Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 19/14

I, Sarah Helen Linton, Coroner, having investigated the death of ***Delray BEASLEY*** *with an inquest held at the* ***Kalgoorlie Courthouse*** *on* ***22 May 2014*** *and at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth****, on* ***26 May 2014*** *find that the identity of the deceased person was* ***Delray BEASLEY*** *and that death occurred between* ***14 June 2010 and 10 July 2010*** *in* ***bushland, approximately 2.7 kilometres north of Western Road, Kalgoorlie****, the cause of death being* ***unascertainable*** *in the following circumstances:*

Counsel Appearing:

Ms C Fitzgerald assisting the Coroner.
Mr S Razi (Aboriginal Legal Service WA (Inc)) appearing on behalf of the family.
Ms B Burke (ANF) appearing on behalf of Nurse Geraldine Nayda.
Mr D Anderson (SSO) appearing on behalf of the WA Country Health Service.

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INTRODUCTION

1. Delray Beasley (the deceased) was found deceased in bushland near Kalgoorlie on 10 July 2010. He was last seen alive at the Kalgoorlie Regional Hospital on 14 June 2010 when he left the hospital of his own accord prior to being formally discharged. The deceased's whereabouts in the period from the time he left the hospital to the time he arrived at the place where he died are unknown.

2. I held an inquest at the Kalgoorlie Courthouse on 22 May 2014 and the Perth Coroner's Court on 26 May 2014.

3. The inquest focused primarily on the circumstances in which the deceased left the hospital and what efforts were made to locate him after he was reported missing, as well as the medical evidence that might serve to narrow the time span during which his death occurred.

4. The documentary evidence included a detailed report of the death prepared by the Western Australia Police comprising two volumes, annexing a large number of witness statements and medical reports.[1]

5. Oral testimony was given by:

   a) some of the medical staff involved in the deceased's care at Kalgoorlie Hospital,
   b) Dr Prempeh from the Bega Garnbirringu Health Service who treated the deceased towards the end of his hospital stay,
   c) a friend of the deceased who saw him in Kalgoorlie,
   d) some police officers who were stationed in Kalgoorlie at the time the deceased went missing,
   e) police officers who were involved in the investigation into the death of the deceased,
   f) Dr Moss, a forensic pathologist who conducted the post mortem, and

[1] Exhibits 1 and 2.

g) Dr Joyce, a medical professor who interpreted the drug concentrations in the deceased's post mortem blood.

Some additional information was also provided after the inquest by Mr Elvis Stokes, a Wongi man and Court Officer employed by the Aboriginal Legal Service in Kalgoorlie, in relation to the area where the deceased was found and how often it is frequented by members of the local community.[2]

THE DECEASED

6. The deceased was an Aboriginal man born in Kalgoorlie on 14 August 1953. He was the third youngest of eleven children. At the age of three months he was sent with some of his siblings to live at the Norseman children's mission.[3]

7. The deceased lived the majority of his life in the Goldfields region. For some time before his death the deceased had been living alone in a pensioner's unit on Otterburn Street, Leonora. He was well known in the local community.[4]

8. The deceased was a long-term alcoholic and his health suffered as a result.[5] He had been diagnosed with alcoholic liver disease and was hospitalised in Kalgoorlie on three separate occasions in 2009 to treat his liver disease.[6] Nevertheless, it seems he continued to drink alcohol to excess on a regular basis.

ADMISSION TO KALGOORLIE HOSPITAL

9. In late May 2010 the deceased was allegedly assaulted in his home in Leonora by another male. He was said to

[2] Email of Mr Elvis Stokes via Mr Razi, ALS, 6.6.14.
[3] Exhibit 2, Tab 10 [3].
[4] Exhibit 2, Tab 3, (1), Tab 28 (1).
[5] Exhibit 1, Tab 8 [5].
[6] Exhibit 1, Tab 1 (1); Exhibit 2, Tab 26.

have been struck with fists and a metal broom handle, causing a lacerated forehead and facial bruising. A man was charged with unlawful wounding in relation to the incident, although the charge was later discontinued following the death of the deceased.[7]

10. The deceased did not immediately seek medical attention for his injuries but was later taken to Leonora District Hospital. The deceased was admitted to Leonora Hospital at 8.20am on 28 May 2010 and treated for injuries to his head and face. At the time of his initial assessment, the treating doctor noted the deceased was a known alcoholic and smelled of alcohol. His facial laceration was sutured and he was kept overnight for neurological observation.[8]

11. The following day the deceased developed a fever and was treated with intravenous antibiotics. He declined food and drink and, although oriented to place and time, was forgetful and drowsy.[9] He was subsequently transferred by the Royal Flying Doctors Service to Kalgoorlie Hospital on 31 May 2010 as his condition was not improving and it was thought necessary to check for possible facial and/or mandibular fractures.[10]

12. The deceased was assessed in the Emergency Department of Kalgoorlie Hospital and was noted to be oriented to time and place but was drowsy and appeared to have a depressed nasal fracture. He was referred for a CT scan and admitted to the ward for observation in the early hours of 1 June 2010.[11]

13. A nursing assessment noted a history of cirrhosis of the liver and portal hypertension/varices, both indicative of liver damage due to chronic alcohol abuse.[12]

[7] Exhibit 2, Tab 3 (2), Tab 16, Tab 17, Tab 20.
[8] Exhibit 1, Tab 3 (2); Exhibit 2, Tab 26, letter 31.5.2010 Dr Du Plessis, Tab 27.
[9] Exhibit 2, Tab 26, letter 31.5.2010 Dr Du Plessis, Tab 27.
[10] Exhibit 2, Tab 28 (1).
[11] Exhibit 2, Tab 26, 28 (2).
[12] Exhibit 2, Tab 28 (2).

