Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 34/14

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Francis Robert WARD****, with an Inquest held at Perth Coroners Court, CLC Building, 501 Hay Street, Perth on 23 September 2014 find the identity of the deceased person was* ***Francis Robert WARD*** *and that death occurred on 8 September 2013 at Rockingham General Hospital, as a result of Pneumonia in a man with Traumatic Brain Injury in the following circumstances –*

Counsel Appearing :

Sergeant L Housiaux assisted the Deputy State Coroner

Ms C Brandstater (Instructed by State Solicitors Office) appeared on the behalf of the Department of Corrective Services

Table of Contents

INTRODUCTION

Francis Robert Ward (the deceased) was a sentenced prisoner at Casuarina Prison at the time of his death.

He was being cared for in the prison infirmary pending transfer to a suitable high level nursing facility, when he deteriorated rapidly on 6 September 2013 and required immediate hospitalisation. While under transfer to Royal Perth Hospital (RPH) the deceased was redirected to Rockingham General Hospital (RGH) where he remained, under palliative care, until his death on 8 September 2013.

He was 90 years of age.

Under the provisions of the *Coroners Act 1996* (section 3 & section 22 (1)(a)) the death of the deceased must be the subject of a public hearing by way of inquest and the deceased's supervision, treatment and care while in custody must be commented upon by the Coroner conducting the inquest (section 25 (3)).

BACKGROUND

The deceased was born on 14 October 1922 in Victoria. He was the youngest, and only male, of four children in a family of practising Seventh Day Adventists. He was educated in Western Australia to year 10 at a Seventh Day Adventist School, and thereafter at a Seventh Day Adventist

College, where he obtained a business diploma in book keeping, which he used in later employment.

He joined the Army following the outbreak of World War II and served in the Medical Corps in both Borneo and Indonesia. He was discharged from the Army in 1946 and thereafter had periods of employment at the Taxation Department and as a Hospital Orderly. Whenever in the prison system the deceased was employed, and was employed in the periods between incarceration.

The deceased never married or had any children.

The first conviction for the deceased was recorded in 1946, and his first term of imprisonment was in 1952, for a term of four years with respect to offences involving children.[1] Thereafter the deceased underwent regular terms of imprisonment for both violence and sexual offences against children. In 1967 he was detained at the Governor's pleasure following a period of imprisonment, and was released in January 1973. He was referred for counselling on various occasions to do with his offending but generally rejected any form of engagement with treatment to address his offending behaviours.

[1] Ex 2, Tab 1

His most recent term of imprisonment commenced in 1994, when he was 71 years of age, and he remained incarcerated since that time.

MEDICAL

The deceased's past medical history on his admission to hospital in 1994 recorded hypertension and rheumatoid arthritis. He had also experienced malaria in 1946 and complaints were recorded of multilevel spinal stenosis, osteoarthritis of his right knee, deafness in his left ear, mild renal impairment, neuralgia in his left hand and an appendectomy at some time.

MOST RECENT PERIOD OF IMPRISONMENT

The deceased was imprisoned on 9 March 1994 to 27 months imprisonment for offences relating to indecent dealing with a child, and he was to be detained indefinitely thereafter due to his risk to the community, with reviews to determine whether he should be released.[2] His prison history since 1994 indicates he was reviewed by the Parole Board, or equivalent, on 21 occasions, but was never granted parole due to his failure to cooperate with any of the treatment programmes recommended prior to his eligibility for release. He was otherwise recorded as a model prisoner.

[2] Ex 2, Tab 6

On his admission to custody his health was recorded as good, other than hypertension and rheumatoid arthritis, and as a result of those problems he was reviewed regularly by health services, and his blood pressure monitored weekly.

In 2001 the deceased was transferred to Bunbury Regional Prison at his request. While there he experienced right inferior vein occlusion in 2002, with right central retinal vein occlusion in 2004, thereafter he developed cataracts and glaucoma.

Due to his age the deceased's health and mobility deteriorated and in September 2006 he was transferred to Acacia Prison, again at his request, where there was an assisted care unit.[3] He remained at Acacia Prison's assisted care unit until he required admission to Swan District Hospital with acute chest and epigastric pains and difficulty breathing on 27 March 2013.

The deceased needed to be transferred to RPH on 30 March 2013 where he was diagnosed with pancreatitis/tendonitis as a result of a gastro intestinal bleed. He was discharged from RPH to Casuarina Prison infirmary on 9 April 2013 where he remained as a sentenced prisoner until his death.

