IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 4760

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of ROBERT KINGSLEY WHITEHEAD

without holding an inquest:

find that the identity of the deceased was ROBERT KINGSLEY WHITEHEAD

born 4 February 1931

and the death occurred on 18 September 2015

at St Vincent's Hospital Melbourne, 41 Victoria Street, Fitzroy Victoria 3065

from:

1 (a) COMPLICATIONS OF GOUT AND OLD SPINAL INJURY, CAUSE UNKNOWN

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Robert Kingsley Whitehead was 84 years of age at the time of his death. Mr Whitehead worked as a train controller until his retirement. His medical history included atrial fibrillation, a spinal injury, peripheral vascular disease, cardiac failure, chronic renal impairment, bilateral foot ulcers and hypertension. Mr Whitehead was prescribed a number of medications including mirtazapine, esomeprazole, buprenorphine and anticoagulants.

2. From 15 July 2015, Mr Whitehead was remanded in custody, primarily at the St John's sub-acute inpatient unit at Port Phillip Prison. On 24 July 2015, he was sentenced to eight years and eight months imprisonment, for sexual offences against six young male victims. The offences occurred during the 1960s to 1980s, and occurred while Mr Whitehead was volunteering at the

'Puffing Billy' tourist railway. Prior to entering custody, Mr Whitehead had been residing at Karingal Seymour, an aged care facility.

3. On 12 September 2015, Mr Whitehead was admitted to the St Augustine's security ward at St Vincent's Hospital Melbourne with a chest infection, and for management of abdominal pain, per rectal bleeding and urinary retention. On admission, the abdominal pain was believed to be secondary to faecal loading. A urine microscopy culture and sensitivity test was positive for leukocytes and mixed organisms. Mr Whitehead had acute on chronic renal impairment and was commenced on intravenous antibiotics. Blood cultures on 14 September 2015 showed gram positive cocci resembling staphylococcus. Mr Whitehead was known to have a methicillin resistant staphylococcus aureus on his right foot, but he refused further investigation for osteomyelitis. He experienced an ongoing clinical deterioration, despite broad spectrum antibiotics. Mr Whitehead had minimal oral intake and active medical treatment was withdrawn on 17 September 2015, with pro re nata (prn) morphine and midazolam commenced. Just prior to midnight on 18 September 2015, Mr Whitehead was declared deceased. Treating clinicians listed a possible cause of his death as 'overwhelming sepsis.'

4. Mr Whitehead's death was reportable pursuant to section 4 of the Coroners Act 2008 (Vic) ('the Act') because he was immediately before death a person placed in custody, as defined by section 3 of the Act.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a full post mortem examination upon the body of Mr Whitehead, reviewed a post mortem computed tomography (CT) scan and e-medical deposition form from St Vincent's Hospital Melbourne, and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Lee observed, *inter alia*, an old spinal cord injury, tophaceous gout, cardiomegaly, congestive cardiac failure, colonic diverticulae and cerebrovascular disease. Acute osteomyelitis was not identified.

6. Antibiotic treatment was required for Mr Whitehead's infected gouty tophi and his urinary tract infection, and Dr Lee observed that pseudomembranous colitis of the rectum was a complication of antibiotic treatment with cephalosporin. The complications of Mr Whitehead's spinal cord injury included faecal impaction and urinary retention. Dr Lee reported that the urinary retention most likely caused a urinary tract infection, which required antibiotic treatment. Congestive

cardiac failure was exacerbated by the acute on chronic renal failure and Mr Whitehead's sedentary status secondary to the spinal injury and acute illness. Dr Lee ascribed the cause of Mr Whitehead's death to complications of gout and an old spinal cord injury.

7. A supplementary report dated 24 August 2016 was provided by Head of Forensic Pathology at the Victorian Institute of Forensic Medicine, Dr Linda Iles. In the report, Dr Iles opined that Mr Whitehead died from a combination of multiple comorbidities. While some, but by no means all, of these medical comorbidities, such as faecal impaction and urinary retention, were consequent to a past spinal cord injury, there was no evidence of injury directly contributing to Mr Whitehead's death. Dr Iles reported that Mr Whitehead died as a result of a combination of multiple natural disease processes.

Police investigation

8. First Constable Mark Soane, the nominated coroner's investigator,[1] conducted an investigation of the circumstances surrounding Mr Whitehead's death, at my direction, including the preparation of the coronial brief. The coronial brief contained a statement made by Consultant Haematologist Dr Ali Bazargan, who was the most senior person involved in Mr Whitehead's care at St Vincent's Hospital between 12 September 2015 and his death. First Constable Soane indicated that efforts to contact Mr Whitehead's brother Peter Whitehead for a statement had been unsuccessful.

