STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Sean Laurence Waygood
Hearing dates:	12 June 2015
Date of findings:	16 June 215
Place of findings:	NSW State Coroner's Court - Glebe
Findings of:	Magistrate Michael Barnes, State Coroner
Catchwords:	CORONIAL LAW – Cause and manner of death; death in custody; standard of health care to maximum security prisoner
File number:	2014/83267
Representation:	Senior Sergeant Harding assisting the State Coroner Ms Boyd of Counsel representing Justice Health Mr Griffiths on behalf of Corrective Services

Findings:	**Identity of deceased** The deceased person was Sean Laurence Waygood. **Date of death** He died on 18 March 2014. **Place of death** Mr Waygood died at the Prince of Wales Hospital, Randwick, New South Wales. **Manner of death** He died from natural causes while serving a prison sentence. **Cause of death** The cause of Mr Waygood's death was acute renal failure caused by bilateral ureteral obstruction due to metastatic colorectal carcinoma.

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The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Sean Laurence Waygood.

Introduction

Mr Waygood was a prisoner serving a jail sentence when he died of natural causes in the Prince of Wales Hospital secure wing.

While none of the findings a coroner must make in all cases is in doubt - the identity of the deceased; the date and place of the person's death; and the manner and cause of the death - because Mr Waygood was in custody when he died, an inquest is mandatory. Reflecting the policy underpinning that requirement, the inquest focused on whether the medical care provide to the deceased while he was in custody was appropriate.

The evidence

Social history

Sean was the younger of two children. He apparently had a stable and loving up-bringing. Apart from asthma he suffered no unusual childhood illnesses.

After he left school Mr Waygood joined the army and succeeded in becoming a commando and being awarded a Green Beret.

He appears to have had a happy marriage and he is survived by four children.

It seems his part time work in the security industry brought him into contact with criminal involved in illicit drugs.

Although Mr Waygood had previously come before the courts for only relatively minor matters, in 2009 he was convicted of a number of serious offences. On the 28 May 2010, he was sentenced at the Sydney District Court to a term of imprisonment of 20 years, with a non-parole period of 15 years for the offences of Conspiracy and Agree to murder, Discharge a Firearm with intent to cause grievous bodily harm, and other serious firearm and drug offences. The earliest release date for parole was the 18 January 2024.

His wife, mother and children visited him regularly while he was in prison. It is clear that his death was a severe blow to each of them. I offer his family my sincere condolences.

Custodial history

On the 23 January 2009, Mr Waygood was received into Corrective Services custody at the Long Bay Correctional Centre. He was assessed by NSW Justice Health where he reported no medical issues or thoughts of self-harm or suicide.

On the 27 January 2011, he was transferred to the High Risk Management Correctional Centre (HRMCC), otherwise known as "Supermax' at Goulburn. Every new reception into this area is placed on a segregation order and accommodated in unit 7 of the HRMCC while they are assessed for suitability into the HRMCC program in accordance with the HRMCC Standard Operating Procedures.

On the 1 March 2011, Mr Waygood was declared an Extreme High Security (EHS) inmate by the Commissioner for Corrective Services. The effect of this placement is that his overall management, classification and placement within the correctional system are overseen by the High Security Inmate Management Committee (HSIMC).

On the 7 March 2011 he was moved out of unit 7 and released from the segregation order and accommodated on unit 8 for normal routine within the centre.

He remained at the HRMCC until his transfer back to Long Bay Correctional Centre in early 2014 to enable on-going medical treatment.

Prison health history

During his first year in custody, Mr Waygood experienced no ill-health of significance.

On the 21 April 2010, he reported an upset stomach with associated abdominal symptoms. This resolved with minimal treatment.

On the 17 May, he complained of increased gas, constipation and a "twisting of intestines". This was again treated as a gastric complaint and seems to have quickly resolved. Pathology tests revealed nothing of significance. He was prescribed Fasigyn tablets for a possible Giardia infection.

Throughout the rest of the year there were apparently no health issues of significance.

On the 5 March 2011, Mr Waygood complained of abdominal discomfort and constipation. He was given Metamucil. The next day the medical notes indicate, "*Nil problems raised*". On the 7 March 2011, the notes record that he "*feels much better".*

On the 15 March 2011, the nursing notes state that Mr Waygood claimed to have been unwell for approximately 10 days, during which time he had experienced some cramping in the stomach. He was unable to eat the previous day and had general pain in his abdomen. He was flushed in the face. It seems Mr Waygood told the nurse that he had *"passed bright frank blood when having bowels opened*." This entry also details that Mr Waygood was unable to be seen because the door to the cell at that point was not able to be unlocked. A further entry for the same day made by a general practitioner who saw Mr Waygood states that he had abdominal discomfort and pain spasms for 10 days. It records him to be tender in left upper and left lower quadrant of his abdomen but it was not distended. A differential diagnosis of pancreatitis or renal calculus was made. He was prescribed tramadol and buscopan for pain relief.

