Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 23/14

I, Barry Paul King, Coroner, having investigated the death of ***Adrian Bernard Williams*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***10 June 2014****, find that the identity of the deceased person was* ***Adrian Bernard Williams*** *and that death occurred on* ***14 April 2013*** *at* ***Royal Perth Hospital*** *from* ***pneumonia in a man with underlying advanced metastatic cancer and chronic airways disease*** in *the following circumstances:*

Counsel Appearing:

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

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INTRODUCTION

1. Adrian Bernard Williams (the deceased) died in Royal Perth Hospital (RPH) from pneumonia in the context of advanced metastatic cancer and chronic airways disease.

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 department) 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 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 10 June 2014.

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 of the reports

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

7. was prepared by First Class Constable Sarah Long of the Western Australian Police Service.[3] The other was prepared by Richard Mudford of the department.[4] Both Senior Constable Long and Mr Mudford were called to give oral testimony relating to their respective reports.

THE DECEASED

8. The deceased was born in Sydney, New South Wales, the younger of two boys born to his parents. After his parents separated when he was 12 months old, he and his brother lived with his mother and grandparents.[5]

9. The deceased went to school until he was nearly 15 and then, according to him, made a living through a number of different jobs. He began to receive a disability pension in 2010 due to a diagnosis of emphysema.[6]

10. The deceased used alcohol and cannabis, but apparently did not use any other common drugs.[7]

11. The deceased had one significant relationship with a woman he had known for about 25 years. The stayed together for about 17 years until 2005, though they remained friends.[8]

12. The deceased had no relatives since his mother, father and brother had all died by 2003. He first travelled to WA in 1987 and had little contact with his brother after that time.[9]

[3] Exhibit 1, Volume 1, Tabs 1-20
[4] Exhibit 1, Volume 1, Tabs 21-37; Volume 2 Tabs 38 and 39
[5] Exhibit 1, Volume 1, Tab 25
[6] Exhibit 1, Volume 1, Tab 25
[7] Exhibit 1, Volume 1, Tab 25
[8] Exhibit 1, Volume 1, Tab 25
[9] Exhibit 1, Volume 1, Tab 25

13. The deceased had criminal convictions in NSW and WA dating from 1973, primarily for alcohol and traffic offences. He also had a number of dishonesty, gambling/horse racing, anti-authority and assault offences.[10] He had been imprisoned in WA for nine months in January 1991 for conspiracy to commit fraud with respect to horse doping.[11]

14. On 14 January 2010 the deceased was charged with supplying a prohibited drug (methylamphetamine) and was placed in Hakea Prison on remand. He was released on bail on 2 February 2010 and, for reasons that are not clear, did not return before the courts again until 13 February 2013 when he was remanded back into custody.

15. On 4 April 2013 the deceased was sentenced in the District Court in Perth to eight years and six months imprisonment backdated to 31 January 2013 for the charge of conspiracy to possess a prohibited drug with intent to sell or supply.

PRE-CUSTODIAL MEDICAL HISTORY

16. By January 2013 the deceased had a history of severe chronic obstructive airways disease (COAD), ischaemic heart disease, lung and liver cancer and non-Hodgkin's lymphoma. It was anticipated that he would die from lung cancer within 12 months. He was receiving palliative chemotherapy on a three weekly basis and oxygen three to four times a day for emphysema.[12]

[10] Exhibit 1, Volume 1, Tab 26
[11] Exhibit 1, Volume 1, Tab 26
[12] Exhibit 1, Volume 1, Tab 25

MEDICAL HISTORY IN CUSTODY

17. Once the deceased was remanded in custody for sentencing, he was placed in Casuarina Prison's infirmary for ongoing care. There he spent most of his time alone in his cell. He was reasonably stable for the next few weeks.[13]

18. On 20 February 2013 the deceased was given his cycle of chemotherapy at RPH and then returned to the prison infirmary where he was monitored daily. He continued to lose weight.

19. On 7 March 2013 the deceased was registered under the Department of Corrective Services' Policy Directive 8[14] as a Phase 1 terminally ill prisoner. His status was escalated the same day under Health Services Procedure PM22[15] to Phase 2 as death was considered imminent.[16].