14. The CT report showed signs of involutional changes to the brain and a severely depressed nasal fracture. There were no signs of any skull fracture or other fractures and no sign of intracranial haemorrhage. Blood tests showed signs of chronic severe liver disease, anaemia, macrocytosis and a low platelet count.[13]

15. The deceased was noted to be going through alcohol withdrawal and his detoxification was being managed by diazepam.[14]

16. During his inpatient stay the deceased was not always cooperative with medical staff and compliant with hospital rules. On more than one occasion he was found smoking in bed or in the toilet. He also left the ward for extended periods of time.[15]

17. On 2 June 2010 the deceased left the ward of his own accord and was located by security guards two blocks away from the hospital, apparently heading to his brother's house.[16] Several hours later he disappeared again and the nursing staff completed a discharge summary. However, later that day he was found asleep in his bed on the ward, having apparently returned of his own volition.[17]

18. On 4 June 2010 the deceased was noted to appear increasingly confused. At this time plans were being put in place to transfer the deceased to Royal Perth Hospital. Another brain CT scan was performed.[18] No interval changes were observed and no evidence of haemorrhage or infarction was present.[19] On the basis of the scan results, the Neurosurgical Registrar at Royal Perth Hospital indicated the deceased was not likely to benefit from neurosurgical review.[20] Accordingly, the plans for his transfer were put on hold.

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[13] Exhibit 2, Tab 26, Tab 28.
[14] Exhibit 2, Tab 26, Integrated Progress Notes & Alcohol Withdrawal Scale.
[15] Exhibit 2, Tab 26, Integrated Progress Notes, Tab 28.
[16] Exhibit 2, Tab 26, Integrated Progress notes.
[17] Exhibit 2, Tab 26, Nursing Discharge Summary 2.6.20101, Integrated Progress Notes.
[18] Exhibit 2, Tab 26, Integrated Progress notes.
[19] Exhibit 2, Tab 28.
[20] Exhibit 2, Tab 26, Integrated Progress notes.

19. On 8 June 2010 Dr Prempeh, who works for the Bega Garnbirringu Health Service (BGHS), was rostered for the week to see Aboriginal patients admitted at the hospital.[21] He first saw the deceased on that date. He noted that the deceased was alert and oriented to time and place but he appeared drowsy and slow to react. His Glasgow Coma Scale assessment was 14 out of 15. Dr Prempeh ordered a repeat head CT scan and x-ray of the neck to rule out a slow intracranial bleed.[22]

20. The further CT scan and x-rays of the cervical spine were conducted on 8 June 2010 and no acute intracranial injury was found.[23]

21. Dr Prempeh saw the deceased again on 9 June 2010 at the request of nursing staff as they had detected deterioration in his neurological status.[24] Dr Prempeh again gave him a GCS of 14 but queried a slight right facial weakness. As a result, Dr Prempeh made a consultation request to a neurologist.[25] He was assessed by a neurologist, Dr Clark, that afternoon, who suggested some further areas of investigation.[26]

22. Dr Clark reviewed the deceased again the following day who concluded that the deceased showed some possible signs of a head injury and suggested that the deceased's family be contacted to obtain more details about his past conditions.[27]

23. Dr Prempeh examined the deceased again on 11 June 2010 and he also indicated that the deceased's family should be contacted for discussion about his condition. When he saw the deceased again later that evening, Dr Prempeh noted that by that stage the deceased was capable of dressing himself, although unsteady on his feet.[28]

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[21] ts 16 (Dr Prempeh).
[22] ts 16-17 (Dr Prempeh).
[23] Exhibit 2, Tab 26, Tab 28.
[24] Exhibit 3, Tab 26, Integrated Progress notes.
[25] ts 18 (Dr Prempeh).
[26] Exhibit 2, Tab 26, Integrated Progress notes.
[27] Exhibit 2, Tab 26, Integrated Progress notes.
[28] ts 18-19 (Dr Prempeh); Exhibit 2, Tab 26, Integrated progress notes.

24. Just before midday on 12 June 2010 the deceased was again reviewed by Dr Prempeh and he was noted to be more alert and responding to questions.[29]

25. At 2.20pm that day the deceased was observed crossing the railway bridge near the hospital. The Hospital Coordinator and doctor were informed and police were notified. The deceased returned to the hospital of his own accord at 6.15pm and was returned to the ward. It was noted that he did not smell of alcohol and was able to walk to his bed and obey requests.[30] All the nursing observations at that time were normal.[31]

26. The deceased had also apparently left the hospital on another day around this time, possibly the day before. Enrolled Nurse Geraldine Nayda (now a Registered Nurse)[32] found him in the foyer of the ward and he admitted he had been out to visit his nephew at his nephew's house and they had shared a few beers before he had voluntarily returned to the hospital. He was showered and returned to bed. This incident was not recorded in the progress notes.[33] He was also apparently known by the nursing staff to leave and go to town to attend to personal matters around this time.[34]

27. The deceased was seen again by Dr Prempeh on 13 June 2010. Dr Prempeh thought the deceased's general condition was improving slightly but wanted the results of all tests followed up due to his slow recovery. He wanted to make sure that there was no other medical condition contributing to that slow recovery. In the evening the deceased was found sleeping in the wrong room and Dr Prempeh thought they should continue his neural observations.[35]

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[29] ts 19 (Dr Prempeh).
[30] Exhibit 2, Tab 26, Integrated Progress notes.
[31] Exhibit 2, Tab 28 (3).
[32] ts 36 (Nayda, G).
[33] ts 37, 46 - 47 (Nayda, G).
[34] ts 43 (Nayda, G).
[35] ts 19 - 20 (Dr Prempeh).

28. On 14 June 2010 Dr Prempeh noted that the deceased was looking much better and was on the mend.[36] He considered that he had improved enough to start arranging for him to go back to the community.[37] As Dr Prempeh explained, the discharge of an Aboriginal patient not from Kalgoorlie takes a while to arrange. In his opinion, the deceased was medically ready to be discharged from hospital but he knew it was going to take some time to arrange with the family.[38] A referral for a social work assessment was made to arrange the discharge with the family.[39]

29. A review of the deceased's medical records was later conducted by Dr Hammond, the Acting Medical Director of the hospital.[40] From her examination of the records, in particular the CT scans, Dr Hammond was "highly confident" that the deceased did not have a significant head injury during that admission.[41] Dr Prempeh agreed with that conclusion.[42] He accepted that many of the deceased's symptoms of head injury, such as confusion and staggering gait, could equally be attributed to alcohol withdrawal and liver disease.[43]

DEPARTURE FROM KALGOORLIE HOSPITAL

30. As noted above, the deceased had left the hospital and returned more than once during this hospital admission, and had also been found asleep in a bed other than his own.