9. Dr Bazargan reported that Mr Whitehead became quite agitated throughout his admission and treatment at St Vincent's Hospital. He became uncooperative, declining oral intake and expressing that the wished to be left alone. Dr Bazargan stated that a bone scan to establish whether an underlying bone infection was present could not be performed, as Mr Whitehead remained uncooperative and did not consent to proceeding with the test.

10. Dr Bazargan stated that he discussed Mr Whitehead's clinical condition with his brother, Peter Whitehead on 17 September 2015, highlighting his multiple comorbidities, extensive eroded gouty tophi, overwhelming infection and declining overall condition despite appropriate treatment. Given Mr Whitehead's medical condition, ongoing agitation and expressed wish to be left alone, Dr Bazargan noted that further treatment would be futile and invasive. Following the discussion, palliative measures were implemented.

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[1] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

Department of Justice and Regulation - Office of Correctional Services Review

11. By way of letter dated 26 November 2015, Emma Catford, Director at the Office of Correctional Services Review (OCSR) provided the court with a report providing an overview of Mr Whitehead's management in custody and the circumstances of his death. The report also included a review conducted by Justice Health of Mr Whitehead's health management.

12. The report noted that due to the nature of his offences, Mr Whitehead was deemed a placement risk, requiring him to be separated from mainstream prisoners. He was also considered a medical risk, due to his medical issues.

13. The Justice Health review identified that Mr Whitehead required a high level of nursing care when he entered custody, and required a wheelchair for mobility and a hoist for lifting. On admission to the St John's sub-acute inpatient unit, it was noted that Mr Whitehead had chronic leg ulcers requiring ongoing wound care. A plan of care was in place to manage his complex healthcare needs. The report noted that records indicated Mr Whitehead had difficulty adjusting to his incarceration, which manifested itself in constant requests for assistance from staff.

14. The report referred to an accident involving Mr Whitehead's motorised wheelchair on 7 September 2015, in which he wedged himself under a bed, while in his wheelchair. Upon releasing himself, he was found to have lacerations on his legs. Mr Whitehead was treated at the St Vincent's Hospital Emergency Department, where his lacerations were sutured and dressings applied prior to returning to Port Phillip Prison.

15. It was noted that Mr Whitehead's condition slowly deteriorated at the St John's unit until he developed a chest infection and was transferred to the St Augustine's secure ward. The review noted his death was not unexpected. There were no recommendations arising from the review of Mr Whitehead's custodial management.

Further information regarding Mr Whitehead's medications

16. By way of letter dated 15 January 2016, the Court received copies of a number of documents found in Mr Whitehead's personal possessions from his brother Peter Whitehead. The documents included a list of Mr Whitehead's prescriptions while at Karingal Seymour. A comparison of the medications listed in this document, with the medications listed in the Justice Health review (at the time of Mr Whitehead's transfer to St Vincent's Hospital), and with the medications listed in the e-medical deposition, indicated that they remained relatively consistent. I note that mirtazapine and esomeprazole were listed in the Karingal records and e-

medical deposition, but not the Justice Health Report. Also, whereas the Justice Health report referred to the anticoagulant rivaroxaban, the e-medical deposition listed warfarin.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Section 52 of the Act mandates the holding of an Inquest if the deceased was, immediately before death, a person placed in custody, save for circumstances where the person is deemed to have died from natural causes, pursuant to section 52(3A). In the circumstances, noting Dr Iles' supplementary report citing Mr Whitehead's death as the result of a combination of natural disease processes, it is therefore appropriate to conclude the investigation by an in-chambers Finding.

FINDINGS

Mr Whitehead was suffering from multiple co-morbidities both preceding and during his term of imprisonment. On the evidence available to me, I find that the provision of care to Mr Whitehead while he was imprisoned at the St John's inpatient unit at Port Phillip Prison, and the St Augustine's ward at St Vincent's Hospital, appears to have been appropriate given the complexity of his presentation. I further find that there was no causal connection between the fact that Mr Whitehead was a person placed in custody and the cause of his death.

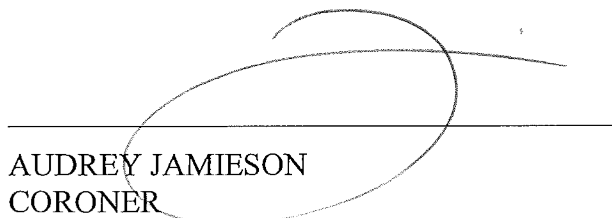
I accept and adopt the medical cause of death as identified by Dr Jacqueline Lee and find that Robert Kingsley Whitehead died from natural causes in the form of complications of gout and old spinal injury, the cause of which is unknown.

Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

Mr Peter Whitehead
Ms Melanie Kyezor, Clinical Risk Manager, St Vincent's Health
Ms Emma Catford, Office of Correctional Services Review, Department of Justice and Regulation
First Constable Mark Soane

Signature:



AUDREY JAMIESON
CORONER

Date: **25 August 2016**