Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 46/14

I, Barry Paul King, Coroner, having investigated the death of ***Gheorghe Gruici*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***11 December 2014****, find that the identity of the deceased person was* ***Gheorghe Gruici*** *and that death occurred on* ***25 June 2013*** *at* ***Royal Perth Hospital*** *from* ***organ failure in an elderly man receiving terminal palliative care for renal failure, a chest infection and infective endocarditis*** in *the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner
Ms J Rhodes (State Solicitor's Office) appearing on behalf of the Department of Corrective Services

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INTRODUCTION

1. Gheorghe Gruici (the deceased) died in Royal Perth Hospital (RPH) from organ failure in the context of significant disease of the kidney and heart.

2. At the time of his death,[1] the deceased was a sentenced prisoner. Under s 16 of the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services (the department) and was thereby a 'person held in care' under s 3 of the *Coroners Act 1996* (the Act). His death was therefore a 'reportable death' under the Act.[2]

3. Under s 19 of the Act, a coroner has jurisdiction to investigate a death if it appears that the death is or may be a reportable death. Section 22(1)(a) of the Act requires a coroner who has jurisdiction to investigate a death to hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care. An inquest into the death of the deceased was therefore required under the Act.

4. Under s 25(2) of the Act, where the death is of a person held in care, the coroner investigating the death must comment on the quality of the supervision, treatment and care of the person while in that care.

[1] Or 'immediately before death' as provided in s 22(a) *Coroners Act 1996*.
[2] Section 3 *Coroners Act 1996*

5. I held an inquest into the deceased's death on 11 December 2014.

6. The evidence adduced at the inquest primarily comprised two comprehensive reports into the circumstances of the deceased's death and of his treatment while in custody: one report was prepared by Detective Senior Constable Hayley Burke of the Western Australian Police,[3] the other was prepared by Richard Mudford of the department.[4] Both Detective Senior Constable Burke and Mr Mudford were called to give oral testimony relating to their respective reports.

7. Mr Mudford's report refers to a departmental procedure whereby an 'Independent Health Review Report' is prepared by an 'independent medical practitioner (non-treating clinician)' following a death in custody.[5] Accordingly, I received into evidence a medical report of the events leading up to the death of the deceased.[6]

8. That report purports to be an independent report, but it was written by a medical officer employed by the department.

9. Mr Mudford explained that the Health Services directorate of the department had been experiencing difficulty in obtaining the services of a suitably qualified external

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[3] Exhibit 1, Volume 1, Tabs 1-20
[4] Exhibit 1, Volume 1, Tabs 21-37; Volume 2 Tabs 38 and 39
[5] Exhibit 1, Tab 14
[6] Exhibit 3

medical practitioner who was also familiar with departmental policies. As a result, the Health Services directorate have created a critical review assessment committee which reviews each death in custody and assigns the review to one of their non-treating clinicians to prepare a report.[7]

10. Mr Mudford agreed that the use of the term 'independent report' was misleading and that the word 'independent' might be removed.[8]

11. I encourage the Health Services directorate to identify future reports by the Critical Review Assessment Committee in terms that do not indicate that they are prepared by persons independent from the department.

THE DECEASED

12. The following information was obtained primarily from a peer-reviewed, independent psychological clinical review/assessment report dated 5 October 2004.[9] The purpose of the assessment was to determine the treatment needed by the deceased.

13. The deceased was born in Deta, Romania on 19 October 1941. He was of Serbian descent and was able to converse in Serbian and Romanian. He had two brothers,

[7] ts 12 per Mudford, R P
[8] ts 12 per Mudford, R P
[9] Exhibit 2, Tab 4

though the eldest died at 20 months and the other died at the age of 27.[10]

14. His father, a labourer and butcher, and his mother drank frequently and often argued. When the deceased was nine years old, he and his parents were removed from their home to another town where they were forced to work for little reward. Eventually they were permitted to return to their home town where they moved in with the deceased's grandfather.[11]

15. At the age of 13 the deceased commenced an 18 month apprenticeship as a hairdresser. He worked in that trade, and then as a labourer and factory worker.[12]

16. He married his wife Zorita in 1964 and had two daughters with her.[13]

17. In 1981 the deceased and his wife moved to Australia and settled in Victoria. Their daughters followed in January 1982. The deceased worked for a car manufacturer until the mid-1980's when he retired on a disability pension due to a back injury. The family moved to Western Australia and bought a house in Westminster.[14]

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[10] Exhibit 2, Tab 4
[11] Exhibit 2, Tab 4
[12] Exhibit 2, Tab 4
[13] Exhibit 2, Tab 4
[14] Exhibit 1, Tab 12

