IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 000635

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: Joseph MALLIA

Delivered On:	2 April 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	2 February 2015
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr R. HARPER of Counsel, instructed by Meridian Lawyers appeared on behalf of Correct Care Australasia Pty Ltd. Ms D. COOMBS of Counsel, instructed by the Victorian Government Solicitor, appeared on behalf of Justice Health.
Police Coronial Support Unit	Leading Senior Constable A. MAYBURY, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of JOSEPH MALLIA

and having held an inquest in relation to this death at Melbourne

on 2 February 2015

find that the identity of the deceased was JOSEPH MALLIA

born on 24 February 1959, aged 53

and that the death occurred on 12 February 2013

at St. Augustine's Ward, St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria 3065

from:

1 (a) METASTATIC PANCREATIC CANCER

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES

1. In 1971, Joseph Mallia and his parents migrated to Australia from Sicily, Italy. His parents have since returned to Italy, and Mr Mallia's only known relatives in Australia are an estranged adult daughter, two cousins, one of whom has had nothing to do with him for years because of his criminal history and the other only resumed contact, visiting him in prison, after he was diagnosed with pancreatic cancer. Mr Mallia had a long term relationship with a woman who told police that she knew him better than anybody but felt unable to assist the coronial investigation of his death as she was still grieving.[1]

2. Consequently, little is known of Mr Mallia's background and personal circumstances, apart from what can be gleaned from police and corrections records. According to those sources, Mr Mallia had a known history of over twenty years of substance abuse, including intravenous use of heroin and other opiates, and a concomitant adult criminal history involving more than 170 criminal charges and a number of custodial sentences. The criminal charges included burglary, theft, robbery, possession and trafficking of drugs, serious assaults, affray and indecent assaults and making threats to kill.[2]

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[1] Exhibit D, balance of the coronial brief, (Statement of Constable R. Frost).

[2] Exhibit D, balance of the coronial brief, at pages 29-45.

3. The same sources indicate that Mr Mallia's medical history included asthma, hepatitis C, abdominal and left leg trauma from a stabbing in 2006, that he continued to smoke until death and was methadone opiate replacement therapy when last in the community.[3]

LAST PERIOD OF INCARCERATION

4. Mr Mallia's last period of incarceration commenced on 18 December 2007 when he was remanded in custody at the Melbourne Assessment Prison. On 24 July 2008, in the County Court at Melbourne, he was sentenced to a total of 2 years, 3 months with a non-parole period of 15 months for offences of threat to inflict serious injury and indecent assault. On 4 September 2008, in Melbourne Magistrates Court, Mr Mallia was sentenced to one year, six months for an offence of causing injury. Finally, on 10 February 2010, in the County Court at Melbourne, he was sentenced to six years, three months with a non-parole period of four years for rape. Taking into account declarations as to pre-sentence detention and directions as to concurrency, Mr Mallia's earliest eligibility for release would have been 8 February 2014.[4]

5. Between 8 March 2011 and 30 August 2012, the period of particular significance in the investigation of his death, Mr Mallia was incarcerated at Barwon Prison, where medical services were provided by Correct Care Australasia Pty Ltd.[5]

MR MALLIA BECOMES UNWELL

6. Mr Mallia first complained to a member of the nursing staff of left flank pain and blood in his urine in late November 2011. At review on 5 December 2011, Dr Michael Plunkett suspected a renal calculus and ordered an urgent CT scan of the kidneys, ureters and bladder, as well as urea and electrolyte levels.[6] The CT scan was first scheduled for 19 December 2011, but Mr Mallia did not have a full bladder as required, and the scan was rescheduled and performed on 30 December 2011.[7]

7. The results of the CT scan were received by Dr Plunkett, and reviewed with Mr Mallia, on 6 January 2012. The radiologist's report identified no calculus of the bladder or the left ureter and no evidence of recent passage of calculi. However, the radiologist did identify a

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[3] Exhibit D, balance of the coronial brief, extracted medical records from St Vincent's Correctional Health/Hospital.

