Coroners Act 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

RefNo: 11/13

I, Barry Paul King, Coroner, having investigated the death of ***Phillip Van Vegten*** *with an inquest held at the* ***Perth Coroner's Court, Court 58, CLC Building, 501 Hay Street, Perth, on 2 April 2013****, find the identity of the deceased person was* ***Phillip Van Vegten*** *and that death occurred on* ***8 August 2011 at Royal Perth Hospital*** *as a result of* ***Pneumonia in a Man with Chronic Pulmonary Disease*** in *the following circumstances:*

Counsel Appearing :

Sergeant Lyle Housiaux assisting the Coroner
Michael Jenkin appearing on behalf of the Department of Corrective Services

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INTRODUCTION

1. Phillip Van Vegten (the deceased) died in Royal Perth Hospital from pneumonia in the context of longstanding chronic obstructive pulmonary disease (COPD) and emphysema.

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

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(e) 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.

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

5. The inquest into the deceased's death was held on 2 April2013.

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 of the reports was prepared by First Class Constable Linda Carter of the Western Australian Police Service. The other was prepared by Richard Mudford of the Western Australian Department of Corrective Services. Both Constable Carter and Mr Mudford were called to give oral testimony relating to their respective reports.

[1] Or 'immediately before death' as provided in the *Coroners Act 1996*.

MEDICAL HISTORY IN CUSTODY

18. On 21 December 2004 the deceased was remanded in custody for sentencing following the convictions mentioned above. He was conveyed to Hakea Prison and then transferred to Casuarina Prison where, due to his medical conditions, he was placed in the infirmary. Over the years until his death, the deceased was

[2] Exhibit I Volume I Tab IZ p.Z

transferred to Acacia Prison, Hakea Prison and Casuarina Prison in order to meet program intervention, wheelchair access and medical requirements.[3] From 22 December 2008 until he died, the deceased was placed in Casuarina Prison.

19. Nursing Care Plans were initially prepared for the deceased daily, and then bi-weekly over time, as required under the departmental Health Services Policy Manual. It appears that the deceased was managed in accordance with those Nursing Care Plans as regularly upgraded.[4]

20. In April 2006 the deceased attended the Royal Perth Hospital Urology Clinic after blood tests revealed elevated prostate-specific antigen levels. Over the next year and a half, further diagnostic examinations were performed, but the deceased refused to attend later external urology appointments.[5]

21. In October 2010 the deceased was admitted to Royal Perth Hospital as a result of a deteriorating respiratory condition. He was diagnosed with COPD and asthma, complicated by pneumonia.

22. The deceased was discharged to the Casuarina Prison infirmary, but in the following month he was again admitted to Royal Perth Hospital where cancerous nodules were found in his lungs. He was determined to be 'Not for Resuscitation' and palliative care was recommended. He was again discharged to Casuarina Prison for ongoing care and assistance with activities of daily living.

23. In January 2011 the decease was registered under the Department of Corrective Services' Policy Directive 8 as a Phase 1 terminally ill prisoner. As such, the deceased was continuously monitored and the department's Director Health Services was notified of the deceased's condition on each review. The Director Health Services

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3 Exhibit 1 Volume Z Tab 1 p.3
4 Exhibit 1 Volume Z Tab 1 pp.6, 17.
5 Exhibit 1 Volume Z Tab 1 p.10, Tab ZZ.

then notified the Manager Sentence Management to advise on the deceased's placement and management.[6]

24. Early in the morning of 21 July 2011, the deceased placed a cell call indicating that he could not breathe properly. Officers attended and administered a ventolin nebuliser which settled his symptoms.

25. Later that same morning, the deceased's oxygen saturation levels dropped, so he was transferred to Royal Perth Hospital. He was diagnosed with an exacerbation of COPD and a spontaneous right pneumothorax. Following treatment, he was discharged back to Casuarina Prison on 25 July 2011.

26. On 27 July 2011 the deceased again placed a cell call indicating that he could not breathe. He was transferred to Royal Perth Hospital where he was admitted under the care of the Medical Respiratory Team. The right pneumothorax was treated with an intercostal catheter with suction. He remained in Royal Perth Hospital.

27. On 6 and 7 August 2011 the deceased aspirated vomit into both lungs. A CT scan showed that he had Wilkes Syndrome, a rare condition characterised by duodenal obstruction leading to aspiration of upper bowel contents.

28. Due to the deceased's co-morbidities, he was not suitable for surgical intervention. Instead, palliative care was provided until he died on 8 August 2011.[7]

COMMENTS ON THE STANDARD OF MEDICAL CARE IN CUSTODY

29. Emeritus Professor Max Kamien provided an independent report which was attached to the report by Mr Mudford.[8] Professor

[6] Exhibit 1 Volume 2 Tab 39.
[7] Exhibit 1 Volume 2 Tab 1 p.12.
[8] Exhibit 1 Volume 2 Tab 25.

