Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 23/15

I, Barry Paul King, Coroner, having investigated the death of ***Constantinas Papakostas*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***7 July 2015****, find that the identity of the deceased person was* ***Constantinas Papakostas*** *and that death occurred on* ***11 December 2011*** *at* ***Royal Perth Hospital*** *from* ***carcinomatosis complicated by recurrent sepsis and multisystem failure in a man with renal cell carcinoma*** in *the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner
Mr D Harwood (State Solicitor's Office) appearing on behalf of the Department of Corrective Services and Royal Perth Hospital
Mr G P Bourhill (instructed by MDA National) appearing on behalf of Dr P Hames

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INTRODUCTION

1. Constantinas Papakostas (the deceased) died in Royal Perth Hospital (RPH) on 11 December 2011 from carcinomatosis complicated by recurrent sepsis and multisystem failure in the context of renal cell carcinoma.

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 (DCS) 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

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

comment on the quality of the supervision, treatment and care of the person while in that care.

5. I held an inquest into the deceased's death on 7 July 2015.

6. The focus of the inquest was on the standard of treatment and care provided to the deceased in relation to renal cell carcinoma while he was in custody.

7. The documentary evidence adduced at the inquest consisted primarily of two reports into the circumstances of the deceased's death and of his treatment while in custody: one report was prepared by Detective Senior Sergeant James Bradley of the Western Australia Police Major Crime Squad,[3] the other was prepared by Lyn Robson of the DCS.[4] Also received as evidence were Royal Perth Hospital files relating to the deceased,[5] and DCS Health Services files, including EcHO records.[6]

8. Oral evidence was provided by, in order of appearance:

    a. Richard Mudford of the DCS;

    b. Dr Andrew Tan, urologist;

    c. Dr Philip Hames, medical officer with the DCS; and

[3] Exhibit 1, Volume 1
[4] Exhibit 1, Volume 2
[5] Exhibit 1, Volume 3
[6] Exhibit 1, Volumes 4-7

d. Dr Cherelle Fitzclarence, Prison Doctor - Deputy Director of the DCS Health Services.

THE DECEASED

8. The deceased was born in Greece on 10 December 1945. He left school at the age of 12 and had limited formal education after that.

9. The deceased immigrated to New South Wales in 1970 and then in 1971 to Western Australia where he worked as a motor mechanic. In 1976 he was granted Australia citizenship. He had poor reading and writing abilities, but he was able to speak English and managed to obtain consistent employment. He last worked as a driver.

10. The deceased was married and divorced twice and had two children with whom he had limited contact during his last incarceration. It appears that he had two sisters in Greece and at least one brother, who may have been in Australia.

11. In December 1999 the deceased was convicted of three counts of selling or supplying amphetamine. He was declared to be a drug trafficker and sentenced to five years imprisonment. He was released on a six month work release order in May 2001 and was then released on parole in November 2001.

12. On 23 May 2005 the deceased was placed in custody at Hakea Prison on remand after pleading guilty to charges of supplying methylamphetamine and possessing methylamphetamine with intent to sell or supply. On 8 August 2005 he was sentenced to eight years imprisonment and made eligible for parole.

13. On 27 October 2005 the deceased was transferred from Hakea Prison to Wooroloo Prison Farm (Wooroloo) where he remained until 13 November 2010 apart from spending 8 days in Casuarina Prison from 24 September 2008 to 2 October 2008. On 13 November 2010 the deceased was transferred to Casuarina Prison and remained there until his death on 11 December 2011.