31. On 14 June 2010, Nurse Nayda, who was working the late shift that day, recalls seeing the deceased four or five times during her shift. He was in his bed on these occasions. The neurological observations of the deceased taken during this time showed he was

[36] ts 20 (Dr Prempeh).
[37] ts 20 (Dr Prempeh).
[38] ts 20 - 21 (Dr Prempeh).
[39] ts 20 (Dr Prempeh).
[40] Exhibit 2, Tab 28, 18 July 2010.
[41] Exhibit 2, Tab 28, 18 July 2010.
[42] ts 26 (Dr Prempeh).
[43] ts 26 (Dr Prempeh).

responsive to stimuli and he was seen to tolerate his evening meal.

32. However, at 7.10pm he was found to be missing from his bed and he had taken the bed linen with him.[44] Nurse Nayda was concerned as it was a particularly cold night and the last time she had seen him he was wearing hospital issue pyjamas[45] and the linen that he had taken would not have kept him warm if he slept in the open.[46]

33. Nurse Nayda questioned the other patients in the room, who said that the deceased was annoyed by the noises coming from some female patients in another room and had left.[47]

34. Another nurse later told police that the deceased had told nurses he was going to 'party', implying he was going drinking, but she acknowledged in a statement that this was hearsay and she could not recall where that information came from.[48]

35. A patient absconding from the hospital was not an uncommon occurrence so Nurse Nayda was familiar with the procedure to follow.[49] She searched the ward and alerted the shift coordinator, then the After Hours Nurse Manager (AHNM also known as the Hospital Coordinator), hospital security[50] and the doctor.[51] She also asked other nurses to keep an eye out for the deceased.[52]

36. Nurse Nayda made an entry in the Integrated Progress Notes at 8.45pm about the events of the evening.[53]

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[44] ts 38 (Nayda, G); Exhibit 2, Tab 4 [9].
[45] Exhibit 2, Tab 4 [17].
[46] t s 40 (Nayda, G).
[47] Ts 43 (Nayda, G); Exhibit 2, Tab 4 [12],
[48] RN Karen Roan, Vol 2, Tab 34 [23].
[49] ts 40 (Nayda, G).
[50] Exhibit 2, Tab 4 [13].
[51] Although in this case Nurse Nayda believes the shift coordinator contacted Dr Prempeh – ts 40.
[52] ts 38 - 39 (Nayda, G).
[53] Exhibit 2, Tab 26, Integrated Progress notes.

37. The Hospital Coordinator that evening, Registered Nurse Sandra Jackson, contacted the deceased's next of kin, leaving a telephone message, and made a note in his hospital file.[54]

38. Although there was no formal hospital procedure for absconding patients at that time,[55] it was not usual hospital procedure to notify the police about a voluntary patient self-discharging.[56] However, in this case Nurse Jackson did notify police as he had taken the hospital bed linen and she thought this required some explanation in case he was observed by police officers in the street.[57]

39. Accordingly, Nurse Jackson telephoned Kalgoorlie Police Station to inform them that the deceased had left the hospital with his bed linen, which was hospital property, and if seen, the hospital staff would appreciate him being returned to the hospital so they could review his care and possibly formally discharge him.[58] She did not know at that time that the deceased still had an IV cannula in his arm, or she would have told the police of this fact.[59]

40. The deceased was not seen again at Kalgoorlie Hospital and a doctor completed a formal discharge summary sheet the following day.[60] The hospital discharge form noted that the deceased had absconded from hospital.[61]

41. Dr Prempeh was not the doctor who signed the formal discharge summary. At the time of the inquest he could not recall whether he was informed that the deceased had absconded from the hospital.[62]

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[54] Exhibit 2, Tab 5, Statement 1 [10] – [12].
[55] Exhibit 2, Tab 5, Statement 2 [36].
[56] Exhibit 2, Tab 5, Statement 2 [53] – [54].
[57] Exhibit 2, Tab 5, Statement 1 [13] – [14], Statement 2 [45] – [46].
[58] Exhibit 2, Tab 5, Statement 1 [15] – [16], Statement 2 [47] – [49] S.
[59] Exhibit 2, Tab 5, Statement 2 [55].
[60] Exhibit 2, Tab 26, Integrated Progress notes; Tab 28.
[61] Exhibit 2, Tab 26.
[62] ts 21 (Dr Prempeh).

42. However, Dr Prempeh noted it is not uncommon for patients of the BGHS to abscond.[63] In Dr Prempeh's experience, they often dislike their freedom being confined, and the hospital staff has no power to compel them to stay unless they fit particular psychiatric criteria.[64]

43. Given Dr Prempeh had not been asked to give a statement in 2010 and had to rely on his memory of events, and it was not uncommon for patients to abscond, it is not surprising that he cannot recall whether he was called in this particular case.[65] Dr Prempeh accepted that it was the usual practise of staff at the hospital to call him if a patient did leave in such circumstances,[66] and did not maintain that it did not occur in this instance.

44. In Dr Prempeh's opinion, it would have been ideal to keep the deceased in hospital for observation for a few more days, and failing that, it would have been preferable if the deceased had left into the care of a responsible carer to watch out for any signs of deterioration in his condition. However, in terms of his physical condition, he did not have any concerns about the deceased being able to make his way in the community on his own at that time.[67] This was so, even though the deceased still had an IV cannula in his arm when he left the hospital. Although problems might have arisen from the cannula, Dr Prempeh's evidence was that those problems would not be life-threatening.[68]

45. Interestingly, it was apparently not that unusual for self-discharging patients in Kalgoorlie to leave with cannulas still in place, as one of the local police officers at the time gave evidence that it wasn't uncommon to find patients with drips still in their hands when on patrol.[69]

[63] ts 21 (Dr Prempeh).
[64] ts 28 (Dr Prempeh).
[65]ts 21 (Dr Prempeh).
[66] Ts 21 – 22, 25 (Dr Prempeh).
[67] ts 22 (Dr Prempeh).
[68] ts 27 (Dr Prempeh).
[69] ts 61 (Daly, L.E.).

