CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATH OF RJR

[2025] SACC 23

Inquest Findings of her Honour Deputy State Coroner Roper

28 August 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a 65-year-old man who was serving a sentence of imprisonment for serious offences when he was diagnosed with metastatic rectal cancer. The inquest examined the standard of medical care provided and whether there was an undue delay in diagnosis.

Held:

1. RJR, aged 65 years of Northfield, died at The Queen Elizabeth Hospital on 10 November 2022. The cause of his death was metastatic rectal cancer with extensive lung metastases.

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

No recommendations made.

Counsel Assisting: MR D EVANS
Hearing Date/s: 11/06/2025
Inquest No: 15/2025 **File No/s: 2760/2022**

INQUEST INTO THE DEATH OF
RJR
[2025] SACC 23

Introduction and reason for inquest

1 RJR (Mr R) was 65 years of age when he died on 10 November 2022. At the time of his death, Mr R was a parolee receiving palliative care at The Queen Elizabeth Hospital. His death was expected following a diagnosis of metastatic rectal cancer in August 2021.

2 Mr R was lawfully incarcerated from 12 October 2013 until 9 November 2022 as he had been sentenced to imprisonment following a plea of guilty to a serious sexual offence.

3 Mr R's full name has not been published in this Finding to protect the identity of the victim of his sexual offending in accordance with section 71A(4)(b) of the *Evidence Act 1929* (SA).[1]

4 Mr R's death was the subject of an inquest as there was reason to believe that the cause of his death, or a possible cause of his death, arose, or may have arisen, during his incarceration. His death is therefore a death in custody pursuant to section 3 of the *Coroners Act 2003,* and an inquest into the cause and circumstances of his death is mandatory. [2]

5 These are the findings of that inquest.

Background

6 Mr R was born on 26 November 1956 in Adelaide.[3] He was the eldest of six siblings and spent his early life in the Riverland area. He did not enjoy school and consequently entered the workforce at a young age. He was a builder by trade and gained employment on commercial fishing charters and at the local juicing factory.

7 In 1996, Mr R married and went on to have three children with his spouse, one of whom was stillborn.[4] In 1997, he sustained a back injury at work and retired on a disability support pension.[5]

8 Mr R often expressed concern to his spouse in relation to his bowel movements.[6] However, the medical records received into evidence indicate that Mr R did not convey this ongoing concern to the general practitioner he attended from 27 May 2011 until 11 October 2013. Interrogation of the general practitioner's medical records indicated that there was only one complaint made relating to bowel function, which was a complaint of constipation with associated bleeding on 20 October 2011.[7]

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[1] See *Channel Seven Adelaide Pty Ltd & Anor v Stockdale-Hall* [2005] SASC 307
[2] Coroners Act 2003, section 21(1)(a)
[3] Exhibit C1a at [5]
[4] Exhibit C1a at [3]
[5] Exhibit C1a at [7]
[6] Exhibit C1a at [23]
[7] Exhibit C9

9 In late 2013, a young person alleged that Mr R had committed sexual offences against them.[8] Mr R was arrested on 12 October 2013 and, after the matter had been listed for trial, entered a plea of guilty. On 5 June 2015 he was sentenced to imprisonment for 12 years and 7 months, with a non-parole period of 8 years, commencing from the date of his arrest.[9] He was released on parole on 9 November 2022. Mr R's spouse ended their marriage during his incarceration.

10 A medical history was obtained from Mr R shortly after he was taken into custody by staff at the South Australian Prison Health Service (SAPHS). No bowel related conditions or complaints were documented at that time.

11 Mr R's general medical history included paroxysmal supraventricular tachycardia, type 2 diabetes mellitus, gastro-oesophageal reflux disease, osteoarthritis, depression, iron deficiency and anaemia.[10] There is no evidence before the Court that any malignancy of the bowel had been identified or suspected prior to Mr R's incarceration.

Cause of death

12 Mr R's death was reported to the State Coroner by way of a medical deposition signed by Dr David Tong.[11] Dr Tong opined that Mr R's death occurred as a result of metastatic rectal cancer with extensive lung metastases. The medical documentation tendered during this inquest is consistent with the stated cause of death. I accept the opinion of Dr Tong and find that the cause of Mr R's death was metastatic rectal cancer with extensive lung metastases.

Medical treatment while incarcerated

13 It is generally accepted that prisoners are entitled to a standard of medical care in custody that is equivalent to that available in the community. The advanced stage of Mr R's cancer at diagnosis necessitates consideration of whether the delay in diagnosis was attributable to any deficiency in the medical care provided, or whether there were missed opportunities for an earlier diagnosis.

