Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 38/16

I, Sarah Helen Linton, Coroner, having investigated the death of ***David WAYMOUTH*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***18 October 2016*** *find that the identity of the deceased person was* ***David WAYMOUTH*** *and that death occurred on* ***20 November 2014*** *at* ***Bunbury Hospital*** *as a result of* ***multi organ failure and sepsis complicating ulcerating colitis and intestinal obstruction in a man with severe constipation, methadone use and recent repair of a right hip fracture*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisting the Coroner.
Ms J Langworthy (State Solicitor's Office) appearing on behalf of the Department of Corrective Services.

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INTRODUCTION

1. David Waymouth (the deceased) died in hospital in Bunbury on 20 November 2014 following a period of ill-health. His death was not unexpected.

2. At the time of his death the deceased was a sentenced prisoner based at Bunbury Regional Prison. He was serving a lengthy combined sentence for various offences and was not eligible to be considered for release on parole until 23 September 2017.[1]

3. As the deceased was a prisoner under the *Prisons Act 1981* (WA) at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[2] I held an inquest at the Perth Coroner's Court on 18 October 2016.

4. The documentary evidence included two comprehensive reports of the death prepared independently by the Western Australia Police and by the Department of Corrective Services (the Department), together comprising two volumes.[3] The authors of both reports were also called as witnesses at the inquest.

5. The inquest focused primarily on the care provided to the deceased while a prisoner, both within the custodial environment and while admitted at hospital.

THE DECEASED

6. The deceased was born on 9 March 1967 in Cardiff, Wales. In July, 1975 he emigrated with his parents and four siblings to Western Australia.

7. As a child the deceased was happy, popular and caring to his family. He lived in various locations in Western Australia. At some stage his parents separated and in about 1980 the deceased's mother and siblings returned to the United Kingdom. The deceased chose to remain in Australia with his father. It appears he was less well supervised in the absence of his mother and he headed down a different path to his siblings and began to act out and get into trouble with the law.[4]

8. He was first convicted as an adult on 6 March 1985. He was sentenced to a term of imprisonment for stealing offences.[5]

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[1] Exhibit 2, Directed Review, p. 3.
[2] Section 22(1) (a) *Coroners Act.*
[3] Exhibits 1 and 2.
[4] Exhibit 1, Tab 9.
[5] Exhibit 2, Tab 1.

9. The deceased met the mother of his first child in the mid 1980's and appeared to settle down briefly. His daughter was born in July 1987. He was sentenced to a lengthy term of imprisonment the following month. Over the subsequent years he continued to re-offend and served regular periods of time in prison.

10. The deceased remained in telephone contact with his mother and one of his sisters over the years and they encouraged him to come to the United Kingdom. He eventually came to visit them in 2009 and stayed with various family members but he was unable to settle and chose to return to Australia. He remained in contact with his family until his mother's death in January 2011, after which time he lost contact with his siblings.[6]

11. It is known by his family that he had another daughter, whose date of birth is unknown, but it does not seem that he kept in regular contact with either of his children.[7]

THE DECEASED'S MEDICAL HISTORY

12. The deceased had a long history of drug abuse, including intravenous heroin use and methylamphetamine. In 1993 he was diagnosed with hepatitis C, most likely as a result of his drug use.[8]

13. The deceased had also experienced ongoing chronic lower back and leg pain and was diagnosed with lumbar disc prolapse and sciatica.[9] He underwent surgery on his back at Sir Charles Gairdner Hospital in March 1996, which was completed without complication, but he continued to experience flare ups thereafter and required pain killers to manage his chronic pain.[10]

14. The deceased also received medical treatment while in prison for asthma, indigestion, ADHD, hypertension, appendicitis and possible epilepsy. The deceased reported having been involved in more than 15 car accidents, which resulted in multiple head injuries, and also a number of violent fights in which he had received head injuries. These were suspected to be the origin of his suspected epileptic seizures, although he was also investigated for organic brain damage.[11]

