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 5th day of November 2019 and the 8th day of May 2020, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Dragni Encheff.

The said Court finds that Dragni Encheff aged 74 years, late of Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia died at Northfield, South Australia on the 19th day of June 2016 as a result of metastatic adenocarcinoma of the lung on a background of ischaemic heart disease, peripheral vascular disease and diabetes. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

1.1. Mr Dragni Encheff died at the Yatala Labour Prison (YLP) Health Centre on 19 June 2016. He was aged 74. At the time of his death Mr Encheff was a prisoner serving a custodial sentence. This is therefore a mandatory inquest pursuant to the Coroners Act 2003. These are the findings of that inquest.

1.2. On 14 October 2002 Mr Encheff was arrested and charged with the murder of his sister-in-law. From that point forward he would remain in custody until his death. On 17 September 2004 following a trial by jury in the Supreme Court of South Australia Mr Encheff was found guilty of murder. On 13 October 2004 Mr Encheff was sentenced to life imprisonment with a non-parole period of 20 years. He would have been eligible for parole in 2022 but for his death.

1.3. I find that Mr Encheff's custody was at all times lawful.

2. Cause of death

2.1. The cause of Mr Encheff's death was established by way of a pathology review conducted by a medical practitioner at Forensic Science South Australia (FSSA). A post mortem examination of Mr Encheff's remains was not necessary to establish that cause. The FSSA report[1] suggests the cause of death was metastatic adenocarcinoma of the lung on a background of ischaemic heart disease, peripheral vascular disease and diabetes. I accept the FSSA report and find that the cause of Mr Encheff's was as stated in the report.

3. Background

3.1. Mr Encheff's daughter, Ms Jeanette Russo, has provided a statement to the Court[2]. Ms Russo visited her father in custody throughout the period of his incarceration. Ms Russo was informed of her father's disease when contacted by the doctors from the Royal Adelaide Hospital (RAH). She stated that her father was aware of the serious nature of his illness. Mr Encheff told his daughter that he did not want to be resuscitated. This was in keeping with the fact that an Advanced Care Directive was in place for Mr Encheff. Ms Russo states that following a CT scan and a biopsy the hospital called her and asked her to come in to assist her father. She was informed that Mr Encheff did not have long to live. Due to Mr Encheff's behavioural issues in prison it was suggested that a brain scan would be conducted to determine whether the cancer had spread to his brain. Ms Russo states that her father died before the brain scan could be conducted.

4. Medical care whilst in custody

4.1. Mr Encheff had been accommodated within the Aged Care Unit of the YLP since 8 May 2016. He would undergo a number of investigations at the RAH between then and the date of his death. He was transferred to the YLP Health Centre approximately two hours prior to his death.

4.2. The statement of Ms Kylee Pierce, a registered nurse at Yatala Labour Prison[3], stated that Mr Encheff suffered from terminal lung cancer, ischaemic heart disease, stroke, sleep apnoea, obesity and type 2 diabetes, depression and peripheral vascular disease.

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[1] Exhibit C2a
[2] Exhibit C3
[3] Exhibit C4

4.3. The statement of Dr Michael Findlay[4] who is employed by the South Australian Prison Health Service confirms Mr Encheff's co-morbidities and describes Mr Encheff's clinical picture prior to his death. On 11 April 2016 Mr Encheff was sent to the RAH with a swollen and infected lower leg that had not responded to treatment. Mr Encheff also had a chronic cough and recent chest pain. Investigations conducted at the RAH identified a mass in his lung which was eventually confirmed to be advanced lung cancer. Mr Encheff was asked to remain for further investigations but he returned to prison against medical advice.

4.4. On 27 April 2016 Mr Encheff was returned to the RAH for review with the Department of Thoracic Medicine.

4.5. On 5 May 2016 at the RAH Mr Encheff underwent a PET scan which was designed to provide an indication of the stage of his cancer.

