Coroners Act 1996
[Section 26(1)]

Western  *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 44/18

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Ronald Alan GIBLETT*** *with an Inquest held at Perth Coroners Court, Court 85, Central Law Courts, 501 Hay Street, Perth, on 5 December 2018, find the identity of the deceased was* ***Ronald Alan GIBLETT*** *and that death occurred on 5 November 2016 at Karnet Prison Farm, Serpentine, as the result of Valvular Ischaemic Heart Disease in association with Coronary Arteriosclerosis in the following circumstances:-*

Counsel Appearing:

Sergeant L Housiaux assisted the Deputy State Coroner

Ms B Loftus (State Solicitors Office) appeared on behalf of the Department of Justice (Corrective Services Division)

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INTRODUCTION

During the morning of 5 November 2016 Ronald Alan Giblett (the deceased) was located deceased in his cell at Karnet Prison Farm (Karnet) by another prisoner. Despite a prompt response once discovered, the deceased could not be revived.

The deceased was 79 years of age.

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

The brief for the purposes of the inquest comprised of one volume of documentary evidence, Exhibit 1, plus the oral testimony of Richard Mudford, Senior Review Officer, Performance Assurance and Risk, Department of Justice.

BACKGROUND

The Deceased

The deceased was born on 12 August 1937 in Northam and left school following year 8 at Kalgoorlie Central High School.

He was the eldest of three children and had a close relationship with his mother before she passed away. He had a stable

upbringing, although he did not get along with his father and self-reported he had been abused by older female cousins when a child.

The deceased worked on remote stations as a stockman until called for national service. He then spent 21 years working for Western Mining Corporation on numerous mining sites before leaving Kambalda to move to Perth where he initially bought a car dealing business.[1] Following selling that business he worked for the Church of Jesus Christ as a custodian until his heart problems required he retire at 56 years of age.

The deceased had generally appeared as a person of good character and conduct with only three minor traffic offences in the decade between 1979 and 1988.

By the time of his incarceration in December 2013 the deceased had been married for 53 years. The deceased and his wife had eight children and a number of grandchildren. It was the deceased's offending, both historically and more recently, which brought him to the attention of the police and threatened his family relationships.

At the time of the deceased's sentencing his wife and one son remained supportive of him, although I note by the time of his death the deceased was no longer as well supported by his wife and family members.

[1] t 05.12.18, p5

The deceased had always had a hobby of bee-keeping and this remained an interest until his death.

Medical

The deceased had an extensive medical history which included a family history of heart disease on both his parents' sides.

The deceased attended Mead Medical Centre until his imprisonment in December 2013. His medical history was extensive and aside from his family history he had suffered ischaemic heart disease with previous myocardial infarctions, stents and coronary artery bypass surgery. He had hypertension, high cholesterol, kidney disease, had a parathyroidectomy, appendectomy, right knee replacement with arthritis in his right hip, gout, osteomyelitis, he had suffered a hernia, he had gastroesophageal reflux disease, coeliac disease and a benign prostatic hypertrophy.

The deceased had no record of any mental health issues, was no longer a smoker and only occasionally drank alcohol.

Incarceration

On 6 December 2013 the deceased pleaded guilty to a number of offences. These were both historic and more recent. He was sentenced by the Perth District Court to a cumulative sentence of four years and 10 months imprisonment with an eligibility for parole. His earliest eligibility for parole was 5 October 2016

and his earliest date of release 5 October 2018. These offences were the first convictions of any significance for the deceased and he was 76 years of age at the time of incarceration.

The deceased was first incarcerated in Hakea Prison to allow assessment of his situation to occur. He was recorded as being calm and cooperative during interview, without presenting any issues and had been expecting a custodial term. He was expecting visits from his wife and did not have any self-harm issues. He was confirmed as suitable for two prison programs related to his offending to reduce his likelihood of recidivism.

On admission to Hakea Prison the deceased underwent a full medical review on 10 December 2013 which recorded normal observations other than a raised blood pressure. He had been medication non-compliant and was referred for blood tests and recommenced on his usual medications. He underwent regular age related screens and vaccinations. By 14 December 2013 the deceased's blood pressure had returned to normal and his blood tests were appropriate. The deceased was commenced on a cardiovascular care plan designed to record and review his cardiac issues.