15. The deceased had also been regularly psychiatrically assessed over the years and was treated for symptoms of depression with mood

[6] Exhibit 1, Tab 9.
[7] Exhibit 1, Tab 8; Exhibit 2, Directed Review, p. 8.
[8] Exhibit 2, Tab 15.
[9] Exhibit 1, Tab 15, Report of Dr O'Gorman.
[10] Exhibit 2, Tab 15, Report of Dr O'Gorman.
[11] Exhibit 2, Tab 15, Report of Dr O'Gorman.

stabilisers and antidepressants. In May 1995 he was reviewed because of rage attacks and nightmares and was trialled on antipsychotic medication. In February 1998 he received treatment for two episodes of self-harm.

16. In February 2004 the deceased was started on the methadone program after attending a substance abuse rehabilitation course and he remained on the program from that time, at least when serving time in prison.[12] He was also regularly prescribed Amitriptyline (assumed to be for his low mood and/or neuropathic type pain).[13]

LAST PRISON TERM

17. In March 2013 the deceased was convicted of three armed robberies and a number of other offences and was ultimately sentenced to a total effective sentence of 5 years and 8 months' imprisonment backdated to commence on 24 January 2012, when he was first taken into custody. He was eligible for parole, with an earliest eligibility date of 23 September 2017.[14]

18. On his reception to Hakea Prison on 24 January 2012 ,when he was first arrested for the above matters, custodial and health at-risk assessments confirmed no evidence of self-harm or suicidal ideation. He received treatment for illicit drug withdrawal and was recommenced on essential medications, including methadone. He remained on the methadone programme throughout his last period of incarceration.[15]

19. In May 2012 he consulted with a prison doctor in relation to his longstanding right leg pain. Blood tests and a CT scan of his back were arranged.[16]

20. In October 2012 the deceased saw a consultant forensic psychiatrist in relation to low mood, sleep and appetite issues (including weight gain). He was diagnosed with major depressive disorder. His amitriptyline dose was increased and he was initiated on a newer antipsychotic medication Abilify (aripiprazole) for mild psychotic symptoms associated with his depression, such as mood instability and impulsive anger. This was changed later in the year to olanzapine due to ongoing unresolved sleep issues.[17] The deceased showed significant subjective improvement on the new medication.[18]

[12] Exhibit 2, Tab 15.
[13] Exhibit 2, Tab 15, Dr O'Gorman's report.
[14] Exhibit 2, Directed Review, p. 3 and Tab 1.
[15] Exhibit 2, Directed Review, p. 3.
[16] Exhibit 2, Tab 15, Dr O'Gorman's report.
[17] Exhibit 2, Tab 15, Dr O'Gorman's report.
[18] Exhibit 2, Tab 15, Dr O'Gorman's report.

21. In February 2013 the deceased consulted with a prison doctor in relation to his longstanding hepatitis C infection. He was referred for a liver ultrasound and blood tests as part of a monitoring process, pending his sentencing the following month.[19]

22. Following his sentencing in March 2013 the deceased was transferred to Bunbury Regional Prison in May 2013 to facilitate his participation in prison programs. During his placement at Bunbury Prison the deceased successfully completed the Cognitive Skills program, as required by his Individual Management Plan. He also gained employment in the prison kitchen, where he received excellent industry reports.[20]

23. During the rest of 2013 the deceased underwent regular blood tests for monitoring of his hepatitis C. In July 2013 the tests indicated advanced liver disease, as well as elevated sugar levels. His mental state was also monitored and appeared to generally be improving after he was commenced on the antidepressant Citalopram for low mood. He continued on methadone and received regular reviews to monitor his dose. He was also seen regularly for management of his increasing weight and put on Optifast to assist him to lose weight, in the hope this would provide some pain relief.[21]