DECEASED'S MEDICAL TREATMENT WHILE IN CUSTODY

14. When received into prison on 23 May 2005 the deceased was recorded as being diabetic, suffering from gout, having undergone a laminectomy and having had problems with urination and continence.[7] Blood test results obtained in his previous incarceration showed that he had a known beta thalassaemia trait.[8]

15. On 2 June 2005 the deceased attended the Hakea Prison medical centre complaining of having blood in his urine (haematuria) a few days beforehand, with the condition

[7] Exhibit 1, Volume 4, MR 010
[8] Exhibit 1, Volume 4, Investigation and Lab Reports

having since resolved. The progress notes indicate that the deceased had no flank pain, groin pain or abdominal pain and that his temperature was 36.3°. He was advised to provide a specimen if the haematuria occurred again.[9]

16. On 25 July 2005 a prison officer in the deceased's unit informed a nurse at the prison medical centre by telephone that the deceased had reported having haematuria again. The nurse recorded in the progress notes that the haematuria was previously noted on 2 June 2005 and recorded that the deceased was for review in the morning.[10]

17. On 26 July 2005 the deceased attended the prison medical centre and saw Dr Philip Hames, an experienced general practitioner employed by the DCS. The deceased told Dr Hames that he had loin pain and dark urine for one to two days, with a similar episode four to five years previously when the haematuria had been treated with medication and had settled. He remembered being told about kidney stones.[11]

18. Dr Hames recorded that the deceased looked well with good colour, that the pain was not severe, and that the

[9] Exhibit 1, Volume 1, Tab 19
[10] Exhibit 1, Volume 1, Tab 20
[11] Exhibit 1, Volume 1, Tab 20

abdomen and loin were not tender. A urine dip test indicated blood, protein and nitrates.[12]

19. Dr Hames diagnosed the deceased with a urinary tract infection from an unknown cause. He prescribed an antibiotic and made a request to the deceased's general practitioner for a copy of x-rays or ultrasound reports of the deceased's kidney four to five years previously.[13] Dr Hames also made a note to consider ultrasound.

20. While the deceased was at the prison medical centre on 26 July 2005 he provided a midstream urine sample for analysis. The results of the analysis, which were sent to Dr Hames that evening, showed a high level of red blood cells, but no protein or nitrite was detected. Those results indicated that the deceased did not have a urinary tract infection.[14]

21. It appears that, also on or about 26 July 2005, the deceased's doctor sent Dr Hames a copy of an ultrasound report dated 7 August 2002, which indicated that a four millimetre kidney stone had been noted.[15]

22. Dr Hames noted on the urine analysis results: 'blood only; await bloods and ultrasound; remains consistent with stones'.[16] In oral evidence Dr Hames explained that

[12] Exhibit 1, Volume 1, Tab 20
[13] Exhibit 1, Volume 1, Tab 18
[14] Exhibit 1, Volume 1, Tab 21
[15] Exhibit 1, Volume 1, Tab 18
[16] Exhibit 1, Volume 1, Tab 21

the reference to ultrasound related to his intention to arrange for an ultrasound scan.[17]

23. On 28 July 2005 Dr Hames wrote in the progress notes that it had been noted by the deceased's doctor that the deceased had an increased albumin/creatinine ratio in 2002. Dr Hames made a note to do a repeat analysis.[18] A urine sample was collected from the deceased on 4 August 2005 and the results were sent to Hakea Prison shortly thereafter[19].

24. After seeing the urine test results, on 23 August 2005 Dr Hames recorded in the progress notes that the deceased's albumin/creatinine ratio was 9.6 when it should have been less than 2.5 and that the albumin level was high at 246. Dr Hames noted that the deceased clearly had some worsening of renal disease as well as mild diabetes.

25. At the prison medical centre the next day, Dr Hames told the deceased that the lab results indicated mild diabetes and that he was developing renal disease (nephropathy). He encouraged the deceased to lose weight, and he changed the deceased's gout medication as it may have contributed to the nephropathy.

[17] ts 48 per Hames, P R
[18] Exhibit 1, Volume 1, Tab 20
[19] Exhibit 1, Volume 1, Tab 22

26. Following Dr Hames' treatment of the deceased in 2005, the deceased did not experience haematuria again until 2008.

27. On 15 June 2006 the deceased went to the prison medical centre with a complaint of left loin pain and back pain and was seen by Dr Hardy. A urine dip test apparently showed no appreciable disease. Dr Hardy's notes make no reference to haematuria and it is not clear whether he considered the possibility of a urinary tract carcinoma, but he did conclude that the cause of the pain appeared to be muscular-skeletal and not renal.[20]

