELD) score of 12-14, indicating only a 6% mortality rate at 3 months. Associated clinical issues included:

    - Portal hypertension - fluid retention and marked oedema (resulting in large fluctuations in weight);
    - Occasional ascites;
    - Grade 2 oesophageal varices; and
    - Hepatic encephalopathy (grade II).

17. Ms Harmer also had iron deficiency, asthma and an allergy to seafood. Her mental health concerns included post-traumatic stress disorder; bipolar affective disorder and substance abuse.

Correctional History [2]

18. Ms Harmer's adult criminal history began when she was aged 17 years. As her mother noted, all her offending was drug related. Ms Harmer was sentenced in the Southport Drug Court in October 2010 for stealing, fraud, break and enter, and possession of stolen goods offences. In early 2012, her intensive drug rehabilitation order was vacated following a breach. After she was resentenced for the original offences, she served a period of 10 months' imprisonment.

19. On 28 May 2013, Ms Harmer was sentenced in the District Court to three years and six months for further offences relating to stealing, fraud and burglary. The sentence was suspended for four years after serving three months. She was then convicted of further offences during the operational period. On 20 March 2014 she was sentenced to one year's imprisonment with a parole eligibility date of 20 July 2014. On 28 August 2014, she was sentenced in the District Court at Beenleigh for breach of the suspended sentence imposed in May 2013 and ordered to serve the balance of the term - three years and three months.

[2] Exhibit C2

20. The sentencing judge took Ms Harmer's significant health problems into account and set an earlier parole eligibility date of 28 February 2015. Attempts were made by Queensland Corrective Services in September and October 2015 to encourage Ms Harmer to apply for parole. However, Ms Harmer did not progress a parole application at that time. Advice from the Parole Board Queensland was that Ms Harmer had made multiple parole applications during previous periods of imprisonment.

CIRCUMSTANCES LEADING UP TO DEATH

21. Between July 2013 and early 2016, Ms Harmer's condition continued to deteriorate. She experienced fluctuating encephalopathy, significant liver pain and discomfort, problems with fluid retention, swelling and ascites, falls with soft tissue injuries and fractures, and recurrent lower limb cellulitis. Her weight was closely monitored due to significant fluid retention and she was managed on a low sodium, high protein diet.

22. In May 2016, Amy Kemp was assigned to Ms Harmer as a 'prisoner carer' to assist with showering, dressing, making her bed and cleaning her cell. At that time, there was no formal mechanism in relation to the selection of carers. The decision was based primarily on whether or not the carer had been subject to drug sanctions. This was an attempt to ensure the inmate's care would not be compromised by a carer under the influence of drugs.

23. Dr Gayle Williams, the Clinical Director of Prison Health Services at West Moreton HHS first met Ms Harmer on 10 June 2016. At that time, Ms Harmer and nursing staff were concerned about increased swelling of her legs and abdomen. Ms Harmer's legs appeared to be infected and she had a crackling sound in the base of both lungs. Dr Williams was concerned about a deterioration of Ms Harmer's liver function and believed that she needed to go to hospital. After a review of the blood results, Ms Harmer was transported to the PAH.

24. Ms Harmer was admitted to the PAH under the care of her Hepatologist, Dr MacDonald for assessment of:

    - a transverse fracture through the proximal phalanx of the right thumb requiring conservative management only;
    - worsening hepatic encephalopathy with asterixis (a clinical sign of hepatic encephalopathy which causes the hands to flap) and obvious mental slowing; and
    - constipation.

25. Ms Harmer was trialled on lactulose, movicol and rifaximin but her progress was considered to be hampered by her opiate dependence. While in hospital, she experienced some improvement in her encephalopathy and constipation. Ms Harmer was discharged back to the BWCC on 15 June 2016. Follow up via the telehealth clinic under Dr MacDonald was scheduled 4-6 weeks later.

26. Dr Williams reviewed Ms Harmer again on 24 June 2016, as she was experiencing increasing falls and progressive encephalopathy. Dr Williams became even more concerned for her wellbeing and arranged for Ms Harmer to be transferred back to the PAH under the care of the Gastroenterology team (despite Ms Harmer's objections). Dr Williams also directly requested palliative care involvement.

27. Dr Williams expressed concern that Ms Harmer was not well enough to be housed in a prison cell, despite the presence of a cell mate/carer. Dr Williams' preference was for Ms Harmer to remain in the secure unit at the PAH until the specialist opinions had been submitted to facilitate her parole application and further care arrangements could be made. Blood tests were done, and she was transferred to the PAH late on the afternoon of Friday, 24 June 2016.

28. At 2:00pm on 24 June 2016, Ms Holman emailed the Director of the Queensland Parole Board seeking advice with respect to expediting a parole application. Ms Holman advised she had spoken with Dr Williams, who considered Ms Harmer needed a palliative bed as she could no longer be managed at the BWCC.

