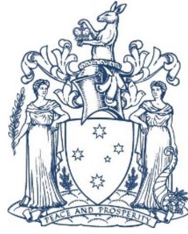

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 005704

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***[1]

Findings of:	Coroner John Olle
Deceased:	HV
Date of birth:	15 March 1940
Date of death:	19 October 2019
Cause of death:	1(a) COMPLICATIONS OF ISCHAEMIC HEART DISEASE
Place of death:	Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria, 3029

[1] This document is an amended version of the Finding into the death of HV dated 13 December 2021. The Finding has been amended pursuant to section 76A of the *Coroners Act 2008* to insert paragraphs 1 – 25 to include circumstances of HV's death.

INTRODUCTION

1. HV was a 79-year-old man died in custody at Port Phillip Prison on 19 October 2019 from natural causes.

2. HV was serving his first term of imprisonment and was waiting trial at the time of his death. HV was initially remanded into the Melbourne Assessment Prison; however, on 29 April 2017 he was transferred to St Augustine's secure ward at St Vincent's Hospital after having a fall. He then spent the majority of his time in custody, including at the time of his death, in the St John's medical unit (St John's) at Port Phillip.

3. HV disclosed heart complications and general poor health soon after being remanded. He had significant health issues including a previous heart attack, atrial fibrillation, pulmonary embolism, pleural effusion and congestive heart failure.

THE CORONIAL INVESTIGATION

4. HV's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). HV's death was reportable as he was in custody of the State immediately before the time of his death.[2] The death of a person in care or custody is a mandatory report to the Coroner. If such deaths occur as a result of natural causes, a coronial investigation must take place but the holding of an inquest is not mandatory.

5. 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death HV. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings

[2] See section 4(2)(c) and (e) of the *Coroners Act 2008* (Vic)

or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Identity of the deceased

8. On 24 October 2019 HV, born 15 March 1940, was visually identified by his son, OV.

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

Medical cause of death

10. Forensic Pathologist Dr Michael Phillip Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 21 October 2019 and provided a written report of his findings dated 20 November 2019.

11. The post-mortem examination revealed an enlarged heart with coronary calcification and pleural effusions. There was no skill or facial fracture, and no intracranial haemorrhage.

12. Toxicological analysis of post-mortem samples identified the presence of Sertraline (0.2 mg/L), Olanzapine (0.02 mg/L), Bisoprolol (0.04 mg/L), and Paracetamol (5.0 mg/L).

13. Dr Burke provided an opinion that the medical cause of death was 1 (a) complications of ischaemic heart disease.

14. I accept Dr Burke's opinion.

Circumstances in which the death occurred

15. On the morning of 19 October 2019, before sunrise, a prisoner sharing HV's cell observed him to be mobile and alert when they each used the bathroom. The prisoner later woke to find HV lying on the floor motionless and attempted to commence cardiopulmonary resuscitation **(CPR).** A correctional officer attended the cell at 7.05am and called a 'Code Black' (death/serious medical incident).

[3] 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.

16. St Vincent's Hospital medical staff attended, observed HV as unresponsive and commenced CPR. A corrections officers also notified the control room who placed a call to emergency services. Ambulance Victoria arrived at approximately 7.20am and attempted to resuscitate HV.

17. Despite resuscitative efforts, HV was unable to be revived and was pronounced deceased at 7.25am.

REVIEW OF CARE

18. As HV died while in the custody of Corrections Victoria, the Justice Assurance and Review Office **(JARO)** reviewed the circumstances of his death to determine if the custodial management of Corrections Victoria met appropriate standards. Additionally, Justice Health, which has responsibility for delivering health services to prisoners, conducted a review of the health care provided to HV.

19. JARO reviewed relevant information regarding HV's death, including his custodial management by Corrections Victoria and Port Phillip and the response to his death.

20. The JARO review noted that HV was a frail prisoner with significant medical problems. HV was involved in seven prison incidents while in custody, all of which were medical incidents. He attended scheduled monthly meetings with his case manager at Port Phillip to develop local plan goals when his health permitted. There were occasions in which his goals were unable to be updated due to his poor health and multiple hospital admissions. He was transferred on 22 occasions to St Vincent's Hospital for medical treatment and was subject to a Mental Health Secure Treatment Order as a result of his deteriorating mental health and psychiatric needs.

21. JARO concluded that HV'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.

22. Additionally, upon reviewing HV's medical record, Justice Health concluded that there was nothing to suggest that the healthcare provided to HV was not in accordance with the *Justice Health Quality Framework 2014.* As such, Justice Health made no recommendations for systemic improvement arising from the death of HV.

23. I accept the findings of both JARO and Justice Health in their reviews of HV's care.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

24. As noted above, HV's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in custody or care, as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that HV died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an Inquest into his death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was HV, born 15 March 1940;

    b) the death occurred on 19 October 2019 at Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria, 3029, from COMPLICATIONS OF ISCHAEMIC HEART DISEASE; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to HV'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:

OV, Senior Next of Kin

Justice Assurance and Review Office

Justice Health

Victoria Police, Coroner's Investigator

Signature:

Date : 13 December 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.