28. The deceased told Dr Hardy that the pain was caused by the cold environment in his unit because the heating had not been switched on.[21]

29. The deceased returned to see Dr Hardy on 6 July 2006.[22] The heating had been turned on in the deceased's unit, but he still experienced lower back and suprapubic pain. Dr Hardy arranged for a urine test and blood tests, including a PSA for prostate cancer. From my reading Dr Hardy's handwritten notes, it appears that the deceased did not present with any further symptoms and

[20] Exhibit 1, Volume 1, Tabs 25 and 26
[21] Exhibit 1, Volume 1, Tab 26
[22] Exhibit 1, Volume 1, Tab 26

that Dr Hardy made no further diagnosis in relation to the deceased's lower back or loin pain.[23]

30. On 25 March 2008 the deceased complained of haematuria while at Wooroloo. A urine analysis was normal but a test for prostate cancer was somewhat raised.[24] The prison doctor, Dr Rozario, arranged for an ultrasound scan to check the prostate, and a scan was done at RPH on 19 May 2008.[25]

31. Due to an administrative error at RPH, the results of the ultrasound scan were misplaced. On 14 July 2008 the deceased enquired about the results while he was at the medical centre at Wooroloo. The receptionist contacted RPH and the results were then faxed to Wooroloo.[26]

32. The ultrasound results did not show prostate cancer; however, they indicated that the deceased appeared to have a renal cell carcinoma measuring 9 cm in diameter in the left upper kidney.[27]

33. On the next day the deceased underwent a CT scan of his chest and abdomen which confirmed the existence of a mass in the left kidney consistent with a necrotic renal cell carcinoma. There was no evidence of regional or distant metastases.[28]

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[23] Exhibit 1, Volume 1, Tab 26; Exhibit 1, Volume 5, Tab 2
[24] Exhibit 1, Volume 1, Tab 30
[25] Exhibit 1, Volume 1, Tab 30
[26] Exhibit 1, Volume 1, Tab 37
[27] Exhibit 1, Volume 1, Tab 37
[28] Exhibit 1, Volume 1, Tab 39

34. On 16 September 2008 the deceased was admitted into RPH. Dr Tan removed the kidney and tumour on 24 September 2008. Dr Tan initially attempted to perform the surgery laparoscopically, but had to revert to open surgery due to the size of the tumour. Dr Tan found that the tumour was confined to the kidney.[29]

35. Following the removal of his kidney, the deceased was monitored by prison doctors and had regular consultations with specialists at RPH.

36. On 14 April 2010 the deceased had an ultrasound scan and a chest x-ray at RPH as requested by a consultant urologist, Dr Julian Mander. The ultrasound did not detect evidence of tumour recurrence, but the x-ray report noted a new nodule in the lung and recommended a CT scan.[30] The reports of the ultrasound scan and the chest x-ray were provided to Dr Hames by 3 June 2010.[31] It appears that a follow up of the scan requested by Dr Mander was not scheduled to occur with a urologist at RPH until 8 September 2010.[32]

37. The deceased showed no symptoms of recurrence until 26 May 2010 when he experienced painless macroscopic haematuria for two days while at Kellerberrin Work Camp. He was sent to the emergency department at RPH where he was given antibiotics. The 8 September

[29] Exhibit 1, Volume 1, Tab 15
[30] Exhibit 2.2
[31] Exhibit 2.3 and 2.2
[32] ts 37 per Tan, A H H

2010 appointment with a urologist was brought forward to 10 August 2010 and a cystoscopy was arranged to examine the inside of the bladder.[33]

38. On 29 July 2010 the deceased complained to a physiotherapist of pain in his left buttock and thigh during the previous two months.

