CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF PETER RAYMOND PORTER

[2025] SACC 31

Inquest Findings of her Honour Deputy State Coroner Roper

14 November 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man who died of natural causes while serving a sentence of imprisonment for murder. The inquest explored whether the medical care provided to him was adequate.

Held:

1. Peter Raymond Porter, aged 65 years of Adelaide, died at the Royal Adelaide Hospital on 31 January 2022. The cause of his death was metastatic prostate cancer complicated by deep vein thromboses.

2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MS R SCHELL
Hearing Date/s: 03/09/2025
Inquest No: 24/2025 **File No/s: 0251/2022**

INQUEST INTO THE DEATH OF PETER RAYMOND PORTER [2025] SACC 31

Introduction and reason for inquest

1 Peter Raymond Porter was 65 years old when he died on 31 January 2022 at the Royal Adelaide Hospital. His death was expected following a diagnosis of prostate cancer in 2013 and the development of deep vein thromboses in January 2021.

2 Mr Porter had been lawfully incarcerated since 1 June 2001, when he was sentenced to life imprisonment for the offence of Murder. As Mr Porter died in custody, an inquest into the cause and circumstances of his death is mandatory.[1]

3 The South Australian Prison Health Service (SAPHS) aims to provide a standard of medical care in custody that is equivalent to that available in the community. However, prisoners are not at liberty to select medical practitioners of their choosing. Accordingly, it is necessary to examine the standard of care provided to Mr Porter by the medical practitioners chosen for him.

Who was Mr Porter?

4 Mr Porter was born on 24 August 1956. He attended secondary school in Victoria, before relocating to the Northern Territory to work on the railways at the age of 14 years. He later moved to Port Pirie where he worked as a truck driver. He married and fathered two children. At the time of the murder, Mr Porter was estranged from his children.

What was the cause of Mr Porter's death?

5 Dr Erin O'Connor, a medical practitioner experienced in providing opinions as to cause of death, conducted an examination of Mr Porter's longitudinal medical history. The matter was also discussed with a senior specialist forensic pathologist at Forensic Science SA, Professor Roger Byard. The resulting pathology review stated that the suggested cause of death of Mr Porter was metastatic prostate cancer complicated by deep vein thromboses. A post-mortem examination was not recommended as the cause of death could be determined from the case notes with some certainty. I agree and find that the cause of Mr Porter's death was metastatic prostate cancer complicated by deep vein thromboses.

When did Mr Porter's symptoms of prostate cancer first present?

6 Mr Porter was remanded into the custody of the Department for Correctional Services on 1 June 2001 and accommodated at the Mount Gambier Prison. Upon his admission into custody, Mr Porter underwent a general health assessment. He did not disclose any medical history and was not taking any medication. There is no documented history of Mr Porter experiencing any symptomatology of prostate cancer or other urological issues prior to his imprisonment in 2001.

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[1] *Coroners Act 2003*, section 21(1)(a)

7 From 17 October 2007, Mr Porter's medical needs were attended to by Dr Kavanagh, who continued to care for him until his transfer to the Adelaide Remand Centre on 13 September 2021.

8 Mr Porter first made a complaint of urinary symptoms to Dr Kavanagh on 28 December 2011. He reported that for the past two months he was waking twice a night to urinate. Dr Kavanagh prescribed medication (Duodart) to alleviate Mr Porter's symptoms of nocturnal urination and recommended a rectal examination of his prostate.

9 Mr Porter refused to consent to a rectal examination of his prostate but agreed to a prostate-specific antigen blood test.[2] This test returned a result of 77 nanograms per millilitre, which is highly elevated. Dr Kavanagh advised Mr Porter of this abnormal result on 9 January 2012 and recommended a urology consult. However, Mr Porter refused, stating that he did not wish to be transferred to Yatala Labour Prison to attend the appointment. Dr Kavanagh instead ordered a prostate ultrasound.

10 On 10 February 2012 Mr Porter's ultrasound appointment was cancelled at the direction of the General Manager of the prison.

11 On 24 April 2012, Mr Porter attended another appointment with Dr Kavanagh, reporting worsening bladder symptoms and sleepless nights. He was upset that his ultrasound appointment had been cancelled. Dr Kavanagh repeated her recommendation that Mr Porter attend Adelaide for a urology consultation, but Mr Porter again declined.

12 Following this consultation, Dr Kavanagh liaised with the General Manager, who consequently approved Mr Porter's appointment for a prostate ultrasound.

13 The ultrasound was performed on 24 May 2012, revealing a mildly enlarged prostate and marked increase in the residual volume of the bladder, known in the medical vernacular as urinary retention. The sonographer raised prostate cancer as a consideration.