29. Following advice from the Parole Board secretariat, Ms Holman sent an application for exceptional circumstances parole to the PAH secure unit for Ms Harmer to sign. The signed form and a Parole Board report were then sent back to the South Queensland Regional Parole Board. In the Parole Board report, Ms Holman recommended that exceptional circumstances parole be granted on the condition that Ms Harmer be admitted to a palliative care or an extended care bed.[3]

30. On Monday, 27 June 2016, Ms Harmer was reviewed by Dr Bachmeier from the palliative care team at the PAH. Dr Bachmeier noted that Ms Harmer was unsure of her release date. Ms Harmer said that she might be able to be released on compassionate grounds. Ms Harmer reported that she was keen to stay with the mother of a fellow prisoner. She admitted that she might use drugs again but denied current drug use in prison. It was noted that she would like to go back to the BWCC as soon as possible as she viewed this as her home. The palliative approach was explained, and she was noted to understand that she had an incurable disease. The plan included obtaining collateral information from her sister, Rachel, with a review the following day.

31. Despite this plan, it does not appear that collateral information was sought from Ms Harmer's sister at this time.

32. On 27 June 2016, the Parole Board met and discussed Ms Harmer's application for leave. The application was deferred for a specialist opinion to be provided to the Parole Board.

33. On 28 June 2016, when reviewed again by Dr Bachmeir, Ms Harmer was again made aware of the severity of her illness and an Advanced Health Directive was discussed but not completed. Ms Harmer reported that she was unaware

[3] Exhibit B15.12

of how serious her condition was. She indicated that that she would like to access parole on compassionate grounds but understood there were many barriers to this. Social issues that were identified included: possible intravenous drug use if released from prison, limited discharge destination options, and psychosocial issues including family estrangement. It was recommended that Ms Harmer stay in hospital for further management. However, Ms Harmer was determined to go back to prison. It was arranged for her to be followed-up by palliative care via telehealth on 14 July 2014.

34. On 28 June 2016, Ms Harmer was also reviewed by the gastroenterology registrar and Dr MacDonald. Although Ms Harmer had grade II hepatic encephalopathy with evidence of mental slowing, it was considered that she had the capacity to make decisions about her care.

35. Significantly, Ms Harmer was noted to have understood the risks of returning to prison, including 'falls, fractures and potential death'. She was advised that the treating team's opinion was that she should remain in hospital for management of her encephalopathy. Ms Harmer was also asked to provide information about her legal representative so that a letter could be prepared to support her parole application.[4] Dr MacDonald's evidence at the inquest was that he discussed the prognosis directly with Ms Harmer during this consultation.

36. Ms Harmer was returned to the BWCC on the evening of 28 June 2016. The PAH records note that she was discharged against medical advice and had the capacity to understand her decision.

37. On 29 June 2016, Ms Harmer was reviewed at BWCC by Dr Ballantyne from the Opiate Treatment Program. Dr Ballantyne observed her speech was slightly slurred and she appeared drowsy. However, this was similar to previous presentations. She was described as calm, lucid, orientated, and could hold a conversation. Ms Harmer informed Dr Ballantyne that she self-discharged from the PAH as she felt that "they were not doing anything new" for her. She restated that she was not using any illicit drugs in prison. Her 14mg daily subutex (buprenorphine) dose and 50mg nightly tapentadol dose were continued.

38. On 30 June 2016, Ms Harmer was again reviewed by Dr Williams who had a long discussion with her. When Ms Harmer asked what Dr Williams felt was her likely prognosis in terms of time left, Dr Williams reported that she had 'weeks to months' to live rather than 'months to years'. However, it was noted that this was very difficult to accurately assess and predict in light of the malignancy of her disease.

39. Nurse Butler was the last nurse to interact with Ms Harmer at 5:15pm on 1 July 2016, when she presented in the medication line for her evening medication. Ms Harmer expressed no concerns about her health and Nurse Butler described her as having normal demeanour, good humoured and cooperative. While she appeared jaundiced and drowsy, this was also not unusual. She was

[4] Exhibit D1.11

administered the usual medications which included a number of laxatives, analgesic and an antibiotic for hepatic encephalopathy.

40. At 6:30pm on 1 July 2016, a lock away muster and head count were carried out with Ms Harmer and Ms Kemp both confirmed as present in their shared cell.

41. Ms Kemp stated that on the previous day, she had noticed that Ms Harmer had been a "lot sleepier than normal". She said this was not uncommon due to the amount of medication Ms Harmer was taking.

42. At about 7:30pm, Ms Kemp and Ms Harmer were watching television in the cell. Ms Kemp reported that Ms Harmer was on her stomach while Ms Kemp rubbed her back. After about 15 minutes she noticed that Ms Harmer was falling asleep.

