IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 4087**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**PRISONER A***
Date of birth:	[redacted]
Date of death:	**17 AUGUST 2018**
Cause of death:	**I(a) ISCHAEMIC HEART DISEASE IN A MAN WITH MULTIPLE SYSTEM ATROPHY (PARKINSONIAN TYPE)**
Place of death:	**LANGI KAL KAL PRISON** **LANGI KAL KAL ROAD** **LANGI KAL KAL VIC 3352**

* This published finding has been de-identified to preserve the privacy of Prisoner A's family.

HIS HONOUR:

BACKGROUND

1. Prisoner A was born on [redacted] and was 55 years old. At the time of his death, Prisoner A was serving a custodial sentence at Langi Kal Kal Prison.

Medical history

2. Prisoner A had a medical history of ischaemic heart disease with a coronary artery stent inserted in 2011, hypertension, hypercholesterolaemia, smoking related lung disease, sleep apnoea and prostate enlargement.

3. In May 2017, Prisoner A reported tremors in his right hand and dribbling on the right side of his mouth, however, a diagnosis was not made by prison medical staff at the time.

4. In November 2017, Prisoner A had an unwitnessed collapse which resulted in an admission at Ballarat Health Services under the neurology team. The working diagnosis was seizure, and possibly atypical Parkinson's Disease. The antiepileptic medication Keppra was commenced. A follow up review by the neurologists at the St Vincent's Movement Disorder Clinic concluded that Prisoner A had Parkinson's Disease, however, did not have a seizure disorder. His antiepileptic medication was consequently ceased and the antiparkinsonian agent Madopar was commenced.

5. On 6 March 2018, Prisoner A was reviewed via video conference by a St Vincent's neurologist who, after hearing that there had been no symptom improvement, increased the Madopar dose. A further review on 3 July 2018 showed no symptom improvement, and an additional antiparkinsonian agent Azilect was added.

6. Throughout July and August 2018, until his death, Prisoner A continued to have his medications monitored and was reviewed by custodial and external medical staff and specialists.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Prisoner A's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death he was a person in the custody of the Secretary to the Department

of Justice.[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[3]

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[4] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

9. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

10. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

13. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

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[1] Section 4, definition of 'Reportable death', *Coroners Act 2008*.
[2] Section 52(2)(b) *Coroners Act 2008*.
[3] Section 52(3A), *Coroners Act 2008*.
[4] Section 89(4) *Coroners Act 2008*.
[5] *Keown v Khan* (1999) 1 VR 69.

(c) 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. These powers are the vehicles by which the prevention role may be advanced.

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

15. Prisoner A was visually identified by [redacted] on 17 August 2018. Identity is not disputed and requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

16. On 22 August 2018, Dr Melanie Archer, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an examination on Prisoner A's body and provided a written report dated 16 May 2019, concluding a reasonable cause of death to be "I(a) Ischaemic heart disease in a man with multiple system atrophy (Parkinsonian type)". I accept her opinion in relation to the cause of death.

17. Toxicological analysis of post mortem specimens did not detect alcohol, common drugs or poisons. The reporting toxicologist noted that the laboratory testing did not cover some of the deceased's prescription medications including glyceryl trinitrate, levodopa, benserazide (Madopar), rasagiline (Azilect), tamsulosin and atorvastatin.

18. In Dr Archer's opinion, the death occurred due to natural causes. Further, she commented that the causes of death in patients with multiple system atrophy includes death due to comorbidities (e.g. ischaemic heart disease), or death from complications of the disorder itself.

[6] (1938) 60 CLR 336.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

19. On 17 August 2018 at 4:00pm, Prisoner A was found in his room with no signs of life and signs of rigor mortis. He had been seen by staff two and a half hours earlier and had voiced no concerns.

Investigation into medical care provided in custody

20. As Prisoner A's death occurred in circumstances where he was reliant on a significant level of medical care while remanded in custody, I considered it prudent to investigate the standard of care provided to Prisoner A. In carrying out this task, I consulted with the Coroner's Prevention Unit.[7]

21. Prisoner A had a known history of ischaemic heart disease. This is a disease process that cannot be cured even with appropriate lifestyle modification, medications and interventions. Once a person has a heart attack, there is always a risk of more. While some patients may show signs of an impending heart attack, such as chest pain, which medical (or prison) staff can respond to, some patients have no warning symptoms before suffering a fatal heart attack. This seemed to be the case for Prisoner A.

22. Further, multiple system atrophy ('MSA') is a rare neurodegenerative condition that affects 1 in 10,000 people. It presents clinically in two forms, one that mimics Parkinson's Disease and one that does not. The diagnosis of MSA Parkinsonian type is clinically considered when a patient does not respond to Parkinson's treatment, plus there is an emergence of autonomic symptoms such as unstable blood pressure, issues with urinary continence and sweating. The diagnosis can only be confirmed on autopsy. Importantly, even if the diagnosis is suspected clinically early, there is no specific treatment and no cure, with death occurring, on average, six to ten years after symptom onset. Treatment is supportive, including trying antiparkinsonian medications for symptom relief. As such, there is no difference in treatment or prognosis if the diagnosis MSA (Parkinsonian type) is made over Parkinson's Disease.

23. Consequently, in Prisoner A's case, I consider that his death occurred due to natural causes and could not be prevented. Further, I consider that the diagnosis and the treatment of his medical conditions, particularly MSA, was reasonable and appropriate.

[7] The Coroners Prevention Unit ('CPU') assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the Coroner and is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

FINDINGS

24. Having investigated the death of Prisoner A, and having considered all of the available evidence, I am satisfied that no further investigation is required.

25. I find that the care provided to Prisoner A by the Department of Justice was reasonable and appropriate in the circumstances.

26. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Prisoner A, born [redacted];

    (b) that Prisoner A died on 17 August 2018, at Langi Kal Kal Prison from natural causes of ischaemic heart disease on a background of multiple system atrophy; and

    (c) that the death occurred in the circumstances described in the paragraphs above.

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

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

    (a) Prisoner A's family, senior next of kin;

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 29 January 2020

Coroners Court of Victoria