IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002515

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

*Amended pursuant to section 76 of the **Coroners Act 2008** on 18 November 2025*[1]

Deceased:	Christopher Gerard McIntosh
Delivered on:	28 October 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	28 October 2025
Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Counsel assisting the coroner:	Ms Olivia Collings, Solicitor
Key words:	Death in custody, Hopkins Correctional Centre, diabetes, ulcer, amputation

[1] This document is an amended version of the Finding into Death With Inquest regarding Christopher Gerard McIntosh dated 28 October 2025. Corrections to paragraphs 60, 61 62, 63, 64, and 65 have been made pursuant to section 76 of the *Coroners Act 2008* (Vic).

INTRODUCTION

1. On 10 May 2022, Christopher Gerard McIntosh, was 54 years old when he died at St Vincent's Hospital. At the time, Mr McIntosh was incarcerated at the Hopkins Correctional Centre (**Hopkins**) in Ararat, Victoria.

2. Little is known about Mr McIntosh's background and personal circumstances. Mr McIntosh was first incarcerated in 1999 when he served a five-year sentence for serious offending. In 2002, he returned to prison due to further serious offending and commenced serving 21-year custodial sentence, with an anticipated release date in mid-2025. From 2002 to 2012, Mr McIntosh was held at Port Phillip Prison, after which he was transferred to Hopkins.

3. Mr McIntosh's medical history included Type II Diabetes mellitus and associated foot ulcers, hypertension, emphysema, asthma, migraines, tinnitus, anaphylaxis and peripheral neuropathy. As a result of a balance disorder, and his chronic foot ulcers, Mr McIntosh had reduced mobility and used a wheelchair.

INVESTIGATION AND SOURCES OF EVIDENCE

4. This finding draws on the totality of the coronial investigation into the death of Mr McIntosh including evidence contained in the coronial file comprising medical records, the E-Medical Deposition Form completed by St Vincent's Hospital Melbourne, the Medical Examiner's Report completed by the Victorian Institute of Forensic Medicine and the report completed by the Justice Assurance and Review Office of the Department of Justice and Community Safety.

5. All of this material, together with the inquest transcript, will remain on the coronial file.[2] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

6. The purpose of a coronial investigation of a *reportable death*[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death

[2] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[3] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or

occurred.[4] It is uncontroversial that Mr McIntosh was a person *'placed in custody or care'* at the time of his death in accordance with section 3 of the Act. As such, section 52(2)(b) requires that I hold an inquest into his death. Section 52(3A) provides an exception such that I am not *required* to hold an inquest if I consider that the death occurred due to natural circumstances. I can nonetheless exercise my discretion to hold an inquest in circumstances where section 52(3A) applies.

7. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[5]

8. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[6]

9. Coroners are empowered to report to the Attorney-General in relation to a death; 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 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.[7] These are effectively the vehicles by which the coroner's prevention role can be advanced.[8]

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indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[4] Section 67(1).

[5] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[6] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[7] See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.

[8] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

10. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[9]

IDENTITY OF THE DECEASED

11. On 10 May 2022, Christopher Gerard McIntosh, born 1 September 1967 was visually identified by his mother, Elaine McIntosh, who signed a formal Statement of Identification to this effect.

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

MEDICAL CAUSE OF DEATH

13. Forensic Pathologist, Dr Joanna Glengarry, of the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 12 May 2022 and provided a written report of her findings dated 14 May 2022.

14. The post-mortem computed tomography (**CT**) scan revealed subcutaneous emphysema and a non-specific increase in lung markings with pleural effusions. Findings of the external examination were consistent with the reported medical history.

15. Dr Glengarry provided an opinion that the medical cause of death was *'1(a) Respiratory failure'* secondary to *'1(b) Prolonged ventilation for the management of sepsis'* due to '1(c) *Infected foot ulcer (requiring an above the knee amputation) in a man with diabetes mellitus'.* Dr Glengarry stated the death was due to natural causes.

16. I accept Dr Glengarry's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

17. While incarcerated at Hopkins, Mr McIntosh attended the Health Clinic for review and dressing of his foot ulcers and received input from clinicians and allied services including an occupational therapist, a podiatrist and a diabetes educator. It was not uncommon for Mr McIntosh to refuse medical treatment or nursing care and insisted on attending to his ulcers himself. Nursing staff provided Mr McIntosh with supplies to facilitate this.

