QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of William Alfred EVANS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/3110
DELIVERED ON:	19 December 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	24 October 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes
REPRESENTATION:	
Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services:	Ms Melinda Zerner

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The *Coroners Act 2003* provides in s. 47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of William Alfred Evans. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

William Evans was 78 years of age when he died in the early hours of 8 September 2010. At the time he was in custody at the Princess Alexandra Hospital Secure Unit (PAHSU) having been transferred there from Arthur Gorrie Correctional Centre (AGCC) ten days earlier.

These findings:

- confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's health care adequately discharged those responsibilities; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

An investigation into the circumstances leading to the death of Mr Evans was conducted by Detective Sergeant Andy Seery from the QPS Corrective Services Investigation Unit (CSIU).

He attended the scene, viewed the body of Mr Evans in situ, before liaising with hospital staff in order to access relevant medical records. He organised for statements to be taken from corrective services officers and nursing staff at the Wolston Correctional Centre (WCC). All documentation pertaining to Mr Evans at the WCC was seized. All patients at the PAHSU were interviewed.

A statement was obtained from the doctor at the PAHSU who declared Mr Evans deceased and from nursing staff who had cared for him in the period preceding his death.

At the request of counsel assisting, Dr Gary Hall from the Queensland Health Clinical Forensic Medicine Unit examined the medical records for the deceased and reported on them.

I am satisfied the investigation was thoroughly and professionally conducted and all relevant material was accessed.

The Inquest

An inquest was held in Brisbane on 24 October 2012. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

Counsel assisting, Mr Johns, proposed that no oral evidence be heard subject to objection from any other party. Mr Johns had earlier written to Mr Evans' wife, enclosing a copy of the police investigation report and explaining that he intended to make this submission. No objection was received to the proposed course from any party and I agreed that the evidence tendered was sufficient for me to make the requisite findings.

The evidence

Personal circumstances and correctional history

William Evans was born in Aberdare, Wales on 9 February 1932. He emigrated to Australia with his wife and four children in 1968. He had a further child and was granted Australian citizenship in 1992. In 1998 his wife died and he re-married later in the year, although that marriage ended in divorce around the time of Mr Evans' later criminal conviction.

On 31 March 2006 Mr Evans was sentenced in the Brisbane District Court to six years imprisonment for the offences of rape and maintaining an unlawful relationship with a child with a circumstance of aggravation. This was his first criminal conviction. One of his victims was his granddaughter. A recommendation was made for post-prison community based release after he had served three years imprisonment. His full-time discharge date was 30 March 2012.

Mr Evans was received at the AGCC and then transferred to the WCC on 2 June 2006. He remained there until 10 May 2010 when he was transferred back to the AGCC as a result of his deteriorating health. On 30 August 2010 he was transferred to the PAHSU.

Medical history

On arrival at the WCC on 2 June 2006, Mr Evans was medically assessed. At this time he stated he did not have any significant physical or psychological illness other than a bad back. He did though complain to medical staff that he had been dribbling urine for the past 14 years. On 21 June 2006 Mr Evans had a renal ultrasound examination. He was noted to have an enlarged prostate which was discovered to be caused by adenocarcinoma. This was treated with ongoing radiation therapy that appeared successful over the course of the following two years.

Mr Evans medical records reveal a sharp deterioration in his mental state from late 2009 onwards, although even at 30 September 2009 medical

records from the PAHSU note a *two year history* of increasing confusion. He was diagnosed as having dementia following assessment at the PAHSU in September 2009. Over the following months his deterioration manifested itself by his wandering into fellow inmate's rooms at night, stealing their belongings and becoming aggressive when confronted. He began to become incontinent of urine and faeces. This eventually resulted in him defecating and urinating in other prisoners cells and smearing walls; a situation that left him vulnerable in a prison setting although in his particular case appears to be managed with a great deal of understanding by his fellow prisoners.

It is clear from the WCC medical records that Mr Evans was considered to require full-time nursing care by the end of 2009. Arrangements were made for him to undergo an Aged Care Assessment Team (ACAT) assessment which resulted in him having approval for ACAT high-level care from 8 October 2009 onwards. This level of care was not available at the WCC and his needs were attended to by volunteer prisoner aides with no formal nursing qualifications or background.

It was ultimately this situation, though, that led to Mr Evans transfer back to the AGCC in May 2010 where his access to other cells and other prisoners was more restricted.

