Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 21/15

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Roy Charles GILBERT****, with an Inquest held at Perth Coroners Court, Court 51, CLC Building, 501 Hay Street, Perth, on 22 June 2015 find the identity of the deceased was* ***Roy Charles GILBERT*** *and that death occurred on 21 December 2013 at Royal Perth Hospital, as a result of Complications in Association with Advanced Gastric Malignancy in the following circumstances:*

Counsel Appearing :

Sergeant L Housiaux assisted the Deputy State Coroner

Ms C Rice (State Solicitors Office) appeared on behalf of the Department of Corrective Services

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INTRODUCTION

Roy Charles Gilbert (the deceased) was a sentenced prisoner serving an indefinite term of imprisonment at his Governor's pleasure at the time of his death.

In August 2013 the deceased was diagnosed with Gastric Adenocarcinoma (stomach cancer), however he was significantly non-compliant with treatment until his condition became severe and he consented to firstly surgery, and later oral chemotherapy. He was registered as a Phase 1 terminally ill prisoner in November 2013, and Phase 2 in December, shortly before his death in Royal Perth Hospital (RPH) from his malignancy on 21 December 2013.

The deceased was 49 years of age and had spent well over 30 years in institutions, with 29 of those in prison.

The provisions of the *Coroners Act 1996* require the death of any prisoner be examined by way of inquest (section 3, section 22(1) (a)) and the coroner conducting the inquest is required to comment on the quality of the supervision, treatment and care of the prisoner while held in custody (section 25 (3)).

BACKGROUND

The deceased was born on 7 August 1964 at Tardun Mission.[1] He was one of eight children to parents who were dependent on alcohol and not involved with their children's upbringing to any significant degree. He was educated in Mullewa and noted to be an under achiever. He suffered emotional and material depravation as a child and left school at 14 years old. He had a significant juvenile criminal justice record which resulted in frequent time spent in correctional institutions.[2]

At 16 years of age the deceased committed his first serious sexual offence which involved a child relative, for which he was sentenced to detention at Riverbank, and then served time at Fremantle and Canning Vale Prisons. He was detained indefinitely and when released back into the community it was difficult to find him suitable accommodation due to his age and the fact he had committed an offence involving a young relative. This meant finding him a placement was an issue. Even in custody, later in his life, appropriate places proved to be a problem.

However, he was released on parole, but was almost immediately found to be reoffending and returned to prison. He was released again in November 1984, when 20 years of

[1] Health Review dated 24.02.2015 by Dr T O'Gorman
[2] Ex 1, tab 18

age, but committed his final set of offences in January 1985, from which time he remained in custody until his death in late 2013.

The above history indicates the deceased was, by the time of his death, thoroughly institutionalised. He had spent 28 years continuously in custody and significant periods before that time.

There is no indication the deceased experienced any serious physical issues before the diagnosis of his illness in 2013 and he was generally regarded as physically fit. There were obviously over time, concerns with his emotional and mental health.

FINAL TERM OF IMPRISONMENT

The deceased committed the offences for which he was sentenced on 30 October 1985, in January 1985. They were serious sexual offences against an unknown female and attracted a sentence of 12 years, following which he was again detained at the Governor's pleasure.

The deceased received regular reviews by the Prisoner Review Board (PRB) which assessed him for suitability for various pre-release programs (PRP) concerned with his offending behaviour, lack of suitable social networks, and very young age. Due to his sexual offending it was essential

he participate in the Sex Offender Treatment Programs (SOTP) but he consistently behaved in such a way that prevented his ever satisfactorily completing any form of sex offender treatment. He continued to behave inappropriately with almost any female with whom he came into contact, be they prison staff, or female prisoners.

PROGRAMS AND PLACEMENT

During the initial finite term of the deceased's imprisonment he was incarcerated in various prison facilities available at that time but was generally considered to be a management problem due to his insulting or threatening behaviour, anger management and use of illicit substances.[3]

During his finite term of imprisonment prison records indicate he maintained a position of denial with respect to his offending and as a result refused to participate in programs designed to address his aggressive, sexual, and threatening behaviour. He behaved badly towards any female prison staff running programs which generally precluded his participation in any programs until approximately 2006, when concern arose with the approach of his indefinite sentence, and the need for him to complete relevant programs for PRB oversight.