[9] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

18. On one occasion, about one year before his death, Mr McIntosh was hospitalised due to his ulcers. On the morning of 1 April 2021, prison staff found Mr McIntosh short of breath, sweating, pale and clammy and activated a Code Black emergency. On examination by clinical staff, he had an elevated temperature, respiratory rate and pulse and a low oxygen saturation. He as treated on site initially before transfer to Ballarat Hospital.

19. Clinicians there diagnosed septicaemia secondary to infected leg wounds and transferred him to St Vincent's Hospital Melbourne (**SVHM**) where he was admitted to the Intensive Care Unit (**ICU**). Mr McIntosh's treatment included antibiotics and an insulin infusion for treatment of sepsis, diabetic ketoacidosis, acute renal impairment and acute hepatitis.

20. He was discharged one week later and returned to the subacute unit at Hopkins for ongoing medical management.

21. On 19 March 2022, Mr McIntosh attended the Health Clinic for a change of his foot dressings. According to a medical record entry, he had three ulcers to the right foot, and four ulcers to the left foot. They appeared clean with *'nil signs of infection'*.

22. On 4 April 2022, at 11.24 am, Mr McIntosh entered the Health Clinic. A nurse recorded that when Mr McIntosh attended the Health Clinic, there *'was an immediate overpowering offensive odour coming from his feet/dressings'*. The left foot appeared *'macerated'*, there was green exudate from the ulcers and Mr McIntosh reported that *'a large amount of skin had peeled away'* the previous day. A clinician and surgeon reviewed Mr McIntosh and advised he needed intravenous antibiotics and surgical debridement of the ulcers.[10] They recommended that he be transferred to St Vincent's Hospital Melbourne (**SVHM**) for treatment.

23. Mr McIntosh declined the clinicians' recommendations. He refused to be transferred to SVHM or to be admitted to the Hopkins' subacute medical ward for intravenous antibiotics. Mr McIntosh said this was because he had to *'get his affairs in order'*. Medical records of this visit also read, *'he states that he wants his wounds to get really bad as it will "get [him] out of prison sooner'"*.

24. Clinicians were able to negotiate that if they *'could facilitate him speaking to these people who he must organise his affairs with'*, that he will *'consider'* going to hospital.

[10] The surgical removal of dead, damaged or infected tissue.

25. Clinicians reiterated the severity of his condition and his poor prognosis without treatment. They attempted to persuade Mr McIntosh to accept a hospital transfer without success. Mr McIntosh also refused treatment with intravenous antibiotics, and to be transferred to the subacute ward at Hopkins.

26. Mr McIntosh accepted oral antibiotics and dressings and signed a Refusal of Treatment Form. He was booked in for a wound review and dressing change following morning at 10 am.

27. At 10.53 am the following morning, on 5 April 2022, Mr McIntosh attended the wound care appointment. According to medical records, his leg *'appear[ed] worse than yesterday'* and *'the necrosis [was] evidently spreading across the wound and into the surrounding periwound'.* The health practitioner took Mr McIntosh's vital signs and recorded that he reported no other symptoms of infection, he did not have a fever and still had an appetite.

28. The wounds were thoroughly cleaned, and topical treatment and dressings were applied.

29. The same morning, at 11.40 am, Mr McIntosh told a registered psychiatric nurse that he had *'reconsidered [the] situation over night'*, changed his mind and would accept a transfer to SVHM. Clinicians and Justice Health staff organised for Mr McIntosh to be transferred to the SVHM Vascular Unit on 7 April 2022.

30. That afternoon, Justice Health held a case conference with the Nurse Unit Manager of the St Augustine's Ward of SVHM, the clinical governance team and a Corrections Victoria representative. The group discussed Mr McIntosh's history, that he was due to be admitted to SVHM on 7 April 2022. They organised for a *'change of attending officers'* and for escorts to transport Mr McIntosh.

31. Throughout the day, clinicians at Hopkins spoke to SVHM to organise referrals including to the vascular registrar and the emergency department.