EFFORTS TO LOCATE THE DECEASED

46. Constable Leah Daly was rostered on duty at the Kalgoorlie Police Station on the evening of 14 June 2010. She took the call from Nurse Jackson reporting that the deceased had left the hospital prior to being discharged. Consistent with the statement of Nurse Jackson, Constable Daly recalls that Nurse Jackson was less concerned about the deceased's welfare and more concerned about notifying the police that the deceased had taken the hospital bed linen. Nurse Jackson asked if the police could keep an eye out for the deceased and bring him back to the hospital if they saw him.[70]

47. It would appear that, given the hospital staff was not indicating that the deceased was physically or mentally unwell, Constable Daly was not required to accept the report that evening.[71] However, she did so as she thought the hospital wanted the bed linen back and they had asked the police to look out for him.[72]

48. Constable Daly placed a 'look out to be kept for' (LOTBKF) the deceased on the police dispatching system, which recorded it as a CAD job. She gave the job a low priority rating given the hospital had not identified a welfare concern.[73] Constable Daly also believes she broadcasted the details over the police radio communication for the information of patrolling vans.[74]

49. Former police officers Charles Leonard Smith and Damian Parkin gave evidence that they were working nightshift on the evening of 14 – 15 June 2010 on van patrol. Neither man had an independent recollection of that night, so they could not recall if they saw a LOTBKF CAD job relating to the deceased.[75] However,

[70] ts 57 – 58 (Daley, L.E.); Exhibit 2, Tab 14 [2] – [14].
[71] ts 59 – 60 (Daley, L.E.); Exhibit 1, Tab 17.
[72] ts 59 – 60 (Daley, L.E.).
[73] Exhibit 2, Tab 14 [15] – [21].
[74] ts 58, 62 - 63 (Daley, L.E.); Exhibit 2, Tab 14 [22].
[75] ts 31 (Smith Leonard, C), 34 – 35 (Parkin, D B).

both confirmed that if they had seen a man in hospital pyjamas carrying linen, tasking permitting they would have stopped to speak to the man and establish if there were any welfare concerns.[76] Inspector Wilde from the Goldfields-Esperance Police District agreed that he would definitely expect any police officer to stop in those circumstances.[77]

50. Some doubt was raised in a later internal investigation as to whether Constable Daly did, in fact, radio broadcast the information about the deceased that night after she entered the CAD job into the system.[78] In the end, it is undeterminable whether a radio broadcast was, in fact, made that night as a result of the effect of the lapse of time on the memory of the witnesses. However, I find it is of little significance whether the radio broadcast was made that night given:

    a) the CAD job was entered and available in the patrolling vans; and
    b) I accept that the police officers on patrol that night would in any event have stopped if they were confronted with a person matching the description of the deceased that night.

51. The CAD task was closed by a police sergeant in the Midland Police Operation Centre at 4.48am on 16 June 2010. This was apparently in contravention of police procedure, which required liaison with the local police station before the task was closed.[79] However, given 32 hours had elapsed by that time and the deceased had not been seen by patrolling police in the area, it seems unlikely that the closure of the job would have impacted upon the locating of the deceased by police after this time.

52. As it stands, there is little evidence as to where the deceased went after he left the hospital that night. After

[76] ts 32 (Smith Leonard, C), 34 - 35 (Parkin, D B).
[77] ts 14 (Wilde, R.).
[78] ts 65 – 66 (Begg, R.); Exhibit 1 – Report of Inspector Stingemore Aug 11, p.6.
[79] ts 66 – 67 (Begg, R); Exhibit 1 - Report of Inspector Stingemore Aug 11, p.6 and Tab 8.

the deceased's body was found, police officers made inquiries with all family members that could be located and door knocks were conducted within the town site of Kalgoorlie. Only a few people reported any contact with the deceased in that period, and statements were taken from those people.[80] As will be discussed further below, the information those witnesses provided does not greatly assist in determining the whereabouts of the deceased in the period after he left the hospital on 14 June 2010.

FINDING THE DECEASED

53. On 10 July 2010 Aaron Smithson, a Kalgoorlie resident, decided to go and collect some firewood. He drove to a location at the end of Western Road, where the road turns into gravel, and then travelled along the gravel road alongside the gas pipeline. While driving alongside the gas pipeline Mr Smithson saw something on the side of the road that caught his attention. He turned his vehicle around and drove back to check what it was.[81]

54. As his vehicle got closer Mr Smithson realised it was the body of a person. He called out from his vehicle to the person but received no response. It appeared to Mr Smithson that the person was deceased so he contacted the police.[82]

55. Mr Smithson then drove out to the end of the bitumen road and waited to meet the police and escort them to the location of the person.[83]

56. Constables Jay Leeder and Graham Blake were on duty on the afternoon of 10 July 2010. They were tasked to attend to meet Mr Smithson. They met Mr Smithson on Western Road, Kalgoorlie and drove approximately

[80] ts 13 – 14 (Wilde, R).
[81] Exhibit 2, Tab 12 [2] – [12].
[82] Exhibit 2, Tab 12 [13] – [22].
[83] Exhibit 2, Tab 12 [26] – [27].

2.7 kilometres to the location where Mr Smithson had seen the person.[84]

57. Constable Leeder inspected the scene and noted the person appeared to be a deceased aboriginal male lying on his left hand side with one arm up resting near the face and the other arm stretched out almost straight. It appeared like the natural position of someone sleeping.[85] There were no signs of a struggle and no cuts or bruises on the body, although there were signs of advanced decomposition.[86] Some personal items, including a pair of thongs and a comb, were on the ground nearby, which were seized.