[4] Exhibit D, balance of coronial brief, page 26.

[5] Previously GEO Care Australia Pty Ltd and before that Pacific Shores Health Pty Ltd – see transcript page 1.

[6] Exhibit A, statement of Dr Michael Plunkett dated 21 October 2014 and transcript page 15.

[7] Exhibit D, the balance of the coronial brief, statement of Mr John Hoogeveen, General Manger GEO Care dated 6 June 2014 at page 20.

distension in a segment of the pancreatic duct in the tail of the pancreas. The radiologist's advice about this finding was that *"While the appearance can be seen in chronic pancreatitis the possibility of an early pancreatic malignancy cannot be excluded. Further imaging with MR may be of benefit"*[8].

8. As will be discussed in some detail below, on 6 January 2012, and for about six months thereafter, Mr Mallia refused an MRI and further investigation of this mass, in the context of refusal of a transfer to Port Phillip Prison (PPP) or access to St Vincent's Correctional Health Services.[9]

9. On the morning of 30 August 2012, Dr Plunkett reviewed Mr Mallia and found him quite ill, pale and obviously in pain. While Dr Plunkett was aware that Mr Mallia had previously refused treatment, he nevertheless arranged for him to be transported to St Vincent's Hospital Melbourne (STVHM) by emergency ambulance. Although he could not recall the precise discussion with Mr Mallia at the time, he testified at inquest that he had no doubt that he would have explained to Mr Mallia what he was going to do.[10]

ADMISSION TO ST VINCENT'S HOSPITAL MELBOURNE

12. Mr Mallia was admitted to St Augustine's Ward for investigation of his abdominal pain and was subsequently diagnosed with metastatic pancreatic cancer.[11] He commenced chemotherapy but refused treatment on a number of occasions, and continued to experience pain, requiring review by the palliative care team and significant analgesia.

13. Between his initial admission to St Augustine's Ward and his final admission on 20 January 2012, Mr Mallia was transferred between St Augustine's at STVHM and St John's Unit, the hospital unit at PPP, depending on his clinical condition and the acuity of his medical and nursing needs. His clinical course was complicated by ascites (accumulation of abdominal fluid) and in the latter stages by coughing and worsening shortness of breath. [12]

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[8] Exhibit D, balance of the coronial brief, Medical Imaging Report dated 6 January 2012, extracted from the medical records and appearing at pages 68-69 of the coronial brief.

[9] See paragraphs 23 and following below.

[10] Transcript pages 14-19.

[11] According to the Justice Health Report (page 42 and following) the discharge summary from STVHM noted that a CT scan of the abdomen and pelvis showed a mass at the head of the pancreas consistent with pancreatic malignancy, with invasion of the splenic and portal veins and peritoneal node metastasis.

[12] Ibid at pages 42-44

14. On 20 January 2013, Mr Mallia was once again transferred from St John's to St Augustine's, for what would be his final admission. He was admitted under the Oncology Team with escalating abdominal pain, nausea and vomiting, and constipation, on a background of progressive metastatic pancreatic cancer. Mr Mallia was deemed unsuitable for any further anticancer therapy and clinical management was aimed at good symptom control. In late January 2013, Mr Mallia was commenced on a subcutaneous infusion of analgesia with dosage and the choice of analgesics periodically reviewed to optimise pain relief and comfort.

15. After Mr Mallia was reviewed by the treating team on 31 January 2013, they documented that he was not for Medical Emergency Team (MET) calls and was for palliative measures only. In discussion with his family, the treating team clarified that Mr Mallia's prognosis was short and that treatment aims were comfort and end of life care. Mr Mallia passed away at 10.45pm on 12 February 2013, after a visit from family members earlier that day.