18. There is evidence indicating that the deceased was verbally, physically and emotionally abusive to his wife.[15] He had suffered from a serious mental illness in the form of paranoid psychosis, and probably paranoid schizophrenia. In the early 1990s he had been referred to a psychiatrist and had been prescribed the antipsychotic drug trifluoroperazine.[16]

19. In 1995 the deceased's mother came from Romania to live with him and his wife. In May 1997 the deceased's wife and mother left the house to stay in his daughter's flat because of the deceased's violence and threats against his wife. After she moved out, the deceased's wife continued to visit him. She moved back with him in June 1997. [17]

20. On the evening of 8 October 1997 the deceased and his wife argued about money that she had paid to a government department and about the making of soup for dinner. The deceased lost his temper, smashed some plates on the floor and ultimately stabbed his wife several times with a kitchen knife, causing her death.

21. The deceased was convicted of murder on 21 October 1998 in the Supreme Court in Perth and was sentenced to life imprisonment.

[15] Exhibit 2, Tab 4
[16] Exhibit 1, Tab 12
[17] Exhibit 2, Tab 4

PRE-CUSTODIAL MEDICAL HISTORY

22. On 9 October 1997 the deceased was received into prison on remand. He was identified at the time as suffering from several medical conditions, including tinnitus, dental issues, arthritis, high cholesterol, asthma and gastric issues. There were concerns about lung function, diabetes and back pain. He was overweight and smoked 40 cigarettes a day.

23. Correspondence with treating medical practitioners indicated that the deceased had been treated for polyarthralgia, occipital neuralgia and was known to have suffered from oesophagitis, depression, hyperlipidaemia, chronic bronchitis and impaired lung function.

MEDICAL HISTORY IN CUSTODY

24. The following information has been taken primarily from Mr Mudford's report.[18]

25. While on remand in custody at the CW Campbell Remand Centre until October 1998, the deceased frequently attended the prison medical centre complaining of 'all-over pain', comprising headaches and pain in the legs, neck and abdomen. He was also noted to be experiencing hallucinations and delusions.

[18] Exhibit 1, Tab 14

26. Following sentencing, the deceased was moved to Casuarina Prison where he stayed for about three years. He suffered from continued coughing, frequent vomiting and stomach pain as well as mental health issues. He was treated by prison doctors, psychiatrists, nurses and other staff. He experienced respiratory and cardiac problems, diabetes and psychiatric issues.

27. In early 2001 the deceased was placed on a diabetic diet. In August 2001 he saw a surgical consultant at Fremantle Hospital who diagnosed him with reflux and prescribed omeprazole. Due to the deceased's age, obesity and prior surgery he was not considered appropriate for further surgery.

28. In September 2001 the deceased was transferred to Acacia Prison where he remained for three years. He was grossly overweight at this time. He continued to complain of gastric reflux and abdominal pain. He was treated by prison doctors and was sent for external radiological and gastroenterological procedures in 2002.

29. By August 2003 the deceased had lost a considerable amount of weight. He went for an abdomen CT scan and a chest x-ray to check for possible pulmonary and pancreatic neoplasms. None were seen.

30. The deceased's weight continued to decrease. As he refused to be admitted in a hospital, he was transferred to the infirmary at Casuarina Prison as an alternative.

He stayed there for nine weeks, during which time no physical explanation for his condition was found. A psychiatric review noted his depression and a long history of hypochondriasis. He was assessed to be suffering from delusional disorder/psychosis. He was returned to Acacia Prison and placed in the geriatric unit.

31. For the next six or seven months the deceased complained about his all-over pain as well as diarrhoea and lack of appetite. In August 2004 he underwent mesh repair of an incisional hernia and right inguinal hernia. He also underwent comprehensive independent clinical assessment which recommended that he continue to receive psychiatric care.

32. Throughout the rest of 2004 and all of 2005 the deceased complained of the same previous symptoms. In June 2005 he was reviewed by a gastroenterologist at RPH for ongoing dyspepsia.

33. In January 2006 the deceased attended the RPH urology clinic to investigate lower urinary tract symptoms. He underwent a cystoscopy in August 2006 which revealed a mild occlusive prostate. Further testing showed a small functional capacity bladder. Symptoms persisted for months but improved with medication. All other investigations were normal and the deceased was discharged from the clinic.

34. In 2007 the deceased was reviewed by a consultant forensic psychiatrist who noted that his risk to others was extremely low, making him suitable to be accommodated in an aged care unit by elderly mental health services. A number of community based services were contacted, but the deceased did not meet the criteria for any of them.

35. In April 2007 he was transferred to Swan District Hospital (SDH) for six days following a bout of epigastric pain. He was diagnosed with chronic obstructive pulmonary disease with pneumonia and ventricular hypertrophy.