58. Constable Leeder observed medical tags on the left wrist in the name of the deceased, as well as other signs that he had received medical treatment, including an instrument in his bicep.[87] He and his partner made enquiries with the hospital and were advised that the deceased had self-discharged on 14 June 2010.[88]

59. Photographs were taken at the scene and the deceased was transported to the mortuary, where Leeder conducted a further examination of the deceased to confirm that there were no signs of violence.[89]

CAUSE OF DEATH

60. On 14 July 2010 a post mortem examination of the deceased was conducted by Dr McCreath, a forensic pathologist, and Dr Moss, who was then a forensic pathology registrar and is now a forensic pathologist.[90]

61. During the initial examination they observed decomposition changes, which were more advanced to the face and head, although also present in the rest of

[84] Exhibit 2, Tab 13 (Leeder) [2] – [6].
[85] Exhibit 2, Tab 13 (Blake)
[86] Exhibit 2, Tab 13 (Leeder) [11] – [14], [17] – [18].
[87] Exhibit 2, Tab 13 (Leeder) [15].
[88] Exhibit 2, Tab 13 (Leeder) [31] – [33].
[89] Exhibit 2, Tab 13 (Leeder) [24] – [30].
[90] Exhibit 1, Tab 1, Amended Confidential Report to the Coroner; ts 68 (Moss, D. (Dr)).

the body. There was evidence of medical intervention, with an intravascular cannula still present in the crook of the elbow along with several medical dressings. There was no evidence of significant injury, including no signs of a significant head injury.[91]

62. Dr McCreath and Dr Moss observed signs of cirrhosis in the liver but no other naked eye evidence of significant natural disease.[92] Further investigations, including histology and toxicology, were performed. Microscopic examination showed extensive post mortem changes but no apparent abnormality in the heart, lung or kidneys that would have a bearing on the causes of death. There was evidence of established cirrhosis but no evidence of any other natural disease that would definitely account for death.[93]

63. According to Dr McCreath and Dr Moss, people with established liver cirrhosis are at an increased risk of sudden death. However, this is usually due to the effects of liver failure, gastrointestinal haemorrhage or inter-current infection. No evidence of any of these conditions was found in this case, which would have been expected to be visible when the deceased was still in hospital.[94]

64. Cirrhosis of the liver may also cause biochemical abnormalities, especially in alcoholics.[95] However, due to decomposition, testing could not be conducted for such abnormalities. Therefore, this does remain a possible explanation for death.[96]

65. Toxicology analysis showed therapeutic levels of diazepam and its metabolite desmethyldiazepam. There was no evidence of drugs of abuse. Alcohol was present at a very low level in the blood and urine, although it was noted that these might be explained by post

[91] ts 74 (Moss, D. (Dr)).
[92] Exhibit 1, Tab 1, Amended Confidential Report to the Coroner and Letter to the Coroner dated 2.9.2010.
[93] Exhibit 1, Tab 1, Letter to the Coroner dated 2.9.2010.
[94] ts 71 (Moss, D. (Dr)); Exhibit 1, Tab 1, Letter to the Coroner dated 2.9.2010, p 2.
[95] The evidence indicates that the deceased was an alcoholic.
[96] Exhibit 1, Tab 1, Letter to the Coroner dated 2.9.2010, p 2.

mortem decomposition.[97] There was no suggestion any of the toxicological results informed a cause of death.[98]

66. One other possible cause of death, raised more by the circumstances in which the deceased's body was found rather than from the results of the post mortem examination, is as a result of hypothermia or "exposure". Given that the deceased was found outdoors at a cold time of year,[99] Dr Moss concluded it was certainly a possibility. No definite findings were found to support this (for example, "Wischnewsky spots" in the stomach), but their absence does not preclude the possibility as they are not present in every case.[100]

67. I accept the evidence of Dr Moss that all avenues of investigation have been exhausted in relation to ascertaining a cause of death in this matter and that in the opinion of the forensic pathologists, the cause of death is unascertainable.[101]

68. I find that the cause of death is unascertainable, although I note there is no evidence to suggest that the death arose other than by way of natural causes or exposure.

TIME OF DEATH

69. As mentioned above, the last time the deceased was seen alive was at the hospital on 14 June 2010, sometime before he left at around 7.00pm. When his body was found on 10 July 2010, it was apparent that he had not had died that day. However, how closely his death followed his departure from the hospital on 14 June 2010 is unclear.

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[97] ts 73 (Moss, D. (Dr)); Exhibit 1, Tab 1, Letter to the Coroner dated 2.9.2010, p.1; ts 81 (Joyce, D. (Dr)).
[98] ts 73 (Moss, D. (Dr)).
[99] The range of minimum temperatures for Kalgoorlie at that time of year range from 0.16 degrees up to 13.2 degrees – Exhibit 2, Tab 25.
[100] ts 72, 76 - 77 (Moss, D. (Dr)); Exhibit 1, Tab 1, Letter to the Coroner dated 2.9.2010, p.2.
[101] ts 68 – 69 (Moss, D. (Dr)); Exhibit 1, Tab 1, Letter to the Coroner dated 2.9.2010, p.2.

Witness Sightings

70. When he was found, the deceased was no longer wearing his hospital pyjamas.[102] Accordingly, it is apparent that he had an opportunity after leaving the hospital to obtain new clothing and get changed into them before he went to the bushland location.

71. The police made enquiries within the community to determine if anyone could be identified who had had contact with the deceased after he left the hospital that day.[103]

72. No family members reported contact with the deceased and no hostels or short stay accommodation providers in the Kalgoorlie/Boulder region had any record of the deceased staying at their premises during this period.[104]

73. A door knock of local businesses identified Ms Suzanne Webb, an employee of a second hand clothing business in Kalgoorlie called RagCo, who believed that she recognised the deceased as a customer when shown a photograph of him by police officers on 21 July 2010.[105] She recalled that he had been a customer at the store in early July in company with a female Aboriginal Support worker from the hospital known as Marilyn. At that time, he was apparently wearing hospital pyjamas.[106]

74. The only female Aboriginal support worker working at the hospital at that time was Marilyn McKenzie.[107] Ms McKenzie knew the deceased well[108] and had dealings with him during his last hospital admission,[109] including on the last day of his hospital admission.[110] Ms McKenzie provided a statement to police indicating that she had been informed by the hospital of his self-

[102] Exhibit 3, photo 3.
[103] Exhibit 2, Tab 3, p. 5.
[104] Exhibit 2, Tab 3, p. 8.
[105] Exhibit 2, Tab 3, p. 8.
[106] Exhibit 2, Tab 3, p. 5 – 6; Tab 11 [3] – [10].
[107] Exhibit 2, Tab 3, p. 6.
[108] Exhibit 2, Tab 6 [2] – [3].
[109] Exhibit 2, Tab 6 [4] – [8].
[110] Exhibit 2, Tab 26, Integrated Progress notes – entry 14.6.2010.

discharge about a week after the deceased went missing. She did not see the deceased after he left the hospital and she denied taking him to RagCo. She had, however, taken other patients there and believes Ms Webb may have confused the deceased with another patient.[111] As there is no reason to doubt Ms McKenzie's credibility or reliability on this point, I accept her evidence and find that Ms Webb (who did not actually know the deceased) was mistaken as to the identity of the person who accompanied Ms McKenzie to the store.