INVESTIGATION – SOURCES OF EVIDENCE

16. This finding is based on the totality of the material the product of the coronial investigation of Mr Mallia's death. That is the brief of evidence compiled by First Constable Rohan Frost from Fitzroy Police, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[13] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

REPORTABLE DEATHS & THE PURPOSE OF A CORONIAL INVESTIGATION

17. Apart from a jurisdictional nexus with the State of Victoria, *reportable* deaths are, generally, deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury.[14] However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Mr

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[13] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[14] See generally the definition of "reportable death" in section 4 of the Act.

Mallia's death was reportable as he was *a person placed in custody or care.*[15] This is one of the ways in which the *Coroners Act 2008* recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

18. Another protection is the requirement for mandatory inquest. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[16] this was a mandatory or statutorily prescribed inquest as Mr Mallia was, immediately before death, a person in the legal custody of the Secretary to the Department of Justice, and thereby a person placed in custody or care.[17]

19. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[18] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[19]

20. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[20] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety

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[15] See section 3 for the definition of a "person placed in custody or care" which includes "a person in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police" and section 4(2)(e) of the definition of "reportable death" which includes "the death of a person under the control, care or custody of the Secretary to the Department of Justice or a police officer".

[16] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

[17] Section 52(2) provides that a coroner must hold an inquest if the death or cause of death occurred in Victoria and the deceased was, immediately before death, a person placed in custody or care. Section 52(3) provides for exceptions that are irrelevant for present purposes.

[18] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[19] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[20] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[21] These are effectively the vehicles by which the prevention role may be advanced.[22]

21. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an offence.[23] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions *if the coroner believes an indictable offence may have been committed in connection with the death.*[24]

FINDINGS AS TO UNCONTENTIOUS MATTERS

22. In relation to Mr Mallia's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity and place of death were not at issue. I find, as a matter of formality, that Joseph Mallia, born on 24 February 1959, aged 53, died on 12 February 2013 at St. Augustine's Ward, St. Vincent's Hospital, 45 Victoria Parade, Fitzroy, Victoria 3065.

23. The medical cause of death was similarly uncontentious. On 14 February 2013, Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (VIFM) performed an external examination on the body of Mr Mallia in the mortuary, reviewed the circumstances of the death as reported by the police to the coroner, a medical deposition and records from St Vincent's Hospital and post mortem CT scanning (PMCT) of the whole body (also performed at VIFM), and provided a written report of his findings.

24. Dr Burke advised that his findings on external examination were unremarkable, that PMCT showed peritoneal thickening with liver masses and pleural effusions and that it would be reasonable in all the circumstances to attribute death to *metastatic pancreatic cancer,* without

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[21] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[22] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[23] Section 69(1).

[24] Sections 69 (2) and 49(1).

the need for autopsy. Based on that advice, I find that Mr Mallia's cause of death is metastatic pancreatic cancer.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

25. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Mr Mallia's death was the circumstances in which he died. Specifically, the adequacy of the clinical management and care provided to him in relation to the disease to which he ultimately succumbed, and/or whether there was an unreasonable delay in diagnosing pancreatic cancer that may have caused or contributed to his death.

26. I note for completeness that the investigation of Mr Mallia's death proceeded on the unchallenged understanding that any delay in the diagnosis and treatment of pancreatic cancer, in particular, was likely to have a significant impact on the outcome for the patient,[25] and on the unchallenged assumption that any patient/prisoner has the right to refuse medical treatment.

27. It is also important to note that there was no suggestion of any issues with clinical management and care provided to Mr Mallia on and from 30 August 2012, that is from his initial transfer to St Augustine's Ward and his management between that ward and St John's at PPP, until his death on 12 February 2013. Details of the clinical management and care provided to Mr Mallia during this period are outlined in a statement provided by Dr Tamsin Ann Bryan, Principle Physician for St Vincent's Health Palliative Care Consultation Service,[26] as regards his admissions to St Augustine's and in the Justice Health Report[27] as regards St John's/PPP.