39. On 10 August 2010 Dr Tan performed the cystoscopy and found a large vascular prostate which bled easily on contact. He found no bladder neoplasm.[34]

40. On 19 August 2010 Dr Hames referred the deceased for a lumbar spine x-ray because of concerns that the pain experienced by the deceased in his left hip may have been be due to the renal cell carcinoma having metastasised.[35]

41. The deceased underwent the lumbar spine x-ray on 26 August 2010. No definite bony lesion was seen but the report indicated that, if there was concern remaining regarding potential neoplastic deposit, a bone scan would be indicated.[36]

42. Dr Hames saw the deceased on 6 September 2010 and noted that he was very tender over the left lower lumbar region and that he had sciatic symptoms. Dr Hames

[33] Exhibit 1, Volume 3, 28 May 2010
[34] Exhibit 2.5
[35] ts 55 per Hames, P R
[36] Exhibit 2.4

prescribed tramadol and referred the deceased back to the physiotherapist.[37]

43. On 26 September 2010 the deceased attended the Wooroloo medical centre and saw a clinical nurse. He said that he could not sleep because his hip was very sore and more swollen where the kidney had been removed. The clinical nurse made an appointment for the deceased to see a medical officer on 28 September 2010.[38]

44. On 28 September 2010 Dr Fitzclarence conducted a thorough review of the deceased and noted that the CT scan recommended in the report for the chest x-ray of 14 April 2010 had not been done. She ordered a chest CT scan, a bone scan and blood tests.[39]

45. On 18 October 2010 a Dr Siew from the RPH nuclear medicine department contacted the Wooroloo medical centre by telephone and reported that the bone scan had revealed a large metastasis on the left pelvis, probably related to the previous left renal cell carcinoma. Dr Siew said that the deceased would need to see an oncologist for palliative care and that the analgesics currently prescribed were far from adequate.[40]

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[37] Exhibit 3
[38] Exhibit 3
[39] Exhibit 3
[40] Exhibit 1, Volume 6; Exhibit 2.6

46. The deceased was admitted to RPH on 27 October 2010 for further investigation and consideration of radiotherapy. He was discharged on 12 November 2010 to Casuarina Prison where he was monitored by prison health staff with close liaison with the RPH oncology team.[41]

47. On 2 April 2011 the deceased was returned to RPH with urinary sepsis and was treated with antibiotics. The deceased was discharged back to Casuarina Prison on 15 April 2011.[42]

48. In September 2011 the deceased was diagnosed with a pulmonary embolus, which is not unusual with metastatic cancer, as well as a heart arrhythmia and a lesion in his liver.[43] He stayed in the medical centre at Casuarina Prison until 23 November 2011 when he was sent back to RPH, where it was noted that there had been a significant progression of the metastatic disease.[44]

49. The deceased's condition was thought to be improving, but on 2 December 2011 he experienced a sudden deterioration. He was treated with various measures, but his condition continued to deteriorate until he died on 11 December 2011.[45]

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[41] Exhibit 1, Volume 1, Tab 17
[42] Exhibit 1, Volume 1, Tab 17
[43] Exhibit 1, Volume 1, Tab 17
[44] Exhibit 1, Volume 1, Tab 12
[45] Exhibit 1, Volume 1, Tab 12

CAUSE AND MANNER OF DEATH

50. Forensic pathologist Dr G A Cadden conducted a post mortem examination on 19 December 2011 and found pooling of fluid in the lungs and metastatic tumour.[46] Toxicological analysis did not indicate drug toxicity[47] and a macroscopic examination of the brain by neuropathologist Dr V A Fabian showed no significant abnormalities.[48]

51. Dr Cadden reviewed the RPH clinical record for the deceased and noted that in the most recent admission the emphasis of the treatment had been on sepsis, with some added elements of possible hepatic encephalopathy with possible cardiac complications given that the deceased was a known sufferer of diabetes mellitus.[49]

52. Dr Cadden formed the opinion, which I adopt as my finding, that the cause of death was carcinomatosis complicated by recurrent sepsis and multisystem failure in a man with renal cell carcinoma.[50]

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

[46] Exhibit 1, Volume 1, Tab 5
[47] Exhibit 1, Volume 1, Tab 6
[48] Exhibit 1, Volume 1, Tab 7
[49] Exhibit 1, Volume 1, Tab 5
[50] Exhibit 1, Volume 1, Tab 5

COMMENTS ON THE SUPERVISION TREATMENT AND CARE OF THE DECEASED

54. Dr Tan provided a report[51] in which he expressed the view that the deceased's symptom of haematuria in 2005 should have been investigated with a CT-IVU; that is, a CT scan of the urinary tract with intravenous contrast.