32. On the morning of 6 April 2022, Mr McIntosh did not attend his morning wound assessment appointment. He was rebooked for the next availability and attended the clinic that afternoon at 3.42 pm. Since his initial assessment, on 4 April 2022, there had been a *'massive deterioration',* and Mr McIntosh continued to refuse all care prior to his transfer to SVHM the following day. During this appointment, he only allowed for a change of the dressings and vital observations.

33. That afternoon, Mr McIntosh consented for blood tests but *'flatly refused'* being monitored in the subacute ward.

34. At 5.21 pm, Mr McIntosh had another dressing change appointment. The wounds were cleaned and re-dressed. Mr McIntosh is recorded as *'looking quite unwell'* and told staff that he *'[had] not eaten for 2 days'* as he found the odour from his wound was *'turning him off food'*. It was again suggested that Mr McIntosh be admitted to the subacute ward, and he refused and was *'adamant'* that he would not be treated as an inpatient. The medical practitioner took Mr McIntosh's vital signs, recorded that he had reduced urine output, was short of breath and required a Ventolin (salbutamol) inhaler several times a day. The medical practitioner again suggested Mr McIntosh be admitted, and he refused.

35. However, by 7.51 pm, Mr McIntosh agreed to be admitted to the subacute ward. His vital signs were taken. He had a heart rate of 110 beats per minute, an oxygen saturation of 94% and blood sugar level of 4.6 mmol/L. During the evening, he was given food, antibiotics, anti-inflammatories and analgesics and his blood sugar level was monitored.

36. The following morning, at 8.08 am on 7 April 2022, Mr McIntosh had *'declined cognitively overnight'* however, remained conscious with a Glasgow Coma Scale score of 14.[11] Pathology results showed that he had an extremely elevated c-reactive protein (**CRP**) – a marker of inflammation – and white cell count and neutrophils, he also had significantly reduced kidney function. Mr McIntosh rated his pain at a 4/10 and was prepared and ready for transfer to SVHM.

37. At 9.16 am, a pre-organised non-urgent ambulance transported Mr McIntosh to SVHM. The multidisciplinary high risk foot service, comprising infectious diseases, vascular surgery and podiatry team members, assessed Mr McIntosh and prescribed broad-spectrum antibiotics. Testing revealed that Mr McIntosh was in systemic sepsis. That evening, clinicians performed a below-the-knee amputation.

38. The following day, on 8 April 2022, clinicians observed that the infection had spread, affecting the remaining limb tissue. Mr McIntosh returned to theatre and clinicians performed an above-the-knee amputation. Following the operation, he was intubated and remained in the Intensive Care Unit (**ICU**).

[11] The Glasgow Coma Scale (**GCS**) is used to measure an individual's level of consciousness (generally after a head injury) by applying a set of external stimuli. GSC scores range from 3 (deep coma or death) and 15 (fully alert and oriented).

39. On 14 April 2022, clinicians attempted to extubate Mr McIntosh. However, this was unsuccessful, and they inserted a tracheostomy. Clinicians de-escalated his antibiotic treatment, but Mr McIntosh experienced further fevers and required re-escalation to broad-spectrum antibiotics.

40. On 22 April 2022, clinicians performed a bedside bronchoscopy which demonstrated the posterior wall of the trachea was occluding Mr McIntosh's airway. They replaced the tracheostomy tube with a new one but there was no improvement in his condition.

41. During a cuff-down period,[12] clinicians spoke to Mr McIntosh about his goals of care. He expressed a desire for care to be withdrawn, and clinicians spoke to his mother, who supported his wishes. On 10 May 2022, Mr McIntosh's tracheostomy tube was decannulated, and he was commenced on a comfort pathway. At 4.04 pm, on 10 May 2022, Mr McIntosh was declared deceased.

MEDICAL TREATMENT PROVIDED TO MR MCINTOSH WHILE INCARCERAED AT HOPKINS CORRECTIONAL FACILITY

42. On the basis that Mr McIntosh's ulcers deteriorated substantially during his period of incarceration, I considered the level of medical care provided to him with two key foci:

    (a) Whether Mr McIntosh's chronic diabetic ulcers were appropriately managed; and,

    (b) Whether the delay in transferring Mr McIntosh to SVHM, from 5 to 7 April 2022, impacted his clinical course, and consequently, the fatal outcome.

