Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 4/15

I, Barry Paul King, Coroner, having investigated the death of ***Valfrids Klavins*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***3 February 2015****, find that the identity of the deceased person was* ***Valfrids Klavins*** *and that death occurred on* ***9 January 2012*** *at* ***Sir Charles Gairdner Hospital*** *from* ***complications of mesothelioma*** in *the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner
Mr N Barron (State Solicitor's Office) appearing on behalf of the Department of Corrective Services

Table of Contents

INTRODUCTION

1. Valfrids Klavins (the deceased) died in Sir Charles Gairdner Hospital (SCGH) from complications of mesothelioma.

2. At the time of his death,[1] the deceased was a sentenced prisoner. Under s 16 of the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services (the DCS) and was thereby a 'person held in care' under s 3 of the *Coroners Act 1996* (the Act). His death was therefore a 'reportable death' under the Act.[2]

3. Under s 19 of the Act, a coroner has jurisdiction to investigate a death if it appears that the death is or may be a reportable death. Section 22(1)(a) of the Act requires a coroner who has jurisdiction to investigate a death to hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care. An inquest into the death of the deceased was therefore required under the Act.

4. Under s 25(2) of the Act, where the death is of a person held in care, the coroner investigating the death must

[1] Or 'immediately before death' as provided in s 22(a) *Coroners Act 1996*.
[2] Section 3 *Coroners Act 1996*

comment on the quality of the supervision, treatment and care of the person while in that care.

5. I held an inquest into the deceased's death on 3 February 2015.

6. The evidence adduced at the inquest primarily comprised two comprehensive reports into the circumstances of the deceased's death and of his treatment while in custody: one report was prepared by Sergeant Anthony George of the Western Australian Police,[3] the other was prepared by Richard Mudford of the DCS.[4] Mr Mudford was called to give oral testimony relating to his report. Also in possession of the Court were extensive medical records relating to the deceased obtained from the DCS.

THE DECEASED

8. The following information was obtained primarily from a pre-release report dated 1 August 1974,[5] an undated review of sentence report,[6] and an independent psychological clinical review/assessment report dated 24 May 2004.[7]

[3] Exhibit 1, Tabs 2-20
[4] Exhibit 2
[5] Exhibit 2, Tab 2
[6] Exhibit 2, Tab 3
[7] Exhibit 2, Tab 4

9. The deceased was born in Latvia on 16 September 1946 and immigrated to Northam in Western Australia when he was two years old. When he was five years old his father died in a motorcycle accident.

10. The deceased's mother married a building contractor who would work in the country for weeks at a time. The deceased's mother and step-father had a daughter and a son together and eventually moved to Perth. When the step-father was home from the country he would drink excessively and would physically abuse the deceased's mother and show neither interest nor emotion towards the children.

11. When the deceased was 14 years old his mother and step-father separated. When he was 15 he left school and went to Margaret River where he worked as a farmhand.

12. After two months in Margaret River the deceased obtained work on a farm in Morawa, where he stayed for two years. He then went to Port Hedland and worked as a labourer for a year before returning to Perth.

13. In May 1965 the deceased was 18 when he had his first conviction for stealing. Nine months later he was

convicted for unlawful use of a motor vehicle and was sentenced to imprisonment for the first time.[8]

14. In 1967 he arranged for three girls to go to Port Hedland with him to work as prostitutes at the single men's camp. He was 20 years old at that time and two of the girls were wards of the State. He was convicted of two counts of living off the earnings of prostitution in January 1968 and sentenced to four years imprisonment.[9]

15. In 1971 while on a short release from prison, the deceased started a relationship with a 15 year old girl who ran away with him for six or seven months to avoid her disapproving parents. They stole a motor vehicle and carried out a number of burglaries before the deceased was apprehended and imprisoned. His girlfriend had become pregnant and had a daughter while the deceased was in prison. Their relationship ended before he was released in 1974.

16. In 1974 the deceased met his first defacto wife. He had two sons with her. That relationship ended in 1980 while they were in eastern Australia.

17. Following the breakup with his first defacto wife, the deceased went to Gosford in New South Wales where he

[8] Exhibit 2, Tab 5
[9] Exhibit 2, Tab 5

met his second defacto wife. They had three sons and remained together until 1988 when the deceased was sentenced to 10 years imprisonment for sexual assaults of two women in Western Australia in 1987 and 1988. The second sexual assault occurred while he was on bail for the 1987 assault.

18. Apart from the deceased's criminal activity in Western Australia, he had convictions in Victoria, New South Wales and Queensland for traffic, disorderly behaviour and burglary and dishonesty-related offences.

19. In 1996, after being released for about nine months, the deceased stupefied and sexually assaulted a 16 year old girl near Kalgoorlie and Esperance. He was arrested, charged and kept as a remand prisoner for 19 months before being sentenced to 14 years imprisonment and ordered to be detained indefinitely.

20. The deceased spent his first year as a convicted prisoner under that sentence at Canning Vale Prison, after which he was transferred to Casuarina until August 2006 when he was transferred to Acacia Prison. He remained at Acacia Prison until his death in January 2012.

21. By the time he died, the deceased had spent about 30 years in prison.

22. In 1997 the deceased was assessed as having a personality meeting the criteria for an antisocial personality disorder with some indications of a borderline personality disorder.

