**Coroners Act 1996**
**[Section 26(1)]**

*Western* *Australia*

# RECORD OF INVESTIGATION INTO DEATH

*Ref No: 4/ 19*

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of* ***William John DAVIS*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***4 February 2019*** *find that the identity of the deceased person was* ***William John DAVIS*** *and that death occurred on* ***18 October 2016*** *at* ***Karnet Prison Farm****, from* ***Subarachnoid Haemorrhage due to a Ruptured Berry Aneurysm*** *in the following circumstances:-*

**Counsel Appearing:**

Sergeant L Housiaux assisted the Coroner

Mr F Cardell-Oliver (State Solicitor's Office) appeared on behalf of the Department of Justice

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# INTRODUCTION

1. William John Davis (the deceased) died on 18 October 2016 at Karnet Prison Farm as a result of a subarachnoid haemorrhage caused by a ruptured berry aneurysm.

2. At the time of his death the deceased was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Corrective Services, as it then was.[1]

3. Accordingly, immediately before his death, the deceased was a "person held in care" within the meaning of the *Coroners Act 1996* (Coroners Act) and his death was a "reportable death".[2]

4. In such circumstances, a coronial inquest is mandatory.[3]

5. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[4]

6. I held an inquest into the deceased's death on 4 February 2019. Members of the deceased's family were in attendance.

7. The documentary evidence adduced at the inquest included two independent reports of the deceased's death prepared by the Western Australia Police[5] and by the Department of Corrective Services[6] respectively, which together comprised two volumes.

8. Mr Richard Mudford, the author of the report by the Department of Corrective Services, was called as a witness at the inquest.

9. The inquest focused on the care provided to the deceased while he was a prisoner, as well as on the circumstances of his death.

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[1] Section 16, *Prisons Act 1981*
[2] Sections 3 & 22(1)(a), *Coroners Act 1996*
[3] Section 22(1)(a), *Coroners Act 1996*
[4] Section 25(3) *Coroners Act 1996*
[5] Exhibit 1, Volume 1, Tab 2
[6] Exhibit 1, Volume 2, Tab 1

## THE DECEASED

### *Background*[7,8]

10. The deceased was born in Maryborough in Queensland, on 27 April 1979, and had three siblings. At the time of his death he was 37 years of age.

11. The deceased's parents struggled with drug and alcohol dependency and were reportedly violent towards the deceased and his siblings. When he was about 2 years of age, the deceased sustained a concussion type injury and was then neglected by his parents.

12. As a result, the deceased and his siblings were taken into State care. When the deceased was about 2½ years of age, he and his siblings were adopted. The deceased's adoptive parents provided him and his siblings with a supportive environment.

13. The deceased reported a significant history of illicit drug and alcohol abuse and said he began using cannabis when he was 13 years of age. He said that his adoptive parents supported him as he struggled with depression and undertook a number of drug rehabilitation programs.

14. The deceased was reportedly intelligent and academically gifted, but lacked motivation. As a result of his medical condition, he was socially isolated at school and had a difficult time.

15. After completing his schooling, the deceased attended university in Queensland to study music, language education and computer science. It appears that the deceased's alcohol and substance abuse interfered with his studies and he left Queensland and travelled to Tasmania. He attempted to resume his studies there, but was unsuccessful.

16. In 2001, while still in Tasmania, the deceased met a woman who had three children from a previous relationship. He and his partner had a daughter together and subsequently moved to Western Australia.

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[7] Exhibit 1, Vol. 2, Tab 1, pages 4-5
[8] Exhibit 1, Vol. 1, Tab 18, pages 33-36

17. In 2002, the deceased's daughter was reportedly taken into State care because the deceased and his wife were found to have issues with illicit drug and alcohol abuse.

18. The deceased and his partner separated in 2006.

19. As a result of his medical condition, the deceased was unable to undertake paid employment. Instead, he relied on Centrelink payments for most of his adult life.

