CORONERS ACT, 2003

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 12th day of September 2013 and the 13th day of August 2015, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of John George Charles Hill.

The said Court finds that John George Charles Hill aged 71 years, late of Mount Gambier Prison, Benara Road, Mount Gambier, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 28th day of July 2011 as a result of acute pyelonephritis with contributing ischaemic heart disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. John George Charles Hill was aged 71 years when he died on 28 July 2011. At the time of his death he was serving a sentence of imprisonment of 6 years with a non-parole period of 3½ years. This sentence of imprisonment was imposed following convictions for certain offences. Mr Hill had been in custody since 9 February 2010 following his extradition from Western Australia. The sentence of imprisonment was backdated to 9 February 2010. He would have been eligible for parole in August 2013.

1.2. Mr Hill had for the most part served his sentence of imprisonment at the Mount Gambier Prison.

1.3. Mr Hill died at the Flinders Medical Centre. Prior to his death Mr Hill had been diagnosed with advanced gastric cancer and had undergone surgery. He had been transferred to the Flinders Medical Centre for treatment of an ischaemic leg. In the

event, Mr Hill's death on 28 July 2011 was sudden. On that day he was guarded within the Flinders Medical Centre by an escort officer employed by G4S who provide guard and escort services to the Department for Correctional Services. It was this escort officer who in fact discovered that Mr Hill was not breathing. Medical personnel were summoned to Mr Hill's room where a Dr Santosaputri certified life extinct. This was a death in custody and so an Inquest into the cause and circumstances of Mr Hill's death was mandatory pursuant to the provisions of the Coroners Act 2003.

1.4. The deceased Mr Hill had a previous medical history of hypertension, high cholesterol and heart disease in respect of which stents had been inserted in the 1990s. This medical history was known to correctional authorities when Mr Hill began his sentence.

2. Cause of death

2.1. A post-mortem examination of Mr Hill's body was performed by Dr Neil Langlois who is a forensic pathologist employed at Forensic Science South Australia. Dr Langlois' post-mortem report was received into evidence[1]. In his report Dr Langlois recites Mr Hill's recent medical history including the discovery of carcinoma of the stomach with spread into the lymph nodes. He also notes the partial gastrectomy that had taken place on 17 June 2011 as a palliative procedure which had also revealed metastatic disease. He also notes the admission to the Flinders Medical Centre as a result of a complaint of lack of sensation in Mr Hill's ischaemic left leg. This had required chemical lumbar sympathectomy on 27 July 2011, the day prior to his death.

2.2. The previous history of ischaemic heart disease with stents was also noted by Dr Langlois. Dr Langlois expresses the cause of Mr Hill's death as acute pyelonephritis with contributing ischaemic heart disease. He explains that acute pyelonephritis is inflammation of the kidney due to infection, which in most cases has ascended from the bladder and spread from the blood. In Dr Langlois' opinion this was the cause of Mr Hill's death. The acute pyelonephritis resulted in renal impairment and raised blood potassium levels which are toxic to the heart and can cause sudden death. Dr Langlois also discusses Mr Hill's pre-existing ischaemic heart disease. He explains in

[1] Exhibit C4a

his report that the heart would be weakened as a result of this and be vulnerable to the effects of renal failure. It contributed to Mr Hill's death in that sense.

2.3. I note that acute pyelonephritis was not a diagnosis that had been made prior to Mr Hill's death. However, Mr Hill was clearly very ill from his metastatic cancer and the undiagnosed acute pyelonephritis can be seen as a complication of his overall clinical picture. In my view it constitutes the ultimate mechanism by which Mr Hill died. I refer to the report of Dr Nicholas Rieger who, on behalf of the Coroner, provided an independent expert overview of Mr Hill's management, in particular in relation to the management of his abdominal cancer. Dr Rieger is a colorectal and general surgeon. In his report[2] he states that he does not necessarily consider that the acute pyelonephritis was one of the principal causes of Mr Hill's death. He agrees that Mr Hill's ischaemic heart disease would have been a contributing factor, but opines that the more notable causes of death would have been deterioration related to Mr Hill's recent surgery for metastatic gastric cancer and also to the surgery undertaken in respect of his ischaemic leg, for which he had been transferred to the Flinders Medical Centre. However, Dr Rieger does explain in his report that there would be a relationship between Mr Hill's cancer and the development of pyelonephritis which would be related to an episode of sepsis where there was a known bacteraemia from a blood culture result. This had involved both staphylococcus and E-coli. He suggests that someone who is bacteremic would be susceptible to developing an infection that could spread to the kidneys. Such bacteraemia is not an uncommon problem in a person who is having major surgery and experiencing other major events such as an ischaemic leg.