[3] Ex 2, Tab 4

In May 2013 the deceased was found to be hypotensive and blood tests indicated he was anaemic. On 15 May 2013 he fell in the toilet and received a laceration. The following day his haemoglobin levels had dropped. Due to his history of gastrointestinal bleed, low blood pressure and recent head injury he was transferred back to RPH ED for further assessments. There he was given an iron infusion to correct his anaemia and diagnosed with acute-on-chronic renal failure.

A bruise was noticed on the back of his head with a mild ooze but neurological examination showed normal power and sensation in all limbs, although there was a mild left sided tremor with increased tone, and some left sided uncoordination, however, he was orientated in time, place and person.

A CT scan of his head showed cerebral involution with age appropriate small vessel ischaemic change. There was no evidence of haemorrhage or cortical infarction. He was discharged back to prison on 24 May 2013 with a request the prisoner GP conduct cardiovascular investigations.

On 27 May 2013, while in the prison infirmary, the deceased had another fall after tripping over his Zimmer frame, but did not appear to sustain any major injuries. Following 24hr BP monitoring there were no significant abnormalities noted other than a first-degree AV block.

The deceased also suffered falls on 31 May 2013 and 8 June 2013 but did not appear to suffer anything other than soft tissue injuries.

On 13 June 2013 the deceased experienced another unwitnessed fall following which he was found to have a left swollen calf and appeared to be confused. He was again transferred to RPH where a CT scan showed a small right subdural collection which was deemed to be a sub-acute haematoma without massive effect.[4] X-ray of his left leg and venous duplex scan were normal and he was discharged on 21 June 2013 to the prison infirmary, but transferred back to RPH the following day after he vomited large amounts of blood.

A gastroscopy showed esophagitis, hiatus hernia and a healed duodenal ulcer. He was discharged again on 25 June 2013 to continue with his medication.

The deceased continued to experience falls but did not appear to suffer any major injury. He was provided with regular falls risk assessments and on 25 July 2013 was given a falls alarm.[5] The deceased was becoming incontinent and required regular assistance with activities of daily living. From time to time he was confused and

[4] Ex 1, Tab 16
[5] Ex 1, Tab 18

agitated and his cognitive functioning appeared to be in decline.

On 11 August 2013 one of the deceased's soft tissue injuries became infected and he developed a urinary tract infection. He was requiring full time nursing care in the prison infirmary and it was becoming increasingly difficult to mobilise him.

The cells in the infirmary are locked overnight and the nursing staff, while present, require the assistance of the recovery team to assist people if they become aware of problems in a cell overnight.

On the evening of 17 August 2013 the deceased was observed to be lying across the bottom of his bed. The recovery team was called and by the time the deceased was accessed he was lying on the floor. He was put back to bed and a foam mattress placed below the bed on the floor.[6] A bruise was noted on his head.

The following morning he was reviewed and noted to be again lying across his bed with bruising to his hip, buttock and head. At 10am he was assessed as unable to communicate, with signs of a stroke including incoherent speech, leaning to the left, and a flaccid left arm.

[6] Ex 1, Tab 14

The deceased was transferred to RPH ED where he was diagnosed with an acute subdural haemorrhage. Due to his age and poor prognosis he was deemed unsuitable for surgical intervention and the decision was made to treat him conservatively.[7]

The deceased was added to the terminally ill list *"prisoner with a terminal illness policy"* held by the Department on 20 August 2013 as a phase one (high probability of death) patient/prisoner.[8] He had been elevated to phase two (death imminent) the same day. As a result of that classification the Department briefed the Minister on the deceased's condition and made inquiries as to his eligibility for a Royal Prerogative of Mercy (RPOM) to be exercised for his release pending his death. That process was still in operation by the time the deceased died, however, efforts continued to be made to obtain a suitable placement for the deceased in view of his need for high care nursing.

The deceased was stabilised and returned to Casuarina Prison infirmary on 4 September 2013 with a requirement for full nursing care. Efforts were made to locate a high level nursing care placement for him as soon as possible.

The infirmary progress notes indicate the deceased was very unwell and drifting in and out of lucidity.

[7] Ex 1, Tab 16
[8] Ex 2, Tab 16

On 6 September 2013 the deceased's condition deteriorated further. Nursing staff recorded he was unable to take fluids and had a rapid respiratory rate. Arrangements were made for him to be transferred back to RPH with a provisional diagnosis of possible aspiration, after choking earlier that morning.

It was during transfer of the deceased from Casuarina infirmary back to RPH his condition deteriorated dramatically and the ambulance was diverted to RGH for resuscitation.

At RGH the deceased was placed in the palliative care unit and after assessment it was decided he should be treated conservatively.[9] All active treatment was withdrawn after he had contact with his niece, his next of kin. At all times the deceased remained under guard as a custodial patient.

