CITATION: *Inquest into the death of Josef Lear* [2022] NTLC 002

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0040/2021
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HEARING DATE(s):	2 November 2021
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Death in custody, natural causes**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for family:	Mark Thomas

Judgment category classification:	A
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0040/2021

In the matter of an Inquest into the death of

JOSEF LEAR

ON 7 March 2021
AT The Hospice, Royal Darwin Hospital

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Josef Lear was born in Czechoslovakia on 12 February 1941. He died when 80 years of age at the Hospice of the Royal Darwin Hospital (RDH) due to metastatic oesophageal cancer. Mr Lear was described as a timid and quiet man. Prior to his retirement in 2018 he was working as an accounts clerk for the Lichfield Shire Council.

2. Mr Lear migrated to Australia with his parents when he was 14 years of age and settled in Orange, NSW. He is said to have completed an apprenticeship as a mechanic. He married and had two children, Nicholas and Annette. His marriage ended and in or about 1976 he married Yana. They remained together until his death. She had three children from a previous relationship.

3. In 2017 he was charged with the historical sexual offences, the rape and indecent assault of a step-child when she was 11 years of age. He received a sentence of 7 years with a non-parole period of 5 years dated from 16 March 2018. His earliest date for release was 16 March 2023. He was 77 years of age at the time and described as 'thin'. He was said to be softly spoken but clear and coherent. He was noted to be 'quite frail'. He was known to suffer from Diabetes Mellitus Type 2 and Hypertension.

4. On 25 March 2018 he suffered a fainting spell in prison and suffered a cut to his right eyebrow. On assessment he said he had suffered a similar episode while mowing the lawn a few months before. He was sent to the RDH and fitted with a Holter Monitor to record the activity of his heart. It was found that he had a drop in blood pressure on standing but otherwise the tests were unremarkable. He was prescribed medication and released back to the prison with follow-up outpatient appointments.

5. The dizzy spells continued for a month or so and he was allowed to use a chair during muster and began to move more slowly to avoid a significant change in blood pressure. However, after changes to his medication the dizzy spells became less problematic. Dizziness returned intermittently in October with the hot weather and he said generally occurred between 1 – 3pm. His main physical issue appeared to be osteoarthritis in the cervical spine for which he was prescribed ibuprofen.

6. He initially had issues adjusting to his circumstances in prison and frequently 'ruminated' on what he believed to be the injustice of his imprisonment and being let down by the legal system. He had appealed his sentence said he had considered appealing further but was told it would cost $100,000 and the outcome was unlikely to change a great deal.

7. On 2 September 2019 he sought medical assistance relating to a harsh cough, but that had improved by the time he saw the nurse. On 14 June 2020 he asked to see a doctor about a number of issues including 'coughing and phlegm. He had an x-ray and saw the doctor on 26 June 2020 for review. It was recorded that he had suffered from a cough for about a year with clear sputum. He also had anaemia and was referred to haematology.

8. On 10 August 2020 he complained that his coughing was getting worse and he was getting hiccups and burping when eating. He said he got a bubbling in the back of his throat after eating. He said he was swallowing okay but that eating took a long time. He said the prison food was too flavoursome

and spicy. He thought he might need a special diet. He was prescribed Mylanta and omeprazole. However that did not resolve his issues and on 27 August 2020 he asked to see a doctor. He said he thought there was something wrong with his stomach.

9. On 1 September 2020 he wrote on his health request form that his eating disorder was getting worse. He said that as soon as he started eating he was getting hiccups and burping and had pain in his chest. He said at first it was just spicy meats but now he couldn't even eat sandwiches. He said he was throwing away most of his food.

10. He was seen by the doctor on 3 September 2020. He said breakfast and lunch were normally okay but dinner was the worst. He had lost 1.8 kilograms since May 2020. He was referred for urgent gastroscopy

11. On 13 September 2020 he complained that his eating disorder was worsening. He said he thought he needed to see a specialist. He said his throat was agitated all the time. A report was run on his weight that showed that he was 70.4 kilograms shortly after his incarceration and was now 60.4 kilograms. However the loss of weight had not accelerated in the last year. For instance, in September 2019 (i.e. one year before) he was 63.4 kilograms.

12. He was seen by the doctor on 16 September 2020. He told her it had been really hard to eat and drink over the last two weeks. He said after about three mouthfuls he would hiccup. He said he was "almost scared to eat and even drinks were hard to keep down". He could only sip slowly. He said his throat was sore at times and it felt like he had mucous in his throat. He was referred for X-ray.