On the 16 March, the medical notes record that Mr Waygood was still experiencing some cramping and that he hadn't eaten breakfast. Later on that day the notes indicate that "*the pain is much improved".*

On the 17 March the medical notes record that his pain was improving. Consistent with this he was seen working in the library.

On the 18 March a Visiting Medical Officer (VMO) examined Mr Waygood and recites that he reported abdominal pain for the past 14 days but that it was *"getting better over last 2 days."*

On the 20 March the notes state that when examined by a nurse Mr Waygood told him/her that he was in pain, had been vomiting, and his stomach was bloated. "*When lying flat, patient was quite distressed and in obvious pain, his whole body was quivering and his jaw was jittering".*

The VMO was contacted and requested that Mr Waygood be sent to Emergency Department at the Goulburn Base Hospital for review. This resulted in some disagreement between the medical staff and the custodial staff.

The medical notes indicate that Department of Corrective Services staff requested that he be sent to Long Bay Hospital rather than Goulburn. The after-hours Nurse Manager was contacted and requested that the on-call medical officer be contacted regarding this decision. That doctor, who was working at Long Bay, was contacted and asked that Mr Waygood be sent to Goulburn Hospital for urgent review. The medical notes record that the Goulburn Correctional Centre General Manager, Michelle Paynter, became involved and refused to send Mr Waygood to Goulburn Hospital due to his extreme high risk status. The VMO was requested to consult with Ms Pointer regarding this refusal. After doing so the VMO agreed that Mr Waygood could go to the Long Bay Hospital.

As it transpired the debate was rendered nugatory by events: on route to Long Bay Hospital, Mr Waygood's condition deteriorated and the vehicle transporting him was redirected to Goulburn Base Hospital.

Upon admission a CT scan of his abdomen quickly demonstrated an acute obstruction in his sigmoid colon due to a mass suspected of being malignant. What were thought to be metastases were also detected in his liver.

On the 22 March, Mr Waygood underwent a sigmoid colectomy to enable the removal of that part of the colon affected by the lesion. Because the obstruction had been in place for a number of days, the colon could not be rejoined and so a colostomy was fashioned.

A pathology report confirmed the patient had colon cancer. Five of 10 lymph nodes were positive for metastatic disease.

On 1 April 2011, Mr Waygood was transferred to Long Bay Hospital for further oncology review at the Prince of Wales Hospital (POWH).

On the 24 May 2011, a PET scan at the POWH determined that Mr Waygood had further lesions in his liver, indicating a high grade tumor.

On the 1 July 2011, he underwent a left liver resection at the POWH for a segment 4 high grade liver metastasis.

On the 6 September 2011, chemotherapy was commenced and continued through to March 2012.

In May 2012 in the POWH the Hartman's procedure was reversed. During this procedure it was noted that a further tumor had developed on the rectal stump. It was also re-sectioned and the colon was rejoined.

In September 2012 a medical report was prepared by the treating oncologist indicating that Mr Waygood's colon cancer had metastasized to the pelvis and lung. The report cited that the condition was incurable and terminal, with an average life expectancy of someone who develops lung metastases from colon cancer at 12-18 months.

In March 2013, Mr Waygood was readmitted to the POWH with acute renal failure. Stents were inserted and dialysis undertaken.

In June 2013, a repeat CT scan noted the slowly progressive pulmonary metastases.

In January 2014, he was readmitted to the POWH with urosepsis and acute renal failure.

In February, due to the side effects of the chemotherapy, Mr Waygood declined any further treatment which for some months had only been palliative in any event.

On 14 March, he was transferred to the POWH suffering multi system failure. Four days later, on 18 March, Sean Waygood passed away.

Investigation

Autopsy results

Even though the cause of Mr Waygood's death was well known even before it occurred, because he was in custody at the time of his death and for a considerable period before, an inquest was mandatory so that the standard of health care provided to him while he was in custody could be independently critiqued.

The cause of Sean's death is cited in the post mortem report under the hand of Pathologist Rebecca Irvine as acute renal failure and ureteral obstruction due to metastatic colorectal carcinoma.

Complaint to HCCC

Relevantly, on 14 November 2011, Mr Waygood raised concerns about his health care to that point in a complaint he made to the Health Care Complaints Commission (HCCC). He outlined the course of his illness commencing with bloating, abdominal

pains and constipation in August and November 2010 and noted the symptoms passed.

He complained of acute abdominal symptoms some months later when he informed a nurse on the 5 March 2011. She gave him Metamucil. On 10 March, the symptoms progressed and Mr Waygood asked to see a doctor. He was told he had to see a nurse first. At this stage he was passing stools with blood. On the 15 March he was seen to by a VMO who allegedly dismissed the bloating and suggested it was referred pain from kidney stones. He was administered 2 injections for the management of his pain.

Mr Waygood complained that the VMO inferred the abdominal pain was due to him either taking drugs or committing an act of self-harm. He stated that the doctor informed him that he believed he had a bacterial infection and that the pain would pass soon. He was not prescribed any medication.