<u>Management of Mr McIntosh's chronic diabetic ulcers</u>

43. At the time of Mr McIntosh's transfer to Hopkins, he had existing chronic diabetic ulcers to his feet. The ulcers were often difficult to manage – at times appearing macerated, hypergranulated with varying odour and exudate.

44. Evidence indicates that Mr McIntosh could be a difficult patient and was noted to be *'unlikely to follow instruction'*. He often refused treatment and failed to attend medical appointments without reason: there are at least nine documented occasions when Mr McIntosh declined nursing assistance for wound care. On 28 June 2021, the podiatrist recommended

[12] A 'cuff down' period in tracheostomy care refers to the time when the cuff of the tracheostomy tube is deflated, allowing air to flow around the tube and into the upper airway. A cuff down period generally occurs in the weaning process, and allows patients to breathe and speak more naturally, before removal of the tracheostomy tube.

multidisciplinary care including orthopaedic input or a referral to the Ballarat high-risk foot team but Mr McIntosh declined. The podiatrist warned Mr McIntosh that without escalated treatment, he could suffer complications including amputation but he continued to refuse.

45. Justice Health records indicate that Mr McIntosh signed at least two Refusal of Treatment Forms (including that of 4 April 2022). In July 2021, blood glucose testing returned an elevated result, and Mr McIntosh declined clinician's direction to attend the Hopkins' Health Clinic for further assessment.

46. During his incarceration, Mr McIntosh told clinicians that he wanted to manage his own wound dressings. On at least 19 occasions, staff provided him with medical supplies to do so. However, I note that there is no documentation indicating that Mr McIntosh received appropriate training or education on wound care.

47. From time to time, Mr McIntosh's ulcers deteriorated, and his care needs escalated. From 2015 to 2020, he experienced five episodes of leg cellulitis. On two occasions, he was provided antibiotics and admitted to the Hopkins' subacute unit. Mr McIntosh received input from clinicians, podiatrists, occupational therapists and registered nurses. On one previous occasion, Mr McIntosh's required hospitalisation due to infection. In April 2021, Mr McIntosh was admitted to Ballarat Base Hospital due to sepsis, presumably from his ulcers. He recovered and returned to Hopkins. On 28 June 2021, a podiatrist consulted with Mr McIntosh and advised him he was no longer able to apply his own dressing since he was not adhering to the required regime. Mr McIntosh nonetheless continued to attend to his own dressings.

48. Throughout early 2022, medical records indicate that there were no signs of infection to the ulcers.

49. Mr McIntosh's last recorded attendance at the Health Clinic occurred on 19 March 2022. There is no indication that health staff members attended to or checked on Mr McIntosh or his ulcers for the following two weeks, until 4 April 2022. By this time, Mr McIntosh's left foot ulcer had become necrotic and infected.

<u>Delay in transporting Mr McIntosh to St Vincent's Hospital Melbourne</u>

50. On 5 April 2022, at 11.40 am, after initially refusing treatment, Mr McIntosh informed a nurse that he was willing to attend SVHM per clinicians' recommendation. However, it was not until two days later, on the morning of 7 April 2022, at 9.16 am, that he was transported via

ambulance to the hospital. By this time, his condition had severely deteriorated. I sought to determine the reason for the delay, and further, whether an earlier admission to SVHM might have changed his outcome.

51. Justice Health records of the consultation of 4 April 2022, at 11.24 am, indicate that Mr McIntosh was *'argumentative about the severity of his condition'* and despite warnings of a probable amputation, he told clinicians, *'my mind is made up'*. Mr McIntosh stated that he needed to *'get his affairs in order'* before he would accept a transfer to SVHM. Evidence also indicates that Mr McIntosh was reluctant to leave Hopkins due to the possibility of returning to Port Phillip Prison where he believed *'prisoners were treated poorly'*.

52. When Mr McIntosh spoke with a nurse the following morning, he stated he had *'reconsidered [the] situation overnight'* and that he would accept a transfer to SVHM. An entry in the Justice Health medical records of this appointment read, *'[Mr McIntosh] is accepting of going back to Melbourne to address his Health concerns on Thursday'*.