75. Another person who thought he saw the deceased during this period was an indigenous man named Kenneth Smith. Mr Smith knew the deceased and believed he saw him around early July 2010 drinking with some other people in a Coles carpark in Kalgoorlie. He recalled the deceased looked in good health and was wearing a light coloured long sleeve top and black jeans.[112] He could not provide any further details about the meeting.

76. The only other person police identified who said he saw the deceased in the time period after he left the hospital and before his death was a local man by the name of Lewis Wallam. Mr Wallam had known the deceased since 1972[113] and would usually catch up with him a couple of times a year, although he hadn't caught up with him in the year before his death.[114]

77. Mr Wallam was initially very specific about the date he saw the deceased. In his first statement, provided to police in July 2010, Mr Wallam stated that he saw the deceased at about 2.30pm on Thursday, 1 July 2010 when he was driving along Maritana Street in Kalgoorlie.[115] He was equally certain of that date when he gave a signed a statement in March 2011.[116] At the

[111] Exhibit 2, Tab 6 [9] – [12].
[112] Exhibit 2, Tab 3, p.6; Tab 9 [2] – [5].
[113] ts 49 (Wallam, L.J.).
[114] Exhibit 2, Tab 8 Statement 20.7.10 [2] – [4].
[115] Exhibit 2, Tab 8 Statement 20.7.10 [7].
[116] Exhibit 2, Tab 7, Statement 17.3.11 [3] – [5].

time he gave those statements he recalled the deceased was wearing dark coloured trousers and a light blue or grey shirt (which is not dissimilar to the description of the clothing given by Mr Smith) and carrying a dark coloured blanket.[117] He also observed that the deceased looked very unwell.[118]

78. However, in about April 2014 Mr Wallam again spoke to one of the investigating police officers in this matter and provided a statement[119] indicating that after being told some information by Inspector Wilde, he was still certain that he had seen the deceased in the manner described in his earlier statements but accepted it could have been several days or a week earlier than 1 July 2010.[120] He apparently also thought that the deceased had been wearing blue pyjama type pants at the time.[121]

79. Mr Wallam was called as a witness at the inquest in Kalgoorlie. He remained firm that he had seen the deceased but was less certain that the date he saw him was 1 July 2010.[122] Instead, he accepted that the date might have been earlier, possibly by a week or two, namely in mid to late June 2010.[123]

80. At the inquest he also indicated that he recalled the deceased was wearing natural green pyjamas at the time he saw him and a brown blanket (not matching the grey blanket found near his body on 10 July 2010).[124]

81. I accept the evidence of both Mr Wallam and Mr Smith that they saw the deceased in Kalgoorlie sometime after he left the hospital and before he was found deceased on 10 July 2010. It seems most likely that he was wearing the same clothing when he was seen by both men, namely a light coloured top and dark coloured

[117] Exhibit 2, Tab 7 Statement 17.3.11 [13] - [14]; Exhibit 2, Tab 8 Statement 20.7.2010 [10].
[118] Exhibit 2, Tab 7 Statement 17.3.11 [34] - [36]; Exhibit 2, Tab 8 Statement 20.7.2010 [11], [15].
[119] Unsigned copy in the brief – Exhibit 2, Tab 8A.
[120] Exhibit 2, Tab 8A [5] (unsigned and undated).
[121] Exhibit 2, Tab 8A [6] (unsigned and undated).
[122] ts 49, 51 (Wallam, L.J.).
[123] ts 51 (Wallam, L.J.).
[124] ts 52 (Wallam, L.J.).

jeans (assuming Mr Wallam's earlier recollections are the most reliable). I note that this clothing description does not match the clothing that the deceased was found wearing when he was located on 10 July 2010.[125]

82. As to when they saw the deceased, I note that neither man is definite as to the exact date they saw him. Both men appear to believe it was on or about 1 July 2010, although Mr Wallam later conceded at the inquest it could have been up to a week, or more, earlier.

Financial Records

83. The police obtained the deceased's banking records from Westpac Bank, which revealed that he had a number of accounts, all of which were in credit at the time of his death. Two ATM transactions were recorded, one on 1 June 2010 and one on 7 June 2010, both in Kalgoorlie. No later transactions were recorded.[126]

84. The entry of Marilyn McKenzie in the deceased's Integrated Progress notes on 14 June 2010 indicates that the deceased had reported that he had lost his key card but Ms McKenzie observed that the card was attached to the medical file. Ms McKenzie also recorded that a relative of the deceased had come in the week prior and accessed the keycard (which is around the time of the two ATM transactions recorded) and accordingly the card had been cancelled and the bank would not issue a new one until the deceased was well enough to enter the bank and obtain a new one on his own.[127]

85. There is no evidence that the deceased took steps to obtain a new keycard after he left hospital and certainly there are no new financial transactions recorded, despite the fact the deceased had considerable amounts of funds available to him. The absence of any

[125] Exhibit 2, Tab 13 [11], [13]; Exhibit 3, photo 3 – grey coloured trousers and a dark blue and white coloured t-shirt, with a dark green coloured long sleeved jacket nearby.
[126] Exhibit 2, Tab 3, pp. 8 – 9.
[127] Exhibit 2, Tab 26, Integrated Progress notes, entry 14.6.2010, Marilyn M.

transactions after he left the hospital supports the conclusion that he died in a period closer to the time he left the hospital, as it seems unlikely that the deceased would have remained in the community for any substantial period of time without any obvious means of support, away from his home and not being supported by relatives.