[3] Ex 2

In addition to difficulties with the deceased completing long term PRP, was the refusal of persons in the community to be involved due to his behaviour and offending. He did successfully complete a reasoning and rehabilitative cognitive skills programme which gave him some ability to understand the consequences of his behaviour. The prison conduct reports indicate a significant improvement in his general demeanour and behaviour following completion of that program. It appeared the deceased had the ability to reason, but had generally not received the experiences which would allow him to successfully control his aggression for long term improvements. A lot of attention was directed towards attempting to provide the deceased with coping skills, but his tendency to then fixate on female staff members assisting him made any continuation of progress untenable.

By 2005 the PRB had deferred the deceased's inclusion in PRP activities until he completed a medium indigenous SOTP and had been appropriately assessed, including a psychological risk assessment. The deceased completed the SOTP however this left issues relating to anger and his consideration for a PRP was deferred to allow him to complete Managing Anger and Substance Abuse Programs in April 2006.

His success in completing the first part of a PRP was destroyed by his possession of a pornographic video and so

deferred until he had completed a period of psychological counselling.

Legislative changes through the period of the deceased's incarceration altered some of the criteria applicable via the PRB pending supervision towards release. There was some difficulty in finding a placement for the deceased which would allow him to successfully complete some of his PRP. Changes in psychological assessment also occurred during the period of the deceased's incarceration and there was some dispute between practitioners as to his appropriate personality classification and his suitable PRP.

The deceased's attitude to females remained problematic during the course of his imprisonment which further caused difficulties in placing him on appropriate PRP. Essentially, despite there being some comment the deceased's insightfulness to appropriate relations with females was evident, his behaviour and interactions remained inappropriate, thus effectively precluding him from successful consideration for PRP.[4]

As a result of the deceased's inappropriate interaction with female staff and prisoners he was moved to Acacia Prison in May 2012. The deceased appears to have been successful in the Acacia environment, was in a self-care placement, employed and in telephone contact with his family. While

[4] Ex 2

he was identified as requiring individual psychological counselling after he had completed the indigenous family violence program, that program became unavailable and the deceased was awaiting placement on a replacement program, scheduled to commence after the date on which he eventually died.

The deceased was diagnosed with stomach cancer in August 2013 and as a result of his need for frequent medical review was transferred to the Casuarina Prison Infirmary in October 2013. While he was returned to Acacia Prison briefly between 25 November 2013 and 10 December 2013 as his preference, his significant deterioration saw him return to Casuarina Prison for access to the infirmary until his final transfer to RPH. Obviously consideration of any suitable programs once he was diagnosed as terminally ill became immaterial.

MEDICAL HISTORY

The deceased did not present with any obvious physical problems when first received into custody despite his apparently dysfunctional upbringing. However, not unexpectedly, he did receive input for his psychological status from almost the beginning of his prison term as a result of depression and the nature of his offending and its effect on other prisoners by way of reprisals.

He was described as *"an extremely emotional and fragile prisoner who often had difficulty managing his own anger and frustrations"*[5]. In addition difficulties for those family members with whom he was in contact caused him some concerns. In 1988 he required hospitalisation after swallowing razor blades. Following that he spent some months with frequent review by the Forensic Case Management Team (FCMT) however, the deceased's inappropriate relationship with female persons with whom he came into contact remained a feature of his difficulties while in custody. He was assessed as having an antisocial personality disorder but no treatable psychiatric condition.

Throughout his prison life the deceased was reviewed by prison medical staff and referred to external facilities for consultant care and management, generally through RPH. This included ophthalmology, urology, podiatry and later oncology. The deceased was provided with access to medical screening and investigations but was often not compliant with advice or diagnostic referrals.

The first indication he may be experiencing gastro-intestinal difficulties occurred in late 2009 when he first complained of constipation and was treated. About 14 months later in February 2011 he again complained of constipation and was again treated with fibre supplements and laxatives. He

[5] Ex 2

further complained of difficulties between then and May 2011 but declined any suggested medical investigation.