The deceased was originally a protected prisoner due to his offending, but appeared to settle into the prison routine well and comply with staff instructions. He required minimal supervision within the prison system, kept to himself to a certain extent, but interacted appropriately at all times. His

security rating was reduced to minimum on 18 December 2013 which allowed for his transfer to Karnet and easier prison visits once transferred.

That transfer occurred on 25 February 2014 and he remained at Karnet until his death on 5 November 2016. There were no loss of privileges or disciplinary convictions recorded in his prison reviews. He was employed as a storeman in the gardens where he was reported to be self-motivated with a good work ethic. He was content at Karnet where he could receive visits from friends and complete prison programs aimed at reducing his reoffending potential.

The deceased also completed gate keeper training aimed at training him to be in a position to assist fellow prisoners should he believe they were exhibiting signs of mental unwellness.

On 17 April 2014 the deceased had a period of chest pain, however, ECG and troponin tests were negative for heart attack. Otherwise the deceased's main contact with the medical centre was for minor issues and anything more serious was treated by transfer to Armadale Hospital.

The deceased continued to have his bloods monitored and since reinstitution of all his appropriate medications his results remained normal. His cardiovascular care plan was reviewed on 17 November 2014 and he had his regular annual

health check on 3 December 2014. His next cardiovascular care plan review on 5 May 2015 documented he was well. However, on 19 October 2015 the deceased had some chest pain accompanied by a cough and cold symptoms. His observations and ECG were normal and he was diagnosed with an upper respiratory tract infection (URTI).

The deceased's annual health assessment in January 2016 indicated he remained stable. That continued through his next cardiovascular care plan review in April 2016 which included a caution to improve his diet.

The deceased complied with all regular medical reviews necessary and did not complain of any symptoms which could relate to any of his known illnesses.

At the time of his death while incarcerated the deceased had completed programs towards his suitability for parole, however, parole was denied due to a consideration the deceased no longer had support in the community, and his age indicated he would not be able to support himself. It had been the deceased's intention to find accommodation through Outcare[2] and participate in voluntary work.

[2] Ex 1, tab 19, 20 attachment 20

5 November 2016

The deceased was housed in cell 9, C wing, unit 3, which was a self-cared unit. On the morning of 5 November 2016 the morning muster was completed by prison officers (PO) Mark Ridley and Paul Coppendale. The purpose of the muster was to ensure body movement within each cell prior to unlock. PO Ridley checked the deceased in cell 9 and stated he would have raised an alarm had there been no response from the deceased. Following the morning muster PO Ridley remained on the wing while PO Coppendale left to facilitate prisoner visits. PO Ridley was stationed in the control unit.[3]

Following unlock the deceased was observed by prisoner Kenneth Buswell at approximately 7.00 am, brushing his teeth in the sink area. They exchanged greetings, but did not say anything further. Mr Buswell was aware the deceased was expecting a visitor and looking forward to that visit.[4]

The deceased was seen later by prisoner Eric Cosford in the kitchen area. Mr Cosford reported the deceased was in good spirits as he was expecting visitors and when he saw him at approximately 7.45 am the deceased was washed, dressed and showered ready for his visit. The two of them chatted for about 4-5 minutes on their plans for the day and Mr Cosford then saw the deceased returning towards his room. He observed the deceased close his door. Mr Cosford then went to his area

[3] Ex 1, tab 9
[4] Ex 1, tab 12

of employment. He was uncertain as to whether the deceased had closed his door or merely pulled it to.[5] Mr Buswell returned from his prison work at approximately 7.40 am.

PO Ridley reported he started calling prisoners to attend their visits before 8.30 – 9.00 am, as the information came through from the visitors area. PO Ridley noted the deceased was on the first group of prisoners for the morning and those prisoners were required to go to the control booth to have their movement form stamped. PO Ridley called the deceased's name over the public address system but received no response. He then called the deceased a second time and was waiting for him to respond. Mr Cosford returned to C wing at approximately 9.00 am and heard one of the visitor announcements over the public address system.