43. According to correctional staff, there were two secure head counts conducted during the night shift, namely between 10:29pm and 10:44pm and 1:31am and 1:44 am on 2 July 2016. No concerns were identified during the night in relation to Ms Harmer's unit.

44. At 6:45am on 2 July 2018, Ms Kemp woke up and found Ms Harmer was still on her stomach. She thought this was unusual as Ms Harmer normally slept on her back. Ms Kemp was unable to find a pulse and immediately called for assistance.

45. At 6:58am Nurses Portman and Volleberg responded to the emergency call for Ms Harmer. On their arrival, they found Ms Harmer in her bed lying face down on her pillow with her arm extended. There was extensive discolouration of her skin which was cyanosed, mottled and cold, with evidence of pooling of fluid and oedema. There was a small amount of blood and blood-stained mucus on her pillow beside her left cheek. She was unresponsive with no signs of life. Signs of post-mortem lividity and rigor mortis were present. She was declared life extinct at approximately 7:00am.

AUTOPSY

46. The views of Ms Harmer's family were sought in relation to autopsy. As Ms Harmer's mother objected to an internal autopsy a direction was given for an external autopsy only with toxicology testing. Senior Forensic Pathologist, Dr Beng Ong, conducted an external autopsy examination on 4 July 2016. Dr Ong noted that Ms Harmer was morbidly obese and there were no suspicious injuries. Toxicology analysis revealed the presence of drugs which Ms Harmer at been prescribed at therapeutic levels except for sertraline, which was slightly raised.

47. Dr Ong reviewed Ms Harmer's medical records. He noted her extensive medical history and that there was a high risk of potential death. Post-mortem examination did not identify any suspicious injuries or additional features that would explain the death. In his report, Dr Ong concluded that Ms Harmer's cause of death was:

> *1(a) Consistent with complications of decompensated liver failure, due to or as a consequence of*

1(b) Cirrhosis secondary to Hepatitis C infection with non-alcoholic steatohepatitis.

MECHANISM OF DEATH

48. As there was no internal autopsy carried out, the exact mechanism of Ms Harmer's death was not able to be determined. Dr MacDonald and Dr MacCormick agreed that the coexistence of worsening encephalopathy and opiate use would have increased her risk of death above the risk normally associated with advanced liver disease with a MELD score of 12.

49. Dr MacCormick considered it likely that Ms Harmer had suffered a respiratory arrest due to airway compromise as a result of her prone position on her bed, facial oedema and obesity with potential obstructive sleep apnoea. This likely occurred in the context of an altered level of consciousness from hepatic encephalopathy, the potential somnolent effects from sertraline, pregabalin, and quetiapine, and respiratory depression from opioid toxicity (tapentadol and buprenorphine).

MANAGEMENT OF HEPATITIS C IN PRISONS

50. Chronic Hepatitis C (HCV) infection is a major public health challenge for Australia and is the most common cause of disease requiring liver transplant. Prisoner populations have a high prevalence of HCV infection (estimated at 30%) which reflects the close relationship between injecting drug use, HCV infection and incarceration.

51. The *Australian recommendations for the management of Hepatitis C virus infection: a consensus statement 2017* [5] ('Consensus Statement') was first published in March 2016 and updated in 2017. Previously, the treatment of HCV involved interferon therapy, which had limited efficacy and was poorly tolerated.

52. The introduction of direct-acting antiviral (DAA) therapies for HCV that are highly effective and well tolerated is a major medical advance. Most people who start treatment will now be cured. Several of the new HCV medicines were listed on the Pharmaceutical Benefits Scheme (PBS) on 1 March 2016. Listing under the PBS S100 makes provision for the treatment of prisoners through the Highly Specialised Drugs Program.

53. The Consensus Statement recommends a nurse led model of care in prison populations supported by specialist teleconferencing. Authorised nurse practitioners experienced in the treatment of chronic HCV infection can now prescribe DAAs independently under the PBS but are currently prohibited from doing so in prisons under the Highly Specialised Drugs Program.

[5] Exhibit C6, http://hepcguidelines.org.au/

CONCLUSIONS ON ISSUES

The adequacy of the health and palliative care received by Ms Harmer from Queensland Corrective Services and their in-prison health providers

Adequacy of health care

54. It is accepted that the standard of health care expected within corrective services facilities is required to be commensurate with that available in the general community.

55. Dr MacCormick's opinion was that Ms Harmer's case was very complex and challenging from both a symptom control and pain management perspective. She had acute and chronic pain issues combined with significant opioid tolerance, and suspected noncompliance with the conditions of her opioid replacement program. This entailed possible diversion of her opioid replacement therapy and potential ongoing intravenous drug use. Dr MacCormick considered that it would have been very difficult to clinically differentiate the effects of hepatic encephalopathy from drug induced central nervous system depression.