Following his declining to be involved in a chronic disease screen he made few complaints until in May and June 2013 he again presented with complaints of ongoing constipation and haemorrhoids. He described feeling bloated and asked for a medical review.

The deceased failed to attend his review on 4 July 2013 but did attend for a reappointment on 15 July 2013. He again declined pathology screening, however, eventually agreed to a colonoscopy. It became apparent he was experiencing weight loss, and constipation with vomiting was noted. He attended RPH for a colonoscopy, Computed Tomography (CT) scan of the abdomen and pelvis, and a barium swallow procedure on 15 August 2013.

Those investigations indicated a likely gastric adenocarcinoma of the stomach. His oesophagus and stomach were full of food and there was gastric outlet obstruction. He was maintained in RPH for two days and a stomach biopsy showed a poorly differentiated adenocarcinoma against a background of active chronic gastritis. The CT showed gastric outlet obstruction with thickening of the pylorus and first part of the duodenum with associated lymph node enlargement. The deceased was provided with nourishing fluids and was discharged

back to Acacia Prison on 17 August 2013 with a diagnosis of stomach cancer.

The deceased refused to stay in the prison observation unit and demanded to be returned to his cell block advising medical services he would take care of himself. His diet consisted of clear fluids and Ensure and he continued to visit the infirmary regularly for review.

On 23 August 2013 the deceased's weight appeared to stabilise slightly. He discussed treatment for his malignancy by way of surgery and chemotherapy with nursing staff in the infirmary and thereafter appeared to again lose weight slowly, it was thought his weight loss was due to persistent vomiting. He had not opened his bowels since hospital or been able to eat solid food. The medical staff were concerned the deceased was developing a gastric obstruction and sought advice from the Oncology Unit at RPH.

He was seen in RPH on 4 September 2018 and presented to the prison infirmary with prescriptions for dexamethasone and pantoprazole to reduce his vomiting.

Investigations continued for surgical review with a plan to start chemotherapy following surgery. Mr Stephen Archer, Consultant Surgeon, noted the deceased's history of intermittent vomiting and weight loss and noted the semi-

obstructing malignancy at the gastric antrum, and that CT scan had shown a locally advanced malignancy. The PET scan showed intense activity and the possibility of a polyp in the ascending colon.

On 3 October 2013 the deceased was readmitted for a diagnostic laparoscopy which showed extensive peritoneal metastatic disease with right hypochondrium peritoneal metastasis tethering the right colon to the anterior abdominal wall. The peritoneal area was washed and his future management was discussed with the Oncology and Gastroenterology teams. Meanwhile the deceased returned to prison.

The deceased was reviewed by Dr Hardy on 9 October 2013 at the prison infirmary and his weight had again fallen. He continued to complain of nausea with occasional abdominal cramps. By 12 October 2013 he was finding it difficult to walk although he had begun to eat a little. His weight dropped again and it was decided the deceased would be better dealt with at the Casuarina Prison Infirmary rather than Acacia. Therefore following his next appointment at RPH he was transported to Casuarina where it was believed he would be more easily cared for.

On 12 October 2013 the deceased was readmitted to RPH for management of his gastric outlet obstruction secondary to metastatic gastric adenocarcinoma. The gastroscopy

showed marked deformity resulting in gastric outlet obstruction and it was not possible to place a stent at that time. The deceased was maintained at RPH and on 17 October 2013 a repeat gastroscopy with general anaesthetic was performed and on this occasion a stent was passed through the obstructive antrum. The deceased's surgeon advised the Acacia Prison doctor the deceased had a very aggressive disease and chemotherapy had been started with a mixture of drugs. Following further investigations for correct placement of the stent and the deceased's recovery from that procedure and adjustment to his chemotherapy dosage, he was discharged back to Casuarina Prison Infirmary on 23 October 2013.

While at Casuarina the deceased appeared to be improving initially but by 28 October 2013 he was looking unwell and cachectic. He had very low blood pressure and was unable to tolerate very much oral intake.

On 2 November 2013 the deceased started to refuse some of his fluids and complained of tiredness and nausea. On 4 November 2013 the deceased was returned to RPH for chemotherapy and on 5 November 2013 stated he was feeling much better and stronger. On 5 November 2013 he was registered as a Phase 1 (high probability of death) on the Department's terminally ill prisoner list. This resulted in him being placed on the Support and Monitoring System (SAMS) and reviewed by case conference.