14 Dr Thomas Turnbull, then Medical Director of the SAPHS, provided an affidavit to the Court wherein he detailed the medical care provided to Mr R during his incarceration, irrespective of whether he was housed within a public or private correctional facility.[12] The Court has also received into evidence, and I have had regard to, the original records of the SAPHS.

15 The first significant medical event during Mr R's incarceration was a myocardial infarction in 2014. Subsequently, he presented to hospital with cardiac-related issues on several occasions. As these presentations are not pertinent to the cause or circumstances of death they will not be detailed further.

16 Relevantly, however, Mr R underwent a faecal occult blood test in March 2015 while housed in the Mount Gambier Prison.[13] Two specimens were collected and submitted to

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[8] Exhibit C1a at [9]
[9] Exhibit C6b at [1]
[10] Exhibit C2 at [4]
[11] Exhibit C2a
[12] Exhibit C4
[13] This correctional facility is privately managed and operated by G4S Custodial Services Pty Ltd: Exhibit C4 at [4]

SA Pathology for analysis, one dated 28 March 2015 and the other dated 29 March 2015. The 28 March 2015 specimen returned a positive result, whereas the 29 March 2015 specimen returned a negative result.[14]

17 The pathology report read:

> 'This positive result is consistent with bleeding from the large bowel and/or rectum. A positive test should be followed by a definitive investigation, preferably colonoscopy.'

18 The results were considered by Dr Kavanagh on 5 May 2015, who noted that the result was 'positive/negative' and ordered that a repeat test be performed.

19 A repeat test was performed which returned a negative result in August 2015.[15] The pathology report included a comment that a negative result does not rule out intermittent or very low amounts of bleeding, or bleeding from the upper GI tract.

20 It does not appear that any further investigations were recommended or conducted following this negative result. While Mr R continued to consult with Dr Kavanagh after this date, and prior to his transfer to the Port August Prison, there is no record of any complaints of gastrointestinal symptoms or rectal bleeding to Dr Kavanagh.

21 In January 2018, Mr R was transferred to the Port August Prison, a custodial facility managed by the Department for Correctional Services.[16]

22 In August 2018, Mr R was clinically assessed following an unconscious collapse preceded by dizziness. It was noted on examination that he was experiencing abdominal pain and right iliac fossa tenderness. Blood tests revealed raised inflammatory markers. These symptoms were further investigated with a CT scan of the abdomen and pelvis which demonstrated thickening of the appendix and inflammatory change adjacent to this in keeping with appendicitis.

23 A decision was made to manage Mr R's suspected appendicitis conservatively with intravenous antibiotics as his atrial fibrillation was being treated with the anticoagulant medication apixaban. Surgical intervention would have required temporary cessation of anticoagulation.

24 Mr R consented to a colonoscopy, which was ordered to exclude appendiceal orifice obstruction as a cause of the appendicitis.[17]

25 A colonoscopy was arranged for 4 October 2018. However, this procedure was postponed as Mr R reported that the kitchen did not provide him with appropriate meals and as such, his bowel preparation was incomplete. The colonoscopy was instead performed on 25 October 2018 at the Port Lincoln Hospital. Unfortunately, this procedure was deemed incomplete due to poor bowel preparation, resulting in the colonoscope only being advanced to the descending colon. A repeat colonoscopy was recommended, but declined by Mr R, who signed documentation to acknowledge his decision to refuse the procedure

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[14] Exhibit C9, Volume 1
[15] Exhibit C9, Volume 1
[16] Exhibit C4 at [4]
[17] Letter of Mr Quentin Ralph, 8 April 2019

contrary to medical advice. Mr R's symptoms reportedly resolved, and he was discharged to the Port Lincoln Prison.

26 In April 2019, Mr R was again offered an appendectomy due to reports of right iliac fossa pain. He declined, stating that he did not feel his symptoms were sufficiently severe as to warrant surgical intervention.[18]

27 In June 2020, routine investigations revealed blood in Mr R's urine and faeces. Appointments were made for Mr R to undergo a renal ultrasound and a repeat colonoscopy.[19] He underwent the ultrasound, but declined the colonoscopy.[20] Mr R is noted to have declined the colonoscopy in the hope that a reduction in his apixaban dosage might alleviate his symptoms. A note recorded by Dr Dhaliwal dated 10 August 2020 stated that Mr R:

> '…decided NOT to pursue any investigations. ALL RISKS explained!' [21]

28 A CT scan of the abdomen and pelvis was performed on 26 August 2020 in lieu of the recommended colonoscopy. The clinical information section of the report included reference to the positive faecal blood test and that the patient was 'not keen on colonoscopy'. This investigation did not result in the detection of any abnormality relating to the bowel.