56. Although Ms Harmer was only 38 years of age, she had very complex medical issues because of her severe liver disease. Unfortunately, the diagnosis of Ms Harmer's chronic liver disease was made late in the course of her illness. This may have been as result of lifestyle factors and poor engagement with health services. It could not be established during the inquest when Ms Harmer was first diagnosed with HCV.

57. Ms Harmer was also not a suitable candidate for interferon or liver transplant. Dr MacDonald acknowledged that Ms Harmer may have been eligible for DAA's (which had become available in Queensland prisons in late 2016) but noted that Ms Harmer was very ill and that DAA's do not necessarily reverse the damage. Dr MacDonald said that in Ms Harmer's case, the damage had already been done.

58. Dr MacCormick considered that Ms Harmer received regular and appropriate medical, nursing, and allied health review in the prison medical Centre. She also had appropriate access to specialist care and hospital treatment. The health care provided by all of her treating clinicians was of a high standard, despite the very challenging circumstances, clinically and socially. I agree with those conclusions.

59. The evidence at the inquest indicated that the West Moreton HHS[6] is currently carrying out the following steps to improve the treatment and care available to prisoners in BWCC in relation to HCV:

[6] Exhibit B17, pages 9-10

- A pathway for screening and management of blood borne viruses has been drafted and is under review;
- Approximately 200 patients within the West Moreton HHS prison catchment had been treated with DAAs;
- West Moreton HHS has contracted with Hepatitis Queensland for the provision of a fibro scanner for use within its service area and are currently in the process of purchasing its own fibro scanner;
- A hepatitis health needs assessment has been undertaken at BWCC;
- A Hepatitis B/C vaccinations and screening learning module is under development for West Moreton HHS staff;
- West Moreton HHS has recently sourced funding for recruitment of a Nurse Navigator role (nurse practitioner level) to assist with chronic disease management in its service area. This position will work under the clinical supervision of medical practitioners and participate in a fortnightly telehealth link with the PAH Hepatology clinic for multidisciplinary coordination of care. The Nurse Navigator will be able to prescribe medications but due to the current limitations of the S100 listing, this would not include DAA's.

60. Dr McDonald acknowledged that BWCC was unique in Queensland in the sense that female prisoners are able to access the opioid replacement program. He said that if male prisons were to transition to the opioid replacement program, there would be benefit in amending the S100 PBS listing so that Nurse Practitioners can also prescribe DAA's in the correctional setting.

Adequacy of palliative care

61. Dr MacCormick said that given the severity of Ms Harmer's illness in June 2016, it was inappropriate for Ms Harmer be housed in a prison cell. She considered that Ms Harmer clearly required inpatient palliative care. Dr MacCormick's view was that it would have been appropriate to keep Ms Harmer in hospital as the available alternatives did not adequately meet her needs.

62. It was submitted on behalf of Ms Harmer's family that she should not have been returned to BWCC from the PAH. It was submitted that her return involved a tacit agreement between Queensland Health and BWCC that her needs could be met at the prison. It was also submitted that Ms Harmer's election to return did not entail a refusal of nursing care at the BWCC, and that such care should have been available 24-hours per day. I do not accept the latter submission as Ms Harmer would have been aware that she would be returning to a facility lacking 24-hour care.

63. Before October 2012, a nurse was rostered for 24 hours per day at BWCC. However, the inquest heard that a shortage of nursing staff (despite recruitment attempts) and increasing prisoner numbers were reported to have contributed to this reduction in staffing. At the inquest, differences of opinion were expressed by West Moreton HHS and QCS about the need for a 24-hour nursing service at BWCC. Such care is available to the Brisbane Youth Detention Centre and the Brisbane Correction Centre.

64. Dr MacCormick said that 24-hour nursing would enable nursing support to be available to prisoners who are unwell, whether temporarily or on a long-term basis. She said that if 24-hour nursing care was available, the correctional centre would be able to accommodate a broader range of prisoners, with health issues of varying complexity. However, Dr MacCormick also acknowledged that having 24-hour nursing presence would not necessarily have been sufficient to care adequately for Ms Harmer. Ideally, Ms Harmer would have been located in a bed in close proximity to the medical centre and resuscitation equipment, with access to PRN medications and increased nursing observations.

65. At the inquest, Ms Holman was asked whether Ms Harmer might have been forced to return to the hospital under s 21 of the *Corrective Services Act 2006*. That section provides, among other things, that a prisoner must submit to a medical examination or treatment by a doctor if the doctor considers the prisoner requires medical attention.

66. Ms Holman's evidence was that obtaining Ms Harmer's agreement to treatment was the preferred approach as she had the capacity to make decisions about her health care. It was also submitted on behalf of QCS that, while the power under s 21 exists, no "formal request" was made by a doctor for the power to be exercised in relation to Ms Harmer.

