JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORAM	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	12 FEBRUARY 2020
DELIVERED	**:**	20 FEBRUARY 2020
PUBLISHED	**:**	20 FEBRUARY 2020
FILE NO/S	**:**	CORC 394 of 2016
DECEASED	**:**	WUMBIE, ERIC

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner

Ms D Underwood (State Solicitor's Office) appeared for the Department of Justice

Ms A Barter (Aboriginal Legal Service of Western Australia Inc.) appeared for the deceased's sister, Ms D Donation

Coroners Act 1996

(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Eric WUMBIE*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 12 February 2020, find that the identity of the deceased person was* ***Eric WUMBIE*** *and that death occurred on 13 April 2016 at Fiona Stanley Hospital from valvular and ischaemic heart disease in the following circumstances:*

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INTRODUCTION

1. Eric Wumbie (Eric)[1] died on 13 April 2016 at Fiona Stanley Hospital (FSH) from valvular and ischaemic heart disease. At the time of his death, Eric was a sentenced prisoner in the custody of the Chief Executive Officer of the Department of Corrective Services, as it then was.[2]

2. Accordingly, immediately before his death, Eric was a "person held in care" within the meaning of the *Coroners Act 1996* (WA) and his death was a "reportable death".[3] In such circumstances, a coronial inquest is mandatory.[4]

3. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[5]

4. I held an inquest into Eric's death on 12 February 2020 which his sister, Ms Donation, attended by way of a video-link from Derby.

5. The documentary evidence adduced at the inquest included independent reports of Eric's death prepared by the Western Australia Police[6] and by the Department of Justice[7] respectively, which together comprised two volumes.

6. Associate Professor Michael Nguyen, a Consultant Cardiologist at FSH; and Mr Richard Mudford, a Senior Review Officer employed by the Department of Justice (and the author of the Death in Custody Review) were called as witnesses at the inquest.

7. The inquest focused on the care provided to Eric while he was a prisoner, as well as on the circumstances of his death.

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[1] Family members asked that the deceased be referred to as "Eric" at the inquest and in this finding
[2] Section 16, *Prisons Act 1981* (WA)
[3] Sections 3 & 22(1)(a), *Coroners Act 1996* (WA)
[4] Section 22(1)(a), *Coroners Act 1996* (WA)
[5] Section 25(3) *Coroners Act 1996* (WA)
[6] Exhibit 1, Vol 1, Tab 2, Police Investigation Report
[7] Exhibit 1, Vol 2, Death in Custody Review

THE DECEASED

Background[8,9,10]

8. Eric was born in Derby on 5 December 1978 and was 37 years of age when he died on 13 April 2016.[11] When he was a child, he and his family lived at the Kupungarri Community approximately 300 kilometres north east of Derby. Eric enjoyed playing sport, especially football and basketball and after finishing year 11, he worked as a station hand on several cattle stations.

9. Eric later obtained employment in the construction and mining industries through the Community Development Employment Program. In 2006, he became the Chair of the Imintji Community and assisted with the development of local infrastructure.

10. Eric had a close and loving relationship with his family, including his five siblings.[12] In 1995, he met his former partner and together they had six children.[13] They separated in 2010, and Eric entered into a relationship with a new partner in 2014.

Offending History[14,15]

11. During the period 1995 to 2015, Eric accumulated 41 convictions for offences which mainly related to traffic and domestic violence issues. He served three separate periods of imprisonment and according to the Department, there was a correlation between Eric's alcohol consumption and his offending behaviour.

12. On 16 May 2015, Eric appeared before the Magistrates Court at Derby charged with two counts of aggravated common assault, one count of assault occasioning bodily harm and one count of aggravated unlawful wounding. He was initially remanded in custody, but was released on bail on 27 May 2015.