13. On 24 September he wrote on a health request form: "my eating 'disorder' is worsening. I have been hardly eating this week. Have to eat very slowly and

if I try to force myself to eat more than a slice of bread or 2 Weet-bix, I get hiccups followed by burps and chest pain and bring up (vomit)".

14. On 28 September 2020 he wrote on his health request form: "My illness is getting worse and I am getting weaker, can hardly walk and feel giddy. Have hardly been eating or drinking. The Sustagen helped a bit, but even that now upsets my stomach … I fear if I don't get help soon I will collapse".

15. He was reviewed by the doctor on 30 September 2020. He said he was unable to eat anything. He was kept in the medical unit that night with a plan to admit him to hospital the next morning.

16. He was admitted at 10.57am on 1 October 2020. He was 56 kilograms and looked drawn. He said it took him 1 – 2 hours to drink a cup of tea. A CT Chest and Upper abdomen with IV contrast was performed. No oesophageal or mediastinal abnormality was noted. A gastroscopy was performed the next day. A biopsy at the gastro oesophageal junction (where the oesophagus meets the stomach) identified adenocarcinoma and extensive wall thickening extending into the stomach. A CT scan showed a nearby node measuring 23mm x 18mm thought likely to be malignant and approximately 6 lesions in his liver that were considered likely to be metastases.

17. He was referred to the oncology team. After the gastroscopy his ability to eat and drink initially improved. He remained in hospital until discharged on 14 October 2020 after undergoing a positron emission tomography (PET) scan to assess the liver metastases. The PET scan identified at least one likely metastatic site in the liver. He had an ultrasound on 27 October 2020 that suggested potential malignancy of 3 lesions in the liver.

18. On 3 November 2020 he attended an outpatients' appointment at the Alan Walker Centre and received the formal diagnosis of the cancer, his prognosis and options. He opted for chemotherapy to start on 13 November 2020. He believed it would give him a "couple of years". The oncologist

believed his prognosis was less than 6 months if he was unable to tolerate chemotherapy. He required the medication twice a day. But the tablets made him retch.

19. By 16 November 2020 he was having the same difficulties with eating and drinking as he had prior to the gastroscopy. On 19 November 2020 he was noted to be frail and weak and a wheelchair was used to move him around the clinic. He was transferred to RDH at 1.30pm. It was thought his prognosis at that time was more likely "weeks to short months" and that the complexity of his condition was such that he might no longer be able to be cared for at the prison. He was advised by the doctor to seek early release so as to be able to die in the community.

20. By 2 December 2020 it had been determined that he had neutropenia (very few neutrophils in blood making him susceptible to infection) and was unable to continue with chemotherapy. It was agreed to change to radiation treatment. By that stage he was no longer able to walk unaided to the bathroom and required assistance with the activities of daily living. He was returned to the prison on 3 December 2020. The plan was for palliative radiotherapy the next week.

21. By 3 December 2020 Mr Lear indicated that his issues with eating had improved when eating more frequent and smaller meals. He said he understood that he didn't have long to live, "months maybe". He said he was not afraid of dying but would like to be kept comfortable. On 10 December 2020 he signed an Advance Personal Plan. He indicated that nearing death he did not want to be in prison. He received radiotherapy treatment from 9 December 2020 to 22 December 2020.

22. On 18 December 2020 he was feeling a little better. He thought that after radiotherapy was complete he may not go back to chemotherapy and indicated his lawyer had lodged an application seeking his early release.

23. However on 24 December 2020 he was unable to eat or drink and was transferred to RDH. During the course of his stay some restrictions due to his custodial status were eased:

a. From 29 December 2020 his restraints were removed; and

b. From 8 January 2021 his family were allowed to visit as much as they wished consistent with RDH visiting hours.

24. A family meeting was held on 22 January 2021. It was stated that he had stage 4 oesophageal cancer, chemotherapy had not been tolerated and he was being fed orally and intravenously. However that could not continue and the other options carried significant risks. There was a discussion of the issues he would face in feeding and visitation of family if returned to the prison setting. He said he would rather have quality of the life he had left.

25. He was transferred back to the prison in the evening of 2 February 2021. He continued to deteriorate and on 7 February 2021 had a fall when going to the toilet in the early hours of the morning and hit the back of his head. When the medical staff arrived in the morning they found him on the floor unable to get up. He had moved a pillow to the floor and partially pulled blankets over him.

