IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 4389

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	KLW
Date of birth:	Removed to protect deceased's identity
Date of death:	19 August 2021
Cause of death:	1(a) complications of acute myeloid leukaemia
Place of death:	St. Vincent's Hospital Melbourne 41 Victoria Parade, Fitzroy, Victoria, 3065
Keywords:	Death in custody; natural causes

INTRODUCTION

1. On 19 August 2021, KLW[1] was 76 years old when he died at St Vincent's Hospital (**St Vincent's**).

2. At the time of his death, KLW was in the legal custody of the Secretary to the Department of Justice and Community Safety (**DJCS**) serving a term of imprisonment at Loddon Prison (**Loddon**).

THE CORONIAL INVESTIGATION

3. KLW'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.
4. 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.

5. 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.

6. The Justice Assurance and Review Office (**JARO**) of the DJCS conducted a review of the custodial management and healthcare provided to KLW. I have reviewed the material provided by JARO to assist the coronial investigation and inform this finding.

7. This finding draws on the totality of the coronial investigation into the death of KLW including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

[1] This is a pseudonym.

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.[2]

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

Circumstances in which the death occurred

8. On 20 April 2021, KLW was sentenced to a fourteen-year term of imprisonment. KLW was transferred to Loddon on 23 April 2021.

9. On 16 July 2021, KLW was reviewed by the Loddon Medical Officer as he was experiencing breathlessness and fatigue, following pain relief he had been given the day prior in response to having complained of pain and overnight sweats that day. A decision was made to transfer KLW to Bendigo Hospital.

10. Bendigo Hospital conducted a series of diagnostic tests, including a laparoscopic cholecystectomy. He was discharged to Loddon on 26 July 2021. The discharge summary recorded findings of a lumbar spinal scan as degenerative changes. A computed tomography (**CT**) scan identified hyperechoic densities within the gallbladder, however no other abnormalities were identified.

11. On 29 July 2021, KLW's condition continued to decline. He had a fever, a distended abdomen and pain in his shoulders, legs and lower back. Accordingly, he was transferred back to Bendigo Hospital.

12. On 30 July 2021, Loddon Medical Officer was informed that KLW would need a long inpatient stay. Accordingly, arrangements were made to transfer KLW to St Vincent's where he was admitted to the St Augustine's Ward (**St Augustine's**). Whilst at St Augustine's, diagnostic tests and investigations were undertaken for suspected myeloma.

13. On 17 August 2021, KLW was transferred to the Intensive Care Unit (**ICU**) as his condition had rapidly deteriorated. KLW's family was contacted, and an Acute Resuscitation Plan was implemented.

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[2] 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.

14. At approximately 5.00am on 19 August 2021, KLW was observed to be having difficulty breathing. KLW appeared to be passing away and correctional staff commenced a crime scene log immediately. KLW was pronounced deceased at 5.14am.

Identity of the deceased

15. On 19th August 2021, KLW, born 3 May 1945, was visually identified by his grandson.

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

Medical cause of death

17. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 20 August 2021 and provided a written report of her findings dated 20 August 2021. Dr Fronczek also reviewed the Victoria Police Report of Death (**Form 83**), information in the VIFM contact log, the post-mortem CT scan and the medical deposition from St Vincent's Hospital.

18. The post-mortem examination revealed nothing controversial, and all findings were consistent with KLW's medical history.

19. The CT guided bone biopsy showed features consistent with acute myeloid leukaemia. Examination of the post-mortem CT scan also revealed enhanced lung markings, bilateral pleural effusions, coronary artery and generalised calcifications, calcifications pancreas, right kidney cyst, hypodensities in vertebrae, sternal wires and a stomach band.

20. Dr Fronczek provided an opinion that the medical cause of death was 1 (a) complications of acute myeloid leukaemia.

21. I accept and adopt Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was KLW;

    b) the death occurred on 19 August 2021 at St. Vincent's Hospital Melbourne 41 Victoria Parade, Fitzroy, Victoria, 3065, from complications of acute myeloid leukaemia; and

    c) the death occurred in the circumstances described above.

23. Having considered all of the circumstances, I am satisfied that KLW's custodial and healthcare management was appropriate and met the required standards in accordance with the *Justice Quality Framework 2014*.

I convey my sincere condolences to KLW'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:

Senior Next of Kin

Elizabeth Piper, Acting Director, Justice Assurance and Review Office

Donna Filippich, Legal Counsel, St Vincent's Hospital Melbourne

Signature:

John Olle

Coroner

Date : 07 July 2022

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.