67. While the approach taken by Ms Holman and the PAH is consistent with the fundamental principle of health care that an adult with capacity has the right to refuse treatment, I acknowledge that the application of this principle in a custodial context presents a number of ethical and legal challenges, particularly where palliative care beds are not available within the correctional facility. Having regard to the nature of Ms Harmer's illness, in my view further consideration should have been given to exercise of the power under s 21.

68. Dr MacCormick said that there were various models of palliative care in the community which include hospitals, nursing homes and hospices. It was also noted that palliative care can be provided at home where the patient is primarily cared for by family or carers with intermittent nursing support. Dr MacCormick agreed that in these circumstances, the patient would not have access to constant nursing care. She also noted that not all patients are suitable for at home care, and doubted that it would have been appropriate for Ms Harmer to have been cared for at home. Dr MacCormick considered she needed to be in a nursing home or a hospital.

69. Dr MacCormick was also concerned about the appropriateness of the carer allocated to Ms Harmer at the BWCC. She said that at the time, Ms Harmer was retaining a lot of fluid and had fluctuating oedema. This included facial oedema which automatically gives rise to concern about potential airway oedema and swelling. The fact she was carrying extra weight and fluid gave rise to concerns about sleep apnoea and airway obstruction. This was an additional risk factor to her encephalopathy which meant she was generally drowsy.

70. Dr MacCormick also noted that Ms Harmer was prescribed with higher doses of buprenorphine and tepentadol (both of which are opiate like medications) and may have contributed to further drowsiness and respiratory depression. She said that all these factors increased her risk of airway obstruction when she was left in the prone position. The carer was unlikely to have any awareness of these risks.

71. Dr MacCormick's evidence was that in a setting of higher care, patients are never allowed to lie face down in a prone position. The preference is for them to lay in the lateral position (on their side) or on their back where they can be appropriately supported.

72. Dr MacCormick advised that first aid training teaches skills in relation to airway management and the optimal positions for a patient who has a reduced level of conscious. Her evidence was that there would be benefits for both the carer and the prisoner if prisoner carers could be trained in first aid. Dr MacCormick said that this should be the minimum requirement and noted that in the community, employed carers are required to hold a first aid qualification. She noted that this training can be obtained in a day or two from a range of providers.

73. Submissions on behalf of Ms Harmer's family also expressed concern that Ms Harmer was left in the care of fellow prisoner who was only 21 years of age and lacked any formal skills in health care. The submissions highlighted the lack of a formal policy governing the use of such carers. In her statement[7], Ms Harmer's carer noted that she was very close to Ms Harmer, who treated her like a daughter. She said that when she started caring for Ms Harmer, she was required to sleep on the floor of a cell designed for one prisoner, and Ms Harmer often fell over her during the night. Apart from knowing that Ms Harmer had "issues with her liver" she lacked a detailed understanding of her illness. The carer was clearly not able to provide the type of palliative care that Ms Harmer required.

74. In October 2015, Dr MacDonald had identified a need to consider palliative care options for Ms Harmer should she have another major decline in her liver function. Given her progressive deterioration following that time, there was a missed opportunity before June 2016 to discuss her poor prognosis, commence palliative care planning and seek to progress a timelier application for special circumstances parole. At the inquest West Moreton HHS advised that they were currently recruiting for a Nurse Practitioner in palliative care and disability to facilitate care planning.

75. It is clear that both correctional and treating staff were aware of the limitations in the treatment available to Ms Harmer when she returned to prison following her decision to discharge herself against medical advice on the 28 June 2016. Apart from the formal palliative care input that was being arranged, I consider that Ms Harmer's circumstances meant she was unable to receive appropriate palliative care at the BWCC. I accept the submission from West Moreton HHS that the care able to be provided at the BWCC was not equivalent with the care

[7] Exhibit B6.

that could be provided in a hospital. I also accept that in the absence of Ms Harmer's consent to remain at the PAH, a direction under s 21, or a grant of exceptional circumstances parole, no suitable alternatives were available.

The appropriateness of the facilities available to inmates with chronic or terminal illness at the Brisbane Women's Correctional Centre

76. At the inquest I heard evidence from Ms Finley that that health services provided within the corrective services facilities within the West Moreton HHS catchment are consistent with a primary health care model. This model of care does not encompass higher acuity care such as that available in a hospital. If higher levels of care are required a prisoner is transferred to the PAH.

77. In particular, BWCC does not have a dedicated palliative care unit, nor any other infrastructure to support full time palliative care. Ms Holman said that the BWCC is a small built jail and only has capacity for 258 prisoners. She said that its current running capacity was in excess of 170%.

78. At the time of the inquest, Ms Holman said that no additional infrastructure was available to provide palliative care and it would be necessary to build a facility such as an annex to the BWCC medical centre. However, she said that having regard to the relative infrequency of such cases it was preferable for prisoners to be transferred to a hospital environment where high quality care was available.