26. He was taken to Palmerston Hospital by St John Ambulance. X-rays found there was no damage. The discussion was primarily around his general decline and frailty. However at that time there were no beds available at the Hospice. He was discharged to the prison the following day at 9.10pm. Thereafter Correctional Services Officers checked on him every 30 minutes overnight.

27. By 11 February 2021 his weight was down to 45.6 kilograms. It was said that he was not eating or drinking much. He said he was comfortable and had less pain. It was mainly controlled with a Fentanyl patch.

28. On 12 February 2021 he was found on the floor by Correctional Staff at 1.00am. He said he was attempting to go to the toilet. He had a laceration to his forehead. He was found to be unable to walk without the assistance of two staff members and was encouraged to call for help if he needed to get out of bed.

29. On 17 February 2021 there was a teleconference between the prison doctor, Mr Lear, his family members (Yana, Annette and Nick) and the palliative care consultant. It was discussed that he was getting weaker, the Fentanyl was no longer sufficient, and the use of break-through morphine might have been contributing to his dizziness and his confusion. It was decided to increase the Fentanyl patch dosage. Mr Lear's prognosis was thought to be 3 – 6 weeks. But he would only be accepted at the Hospice if it was believed he had less than two weeks to live. Mr Lear and the family preferred that he stay at the prison rather than be admitted to a "noisy" ward at RDH.

30. On 18 February 2021 he had another fall while being moved from his bed by the physiotherapist. He struck his head and was unsure if he lost consciousness. It was determined that he was no longer able to be cared for at the prison and on 19 February 2021 he was sent to RDH by Ambulance. When he got there he said he did not want any life prolonging treatment and his priority was comfort and dignity. He was admitted under the medical team to ward 3B and then on 3 March 2021 transferred to the Hospice.

31. He passed away peacefully at 3.00pm on 7 March 2021.

32. The circumstances and cause of death are known and not in issue. However pursuant to the Coroner's Act (section 26), I am required to investigate the care, supervision and treatment of Mr Lear while in custody. The test that the medical care must reach is that set out in section 82 of the *Correctional Services Act*:

> 82 (2)The Commissioner must ensure that prisoners are provided with access to health care that is comparable with that available to persons in the general community in the same part of the Territory.

33. Due to the extensive medical history leading to his death and in particular the extensive history of coughing, weight loss and difficulty eating, I obtained a review of the medical treatment from Doctor James Lynch, Fellow, Mentor and Examiner of the Royal Australian College of General Practitioners. In his opinion the medical care was of an excellent standard. He went on to say: "Mr Lear was, in my opinion, provided with a level of care that, most likely, exceeded that he would have been provided in the general community."

34. From the documents obtained from Corrections pursuant to a Coroner's Authority dated 9 March 2021 and the investigation conducted by Police there appeared to be no issues with his care, supervision and treatment and on 20 July 2021 the Department of Correctional Services and the family were advised of the date for the inquest. However there were issues which had not been disclosed.

Issues

35. The Department of Correctional Services did not provide all of their records. In particular an investigation report as to his fall on 7 February 2021 was not provided, nor a number of emails from a barrister on behalf of the family raising issues as to the care and supervision of Mr Lear between 9 December 2020 and 4 March 2021.

36. The family had considerable concerns during the last number of months before his death and many of those concerns persisted to the inquest on 2 November 2021. The family provided to the Coroner's Office an outline of concerns on 29 October 2021 and they were forwarded to Corrections' lawyers that same day.

37. On 1 November 2021 the Acting Commissioner of Corrections provided an affidavit seeking to deal with those concerns. However that affidavit did not mention or attach the emails sent on behalf of the family to Corrections, the investigation report into his fall on 7 February 2021, or a more recent review of the care, supervision and treatment of Mr Lear while in custody.

38. Accordingly, the full extent of the family's concerns was not understood until Annette, the daughter of Mr Lear, gave evidence during the inquest. The Department were invited to provide their responses and the documents previously omitted. The response and documents were received on 7 December 2021.

Family Concerns

39. The overarching concern was that the prison was not the appropriate place for Mr Lear to stay while suffering the significant deterioration in his health. It was believed by his family that he should be allowed compassionate leave to die at home or alternatively be transferred to the Hospice at RDH.