Treatment prior to death

In July 2010 Mr Evans became wheelchair-bound and on 18 July 2010 he was admitted to the PAHSU for investigation of recurrent falls associated with low blood pressure, pallor, and fainting. He was found to be anaemic and his renal function was poor with evidence of acute renal failure compared to his last test which had been conducted on 9 March 2010. He was found to be losing proteins through his urine, a condition called nephritic syndrome. Medical records show he was investigated extensively as to the cause of this and was referred to renal physicians who considered it most likely resulted from a malignancy. He was referred for CT scans of his chest, abdomen and pelvis and a renal tract ultrasound.

None of these examinations revealed the site of a primary lesion. In circumstances where his condition was deemed untreatable and most likely terminal, a decision was made not to pursue the process of seeking out a primary lesion. Mr Evans was transfused with two units of packed red blood cells to treat his anaemia and reduce the associated symptoms and transferred back to the AGCC on 3 August 2010. He remained bed-ridden for the remainder of his time there. The medical file includes correspondence between the Director of PAHSU, Dr Stuart McDonald and the Adult Guardian at the time of Mr Evans discharge.

Dr McDonald stated that Mr Evans' condition was *incurable, irreversible and terminal*. The Adult Guardian agreed with the assessment of Dr McDonald that palliative management only was appropriate thereafter. An Acute Resuscitation Plan was formulated and when Mr Evans returned to hospital on 30 August 2010, following a deterioration in his condition, it was decided, with the agreement of the Adult Guardian, that only palliative care would be

offered. On that date a *Consent to withhold life-sustaining measure* form was signed by a representative of the Adult Guardian on behalf of Mr Evans. It was signed on the basis that due to Mr Evans' *advanced dementia, multiple peritoneal metastasis, cachexia and chronic renal failure* it would be inconsistent with good medical practice to proceed with cardiopulmonary resuscitation.

At the time of his admission to the PAHSU on 30 August 2010, Mr Evans was unresponsive to verbal stimuli. His care was to be supportive measures only, offering oral food and fluids and attending to his personal hygiene. On the morning of 8 September 2010 the attending nurse noticed Mr Evans' breathing to slow and then suddenly stop. The correctional services supervisor was called. Victoria Jepson examined Mr Evans and declared life extinct at 5:57am.

Parole Board and ACAT

In mid-2009 Mr Evans underwent a detailed assessment by ACAT after being referred by the WCC Diversional Therapist. In order to assist with that assessment Mr Evans was first seen by a psychiatrist and an occupational therapist. This resulted in Mr Evans being approved for High Level Residential Care by ACAT on 8 October 2009.

The WCC Diversional Therapist then took steps to organise a placement for Mr Evans in a suitable facility. The only facility with suitable 24 hour dementia specific care that would accept Mr Evans onto their waiting list was Moreton Bay Nursing Unit. Mr Evans was added to the list on 22 January 2010 but it was made clear the wait for a place would be long. Mr Evans was still on the waiting list when he died nearly eight months later.

Mr Evans had made an application for parole as early as 22 December 2008 in preparation for his eligible release date of 31 March 2009. On 10 June 2009, the Parole Board advised Mr Evans they considered him to pose an unacceptable risk to the community and, after considering further submissions from Mr Evans, formally declined his application for parole on 9 September 2009. The board found that Mr Evans did not have an adequate release plan incorporating supportive care in the community to address his illness.

After he had been placed on the waiting list at Moreton Bay Nursing Unit, Mr Evans again applied for parole on 10 March 2010. This was supported by the opinion of Dr McDonald from the PAHSU that by this stage Mr Evans was *disorientated, wheelchair-bound and incontinent of urine and faeces*.

Over the following months the parole board appeared to have explored the option of Mr Evans being placed in another facility, Spiritus St Martin's Nursing Home, but this could not be arranged. They were clearly disinclined to grant parole without Mr Evans having a placement at a suitable facility. In the meantime he had been transferred to AGCC and then, on 30 August 2010, to the PAHSU.

After he had been admitted at the PAHSU, Dr McDonald made contact with St Vincent's Hospital at Kangaroo Point to request they take care of Mr Evans. That hospital has a facility that would allow Mr Evans a temporary placement while he waited on a permanent nursing home spot. A place was made available and Dr McDonald advised the parole board. He also re-iterated his views in relation to Mr Evans' dire medical condition.

The Parole Board granted parole to Mr Evans on 9 September 2010, one day after he had died.

Autopsy results

An external autopsy examination was carried out on 9 September 2010 by an experienced forensic pathologist, Dr Nadine Forde.

Samples were taken for toxicological testing and no drugs or alcohol was detected.

Dr Forde had access to the medical records relating to Mr Evans from the PAHSU. After considering these, the toxicological results and her observations at autopsy, Dr Forde issued a certificate listing the cause of death as:

> *1(a) Acute renal failure;* due to or as a consequence of
>
> *1(b) Metastatic malignancy (primary site unknown)*
>
> Other contributory findings:
>
> *2. Prostatic adenocarcinoma*

Investigation findings

None of the other inmates at the AGCC or the WCC provided information to the investigating officers suggesting foul play or any deficiency or inappropriateness with regard to the treatment received by Mr Evans while in custody.