20. On 13 March 2013 the deceased received the next cycle of chemotherapy at RPH.

21. On 26 March 2013 the deceased developed worsening shortness of breath, dry cough, night sweats, lethargy and anorexia. His pulse rate was raised and his oxygen saturation was only 79% so he was transported by priority 1 ambulance to RPH where he was treated for an exacerbation of the COAD.[17]

22. On 29 March 2013 the deceased was discharged back to Casuarina Prison where he remained in the infirmary under observation.[18]

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[13] Exhibit 1, Tab 24, p.6
[14] Exhibit 1, Tab 33
[15] Exhibit 1, Tab 33
[16] Exhibit 1, Tab 24, p.8
[17] Exhibit 1, Volume 1, Tab 13; Volume 2, Tab 35
[18] Exhibit 1, Volume 1, Tab 23, p.3

23. On 3 April 2013 the deceased was transported to RPH haematology clinic for review.[19]

24. The next day the deceased was taken to the District Court in Perth where he was sentenced to 8 years and 6 months imprisonment from 31 January 2013. After returning to Casuarina Prison the deceased experienced acute respiratory distress so he was taken to RPH by ambulance.[20]

25. At RPH the deceased's condition continued to deteriorate. He was commenced on antibiotic therapy, non-invasive ventilation (BiPAP) and steroids, but he did not improve.

EVENTS LEADING UP TO DEATH

26. During the deceased's last admission to RPH, attempts were made to wean him off the ventilation, but his oxygen saturations dropped significantly at times.[21]

27. On 12 April 2013 the deceased received chemotherapy treatment and was reviewed by the palliative care team who changed his medications to manage his breathlessness. The next day he experienced some confusion, probably as a reaction to the chemotherapy.[22]

28. At approximately 5.00 am on 14 April 2013 the deceased was reviewed by a registrar. His oxygen saturations dropped to 65% so the registrar called for the medical emergency team. His ventilation was increased but he remained unsettled and his

[19] Exhibit 1, Volume 2, Tab 35
[20] Exhibit 1, Volume 2, Tab 35
[21] Exhibit 1, Volume 1, Tab 10
[22] Exhibit 1, Volume 1, Tab 10

breathing was moist. He was given morphine and lorazepam with little effect.[23]

29. At about 10.15 am the deceased became unresponsive. Cardiopulmonary resuscitation was initially attempted but was ceased in view of his not-for-resuscitation order. Death was confirmed 10 minutes later.[24]

CAUSE AND MANNER OF DEATH

30. Forensic pathologist Dr J White conducted a post mortem examination on 16 April 2013 and found:[25]
    a) extensive metastatic cancer involving the lungs, liver and lymph nodes
    b) congestion and oedema of the lungs
    c) consolidated changes to the lungs with abundant purulent secretions
    d) pleural adhesions
    e) scarring and bullae of the lungs (emphysema)
    f) metastatic disease of the liver with features of chronic congestion
    g) turbid ascites
    h) granular kidneys
    i) cachectic appearance
    j) moderate to severe coronary artery disease
    k) right ventricular hypertrophy

31. Microscopy showed widespread moderately differentiated adenocarcinoma and pneumonia. Microbiological samples showed a growth of *Haemophilus influenza* in the left lung tissue.

[23] Exhibit 1, Volume 1, Tab 10
[24] Exhibit 1, Volume 1, Tab 10
[25] Exhibit 1, Tab 6, p.6

32. Dr White formed the opinion, which I adopt, that the cause of death was pneumonia in a man with underlying advanced metastatic cancer and chronic airways disease.

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

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

34. On 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.

35. It appears to me that the standard of care and treatment the deceased received was equal to that which he would have received had he been in the community and been able to take advantage of the medical care available.

CONCLUSION

36. The deceased was a severely ill man when he was placed in the custody of the Chief Executive Officer of the Department of Corrective Services on 13 February 2013. As his condition deteriorated he received the appropriate palliative care during his time in prison and while admitted to RPH.

37. I am satisfied that, had the deceased not been in custody at the time of his death, an inquest would not have been warranted.

B P KING
CORONER
22 July 2014