IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 1115

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	[redacted]
Date of birth:	[redacted]
Date of death:	2 March 2019
Cause of death:	*Complications arising from widely disseminated primary pulmonary small cell carcinoma*
Place of death:	St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria
Other matters	*Person placed in custody or care*, *natural causes*

INTRODUCTION

1. [redacted] born on [redacted] was 39 years of age at the time of his death. He was the youngest of three children, with siblings [redacted] His parents predeceased him.

2. [redacted] had a long criminal history which started when he was 15 years old. He had been incarcerated on many occasions. His offending was often linked to drug use. He was also a long term cigarette smoker.

3. [redacted] was an inmate at Ravenhall Corrections Centre at the time of his death, having been incarcerated on 28 November 2018, his 19th time in custody.[2] He had a history of violence with multiple segregations, 133 prison incidents since 2000, 67 of which involved interpersonal violence towards staff, and was considered a high risk of violence.

4. On 2 March 2019, [redacted] passed away at St Vincent's Hospital having been admitted for care on 23 February 2019.

THE CORONIAL INVESTIGATION

5. [redacted]'s death was reported to the coroner as he was considered to be *a person placed in custody or care* under section 3(1) of the *Coroners Act 2008* **(the Act)** and so fell within the definition of a reportable death under the Act.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

[1] Referred to in this finding as '[redacted]' unless more formality is required.
[2] On 21 October 2018, [redacted] was arrested for theft and criminal damage. He was also wanted at the time for other matters, including assault. [redacted] was remanded on 22 October 2018. According to his CCA records charges included intentionally causing injury, unlawful assault, commit indictable offence whilst on bail, reckless cause serious injury assault with a weapon. He had three active intervention orders against him.

8. Victoria Police assigned Detective Sergeant Wayne Nixon (**DS Nixon**) to be the Coroner's Investigator for the investigation into [redacted]'s death. DS Nixon conducted inquiries on my behalf[3], including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from Dr Foti Blaher, Chief Medical Officer, Correct Care Australasia, Professor Alex Thompson, Director of Gastroenterology, St Vincent's Hospital, the forensic pathologist who examined him and the Coroner's Investigator and other relevant documentation. The Coroner's Investigator had access to [redacted]'s records from Corrections Victoria (from January 2007).

9. As part of the investigation, I referred the case to the Coroners Prevention Unit (**CPU**).[4] The CPU were asked to consider whether the care provided to [redacted] was adequate and whether there was a chance to have detected the lung cancer, which he eventually succumbed to.

10. In the course of the coronial investigation copies of [redacted]'s records were also obtained from Correct Care Australasia (**CCA**).

11. As advice was received from a pathologist that J[redacted]s death was due to natural causes[5], a mandatory inquest was not required.[6]

12. This finding draws on the totality of the coronial investigation into [redacted]s death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[7]

Background

13. [redacted] had a history of psychosis, substance abuse, including methamphetamines from the age of 15, hepatitis C, depression and asthma. During incarcerations in 2016 and 2017, [redacted] experienced paranoid psychotic episodes that responded to the antipsychotic

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[3] The carriage of the investigation was transferred from Deputy State Coroner English.

[4] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of the coroner. The unit 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. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[5] Paragraph 41.

[6] S52(3A) of the Act.

[7] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

medication olanzapine. He had no contact with community mental health services prior to 2016.

14. On 10 December 2018, while an inmate at Melbourne Assessment Prison (**MAP**), [redacted] was assessed by a psychiatrist, after having been mute and noted to be sitting on his bed staring at the ceiling for two days. The assessment was of an acute severe mental illness and he was placed on an Assessment Order under the *Mental Health Act 2014*. [redacted] was transferred to St Vincent's Hospital, Emergency Department (**ED**) for medical treatment as he had stopped eating and drinking and the doctor was concerned about both his physical and mental health. The ED assessment noted that [redacted] was refusing to talk and had been behaving bizarrely with poor oral intake and 10kg weight loss in the preceding month. [redacted]'s oxygen saturation was 94% on room air. His vital signs were otherwise normal. His examination was limited due to lack of co-operation. Investigations included a full blood examination, kidney and liver function tests, inflammatory markers, iron studies, calcium, magnesium and phosphate levels, all of which were normal.

15. [redacted] was treated with intravenous fluids for rehydration. He became agitated and pulled out his intravenous (**IV**) line. He was assessed by the ED consultant and sedated and IV hydration was completed (one litre fluid). No physical cause for his condition was identified. [redacted] ate three packets of sandwiches and drank three cups of orange juice while in the ED and returned to the MAP the same day.