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[8] Exhibit 1, Vol 1, Tab 2, Police Investigation Report, pp3-4
[9] Exhibit 1, Vol 2, Tab A, Death in Custody Review, pp4-5
[10] Exhibit 1, Vol 1, Tab 8, File Note - Discussion with Ms D Donation, p1
[11] Exhibit 1, Vol 1, Tab 1, P100 - Report of Death
[12] I note that the Police Investigation Report states that Mr Wumbie had four siblings.
[13] I note that the Death in Custody Review states Mr Wumbie and his first partner had five children.
[14] Exhibit 1, Vol 2, Tab 1, Deceased's criminal record
[15] Exhibit 1, Vol 2, Tab A, Death in Custody Review, p5

13. On 29 June 2015, Eric was arrested and charged with two counts of breach of protective bail conditions. He appeared in the Magistrates Court at Derby in relation to the six offences referred to above and was sentenced to an aggregate term of imprisonment of one year and eight months. His earliest release date was 27 February 2017.

Prison History[16,17]

14. Eric was received at the Broome Annexe of the West Kimberley Regional Prison (WKRP) on 29 June 2015. He presented with no specific concerns and no health issues were identified. He was accommodated at the WKRP until 24 July 2015 (25 days).

15. Eric's subsequent periods of imprisonment were unremarkable and he was assessed as a quiet individual who complied with prison rules and was polite and courteous. During his last period of incarceration, Eric had the following placements:

a. ***Roebourne Regional Prison (RRP)***
24 July 2015 - 14 January 2016 (174 days)
For muster reasons, Eric was transferred to RRP. He became a peer support prisoner on 22 October 2015 and during his time at RRP, he completed six modules of the Certificate 1 - General Education;

b. ***WKRP***
14 January 2016 – 24 March 2016 (70 days)
In accordance with a request made whilst he was at RRP, Eric was transferred back to WKRP to facilitate family visits. He was taken to Derby Hospital on 21 March 2016, but remained part of the muster at WKRP until 24 March 2016, when he was transferred to FSH; and

c. ***Casuarina Prison (CP)***
24 March 2016 – 13 April 2016 (20 days)
Following his transfer to FSH, Eric was placed on the muster at CP. He was returned to CP on 2 April 2016, but readmitted to FSH on 3 April 2016, where he remained until his death on 13 April 2016.

[16] Exhibit 1, Vol 2, Tab A, Death in Custody Review, pp6-8
[17] Exhibit 1, Vol 1, Tab 29, Cell placement history

16. A request made by Eric for parole was denied by the Prisoner Review Board on 30 March 2016 on the grounds of unmet treatment needs (domestic violence and substance abuse) and his previous unsatisfactory response to community supervision.[18,19]

Overview of Medical Conditions[20,21]

17. As a young person, Eric's physical and mental health was described as "*very good*".[22] In March 2016, he said he had smoked a packet of cigarettes per day for 7 years and was drinking four cartons of beer per month. Departmental records report a discrepancy between Eric's admitted consumption of alcohol and his actual consumption levels. Eric disclosed that he smoked cannabis but denied intravenous drug use.[23]

18. Eric's prison records show that the health screens conducted when he was admitted to prison in 2005, 2011 and 2012 were unremarkable. He had no history of medical conditions and he was not taking any prescribed medication. In January 2013, Eric's cholesterol and triglyceride levels were noted to be elevated, but he had no other risk factors for heart disease.

19. On 16 May 2015, Eric's medical on his receival at RRP was normal and he said he was feeling well. The Department's Total Offender Management Solution (TOMS) database shows that Eric had never presented with any self-harm or suicidal ideation. When Eric was received at prison for the last time on 29 June 2015, he reported no health issues. Departmental records show that from June 2015 to January 2016, he was seen at the medical centre for several minor issues including a swollen knee and minor dental issues.

