

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 29<sup>th</sup> day of January and the 5<sup>th</sup> day of February 2002, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of David Vance Green.*

*I, the said Coroner, find that, David Vance Green aged 42 years, late of Yatala Labour Prison, Northfield died at the Mary Potter Hospice, Strangways Terrace, North Adelaide, South Australia on the 1<sup>st</sup> day of June 2000 as a result of small cell lung cancer.*

### 1. **Reason for inquest**

- 1.1. Mr Green was convicted of rape and threatening life on 31 May 1999 in the District Court of South Australia. On 30 August 1999 his bail was revoked, and on 10 September 1999, he was sentenced to six years' imprisonment, with a non-parole period of two years and six months. He was sent to Yatala Labour Prison ('YLP').
- 1.2. As part of the normal screening procedures for new prisoners, Mr Green was interviewed on 30 August 1999, and no medical problems were noted. However, he complained of a persistent cough.
- 1.3. On 9 September 1999 Mr Green was x-rayed, and on 13 September 1999 a CT scan was performed. On 14 September 1999 there is an entry in the casenotes that he had complained of a productive cough for three weeks.
- 1.4. A mass in the right lung was detected, and a biopsy demonstrated that this was small cell lung cancer. Mr Green received chemotherapy and radiotherapy, but his prognosis was described as 'poor' (see the report of Dr Robinson, Exhibit C4c, p1).

- 1.5. About four hours before his death on 1 June 2000, Mr Green was transferred under guard to the Mary Potter Hospice, and the Acting General Manager of YLP, Mr Derek Taylor, purported to grant him 'unaccompanied leave' pursuant to Section 27(1)(f) of the Correctional Services Act (Exhibit C13).
- 1.6. It is to be noted that Mr Taylor's written authority was signed on 1 June 2000 (Exhibit C13), but does not specify a date or time on which the leave was to commence or expire. Further, section 27(1)(f) is a general purpose section ('for such other purpose as the Chief Executive Officer thinks fit'), whereas Section 27(1)(a) specifically deals with medical treatment.
- 1.7. Section 12(1)(da) of the Coroner's Act defines a death in custody as 'the death of any person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person was detained in custody within the State pursuant to an Act or law of the State'.
- 1.8. At the very least, I consider that this is a case where the cause of Mr Green's death 'may have arisen' while he was detained in custody at YLP, pursuant to his sentence of imprisonment. It is noted that Mr Green's history of coughing was relatively brief, and that he had a particularly aggressive form of cancer.
- 1.9. Accordingly, I find that Mr Green's death may have arisen while he was detained in custody pursuant to an Act or law of the State within the meaning of Section 12(1)(da) of the Coroner's Act, 1975, and that an inquest was therefore mandatory pursuant to Section 14(1a) of the said Act.
- 1.10. Alternatively, I find that Mr Green was not validly on leave at the time of his death due to the technical issues mentioned above, and so his death occurred while he was so detained. An inquest was mandatory for the same reason.

## **2. Introduction**

- 2.1. As I have already outlined, after his cancer was diagnosed, Mr Green received intensive treatment.
- 2.2. He continued to receive chemotherapy and radiotherapy at the Royal Adelaide Hospital between September 1999 and February 2000.
- 2.3. On 7 May 2000, Mr Green's condition deteriorated and he was admitted to the Royal Adelaide Hospital.

- 2.4. At about 3:15pm on 1 June 2000, Mr Green was transferred to the Mary Potter Hospice, as the doctors were of the opinion that he was in the terminal phase of his illness. Mr Green had declined further medical treatment in relation to his condition other than pain management, and had requested the transfer.
- 2.5. Dr Soteroula Christou, who admitted Mr Green to the Hospice on that day, found that he had low blood pressure and a high pulse rate. He was having difficulty breathing and was distressed. He was partially unresponsive.
- 2.6. Mr Green continued to receive palliative care until he died later that evening. The nursing staff noted that his pulse and breathing had ceased at 7:25pm (Exhibit C6a, p2). Dr Jamie Mattner was called to the Hospice at about 9:20pm, and found that Mr Green's pupils were fixed and dilated and there were no breath or heart sounds. He was formally pronounced deceased at 9:30pm.
- 2.7. Dr Mary Brooksbank, the Director of the Palliative Care Unit at the Royal Adelaide Hospital and Medical Director at the Mary Potter Hospice has described the palliative care received by Mr Green during his admissions to the Royal Adelaide Hospital and Mary Potter Hospice. She states:

‘Mr Green received the same level of care for his condition as any other patient in the community would receive.’  
(Exhibit C5a, p3)

Dr Robinson made the same comment (Exhibit C4b, p2).

- 2.8. I accept that evidence, and confirm that there is no evidence before me indicating any concern with the level of care received by Mr Green throughout his treatment.

### **3. Report of Death**

- 3.1. Mr Green's death was not initially reported to my office as is required pursuant to Section 31(4) of the Coroner's Act 1975. Mr Taylor, the Acting General Manager of YLP, described this as an 'oversight'.
- 3.2. The death was eventually reported about six weeks later.
- 3.3. The on-call Manager at YLP, Mr Kym Maslen, states that the death was not reported because he did not consider it a death in custody since it occurred outside the prison, while the prisoner was on unaccompanied leave. He said:

‘I assumed that the hospital would notify the Coroner of the death.’ (Exhibit C9a, p1)

Mr Maslen's assumption was invalid. If Mr Green's death was not a death in custody, there was no other reason why it needed to be reported pursuant to Section 31 of the Coroner's Act.

- 3.4. Mr Maslen said that he consulted YLP Standard Operating Procedure 6 ('SOP6'), which relates to deaths in custody, and decided that it did not apply to these circumstances. The document is part of Exhibit C12. I agree that it does not deal with these circumstances.
- 3.5. I accept that the failure to report Mr Green's death was not a deliberate attempt to avoid the provisions of the Coroner's Act. However, staff at the Department of Correctional Services should understand that the definition of a death in custody is wider than simply a death occurring within the prison walls.
- 3.6. I agree with Mr Maslen that SOP6 should be revised in light of these events to adequately reflect the legal position. I draw this matter to the attention of the Chief Executive Officer of the Department of Correctional Services.

#### **4. Recommendations**

- 4.1. The issue regarding SOP6 is a procedural issue, and does not directly relate to the cause of Mr Green's death. In my view, Mr Green's death was not preventable in any way.
- 4.2. Accordingly, there are no recommendations pursuant to Section 25(2) of the Coroner's Act, 1975.

*Key Words: Death in Custody; Correctional Services (natural causes)*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 5<sup>th</sup> day of February, 2002.*