36. In the following month the deceased underwent an ultrasound which revealed a fatty liver and a mildly enlarged prostate. A CT scan of the head showed probable cerebral cortical atrophy.

37. In February 2008 the deceased attended RPH for gastric and duodenal biopsies. An early gastric carcinoma was found. In June 2008 the deceased underwent a subtotal gastrectomy.

38. Following the operation the deceased's symptom persisted, apparently due to the deceased's refusal to comply with his medication regime or to eat properly. His condition deteriorated, requiring appointments with specialists and close monitoring.

39. In February 2009 the deceased was admitted to RPH with abdominal pain and vomiting. He was diagnosed with

faecal loading, treated conservatively and returned to Acacia Prison after six days.

40. In July 2009 the deceased was admitted to the Franklin Centre at Graylands Hospital for 19 days for observation and assessment. A consultant psychiatrist considered that the deceased would require a supervised psychiatric hospital rather than a nursing home. After returning to Acacia Prison, the deceased drank Coca Cola obsessively and he failed to comply with his medication regime.

41. In May 2010 the deceased was transferred to SDH with a urinary tract infection.

42. During 2011 the deceased's condition and mental health were monitored by prison medical staff with regular pathology testing and adjustments to medication.

43. The deceased was not admitted to hospital during 2012, but the ongoing symptoms relating to his physical and mental health continued and were treated by prison medical staff.

44. In January 2013 blood tests showed chronic renal failure. The deceased was referred to the RPH renal clinic.

45. In March 2013 he experienced chronic abdominal pain and a very high blood pressure. He was transferred to SDH and admitted for eight days. The principal diagnosis was stool infection and a non-ST elevated myocardial infarction.

46. Upon return to Acacia Prison the deceased was placed in the medical ward and on 22 March 2013 he was transferred to the Casuarina Prison infirmary due to the need for 24 hour nursing care.

EVENTS LEADING UP TO DEATH

47. The deceased's condition continued to deteriorate. In May 2013 blood tests indicated acute renal failure and bilateral oedema. He was transferred to RPH where he was admitted into the renal ward for over two weeks and commenced on dialysis twice weekly.

48. On 20 May 2013 the deceased was registered as Phase 1 on the department's terminally ill prisoner register, indicating a high probability of death. On 27 May 2013 he was transferred back to Casuarina Prison.

49. On 18 June 2013 the deceased was taken to RPH with a suspected stroke. Blood tests indicated the presence of infection. He was admitted into the renal ward and was diagnosed with sepsis. On 19 June 2013 he was registered as Phase 2 on the department's register, indicating that death was imminent.

50. On 21 June 2013 the infectious diseases team at RPH were concerned that the deceased may have developed infective endocarditis.

51. On 22 June 2013 the deceased developed respiratory distress, and a chest x-ray indicated possible aspiration pneumonia. Following discussions between RPH staff, the department's Director of Health Services and the deceased's daughter, the deceased was treated palliatively until he died on the evening of 25 June 2013.

CAUSE AND MANNER OF DEATH

52. Chief Forensic Pathologist Dr C T Cooke conducted a post mortem examination on 27 June 2013 and found:[19]

a) small scarred kidneys consistent with chronic renal failure;
b) pulmonary congestion and oedema with features of bilateral pneumonia;
c) infective endocarditis;
d) left ventricular hypertrophy with mottled discolouration of parts of the heart muscle; and
e) congestion of the liver and spleen.

53. Microscopy confirmed the above changes and microbiological testing showed mixed bacteria in the samples from the lungs and heart, including a yeast organism, *Candida albicans*. Toxicological analysis showed a number of medications consistent with palliative care.[20]

[19] Exhibit 1, Tab 6
[20] Exhibit 1, Tab 6

54. The Chief Forensic Pathologist formed the opinion, which I adopt, that the cause of death was organ failure in an elderly man receiving palliative medical care for renal failure, a chest infection and infective endocarditis.

55. I find that death occurred by way of natural causes.

COMMENT ON THE SUPERVISON, TREATMENT AND CARE OF THE DECEASED WHILE IN CUSTODY

56. On the information available to me, I am satisfied that the quality of the supervision, treatment and care of the deceased while in the custody of the Chief Executive Officer of the Department of Corrective Services was appropriate.

57. It appears to me that the standard of care and treatment the deceased received was at least equal to that which he would have received had he been in the community and been able to take advantage of the medical care available.

CONCLUSION

58. When he was placed in custody the deceased had significant medical problems. His condition deteriorated further over time.

59. The department's care of the deceased was complicated by his serious mental illness, but the deceased was provided with suitable treatment and care from departmental

medical staff and through referrals to specialists and hospitals. During his last days he was given appropriate palliative care until he died.

B P King
Coroner
30 December 2014