29 In May 2021, Mr R reported rectal bleeding, which he stated had occurred intermittently for years but was worsening. On 17 June 2021, colonoscopy was again recommended. On this occasion, Mr R advised that he would now be willing to undergo the procedure.[22]

30 On 17 August 2021, Mr R underwent a colonoscopy which revealed a large necrotic rectal mass.[23] Histological examination of the tissue obtained by biopsy confirmed that the mass was adenocarcinoma. A CT scan was performed which demonstrated liver and lung metastases. The investigations conclusively established a diagnosis of metastatic rectal carcinoma.

31 Mr R was housed at the Adelaide Remand Centre[24] from 16 September 2021 to facilitate his medical treatment at the Royal Adelaide Hospital.[25]

32 On 21 September 2021, Mr R's case was discussed at the Royal Adelaide Hospital's colorectal multidisciplinary team meeting and a treatment plan was developed which commenced with induction chemotherapy followed by re-staging scans to evaluate the progression of the malignancy and the response to treatment.[26]

33 Mr R completed six cycles of induction chemotherapy. A CT scan performed in February 2022 showed a partial response to treatment including a significant reduction in the size

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[18] Letter of Mr Quentin Ralph, 8 April 2019
[19] Exhibit C9, 4 June 2020
[20] Exhibit C9, 8 July 2020
[21] Exhibit C11
[22] Exhibit C9, 8 May 2021 & 17 June 2021
[23] Exhibit C2 at [4]
[24] This facility is privately managed and operated by SERCO: Exhibit C4 at [4]
[25] Exhibit C4 at [9]
[26] Exhibit C4 at [13]

of the lung and liver metastases.[27] Mr R's case was revisited at a colorectal multidisciplinary team meeting on 22 February 2022 and decision was made to switch to radiotherapy with adjuvant capecitabine, an oral chemotherapy medication.[28]

34 On 24 April 2022, Mr R presented to the Royal Adelaide Hospital following a witnessed fall in which he hit his head and fractured the base of the fifth metatarsal and cuboid bone of his left foot.[29] Upon his return to the Adelaide Remand Centre, he was seen by Dr Wade.[30] During this consultation, Mr R advised that he did not wish to undergo further radiotherapy, citing difficulty with the prison transport arrangements. Specifically, he reported that getting on and off the bus caused him difficulty due to his fractured foot. Mr R's chemoradiation medication was ceased in accordance with his wishes.[31]

35 Mr R was reviewed by an oncologist on 10 May 2022. He reported that he had cancelled his final two radiotherapy sessions because of the pain caused by his fractured foot and his concerns regarding transportation.[32] Enquires were directed as to whether alternative transport could be arranged to facilitate completion of his radiotherapy. There is no documentation in relation to whether these enquiries were in fact made, or whether any alternative transport options were made available. However, there is no evidence to suggest that his radiotherapy was discontinued prematurely due to a lack of access to care.

36 Mr R underwent a flexible sigmoidoscopy to inspect his cancer in June 2022.[33] On 1 July 2022, his case was revisited at the colorectal multidisciplinary team meeting and a recommendation was made to commence second line chemotherapy.[34]

37 On 29 July 2022, after a further CT and MRI scan, Mr R discussed his goals of care with the Central Adelaide Palliative Care Service.[35] He indicated that he did not consent to cardiopulmonary resuscitation or an intensive care admission, and that he wished to focus on comfort care. He also expressed a desire to be transferred to the Port Lincoln Prison where his friends were housed.[36] This request was granted, and he was transferred on 19 August 2022.

38 On 8 September 2022, a blood test revealed an infection and Mr R was administered antibiotics.[37]

39 On 12 September 2022, Mr R was reviewed by a medical practitioner who described him as cachectic. The second line chemotherapy recommended by the multidisciplinary team was not able to be progressed due to his poor health and wellbeing.[38]

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[27] Exhibit C2 at [6]
[28] Exhibit C2 at [6]
[29] Exhibit C2 at [8]
[30] Exhibit C2 at [8]
[31] Exhibit C4 at [13]
[32] Exhibit C4 at [14]
[33] Exhibit C2 at [9]
[34] Exhibit C9, Volume 4
[35] Exhibit C2 at [11]; Exhibit C4 at [18]
[36] Exhibit C4 at [18]
[37] Exhibit C4 at [20]
[38] Exhibit C4 at [22]

40 A further medical review occurred on 13 October 2022. It was noted that Mr R's condition had massively deteriorated and that he was frail.[39] A medical request for transfer to Adelaide was made,[40] and Mr R was transferred to Yatala Labour Prison the following day.[41] On 15 October 2022, he was taken to the Royal Adelaide Hospital where he reiterated his earlier directive that he wished to receive ward-based measures only.[42] He was noted to be tachycardic, hypotensive and hypoxic. The impression was of symptomatic anaemia from metastatic rectal cancer. Mr R was administered a blood transfusion and then discharged to Yatala Labour Prison.[43]

