CORONERS ACT, 1975 AS AMENDED

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 23rd and 24th days of March, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Kevin James.

I, the said Coroner, do find that Kevin James, aged 70 years, late of Yatala Labour Prison, died at Modbury Hospital on the 7th day of December, 1998 as a result of spontaneous left frontal intracerebral haemorrhage. I find that the circumstances of death were as follows:-

1. **Reason for inquest**

1.1 On 21 May 1998 in the District Court of South Australia Mr. James was sentenced to four years and six months imprisonment, with a non-parole period of two years and nine months, for unlawful sexual intercourse involving a child. At the time of his death, Mr. James was serving his sentence at the Yatala Labour Prison. He had been transferred to Modbury Hospital in the late stages of his illness, and remained a prisoner. Accordingly, at the time of his death, Mr. James was "detained in custody pursuant to an Act or law of the State" within the meaning of Section 12(1)(da) of the Coroners Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of the said Act.

2. **Background**

2.1 Mr. James was born on 8 May 1928. He had a medical background of chronic obstructive airways disease with severe interstitial lung disease and chronic respiratory failure. He was oxygen and steroid dependent. He also suffered from osteoporosis (see the statement of Dr. Vanmali, Exhibit C.2b).

2.2 On 5 September 1998 Mr. James was transferred from Yatala Labour Prison to Modbury Hospital. He was diagnosed as having suffered a stroke (cerebro-vascular

accident or CVA). He was observed in hospital and then returned to Yatala Labour Prison on 8 September 1998, having appeared to have recovered.

2.3 On 18 September 1998 Mr. James was noted by prison officers to be behaving erratically and was incoherent. He was escorted to the infirmary by correctional officers, where he was seen by Dr. R.M. Creaser, a medical practitioner. Dr. Creaser thought that Mr. James' condition had deteriorated further, and that he had either suffered a further stroke or his respiratory condition had worsened (Exhibit C.5a, p2). Dr. Creaser decided to refer Mr. James to the Queen Elizabeth Hospital where he had been treated previously.

2.4 While waiting in the corridor outside Dr. Creaser's office, Mr. James was seen to collapse. Registered Nurse J.D. Mulqueen was present and caught him as he fell so that he did not fall to the floor. She said that he began to fit (Exhibit C.7a, p2). An ambulance was called and Mr. James was transferred to Modbury Hospital in an unconscious state.

2.5 When he arrived at Modbury Hospital, Mr. James was noted as apnoeic (not breathing), cyanosed (blue) with no palpable pulse and showing a broad-complex bradycardia (slow pulse rate) of approximately ten beats per minute. He was intubated and ventilated. Initial investigations led to an initial diagnosis of "infective exacerbation COPD (chronic obstructive pulmonary disease) with hypoxic seizure and primary respiratory arrest" (see the statement of Dr. Vanmali, Exhibit C.2b, p1).

2.6 Mr. James was treated extensively with medication. Further investigations revealed that he had suffered a small anterior myocardial infarction, and also a recent CVA.

2.7 A tracheostomy was performed on 24 November 1998.

2.8 An electro-encephalogram demonstrated that, although Mr. James' brainstem function was intact, he had suffered diffuse hypoxic brain injury and that the overall outlook was extremely poor with little likelihood of significant functional recovery (Exhibit C2b, p2).

2.9 In consultation with the family, it was decided not to pursue aggressive management, and Mr. James was transferred out of the Intensive Care Unit on 1 December 1998.

2.10 Mr. James developed pneumonia and septicaemia and was treated with intravenous fluids and antibiotics.

2.11 Mr. James suffered a respiratory and cardiac arrest on 7 December 1998 and could not be revived. He was pronounced deceased at 3.08a.m. on 7 December 1998 (Exhibit C.2b, p2).

3. Cause of death

3.1 A post mortem examination was carried out on the body of the deceased by Dr. J.D. Gilbert, forensic pathologist, on 7 December 1998. Dr. Gilbert diagnosed the cause of death as "spontaneous left frontal intracerebral haemorrhage".

3.2 Dr. Gilbert commented:-

> 'Death was due to a spontaneous left frontal intracerebral haemorrhage. This had followed a similar left parietal haemorrhage two and half months previously and cerebral amyloid angiopathy was considered clinically as a possible underlying cause. The neuropathological findings were not to hand at the time of this report. No septic cause for the spiking fever that preceded death was found at autopsy' (Exhibit C3a, p4)

3.3 A neuropathological examination was carried out by Dr. Grace Scott, neuropathologist, on 15 December 1998. Dr. Scott confirmed the presence of a left frontal intra-cerebral haemorrhage, and scarring secondary to previous haemorrhage in the left parieto-occipital region (months to years previously) (Exhibit C.4a, p2). This confirms the fact that Mr. James suffered a left parieto-occipital CVA in September 1998 as had been previously diagnosed.

4. Conclusion

4.1 This matter was investigated in an appropriate manner by Detective Senior Constable J.M. Brown of the Holden Hill Police Station as a death in custody. The investigation demonstrates that Mr. James was in the end-stages of a terminal illness, namely chronic obstructive pulmonary disease, when, in September and November 1998, he suffered cerebro-vascular accidents. On each occasion this exacerbation of his condition was noticed quickly, treated appropriately by correctional and medical staff at Yatala Labour Prison, a prompt transfer to Modbury Hospital was arranged in each case, and Mr. James was treated appropriately at Modbury Hospital in each case.

4.2 In those circumstances, there is no ground for any criticism of any person involved in Mr. James' detention and/or treatment.

4.3 For the same reason, there is no cause for me to make recommendations pursuant to Section 25(2) of the Coroners Act.

Key Words: death in custody

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 24th day of March, 2000.

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Coroner

Inq.No.12/2000