28. In this regard, I note the expert opinion of A/Prof Jeremy Schapiro, Consultant Physician in Medical Oncology, provided at the request of the Department of Justice, evaluating the clinical management and care provide to Mr Mallia from definitive diagnosis in August 2012,

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[25] A/Prof Jeremy Scapiro provided an expert opinion, at the request of the Department of Justice, that includes the following *"As is always the case with pancreatic cancer, when the caner proresses, health deteriorates rapidly and there is little active treatment that can be provided other than palliative care which was administered in an appropriate manner."* Exhibit D, balance of the coronial brief, at page 19.

[26] Exhibit D, balance of the coronial brief, statement of Dr Tamsin Ann Bryan dated 21 Mareh 2013 at pages 12-15 of the coronial brief.

[27] Exhibit D, balance of the coronial brief, Justice Health Report dated 21 May 2013, at pages 43-44 of the coronial brief.

concluding in the following terms – *"I determine that the patient's access to treatment, time limits of treatment and quality of care based on contemporary practice during incarceration was consistent with the care that would be expected to be available and delivered in the public sector."*

CLINICAL MANAGEMENT & CARE AT BARWON PRISON

29. Accepting for present purposes that from 6 January 2012 Mr Mallia was in fact refusing further investigation and treatment for pancreatic cancer, it is apparent from the available evidence that he sought and obtained medical treatment and/or nursing care over the same period in respect of other medical problems.

30. On six occasions between February and April 2012, Mr Mallia was seen by a registered nurse, generally for relatively minor matters. On one of these occasions, on 22 March 2012, he saw the nurse regarding a mass in his left chest. A breast ultrasound was arranged for 2 May 2012 but Mr Mallia declined that investigation and, according to the medical records, signed a "release" indicating that the lump had gone.[28]

31. In addition, from 22 March 2012, Mr Mallia saw a psychiatrist or psychiatric nurse on some six occasions about poor sleep, medication issues and anxiety about his own safety within the prison. On one of these occasions, on 15 April 2012, he discussed his concerns and anxiety about the left chest mass and was reassured.[29]

32. The medical records document complaints from Mr Mallia about generalised abdominal pain and bowel problems from 27 June 2012, and thereafter a number of missed appointments to see a doctor about these complaints.[30] When Dr Plunkett finally saw Mr Mallia on 31 July 2012, he gave a history of one month's abdominal pain and straining when going to the toilet. There was no complaint of bleeding per rectum, no alteration in bowel habits and no familial history of bowel cancer noted. Dr Plunkett referred Mr Mallia to the colorectal clinic at St Vincent's Hospital Melbourne. Mr Mallia cooperated, to the extent of providing samples to nursing staff for a Faecal Occult Blood Test (FOBT) to investigate for bowel cancer and/or

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[28] Exhibit D, balance of coronial brief, Release of Responsibility for Health Services, signed by Mr Mallia on 2 May 2012, extracted from the medical records and appearing at page 73 of the coronial brief. Transcript page 17.

[29] See paragraphs 6 and following above, especially from paragraph 30.

[30] Exhibit D, balance of the coronial brief, clinical entry dated 27 June 2012 (and following) extracted from the medical records and appearing at pages 58-60 of the coronial brief. I note that Mr Mallia apparently missed appointments with Dr Plunkett (documented as "declined to be seen") on 29 June, 2 July and 3 July 212.

gastro-intestinal bleeding but again largely declined medical attention,[31] and from 30 August 2012, as discussed above, was overtaken by events.[32]

MR MALLIA'S "REFUSAL" OF MEDICAL TREATMENT

33. A fundamental issue is whether Mr Mallia was actually refusing treatment on and from 6 January 2012. On its face the "Release of Responsibility for Health Services" signed by Mr Mallia on that date and witnessed by a registered nurse, refuses referral to community of correctional health agency and the reasons for this is documented as *"Don't want to go to PPP have too much drug debt and fear for safety".*[33] While it is apparent that this was treated by clinical staff as a refusal of medical treatment, it is at least arguable that what Mr Mallia was in fact refusing was transfer to PPP.[34]