The examination of Mr Evans' room at the PAHSU revealed no signs of violence.

The CSIU investigation into Mr Evans' death did not lead to any suspicion that his death was anything but natural.

Medical Review

The medical records pertaining to Mr Evans were sent by counsel assisting to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Gary Hall. He considered the treatment provided to Mr Evans at PAHSU was *exceptional*, noting that:

> *…he was extensively investigated as to the cause of his renal failure in an appropriate timeframe, and due attention was paid*

to his well-being and dignity in his clinical path once diagnosis was established."

Dr Hall went on to say:

With regard to his medical management in the WCC, AGCC, I believe that he received as good attention as he could in the circumstances, however these circumstances fall short of what I would deem acceptable. My belief is that Mr Evans would have best been managed in a dementia-specific high-level nursing home facility, and this probably would have been most appropriate at the time that the ACAT assessors determined that he needed such care. I applaud the patience and understanding of his fellow inmates who attended to his cares, as I am sure that this would have tested their mettle to the nth degree, given their lack of appropriate training.

Conclusions

I conclude that Mr Evans died from natural causes. I find that none of the correctional officers or inmates at AGCC or WCC caused or contributed to his death.

I am satisfied Mr Evans was given appropriate medical care by staff at the PAHSU and while he was in custody at the WCC and the AGCC. Adequate and appropriate assistance was given to him in those facilities with regard to his application for parole and with regard to placing him in an appropriate facility.

It is a well recognised principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. I accept the submissions of counsel for Queensland Corrective Services (QCS) that the difficulty of obtaining a place in a dementia-specific high level nursing home is one faced by members of the community generally. In this case Mr Evans was accepted onto a waiting list within a short time after his ACAT assessment. That was the same waiting lists on which other members of the community suffering the same as Mr Evans would have been placed. Although the opinion of Dr Hall that Mr Evans would have been better served in such a facility is inarguable, there is nothing to suggest that Mr Evans' failure to obtain a placement at Moreton Bay Nursing Unit was linked to his being a prisoner.

I acknowledge that Mr Evans' daily needs were necessarily attended to by fellow, untrained inmates. Although this placed him in a different situation to what would be the case out of prison, I am satisfied it did not, in this particular case, result in a lesser standard of care.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a

result of considering all of the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was William Alfred Evans.

How he died - Mr Evans died while in custody within the secure unit of the Princess Alexandra Hospital from the effects of untreatable cancer.

Place of death – He died at Buranda in Queensland.

Date of death – He died on 8 September 2010.

Cause of death – Mr Evans died from natural causes, namely acute renal failure caused by metastatic malignancy of unknown origin.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

In this case the Department of Community Safety (encompassing QCS) was asked to provide evidence of the steps taken to address the likely increased incidence of prisoners requiring care similar to that needed by Mr Evans due to the increasing age of the prison population. The inquest received evidence from Ms Kerrith McDermott, General Manager, Operational Service Delivery for QCS. She advised that her Department had been made aware that the president of the Queensland Parole Board has considered a review of the rules governing parole for the ageing prison population. It has been decided, for the present, that no changes are warranted as the relevant legislation already provides for the application and granting of exceptional circumstances parole.

As can be seen in this case, one of the problems in persuading the parole board that exceptional circumstances parole should be granted, is placement within an appropriate facility for the person's needs within the community. As Ms McDermott advised since Mr Evans' death, QCS has contracted the South Queensland Correctional Centre (SQCC) to provide a palliative care, frail and elderly unit. This unit was commissioned as operational on 2 January 2012. It provides accommodation for up to four male prisoners and provides a level of care not available at any other corrective services facility. Special needs nurses provide care and services as required 24 hours per day and a doctor is on-site twice per week for six hours each time as well as being on call 24 hours per day.

Dr Hall generally applauded this initiative by QCS although expressed some reservations in relation to the potentially bureaucratic process by which prisoners are chosen for placement in the unit. I trust that the senior QCS staff involved in deciding who should have access to the facility will be guided by medical advice regarding the prisoners in their care.

I am satisfied the provision of these places addresses the immediate care issues that arose in the case of Mr Evans. The other solution to preventing a repeat of the situation confronting Mr Evans involves a significant increase in the high-level care places available for elderly members of the community generally. That is a problem which extends beyond the scope of this inquest and beyond the potential for me to make any useful recommendation.

I close the inquest.

Michael Barnes
State Coroner
Brisbane
19 December 2012