## *Offending History*

20. Between 1997 and 2012, the deceased was convicted of minor offences on six occasions. The charges related to theft, breaking and entering a premises, trespass, possession of cannabis, and traffic offences. Fines were imposed with respect to those offences.[9]

21. On 6 December 2012, the deceased pleaded guilty in the District Court of Western Australia at Perth, to seven sexual offences committed against his step-daughter between 2010 and 2011.[10]

22. He was sentenced to an aggregate term of imprisonment of 6 years (backdated to 28 October 2012). He was made eligible for parole and had an earliest eligibility date for parole of 27 October 2016.[11]

## *Overview of Medical Conditions*

23. When he was 9 years of age, the deceased was diagnosed with an inherited connective tissue disorder known as Ehlers Danlos Syndrome (EDS). EDS describes a group of connective tissue disorders caused by inherited alterations in genes affecting the formation of collagen. Most types of EDS affect the joints and the skin. [12]

24. Symptoms can include loose and unstable joints (that are prone to dislocation), fragile skin (that tears and bruises easily) and debilitating musculoskeletal and joint pain.[13]

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[9] Exhibit 1, Vol. 2, Tab 1.1
[10] Exhibit 1, Vol. 1, Tab 18
[11] Exhibit 1, Vol. 2, Tab 1.4
[12] Exhibit 1, Vol. 2, Tab 2
[13] Exhibit 1, Vol. 2, Tab 1.2

25. The severity of the symptoms caused by EDS can vary from person to person. There is no cure for EDS and treatment is symptomatic in nature.[14]

26. In terms of his mental health, the deceased was diagnosed with Attention Deficit Hyperactive Disorder as a child and treated with medication for a time.[15] The deceased also had a long history of depression and numerous hospital presentations and admissions relating to self-harm.

27. The deceased attempted suicide on several occasions including in 2011 following the death of his adoptive mother. He was treated at the Alma Street Mental Health Service on that occasion and in total, had five admissions there relating to suicidal ideation.[16,17]

28. The deceased reported weekly instances of cutting behaviour as a means to control his emotions.[18]

29. The deceased's most significant medical complaint at the time of his death was pain, burning and pins and needles in his legs. Despite these symptoms being extensively investigated, a cause was not identified. The deceased was wait-listed to see a pain specialist at the time of his death.[19]

## ***Aneurysms & EDS***

30. An aneurysm is an abnormal bulge or swelling in a blood vessel. An intracranial berry aneurysm is a round or berry-like weakness in an artery in the brain.

31. A study in the United States of America estimated that between 0.4-6% of the general population may have intracranial berry aneurysms.[20]

[14] Exhibit 1, Vol. 2, Tab 2
[15] Exhibit 1, Volume 1, Tab 18, page 36
[16] Exhibit 1, Volume 1, Tab 18, page 36
[17] Exhibit 1, Vol. 2, Tab 1.5
[18] Exhibit 1, Vol. 2, Tab 1, page 5
[19] Exhibit 1, Vol. 2, Tab 1, page 7
[20] Singer RJ, Ogilvy CS, Rordorf G, Biller J & Wilterdink JL "Screening for Intracranial Aneurysm", UptoDate, 07 Nov 2016

32. The rate of occurrence of intracranial berry aneurysms for people diagnosed with a sub-type of EDS known as vascular EDS appears to be higher, but there does not appear to be any consensus in the literature.[21]

33. There is also no consensus in the literature about the clinical benefits of routine screening for intracranial aneurysms for people with the vascular form of EDS who are otherwise asymptomatic.[22]

34. This is unsurprising given that, in the majority of cases, aneurysms are asymptomatic and any corrective surgery carries significant risk.

35. There is no evidence about which form of EDS the deceased was diagnosed with. In any event, for the reasons I have explained, even if the deceased had vascular EDS, there is no evidence that routine screening would have been appropriate in his case.

## THE DECEASED'S PRISON HISTORY[23]

### *Hakea Prison – Remand*

36. The deceased was remanded in custody at Hakea Prison from 19 April 2012 to 30 April 2012, until his bail conditions could be satisfied. During the admissions procedure at Hakea Prison, the deceased disclosed a history of self-harm and presented as depressed, tearful and distressed.