2.4. While there may be some difference of opinion between Dr Rieger and Dr Langlois as to the precise mechanism involved in Mr Hill's death, the difference is not of significance and in any case I would prefer the view of the forensic pathologist Dr Langlois that the cause of death is acute pyelonephritis with contributing ischaemic heart disease. I find that to have been the cause of Mr Hill's death, recognising of course that this cause is very much connected with Mr Hill's dire clinical presentation leading up to his death.

[2] Exhibit C9a

3. Background and the events leading to Mr Hill's death

3.1. It has been necessary in this case to examine the course of Mr Hill's illness as it has been mildly suggested that there may have been some delay in diagnosis.

3.2. On 15 February 2011 Mr Hill complained of chest pain after fainting in the laundry of the Mount Gambier Prison. That day he was transferred to the Royal Adelaide Hospital. Mr Hill experienced an episode of black, watery, offensive stools. Faecal occult blood tests returned a positive result. He also had mild generalised abdominal pain. Dr Rieger expresses the view that the clinical picture at that stage would fit with gastric cancer evident at that time. No further investigation was performed. A colonoscopy that had been booked was ultimately cancelled and rescheduled. In the interim Mr Hill was noted to be anaemic.

3.3. On 9 May 2011 an X-ray ordered by Dr Kavanagh, a local Mount Gambier doctor, revealed, with a barium meal and swallow, a delayed gastric emptying but no actual cancer growth itself. Dr Kavanagh determined that it was prudent to investigate the matter further. When Mr Hill's anaemia was taken into consideration he was transferred to the Mount Gambier Hospital. At the Mount Gambier Hospital a laparotomy was performed which revealed the metastatic cancer, resulting in the partial gastrectomy. The histopathology at the time confirmed advanced metastatic carcinoma involving the stomach with lympho vascular invasion, multiple involved lymph nodes and omental deposits of carcinoma. Tumour deposits were noted on the small bowel and also seen within the liver. The partial gastrectomy was palliative in nature. The metastatic gastric cancer was confirmed in mid June 2011.

3.4. On 3 July 2011 during a consult with the surgical team, discussions were engaged in regarding a good palliative care plan for Mr Hill. Mr Hill indicated that he did not wish to be '*for resuscitation*' and that the emphasis of his treatment should be on relief of symptoms. He signed the good palliative care plan that day. The plan would ultimately travel with Mr Hill to the Flinders Medical Centre to which he would be transferred.

3.5. On 23 July 2011 Mr Hill had an aortobifemoral angiogram and findings showed a new extensive other upper abdominal lymphadenopathy around the celiac trunk, pancreas, paraortic and porta hepatis region. Further lymphadenopathy was found adjacent to what appeared to be a remnant of the proximal stomach. Mr Hill then

developed ischaemia of the leg and for all these reasons he was transferred to the Flinders Medical Centre on 25 July 2011. As seen, he died three days later.

4. Conclusions

4.1. In his report Dr Rieger comments on Mr Hill's clinical course. He notes that there was a delay in Mr Hill being seen within the public system at the Mount Gambier Hospital but viewed this as probably within the realms of normality for such a service. During this time his progress was monitored appropriately within the prison service and Dr Rieger feels that at this time he was well managed. Dr Rieger is of the view that the life expectancy with Mr Hill's gastric cancer would have been in the order of months. He does not believe that his condition should have been detected any sooner. In addition, Dr Rieger expresses the view that he does not see any earlier opportunity to have made a diagnosis of pyelonephritis and was in any event uncertain as to its clinical relevance.

4.2. Dr Rieger concludes his report with the following observation:

> 'Essentially I feel that this was a palliative situation in someone who had metastatic gastric cancer for which the outlook was poor. Overall his main contributing factors would have been the surgery that he had, the metastatic disease that he had, his known ischaemic heart disease, his ischaemic leg and then more subtle factors such as the pyelonephritis.' [3]

4.3. The Court's conclusion is that Mr Hill died of causes that were natural and in the circumstances unavoidable. There is no evidence that his custodial circumstances served to Mr Hill's disadvantage as far as access to public health services were concerned.

4.4. Mr Hill's custody was at all times lawful, including at the time of his death.

4.5. I note that the police investigation conducted by Detective Brevet Sergeant O'Brien led to a conclusion, as expressed in her report[4], that all care appeared to have been taken by medical staff in order to facilitate the most humane treatment possible. The conclusion is also reached by SAPOL that it does not appear that an earlier review would have altered the outcome of the deceased's diagnosis, an observation that is

[3] Exhibit C9a, page 4
[4] Exhibit C15b, page 12

consistent with the independent expert opinion of Dr Rieger. I find that to have been the case.

5. Recommendation

5.1. I do not see the need to make any recommendation in this matter.

Key Words: Death in Custody; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 13th day of August, 2015.

Deputy State Coroner