IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000173

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Paul Arthur Phelps
Date of birth:	22 October 1947
Date of death:	9 January 2024
Cause of death:	COMPLICATIONS OF METASTATIC RENAL CANCER IN A MAN WITH MULTIPLE MEDICAL CO-MORBIDITIES
Place of death:	Port Phillip Prison 451 Dohertys Road Truganina Victoria 3029
Keywords:	Death in custody, natural causes

INTRODUCTION

1. On 9 January 2024, Paul Arthur Phelps was 76 years old when he died of natural causes at Port Phillip Prison.

THE CORONIAL INVESTIGATION

2. Mr Phelps' 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. At the time of his death, Mr Phelps was a person placed 'in care or custody' for the purposes of the Act. As such, section 52(2)(b) requires that an inquest be held into Mr Phelps death. However, an exception is provided by section 52(3A) such that an inquest need not be held where the coroner is satisfied that the death occurred due to natural causes.

4. I am satisfied that Mr Phelps' death occurred due to natural causes, removing the need to hold an inquest.

5. It remains that as a coroner, I am responsible 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. First Constable (FC) Joel Van de Velde was assigned as the Coronial Investigator for the investigation of Mr Phelps' death. FC Van de Velde conducted inquiries on my behalf and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Mr Phelps 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.

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

Background

8. In November 2020, Mr Phelps commenced a sentence of imprisonment of eight years. At this time, Mr Phelps had been diagnosed with multiple chronic illnesses including hypertension, hyperlipidaemia, non-Hodgkin's lymphoma, lung adenocarcinoma, renal cell carcinoma, and chronic kidney failure.

9. Mr Phelps spent the bulk of his sentence at Hopkins Correctional Centre in Ararat, but his poor physical health necessitated frequent visits to the St John's Unit[2] of Port Phillip Prison in Truganina and he had several admissions to St Vincent's Hospital Melbourne.

10. Mr Phelps was managed as a Urology and Oncology outpatient of St Vincent's Hospital Melbourne. At the St John's Unit of Port Phillip Prison, Mr Phelps received care from medical, nursing and allied health staff.

Circumstances in which the death occurred

11. On 10 November 2023, a family meeting was held to define goals for Mr Phelps' care. Due to his declining health, it became apparent that the efficacy of ongoing hospital admissions was questionable. Accordingly, Mr Phelps' family decided that he should remain at the St John's Unit and would receive end-of-life care once appropriate.

12. Throughout November and December 2023, Mr Phelps' condition deteriorated significantly. In January 2024, he demonstrated fluctuating and worsening confusion and drowsiness. Clinicians prioritised pain and symptom management.

13. On 8 January 2024, the medical officer ceased Mr Phelps' oral medications and commenced comfort care.

14. On 9 January 2024, at 7:08pm, during medication rounds, a custodial officer and nurse entered Mr Phelps' cell and found him unresponsive. The custodial officer activated a Code Black and additional custodial and health staff attended Mr Phelps' cell where, a short time later, a clinician declared Mr Phelps deceased.

[2] A medical unit within Port Phillip Prison.

15. On 21 August 2024, the Victorian Department of Justice and Community Safety finalised its review into Mr Phelps' death (**JARO review**). The JARO review found that the custodial management, including health care, provided to Mr Phelps was appropriate and met the required standards. The report did not make any recommendations in response to his death.

16. I am satisfied that the JARO review was comprehensive, and I agree with its conclusions.

Identity of the deceased

17. On 9 January 2024, Paul Arthur Phelps, born 22 October 1947, was visually identified by prison officer, Rhonda Pacula.

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

Medical cause of death

19. Forensic Pathologist, Dr Judith Fronczek, of the Victorian Institute of Forensic Medicine conducted an examination on 10 January 2024 and provided a written report of her findings dated 16 January 2024.

20. The post-mortem CT scan showed brain atrophy, right kidney tumour with metastatic lymph nodes and direct invasion into the peritoneum, right psoas muscle and duodenum. It also showed right hydronephrosis likely due to direct invasion of the kidney tumour into the right ureter, coronary artery calcifications, mitral valve and aortic valve calcifications and enhanced markings of the lower lobe of the left lung and of the upper lobe of the right lung.

21. Dr Fronczek provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF METASTATIC RENAL CANCER IN A MAN WITH MULTIPLE MEDICAL CO-MORBIDITIES. Dr Fronczek stated the death occurred due to natural causes.

22. I accept Dr Fronczek's opinion.

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 Paul Arthur Phelps, born 22 October 1947;

    b) the death occurred on 9 January 2024 at Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria, from COMPLICATIONS OF METASTATIC RENAL CANCER IN A MAN WITH MULTIPLE MEDICAL CO-MORBIDITIES; and

    c) the death occurred in the circumstances described above.

24. I find that Mr Phelps' died from natural causes.

25. I am also satisfied that there are no issues of concern connected with the care of Mr Phelps whilst he was in custody.

I convey my condolences to Mr Phelps' family for their loss.

I thank the Coronial Investigator and those assisting for their work in this investigation.

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:

Ms Judith Allan, Senior Next of Kin

St Vincent's Hospital Melbourne

Barwon Health

Victorian Department of Justice and Community Safety

FC Van De Velde, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 01 April 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.