34. The Release also refers to the risks of refusal having been explained to Mr Mallia by Dr Plunkett at that day's appointment. Dr Plunkett documented his discussion with Mr Mallia in the clinical notes, including the need for an MRI and specialist referral, the possibility of cancer and a potential cure.[35] Dr Plunkett expanded on this discussion in his statement, maintaining that he was direct and concise in conveying the need to rule out pancreatic cancer and that his best chance of a cure was an MRI, and if the diagnosis was confirmed, early commencement of treatment.[36]

35. At inquest, Dr Plunkett testified that he got the impression that Mr Mallia did not want to go to PPP or to leave Barwon Prison, but not that he had any concerns about an MRI as such.[37] Based on his extensive experience in providing medical treatment in a custodial setting, Dr Plunkett testified that he was aware that many prisoners refused to go to PPPP for a range of

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[31] Exhibit A, statement of Dr Plunkett.

[32] See paragraphs 33 and following.

[33] Exhibit D, balance of the coronial brief, extracted from the medical records and appearing at page 70 of the coronial brief is the Release. I note that the referral was to Dr Lighfoot for further investigation and MRI re ongoing abdominal pain. See transcript pages 6-7 where Dr Plunkett explains his choice of Dr Lightfoot.

[34] See discussion at paragraph XX below for the significance of this.

[35] Exhibit D, balance of the coronial brief, extracts from the clinical records at page 50, entry dated 6/1/12. See also transcript page 33 where Dr Plunkett deciphers his handwritten note

[36] Dr Plunkett also said in his statement that he found the consultation distressing as Mr Mallia was potentially denying himself his best chance of a cure. Exhibit A, statement of Dr Michael Plunkett received 21 October 2014. See also transcript page 27 where, in cross-examination by Mr Harper, Dr Plunkett agrees that his impression on receipt of the CT scan results was of chronic pancreatitis but that there was a need to exclude the possibility of pancreatic cancer.

[37] Transcript pages 5, 14 and 22.

reasons, such as a desire not to leave their current unit and friendship group.[38] He also expressed the belief that, in common with many other male prisoners/patients, Mr Mallia was simply in denial about the potential severity of his illness.[39]

36. At the 6 January 2012 appointment with Mr Mallia, Dr Plunkett scheduled a further appointment on 20 January 2012 in the hope of persuade him to change his mind about treatment/transfer to PPP.[40] He also made a request through his (ie Correct Care's) health services manager on site for an MRI to be performed locally, that is at Barwon Health/Geelong Hospital, citing Mr Mallia's refusal to attend PPP. That manager in turn contacted Justice Health whose reply via a Clinical Standards and Review Officer was to refuse the request. Dr Plunkett's rationale was that he might be able to persuade Mr Mallia of the need for treatment if armed with an MRI confirmation of pancreatic cancer.[41]

HEALTH SERVICES IN THE CUSTODIAL SETTING

37. As demonstrated by this case, there is an imperfect analogy between access to healthcare in the custodial setting and access to the public health system in the community. In the current paradigm, any person entitled to public health care in the community has a choice of hospitals/health services and can elect to go to another hospital or health service if they are unhappy with the clinical management and care they are receiving. Prisoners are not in the same position and are reliant on arrangements made by the State for their health care needs.

38. Ms Larissa Strong, Director of Justice Health, provided a statement and testified at inquest. She outlined the role of Justice Health in overseeing the delivery of all health care services to prisoners in the Victorian corrections system, including the provision of health care in satisfaction of prisoners' statutory right to access to reasonable medical care and treatment necessary for the preservation of health.[42] Ms Strong explained that health services, in both

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[38] In his statement, Exhibit A, Dr Plunkett stated – *"It is not uncommon for prisoners to refuse medical treatment because of the upheaval that it incurs. They leave a unit where they have gained extra privileges due to the time spent there like for example, having a single cell or a favourable job and the comfort and security with the other prisoners. Personal belonging have to be transferred as well which may limit their desired possessions."* Also transcript page 23.