16. On 13 December 2018 [redacted] was mute again and the psychiatric diagnosis was catatonia[8]. He was transferred to St Vincent's Hospital for rehydration. Dr Blaher wrote in his summary that [redacted] was aggressive while at St Vincent's Hospital and he did not co-operate with a CT scan of the brain.

17. On 14 December 2018 [redacted] was transferred from MAP to Thomas Embling Hospital (**TEH**) under a secure treatment order and admitted there until 17 January 2019[9]. The admission diagnosis was catatonia.

18. On 15 and 16 December 2018 [redacted] was transferred to the Austin Hospital for intravenous rehydration.

[8] A neuropsychiatric behavioural syndrome that is characterized by abnormal movements, immobility, abnormal behaviours, and withdrawal.
[9] See Forensicare Discharge Summary on page 169 of CCA records.

19. On 16 December 2018 an urgent application was made to the Mental Health Tribunal for electroconvulsive therapy (**ECT**), and ECT was administered for treatment of his condition. [redacted] had four ECT treatments between 18 and 24 December 2018. On 18 December 2019 [redacted]'s vital signs were normal and on 20 December 2019 physical examination was normal.

20. The TEH discharge summary noted that [redacted] had recovered well from the catatonia due to the ECT and medication and had returned to his baseline. The ECT was noted to have had a profoundly beneficial effect. The discharge summary noted that throughout the admission [redacted] had declined all of the following: treatment of his hepatitis C (despite repeated attempts), legal advice for the mental health tribunal hearings and any leave.

21. On 15 January 2019, [redacted] was due to appear via tele-court at the Melbourne Magistrates' Court but refused to attend.

22. On 17 January 2019 [redacted] was transferred to the Erskine (Subacute) Psychiatric Unit at Ravenhall Corrections Centre for a period of stabilisation post discharge from TEH. Dr Jessica Gabriel, psychiatry registrar, described in her admission assessment the working diagnosis as an "Acute psychotic episode (?drug induced) / bipolar affective disorder." Her formulation at the completion of her assessment included: there was no evidence of psychosis or affective (mood) symptoms, and suffered a possible acquired brain injury from extensive polysubstance use from a young age and head injury sustained in a motor vehicle accident. She ordered pathology tests and an ECG.

23. The consultant psychiatrist responsible for [redacted] care was Dr Evrard Harris. On 22 January 2019, Dr Harris attempted to review [redacted] but he declined.

24. On 25 and 29 January 2019 [redacted] again declined a review by Dr Harris.

25. On 8 and 14 February 2019 Dr Harris saw [redacted] but [redacted] did not engage with him.

26. On 12 February 2019 the psychiatry registrar ordered pathology. There were several reviews each day during [redacted] admission. During each review every clinician indicated that [redacted] took medication as required, but often politely declined to engage with staff, preferring to stay in his darkened room watching TV or walk laps of the courtyard. He collected his meals and interacted politely when required. He indicated that he wanted to return to mainstream prison.

27. On 20 February 2019 [redacted] was noted to be normal and walking laps of the courtyard.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

28. On 21 February 2019 at 4.31pm, registered psychiatric nurse (**RPN**) Melissa Lombardi recorded that [redacted] refused his medications and was sleeping in his room all day and had not had his meals.

29. At 3.00pm she approached him and he appeared to be sleeping. He woke to her voice and approached the door saying he was OK.

30. At 5.10pm RPN Lombardi approached [redacted] again as he had complained to guards that he wasn't feeling well. When she assessed him, [redacted] was pale and jaundiced and had difficulty breathing. He had bruises on his legs and face and said he had fallen the night before.[10] His abdomen was distended and he reported pain everywhere. Vital signs were abnormal with an elevated heart rate of 135 beats per minute, blood pressure 97/62 mmHg and respiratory rate elevated at 32 breaths per minute.

31. A code black was called at 5.15pm. Dr Jacob Schluter, psychiatry registrar, assessed [redacted] reported that he had been extremely thirsty, feeling faint, not passing urine and feeling very bloated. An ambulance was called and arrived at 5.36pm and [redacted] was taken to St Vincent's Hospital.

32. [redacted] was admitted to the Intensive Care Unit at St Vincent's Hospital with multi-organ failure and extensive gastro-intestinal haemorrhage. Despite treatment, [redacted] was declared deceased at 1.17pm on 3 March 2019.

Identity of the Deceased

33. On 2 March 2019, [redacted] visually identified his brother [redacted] born [redacted].

34. Identity is not in dispute and requires no further investigation.

[10] He said that he didn't want to inform nursing staff of the falls as he thought he could *sleep them off*.

Medical cause of death

35. Specialist Forensic Pathologist Dr Malcolm Dodd from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy examination on 5 March 2019 and provided a written report of his findings dated 18 September 2019.

