IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006750

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Anthony George Creaton
Date of birth:	6 January 1967
Date of death:	24 November 2022
Cause of death:	1a: acute myocardial infarction 1b: coronary artery thrombosis due to coronary artery atherosclerosis 2: COVID-19 infection, cardiac hypertrophy
Place of death:	97 Riding Boundary Road, Ravenhall, Victoria, 3023
Keywords:	In custody – natural causes, prison healthcare

INTRODUCTION AND THE CORONIAL INVESTIGATION

1. On 24 November 2022, Anthony George Creaton (**Tony**) was 55 years old when he died at Ravenhall Correctional Centre **(Ravenhall)** from a heart attack.

2. Tony'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.

3. 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. A coroner need not hold an inquest if a person's death in care or custody was 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. Judicial Registrar Katherine Lorenz, then coroner, initially held carriage of this investigation. I took carriage of this matter upon my appointment in September 2024 and following Judicial Registrar Lorenz's departure.

7. This finding draws on the totality of the coronial investigation into the death of Anthony George Creaton. The Court was assisted by the provision of the Department of Justice and Community Safety's report of their review into the death.

8. 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

RELEVANT MEDICAL BACKGROUND

9. Tony had several chronic health conditions including asthma, high blood pressure, and non-insulin dependent diabetes.

10. Tony was taking the diabetes medications gliclazide, sitagliptin, and metformin, the heart medication perindopril, the reflux medication pantoprazole, and the antihistamine fexofenadine.

11. Tony had a needle phobia which contributed to his refusal to be vaccinated against COVID-19, recommended dental treatment, and regular blood tests.

12. Tony was assigned a medical M2 risk rating, which means that he had medical conditions requiring regular or ongoing treatment. Tony had a treatment plan with regular reviews.

13. However, Tony frequently refused the recommended care as outlined in his care plan including blood sugar monitoring. He also did not consistently collect his regular medication.

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

Circumstances in which the death occurred

14. On 13 November 2022, at around 9:34am, Tony reported to unit staff that he had chest pain. A Code Black was initiated, and Tony was assessed by a registered nurse.

15. Tony described his chest pain as a *"dull ache to central chest since 9pm last night"* and that it had progressively worsened, was worse laying down, and eased when burping.

16. Tony also reported that the pain started after his regular antacid was ceased and replaced with pantoprazole, another treatment for gastro-oesophageal reflux.

17. The nurse gave Tony an antacid and advised him to stay sitting after eating and to avoid trigger foods.

18. A further nursing review was scheduled for the following day. No referral was made to a medical officer.

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

19. At about 4:55pm, a further Code Black was called for Tony who stated: *"I can't breathe, my chest is killing me"*.

20. A different nurse reviewed Tony and documented that he had epigastric pain and headache. A Rapid Antigen Test (**RAT**) for COVID-19 returned a positive result and Tony was transferred to an isolation unit in accordance with COVID-19 guidelines.

21. No referral to a medical officer was made.

22. Nursing staff performed daily check-ins at the isolation unit.

23. On 14 November 2022, Tony again stated that he had chest pain that morning.

24. Nursing staff attributed this to COVID symptoms and planned to continue to monitor Tony.

25. Tony had an otherwise uneventful COVID-19 isolation and infection and was discharged from the isolation unit on 22 November 2022.

26. On 23 November 2022, Tony had bloods taken for an unrelated appointment earlier that month for his general healthcare.

27. On 24 November 2022, during morning count at about 7:20am, prison staff found Tony unresponsive. A Code Black was activated while staff immediately commenced CPR.

28. At about 7:26am, health staff arrived and took over resuscitative efforts.

29. At about 7:40am, paramedics from Ambulance Victoria attended who confirmed that, unfortunately, Tony was deceased and could not be revived.

Identity of the deceased

30. On 24 November 2022, Anthony George Creaton, born 6 January 1967, was visually identified by a staff member at Ravenhall Correctional Centre, who completed a statement of identification.