14 On 6 June 2012, Dr Kavanagh discussed the results of the ultrasound with Mr Porter. He flatly refused her strong recommendation that he attend the Royal Adelaide Hospital or be transported to Adelaide to see a urologist.

15 On 8 August 2012, Mr Porter advised Dr Kavanagh that his bladder symptoms had settled, and he wished to cease taking Duodart.

16 However, Mr Porter's bladder symptoms fluctuated over time, and he reported bed wetting at night in April 2013. Dr Kavanagh noted:

> 'Ceased Duodart as thought whole thing was fixed!! Advised needs to continue this. Still does not want to see urologist.'

17 In May 2013, Mr Porter experienced a bladder infection, which was treated with antibiotics.

18 On 12 June 2013, Dr Kavanagh had a 'strong conversation' with Mr Porter, in which she advised him again that he needed to go to Adelaide, and that she would refer him to the Royal Adelaide Hospital. When the referral was not promptly responded to, Dr Kavanagh

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[2] Prostate specific antigen (PSA) is a protein made by normal prostate cells and cancerous prostate cells. An elevated level of this protein in the blood may be a sign of prostate cancer. A PSA above 4 ng/mL is considered elevated.

directed nursing staff to send the referral again, including the pathology results, and to mark it as 'urgent'.

19 By 25 June 2013, Mr Porter was using absorbent pads to manage overnight urination.

20 On 3 July 2013, Dr Kavanagh attended upon Mr Porter in his cell due to his frailty. Mr Porter's blood test results indicated a further deterioration in kidney function and his prostate-specific antigen had risen to 110 nanograms per millilitre. Dr Kavanagh contacted the Urology Registrar at the Royal Adelaide Hospital to discuss Mr Porter's case, and it was agreed that Mr Porter would be transferred to the Royal Adelaide Hospital as soon as possible.

21 Mr Porter was admitted to the Royal Adelaide Hospital on 4 July 2013. His principal diagnosis was recorded as 'metastatic prostate cancer'. A urinary catheter was inserted, and Mr Porter underwent a transurethral resection of his prostate. Histological analysis of the biopsy taken during this procedure confirmed prostatic adenocarcinoma.

22 From 28 December 2011, Mr Porter had reported symptoms consistent with prostate cancer. The results of the medical investigations conducted throughout 2012 and early 2013 were also consistent with prostate cancer. However, a definitive diagnosis was not reached until Mr Porter attended the Royal Adelaide Hospital in July 2013.

Was there a delay in the diagnosis of prostate cancer?

23 An ultrasound ordered by Dr Kavanagh to investigate Mr Porter's symptoms was cancelled at the General Manager's direction on 10 February 2012. The case notes do not explain why. To my mind, it is difficult to conceive of a situation whereby it would be appropriate for an investigation ordered by a medical practitioner to be cancelled by a General Manager. However, I have not reached a comfortable level of satisfaction that any criticism of this decision ought to be made. Further, I find that this decision had no bearing on the events that followed, given that following the ultrasound in May 2012, Mr Porter refused the resulting recommendation to see a urologist in any event.

24 While the delay of 18 months between symptom onset and diagnosis appears to be lengthy, it was attributable to Mr Porter refusing to undergo the necessary investigations recommended by Dr Kavanagh. I attribute no fault to Dr Kavanagh or any other medical practitioner regarding the delayed diagnosis.

Did Mr Porter receive adequate medical treatment?

25 At the time of diagnosis, Mr Porter's cancer was staged as N1 M1 iPSA 77, indicating that the disease had spread to nearby lymph nodes as well as distant organs. An oncologist commenced Mr Porter on the androgen deprivation medication Zoladex.[3] He was discharged back to Mount Gambier Prison on 15 August 2013.

26 A CT scan was performed on 3 December 2013 and showed no metastatic spread of the cancer. In particular, no focal bone lesions were detected. For some time, Mr Porter's condition appeared to be stable. He continued Zoladex until his prostate-specific antigen began to rise, and he switched to degeralix injections.[4]

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[3] A hormone treatment used to treat symptoms of prostate cancer, administered via a three-monthly implant

[4] This medication is a gonadotropin-releasing hormone receptor antagonist which deceases the amount of testosterone in the body which may slow or stop the spread of the disease

27 By late 2016, however, Mr Porter had become quite frail. Dr Kavanagh requested that Mr Porter be transferred to the High Dependency Unit at the Yatala Labour Prison as his health had become difficult to manage at Mount Gambier Prison. However, this did not occur.

28 Mr Porter continued to express reluctance to be transferred to Adelaide. Accordingly, Dr Kavanagh monitored Mr Porter with regular blood tests and oncology input. When Mr Porter's kidney function began to decline in 2018, he was referred to the Royal Adelaide Hospital Urology Unit.