[39] Exhibit A and transcript page 20

[40] Exhibit A and transcript page

[41] Exhibit A and transcript pages 9-10. This rationale was not articulated to Justice Health at the time but it is apparent from Ms Strong's evidence that this omission was immaterial to the decision of Justice health not to approve the request that was *"consistent with the arrangement that govern the provision of access to teriary care. Then and now, the contractual arrangements are for all specialist examinations to be coducted at Port Phillip, and any referral for MRIs to be performed at St Vincent's Hospital."* Exhibit B paragraphs 11-12, transcript pages 39-40.

[42] Exhibit B, statement of Ms Larissa Jane Strong dated 1 December 2014. See also section 47(1)(f) of the ***Corrections Act 1986*** which relevantly provides that every prisoner has *"the right to have access to reasonable medical care and treatment necessary for the preservation of health including, with the approval of the principal medical officer but at*

public and private prisons, are delivered by external health service providers pursuant to the policy and standards set by Justice Health.

39. Primary general healthcare is provided in all prisons and is supported by a multidisciplinary model which includes access to General Practitioners, nursing and allied health services. At the material time at Barwon Prison, these services were provided by Correct Care Australasia Pty Ltd.[43] Prisoners not requiring admission but requiring more complex and/or specialised care are referred by the primary care provider to specialist or allied health professionals for an outpatient appointment. Specialist outpatient appointments are only available at PPP, are subject to public hospital waiting lists and access is based on clinical priority.

40. Prisoners requiring prison-based in-patient management are accommodated in St John's Ward at PPP which is a 20 bed low acuity nursing and medical service operated 24 hours a day seven days a week by St Vincent's Correctional Health.

41. Similarly, prisoners requiring tertiary health care and/or admission for more complex management are transferred to public hospitals, with the majority of prisoners accessing services via St Augustine's Ward, SVHM, a purpose built secure inpatient unit. Prisoners requiring elective surgery are subject to the usual strictures around public hospital waiting list.[44]

42. Significantly, given Mr Mallia's reluctance to be transferred to PPP, other than in circumstances of high acuity or emergencies, access to either outpatient specialist care, tertiary diagnostic modalities, prison-based inpatient care or tertiary inpatient care necessitates transfer to PPP with rare exceptions.[45]

43. There is limited scope for departure from these norms. Ms Strong explained that there is an established process for prisoners to seek alternative treatment at their own expense subject to the approval of the principal medical officer, a creature of statute appointed for the purposes of section 47(1)(f) of the *Corrections Act 1986*.[46] Apart from needing to obtain the approval of the principal medical officer, a prisoner would need to have the financial resources to pay

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the prisoner's own expense, a private registered medical practitioner, dentist, physiotherapist or chiropractor chosen by the prisoner,"

[43] See paragraph 5 and footnote 5 above.

[44] Paragraphs 38-41 draw almost entirely on Ms Strong's statement (Exhibit B) and her evidence at inquest (transcript pages 35 and following.

[45] Transcript pages24-25.

[46] See footnote 40 above.

for such treatment and for any associated transport and security costs.[47] Common sense would suggest that this option would be beyond the means of the majority of prisoners. Although she did not have access to any statistics, Ms Strong testified that such applications, when they are made, are generally expected to be supported by the primary care provider at the particular prison, and are generally approved, but not always.[48]

44. Another possibility was that if Justice Health had been made aware of Mr Mallia's reluctance to be accommodated at PPP, they could have endeavoured to make arrangements with the Sentence Management Unit of Corrections Victoria, for an acceptable alternative placement from which he could access the required specialist referral and/or MRI.[49] Of course, Mr Mallia could initiate a discussion along these lines with the Sentence Management Unit (SMU) on his own behalf. It was apparent that Mr Mallia had sought the intercession of the SMU in May 2012, when he felt his safety was at risk at Barwon Prison and that he can be assumed to have understood that he could do so again in relation to a placement at PPP to facilitate medical treatment.[50]