The deceased died on 8 September 2013 before there was any response to the RPOM early release process.

POST MORTEM REPORT[10]

A post mortem examination was conducted on 10 September 2013 by Dr Gerard Cadden, Forensic Pathologist of PathWest. At post mortem Dr Cadden noted a right sided subdural haematoma, bilateral lower lobe

[9] Ex 1, Tab 17
[10] Ex 1, Tab 6, 7 & 8

pneumonia and pulmonary congestion, coronary and generalised atherosclerosis and some renal cyst formation.

Neuropathology revealed a traumatic brain injury by way of a large acute-on-chronic-right-subdural haematoma with midline shift left and transtentorial herniation (unilateral right uncal notch).

Toxicology detected various medications consistent with the deceased's appropriate care but none which would have any bearing on the cause of his death.

At the conclusion of all the investigations Dr Cadden concluded the cause of the deceased's death to be Pneumonia in a man with traumatic brain injury.

The history would seem to be a fall causing the formation of a small right frontal subdural haematoma, detected on 13 June 2013 following a CT scan at RPH.

On 17 August 2013 the deceased suffered another fall following which he appeared to exhibit symptoms of stroke. He was taken back to RPH on 18 August 2013 where another CT scan identified a large acute-subdural-haemorrhage overlying the right fronto temporal parietal region on top of a subacute/chronic subdural collection.

The deceased was not considered suitable for neurosurgical intervention and was treated conservatively. He developed pneumonia, a known complication of patients suffering traumatic brain injury followed by palliative care, especially in a patient of the deceased's age and co-morbidities.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 90 year old sentenced prisoner serving time at Casuarina Infirmary as a result of his, not unexpectedly, deteriorating age related health.

Due to his age he had a number of comorbid medical conditions and was at high risk for mechanical falls. He developed as a falls risk and was assessed as such by the nursing staff at Casuarina Prison.

On 13 June 2013 the deceased suffered the first fall which appears to have initiated his terminal decline when he suffered a small right frontal subdural haematoma which was appropriately treated conservatively.

He then had another fall on 17 August 2013, where he developed signs of a more extensive bleed. On examination at RPH it was observed on CT scan he had a large acute subdural haemorrhage overlying a prior subacute/chronic subdural collection. As a result of his general age and frailty he was not a suitable candidate for neurosurgical

intervention and was treated conservatively. He was returned to the Casuarina Infirmary for palliative care pending transfer to a facility which could provide him with ongoing high level care.

On 6 September 2013 the deceased became short of breath and was to be transferred back to RPH but deteriorated significantly before that could be achieved. He was rerouted to RGH where he was treated in the palliative unit until his death on 8 September 2013.

The deceased was essentially a frail elderly man with multiple comorbidities, who as a result of his frail state suffered a number of falls. He incurred a brain injury which led to palliative care as a result of which he developed a known complication of brain injury, pneumonia, and died.

I find death arose by way of Accident.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED

The deceased's medical records indicate the deceased received extensive medical care as he aged, and as his health became an issue. His hypertension had been managed and monitored since his incarceration in 1994 and he had regular blood tests and regular health checks to ensure he was adequately managed. As his health issues

arose so he had been reviewed by appropriate consultants and their care incorporated into the deceased's management whilst in custody.

The deceased's extensive co-morbidities by the final year of his life pre-disposed him to be a falls risk and that was acknowledged as far as is reasonable in a custodial environment. He was permanently located in the prison infirmary to support his high level nursing needs, and attempts were being made for his appropriate care in a high level of care facility at the time of his death, shortly after his second relevant fall.

While I note the second fall on 17 August 2013 appears to have occurred while infirmary staff were waiting for the recovery team to attend and assist them with the deceased, there is no doubt the deceased was receiving appropriate medical care in a custodial setting. Nursing staff may have prevented the deceased's fall from the bed before it occurred had he not been in a locked cell and immediately accessible to them when they noticed his awkward positioning on his bed.

It may have been an option to provide the deceased with a mattress beside his bed, with the bed pushed to the wall, at the time he was provided with his falls alarm in July 2013. This is done, in other settings, where there is a risk of patients falling from beds on to the floor. It was not

canvased at inquest and it is not clear to me there would be a security risk for infirmary staff if this had occurred prior to the fall on 17 August 2013.

Other than the issue of a mattress on the floor earlier, it is doubtful the deceased's demise would have been any differently managed had he been in the community at large. He was appropriately managed by the health services in the prison system who at that time did not have a specific falls management policy. The deceased was of an unusual age to still be in a custodial setting.

I find the deceased's supervision, treatment and care were adequate and reasonable.

E F Vicker
DEPUTY STATE CORONER
22 October 2014