41 Mr R reported a fever on 27 October 2022 and an x-ray was performed to rule out any new serious issues.[44]

42 On 4 November 2022, Mr R was taken to The Queen Elizabeth Hospital after experiencing chest pain and breathlessness.[45] A CT angiogram revealed significant progression of pulmonary metastases, and a chest x-ray showed progression of pulmonary lesions. New hypoxia was identified, which was thought to be secondary to the progression of the cancer.[46] Mr R was immediately admitted under the palliative care team and administered medications to ease his symptoms.[47]

43 It was noted by hospital personnel that Mr R had verbalised a desire to die as a free man. Mr R had filed an application for release on parole on 12 September 2022, stating that he knew what he did was wrong, and he was 'so sorry'. Following advice in relation to Mr R's medical condition, the Parole Board granted the order for release on 9 November 2022.[48]

44 On 10 November 2022, Mr R was noted to be unresponsive and comfort care was commenced to ensure that he was not in distress. Mr R was certified life extinct at 6:30pm on 10 November 2022.

45 The death was reported to the State Coroner and police attended The Queen Elizabeth Hospital. An examination of the body was conducted, and no signs or violence or injury were noted. Mr R was identified via fingerprints and visual identification.

Timeliness of diagnosis

46 Detective Brevet Sergeant Tiss of South Australia Police was appointed as the investigating officer in relation to the coronial investigation of the death of Mr R. She provided a detailed report to the State Coroner in which she interrogated the medical records and comprehensively outlined the medical treatment received by Mr R while in custody. She described the care and treatment provided to Mr R by the Department for

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[39] Exhibit C2 at [12]
[40] Exhibit C4 at [23]
[41] Exhibit C4 at [24]
[42] Exhibit C2 at [13]
[43] Exhibit C4 at [25]
[44] Exhibit C4 at [27]
[45] Exhibit C2 at [15]
[46] Exhibit C2 at [16]
[47] Exhibit C3 at [6]
[48] Exhibit C9

Correctional Services and SAPHS as optimal, and perhaps of a higher standard than he would have received had he been residing in the community.[49] I agree.

47 Mr R's malignancy was advanced at diagnosis. This indicated that the disease was present and potentially detectable at an earlier stage. It cannot be determined with certainty when he first developed rectal cancer, or at what point in time it could have been detected. The first report of rectal bleeding was made in 2011. In March 2015, Mr R returned a positive faecal blood test which was documented to be consistent with, although not diagnostic of, bleeding from the large bowel and/or rectum. By May 2021, Mr R reported that he had been experiencing rectal bleeding for years. However, the CT scan of his chest, abdomen and pelvis on 26 August 2020 did not provide evidence of any bowel abnormality.

48 A colonoscopy was recommended by the pathologist reporting on the March 2015 faecal blood test results; colonoscopy being a definitive investigation to determine the source of rectal bleeding. However, it appears that Dr Kavanagh made a clinical decision to order a repeat blood test instead of a colonoscopy. The notes of that consultation refer to the blood test results as being positive/negative, likely due to the positive result on one day and a negative result on the next. I make no criticism of the decision of Dr Kavanagh to commence with a non-invasive investigation in these circumstances.

49 An incomplete colonoscopy was performed in 2018. The evidence does not permit any inference to be drawn as to the reason for Mr R's poor bowel preparation on that occasion. As Mr R declined a repeat procedure, no finding can be made as to the presence or absence of rectal cancer at that time. Mr R again refused a colonoscopy in 2020 and did not provide his verbal consent until 17 June 2021.

50 If Mr R's rectal cancer was present and capable of detection via colonoscopy prior to 17 June 2021, any delay in diagnosis was attributable to Mr R declining the recommended investigations.

51 Following his verbal consent, Mr R waited two months for his colonoscopy. This timeframe does not differ significantly from what would typically be expected in a community setting.

52 In my opinion Mr R's care and treatment was appropriate.

Conclusions

53 Mr R was sentenced by the District Court to a period of imprisonment in respect of a serious offence and was therefore lawfully in custody from 12 October 2013 until his release on parole on 9 November 2022.

54 I find that Mr R's cause of death was as Dr Tong declared; that is, metastatic rectal cancer with extensive lung metastases.

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[49] Exhibit C6, p19

55 I find that Mr R's cause of death is likely to have arisen during his period of lawful incarceration.

56 The investigation did not establish any issues that contributed to the death of Mr R, other than his refusal to undergo investigations that may have resulted in earlier diagnosis.

57 I have no recommendations to make.

Keywords: Death in Custody; Prison; Natural Causes