79. I note that the Queensland Government announced on 3 July 2018 that the privately operated South Queensland Correctional Centre will be repurposed as a women's correctional centre to relieve pressure in the system for women prisoners. That centre currently has a small medical unit with a four bed Advanced Care Unit with some capacity to support palliative care. It is not known whether that capacity will be maintained following the transition.

80. Currently, where a prisoner from BWCC requires acute palliative care services, the options are limited. These involve either a transfer to the PAH secure unit, or interagency cooperation between West Moreton HHS and QCS to assist the prisoner in obtaining parole on compassionate grounds. Where a prisoner wishes to return to the correctional facility, a prisoner carer model is adopted. Ms Holman agreed that carers should be required to have basic first aid qualifications but noted that QCS staff do not have access to detailed health information about prisoners. This, in turn, would limit the amount of information that might be shared with a prison based carer.

81. In her evidence Ms Finley, the Nursing Director Prison Health, at West Moreton HHS agreed that the standard of care expected within corrective services

facilities is commensurate with that available in the community as reflected in a number of national and international guidelines.[8]

82. Dr MacCormick's evidence was that the treatment of a palliative patient in the correctional setting presents many challenges. She noted that these patients often require access to strong opiate and benzodiazepine medications for pain management. Access to such medications in prison is highly controlled due to risks associated with substance abuse and diversion. Palliative patients in prison may also experience increased falls as walking sticks and frames can also be used as weapons.

83. Dr MacCormick acknowledged that the same standard of palliative care as that available in the community may not always be achievable in the correctional setting, particularly in cases where there are no palliative beds.

84. Palliative Care Australia (in alignment with the World Health Organisation) defines palliative care in the contemporary Australian context as:

> "*Palliative care is person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary treatment goal is to optimise the quality of life."*

85. Palliative Care Australia has published National Palliative Care Standards[9] with the following elements underpinning this definition of palliative care:

    a. Palliative care should be strongly responsive to the needs, preferences and values of people, their families and carers. A person and family-centred approach to palliative care is based on effective communication, shared decision-making and personal autonomy.
    b. Palliative care should be available to all people living with an active, progressive, advanced disease, regardless of the diagnosis.
    c. Palliative care affirms life while recognising that dying is an inevitable part of life. This means that palliative care is provided during the time that the person is living with a life-limiting illness, but it is not directed at either bringing forward or delaying death.

86. These Standards articulate and promote a vision for compassionate and appropriate specialist palliative care. The Standards recognise the importance of care that is person centred and age appropriate. In particular, they point to the requirement for specific attention to the needs of people who may be especially vulnerable or at risk, including those in custody.

87. It was clear from evidence at this inquest that there are significant challenges associated with the provision of quality palliative care to prisoners, including at BWCC, and that the available facilities are generally inadequate for this

[8] The United Nations Standard Minimum Rules for the treatment of Prisoners; The World Health Organisation Guide to Health in Prisons; and The Royal Australian College of General Practitioners Standards for Health Services in Prisons
[9] http://palliativecare.org.au/standards

population. As noted above, I agree with the submission from West Moreton HHS that such care is best provided outside the prison environment.

The process by which Ms Harmer's application for special circumstances parole was considered in June 2016 and whether the process for the consideration of applications for such parole from prisoners requiring palliative care could be enhanced.

88. In June 2016, the Southern Queensland Regional Parole Board, had the power to grant a prisoner's release to exceptional circumstances parole under ss 176 and 177 of the *Corrective Services Act 2006*. The Southern Queensland Regional Parole Board was bound to consider the Queensland Parole Board Guidelines to the Queensland Regional Parole Boards and, in particular Guideline 5.7:

> *"The regional board may release a prisoner on parole if the Regional Board is satisfied that exceptional circumstances exist in relation to the prisoner. If parole is granted, in the case of a prisoner claiming exceptional circumstances for serious medical reasons, the Regional Board should first obtain advice from Queensland Health on the management of the prisoner's medical condition".*

89. The considerations relevant to the determination of such applications set out *Leggett v Queensland Parole Board*[10] are likely to have formed part of the Southern Queensland Regional Parole Board's decision making.

90. Ministerial Guidelines to the Parole Board Queensland, current as at 21 September 2017, are relevant to current decisions of the Board. The relevant guideline is almost identical to that contained in the previous guidelines. Section 5.7 of those guidelines provides:

> *"Parole Board Queensland may release a prisoner on parole, if satisfied that exceptional circumstances exist in relation to the prisoner. If parole is granted, in the case of a prisoner claiming exceptional circumstances for serious medical reasons, Parole Board Queensland should first obtain advice from Queensland Health or other approved medical specialists on the seriousness, and management of, the prisoner's medical condition".*

91. As noted above, Ms Harmer's application for exceptional circumstances parole was deferred on 27 June 2016 to enable a specialist opinion to be provided to the Parole Board. Dr MacCormick's interpretation of section 5.7 of the Guidelines was that it enables any doctor working for Queensland Health to advise the Board, not necessarily a specialist. She was not aware of criteria that can be accessed for doctors which may be of assistance to help make this decision and suggested that it would be beneficial for criteria to be developed to assist doctors in the provision of reports to the Parole Board. Dr MacCormick also indicated that the independent doctors at the CFMU may be able to assist the Parole Board in these matters.