On 7 November 2013 RPH informed the infirmary staff the deceased had started chemotherapy again and that he required inpatient admission for another stent. The deceased's condition had fluctuated and his compliance with treatment and diet was erratic. He maintained he wished to be returned to Acacia Prison where he felt more comfortable. The medical staff at Acacia Prison believed they could manage the deceased's condition and he was returned to them on 25 November 2013 where he refused accommodation suitable to the nursing staff and returned to self-care.

By 27 November 2013 he was very unwell, was appearing very frail and refusing his medications. In an effort to determine his state of mind he was interviewed by the Aboriginal Health Nurse with a peer support worker and was reported to be fully lucid and culturally appropriate.

On 30 November 2013 the deceased complained that his gastric stent was too small. He wished for it to be removed. Advice was sought from RPH. Suggested blood tests showed low albumin, elevated C reactive protein and anaemia. His liver and renal functions were normal.

On 6 December 2013 the deceased continued to complain about his gastric stent and he was referred to the ED at RPH for assessment of his gastric outlet function. He was

treated for dehydration with intravenous fluids and was initially very uncooperative with staff. His surgeon referred him to a palliative care consultant informing that consultant the deceased had been given three cycles of chemotherapy for metastatic gastric cancer and was currently having no oral nutrition but nasogastric and intravenous therapy.

A CT body scan reported the gastroduodenal stent to be in place but there still appeared to be ongoing gastric outlet obstruction with the gastric tumour remaining essentially unchanged, the development of marked ascites with extensive widespread soft tissue wasting and oedema. The surgeon noted this was *"likely a sign of poor progression and poor response"* to chemotherapy. It was noted he was difficult to manage, demanding/aggressive, uncooperative and determined to undermine his proper treatment and management.

A palliative care specialist reviewed the deceased and found he was able to tolerate liquids, although there was difficulty with water. He was provided with medication and returned to the Casuarina Infirmary that day for review and monitoring by the nursing staff. It was noted the deceased was no longer a candidate for chemotherapy and was placed in palliative care in the Casuarina Prison Infirmary. Two days later he was readmitted to RPH for ongoing nausea and vomiting but again refused to cooperate with management

and was discharged, against medical advice, arriving back at the prison infirmary on 13 December 2013.

It was noted that psychologically the deceased was quiet, fearful of death and dying.

The deceased was again reviewed by RPH on 16 December 2013. He continued to deteriorate. The tumour progressed to obstruct his gastric outlet and a new stent was inserted to overcome the obstruction. The deceased continued to be difficult whilst in hospital and required sedation for management.

On 16 December 2013 he was escalated to Phase 2 (death imminent) on the Department's terminally ill register. The deceased's condition continued to deteriorate and he was kept in RPH under prison guard as required by prison regulations. The deceased then remained in RPH as an inpatient and, although difficult to manage, only demanded return to prison on one occasion. Both the hospital notes and the Serco staff records, indicate the deceased was managed as a terminally ill prisoner with appropriate medical interventions and family and official visits. Due to his behaviour his restraints were maintained until, by 21 December 2013, he had deteriorated to the extent he was unresponsive.

The deceased died on 21 December 2013 in the presence of a Serco guard.

POST MORTEM REPORT

A post mortem examination was conducted on 27 December 2013 by Dr J White of PathWest Medical Laboratory. Dr White confirmed advanced gastric malignancy in the body and antrum of the deceased's stomach with evident gastric outlet obstruction. There were metastases in the abdominal cavity with involvement of the omentum, small bowel mesentery, extension into the wall of the splenic flexure with focal obstruction and evident lymph node metastases.

There was also pulmonary oedema and effusions, ascites in the abdominal cavity, congestion of the liver, scarred kidneys and mild to moderate coronary atherosclerosis.

Dr White formed the opinion death was as a result of complications in association with his advanced gastric malignancy. The complications being the aggressive spread of the deceased's tumour affecting his gastric outlet despite chemotherapy and the placing of appropriate stents.

