IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 005313

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Mr N
Date of birth:	[redacted] 1959
Date of death:	14 September 2022
Cause of death:	1(a) Metastatic small cell lung carcinoma (palliated)
Place of death:	St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria
Key words:	Person placed in custody or care, metastatic small cell lung carcinoma, palliation, natural causes

At the direction of Coroner Sarah Gebert, the name of the deceased and his family members have been replaced with pseudonyms to protect their identities. Identifying details have also been redacted.

INTRODUCTION

1. On 14 September 2022, Mr N was 62 years old when he died in hospital from natural causes.

2. At the time of his death, Mr N was serving a custodial sentence.

THE CORONIAL INVESTIGATION

3. Mr N's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). 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. Victoria Police assigned Senior Constable Alexander Urano, to be the Coronial Investigator for the investigation of Mr N's death. The Coronial 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 brief of evidence.

7. This finding draws on the totality of the coronial investigation into Mr N's death, 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]

[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.

Background

8. Mr N had two children, AC and GL, with his first partner. They separated whilst the children were still young, and the children subsequently lived with their mother in Kyabram. Mr N visited them every couple of weeks.

9. Mr N's son, AC, recalled that he had a good relationship with his father. Sometimes, AC felt like he was the responsible adult in their relationship, telling his dad to *"pull his head in".* But they were mates.

10. In 1991, Mr N married PI. They later separated in 2003.

11. According to Senior Constable Urano, Mr N had a long history of police involvement which was generally in connection with his illicit drug use and/or theft and dishonesty related offending. He served multiple terms of imprisonment.

12. When not in prison, Mr N experienced homelessness and lived a transient life, never maintaining steady employment. In 2021, he moved to a one-bedroom flat in Sebastopol in Ballarat. AC stated that his dad got off drugs at this time.

13. In August 2022, Mr N was convicted of armed robbery and sentenced to 18 months imprisonment with a two-year Community Correction Order to commence following his release from custody. He was due to be released on 26 June 2023.

14. In addition to illicit drug use from a young age, Mr N's medical history included hepatitis C, epilepsy, emphysema, chronic obstructive pulmonary disease, and he smoked cigarettes.

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

Circumstances in which the death occurred

15. Whilst in custody at Ravenhall Correctional Facility, Mr N was transferred to St Vincent's Hospital due to worsening abdominal pain on 20 August 2022. Subsequent investigations revealed that Mr N was suffering from metastatic high grade small cell neuro-endocrine cancer.

16. According to Dr Genni Newnham, medical oncologist at St Vincent's Hospital, palliative treatment with combined chemo-immunotherapy was initially discussed with Mr N. However, his condition deteriorated and, in the end, he did not receive any active anti-cancer treatment.

17. His admission was also complicated by poorly controlled pain, episodes of rapid atrial fibrillation, and unstable blood sugar levels.

18. Mr N subsequently developed sepsis and multi-organ failure. On 31 August 2022, Mr N was transitioned to comfort care following discussion with his family.

19. Mr N passed away peacefully at 4.58pm on 14 September 2022.

Identity of the deceased

20. On 19 September 2022, Mr N, born [redacted] 1959, was formally identified via fingerprint identification.

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

Medical cause of death

22. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 15 September 2022 and provided a written report of his findings dated 28 September 2022.

23. The post-mortem examination revealed ascites, periportal lymph node metastases, liver metastases, pulmonary emphysema, left hilar lung mass, bilateral lung changes, and pleural effusions.

24. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Metastatic small cell lung carcinoma (palliated)"* and the death was due to natural causes.

25. I accept Dr Bouwer's opinion.

FURTHER INVESTIGATION

Department of Justice and Community Safety review

26. When a person dies in prison, the Department of Justice and Community Safety (**DJCS**) conducts a review of the circumstances and management of the death.

27. DJCS's review found the custodial management of Mr N met the required standards. His case manager met with him monthly, as per the relevant policy requirements. During these appointments, he developed local plan goals focused on employment, maintaining contact

with family, and resolving legal matters. He later developed additional goals relating to his health and remaining incident free.

28. In late May 2022, Mr N presented to medical staff with abdominal and shoulder pain.

29. Following persistent abdominal pain, he was reviewed by the medical officer (**MO**) on 15 June 2022. On assessment, there was mild tenderness noted in the upper abdominal region. The MO ordered an urgent ultrasound and blood tests.

30. However, the ultrasound was delayed due to the unavailability of the mobile ultrasound. Mr N was referred to St Vincent's Hospital radiology.

31. By 14 August 2022, Mr N presented to the nurse clinic citing sharp abdominal pain and he presented with possible jaundice. The ultrasound had not yet occurred.

32. Due to the unavailability of medical staff, the health services manager determined Mr N required hospitalisation. However, Mr N refused to go to hospital, stating that he would only go to hospital if a doctor deemed it necessary. Mr N subsequently completed a refusal of treatment form and was referred for an MO review.

33. On 15 August 2022, the MO reviewed Mr N, and identified a tender, firm epigastric mass. It was documented that he had abnormal fluid build-up, with fluid concentration in his flanks. Mr N was again referred to St Vincent's Hospital for urgent blood tests and an ultrasound.

34. On 18 August 2022, Mr N reported persistent abdomen tenderness and was referred for another MO review.

35. On 20 August 2022, Mr N attended the clinic in an unwell state. He was transferred to hospital for further management and assessment.

36. While DJCS noted that nurses followed up the ultrasound referral to St Vincent's Hospital on three occasions between 15 July and 15 August 2022, there were missed opportunities to undertake further follow-up on the ultrasound referral. Further, there appeared to be a period of one month where no action was taken.

37. Whilst DJCS identified an area for improvement, they found the overall healthcare and response provided by health staff appeared appropriate given Mr N was reviewed on each occasion when he reported issues of abdominal pain and was referred to hospital for further assessment/treatment where necessary.

Coroners Prevention Unit review

38. As part of my investigation, I also obtained advice from the Coroners Prevention Unit[2] (**CPU**) regarding the medical care Mr N received in the lead up to his death.

39. Upon reviewing the available medical records, the CPU advised that the first symptoms Mr N experienced was abdominal pain related to metastases.

40. There was no record of any earlier reported complaints that may have resulted in an earlier diagnosis (such as coughing up blood) and treatment that may have resulted in a different outcome.

41. The CPU concluded that medical care he received was reasonable.

42. I accept the CPU's conclusion.

FINDINGS AND CONCLUSION

43. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Mr N, born [redacted] 1959;

    (b) the death occurred on 14 September 2022 at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, from metastatic small cell lung carcinoma (palliated); and

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

[2] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

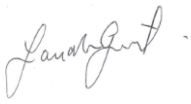
I convey my sincere condolences to Mr N's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published (in de-identified form) 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:

GL, senior next of kin
St Vincent's Hospital
Justice Health
Justice Assurance and Review Office
Correct Care Australasia Pty Ltd (care of Merdian Lawyers)
Senior Constable Alexander Urano, Victoria Police, Coroner's Investigator

Signature:



Coroner Sarah Gebert

Date: 08 August 2024

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.