



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 18th day of November 2015 and the 4th day of August 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of William Matthew Reed.

The said Court finds that William Matthew Reed aged 45 years, late of the Adelaide Remand Centre, 208 Currie Street, Adelaide, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 23rd day of August 2013 as a result of aspiration pneumonia secondary to left middle cerebral artery infarct complicated by infective endocarditis with septic emboli. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. William Matthew Reed was 45 years of age when he died on 23 August 2013 after suffering a large left-sided middle cerebral artery or MCA stroke. At the time of his death Mr Reed was a remanded prisoner awaiting sentencing and was being held in cell 26 of unit 4 in the Adelaide Remand Centre. He suffered the stroke on 21 August 2013 at the Remand Centre and was transferred to the Royal Adelaide Hospital where his condition worsened, culminating in his death.

2. Background

2.1. Mr Reed had been arrested on 26 June 2013 for theft of some tools valued at \$6,867. He was initially remanded at the City Watch House, but was transferred to the Adelaide Remand Centre.

- 2.2. On 8 August 2013 Mr Reed appeared in the Adelaide Magistrates Court and entered pleas of guilty. A date for sentencing submissions was set for 23 September 2013.
- 2.3. Upon admission to the Adelaide Remand Centre Mr Reed was documented as having the following medical history: an IV drug user, participant in the methadone program, hepatitis C, anxiety and depression, asthma, long-term smoker, a splenectomy following trauma and having a denture. It was further recorded that he consumed or used OxyContin, benzodiazepines and one to two bottles of vodka per day.
- 2.4. Mr Reed was seen by medical staff on a daily basis until 8 July 2013, and then a total of 20 more times in the remaining 56 days that he was incarcerated. Mr Reed did not present with signs or symptoms of stroke at any of these consultations, or any signs or indications of precursor to that event.

3. Events leading to Mr Reed's death

- 3.1. On the morning of 21 August 2013 Mr Reed was observed to be exhibiting signs that his cellmate, who had previously undertaken a first aid course, considered to be consistent with Mr Reed having suffered a stroke. His cellmate first noticed this at around 6am. However, upon speaking to Mr Reed, his cellmate was dissuaded from buzzing the intercom and alerting staff because Mr Reed said he did not want to go to hospital.
- 3.2. The usual prisoner count was conducted at around 8am in the morning by corrections staff and then the cells were unlocked to allow prisoners free time within the unit. It was after this process that Mr Reed's cellmate approached the corrections officers and reported his concerns that his cellmate had suffered a stroke.
- 3.3. Staff immediately went to cell 26 to check on Mr Reed and found him to be sitting on the lower bunk in his cell. He was quite obviously unwell, but he was conscious and was talking and able to engage with staff.
- 3.4. Infirmary nurses were called to assess Mr Reed. They observed that his speech was slurred and he had difficulty forming his words or articulating. He was leaning heavily to his left side. Upon asking him to poke out his tongue they noted that it was obviously deviated to the left. He had slight facial droop. He was complaining of a headache. He did not want to go to hospital. He was oriented to place, time and date. His pupils

were equal and reactive, and he said that he had arisen at about 6am to have a shower and had fallen over during his shower. He agreed that this was not the usual time to have a shower, but that he had awoken with a headache and that is what he felt the need to do.

- 3.5. It is to be noted that the nurses checked his head for any wounds or signs of injury from the fall that he alleged. There were no injuries from the fall.
- 3.6. The nurses formed the opinion that Mr Reed had suffered a stroke and an ambulance was called immediately. He was taken to the Royal Adelaide Hospital where an assessment was undertaken by the stroke team. The stroke was confirmed after appropriate investigation, and despite attempts at treatment Mr Reed deteriorated. By 22 August 2013 it was noted that one of his pupils was fixed and dilated. This was a sign of brain injury and that intracranial pressure was increasing. After discussions with the on-call neurologist and family members, a decision was made for palliative care. A repeat CT scan then showed a large left MCA territory infarct with significant mass effect.
- 3.7. Unfortunately, Mr Reed had suffered a spontaneous, unpredictable medical event. He did not respond to appropriate medical treatment and died within a short time.

4. Reason for Inquest

- 4.1. At the time of his death, because Mr Reed was a remand prisoner and as such his was a death in custody within the meaning of that expression in the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

5. Cause of death

- 5.1. The medical deposition reporting his death to the Coroner gave the cause of death as aspiration pneumonia secondary to left middle cerebral artery infarct complicated by infective endocarditis with septic emboli, and I so find.

6. Conclusion

- 6.1. There were no shortcomings in Mr Reed's treatment in prison and in hospital.

7. Recommendations

7.1. I have no recommendations in this matter.

Key Words: Death in Custody; Prison; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 4th day of August, 2016.

State Coroner

Inquest Number 33/2015 (1417/2013)