4.6. On 9 May 2016 Mr Encheff's case was reviewed by the respiratory physician at the RAH. He informed the physician that he had discussed his situation with his family and had decided he would like the cancer further investigated. He also wanted to ascertain treatment options.

4.7. On 23 May 2016 Mr Encheff returned to the RAH for a lung functioning test and biopsy.

4.8. On 26 May 2016 a review by the RAH lung cancer multidisciplinary team recommended palliative chemotherapy for symptom control. Mr Encheff's tumour was at an advanced stage. Medical advice was to the effect that there was no effective treatment available for him.

4.9. The hospital discharge summary of 27 May 2016 indicates that a medical oncology appointment was arranged for 1 June at the RAH Cancer Centre. A further appointment for a CT scan of the brain was arranged for 22 June 2016. However, Mr Encheff died on 19 June 2016 before that appointment could be undertaken.

4.10. In his witness statement Dr Findlay, to whom I have referred, indicates that while the possibility of palliative chemotherapy was offered to Mr Encheff, consideration also needed to be given to all of his other comorbidities as well as to the significant negative

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[4] Exhibit C6

side effects of chemotherapy. He explains that the duration from diagnosis to treatment would depend, among other things, on whether the patient was willing to undergo that treatment; the treatment being no more than a recommendation made to the patient. If the treatment is regarded as palliative, as it was to be in this case, then the urgency was not as significant. Dr Findlay also goes on to say in his statement that this treatment would have occurred at the RAH. However, Dr Findlay was under a suspicion that there had been some reluctance on Mr Encheff's part to undergo chemotherapy having regard to its significant side effects. As well, the lack of optimism for cure may have meant that palliative chemotherapy was not an appealing option for him. In the event palliative chemotherapy was not commenced, one of the factors being the intervention of Mr Encheff's death. In any event, as Dr Findlay explains, the reality was that although chemotherapy was an option, it would probably not have made any difference to Mr Encheff's quality of life or life expectancy.

5. The circumstances of Mr Encheff's death

5.1. In the statement of Ms Chantelle Martin, a correctional officer at the YLP[5], she asserts that at about 1:10pm on 19 June 2016 she checked on Mr Encheff in his room. At that stage she could see his chest moving up and down. Ms Pierce, the registered nurse to whom I have referred, states that at 2:25pm nursing staff at the Health Centre at YLP advised her that Mr Encheff's breathing had appeared to slow. Ms Pierce and other nursing staff entered his room where they found that Mr Encheff in cardiac arrest. Resuscitation was not attempted which was consistent with the terms of Mr Encheff's Advanced Care Directive. Life extinct was declared at 3:00pm.

6. Conclusions

6.1. The circumstances of Mr Encheff's death were thoroughly investigated by Detective Brevet Sergeant Jason Olsen of the SAPOL Corrections Section. In his report[6] Mr Olsen expresses the conclusion that Mr Encheff's death was the culmination of deteriorating health caused by his lung cancer as exacerbated by his comorbidities. Mr Olsen concluded that Mr Encheff was accorded adequate medical care. He concluded that once Mr Encheff's lung cancer was detected he was subject to further timely investigations.

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[5] Exhibit C5

[6] Exhibit C9a

6.2. There is no reason for this Court to conclude other than in accordance with Mr Olsen's investigations. In particular, there is no evidence that if Mr Encheff's health had been investigated and treated in the community his investigations and treatment would have been any more rapid or more effective.

6.3. In my view Mr Encheff's custodial circumstances did not in any way contribute to his death. I would add that in the opinion of Mr Encheff's daughter, Ms Jeanette Russo, as expressed in her witness statement, she could not fault the Prison Health staff, describing them as '*fantastic*'. She also expressed the opinion that her father would not have received better treatment in the community[7]. I so find.

7. Recommendations

7.1. I make 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 8th day of May, 2020.

Deputy State Coroner

Inquest Number 36/2019 (1112/2016)

[7] Exhibit C3, page 2