20. In passing, I note that at around the time of Eric's death, there was an issue with hospitals not always forwarding discharge summaries when prisoners were sent back to prison after receiving treatment. I am informed that in the past 18 months, there have been significant improvements in this area and that discharge summaries are now routinely received. I am further informed that the Department is looking at the electronic transmission of discharge summaries, which would mean they would be automatically imported into the relevant prisoner's medical record.[24,25]

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[18] Exhibit 1, Vol 1, Tab 24, Letter - Prisoners Review Board (30.03.16)
[19] See also: Exhibit 1, Vol 1, Tab 49, Transcript of sentencing remarks (20.08.15)
[20] Exhibit 1, Vol 2, Tab A, Death in Custody Review, p5 & pp8-10
[21] Deceased's Department of Corrections medical records
[22] Exhibit 1, Vol 1, Tab 8, File Note - Discussion with Ms D Donation, p1
[23] Exhibit 1, Vol 1, Tab 16, FSH Discharge summary (24.03.16)
[24] Exhibit 1, Vol 2, Tab A, Death in Custody Review, p5 and ts 12.02.20 (Mudford), pp23-24
[25] Email from Ms D Underwood (State Solicitor's Office) to Sergeant L Housiaux (14.02.20)

EVENTS LEADING TO DEATH

Eric's first complaint of heart issues[26,27]

21. Eric first complained of cardiac symptoms on 17 February 2016, when he reported experiencing shortness of breath on exertion. He was noted to have no family history of heart issues and did not complain of chest pain. On examination, his chest was clear and his heart sounds were normal but his abdomen was tender. He was given medication for possible gastro-oesophageal reflux and was also treated for helicobacter pylori, which a breath test confirmed he had.

22. On 12 March 2016, Eric complained of feeling unwell. He reported pains in his chest and abdomen and shortness of breath. His pulse was slightly elevated but his blood pressure and oxygen saturations were normal.

23. On 20 March 2016, Eric reported feeling unwell. A nurse noted his chest was clear, but his face and ankles were swollen and there was a trace of protein in his urine. He was referred to a medical officer and seen the next day.

24. When reviewed by the medical officer on 21 March 2016, Eric had a higher level of protein in his urine and his face, ankles, legs and abdomen were swollen. There was concern he may have a kidney condition and he was transferred to Derby Hospital (DH) for assessment. On admission to DH, Eric was diagnosed with heart failure[28] and on 23 March 2016, he had a test called an echocardiogram (echo). The echo showed he had a dilated ascending aorta, biventricular failure and severe aortic regurgitation (i.e.: where a valve in the heart does not close properly and blood leaks back into the heart's main pumping chamber).[29]

25. Eric was also found to have a left ventricular ejection fraction of only 30%. The ejection fraction measures the percentage of blood leaving the heart each time it contracts. A "normal" left ventricular ejection fraction is considered to be above 50%.[30,31]

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[26] Deceased's Department of Corrections medical records
[27] Exhibit 1, Vol 2, Tab A, Death in Custody Review, p5 & pp8-10
[28] Exhibit 1, Vol 1, Tab 35, Senior Officer C Enyon - Incident description report (21.03.16)
[29] ts 12.02.20 (Nguyen), p12
[30] ts 12.02.20 (Nguyen), pp13-14
[31] See: also https://www.mayoclinic.org/ejection-fraction/expert-answers/faq-20058286 where an ejection fraction of 55% or higher is said to be normal

26. Following the echo, Eric was immediately transferred to Broome Regional Hospital, where he was treated with intravenous antibiotics. He was subsequently transferred to FSH by the Royal Flying Doctor Service.[32]

Admission to FSH - 24 March 2016[33,34,35]

27. On arrival at FSH, Eric gave a history of shortness of breath, swelling (oedema), distension of the abdomen, reduced exercise tolerance, difficulty breathing when lying prone at night and palpitations. He was admitted under a consultant cardiologist and diagnosed with congestive cardiac failure.

28. Eric had a liver function test, the results of which were grossly abnormal. An ultrasound showed he had abnormal fluid build-up in his abdomen (ascites) and an echo confirmed the previously identified aortic regurgitation, dilated ascending aorta, and severe left ventricular failure. Eric's heart failure was treated with intravenous diuretics (medication which increases the amount of fluid excreted by the body and thereby reduces strain on the heart). Tests over the next few days also showed that Eric had severe proximal left anterior descending artery stenosis, a severely dilated aortic root, a severely dilated left ventricle and severe pulmonary hypertension.

