IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 2196**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR PHILLIP BYRNE, CORONER**
Deceased:	**RODNEY CHARLES COLLINS**
Date of birth:	**30 AUGUST 1945**
Date of death:	**10 MAY 2018**
Cause of death:	**I (a) NON SMALL CELL CARCINOMA OF THE LUNG**
Place of death:	**ST AUGUSTINE'S SECURE WARD IN ST VINCENT'S HOSPITAL**

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

I, PHILLIP BYRNE, Coroner having investigated the death of RODNEY CHARLES COLLINS without holding an inquest:
find that the identity of the deceased was RODNEY CHARLES COLLINS
born on 30 August 1945
and the death occurred on 10 May 2018
at St Augustine's secure ward at St Vincent's Hospital

from:

I (a) NON SMALL CELL CARCINOMA OF THE LUNG

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

1. Rodney Charles Collins, 72 years of age at the time of his death, died at St Augustine's secure ward at St Vincent's Hospital having been transferred from Barwon Prison where he was serving a life sentence.
2. Although it was clear Mr Collins's death was expected and due to natural causes, it was "reportable" under the Coroners Act 2008 as he was in custody at the time of his death.
3. Consequently, Mr Collins's death was reported to the coroner. Having considered the circumstances and having conferred with a forensic pathologist, I directed an external only post mortem examination.
4. The directed post mortem examination was undertaken by Forensic Pathologist Dr Joanna Glengarry of the Victorian Institute of Forensic Medicine (VIFM). Dr Glengarry advised that Mr Collins's death was due to:

   1 (a) non small cell carcinoma of the lung.

   I am entirely satisfied Mr Collins's death was due to natural causes.

5. Following established protocols, I left my investigation in abeyance to enable the Justice Assurance and Review Office (JARO) to undertake its review of the death in custody.

6. I have received the JARO report accompanied by a review report by Justice Health. By way of explanation, the JARO review relates to the correctional management of Mr Collins whereas the Justice Health review examines the health care provided to Mr Collins while he was in custody.

7. Having examined each report, I am satisfied that:

    a) the custodial management of Mr Collins met the required standards prescribed by Corrections Victoria; and

    b) the health care provided to Mr Collins, particularly during his terminal illness, was in accordance with the Justice Health Quality Framework 2014.

8. I have concluded no further investigation is warranted, and, as Mr Collins's death was due to natural causes, I finalise my investigation by way of this Finding Without Inquest.

FINDING

9. I formally find Rodney Charles Collins died at St Augustine's secure ward in St Vincent's Hospital on 10 May 2018 due to non small cell carcinoma of the lung.

10. Pursuant to section 73 (1) (B) of the *Coroners Act 2008* (Vic), I direct that this finding be published on the Coroners Court of Victoria website.

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

    - Senior Next of Kin;
    - Ms Michelle Gavin, Director, Justice Assurance and Review Office;
    - Ms Donna Filippich, Legal Counsel, St Vincent's Hospital; and
    - First Constable Thomas Mills, Reporting Officer.

Signature

PHILLIP BYRNE
CORONER

Date: 7 January 2019