24. On 27 August 2013 the deceased declined to attend an internal appointment for a liver ultrasound.[22]

25. On 7 February 2014 a CT scan of the deceased's back showed L5 nerve root compression bilaterally and S1 compression on the right. He reported experiencing burning and stabbing pain and did not feel methadone and amitriptyline were doing much for him by way of analgesia. He was initiated on pregabalin as a pain relieving medication and referred for a nerve-root sleeve injection. On 1 May 2014 he underwent CT guided injections into his spine without complication.[23]

26. A review two weeks later found his left-sided pain had improved although his right-sided pain was ongoing. His pregabalin dose was increased and he was given the non-steroidal anti-inflammatory medication naproxen.[24]

27. During 2014 the deceased continued to be reviewed regularly by the prison psychiatrist and prison counselling service and his mental state remained stable. Also throughout 2014 he was given dental and podiatric treatment and prescribed reading glasses.[25]

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[19] Exhibit 2, Tab 15, Dr O'Gorman's report.
[20] Exhibit 2, Directed Review, p. 3.
[21] Exhibit 2, Tab 15, Dr O'Gorman's report.
[22] Exhibit 2, Tab 15, Dr O'Gorman's report.
[23] Exhibit 2, Tab 15, Dr O'Gorman's report.
[24] Exhibit 2, Tab 15, Dr O'Gorman's report.
[25] Exhibit 2, Tab 15, Dr O'Gorman's report.

28. On 18 July 2014 the deceased saw a prison doctor in relation to an infected right hand and wrist (cellulitis). He did not respond to oral antibiotics and was referred to Bunbury Regional Hospital on 23 July 2014 for intravenous antibiotics. His infected arm was subsequently reviewed on 1 and 8 August 2014 by a prison doctor and he was found to have only shown a partial response to antibiotics and still had ongoing pain and swelling. He was referred for blood tests and an ultrasound to rule out a blood clot. On 22 August 2014 he had a Doppler of his arm, which showed no evidence of deep vein thrombosis.[26] The deceased registered a complaint with the Bunbury Prison Superintendent in relation to the medical care provided, which he considered inadequate and had led him to commit a prison offence by secreting pain medications. He had an interview with the Superintendent on 27 August 2014 to discuss his concerns.[27]

29. The deceased was reviewed again by a prison doctor and it was noted the infection had cleared and his arm was back to normal.[28]

EVENTS IN NOVEMBER 2014

30. Overnight on 3 to 4 November 2014 the deceased fell from his bed in his cell. He apparently normally kept a chair next to his bed to avoid this occurring, but had not done so that evening.[29] He was in a single occupant cell so there was no cellmate to assist him.[30] He did not call for help overnight as he was aware there were no medical staff on duty overnight (although prison staff could have called for an ambulance if he had alerted them to his situation). During the morning unlock of cells on 4 November 2014 the deceased reported the incident to prison staff. He was taken to the prison health centre in a wheelchair as he was in pain and unable to walk. It was suspected by health staff that he had a fractured hip. After an e-consult with a doctor the deceased was transferred via ambulance to Bunbury Hospital.[31]

31. An x-ray and CT scan of the deceased's right hip confirmed a right sub-capital fracture of the neck of femur and he was admitted as an inpatient with surgery planned. He underwent total right hip replacement surgery under the care of Orthopaedic Surgeon Mr Koula Pratsis. The deceased's post-operative recovery was uncomplicated although he did have marked constipation, which was treated.[32]

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[26] Exhibit 2, Tab 15, Dr O'Gorman's report.
[27] Exhibit 1, Tab 2, p. 4 and Tab 22.
[28] Exhibit 2, Tab 15, Dr O'Gorman's report.
[29] Exhibit 2, Tab 2, p. 5.
[30] Exhibit 1, Tab 21.
[31] Exhibit 1, Tab 2, p. 5 and Tab 11; Exhibit 2, Tab 10 and Tab 15, Dr O'Gorman's report.
[32] Exhibit 2, Directed Review, p. 4 and Tab 15, Dr O'Gorman's report.

