FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 1405/08

Inquest into the Death of GEORGE SAMUEL HOLMES

Delivered On: 17th June, 2011

Delivered At: Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE 3000

Hearing Dates: 6th June, 2011

Findings of: Coroner Paresa Antoniadis SPANOS

Representation: Sergeant David DIMSEY, Police Coronial Support Unit, to assist the Coroner

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Court reference: 1405/08

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner

having investigated the death of:

Details of deceased:

Surname: HOLMES
First name: GEORGE
Address: Port Phillip Prison, Laverton, Victoria 3028

AND having held an inquest in relation to this death on 6th June, 2011

at Melbourne

find that the identity of the deceased was GEORGE SAMUEL HOLMES born on the 11th February, 1922

and that death occurred on the 7th April, 2008

at St Vincent's Hospital, Victoria Parade, Fitzroy, Victoria 3065

from: 1(a) CARDIOVASCULAR DISEASE IN A MAN WITH SUBDURAL HAEMORRHAGE (IN KEEPING WITH A FALL)

in the following circumstances:

1. Mr Holmes was an 85 year old man with a past medical history which included acute myocardial infarction (heart attack), cerebrovascular accident (stroke) and atrial fibrillation (an abnormal heart rhythm). His regular prescription medications at the time of his death were Warfarin, Atacand, Digoxin, Pravastatin and Panadeine.

2. On 14 March 2008, Mr Holmes was sentenced by Her Honour Judge Millane of the County Court to a total effective sentence of four years and five months, with a minimum non-parole period of 24 months, for offences of indecent assault and gross indecency.

3. On 20 March 2008, after spending one week in the Melbourne Assessment Prison, Mr Holmes was transferred to Port Phillip Prison. He was first classified to the Borrowdale Unit and

then, on 26 March 2008, transferred to the Alexander North Unit, a closed unit offering some protection to the prisoners housed therein. He shared a cell with GCH, a man in his seventies, who had also been sentenced on 14 March 2008 for sexual offences against children. The two did not know each other before they commenced sharing a cell, and there is no evidence of any ill will or animosity between them. Nor was there any evidence of any threats or acts of violence against Mr Holmes by anyone else since he became a prisoner.

4. In his statement to the police, GCH stated that at about 5.30am on 4 April 2008, he heard Mr Holmes get out of bed and go to the toilet when he then heard a bang and saw Mr Holmes on his knees hanging onto the side of the bed. GHC asked him 'if he was okay' and he said he was 'alright'. A few minutes later GCH saw Mr Holmes in the same position looking as if he was trying to get up but couldn't. GCH got out of bed and helped Mr Holmes back into bed. By about 5.45am Mr Holmes had fallen asleep and was breathing 'as normally as he does when he sleeps as well as coughing.'

5. At about 7.50am, when he realised that Mr Homes had not yet woken, he reported the matter to corrections officers. When Mr Holmes failed to respond to their instructions to get up, they observed that he was awake but non-responsive and called for medical assistance.

6. Mr Holmes was taken to the prison hospital facility and, from there, to St Vincent's Hospital where investigations revealed a right sided acute on chronic subdural haematoma with significant mass effect. Urgent surgical intervention by way of burr hole drainage of the subdural haematoma was undertaken. Mr Holmes made a satisfactory recovery following surgery and was in a stable condition until 9.00pm on 5 April 2008 when he developed respiratory distress. He was reviewed by the Medical Team and the Intensive Care Unit with differential diagnoses of non-STEMI myocardial infarction, aspiration pneumonia and exacerbation of heart failure. No pulmonary embolus was found and a CT brain demonstrated satisfactory drainage of the subdural haematoma and relief of mass effect.

7. On 6 April 2008, medical staff discussed Mr Holmes' prognosis with his daughter and a decision taken that he was not to be resuscitated in the event of a fatal arrhythmia or respiratory distress. Mr Holmes' condition deteriorated and on 7 April 2008 he had a witnessed ventricular tachycardic arrest and passed away.

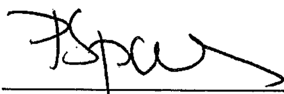
8. An autopsy was performed by Senior Pathologist Dr Malcolm Dodd from the Victorian Institute of Forensic Medicine (VIFM) who reviewed the circumstances as reported by the police, and the medical records and deposition from St Vincent's Hospital and formulated the cause of death as above. In addition, Dr Dodd advised that the cause of death *"would appear to be one of a combination of extensive cardiovascular disease in a man who would appear to have sustained a fall leading to a diffuse but thin layered acute subdural haemorrhage ... All evidence would suggest that the deceased had collapsed in his cell ... cardiovascular disease in all probability has led to the fall as described in the summary of circumstances report. A fall would be sufficient to cause a subdural haemorrhage. Cranial fractures were not identified."*

9. As Mr Holmes was a person placed in custody immediately before he died,[1] his death is reportable to the coroner, irrespective of the cause of death, and an inquest is mandated as part of the coronial investigation of his death.[2] In this respect, the *Coroners Act 2008,* recognises the vulnerability of those in the custody of the State by ensuring that there is always a level of coronial scrutiny of the care they received, at least insofar as it may have caused or contributed to the death.

10. This finding is based largely on the investigation and brief of evidence compiled by Sergeant Peter Britton from Wyndham North Police Station. I have also considered a 16 page "Report into a Death in Custody" from the Office of Correctional Services Review which concluded that Mr Holmes received appropriate custodial management from all responsible for him during his three weeks in custody prior to his death, and that the response to the incident of his death was timely and efficient. The report had a number of attachments including a separate review of Mr Holmes' death conducted by Justice Health, and an Internal Management Review conducted by the management of Port Phillip Prison which I have also considered.

11. I find that Mr Holmes died from natural causes whilst serving a sentence of imprisonment. having considered the material available to me and, in light of the cause of death as formulated by Dr Dodd, I find no evidence that any want of care or clinical management caused or contributed to Mr Holmes' death.

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 17th June, 2011

1 See definition of "person place in custody or care" in section 3 of the *Coroners Act 2008* which includes, relevantly, *"a person in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police".*

2 Section 52(2)(b) of the Act.