40. On of 9 December 2020 Mr Mark Thomas, a barrister in Darwin, sought on behalf of the family that the Commissioner of Corrections permit Mr Lear General Leave on Compassionate grounds so that he could die at home. Included in that letter were a number of concerns the family had as to his care at that time. The concerns raised included the use of handcuffs and shackles despite his immobility and frailty, and being transported in the caged vehicle to medical appointments in circumstances where he wasn't able to keep himself in the seat and was falling. It was said his food was not appropriately prepared so as to enable him to swallow it.

41. It appears that the prison authorities would have given the application serious consideration if they had been able to do so. However, they responded that the Commissioner was unable to use the powers to provide

General Leave due to a Ministerial Direction that concerned prisoners who had committed serious sexual offences (or murder).

42. The family were frustrated that Mr Lear was not transferred to the Hospice at an earlier time. Although, the evidence was that was not a matter within the control of the prison authorities.

43. The refusal to provide Mr Lear compassionate leave left the family with ongoing concerns and they felt that the only time those concerns were taken seriously was when their barrister wrote to the prison authorities. In some instances that did appear to be the case.

Food

44. The Department indicated that the requests relating to a change of diet for Mr Lear were received from the medical staff and were acted upon by the prison kitchen. An email from the Health Care Manager on 17 December 2020 noted the adding of custard and white bread to the soft food diet. At that stage the approved diet included soft scrambled eggs, custard, soup, jelly, mashed potatoes, frittata, oats, Jatz, baked beans, juice poppers and oranges.

45. The family maintained that the food actually provided, such as hard boiled eggs, was inconsistent with the approved diet.

Restraints (cuffs and shackles)

46. On 11 October 2020 the family asked for the removal of the restraints due to the progression of Mr Lear's deterioration and noted that he was not a threat of escape. It was said that the lack of movement had increased his bed sores.

47. On 7 December 2020 the issue of shackles and handcuffs during transport was raised by the Primary Health Manager with the Deputy Superintendent. She noted in part:

> "We have previously raised concerns regarding suitability of the security protocols in relation to [Mr Lear's] current frail state of mobility and health … I have been advised that this client was transported in a van with no seatbelt and hand cuffed. This client is receiving chemotherapy and cancer treatments with makes him vulnerable to feeling nausea and sickness during transport … General risks currently are:
>
> - High risk of falls – due to shackles
> - Bruising and haematoma to wrist and ankle from shackle caused by ongoing abrasion and pressure area to sites
> - Nausea and vomiting – as a result of unrestrained transport
> - Restrictive practice involved with inability to move from bed/chair over extended period of time – pressure area sores
> - Prolonged standing – causing fatigue due to his current treatment".

48. The Deputy Superintendent responded the same day that the prison was bound by Ministerial directives relating to the escort of sex offenders that required shackles and cuffs to be used.

49. The following day the Primary Health Manager sought copies of the directives. Her concerns were elevated to the Acting Commissioner. He responded on 9 December 2020 that he expected the risk assessment to reflect the need for dignity as well as protection for the public. He went on to say:

> "I do not expect that individual to be shackled or unnecessarily cuffed".

50. A review was undertaken of the security arrangements for Mr Lear and on 17 December 2020 it was indicated that he should travel in a normal seat rather than in the cage of the transport vehicle. There was no indication as to hand cuffs and shackles, however on 29 December 2020 a direction was made that handcuffs and shackles were to be removed when he was in hospital.

51. I note that it took well over two months for this request from the family to be considered and resolved.

Visitation times

52. Despite his deteriorating condition, family were only able to see Mr Lear once a week whether that was at the prison or the hospital. The family was significantly concerned that their visit to Mr Lear arranged for 27 December 2020 was cancelled due to him being taken to RDH and their request to visit him at RDH was refused for no apparent reason by the Superintendent.

53. On 7 January 2021 the barrister for the family wrote to the prison authorities asking that family be permitted to see Mr Lear every day. That request was approved and from that time the family were able to visit each day and when at the hospital at any time within normal visiting hours.

Clothing

54. The standard issue clothing Mr Lear wore in the prison and while in hospital wasn't sufficient to keep him warm. He was frail and very thin. Increasing the blankets made the bedding too heavy. The family was told they would have to submit a form but said that despite a number of requests no form was provided. Again they asked their barrister to help. His daughter said that after he intervened they were permitted to provide warmer clothing.