55. Dr Tan said that the symptoms and the results of investigations carried out by Dr Hames on 23 August 2005 were not enough to explain the haematuria. He said that it was not sufficient to rely on a three year old ultrasound of a small kidney stone.[52]

56. Dr Tan agreed that there is a high incidence of urinary tract carcinoma among patients with visible haematuria, with risk factors increasing with age. He said that the incidence when there is no evidence of a kidney stone or infection is probably about 60 per cent. For that reason, imaging is done to exclude both kidney stones and carcinoma.[53]

57. Dr Tan said that imaging should have been done at the point when the urine test indicated that there was no infection. His view was that, had the tumour been present in 2005, a CT or ultrasound scan would probably have picked it up.[54] He said that, judging by the pathology of the tumour when he removed it - an

[51] Exhibit 1, Volume 1, Tab 15
[52] ts 32 per Tan, A H H
[53] ts 39-40 per Tan, A H H
[54] ts 22 per Tan, A H H

intermediate to slightly more aggressive cancer - it probably would have been present at that time, albeit at a smaller stage. He said that it was also possible that it occurred between 2005 and 2008, but he could not be sure either way.[55]

58. Dr Hames agreed with Dr Tan's view that it would have been prudent to have sent the deceased off for imaging. He said that he had no recollection of seeing the deceased on 26 July 2005, but looking back through the notes he said that, if he had noticed the episode of painless haematuria a month or six weeks previously, he would have been alerted to the more likely possibility of a carcinoma and he would have arranged for a scan.[56]

59. Dr Hames said that it appeared that he moved towards pursuing the deceased's diabetes and progressive kidney disorder and 'had left the blood behind'. He assumed that he had been distracted by the diabetes.[57]

60. Two other issues arise in relation to Dr Hames' care of the deceased. The first relates to his apparent failure to take steps following receipt of the x-ray report of 14 April 2010 in which a pulmonary nodule was identified. I am satisfied that the report was requested by Doctor Mander for follow up with an appointment at the RPH urology

[55] ts 22 per Tan, A H H
[56] ts 59 per Hames, P R
[57] ts 58 per Hames, P R

unit, so it was not unreasonable for Dr Hames to assume that follow up would be arranged at RPH.

61. The second issue relates to Dr Hames' apparent failure to arrange for a bone scan of the deceased following the x-ray of the deceased's lumbar spine at Swan District Hospital on 26 August 2010. Dr Hames said that he elected to leave it for a couple of weeks since it was more pain, unpleasantness and inconvenience to the deceased.[58] He said that the x-ray showed no obvious bony problem with the back. His plan was to send the deceased for more physiotherapy to see if that cleared up the symptoms before doing anything else.[59]

62. I have no basis to conclude that Dr Hames was unreasonable in not arranging for a bone scan in August 2010.

63. Another issue relating to the deceased's treatment involves the care provided by Dr Hardy in June 2006.

64. As noted above, the deceased presented to Dr Hardy with left lower back and loin pain, similar to the description of the pain he experienced when he saw Dr Hames. On this occasion, he had no gross haematuria and there is no reason to suspect that the deceased told Dr Hardy about the episode occurring about a year earlier.

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[58] ts 58 per Hames, P R
[59] ts 64 per Hames, P R

65. Dr Hardy arranged for several tests, none of which revealed a significant abnormity that could not be explained by the deceased's diabetes or thalassaemia.[60]

66. In these circumstances, it appears to me that the treatment and care provided by Dr Hardy was appropriate.

67. Further issues relating to the deceased's treatment while in custody were: RPH's failure to send the ultrasound report of 19 May 2008 to Wooroloo because of an administrative error, and the failure for RPH to arrange for a CT scan of the deceased's lungs when the report of the the x-ray of the deceased's chest on 14 April 2010 indicated a possible pulmonary nodule.