Mr Buswell was sitting having a smoke when he heard PO Ridley's call for the deceased. Mr Buswell did not see the deceased come out of his room so he went and checked the deceased's room. As Mr Buswell approached the room he could see the deceased's feet on the bed, through the door which was ajar. He knocked and called out, but received no response so he pushed the door open further.

Mr Buswell observed the deceased on his back, on his bed with his mouth open. He observed no movement from his chest area or abdomen and as a result called out to prisoner Michael

[5] Ex 1, tab 12

Cooper. Mr Cooper went into cell 9 and saw the deceased lying on the bed and believed he heard a gurgling sound. As a result Mr Cooper placed the deceased into the recovery position and asked Mr Buswell to go and inform the prison officers there was an issue for the deceased.[6]

PO Ridley noted Mr Buswell run to the control room for unit 4 while yelling and pointing to C block as he ran. PO Ridley ran to C block and heard PO Butterfield calling a medical emergency (code red) over the radio. PO Ridley went into cell 9 and saw the deceased on his side, facing towards the door, on his bed. He observed two prison officers trying to get a response from the deceased while Mr Cooper was asked to return to his cell.

PO Ridley left to obtain the Oxy Boot and Oxy Viva and when he returned to the cell, found the deceased had been placed on the floor in the recovery position. The deceased was then rolled onto his back by PO Ridley and PO Butterfield who commenced cardiopulmonary resuscitation (CPR). The defibrillator recorded no shockable rhythm so no shocks were given and at that point the nurse entered to assist.[7] CPR was continued pending the arrival of the St John Ambulance (SJA) paramedics.

[6] Ex 1, tab 10
[7] Ex 1, tab 9

SJA service had been called at 8.59 am and arrived at cell 9 at 9.22 am. The paramedics observed competent CPR in progress.[8] CPR was ceased at 9.45 am as there were no signs of life.[9]

Cell 9 was secured until the arrival of the Coronial Investigation Squad (CIS)[10] when the scene was examined and photographs taken. The deceased was identified.[11] Following forensic and further investigations it was determined by CIS there were no signs the death of the deceased had been caused or contributed to by any other person.

POST MORTEM REPORT

The post mortem examination of the deceased was undertaken by senior pathologist, Dr Clive Cooke, PathWest Laboratory of Medicine WA.[12]

Dr Cooke noted changes related to the resuscitation attempts, including fractures to the ribs at the front of the chest and a small amount of internal bleeding. He observed enlargement of the heart, with scarring of part of the heart muscle (ischaemic heart disease) and thickening of some of the heart valves. The arteries on the surface of the heart were calcified and narrowed (calcified coronary arteriosclerosis) and there

[8] Ex 1, tab 17
[9] Ex 1, tab 5
[10] Ex 1, tab 3
[11] Ex 1, tab 4
[12] Ex 1, tab 6

was a coronary artery bypass graph in place which also showed arteriosclerosis. This was all in keeping with the deceased's prior known heart disease. There was apparently benign enlargement of the prostate gland, fine scarring of the kidneys and several small nodules in the spleen. At that stage the cause of death was undetermined pending further investigations.

On 6 February 2017 Dr Cooke completed all further investigations which included histology and confirmed the changes to the heart muscle. The nodules in the spleen showed features of B-cell malignant lymphoma. Neuropathology indicated no significant abnormalities, microbiology showed the presence of some bacterial organisms not considered to be of significance to the death, while toxicology indicated the presence of medications consistent with the deceased's known medical care.[13]

Following assessment of those investigations Dr Cooke was of the opinion the cause of death for the deceased was best described as valvular and ischaemic heart disease in association with coronary arteriosclerosis.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 79 year old sentenced prisoner, resident at Karnet at the time of his death. The

[13] Ex 1, tab 7

deceased had suffered significant cardiac disease to the extent he was retired from his employment long before he was sentenced to a period of imprisonment. Prior to his retirement on grounds of ill health the deceased had always been employed, been in a long term marriage, and fathered eight children.

The deceased had a significant medical history in the community, starting with a family background of cardiac disease. Management of his cardiac issues dated back as far as balloon dilation in 1990. He appears to have maintained reasonable medical intervention in the community through his general practitioners until the time of his incarceration in 2013.