[10] [2012] QSC 121

92. Mr Shields' evidence was that applications for exceptional circumstances parole are given priority and are immediately provided to the President of the Parole Board. If the President is not available, the application will be given to a Deputy President and a decision was made on the same day about when the matter would be heard. Mr Shields stated that the decision to grant special circumstances parole was at the Parole Board's absolute discretion and was not limited to medical circumstances. Although clause 5.7 of the Guidelines suggests that the Board should obtain medical advice "*if parole is granted*", it is clear that such advice forms part of its consideration of the application.

93. Mr Shields said that the Parole Board had recently visited number of the prisons including Wolston Correctional Centre, Arthur Gorrie Correctional Centre, BWCC and Numinbah. The Parole Board has been engaging with prisoners, General Managers and the Prisoner Advisory Council. The key messages being conveyed include what exceptional circumstances parole is, and what it is not. Mr Shields said that there only so many files can be considered by the Parole Board at any given time, and it is important that only meritorious applications are dealt with.

94. Mr Shields advised that an evidence-based approach is taken in applications for exceptional circumstances parole on medical grounds. The factors Parole Board consider include reduced life expectancy, risk of sudden death, capacity of the relevant correctional facility to provide palliative care, and other social issues including the risk of re-offending and ongoing drug use.

95. Mr Shields agreed that someone who was so unwell as to require palliative care would generally be regarded as posing a reduced risk to the community.

96. He reiterated that there is an ageing prison population and said there were many prisoners currently being convicted for historical sexual offences for which they received significant terms of imprisonment. Although many of these offenders become eligible for parole, they have difficulty finding accommodation in the community due to the nature of their offending. Mr Shields noted that significant funding was required to unlock accommodation that allows persons to live their lives with dignity in the community after serving a term of imprisonment, at the same time as being protected and cared for.

97. Mr Shields referred to the decision of the Supreme Court in *Attorney-General for the State of Queensland v Guy*[11] in which the issue of finding accommodation for an aged sex offender was raised. The Chief Justice stated:

> *"It seems to me that a time will come when there are enough offenders in the respondent's category of age and debility falling within the compass of the Dangerous Prisoners (Sexual Offenders) Act to require the setting up of supported accommodation for them. It is deeply troubling to think that people who could be managed and rendered relatively risk-free with appropriate support and accommodation, must instead, be imprisoned as the only option."*

[11] https://archive.sclqld.org.au/qjudgment/2017/QSC17-105.pdf

98. Mr Shields's evidence was that a facility is needed where such prisoners can be paroled to, and he agreed that the lack of beds was a basic problem for not just palliative prisoners but also the elderly and infirm.

99. Mr Shields said that this is also an issue for young offenders. He said that a common pathway for such offenders is to appear before a sentencing magistrate and receive a term of imprisonment, subject to court ordered parole which enables them to leave court on the same day. Often, they have no accommodation options and inevitably re-offend during the parole period and are then sent to prison following a breach. In his experience, a person who cannot source accommodation in the community will be unable to source accommodation while in prison.

100. Mr Shields noted that in addition to the Parole Board's recent visits to correctional centres, QCS is compiling information packs to improve parole planning. This may ensure parole applications can be made in a timely manner, rather than at the very final stages of a prisoner's illness.

101. The Parole Board is also working with organisations such as the Prisoners Legal Service and Sisters Inside to ensure that matters can be expedited. Mr Shields noted that during the sentencing hearing for Ms Harmer in 2014, a medical report from Dr MacDonald had been tendered report but QCS did not have a copy of this report on its file when Ms Harmer's parole application was made in June 2016. This was a common problem and delays in the consideration of exceptional circumstances parole applications could be avoided if medical reports tendered during sentencing hearings were on the QCS file. The reports would then be available to the Parole Board at the earliest opportunity when parole applications were considered.

102. It is clear that the consideration of Ms Harmer's application for exceptional circumstances parole in June 2016 followed the process set out under the Guidelines. Unfortunately, the Southern Queensland Regional Parole Board's consideration of the application was delayed by the lack of access to Dr MacDonald's report which was tendered at Ms Harmer's sentencing hearing. Her application was deferred to enable a specialist opinion to be obtained. The Parole Board also did not have access to Dr Williams' detailed email dated 24 June 2016 about Ms Harmer's progressive and significant deterioration.[12] Mr Shields indicated that this email may have provided a sufficient basis for the Board to grant exceptional circumstances parole.