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

Medical cause of death

32. On 2 December 2022, Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an autopsy and provided a written report of the findings.

33. The autopsy showed significant cardiac findings including:

    a) Cardiac hypertrophy

    b) Resolving fibrinous pericarditis

    c) Pericardiac effusion

    d) Acute on subacute posterior left ventricular myocardial infarction

    e) Thrombosis of the right coronary artery

    f) Moderate coronary artery atherosclerosis (up to 50% occlusion)

    g) Patchy areas of subacute infarction of the right ventricle

34. Dr Archer considered that the cause of death was acute myocardial infarction due to sudden blockage of the right coronary artery by thrombus. The underlying reason for the thrombosis was likely to be coronary artery atherosclerosis. COVID-19 infection was considered to be a contributing factor, and cardiac hypertrophy was also considered to be a contributing factor. Dr Archer commented that the age of the myocardial infarction was difficult to determine, but changes ranged from in the order of approximately days to weeks.

35. Toxicological analysis of postmortem samples identified the presence of Tony's regular diabetes medications gliclazide and metformin. Trace paracetamol was also detected.

36. Postmortem biochemistry showed an elevated C-reactive protein at 102mg/L (reference range <5mg/L).

37. Postmortem microbiology did not detect COVID-19 nor any other viruses.

38. Dr Archer provided an opinion that the medical cause of death was:

    1(a) Acute myocardial infarction

    1(b) Coronary artery thrombosis due to coronary artery atherosclerosis

    Contributing Factors

    COVID-19 infection, cardiac hypertrophy

39. Having considered the available information, Dr Archer was of the opinion that the death was due to natural causes.

40. I accept Dr Archer's opinion.

FURTHER INVESTIGATIONS

Department of Justice and Community Safety Review

41. 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. This review was provided to the Court.

GEO-CCA joint Root Cause Analysis

42. The DJCS report advised that GEO Group Australia **(GEO)**, the group responsible for operating Ravenhall, and Correct Care Australasia **(CCA)**, the contracted primary healthcare provider, undertook a joint Root Cause Analysis (**RCA**) following Tony's death. The report noted that the RCA did not identify any root cause or contributing factors to the death nor were any system or process improvement opportunities identified.

43. However, on my review, I consider that the RCA was necessarily ineffective as the cause of death was not known by the authors. This was acknowledged in the report which found that *"that the root cause cannot be appropriately determined without a cause of death"*.

44. The RCA went on to say that its utility is limited to a review of the healthcare provided to Tony while at Ravenhall. While there was reference in the RCA to Tony's two reports of chest pain on 13 November 2022, there was no comment as to whether consideration should have been given to the cause of the chest pain being cardiac, as opposed to epigastric, nor was there reference to the CCA policy requiring medical review when a prisoner reports chest pain, discussed below.

45. I do not consider that any substantial weight can be given to the absence of findings or learnings from the RCA.

Challenges in meeting primary health needs

46. The DJCS report noted that Tony's diabetes was poorly controlled. A significant contributing factor was non-compliance with recommended health interventions and consistently failing to attend his recurring appointment at the diabetic clinic.

47. Health staff documented regular educational discussions with Tony about the importance of adherence to medications, maintaining general health, and attending appointments.

Response to chest pain was inappropriate and inconsistent with policy

48. The DJCS report explained that CCA's policy stated that patients who present with chest pain are to be immediately assessed by a medical officer. If a medical officer is unavailable, then an ambulance must be called, and the patient must be assessed by a paramedic to determine whether transfer to hospital is required.

49. The DJCS report found no evidence to suggest that the treating nurses considered contacting a medical officer for assessments on either occasion following the two Code Blacks, nor was an ambulance called.

50. The report went on to say that there was no evidence that there was any further assessment to determine that the pain was not cardiac related. It was identified that Tony's care and management in response to his reported chest pain was inconsistent with CCA's management of chest pain policy requirements.