32. In the subsequent days assessment by hospital physiotherapy staff confirmed that the deceased was mobilising well with a Zimmer frame and was carrying out his daily activities without issue. On 7 November 2014 the Occupational Therapist (OT) from Bunbury Hospital contacted prison staff to discuss protocols regarding hip replacement and requirements after surgery. Discharge was planned for the following day and the hospital was able to provide the OT equipment and anti-coagulation therapy the deceased required.[33]

33. The deceased was discharged from hospital at 8.00 am on 8 November 2014 and returned to prison. Follow up was arranged in the orthopaedic clinic for two weeks' time. However, on the same day, and only a couple of hours after his return to prison, the deceased fell while attempting to use the toilet in his cell. This occurred just prior to a specially ordered toilet chair being delivered to the deceased's cell by nursing staff.[34]

34. Prison officers were alerted by another prisoner that the deceased needed assistance. They attended the deceased's cell and requested a nurse, who attended immediately and provided pain relief before placing the deceased in a wheelchair and taking him to the medical centre. He appeared confused and required oxygen. It was also noted that he was impacted with faeces. After discussion between prison nursing staff and the on-call doctor the deceased was transferred by priority ambulance back to Bunbury Hospital for further assessment and treatment.[35]

35. Following re-admission to hospital the deceased was found to have a dislocated right hip (related to the fall), pneumonia and pulmonary embolism (clots in the lungs). Both blood clots and infection are known risks of the surgery the deceased had undergone. He also continued to have marked constipation. The deceased underwent a closed reduction of the dislocated right hip and was managed for hospital acquired pneumonia. He spent a period of time in the High Dependency Unit due to his oxygen requirements but later was transferred to the surgical ward when his condition stabilised.[36]

36. On 10 November 2014 he deteriorated and a medical emergency team response call was made. Following investigations, a bowel obstruction was suspected, which was treated conservatively, and a dislocated right hip was also noted (which was relocated by the orthopaedic team on 12 November 2014).[37] On 10 November 2014 the deceased's next of kin were advised of his deteriorating condition.[38]

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[33] Exhibit 2; Exhibit 3 - Bunbury Hospital Discharge Summary 8.11.2014.
[34] Exhibit 1, Tab 2, p. 6 and Tab 11.
[35] Exhibit 1, Tab 2, p. 6 and Tab 11; Exhibit 2, Directed Review, p. 4, Tab 11 and Tab 15, Dr O'Gorman's report.
[36] Exhibit 1, Tab 2, p. 3 and Tab 12; Exhibit 2, Tab 15, Dr O'Gorman's report.
[37] Exhibit 1, Tab 2, p. 3 and Tab 12; Exhibit 2, Tab 15, Dr O'Gorman's report.
[38] Exhibit 2, Directed Review, p. 4.

37. From 11 to 17 November 2014 the deceased continued to receive intensive care, including sedation and mechanical ventilation. Various treatments were instituted to alleviate his ongoing constipation and the source of his sepsis continued to be investigated.[39]

38. On 19 November 2014 a decision was made for the deceased to undergo bowel surgery. Prison nursing staff were informed that the deceased's medical status was critical following peritoneal sepsis secondary to bowel obstruction/perforated bowel. He was placed on the Department's terminally ill list. The deceased went to theatre later that afternoon and underwent a total colectomy and loop ileostomy.[40]

39. On 20 November 2014 the deceased developed multi-organ failure and it was felt he was unlikely to survive. Approval was given for the deceased's restraints to be removed due to his rapidly deteriorating health. He was reviewed by an ICU consultant in conjunction with a surgeon and intensivist and all agreed that the deceased's condition was unsurvivable. At midday the deceased's life support machines were turned off and he was pronounced life extinct at 12.40 pm.[41]

CAUSE AND MANNER OF DEATH

40. On 2 December 2014 a forensic pathologist, Dr J White, conducted a post-mortem examination of the body of the deceased. Following the examination further investigations were completed and the deceased's medical records were reviewed. At the conclusion of all investigations Dr White formed the opinion the cause of death was multi organ failure and sepsis complicating ulcerating colitis and intestinal obstruction in a man with severe constipation, methadone use and recent repair of a right hip fracture.[42]