103. It was submitted on behalf of Ms Harmer's family that Ms Holman should have attached Dr Williams' email of 24 June 2016 to the application that was lodged by Ms Holman with the Parole Board. The family submitted that the fact Ms Harmer was not released to parole prior to her death represented a missed opportunity for her to reconnect with her family before her death, and to die in accordance with a palliative care plan that she might have been engaged in preparing.

104. While Ms Holman's evidence was that she was not aware of the precise details of Ms Harmer's illness, it is likely that Dr Williams would have shared the

[12] Exhibit B13.4

relevant information with her in support of Ms Harmer's parole application had she been asked to do so and was made aware of its significance in that context. Dr Williams' advocacy on Ms Harmer's behalf had prompted the application for parole by Ms Holman.

105. I agree with the family's submission that the information submitted to the Parole Board was not the best available evidence. Unfortunately, this reflects the reality that an application for parole was not made by Ms Harmer or anyone else on her behalf at an earlier time during her final period in custody, when better quality material could have been presented in support of the application. I make no adverse comments in relation to this. It was clear that Ms Harmer was aware of her right to apply for parole from early 2015, and although she had made many parole applications during previous periods of imprisonment she elected not do so.

106. It was clear from Mr Shield's evidence the Parole Board Queensland and QCS are actively seeking to increase awareness of the parole process and the circumstances in which applications for exceptional circumstances parole, including from persons requiring palliative care, are appropriate. Although the Parole Board Queensland expedites the hearing of applications, one of the major barriers to the granting of exceptional circumstances parole is suitable supported accommodation for prisoners requiring palliative and other care. The other barrier is access to comprehensive and timely information in support of such applications.

107. In the context of Queensland's burgeoning prison population, where it is appropriate to do so, such prisoners should be removed from maximum security prisons to other facilities that are better able to manage their health and other needs at a lower cost.

Findings required by s 45 of the Coroners Act 2003

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased	Jay Maree Harmer
How she died	Ms Harmer died in custody after a lengthy history of serious illness, including Hepatitis C and non-alcoholic steatohepatitis with cirrhosis, oesophageal varices, chronic encephalopathy, asthma, depression and opiate dependence. Most of these conditions could not be treated, and Ms Harmer was referred to palliative care in June 2016 after her health deteriorated significantly. She elected to return from the Princess Alexandra Hospital Secure Unit to

the Brisbane Women's Correctional Centre while waiting for an application for exceptional circumstances parole to be considered.

Ms Harmer likely died from respiratory arrest due to airway compromise in the prone position, in the context of an altered level of consciousness and respiratory depression from hepatic encephalopathy, the somnolent effects of the range of medications she was taking (sertraline, pregabalin and quetiapine) and respiratory depression from opioid toxicity.

Place of death

Ms Harmer died at the Brisbane Women's Correctional Centre, Wacol, in the State of Queensland.

Date of death

Ms Harmer's death occurred at some time between the evening of 1 July 2016 and 6:45am on 2 July 2016.

Cause of death

The medical cause of death was consistent with complications of decompensated liver failure; due to or as a consequence of, cirrhosis secondary to hepatitis C infection with non-alcoholic steatohepatitis.

COMMENTS AND RECOMMENDATIONS

108. The *Coroners Act 2003* enables a coroner to comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

109. Having regard to my conclusions in relation to the issues that were considered at this inquest I make the following recommendations under s 46 (1) of the Coroners Act:

1. **That the Queensland Government comprehensively review the current model for the provision of palliative care to prisoners with a view to improving how and where palliative care is delivered, including the provision of a range of post-release supported accommodation options for infirm prisoners eligible for parole, including exceptional circumstances parole.**

2. **That Queensland Corrective Services develop a formal policy in relation to the selection, training and management of prisoner carers, including a requirement that prisoner carers be trained in the provision of basic first aid.**

3. **That the Queensland Government ensure that the Parole Board Queensland has access to any medical, psychiatric and psychological reports that are tendered during sentencing proceedings. This may be facilitated by requiring that such reports are the subject of a court order that a copy of relevant reports be provided to Queensland Corrective Services, as well as enhanced information sharing between Queensland Corrective Services and Queensland Health at the time the parole application is being prepared.**

4. **That Queensland Corrective Services and the Parole Board Queensland prepare guidelines to assist doctors to address relevant considerations when preparing reports in relation to exceptional circumstances parole applications. The guidelines should also clarify the level of expertise required of the authors of such reports. Consideration should also be given to obtaining advice from the Clinical Forensic Medicine Unit in these matters.**

110. I close the inquest.

Terry Ryan
State Coroner
Brisbane
10 August 2018