Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref : 18/13

I, Barry Paul King, Coroner, having investigated the death of ***Ronald Graham Williams*** *with an inquest held at the* ***Perth Coroner's Court, Court 58, CLC Building, 501 Hay Street, Perth,*** *on* ***7 May 2013****, find the identity of the deceased person was* ***Ronald Graham Williams*** *and that death occurred on* ***14 August 2011*** *at* ***Swan District Hospital*** *as a result of* ***Coronary Atherosclerosis*** *in the following circumstances:*

Counsel Appearing :

Sergeant Lyle Housiaux assisting the Coroner
Hannah Stapp appearing on behalf of the Department of Corrective Services
Estelle Blewett appearing on behalf of Serco Australia Pty Ltd

Table of Contents

INTRODUCTION

1. Ronald Graham Williams (the deceased) died in Swan District Hospital from coronary atherosclerosis.
2. At the time of his death[1], the deceased was a sentenced prisoner so, under s 16 of the Prisons Act 1981, he was in the custody of the chief Executive Officer of the Department of Corrective Services and was thereby a 'person held in care' under the Coroners Act 1996 (the Act). His death was, therefore, a 'reportable death' under the Act.
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(e) 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.
4. Under s 25(2) of the Act, where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.
5. An inquest into the deceased's death was held on 7 May 2013.
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 was prepared by Detective Senior Constable (now Detective Sergeant) Ian Lewis of the Western Australian Police Service. The other was prepared by Richard Mudford of the Western Australian Department of Corrective Services. Detective Sergeant Lewis and Mr Mudford were called to give oral testimony relating to their respective reports.

[1] Or 'immediately before death' as provided in the Coroners Act 1996.

THE DECEASED

7. The deceased was born in Gnowangerup on 12 July 1959. He had seven siblings. His father was a well respected elder in the Noongar community in the Great Southern. In 1969 the deceased and his family moved to Perth
8. The deceased left school when he was 13 years old in order to start work. He went back to school when he was 15 but did not complete year 10.
9. The deceased had three daughters with three different partners and also helped raise three other children.
10. He had worked as a builder and roof tiler as well as a shearer and roustabout. He was a talented painter and was a keen teacher of painting and ceramics, but abused alcohol and cannabis.
11. The deceased began his criminal history in 1973 when he was 14. He was committed by the Geraldton Children's Court into the care of the Child Welfare Department following a number of offences. From then until 2009 the deceased had numerous convictions for offences relating to property, traffic and violence, among other categories. He had been sentenced to terms of imprisonment 22 times.[2]
12. The deceased's last period of incarceration commenced on 8 September 2009. He had been sentenced to two years and seven months imprisonment with parole eligibility, but was not granted parole due to his refusal to participate in any treatment programs, his poor prison conduct, and the risk of him re-offending. He spent the first five months of his sentence at Hakea Prison before being transferred to Acacia Prison where he remained until the day of his death.[3]

[2] Exhibit 1, Volume 2, Death in Custody Review p5-6, Tab 4
[3] Exhibit 1, Volume 2, Death in Custody Review p8, 10, Tab 4

especially football.

14 AUGUST 2011

27. On the morning of 14 August 2011 the deceased went to a football game between two teams of prisoners at a football oval at Acacia Prison. He was the coach of one of the teams. During the game, the deceased became excited, yelling loudly to give directions to his players. The game finished at about 11:00 am.[16]
28. After the game, the deceased and his nephew, who was also a prisoner, were walking from the oval towards the cell blocks when the deceased had to stop and sit down on a low wall. He told his nephew that his chest was tight.[17]
29. The deceased's nephew called a prison officer who ran over to the men. When she heard what the problem was, the officer immediately used her radio to initiate a medical emergency procedure known as a Code Blue.
30. About a minute and a half later, the registered clinical nurse on duty at the prison's medical centre, Nurse Fiona Cobley, used a

[13] Exhibit 1, Volume 3, EcHO notes p9
[14] Exhibit 1, Volume 3, EcHO notes p9
[15] Exhibit 1, Volume 3, EcHO notes p2
[16] Exhibit 1, Volume 2, Tab 6
[17] Exhibit 1, Volume 2, Tab 5

motorised cart to attend the deceased in company with a prison officer. Nurse Cobley ascertained the deceased's complaint and arranged for him to be taken directly to the medical centre for assessment.[18]