Toxicology reflected his medical and hospital care.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 49 year old detained prisoner who had spent all his adult life in the prison system and was generally physically well but with bouts of depression related to his offending and incarceration.

The deceased first showed signs of gastrointestinal tract issues in 2009 to 2011 but these appeared to respond to laxative treatment. Problems seemed to reoccur in May and June of 2013, however, no reason for his recurrent constipation was identified until, in July 2013, it was noted he was losing weight and complaining of abdominal discomfort and bloating. He was referred to the Gastroenterology Department at RPH who monitored his progress. In August 2013 he was found to be still losing weight and was now vomiting after meals which prompted the booking of a gastroscopy and colonoscopy for 15 August 2013.

He was admitted to RPH on 12 August 2013. He was continuing to lose weight and vomited his preparatory bowel preparation.

The gastroscopy was conducted on 15 August 2013 and as a result of that and further investigations he was diagnosed with a poorly differentiated adenocarcinoma of the stomach. This was resulting in gastric outlet obstruction.

A stent was endoscopically passed through the obstruction and the deceased was monitored by the oncology team at RPH for placement of the stent and the commencement of chemotherapy. Thereafter he was managed by RPH oncology with the assistance of medical staff at both the Casuarina Prison Infirmary and the Acacia Prison Infirmary depending on his location, while he underwent three cycles of chemotherapy.

An exploratory laparoscopy in October 2013 showed metastases throughout the peritoneal cavity. The deceased's tumour continued to spread despite aggressive treatment until chemotherapy was withdrawn and palliative therapy commenced.

The deceased slowly declined over the coming weeks until he was admitted to RPH for the last time on 16 December 2013 at which time he was declared a terminally ill prisoner, Phase 2, with death imminent.

The deceased died in hospital under Serco guard on 21 December 2013. He died of the complications of his advanced gastric malignancy.

I find death occurred by way of Natural Causes.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED

The deceased had a dysfunctional childhood with poor parenting which resulted in serious and inappropriate behaviour with females. He committed offences which resulted in him spending portions of his teenage years in institutional facilities.

At the age of 16 years he committed a serious and concerning sexual offence against a two year old female niece and as a result was incarcerated. He was provided with an indefinite term to that period of imprisonment which saw his release back into the community, under supervision, in the hope his behaviour had been modified. Unfortunately, he breached very quickly and was returned to prison, now an adult, for an additional period of time.

The deceased was again released in November of 1984, but by early January of 1985 had again committed a series of extremely serious sexual offences against an unknown female victim in the household in which she was caring for four children. This resulted in the deceased then becoming incarcerated from January 1985 until his death in December 2013.

Despite numerous attempts at providing the deceased with programs to correct his offending behaviour his attitude to females remained problematic and any positive role models

appeared to result in him developing a fixation with inappropriate sexual content. Unfortunately, due to his behaviour he was largely unsuccessful at maintaining any progress with relevant programs. He was provided with individual counselling but maintained a questionable perception of his interaction with females, despite having normalised hopes for a girlfriend and ultimately a family.

While some of the programs, not related to his sexual offending, but to management of his anger and frustration were successful and appeared to improve his cognitive functioning, they were unable to address the difficulties with his interaction with females. The deceased never became appropriate for release due to the nature of his offending and its severe effect on his victims.

He therefore remained incarcerated, obtained prison employment and continued with his institutional life until diagnosed with stomach cancer in August 2013.

Following his diagnosis the deceased remained under care of the Oncology Department at RPH and prison medical practitioners. His treatment and care was often problematic due to his refusal to comply, initially with screening procedures, and later with medication. On the occasions he did accept appropriate intervention it was provided as efficiently as possible despite his, on occasions, discharging himself from medical care against advice. He was provided

with medical treatment and appropriate management at all times when he would allow that to occur and was permitted to stay in a prison environment as his preference whilst that environment was still able to provide his adequate management.

Overall, his treatment by the Department in conjunction with the intervention he would allow from RPH was appropriate and the quality of his supervision, treatment and care reasonable in view of the aggressiveness of his cancer and periods of noncompliance with management.

E F Vicker
Deputy State Coroner
8 July 2015