29 On 25 February 2019 Mr Porter reported chest wall pain. Dr Kavanagh ordered an x-ray which revealed dual pulmonary emboli.[5] An anticoagulant medication, apixaban, was commenced and a referral was made to a cardiologist. Mr Porter also met with a urologist on 18 June 2019 in relation to his impaired renal function.

30 On 14 August 2019, Mr Porter underwent a whole-body bone scan. This did not support a diagnosis of metastases in the bone.

31 On 25 February 2020, Mr Porter asked Dr Kavanagh to formally document that he did not wish to be transported to Adelaide for any treatment.

32 In November 2020, it was determined that Mr Porter's cancer had metastasised to the bone and was classified as castrate resistant.[6] He continued to be treated and monitored closely by Dr Kavangh and her nursing staff, including daily temperature checks.

33 In May 2021, a CT scan identified that the cancer had progressed. Mr Porter was offered chemotherapy in June 2021, which he declined as the treatment would need to be performed in Adelaide. Dr Kavanagh spent many hours explaining to Mr Porter he needed to undergo chemotherapy in Adelaide, but to no avail. Mr Porter told Dr Kavanagh that if he were transferred to Adelaide, he would refuse treatment. He wanted to have chemotherapy in Mount Gambier, but this could not be facilitated. Dr Kavanagh explained to Mr Porter that his refusal to undergo chemotherapy would shorten his life expectancy. She also explained that the intention of the chemotherapy was palliative and not curative, which angered Mr Porter. Dr Kavanagh's notes of her conversations with Mr Porter were thorough and I accept that they are an accurate reflection of her conversations with him.

34 On 17 June 2021, a registered nurse spoke with Mr Porter about his need to undergo chemotherapy in Adelaide. However, he continued to refuse treatment. He also declined to sign the form documenting his refusal to accept medical advice.

35 Oncologist Dr Arwa also attempted to persuade Mr Porter to travel to Adelaide for treatment on 29 June 2021, explaining to him clearly and repeatedly that if he did not do so, his disease would progress and spread. He refused. Other offers were made and refused on 23 July 2021, 28 July 2021 and 25 August 2021.

36 At some stage between 25 August and 13 September 2021, Mr Porter was provided with another form to confirm his refusal to accept medical advice. He stated that he had changed his mind and now wished to see his specialist. On 13 September 2021, Mr Porter

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[5] A condition where one or more of the arteries in the lungs becomes blocked by a blood clot
[6] A type of prostate cancer that continues to progress despite treatment with androgen-deprivation therapy

was transferred to the Adelaide Remand Centre to facilitate his chemotherapy, which commenced in October 2021.

37 On 21 January 2022, Mr Porter was admitted to the Royal Adelaide Hospital for clot retention.[7] By this stage Mr Porter had developed associated conditions of haematuria,[8] anaemia, progressive renal failure and painful bony metastases.

38 His condition declined rapidly, and the Palliative Care Team became involved. Mr Porter had developed left lower limb swelling and an ultrasound confirmed multiple extensive deep vein thromboses. He was recommenced on anticoagulation medication, which had been held since 10 January 2022. However, this worsened the bleeding from the prostate.

39 On the morning of Saturday 29 January 2022, Mr Porter rose from his bed to allow nurses to change the sheets. He reported that he was exhausted and immediately returned to bed. After discussion with his treating team, Mr Porter decided to transition to comfort care.

40 During the evening of 30 January 2022, Mr Porter further deteriorated with low blood pressure and ongoing bleeding. He was declared life extinct at 9:31am on Monday 31 January 2022.

Conclusions

41 Mr Porter's death occurred 8 years, 6 months and 28 days after his diagnosis. I find that he received adequate medical care during his incarceration.

42 I have considered the impact of Mr Porter's decision to decline chemotherapy in June 2021. I find that Dr Kavanagh and Dr Arwa appropriately explained the risks of this decision to Mr Porter. There was no suggestion that Mr Porter had impaired decision-making capacity such that an order compelling treatment ought to have been sought. I find that Mr Porter was entitled to make the informed decision he made to refuse medical treatment.

43 In any event, Mr Porter's illness was advanced by this stage, having metastasised to the bone. There was no hope of a cure. I find that Mr Porter received adequate medical treatment during his incarceration within the bounds of his expressed wishes.

44 The investigation did not establish any issues that contributed to the death of Mr Porter, other than his refusal to be transferred to Adelaide for recommended medical investigations and treatment.

45 I have no recommendations to make.

Keywords: *Death in Custody; Prison; Natural Causes*

[7] The accumulation of blood clots in the bladder
[8] Blood in the urine