37. Because of the nature of the offences with which he was charged, the deceased was given protected prisoner status and was monitored under the At Risk Management System (ARMS) and referred to the Prisoner Counselling Service (PCS).[24]

[21] Kim ST, Brinjikji W, Kallmes DF "Prevalence of Intracranial Aneurysms in Patients with Connective Tissue Diseases: A Retrospective Study, American Journal of Nuroradiology (sic), August 2016, 37(8)
[22] Hitchcock E & Gibson WT "A Review of the Genetics of Intracranial Berry Aneurysms and Implications for Genetic Counseling", Journal of Genetic Counseling, (sic) 2017; 26(1)
[23] Exhibit 1, Vol. 2, Tab 1, pages 7-11
[24] Exhibit 1, Vol. 2, Tab 1.5

38. The deceased was remanded in custody again between 18 May 2012 and 13 June 2012 when his surety was withdrawn.

39. During the admission procedure on that occasion, the deceased was noted to be withdrawing from alcohol and his answers to questions about the future were evasive. As a result, he was again monitored under the ARMS and referred to the PCS.[25]

### *Hakea Prison – Sentenced Prisoner*

40. The deceased was admitted to Hakea Prison on 6 December 2012 after being sentenced in the District Court of Western Australia. On admission, he was malnourished and required treatment for alcohol withdrawal. He also had gastro-oesophageal reflux secondary to alcohol abuse.

41. During the admission process, the deceased disclosed a self-harm incident one week earlier and numerous "slashes" in the previous 12 months. Given those matters and the deceased's alcohol withdrawal issues, he was monitored under the ARMS until 13 December 2012.[26]

42. The deceased remained at Hakea Prison until 21 January 2013 when he was transferred to Acacia Prison.

### *Acacia Prison – Sentenced Prisoner*

43. The deceased was received at Acacia Prison on 21 January 2013. He was monitored under the ARMS for about three weeks in March 2013 when he disclosed he was having difficulties coping with his incarceration.[27] In June 2013, he was again monitored under the ARMS, this time for two days, following a self-harm incident involving cutting.[28]

44. The deceased was regularly reviewed by the Prisoner Risk Assessment Group (PRAG) and received psychological counselling from the PCS. He was also referred for psychiatric review.

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[25] Exhibit 1, Vol. 2, Tab 1.5
[26] Exhibit 1, Vol. 2, Tab 1.6
[27] Exhibit 1, Vol. 2, Tab 1.9
[28] Exhibit 1, Vol. 2, Tab 1, page 9

45. In September 2013, the deceased's PCS counsellor reported that the deceased had expressed high levels of anxiety about his transfer to Karnet Prison Farm, which was scheduled for early 2014.

46. In addition to continuing as a client of the PCS, the deceased was also managed under the Support and Monitoring System (SAMS) from 11 December 2013.

47. The deceased's SAMS records show that he received regular welfare checks by prison staff. Initially, these were daily but later, they were conducted on a weekly basis. No significant issues were identified.[29]

## *Karnet Prison Farm – Sentenced Prisoner*

48. The deceased was transferred to Karnet Prison Farm on 11 February 2014. At the time of his admission, he was receiving weekly welfare checks under the SAMS and his progress was discussed at monthly PRAG meetings.

49. The deceased was assessed as coping well with his incarceration and was removed from SAMS in June 2014.

50. The deceased's classification reviews and contact reports record no significant changes to his circumstances and he had a very good conduct record during his time in prison.[30]

51. At the time of his death, the deceased was classified as a minimum security prisoner at Karnet Prison Farm.[31]

## *Application for Parole*

52. The deceased's undated application for parole[32] was approved by the Prisoners Review Board Western Australia by letter dated 30 September 2016.[33] He was due for release from prison on 27 October 2016.

[29] Exhibit 1, Vol. 2, Tab 1. Page 9
[30] Exhibit 1, Vol. 2, Tab 1.12
[31] Exhibit 1, Vol. 2, Tab 1.11
[32] Exhibit 1, Vol. 1, Tab 29
[33] Exhibit 1, Vol. 1, Tab 27

## THE EVENTS OF 18 OCTOBER 2016[34,35]

53. On 18 October 2016, the deceased was housed in cell C-9 in C Wing, Unit 3 at Karnet Prison Farm. C Wing is a self-care unit and prisoners are responsible for making their own meals.

54. On the morning of 18 October 2016, the deceased showered, had breakfast and presented for morning roster as usual at 7.30 am.

55. At 8.20 am, the deceased attended the Prison's medical centre and was given his prescribed medication.[36] He returned to his cell and spoke to several prisoners also housed on C Wing until about 9.00 am.