41. I accept and adopt the conclusion of Dr White as to the cause of death. I find that the manner of death was natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

42. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

[39] Exhibit 1, Tab 2, p. 4 and Tab 12.
[40] Exhibit 1, Tab 2, p. 4 and Tab 12; Exhibit 2, Tab 15, Dr O'Gorman's report.
[41] Exhibit 1, Tab 2, p. 4 and Tab 12; Exhibit 2, Tab 12; Exhibit 4 - Integrated Progress Notes, 20.11.2014.
[42] Exhibit 1, Tabs 6 and 7.

43. The evidence before me indicates that the deceased was a 47 year old man with an extensive medical history. He had been treated for many years with a variety of medications to control his anger, depression, drug abuse and chronic pain. Much of the medical treatment had been provided in prison, due to his extensive forensic history. In an effort to reduce his drug use, he was involved in the methadone program for many years, which was supported in the prison system.

44. On 4 November 2014 the deceased fell out of his bed in his cell. A photograph of the bed shows it to be a basic single bed, not overly high from the ground. It was placed against two walls and a plastic chair is present on the other side, which is presumably the chair the deceased often used to reduce the risk of him rolling out of bed.[43] There is nothing inherently dangerous in the configuration of the bed, although I note the deceased was a very large man with chronic pain and sleep issues, which might have made it more difficult for him to sleep comfortably in what is a normal sized single bed. However, it does not appear in the prison records that he had ever raised this as an issue with prison staff prior to this incident. A review by the Prison Superintendent after the event indicated it was an unfortunate accident and that had the deceased felt prone to this occurring again, options to mitigate the risk were to be considered and discussed with the deceased.[44]

45. At the time he was returned to prison from hospital on 8 November 2014 steps were taken to provide the deceased with a shower chair and toilet chair in his cell. Unfortunately, he fell from the toilet just prior to this equipment being delivered to his cell. The delay in providing the equipment was due to the need for prison staff to examine the equipment to ensure they were safe for use within the prison and did not present a security risk.[45] The deceased could have asked prison staff for assistance in toileting in the interim, but it seems he understandably preferred to maintain his privacy, which was his right.

46. After the fall the deceased was transferred back to hospital and did not return to prison again prior to his death, so any further safety procedures did not need to be explored.

47. After returning to hospital on 8 November 2014 the deceased's condition continued to deteriorate. As the deceased's health declined, the deceased was managed as part of a multidisciplinary team with input from various specialists. His symptoms were reviewed and investigated appropriately and every effort was made to accurately diagnose and manage his various problems. Unfortunately, he developed known complications of his surgery, which resulted in his death.

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[43] Exhibit 1, Tab 21.
[44] Exhibit 1, Tab 21.
[45] T 11 – 12.

48. The various records and medical reports indicate throughout his many prison terms the deceased received regular medical treatment by prison doctors and nurses for a variety of ailments and was also seen by specialists and transferred to hospital for more extensive medical treatment whenever required. In my view, the treatment provided for his medical conditions while in prison appears to have been reasonable and appropriate. His management at Bunbury Hospital also appears to have been reasonable and of an appropriate standard.

49. In these circumstances, I am satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death.

CONCLUSION

50. On 4 November 2014 the deceased, who was a sentenced prisoner, fell and sustained a hip fracture while in prison. He was taken to hospital and underwent successful hip replacement surgery. The surgery carries a number of risks and at the time he underwent the surgery, the deceased also had a number of additional risk factors for surgery. These included his obesity and liver disease secondary to chronic hepatitis C infection.

51. Unfortunately, in the deceased's case several of the post-operative risks materialised. Despite further surgical intervention, he was unable to recover and ultimately died as a result of post-operative complications. Prior to his death he was provided with a high standard of medical care but it was not enough to prevent his death.

S H Linton
Coroner
24 October 2016