53. In the afternoon of 5 April 2022, the Clinical Governance team and the Nurse Unit Manager of the St Augustine's Ward of SVHM held a conference to discuss Mr McIntosh's admission. The Justice Health records referring to this meeting read, *'Proposed day of arrival will be Thursday as suggested by Chris?'*[13]

54. To better understand whether the transfer was scheduled on 7 April 2022 in accordance with Mr McIntosh's suggestion (or an extraneous matter), the Court sought a statement from Kathryn Whitehead, Health Service Manager of GEO Healthcare.[14] On this point, Ms Whitehead said, *'I recall that Mr McIntosh specifically requested that his transfer to hospital occur on Thursday 7 April 2022 and that he continued to decline to be transferred at an earlier time despite this option being consistently offered by staff'*.

55. Ms Whitehead stated that Mr McIntosh wanted to secure NDIS funding for a new wheelchair before he was transferred to hospital and therefore wanted to defer a hospital transfer until 7 April 2022 so he could speak to the Occupational Therapist completing his NDIS application.

[13] Corrections Victoria have not been able to locate a copy of the minutes relating to this meeting. The only substantive reference to the discussion(s) held is in the Justice Health records entry of 2:10pm on 5 April 2022.
[14] At the time of Mr McIntosh's death, Kathryn was a Registered Nurse. From 1 July 2023, GEO Group Australia Pty Ltd (trading as GEO Healthcare) was the successful tenderer and assumed the provision of primary healthcare services as Victorian Mens' Public Prisons, including Hopkins Correctional Centre. For the relevant time that Mr McIntosh was in custody in 2022, Correct Care Australasia was the primary healthcare provider.

He was insistent to remain at Hopkins until 7 April 2022 despite Ms Whitehead's suggestion to have a telephone call with the Occupational Therapist.

56. Whilst awaiting the hospital transfer, Mr McIntosh refused to be admitted to the Hopkins' sub-acute unit until the evening of 6 April 2022, at 7.51 pm, and received dressing changes. Clinicians organised a referral to the Vascular Unit of SVHM and organised an appointment for around midday on 7 April 2022.

57. At my request, a vascular surgeon of SVHM provided a statement and addressed the impact of the delay on Mr McIntosh's clinical course. The surgeon stated that biochemical and haematological parameters were consistent with systemic sepsis at the time of Mr McIntosh's arrival at SVHM. According to the surgeon:

> *'It is reasonable to speculate that the degree of sepsis present at the time of transfer was substantially more severe than in the prior two days, and indeed at the time of transfer, tachycardia was the only observation pointing to systemic sepsis'.*

58. They recalled that by the time Mr McIntosh arrived at SVHM, his *'left foot was unequivocally unsalvageable'.* However, the surgeon qualified that even if Mr McIntosh had been transferred 24-48 hours earlier, *'limb salvage would have been unlikely to be possible'.*

59. The surgeon concluded that it is difficult to speculate on the degree of systemic sepsis present from 5 to 7 April 2022. They stated:

> *'In hindsight, earlier transfer may have resulted in major amputation occurring at an earlier time point, but even if this had taken place, there is no certainty that Mr McIntosh would not have suffered with the ultimately fatal complications of sepsis'.*

JUSTICE ASSURANCE AND REVIEW OFFICE REPORT

60. On 11 May 2024, the Department of Justice and Community Safety completed its report into Mr McIntosh's death (**the DJCS Report**).[15]

61. The DJCS Report[16] summarised Mr McIntosh's medical history and treatment he received while incarcerated at Hopkins. While the report concluded that his medical treatment was

[15] 'the Justice Assurance Review Office' removed and 'JARO' amended to 'DJCS' pursuant to section 76 of the *Coroners Act 2008* (Vic).
[16] 'JARO' amended to 'DJCS' pursuant to section 76 of the *Coroners Act 2008* (Vic).

overall reasonable, it *'identified several missed opportunities by health staff to appropriately manage Mr McIntosh's wound care needs'*.

62. The DJCS Report[17] stated that it was of particular concern that there was no documentation that Mr McIntosh received education or training on wound care management, even though he insisted on and was permitted to at tend to his own wounds.