68. In a letter of 6 August 2008 the Clinical Services Executive at RPH apologised to the DCS for the failure to send the ultrasound report. The cause of the failure was identified and the procedural causes of the failure were rectified in 2008.[61]

69. As to the lack of a CT scan following the chest x-ray, it appears that follow up to the x-ray was planned to occur at the next review of the deceased by a urologist, in this case on 9 September 2010.[62]

[60] Exhibit 1, Volume 5, Tab 2, Investigation and Lab Reports
[61] Exhibit 1, Volume 1, Tab 40
[62] Exhibit 1, Volume 3, Tab 1

70. As noted above, on 26 May 2010 the deceased had an episode of haematuria which led to the deceased undergoing a cystoscopy on 10 August 2010. That explains why the review on 9 September 2010 did not take place, but the delay from the date of the x-ray in April to the urology review in September seems excessive.

71. Dr Tan explained that it was not unusual for scans to be done in April but the attendance at a review not to take place until September.[63] While that may be the case, it is difficult to understand how steps were not taken to follow up urgently on a finding of a new nodule, especially when there was concern to ensure that the deceased's renal cell carcinoma had not metastasised.

COMMENTS ON THE QUALITY OF TREATMENT AND CARE OF THE DECEASED

72. In the light of the foregoing, it is clear that, due to the delays in identifying and treating the deceased's renal cell carcinoma, the standard of treatment and care received by the deceased while in custody was inadequate.

73. Dr Hames should have arranged for investigations by way of imaging in 2005 when the deceased experienced recurrent episodes of haematuria, RPH should not have

[63] ts 38 per Tan, A H H

misplaced the potentially significant ultrasound report of 19 May 2018, and the delay to the follow-up to the x-ray of 14 April 2010 was excessive.

74. Of these issues, the most significant and the most difficult to explain confidently is Dr Hames' failure to arrange for imaging.

75. The evidence indicates that Dr Hames understood the clinical importance of the deceased's haematuria and took appropriate steps initially to investigate its cause. He had made a note of his intention to arrange for an ultrasound scan but, over the month following the deceased's presentation on 26 June 2005, his attention was distracted from the haematuria.

76. It may be, as Dr Fitzclarence surmised, that Dr Hames accepted the deceased's account of a history of renal stones and his suggestion that the episode in 2005 was just the same as he had experienced before.[64] Given Dr Hames' original intention to arrange for an ultrasound scan, that explanation seems unlikely.

77. It may be, as Dr Hames suggested, that he was distracted from the haematuria by the urine test report of 5 August 2005 which indicated diabetic nephropathy.

[64] ts 75 per Fitzclarence, C A

78. I infer that the fact that the deceased did not present again with haematuria may have also given Dr Hames some confidence in his diagnosis and treatment.

79. An issue affecting prison doctors in 2005 was the state of the DCS medical record keeping system. Dr Fitzclarence described how, at that time, the system was purely handwritten and, where a prisoner's medical records had more than one volume, only the latest volume would be kept at the prison with the prisoner.

80. One of the problems related to the use of the handwritten system of medical records in 2005 was that the time-consuming process of reviewing previous records meant that the fact that a patient's symptoms on presentation were recurrent might not be apparent to medical staff if the patient did not tell them.

81. In this case, the deceased had an appointment to see Dr Hames on 25 July 2005 specifically because of a new incident of haematuria, and an earlier incident had occurred on 2 June 2005. Those facts were clearly apparent on the latest progress notes.

82. However, when Dr Hames received the urine test report of 5 August 2005, the relevant progress notes entries were on another page from those relating to haematuria.[65] It is possible that Dr Hames was

[65] Exhibit 1, Volume 1, Tab 20

influenced by the entries on the latest page, which refer to an increased albumen/creatinine ratio in 2002 and do not mention haematuria.