29. Associate Professor Nguyen said that aortic regurgitation can be caused by a connective tissue disorder (e.g.: Marfan syndrome), or damage to the heart valve caused by an infection. It can also be caused by rheumatic fever, although this was unlikely in Eric's case, because his mitral valves (which are usually damaged with rheumatic fever) were free from disease. Associate Professor Nguyen concluded that the cause of Eric's aortic regurgitation could not be identified.[36]

30. Eric's condition improved during his admission at FSH and he was reviewed by Dr Slimani, a consultant cardiothoracic surgeon. Dr Slimani recommended coronary artery bypass surgery and an aortic valve replacement and said that surgical correction of Eric's condition was the only available treatment.

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[32] Exhibit 1, Vol 1, Tab 20, Derby Hospital discharge summary (23.03.16)
[33] Exhibit 1, Vol 1, Tab 16, FSH Discharge summary (02.04.16)
[34] Exhibit 1, Vol 1, Tab 15, Report - Dr E Slimani (06.02.19)
[35] Exhibit 1, Vol 1, Tab 17, Report - Dr M Nguyen (02.08.19)
[36] See also: ts 12.02.20 (Nguyen), pp14-15

31. Dr Slimani said that Eric's heart condition would have been present for a significant time and would have developed over the previous three to five years. He said that had Eric undergone cardiac testing at a much earlier stage, Eric would likely have had surgery at that time. Dr Slimani also said that Eric's degree of ventricular impairment was rare and one of the worst cases he had seen.[37]

32. In his evidence, Associate Professor Nguyen said that it was not uncommon for patients with severe heart failure to be asymptomatic, especially young patients. He said that the heart murmur associated with aortic regurgitation was subtle and could easily be missed. Associate Professor Nguyen said that where a patient was not exhibiting cardiac symptoms (as in Eric's case), there would be no reason to carry out investigations such as an echo.[38]

33. In any event, by 2 April 2016, Eric's condition was considered sufficiently stable for him to be followed up in the outpatient clinic, where his surgery could be planned. As a result, he was discharged to the infirmary at Casuarina Prison which was described in the following terms by the Office of the Inspector of Custodial Services:

> The infirmary is a state-wide facility for 20 prisoners who require ongoing medical and nursing care that is not available in the general prison system. This includes terminally ill prisoners, prisoners requiring dialysis, and prisoners who are recovering after going to hospital (for example, after a heart attack or a fracture).[39]

34. Associate Professor Nguyen confirmed that it was common practice to discharge heart patients who are clinically stable. These patients were typically discharged home to await surgery. Associate Professor Nguyen said that with the benefit of hindsight, Eric should probably have remained at FSH awaiting surgery.[40] However, as noted, Eric was discharged to the infirmary at Casuarina Prison where he received full-time nursing care.

[37] Exhibit 1, Vol 1, Tab 15A, Email Ms C Shaw to Sgt L Housiaux (11.02.19)
[38] ts 12.02.20 (Nguyen), pp16-17
[39] Office of the Inspector of Custodial Services, Report No. 110 - Casuarina Prison, July 2017, p17
[40] ts 12.02.20 (Nguyen), pp10-11

Admission to FSH - 3 April 2016[41,42,43,44]

35. On the evening of 3 April 2016, Eric's condition suddenly deteriorated and his cellmate found him coughing up blood and complaining of chest pain. Eric was taken to FSH by ambulance and arrived there at 8.48 pm.

36. On admission, Eric complained of shortness of breath, a productive cough and right-sided chest pain. He denied any peripheral swelling (oedema) or palpitations and his exercise tolerance remained roughly the same as before. He underwent a number of tests and was treated for low sodium and high potassium levels. His impaired liver and kidney function were treated with intravenous medication.