56. There was nothing untoward about these conversations and the deceased appeared to be his normal self.

57. At about 10.00 am, a prisoner housed in C Wing came into the deceased's cell and gave him some bananas. The deceased expressed his thanks and said he would eat them later. He seemed his usual self.[37]

58. At about 10.10 am, several prisoners found the deceased sitting in a chair outside the front of C Wing. He was slumped over and cool to the touch. Brown coloured fluid appeared to have dribbled from his mouth.[38]

59. Two of the prisoners who found the deceased alerted prison officers who called a Code Red medical emergency. Prison officers ran to the deceased's location and immediately began CPR.[39]

60. A short time later, two clinical nurses from the Prison's medical centre arrived and assisted with resuscitation attempts, including the insertion of an airway.

[34] Exhibit 1, Vol. 1, Tab 2, pages 3-5
[35] Exhibit 1, Vol. 2, Tab 1, page 11
[36] Exhibit 1, Vol. 1, Tabs 9, 10 & 16
[37] Exhibit 1, Vol. 1, Tab 11
[38] Exhibit 1, Vol. 1, Tabs 10 & 12
[39] Exhibit 1, Vol. 1, Tabs 10, 12, 14 & 15

61. A defibrillator was attached to the deceased's chest, but it detected a non-shockable rhythm.[40]

62. Ambulance officers arrived at the prison at about 10.34 am and continued resuscitation attempts, but were unable to revive the deceased.[41]

63. The deceased was pronounced dead by an ambulance officer at 10.49 am[42] and the deceased was conveyed to the State Mortuary.[43]

## CAUSE AND MANNER OF DEATH

64. A forensic pathologist conducted a post mortem of the deceased's body on 21 October 2016 and found evidence of the resuscitation efforts and bruising and abrasions to the skin of the deceased's arms and right knee. The skin of the deceased's digits seemed thinned and his fingers and toes had a slender appearance.[44]

65. There was bleeding around the deceased's brain (subarachnoid haemorrhage) associated with a ruptured aneurysm of the right middle cerebral artery and his lungs were congested, although this is a non-specific finding. The deceased's body organs appeared to be otherwise healthy.[45]

66. Neurological examination of the deceased's brain and spine confirmed the presence of a subarachnoid haemorrhage.[46]

67. The forensic pathologist expressed the opinion that the cause of death was subarachnoid haemorrhage caused by a ruptured berry aneurysm. I accept and adopt that conclusion.

68. I find the deceased's death occurred by way of natural causes.

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[40] Exhibit 1, Vol. 1, Tab 16
[41] Exhibit 1, Vol. 1, Tab 17
[42] Exhibit 1, Vol. 2, Tab 1.17
[43] Exhibit 1, Vol. 1, Tab 25
[44] Exhibit 1, Vol. 1, Tab 6
[45] Exhibit 1, Vol. 1, Tab 6
[46] Exhibit 1, Vol. 1, Tab 7

## QUALITY OF SUPERVISION, TREATMENT AND CARE

69. Periodically during his time in prison, the deceased was managed under the ARMS and the SAMS. The deceased's mental health status was also discussed at regular meetings of the PRAG.

70. The deceased was a long-term client of the PCS and received regular counselling sessions. He was also reviewed by the prison psychiatrist. His mental state appears to have stabilised during the latter half of his incarceration.

71. The deceased was seen by prison doctors and nurses for various medical issues and was also reviewed by allied health services including podiatry and physiotherapy. Prison records show that the deceased attended prison medical centres on over 200 occasions during his time in prison.[47]

72. In addition, he attended 17 specialist appointments and was variously reviewed by neurologists, dermatologists and rheumatologists.[48]

73. The deceased received regular visits whilst he was in prison, including from his ex-partner and his daughter.[49]

74. Having regard to all of the circumstances of the deceased's incarceration, I am satisfied that the supervision, treatment and care provided to the deceased was reasonable and appropriate.

M A G Jenkin
**Coroner**
6 February 2019

[47] Exhibit 1, Vol. 2, Tab 1.3
[48] Exhibit 1, Vol. 2, Tab 1.3
[49] Exhibit 1, Vol. 2, Tab 1.10