83. The evidence indicated that the role of a prison doctor is difficult. Dr Fitzclarence described it as a 'tough gig with a patient population with a high rate of chronic disease, a high rate of substance abuse, a high rate of social emotional well-being issues and a high rate of psychiatric illness'.[66]

84. It seems that prison doctors are under a great deal of pressure and, at least in 2005, did not receive much support from the DCS. At that time there was a very high turnover of prison doctors. [67]

85. In the end, it is not now possible to arrive at a conclusion of the most likely reason for Dr Hames' failure. It appears to have been an uncharacteristic oversight to which several factors contributed, including the lack of an efficacious record keeping system.

CHANGES AT THE DCS

86. In 2008 the medical record-keeping system at the DCS was changed to the EcHO electronic system. It turned out to be extremely inefficient for the first two years.[68] The EcHO system has been improved to the point where,

[66] ts 76 per Fitzclarence, C A
[67] ts 79 per Fitzclarence, C A
[68] ts 71-72 per Fitzclarence, C A

according to Dr Fitzclarence, it now aids the DCS to provide better medical care, and continuous improvements are being made.[69]

87. The current EcHO system has a problem list and a summary page which alert medical staff to prisoners' current and ongoing medical concerns.[70]

88. The DCS has also instituted regular small group learning to provide doctors with continuing medical education.[71] The deceased's case is one which has been discussed as a case study.[72]

89. Dr Fitzclarence said that the DCS now has a much lower turnover of prison doctors. There is a better recruiting system and it is a better place to work with support and education.[73]

90. Dr Fitzclarence said that she would hope that the changes to the format of the EcHO system and other safety nets together with the efforts in education mean that it is now unlikely that a prison doctor in Dr Hames' position in 2005 would fail to notice that a patient had previous haematuria.[74]

91. I am satisfied that appropriate steps have been taken to attempt to rectify the systemic issues that may have

[69] ts 71-72 per Fitzclarence, C A
[70] ts 72-73 per Fitzclarence, C A
[71] ts 75 per Fitzclarence, C A
[72] ts 78 per Fitzclarence, C A
[73] ts 79 per Fitzclarence, C A
[74] ts 76 per Fitzclarence, C A

contributed to the inadequacy of the deceased's treatment and care while in custody.

THE OTHER DELAYS

92. As to the delays associated with RPH, I am satisfied that the systemic problem related to the failure to send out the ultrasound scan report was identified and addressed soon after it came to light.

93. As to the issue of the apparent failure of a timely follow-up to a possible lung nodule as identified on a chest x-ray report, the lack of relevant documentary evidence in the RPH notes leaves me unable to make an informed comment.

WOULD THE DECEASED HAVE SURVIVED HAD IMAGING BEEN DONE IN 2005?

94. This issue invites a great deal of speculation.

95. On balance, the evidence supports the conclusion that, given its size and its rate of growth, it is likely that the renal cell carcinoma would have been detected in 2005 had appropriate imaging been done, but it is not possible to be certain.[75]

[75] Exhibit 1, Volume 1, Tab 15; ts 22 per Tan, A H H; ts 77 per Fitzclarence, C A

96. Dr Tan's evidence established that it is at least possible that the deceased would have survived the renal cell carcinoma had it been identified in 2005 instead of three years later by which time it had definitely metastasised.[76]

97. On the basis of that evidence, it is clear that the deceased missed out on a chance of survival, though that chance depended on the existence of an identifiable and non-metastasised tumour in 2005.

98. The evidence does not allow me to quantify that chance, so I can come to no determinative conclusion in relation to this issue.

CONCLUSION

99. While in the custody of the chief executive officer of the DCS, the deceased developed renal cell carcinoma which eventually caused his untimely death.

100. If those responsible for the deceased's treatment and care had undertaken appropriate investigations when the associated symptoms had first become apparent, it is likely that the carcinoma would have been identified and, possibly, cured.

[76] Exhibit 1, Volume 1, Tab 15

101. The failure to carry out those investigations resulted in inadequate treatment and care of the deceased.

102. I accept and acknowledge that the DCS medical practitioners who treated the deceased were competent and diligent, and that in 2005 they daily faced a difficult job with an inefficient information system.

103. I also accept that systemic changes and professional development initiatives implemented by the DCS have led to improvements in the health services provided to prisoners.

B P King
Coroner
28 August 2015