Kamien reviewed three folders of departmental medical records as well as discharge summaries provided by Royal Perth Hospital for each of the deceased's admissions.

30. Professor Kamien noted that the deceased was a sick man by the time he was placed in custody. The deceased was reliant on a wheelchair and had asthma, bronchitis and COPD. He had been treated for deafness, prostate disorder, depression and psoriasis. He was difficult to manage due to his aggressive and manipulative personality and because of his non-compliance with daily hygiene requirements such as daily showering.

31. Professor Kamien provided the following summary to his report:

> Mr Van Vegten suffered from COAD and probable cancer of the prostate gland with secondary spread to his left lung. It is surprising that he reached the age of 65 years. He exhibited markedly abnormal and non-compliant illness behaviour that tested the patience of his medical and nursing attendants. They competently, patiently and even compassionately withstood his testing. His medical care was no different to that he would have received had he not been in custody.

32. I accept Professor Kamien's conclusions.

33. I find that the medical care provided to the deceased while he was in the custody of the Chief Executive Officer of the Department of Corrective Services was appropriate.

34. It is clear that the quality of the care that the deceased received did not contribute to his death in any way.

OTHER ISSUES RELATING TO CARE WHILE IN CUSTODY

35. It appears from the information provided in Mr Mudford's report that the deceased was a difficult prisoner to manage for reasons other than those relating to his medical condition. From June 2005 to March 2011, 21 charges were recorded against him for prison offences such as insulting/threatening behaviour, indecent language, assault and disobeying rules/orders. There were 65 incident reports recorded on TOMS in relation to activities such

as secreting medication, possessing contraband, engagmg 1n misconduct and abusive behaviour to officers, assaulting staff and exhibiting predatory behaviour towards young prisoners.s

36. The deceased was also prone to make allegations of mistreatment by prison staff, including: sexual assault and denial of medical treatment. One allegation was investigated by the Ombudsman, and none of his allegations were substantiated either by the Ombudsman or by Internal Investigation Unit investigators.

37. Because the deceased refused to accept that he had committed the sexual offences for which he was incarcerated, he was ineligible for sexual offending program intervention. Likewise, he was not eligible for a cognitive skills program because, at the time he might otherwise have joined the program, it was not available to prisoners convicted of sexual offences.

38. In about March 2007 the deceased's sister made a claim of disability discrimination to the Human Rights and Equal Opportunity Commission on the deceased's behalf. The claim related mostly to the provision of an electric wheelchair and of hearing aids. The department informed the Commission of the care and supervision provided to the deceased and forwarded to the Commission copies of departmental disability policies and relevant correspondence. It appears that the claim was not maintained, but this is not clear on the material before me.

39. It is clear that at various times between 2005 and 2007 the deceased's electric wheelchair was confiscated as a loss of privilege because he had used it to hide contraband or as a weapon to assault staff. He was provided with a manual wheelchair during such times. In May 2007 the electric wheelchair was returned to him

[9] Exhibit I Volume 2 Tabs I, I2, I5, 30.

while he was at Casuarina Prison, though it appears that he was able to use the manual one satisfactorily.[10]

40. The deceased had hearing loss which was treated with hearing aids. One of his hearing aids was broken in early 2005 and was somehow lost in transit when it was sent away for repair. The audio clinic that had assessed the deceased's hearing would not see him again because of complaints that he had been rude and aggressive towards female staff.

41. The Casuarina Prison Health Services agreed to fund the replacement of both hearing aids subject to an audiologist's report. Subsequent delays caused by the deceased unwillingness to accept help with his manual wheelchair and by long delays for audiology appointments resulted in his not being issued with hearing aids until January 2007. He then stated that the aids did not meet his needs.[11]

42. Though the deceased's hearing continued to worsen, in November 2007, he refused to attend an external audiology appointment in restraints. Issues with the deceased's hearing aids were never resolved.[12]

43. The matters identified above indicate that any management issues detrimental to the deceased arose because of the deceased's own actions or attitude or, as in the case of delays in obtaining appointments, were outside the department's control.

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

44. On the information available to me, I am satisfied that the quality of the supervision, treatment and care of the deceased while in the

[10] Exhibit 1 Volume 2 Tabs 12 and 15.
[11] Exhibit 1 Volume 2 Tabs 12 and 15.
[12] Exhibit 1 Volume 2 Tab 1 p.8.

custody of the Chief Executive Officer of the Department of Corrective Services was exemplary.

45. Given that the deceased was a difficult prisoner and patient who, it appears, presented prison staff and medical professionals with a serious challenge to their patience and compassion, they are to be commended for their forbearance.

CONCLUSION

46. The evidence of the deceased's ongoing respiratory condition together with the post mortem examination make clear that the cause of death was pneumonia in a man with chronic pulmonary disease, and I so find.

47. I find that the manner of death was Natural Causes.

B PKING
CORONER
23 April2013