His falls

55. He fell three times in February due to his frailty, on the 7th, 12th and 18th. The last of those was when being transferred with the help of the physiotherapist and was a major reason for his final transfer to RDH the following day. The other two were unwitnessed and at night during hours when the medical centre in which he was housed was not staffed by nurses. His family was most concerned particularly in relation to the first fall after which they believed he was left unattended on the floor for five hours.

56. That fall was the subject of an investigation by Corrections. There was CCTV within the cell that showed Mr Lear getting out of bed at 4.57am and going to the bathroom. There was a walker at the end of the bed that he did not use. It appears he fell to the floor while in the bathroom because at 5.00am he is seen manoeuvring himself on the floor from the bathroom toward his bed. At 5.16am Mr Lear is seen unsuccessfully attempting to drag himself up onto the bed. He was found on the floor by the dayshift medical staff at 7.06am. He said he had been unable to reach the intercom to call for help (a concern of the family was that the intercom was often not within reach).

57. According to the Operations Manual he should have been checked on at 3.00am and 5.00am by Correctional staff. Two days later the Deputy Superintendent instructed that Mr Lear was to be sighted every 30 minutes.

58. He fell again on 12 February 2021 at 1.10am. On that occasion he fell to the floor from a seated position on his bed. He called out and was heard by Correctional Officers at 1.16am.

59. The family were concerned that in the first fall he was injured and not enough was done to make him comfortable (primarily to provide him an air mattress so as to mitigate pain from his tailbone).

Dignity and Privacy

60. Mr Lear was transferred to the Hospice on 3 March 2021. The next day the family barrister wrote to the prison authorities requesting that the prison guards stand outside the room during the time his family were having end of life discussions with him, when he was having his nappy changed and asking whether his wife could stay overnight with him in the Hospice. The prison authorities replied 14 minutes later, agreeing to the requests and made arrangements for the guards to be placed in a more discrete area.

Administrative error

61. The family was of the belief that after Mr Lear's death the prison provided the incorrect information to Centrelink. In effect it was coded in the system that he had been released to the community. That was said to have added to the grief and impacted his wife's pension adversely.

Response to Concerns by Corrections

62. The Acting Commissioner appeared unsatisfied by the manner in which the concerns of the family had been treated. In November 2021, he finalised amendments to Directive 2.8.17 *Notification of Prisoners Critical Illness, Palliative Care or Serious Injury*. The Directive now requires that the General Manager "must be informed of restraints that are **not** removed from terminally ill or dying prisoners for any reason" and that consideration would be given to family to visit outside normal visiting hours to support the prisoner.[1]

63. The Directive requires that the General Manager must consult with Primary Health Care and ensure a *Final Pathway in Life Medical Care Plan* is completed within 24 hours. There is a requirement that the family be

[1] Paragraphs 7.4 and 7.5 of Directive 2.8.17 Notification of Prisoners Critical Illness, Palliative Care or Serious Injury

consulted and those consultations be documented in relation to a range of aspects including:

- Allocation of accommodation
- Dietary requirements
- Restraints
- Prisoner care
- Return to hospital plan
- Property permitted in possession
- Visits and telephone access
- Name of a Corrections Liaison person
- External hospital protocols
- Hospice arrangements

Comment

64. It was unfortunate that the Department of Corrections did not provide all of the information and documentation relating to the care supervision and treatment of Mr Lear when it was requested or on the two further times that the Acting Commissioner provided information for the inquest. I trust the Commissioner will ensure that there is no repeat of those failures in any future investigations.

65. However, the amendments made to Directive 2.8.17 (if appropriately implemented) appear to address the concerns of the family, particularly the powerlessness they felt at not being able to make their concerns heard and considered without resorting to a legal representative. On hearing the

family’s concerns, the Acting Commissioner has appropriately put in place a process to enable other families to be consulted at such difficult times.

66. I make no recommendations.

Formal Findings

67. Pursuant to section 34 of the Coroners Act, I find as follows:

(1) The identity of the deceased was Josef Lear, born on 12 February 1941 in Czechoslovakia.

(2) The time of death was 3.00pm on 7 March 2021. The place of death was The Hospice, Royal Darwin Hospital.

(3) The cause of death was metastatic oesophageal cancer.

(4) The particulars required to register the death:

1. The deceased was Josef Lear.
2. The deceased was not of Aboriginal descent.
3. The deceased was a prisoner.
4. The death was reported to the Coroner by Darwin Correctional Centre.
5. Doctor Alicia Chua confirmed the cause of death.

Dated this 25 day of January 2022.

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ELISABETH ARMITAGE
TERRITORY CORONER