Medical Evidence

86. Following the post mortem examination, Dr Moss was unable to form any opinion regarding the time of death, other than to indicate that the post-mortem findings, in particular the degree of decomposition, suggested death occurred earlier in the time period rather than in the last couple of days before he was found.[128] Dr Moss noted that at that time of year in Kalgoorlie, the temperatures would not be hot, which would slow down decomposition change.

87. The one striking aspect of the case he observed was that the deceased was found with an intravascular cannula still in his arm, with a relatively clean bandage covering it.[129] Dr Moss noted that the location of the cannula in the crook of the deceased's arm would be subject to a lot of movement and that this sort of cannula, not sutured in place in any way, would pull out easily. In his opinion, the fact that the cannula was still in place and the bandage was still in clean condition and in place, was supportive of death occurring closer in time to when the deceased left the hospital.[130]

88. Nurse Nayda also gave evidence that the cannula present in this case was not very secure and, in her experience, could fall out easily if not cared for properly. That type of cannula is often dislodged by people showering or during the removal of clothing. Consistent with the view of Dr Moss, in Nurse Nayda's opinion it would have been unlikely that the cannula would have

[128] ts 69 (Moss, D. (Dr)).
[129] See Exhibit 3, photos 4 and 7.
[130] ts 69 – 70 (Moss, D. (Dr)).

remained in place in the deceased's arm for very long once he was in the community.[131]

89. The only post mortem finding of Dr Moss that suggested that death had not occurred during the earlier part of the period after the deceased left hospital was the absence of signs of animal predation, which is often seen on bodies that have been outside for significant periods of time.[132] However, given the lack of information available as to the animal population in that area at that time of year, it is of limited assistance in establishing a likely time of death.[133]

90. To assist in narrowing the timeframe in which the deceased died, a report was obtained from a clinical pharmacologist and toxicologist, Doctor David Joyce, as to the information that could be interpreted from the post mortem blood toxicology results. In particular, Dr Joyce considered the interpretability of diazepam and nordiazepam levels in the deceased's blood.[134]

91. Considered in the context of the deceased's known liver disease and the effects of post mortem redistribution, Dr Joyce formed the opinion that the diazepam and nordiazepam levels found in the deceased's blood were consistent with the deceased last being administered diazepam at 6 pm on 5 June 2010 (as recorded in the medical records).[135]

92. On the levels observed, in Dr Joyce's opinion the deceased was more likely to have died within a few days of leaving the hospital, although he could not rule out the possibility that he was still alive on 1 July 2010 (when he was reported to have been seen by Mr Smith and Mr Wallam).[136] However, in Dr Joyce's expert opinion, every day's survival after 14 June 2010 was

[131] ts 41 (Nayda, G.)
[132] ts 77 (Moss, D. (Dr)).
[133] ts 77 (Moss, D. (Dr)).
[134] ts 78 (Joyce, D. (Dr)).
[135] ts 79 – 80 (Joyce, D. (Dr)).
[136] ts 80 (Joyce, D. (Dr)); Exhibit 1, Tab 3, Report dated 14.4.2011, p.7.

progressively less probable, and so survival to 1 July "would seem very improbable."[137]

93. Dr Joyce did pursue an alternative inquiry into the presence of another drug, Ceftriaxone, which would have indicated incontrovertibly that death occurred within a couple of days of the deceased leaving the hospital, if it had been present. However, the result came back with a negative finding, which does not assist with narrowing the time frame for when death occurred.[138]

94. It was put to Dr Joyce, and he agreed, that if the deceased had obtained Valium after his self-discharge from hospital then it would remain detectable for some time afterwards.[139] However, this is really speculative as there is no evidence that the deceased did so, whereas there is clear evidence that the deceased was administered diazepam while in hospital. In Dr Joyce's opinion, which I accept, the levels found in the deceased's post mortem blood are consistent with that being the last time he was administered the drug, assuming he died in a period of days, or at most a couple of weeks, after he left hospital.

Location Where Deceased Was Found

95. The deceased was found in an isolated bushland location, some distance from the hospital (approximately 10 kilometres from Kalgoorlie by road or 7 kilometres by foot).[140] If he had walked there, it would have taken some time, given his reported general poor health, although it is also possible that he was transported by car.

96. A search of the scene by police officers did not identify any suspicious items, or any indication that the

[137] ts 80 (Joyce, D. (Dr)).

[138] ts 80 – 81 (Joyce, D. (Dr)); Exhibit 1, Tab 3, Report dated 11.2.2014, p.2.
[139] ts 84 (Joyce, D. (Dr)).
[140] Exhibit 2, Tab 3, p. 9.

deceased had been camping in the area for any period of time before his death.[141]

97. The location where the deceased was found does not, therefore, assist in narrowing the timeframe for when death occurred.

Conclusion as to time of death

98. Considering all of the evidence in the paragraphs above, I am satisfied that the deceased did not die in the immediate hours after he left hospital, as he clearly had time to change into different clothing at least once, and possibly twice (given the descriptions of clothing given by Mr Smith and Mr Wallam), and had to make his way some distance from Kalgoorlie to the location where he was found.

99. Although I accept that Mr Smith and Mr Wallam saw the deceased in the circumstances they described, neither man purported to be an accurate historian as to date. When weighed against the objective medical evidence, I find that Mr Smith and Mr Wallam are simply mistaken as to the date when they saw the deceased, and it was in fact sometime closer to 14 June 2010.

100. Although I am unable to conclude a precise date when death occurred, I find that death most likely occurred within a period of days after he left the hospital. This is consistent with the evidence in relation to the cannula and bandage, the evidence of Dr Joyce in relation to the diazepam levels and the banking records.

MANNER OF DEATH

101. At the time the deceased was transferred from Leonora to Kalgoorlie Hospital the deceased was in poor health

[141] Exhibit 2, Tab 1, p. 2; Tab 3, p. 9.

and was showing concerning signs that he might be suffering from a head injury.

102. However, I am satisfied that by the time he left the hospital voluntarily on 14 June 2010, his health had improved considerably and the investigations and observations conducted by the medical staff had confirmed that he was not suffering from a significant head injury.