63. While the DJCS Report[18] acknowledged that *'patients have the right to make informed decisions about their own medical needs and can decline medical treatment'*, Mr McIntosh's frequent refusal of assistance *'should have instigated a higher level of vigilance from the treating team to offer additional reviews'*.

64. Further, the DJCS Report[19] identified that poor-record keeping affected Mr McIntosh's treatment. It stated that more regular reviews and documentation of his wound condition, and better monitoring and follow up of referrals could have improved his care. It noted that health staff did not document the follow up of the podiatrist recommendations made in 2021 and there are no documented referrals to the high-risk foot or orthopaedic teams. It stated, *'the apparent absence of an intervention plan for Mr McIntosh's wound care needs is of further concern. These deficiencies in his health care contravened the [Correct Care Australasia] Wound Management policy'*.

65. The DJCS Report[20] made four recommendations:

    (a) Health service providers develop health pathways to guide clinicians in assessment, treatment, and management of patients, and include information on referral pathways for relevant services and specialists,

    (b) All health service providers review and update current wound management policies to include would care management assessment tools and a patient information sheet,

    (c) Justice Health update their system to include the wound management assessment tool and the patient information sheet template – these updated are to be completed by staff; and,

[17] 'JARO' amended to 'DJCS' pursuant to section 76 of the *Coroners Act 2008* (Vic).
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(d) Hopkins Correctional Centre:

(i) Undertake an audit of compliance with Local Plan discussion requirements outlined in the relevant policy. This audit should include a review of the frequency and documentation of case manager meetings;[21] and,

(ii) Address any barriers and rectify any gaps identified by the audit.

FINDINGS AND CONCLUSION

66. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [22]

67. Having applied the applicable standard of proof to the available evidence, I made the following findings pursuant to section 67(1) of the Act:

(a) the identity of the deceased was Christopher Gerard McIntosh, born 1 September 1967;

(b) the death occurred on 10 May 2022 at SVHM, 41 Victoria Parade, Fitzroy, Victoria, 3065;

(c) the medical cause of Mr McIntosh's death was respiratory failure secondary to prolonged ventilation for the management of sepsis due to an infected foot ulcer which required above the knee amputation in a man with diabetes mellitus; and

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

68. I have considered the treatment provided to Mr McIntosh during his incarceration at Hopkins Correctional Facility and find that it was reasonable and appropriate on the whole. He received care from various health practitioners who experienced difficulties managing Mr McIntosh due to his frequent refusal of treatment and insistence on managing the ulcers himself.

[21] Local Plans include meetings between the prisoner and case workers to outline goals. For Mr McIntosh, his 2021 goals related to the management of his medical conditions, the purchase of a new wheelchair and working towards parole. Case notes and monthly discussions were not always appropriately documented and per the JARO Report, it is unclear whether he was adequately engaged by case managers during his final five months in custody.

[22] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

69. Due to severity of Mr McIntosh's condition by the time he agreed to be transferred to hospital and the rapidity with which he deteriorated, the weight of the evidence does not support a finding that surgical intervention or admission two days earlier would have changed the outcome. I find that between 5 and 7 April 2022, health practitioners acted appropriately to deliver urgent care while balancing Mr McIntosh's right to make an informed decision and to refuse medical treatment.

70. I am satisfied any issues in the care provided to Mr McIntosh, specifically relating to referrals to medical teams and specialists, have been adequately identified and canvassed in the Justice Assurance and Review Office report in a manner that obviates the need for further coronial comment or recommendation.

PUBLICATION OF FINDING

71. Pursuant to section 73(1) of the Act, unless otherwise ordered by a coroner, the findings, comments and recommendations made following an inquest must be published on the Internet in accordance with the rules. I make no such order and therefore this finding in its entirety will be so published.

DISTRIBUTION OF FINDING

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

Ms Elaine McIntosh, Senior Next of Kin

Correct Care Australasia, c/- Meridian Lawyers

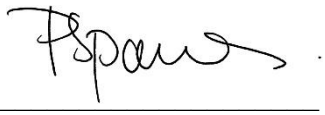
Justice and Assurance Review Office

Department of Justice and Community Safety

St Vincent's Hospital Melbourne

Detective Senior Constable Nathan Dunn, Victoria Police, Coroner's Investigator

Signed:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 28 October 2025

Re-signed: 18 November 2025

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.