31. At the medical centre, Nurse Cobley arranged for a 'Priority One' ambulance to attend and was in the process of attempting to obtain a blood pressure reading of the deceased when he started thrashing around as if he were in a seizure. Officers assisted by holding the deceased down to prevent him from harming himself or those trying to assist him.
32. The deceased then calmed down before again becoming agitated in the beginning of what appeared to be cycles of being agitated and then calm. Nurse Cobley was able to obtain a blood pressure reading of 183/64.
33. Unfortunately, the medical computer had not been functioning that day because of a state-wide outage of the Department of Corrective Services' Electronic Health Online system (EcHO system) so Nurse Cobley was unable to check the deceased's medical history. She was therefore unable to administer any medications without risking harm to the deceased.
34. Susie Stewart, a clinical nurse also on hand, took the deceased's temperature, which was 33.9^{0}. Nurse Stewart covered the deceased with silver space blankets.
35. The nurses were unable to attach ECG pads to the deceased's chest because he was thrashing and sweating. They were unable to make a provisional diagnosis.
36. At 11.42am the ambulance arrived at Acacia Prison with two St John Ambulance volunteers, Paige Criddle and Anna Buckley.
37. Prison staff then transferred the deceased onto the ambulance stretcher and he was placed in the ambulance. Because he was

[18] Exhibit 1, Volume 2, Tab 11

calm at that stage, it was possible to connect the ambulance's ECG monitor to him. The reading was not normal.

38. Nurse Cobley accompanied the ambulance officers in the ambulance because she was concerned with the way in which the deceased was going through cycles of consciousness. She was also concerned that the ambulance officers, being volunteers, may have had limited experience in the situation confronting them. Prison Officer Angela Raddon, also accompanied them in the ambulance.[19]

39. The ambulance left the prison at 12.06pm and drove on Great Eastern Highway towards the Swan District Hospital. Ambulance Officer Buckley was driving while Ambulance Officer Criddle was in the back with Nurse Cobley, the deceased and Prison Officer Raddon.

40. As the ambulance passed Mundaring, the deceased's oxygen saturation suddenly slumped from 94% to 80%, indicating respiratory distress. Nurse Cobley and Ambulance Officer Criddle shouted at Ambulance Officer Buckley to stop the ambulance, which she did.[20]

41. Once the ambulance had stopped, the deceased again started going into a seizure. Nurse Cobley inserted an endo-tracheal tube into the deceased's airway with immediate results. The deceased's oxygen saturation increased to 90% and he became responsive. The ambulance then carried on towards Swan Districts Hospital.

42. Ambulance Officer Criddle and Nurse Cobley continued to monitor the deceased. As the ambulance was travelling down Greenmount Hill, they noticed that the deceased's heart rate increased and then stopped.

43. Ambulance Officer Criddle then applied the defibrillator pads and the defibrillator went through its first cycle. There was no response

[19] Exhibit 1, Volume 2, Tab 37
[20] Exhibit 1, Volume 2, Tab 11

from the deceased. She then commenced manual cardiopulmonary resuscitation (CPR) while waiting for the defibrillator to rest and analyse.[21] Nurse Cobley held onto her to assist her to keep stable in the moving ambulance.[22]

44. Ambulance Officer Criddle applied a second shock about two minutes later as the ambulance was entering the Swan District Hospital. Again the deceased did not respond and Ambulance Officer Criddle conducted manual CPR.

45. Emergency staff at the hospital were awaiting the ambulance's arrival. They rushed the deceased into the priority resuscitation area to conduct further CPR and defibrillation and to administer intravenous adrenaline, but he never regained circulation.[23]

COMMENT ON THE STANDARD OF MEDICAL CARE OF THE DECEASED WHILE IN CUSTODY

49. Emeritus Professor Max Kamien provided an independent report which was attached to the report by Mr Mudford.[26] Professor Kamien reviewed four folders of departmental medical records.

50. Professor Kamien's summary to his report contains the following:

> Mr Williams was known to have cardio-vascular disease and to have had a previous myocardial infarction. He also had dyslipidaemia, hypertension and type 2 diabetes; disorders that predispose to coronary artery disease.
> His medical and nursing care was competent and much better than that of which he would have availed himself when outside of prison.

51. I accept Professor Kamien's conclusions.

52. I find that the medical care provided to the deceased while he was in the custody of the Chief Executive Officer of the Department of Corrective Services was beyond reproach.

53. Registered Clinical Nurse Fiona Cobley deserves particular commendation.

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

54. The deceased's supervision by departmental officers was not a matter in issue at the inquest. That position is consistent with the information available to me, in particular the information provided in Mr Mudford's report incidental to the material relevant to the deceased's medical history.

55. There is certainly no suggestion that the deceased was in any way mistreated as part of his supervision while in custody.

56. On the information available to me, I am satisfied that the quality of the supervision, treatment and care of the deceased while in the

[26] Exhibit 1, Volume 2, Tab 1

custody of the Chief Executive Officer of the Department of Corrective Services was appropriate.

CONCLUSION

57. The evidence of the deceased's ongoing heart condition together with the results of Dr Cadden's post mortem examination make clear that the cause of death was coronary atherosclerosis, and I so find.

58. I find that the manner of death was Natural Causes.

B P KING
CORONER
6 June 2013