36. A toxicological analysis of post mortem samples identified the presence of drugs consistent with therapeutic use and treatment.

37. Autopsy findings included:

- Secondary spread of lung cancer to liver, heart, kidney, lymph nodes and in particular, there was extensive replacement of bone marrow.
- Evidence of acute liver failure (fluid accumulation surrounding the lungs and in the abdominal cavity) and bleeding in the form of a brain haemorrhage
- Extensive evidence of chronic liver disease including oesophageal varices[11] from which there had been bleeding, an enlarged spleen, pancreatic inflammation and cirrhosis of the liver.
- BMI 33.56
- The brain was normal and had no metastases to account for [redacted]s altered behaviour or mental state.

38. Dr Dodd also noted that the tumour was extremely high grade and largely undifferentiated indicating its aggressive nature. He commented,

The … tumour is of such high grade that it has lost its differentiation. Round cell/small cell carcinoma of the lung is often silent and presents in its later stage when the tumour has infiltrated into many vital organs, in particular, the bone marrow.

39. Dr Dodd also commented that the liver's function, which was poor due to chronic liver disease from Hepatitis C, was worsened due to infiltration with tumour from the lung, making bleeding more likely.

40. Dr Dodd provided an opinion that the medical cause of death was *Complications arising from widely disseminated primary pulmonary small cell carcinoma.*

[11] Chronic liver disease causes the liver to shrink making blood flow through the liver difficult. This results in "back pressure" to flow and causes an enlargement of veins in the oesophagus and rectum, and enlargement of the spleen and pancreas due to the resulting congestion. The enlarged veins of the oesophagus are termed oesophageal varices

41. Dr Dodd stated that there was no evidence to suggest that the death was due to anything other than *natural causes*.

42. I accept Dr Dodd's opinion.

FURTHER INVESTIGATION

43. [redacted]s family expressed concerns regarding the management of his hepatitis C and whether the tumour could have been detected earlier. These issues were investigated by the CPU.

Hepatitis C management

44. The CPU noted that [redacted] had a history of mental illness. He had an acute severe mental illness which necessitated his admissions to both TEH from 14 December 2018 to 17 January 2019 and the Erskine Unit at Ravenhall Corrections Centre from 17 January 2019 until 21 February 2019, and required medication and ECT. During this two and a half months of hospital admission [redacted] was reviewed several times per day. The records indicate [redacted] frequently declined interaction with nursing staff and reviews with medical staff including the consultant psychiatrist who attempted to review him recurrently. The psychiatry registrar at TEH noted frequent offers of treatment for Hepatitis C which [redacted] declined.

45. Ultimately, [redacted] was offered investigation and management of his hepatis C which he declined.

Tumour detection

46. The records from TEH and Ravenhall Corrections Centre indicate frequent and appropriate reviews. [redacted] was seen several times a day and did not complain of symptoms that may suggest lung cancer. He had no outward physical signs of advanced cancer until the day of transfer to St Vincent's Hospital.

47. Over the course of his mental illness he was reviewed twice at St Vincent's Hospital on 10 and 13 December 2018 and at the Austin Hospital on 13 and 16 January. He was thoroughly assessed and investigated and, importantly all blood tests were normal, including liver function, two months prior to death with decompensated liver failure.

48. Professor Alex Thompson, St Vincent's Hospital, wrote in his statement that the widely disseminated small cell carcinoma of the lung was not diagnosed nor suspected during his hospital admission and that the presentation was very atypical. He considered [redacted] had appropriate medical care for all the conditions with which he presented and he did not believe further invasive investigation would have established the diagnosis or had any impact on the outcome.

49. Dr Dodd's report emphasised the aggressive nature of the tumour, how rapidly it was likely to have progressed and how the cancer is frequently "silent" until it has extensively replaced the bone marrow leading to infection and haemorrhage. [redacted]'s underlying chronic liver disease contributed to the complications he experienced, and his deterioration was rapid and could not have been predicted.

Conclusion

50. The CPU concluded that the care provided with respect to offers of assessment of hepatitis C were reasonable and that the care at TEH and Ravenhall Corrections Centre was also reasonable. The CPU were unable to identify any opportunities for prevention in the course of the investigation.

51. I accept the CPU's advice on these matters.

FINDINGS AND CONCLUSIONS

52. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the Deceased was [redacted]

    (b) the death occurred on 2 March 2019 at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria from *Complications arising from widely disseminated primary pulmonary small cell carcinoma*; and

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

53. I convey my sincere condolences to [redacted]' family for their loss.

54. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet.

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

[redacted] **senior next of kin**

Meridian Lawyers for Correct Care Australasia

St Vincent's Hospital

Justice Assurance and Review Office (JARO)

Detective Sergeant Wayne Nixon, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

Date: 16 August 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.