45. Finally, Ms Strong testified about innovations under consideration or being trialled by Justice Health in order to provide alternatives for prisoners accessing heath services without the dislocation of transfer to PPP. One such innovation is the "telemedicine" pilot for specialist appointments involving Barwon Prison, PPP and STVHM so that a prisoner in Mr Mallia's position at Barwon would not need to leave the prison physically to attend an appointment with a specialist but could do so via a televised link.[51]

CONCLUSIONS

46. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[52] Moreover, the effect of the authorities is that Coroners should not make adverse findings against or comments about

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[47] Transcript page 47.

[48] Transcript page 38.

[49] Exhibit B and transcript page 42-43. Ms Strong gave an example in evidence where Justice Health had been able to facilitate a (minimum security) prisoner's appointment with a cardiologist, bypassing the need for a transfer to PPP. Security requirements for a maximum security prisoner like Mr Mallia would have made the process more challenging.

[50] Transcript pages 37. See also Exhibit D, balance of the coronial brief, OCSR report at page 35 and transcript page52.

[51] Other innovations involving financial arrangements with public hospitals across the state were also canvassed – see transcript pages 45 and following.

[52] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

individuals or institutions, acting in their professional capacity, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their respective profession/s and so doing, caused or contributed to the death.

47. Having applied the standard of proof to the available evidence, I find that –

- The reasonable and appropriate clinical response to the CT scan report received by Dr Plunkett on 6 January 2012 was specialist referral and/or MRI with the aim of excluding (or diagnosing and then treating) the possibility of pancreatic cancer.
- On 6 January 2012, Dr Plunkett clearly explained to Mr Mallia the need for specialist referral and/or MRI to exclude the possibility of pancreatic cancer and to do so expediently.
- When Mr Mallia signed a Release of Responsibility for Health Services on 6 January 2012, he did so on an informed basis, in the sense that he understood the potential health consequences that might flow.
- While Mr Mallia held real fears and concerns about his safety at Port Phillip Prison, I am unable to determine the extent to which these fears and concerns were the real reason for signing the Release, or the extent to which he was simply in denial about any potential medical problems.
- Mr Mallia was aware of the Sentence Management Unit's role in addressing any concerns about his safety if placed in PPP in order to access medical treatment.
- The eight month delay in diagnosis and treatment between 6 January and 30 August 2012 was material to Mr Mallia's prognosis and likely caused or contributed to his death.
- The clinical management and care provided to Mr Mallia by the staff of Correct Care Australasia Pty Ltd between 6 January and 20 January 2012 was reasonable and appropriate.
- The current health care system for prisoners overseen by Justice Health relies on heavily PPP as a conduit for outpatient specialist appointments and for access to tertiary care at St Vincent's Hospital. For prisoners not classified to PPP who are reluctant to transfer to PPP, this poses an obstacle to their access to reasonable medical care and treatment necessary to health.

- If Mr Mallia's particular circumstances were brought to Justice Health's attention at the material time, it is possible that alternative arrangements could have been made for him to see a specialist and/or undergo MRI, bypassing PPP.
- Albeit unsuccessful, Dr Plunkett's efforts to work around the constraints of the existing system were laudable and in the interests of optimal management and care of his patient.

I direct that a copy of this finding be provided to:

The family of Mr Mallia

Dr Michael Plunkett

Correct Care Australasia c/o Meridian Lawyers

St Vincent's Health

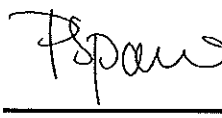
Justice Health

Office of Correctional Services Review

Corrections Victoria

First Constable Rohan Frost c/o O.I.C. Fitzroy Police

Signature:



PARESA ANTONIADIS SPANOS
Coroner
Date: **2 April 2015**