37. Eric was scheduled to undergo an operation known as a Bentall procedure, to address his diseased ascending aorta and coronary bypass grafting to deal with the blockages in his coronary arteries.

38. Dr Slimani reviewed Eric on 12 April 2016, and expressed concern about his "*precarious and deteriorating clinical picture"*. Dr Slimani and Dr Rankin (consultant cardiologist) both felt that without surgery, Eric would not survive the week. Consequently, he was scheduled for surgery on 13 April 2016.

The events of 13 April 2016[45,46,47]

39. Eric was taken to theatre on 13 April 2016 and after he was anaesthetised, but before the start of the operation, he developed a life-threatening heart rhythm (ventricular fibrillation) and then suffered a cardiac arrest.

40. Eric's chest was immediately opened and it was discovered that the membrane surrounding his heart (the pericardium) was fused, which prevented adequate internal cardiac massage or cardioversion. The adhesions to Eric's pericardium were urgently dissected and his heart was successfully defibrillated and a normal rhythm was achieved.

[41] Exhibit 1, Vol 1, Tab 15, Report - Dr E Slimani (06.02.19)
[42] Exhibit 1, Vol 1, Tab 19, Departmental medical records (03.04.16)
[43] Exhibit 1, Vol 1, Tab 35, Incident description reports (03.04.16)
[44] Exhibit 1, Vol 1, Tab 21, St John Ambulance patient care record (03.04.16)
[45] Exhibit 1, Vol 1, Tab 15, Report - Dr E Slimani (06.02.19)
[46] Exhibit 1, Vol 1, Tab 18, Medical officer's operation report (13.04.16)
[47] Exhibit 1, Vol 1, Tabs 9-11, SERCO Critical incident report and reports from attending officers

41. As the surgery continued, Eric's arterial pressure rapidly decreased and he developed ventricular fibrillation. His cardiopulmonary bypass flows also deteriorated and his abdomen became swollen. A surgical procedure called a laparotomy was performed to address what was thought to be internal bleeding. Although some blood was found in his retroperitoneal space, no active bleeding was found.

42. For the next 30 minutes, Eric suffered poor blood flow (hypoperfusion), very low arterial pressure, and low cardiopulmonary bypass flows. His ventricular fibrillation did not respond to defibrillation or multiple doses of adrenaline and no reversible cause could be found for his condition. As a result, the surgical procedure was abandoned and he was declared deceased at 1.20 pm on 13 April 2016.[48]

43. After Eric's death, a prison officer who had supervised him on three separate occasions during his admission to FSH commented that in his view, Eric was well treated by hospital staff.

CAUSE AND MANNER OF DEATH[49]

44. A forensic pathologist (Dr Cadden) conducted a post mortem examination of Eric's body on 18 April 2016. Dr Cadden noted the obvious signs of recent cardiac surgery. Eric's aortic valve had been replaced with a prosthetic valve and a portion of his thoracic aorta above his heart had also been replaced.[50]

45. Dr Cadden found that Eric's surgical sites were unremarkable. There was pooling of fluid in his lungs and in the left chest and abdominal cavities. Focal coronary vessel disease was present but no other significant finding was identified. Toxicological analysis identified a number of medications in Eric's system that were consistent with his medical care.[51]

46. At the conclusion of the post mortem examination, Dr Cadden expressed the opinion that the cause of Eric's death was valvular and ischaemic heart disease. I accept and adopt that conclusion and I find that Eric's death occurred by way of Natural Causes.