He alleged that the lack of action regarding his physical presentations of pain resulted in his intestines being so stretched that they could not be rejoined after removal of the lesion. He states that this left him to manage a colostomy.

The HCCC concluded that the response of the VMO who saw Mr Waygood on 15 March 2011 failed to have sufficient regard to the fact he had reported passing frank blood in the days before that consultation and a longer history of colicky abdominal pain.

The HCCC found the VMO who examined Mr Waygood on the 18 March also failed to acknowledge or adequately respond to Mr Waygood's recent history of malaena and an 11 month history of intermittent abdominal pain and changing bowel habits.

The HCCC was critical of the VMO for failing to make a differential diagnosis of bowel cancer and failing to urgently investigate this possibility.

The conduct of the two VMOs involved was referred to the Medical Council of NSW which in response interviewed the doctors and reviewed the then available evidence. It concluded that the complaint highlighted the difficulties of providing timely and appropriate medical care to a group of patients with complex medical and security problems.

The Medical Council found that the presentation was atypical for the pathology eventually encountered. Mr Waygood's previous episodes of severe abdominal pain had quickly resolved; his condition improved between the 15 and 18 March, and then a further deterioration occurred over the weekend. Examination of his abdomen was unremarkable on the two separate occasions. The facilities available to the doctors were limited and access to imaging was restricted. Both the doctors recognized that there could be a problem that needed further evaluation. Follow-up was organized and enacted.

The Council found that the major problem appears to have been logistical, resulting from the complainants need for the highest level of security available, delaying his

transfer somewhat. Neither of the doctors, nor the treating surgeon, believed that the delay the patient experienced contributed to his long-term prognosis.

Accordingly, the Medical Council found that they did not have any concerns with the assessment, examination and treatment initiated by the medical officers involved.

Coroner's expert

The Court retained an independent expert to review aspects of the case. Professor Richard Fox, an eminent oncologist, reviewed the medical charts and the statements of the nurses and doctors involved in Mr Waygood's care.

In summary, he came to the conclusion that once Mr Waygood was admitted to the Goulburn Base Hospital on 20 March 2011, the care he received for the rest of his life was of the highest standard. He had some concerns about the care provided at the High Risk Offenders Unit but in view of his evidence that the tumor that led to Mr Waygood's death developed over years – up to a decade – there is no basis for concluding any undue care contributed to the death. Once the primary cancer was established and numerous metastases proliferated throughout various organs, Mr Waygood's chance of survival evaporated.

Professor Fox pointed out the danger of using hindsight to critique events. However, he concluded that the abdominal pains experienced by Mr Waygood in 2010 were probably the earliest symptoms of the cancer that took his life. He was also adamant that they were by no means definitive and as they resolved quickly, they did not warrant further investigation in such a young and apparently healthy man.

He was less forgiving of the failure of the VMOs who saw Mr Waygood in March 2011. By that time Mr Waygood had passed blood per rectum and that should have been investigated and colon cancer should have been part of the differential diagnosis. He was confident however, that even had Mr Waygood been hospitalised in early March the outcome would almost certainly have been the same, albeit he would have been spared the pain and discomfort for the intervening days and a colostomy may well have been avoided.

Conclusions

There is no doubt that Mr Waygood died from the complications of colon cancer that had developed in his body over many years. While, with the benefit of hindsight, it is likely that the abdominal discomfort and other symptoms he experienced and reported in 2010 were caused by the tumor developing in his sigmoid colon, it was not unreasonable for the medical staff at the Long Bay Correctional Centre to assume they were caused by something less sinister. When the symptoms resolved, there was no reason to investigate further.

However, by the time the two VMO's at the HRMCC saw Mr Waygood on 15 and 18 March respectively, he had a constellation of symptoms recorded in the medical chart that included the passing of frank blood that should have led to more urgent investigation, in my view. I accept that the slightly earlier detection of the tumor that could have resulted is unlikely to have changed the outcome. Nevertheless, it was in my view sub-optimal care and resulted in Mr Waygood needlessly suffering.

I do not consider the security classification of Mr Waygood as Extreme High Risk compromised his access to adequate care and treatment. There was some uncertainty and confusion about where he should be taken when it was determined that he need to be admitted to a hospital on 20 March 2011, but as matters played out he was taken to the closest hospital in any event.

From that point on I am satisfied that Mr Waygood received a high standard of health care that was as good as he is likely to have received had he been in the community.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Sean Laurence Waygood.

Date of death

He died on 18 March 2014.

Place of death

Mr Waygood died at the Prince of Wales Hospital, Randwick, New South Wales.

Manner of death

He died from natural causes while serving a prison sentence.

Cause of death

The cause of Mr Waygood's death was acute renal failure caused by bilateral ureteral obstruction due to metastatic colorectal carcinoma.

I close this inquest.

Magistrate Barnes
State Coroner