IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 000929

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***
Amended pursuant to section 76 of the ***Coroners Act 2008***

Findings of:	**CORONER JOHN OLLE**
Deceased:	**DARIN LYNDON WHEELDON**
Date of birth:	**02 JANUARY 1976**
Date of death:	**18 FEBRUARY 2020**
Cause of death:	**1(a) ACUTE MYELOID LEUKEMIA.**
Place of death:	**ST VINCENTS HOSPITAL, 41 VICTORIA PARADE, FITZROY, VICTORIA 3065**

INTRODUCTION

1. On 18 February 2020, Darin Lyndon Wheeldon was 44 years old when he died from natural causes at St Vincent's Hospital. At the time of his death, he was in custody at St Augustine's secure ward at St Vincent's Hospital.

THE CORONIAL INVESTIGATION

2. Darin's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Darin's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Darin Lyndon Wheeldon 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.[1]

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[1] 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.

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

Identity of the deceased

7. On 26 February 2020, Darin Lyndon Wheeldon, born 02 January 1976, was identified via circumstantial evidence and fingerprint identification.

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

Medical cause of death

9. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 20 February 2020 and provided a written report of her findings dated 26 February 2020.

10. The post-mortem examination showed cardiomegaly, increased lung markings and an enlarged spleen.

11. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

12. Dr Parsons provided an opinion that the medical cause of death was 1 (a) acute myeloid leukemia. Based on this, Dr Parsons concluded that Mr Wheeldon's death was due to natural causes.

13. I accept Dr Parson's opinion as to the cause of death.

Circumstances in which the death occurred

14. Mr Wheeldon had been a patient of the St. Vincent's Hospital Haematology Department since June 2019 when he was transferred for investigation and management of blood film abnormalities. At that time, investigations demonstrated evidence of an underlying bone marrow dysfunction, myelodysplastic syndrome, with rapid progression to acute myeloid leukemia, an aggressive form of blood cancer.

15. The disease was refractory to initial standard induction therapy as well as second line salvage chemotherapy. Over the proceeding few months until his discharge on 31 December 2019, Mr Wheeldon was commenced on third line therapy which involved complications and interruptions due to various infective complications and dose-intensity limited toxicities.

16. Mr Wheeldon was discharged on 31 December 2019 to St John's, Port Phillip Prison and was due to be admitted into St Augustine's secure ward at St Vincent's Hospital Melbourne on 3 January 2020.

17. On 31 December 2019, whilst at Port Phillip Prison, Mr Wheeldon complained of central stabbing chest pain radiating to his back. An electrocardiogram (ECG) was conducted, however, it did not show any changes and he was therefore managed symptomatically.

18. On the morning of 1 January 2020, Mr Wheeldon attended the nurse's station for his morning medications. The security staff informed nurses that Mr Wheeldon had stated he felt sick and dizzy. The nursing staff noted Mr Wheeldon looked sick and had high blood pressure and asked him to take antihypertensive medications, however Mr Wheeldon refused stating his doctors had previously asked him not to take this medication if he felt dizzy.

19. After consultation with the On-call Medical Officer, Mr Wheeldon was urgently transferred back to St. Vincent's Hospital, where he was admitted on 1 January 2020. He presented with fevers and low blood count and disease progression, which was evident from repeat bone marrow biopsy, leading to change in anti-leukemia therapy. Over the proceeding weeks, Mr Wheeldon's condition continued to deteriorate due to refractory acute myeloid leukemia, acute pulmonary oedema and complications including chest sepsis.

20. At approximately 9:15 am on 18 February[2] 2020, a Computed Tomography (CT) scan of Mr Wheeldon's chest was conducted due to worsening chest infection, deterioration in his respiratory status and possible worsening chest sepsis. However, the scan was unable to be completed as he felt lightheaded. He returned to his room at approximately 9:40 am, where nursing staff tended to him.

21. At approximately 1:05 pm, security members accompanying Mr Wheeldon observed him to stand up from his bed and face towards the window adjacent to his bed. He was told to sit back on his bed for his safety. Mr Wheeldon proceeded to sit on the bed and roll onto his right side. A 'Code Blue' was called, and several hospital staff attended the room at approximately 1:09 pm and observed Mr Wheeldon unresponsive with vomit around him.

22. Hospital staff begun Cardiopulmonary resuscitation (CPR), defibrillation and suction however ceased shortly after upon review of his not for resuscitation status.

[2] This word has been amended from 'January' to 'February', owing to a clerical mistake in the initial publication of this finding.

23. Mr Wheeldon was declared deceased at 1:25 pm.

REVIEW OF CARE

24. When a person dies in prison, the Justice Assurance and Review Office (JARO) conducts a review of the circumstances and management of the death.

25. Mr Wheeldon was initially accommodated at the Melbourne Assessment Prison and then spent periods at Port Phillip, the Metropolitan Remand Centre, Barwon Prison, Hopkins Correctional Centre and finally, St Augustine's secure ward at St Vincent's Hospital.

26. JARO reviewed relevant information regarding Mr Wheeldon's death, including his management by Corrections Victoria and Port Phillip Prison and the response to his death.

27. Upon reviewing the relevant information, JARO found that Mr Wheeldon's custodial management by Corrections Victoria and Port Phillip met the required standards and that the response to his death was consistent with established procedures.

FINDINGS AND CONCLUSION

28. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was Darin Lyndon Wheeldon, born 02 January 1976;

    (b) the death occurred on 18 February 2020 at St Vincents Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065, from acute myeloid leukemia; and

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

I convey my sincere condolences to Darin's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Graeme & Vicki Wheeldon, Senior Next of Kin

Other Applicants

Victoria Police, Coroner's Investigator

Signature:

Coroner John Olle

Date: 31 May 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.