IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003895

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	David Drowley
Date of birth:	23 May 1959
Date of death:	14 July 2022
Cause of death:	1(a) Metastatic lung cancer
Place of death:	St. Vincent's Public Hospital Melbourne, 41 Victoria Parade, Fitzroy, Victoria, 3065
Keywords:	Death in custody, natural causes, terminal lung cancer

INTRODUCTION

1. On 14 July 2022, David Drowley was 63 years old when he passed away at St Vincent's Hospital, Melbourne (**SVHM**). At the time of his death, Mr Drowley was serving a term of imprisonment at Port Phillip Prison (**PPP**).

2. In 2016, Mr Drowley was convicted of multiple counts of serious sexual offending and was sentenced to a term of imprisonment of ten years, with a non-parole period of seven years. He was initially located at Hopkins Correctional Centre, before being transferred to PPP in 2021.

3. Prior to his incarceration, Mr Drowley was a heavy smoker and drinker. He had a history of gastro-oesophageal reflux disease (**GORD**) and was prescribed pantoprazole from about February 2020.

THE CORONIAL INVESTIGATION

4. Mr Drowley's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Mr Drowley was "*a person placed in custody*" pursuant to the definition in section 4 of the Act, as he was a "*person in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police*".[1] 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.

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.

[1] Section 3(1)(e) *Coroners Act 2008* (Vic).

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Drowley's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of David Drowley 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.[2]

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

Circumstances in which the death occurred

9. On 9 August 2021, Mr Drowley presented to a Medical Officer (**MO**) at Port Phillip Prison and reported difficulty swallowing and a soft lump on his neck. He was referred for further testing, and he was subsequently diagnosed with metastatic non-small-cell lung carcinoma on 20 September 2021. He was referred to the Oncology Unit at SVHM for ongoing management and care, and immediately commenced chemotherapy.

10. In mid-December 2021, the lump on Mr Drowley's neck was increasing in size and there were new spots on his lungs. Mr Drowley was then commenced on radiation therapy which continued until March 2022. In March 2022, Mr Drowley commenced a second round of chemotherapy.

11. In May 2022, a repeat CT scan revealed progressive cancer with new liver metastases, increasing lung metastases and probable lymphangitis. By June 2022, Mr Drowley's cancer was noted to have progressed further and he commenced a third round of chemotherapy.

12. On 22 June 2022, Mr Drowley underwent a palliative cordotomy at SVHM, in an attempt to improve his breathing and the volume of his voice. He was discharged from SVHM on 26 June 2022 back to PPP.

13. Over the following two weeks, Mr Drowley's condition continued to deteriorate, and he was provided with palliative and pain medication as required. On 13 July 2022, Mr Drowley presented as confused and agitated, and he was transferred to SVHM via ambulance. He was

[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.

admitted to St Augustine's secure ward at SVHM for palliative and end-of-life care. He passed away on the evening of 14 July 2022 at SVHM.

Identity of the deceased

14. On 22 July 2022, Coroner Ryan made a formal determination identifying the deceased as David Drowley, born 23 May 1959, based on a fingerprint report, the police report of death (Form 83), the preliminary examination form and the Victorian Institute of Forensic Medicine admission photograph and identification report.

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

Medical cause of death

16. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 18 July 2022 and provided a written report of her findings dated 23 August 2022.

17. The post-mortem examination revealed findings consistent with the medical history.

18. Examination of a post-mortem CT scan revealed multiple nodular lung and liver lesions, coronary artery and generalised calcifications and a distended bladder.

19. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

20. Dr Fronczek provided an opinion that the medical cause of death was "*1(a) Metastatic lung cancer*". Dr Fronczek concluded that the death was due to natural causes.

21. I accept Dr Fronczek's opinion.[3]

FURTHER INVESTIGATIONS

22. Following Mr Drowley's passing, I requested information from SVHM, Justice Health and a copy of the report by the Justice Assurance Review Office (**JARO**). I am satisfied that Mr Drowley's cancer was diagnosed promptly following reports of a lump on his neck, and he commenced medical treatment shortly thereafter. Mr Drowley received regular monitoring

[3] Pursuant to section 52(3A) of the Act, a coroner is not required to hold an inquest where the deceased was, immediately before death, a person placed in custody or care, if the coroner considers that the death was due to natural causes.

and treatment by the SVHM Oncology Unit, however his cancer was terminal and he subsequently passed away.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was David Drowley, born 23 May 1959;

    b) the death occurred on 14 July 2022 at St. Vincent's Public Hospital Melbourne, 41 Victoria Parade, Fitzroy, Victoria, 3065, from metastatic lung cancer; and

    c) the death occurred in the circumstances described above.

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:

Michael Drowley, Senior Next of Kin

Justice Assurance and Review Office

Justice Health

St Vincent's Hospital

Senior Constable Alexander Urano, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 20 November 2023

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.