23. The deceased underwent psychological assessment in 2004 to determine his risk and treatment needs three years prior to a first statutory review. The assessment indicated that the deceased was cynical, socially isolated, domineering and impersonal. He was self-indulgent, sensation seeking, impulsive and manipulative. He presented with clinical levels of psychopathy and was assessed as continuing to present a high risk to the community.

24. During this last period of imprisonment the deceased's case was considered nine times by the Prisoner Review Board. He was considered unsuitable for pre-release programs and a danger to the community so was never released.

MEDICAL HISTORY

25. When received into prison for the last time in May 1996 the deceased was diagnosed with high blood pressure.

26. Two months later he was diagnosed with non-insulin dependent diabetes mellitus and was referred to the

prison's chronic disease clinic for treatment. He was tested and monitored regularly and was seen by podiatrists, diabetic specialists and ophthalmologists. In 2007 he was placed on a diabetic care plan in accordance with a new departmental policy.

27. In 1999 and 2000 the deceased was treated for obesity. Despite ongoing monitoring and attempts by staff to encourage the deceased to eat healthy food and to undertake proper exercise, the deceased struggled with the condition over the years.

MESOTHELIOMA

28. On 16 August 2010 the deceased presented to the medical centre at Acacia Prison complaining of shortness of breath on exertion and chest pains. He mentioned that he had been exposed to asbestos in the past. He underwent an electrocardiogram which showed no abnormalities.

29. On 8 September 2010 the deceased saw the prison doctor who sent him to Royal Perth Hospital for a chest x-ray assessment, which showed no focal area of consolidation or right pleural effusion.

30. On 22 February 2011 the deceased attended the cardiology clinic at Royal Perth Hospital. He underwent

an exercise tolerance test which did not show any evidence of ischaemic heart disease. No further investigations were undertaken.[10]

31. The deceased presented to the prison medical centre on 22 July 2011 with increasing shortness of breath. He was transferred to Swan District Hospital with suspected pleural effusion and was admitted for six days for treatment and tests. A respiratory physician referred him for a pleuroscopy to test for cancer and mesothelioma.[11]

32. The deceased underwent the pleuroscopy at SCGH on 17 August 2011. A left-sided video assisted pleuroscopy for formal biopsy was done on 1 September 2011.[12]

33. On 13 September 2011 the respiratory physician confirmed to the Acacia Prison doctor that the deceased had rapidly progressing left-side mesothelioma.[13] He referred the deceased to the medical oncology unit at SCGH for consideration of chemotherapy.

34. An oncologist gave the deceased's prognosis as a six month life expectancy if the mesothelioma were untreated and 12 months if it were treated.

[10] Exhibit 2, Tab 12
[11] Exhibit 2, Tab 14
[12] Exhibit 2, Tab 14
[13] Exhibit 2, Tab 14

35. On 28 November 2011 the deceased was registered by the DCS as a Phase 1 terminally ill prisoner under the DCS Policy Directive 08, indicating a high probability of death.

36. By 13 December the deceased had received three cycles of palliative chemotherapy. The treatment was ceased when a CT scan revealed that it was not providing a benefit. On 16 December 2011 the deceased was registered as a Phase 2 terminally ill prisoner, indicating that death was imminent.

EVENTS LEADING UP TO DEATH

37. The deceased's condition continued to deteriorate.

38. On 30 December 2011 the Acacia Prison medical centre staff assessed the deceased as experiencing shortness of breath, swollen abdomen and excessive fluid in his legs. He was transferred as an emergency patient to Swan District Hospital and was transferred from there to SCGH.

39. The deceased was treated palliatively at SCGH until he died on 9 January 2012.

CAUSE AND MANNER OF DEATH

40. Forensic pathologist Dr D M Moss and forensic pathology registrar Dr A Hewison conducted a post mortem examination on 11 January 2012 and found an extensive tumour which surrounded the left lung and infiltrated the diaphragm, chest wall and ribs and an extensive tumour around the structures of the middle of the chest and around the heart.

41. Microscopic examination showed extensive bronchopneumonia. Microbiological testing showed moderate growth of *Staphylococcus aureus* in both lungs.

42. The forensic pathologists formed the opinion, which I adopt as my finding, that the cause of death was complications of mesothelioma.[14]

43. I find that death occurred by way of natural causes.

COMMENT ON THE SUPERVISON, TREATMENT AND CARE OF THE DECEASED WHILE IN CUSTODY

44. Emeritus Professor Max Kamien reviewed five folders of the DCS medical records relating to the deceased and

[14] Exhibit 1, Tab 5

provided an independent report of the treatment provided to him in the time leading up to his death.

45. Professor Kamien concluded that the deceased's health care during his long period in custody was of a standard that he would have received had he been in the community.

46. On the basis of the information available to me, I am satisfied that the quality of the supervision, treatment and care of the deceased while in the custody of the Chief Executive Officer of the Department of Corrective Services was appropriate.

47. It is apparent that all due care was provided and the management of the deceased was timely, multidisciplinary and at the appropriate level.

CONCLUSION

48. The deceased was an institutionalised prisoner who, due to exposure to asbestos at some stage in his past, developed malignant mesothelioma, which led to his death.

49. My research on the topic of mesothelioma revealed that it is a disease that is notoriously difficult to diagnose. Typically, by the time mesothelioma is identified, it is in

its late stages and no substantial treatment is possible. It is apparent that the deceased's case accorded with that scenario.

50. The evidence before me establishes that the deceased's medical health was managed appropriately throughout his time in custody.

B P King
Coroner
24 February 2015