A number of cardiac related interventions are recorded in his medical history prior to incarceration and on incarceration he was reviewed with respect to his known medical issues and placed on a cardiovascular care plan as appropriate. He was regularly reviewed while in custody and had relatively few concerns with respect to his cardiac disease. At the times he did complain he was appropriately assessed and monitored.

The deceased appeared well once located at Karnet and was able to continue with his hobbies related to beekeeping and lathing which had been a relatively new hobby preceding his incarceration.

The nature of the deceased's offending leading to incarceration certainly put a strain on the deceased's family relationships, but the fact of his ability to be employed in an area in which he was already interested appears to have been conducive to his wellbeing while incarcerated. Generally the deceased appears to have managed well until the event on 5 November 2016.

I note Mr Buswell believed the deceased was under stress with respect to his family relationships and parole, but there was no indication in his prison medical record of any cardiac difficulties for the deceased in 2016.

The deceased's prison medical record indicated he had regular annual reviews, six monthly cardiovascular care plan reviews and was attended by medical staff whenever he had an issue, including transfer to Armadale Hospital in 2014 and 2015 when necessary. There is no indication in the relevant documentation the deceased was struggling with, or complained of, unmanaged medical issues.

Manner and Cause of Death

I am satisfied the deceased exhibited no warning signs he was about to suffer a fatal cardiac arrest when observed by prison staff at unlock on 5 November 2016. He was observed by fellow prisoners to be in a jovial mood and expecting a visit, although it is not clear from whom that visit was to be.

On retreating to his room at approximately 7.45 am the deceased gave no indication he would not be in a position to attend once called to the visitors area.

It is clear that by the time the deceased was called shortly thereafter, sometime between 8.30 and 9.00 am he had suffered a fatal cardiac arrest. He was located by Mr Buswell in his room, unresponsive, and did not recover during the following period, despite medical intervention. He was declared life extinct at 9.45 am on the morning of 5 November 2016 in cell 9 of C wing.

I am satisfied the deceased's naturally occurring coronary arteriosclerosis was appropriately dealt with during his incarceration and that he died without warning as the result of a fatal cardiac arrest, the effects of which could not be reversed.

I find death occurred by way of Natural Causes.

SUPERVISION, TREATMENT AND CARE OF THE DECEASED WHILE IN CUSTODY

The deceased had been known to suffer from coronary artery disease from as early as the 1990s. He had retired relatively early as the result of his cardiac disease and had been treated in the community for his heart condition prior to his incarceration on 6 December 2013.

Following his incarceration the deceased was appropriately assessed by medical staff and placed on a cardiovascular care plan. The deceased's medical file shows regular review of his cardiac situation with appropriate treatment on the occasions there was concern he was experiencing cardiac problems. Intervention on those occasions did not indicate the deceased had suffered a '*heart attack*', however, he was appropriately managed with a cardiac arrest in mind.

The deceased received regular annual reviews and medical intervention when he sought intervention or treatment for other medical difficulties. There is no indication in the documentary evidence the deceased was concerned as to his medical state leading up to his death on the morning of 5 November 2016. While I appreciate the deceased had been declined parole and remained in custody, it does not appear the terms of his incarceration were overwhelmingly onerous for the deceased. He was able to work on the farm and be involved with beekeeping, a hobby he had always enjoyed. I accept fellow prisoners noted he was concerned about his family situation.[14]

The deceased appears to have coped relatively well while incarcerated. Certainly there are no complaints from management's perspective as to his behaviour and although I note he moved to C Wing shortly before his death due to a vacancy, it is not clear whether that was due to any difficulties

[14] Ex 1, tab 11

with his imprisonment. The prisoners in Unit 3, C wing, considered they were a cohesive and supportive group.[15]

I note the deceased was intending to make arrangements through Outcare had he been released into the community, but it is certainly not unreasonable to think the familiarity of his situation in cell 9, C wing at the time of his death, with an occupation he enjoyed was a preferable residential option to finding himself alone in the community, with little familial support at 79 years of age.

I am satisfied the deceased's supervision, treatment and care while in custody were of a good standard.

E F Vicker
Deputy State Coroner
4 April 2019

[15] Ex 1, tab 12