51. The report also noted that CCA would no longer be the health service provider at Ravenhall, but that this was a learning opportunity for the newly appointed provider. No further recommendations were made by DJCS.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Anthony George Creaton, born 6 January 1967;

    b) the death occurred on 24 November 2022 at 97 Riding Boundary Road, Ravenhall, Victoria, 3023, from *acute myocardial infarction* secondary to *coronary artery thrombosis due to coronary artery atherosclerosis* with contributing factors *COVID-19 infection, cardiac hypertrophy*; and

c) the death occurred in the circumstances described above.

53. As noted above, Tony's death was reportable because, immediately before his death, he was a person placed in custody. Section 52 of the Act requires an inquest to be held in these cases, except in circumstances where the person is deemed to have died from natural causes.[2] This determination can be based on an opinion from the forensic pathologist that the death was from natural causes.[3]

54. I am satisfied that Tony died from natural causes, and I consider that no further investigation is necessary which would otherwise require an inquest. Accordingly, I have exercised my discretion under section 52(3A) of the Act to not hold an inquest.

55. As indicated by the DJCS review, the response to Tony's reported chest pain was inconsistent with CCA's management of chest pain policy. I consider that had appropriate action been taken in accordance with the policy, such as referral to a medical officer or calling an ambulance, it may have had a significant impact on Tony's wellbeing and potentially triggered further investigation for his suspected cardiac chest pain. Despite this, I cannot determine that this would have changed the ultimate outcome due to Tony's significant underlying co-morbidities.

56. However, I concur with the findings of the DJCS that this represents a learning opportunity for the newly appointed health provider.

COMMENTS

Pursuant to section 67(3) of the Act I make the following comments in connection with the death and relating to public health and safety:

[2] Section 52(3A) of the Act.
[3] Section 52(3B) of the Act.

1. Deficiencies in care by health service providers in prisons has been the subject of many coronial investigations and inquests.[4] People in custody have a right to quality healthcare that is equivalent to that in the community. The Healthcare Services Quality Framework[5] acknowledges that the State has a duty of care under the *Corrections Act 1986* to provide people in prison with access to reasonable medical care and treatment necessary for the preservation of health.

2. These deficiencies and rights are also reflected in the findings of the December 2022 Final report of the Cultural Review of the Adult Custodial Corrections System, *Safer Prisons, Safer People, Safer Communities*.[6]

3. The Victorian Government responded to the Cultural Review Report in March 2023 acknowledging the recommendation for a public health model for delivery and oversight of health services across the adult custodial corrections system. It noted that from 1 July 2023, primary health services at Dame Phyllis Frost Centre and Tarrengower Prison would be provided by public health services and that all mens public prisons would have a new primary health service provider. It also noted that the Department of Justice and Community Safety would otherwise continue to work with the Department of Health to support better health outcomes for people in custody.[7]

Pursuant to section 73(1B) of the Act, this finding must 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

[4] Specifically on the issue of private health service providers, see, for example, comments of Coroner McGregor in the Finding into the Passing of Veronica Nelson COR 2020 0021 at [881]; Comments of Coroner Peterson in the Finding into the Passing of Michael Suckling COR 2021 1217 at [319].

[5] Justice Health, "Health Services Quality Framework for Victorian Prisons 2025", available at https://www.corrections.vic.gov.au/being-in-prison/health-care/healthcare-services-quality-framework-for-victorian-prisons-2025

[6] "Cultural Review Report", Chapter 21, 687. Available at https://www.vic.gov.au/sites/default/files/2024-03/Final-Report-Cultural-Review-of-the-Adult-Custodial-Corrections-System.pdf

[7] Available at https://www.vic.gov.au/victorian-government-response-cultural-review-adult-custodial-corrections-system/cultural-review at pg. 8

GEO Group Australia

Correct Care Australasia, c/o Meridian Lawyers

Department of Justice and Community Safety

Signature:

Coroner Dimitra Dubrow

Date: 07 October 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.