[48] Exhibit 1, Vol 1, Tab 5, Death in Hospital Form
[49] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report
[50] Exhibit 1, Vol 1, Tab 6, Supplementary Post Mortem Report
[51] Exhibit 1, Vol 1, Tab 7, Toxicology Report

CONTACT WITH ERIC'S NEXT-OF-KIN

Eric's next-of-kin

47. When a prisoner is admitted to prison, their next-of-kin (NOK) details are entered into TOMS. Both Eric's defacto partner and his sister, Ms Donation, were listed as Eric's NOK and their respective telephone numbers were recorded in TOMS.[52]

48. According to a department policy known as PD82, when a prisoner's medical condition deteriorates:

> The superintendent shall, subject to security considerations, arrange for a prisoner's next-of-kin to be advised of the removal of a prisoner to a hospital or other place of assessment/treatment as a result of serious injury or illness.[53]

49. There were no security concerns in Eric's case and so, in accordance with PD82, both Ms Donation and Eric's defacto partner should have been contacted when he was admitted to FSH.

Ms Donation's position

50. Ms Donation says that she received no notification from the Department that Eric had been admitted to FSH, much less that his condition was very serious or subsequently, that he had died. It appears that at some stage, Ms Donation did become aware that her brother was an inpatient at FSH, however, she says that her efforts to speak to him on the telephone were unsuccessful.[54]

Documentary evidence

51. Mr Mudford said he had checked departmental records and there was no record of any contact having been made with Ms Donation about Eric's admission to FSH. Whilst it is possible that efforts were made to contact Ms Donation, Mr Mudford agreed that the lack of any documentation in this regard, left open the inference that no such contact had been attempted.[55]

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[52] ts 12.02.20 (Mudford), pp25-26
[53] Exhibit 3, Policy Directive 82, Appendix 1 - Prisoner Movements - Procedures, para 24.1
[54] ts 12.02.20 (Barter), p26 & pp28-30
[55] ts 12.02.20 (Mudford), p26 & pp29-31

CONCLUSION

52. Although the lack of documentation does not necessarily mean that no efforts were made to contact Ms Donation, it is nevertheless problematic. The uncontradicted evidence in this case is that Ms Donation was not contacted by the Department about Eric's deteriorating medical condition or his subsequent death.[56] Clearly, she should have been.

53. Mr Mudford properly conceded that in accordance with PD82, when a prisoner is admitted to hospital, their NOK should be contacted. He also agreed that when this does not occur, unnecessary heartache and difficulty can result.[57]

54. In this case, the evidence does not allow me to do more than to encourage the Department to make every effort to comply with the requirements of PD82 and to contact the NOK of a prisoner who is admitted to hospital. Quite obviously, the efforts of staff in this regard should be clearly documented on TOMS.

QUALITY OF SUPERVISION, TREATMENT AND CARE

55. Whilst he was in prison, Eric underwent routine medical screens, all of which were normal. The first recorded occasion on which he complained of symptoms that might be heart-related, (namely shortness of breath) was on 17 February 2016.

56. Eric's condition was monitored and he was appropriately referred to the Derby Hospital on 21 March 2016 after he was reviewed by a prison doctor. His subsequent transfers to Broome Hospital and FSH were clearly appropriate. His serious heart condition was not fully identified until his admission to FSH on 24 March 2016. Extensive tests revealed that he had congestive cardiac failure, severe aortic regurgitation, severe left ventricular failure and a dilated ascending aorta.

57. After treatment as an inpatient at FSH, Eric's condition appeared to stabilise and it was decided to plan his surgery on an outpatient basis. As a result, he was discharged back to the infirmary at Casuarina Prison on 2 April 2016. He was appropriately readmitted to FSH on 3 April 2016, when his clinical condition suddenly declined.

[56] ts 12.02.20 (Barter), p26 & pp28-30
[57] ts 12.02.20 (Mudford), p33

58. Tragically, Eric died on 13 April 2016 after suffering complications during surgery to correct his serious heart issues. However, on the basis of the evidence of Dr Slimani and Associate Professor Nguyen, I am satisfied that Eric received a high standard of care whilst he was an inpatient at FSH.

59. After reviewing the departmental records that were tendered into evidence, and having heard from Mr Mudford, I am satisfied that Eric was appropriately managed during the time he was in custody. I am further satisfied that the standard of Eric's supervision, treatment and care whilst he was in custody was reasonable.

I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

CORONER M Jenkin

20 FEBRUARY 2020