103. Although it would have been preferable for the deceased to be formally discharged from hospital into the care of a relative, as had been planned by Dr Prempeh, the hospital staff had no power to prevent the deceased leaving the hospital of his own volition at an earlier stage.[142]

104. After the deceased was found to have left the hospital, the nursing staff took appropriate steps to try to locate the deceased, including searching the hospital and reporting his absence to a family member and the local police. Given there were no identified welfare concerns regarding his health, it does not seem to me that anything more ought to have been done in this regard.

105. When the call was received by Constable Daly, it seems that on the information provided by Nurse Jackson, police procedure indicated Constable Daly should refuse to take the report and redirect Nurse Jackson to the next of kin. However, in the circumstances of the evening it seems to me that Constable Daly exercised good judgment in taking the report, as the report of the deceased taking the bedding suggested he proposed to sleep outside (as concluded by Nurse Nayda), which in the climatic conditions at that time would have been a risk to his health, particularly given he had still not been formally assessed for discharge.

106. Having taken the report, Constable Daly properly entered a CAD report. Whether or not she also made a

[142] Exhibit 2, Tab 5, Statement 1 [17], Statement 2 [32] – [35].

radio call cannot be determined, but it does not appear from the evidence available to me that it would have made any difference if she did not. The CAD report was available to view and any police officers who saw the deceased walking at night in his hospital pyjamas, carrying bedding and with a cannula in his arm would most likely have stopped (tasking permitting) if they had seen him, even if no report was made. The police would not have been able to compel him to return to hospital, but could at least have made some attempt to persuade him to return.

107. As it was, no one could be identified who saw the deceased that night. His whereabouts over the next few days are also unknown, although it is clear that he managed to obtain a change of clothes at some stage and a different blanket to the hospital bedding.[143]

108. The deceased was apparently associating with some people in the Kalgoorlie area over the period after he left hospital, as Mr Smith saw him with a group on one occasion, but the identities of those people are unknown. At the time Mr Wallam saw the deceased, he was alone and clearly unwell.

109. After this time the deceased made his way to the location where he was eventually found. It is unclear whether he walked there or was taken by some form of transport. As to why he went there, the evidence is again not entirely clear, although I accept the evidence of Mr Stokes that while the area appears isolated, it is in fact often frequented by local people for different purposes, including homeless people who camp there.[144] There were no signs on this occasion that the deceased had been camping there, but it may be that he had only just arrived there with this intention. In any event, it does appear that he decided to have a sleep there, as the position in which he was found clearly suggests that he had deliberately lain down and gone to

[143] ts 42 (Nayda, G).
[144] Email of Mr Elvis Stokes via Mr Razi, ALS, 6.6.14.

sleep. There is nothing suspicious about the circumstances in which he was found.

110. The cause of death is unascertainable. The forensic pathologists left open the possibility that the deceased died from complications arising from his liver disease as well as the possibility that he died as a result of exposure. That leaves open the possibility that he died either as a result of natural causes or by accident.

111. In those circumstances, I make an open finding as to how the death arose.

HOSPITAL MISSING PERSONS PROCEDURE

112. I am informed that since this event Kalgoorlie Regional Hospital has adopted a new formalised procedure for when a patient goes missing, which requires the completion of a notification form.[145] That is certainly a positive step as it provides clarity as to the circumstances of the patient, the level of risk if they are not returned to hospital and the people who have been notified of the event.

113. It was submitted to me by counsel appearing on behalf of the family, Mr Razi, that I should recommend that other hospitals adopt a similar procedure in relation to self-discharging patients, particularly if there is a suggestion the patient suffers from neurological impairment.

114. Ms Burke also submitted that consistent State-wide procedures are helpful to nursing staff, who often move from region to region.

115. Mr Anderson, who appeared on behalf of the Department of Health, indicated that this particular form was specific to Kalgoorlie Hospital (although I do note that the form has a blank line to be filled in next to

[145] Exhibit 2, Tab 5, Statement 2, Att "SMLJ-2".

the word 'Hospital' at the top of the form) and different hospitals may have other policies.

116. I am aware that the WA Country Health Service, as part of the Department of Health, does have a formalised Discharge Against Medical Advice Policy, with a specific form to be completed by the patient and medical staff when the hospital staff is aware a patient is choosing to leave the hospital against medical advice. It does seem surprising that the WA Country Health Service does not also have a similar policy and form in relation to patients absenting themselves from hospital without notifying staff.

117. However, although I have heard evidence in this inquest that patients absconding from hospital were a common occurrence at the Kalgoorlie Regional Hospital, I have no evidence before me as to how often it occurs in other regional hospitals and what their policies or procedures are in this regard.

118. Accordingly, although I commend the administrators of Kalgoorlie Regional Hospital for formalising their procedures for these events, I do not consider I am in a position at this stage to make a recommendation that other regional hospitals adopt the same procedure. However, it would seem prudent for the WA Country Health Service to give consideration to a standardised procedure in this regard.

CONCLUSION

119. The deceased was an indigenous man who lived in Leonora and had a longstanding history of chronic liver disease. Following an alleged assault he was admitted to hospital, first in Leonora and then in Kalgoorlie.

120. He was treated for a facial laceration and monitored for signs of a possible head injury. However, in the end it seems that the symptoms of a head injury that he was

exhibiting might have, in fact, been a consequence of his withdrawal from alcohol and liver disease.

121. The deceased's health gradually improved and by 14 June 2010 he was considered by his treating doctor to be well enough to be discharged, but was kept in hospital as he was not a local resident and arrangements needed to be made for the deceased to be appropriately accommodated on discharge.

122. That night he left the hospital, without notifying hospital staff, due to being disturbed by other patients in another room. He took his hospital bedding with him. Despite searches conducted by hospital staff and police being alerted to look out for him, the deceased was not located that night.

123. On 10 July 2010 he was found deceased in bushland on the outskirts of Kalgoorlie. It is most likely that he died at that location within a few days of his leaving the hospital, as a result of complications of his liver disease and/or due to being exposed to the elements on what were cold nights in Kalgoorlie.

124. Whilst I accept that it is distressing for the deceased's family that greater clarity as to the manner and time of his death cannot be achieved, regrettably all avenues for investigation of this matter have been concluded.

S H Linton
Coroner
8 July 2014