IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005418

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	John Stuart Richards
Date of birth:	10 March 1943
Date of death:	13 September 2024
Cause of death:	1(a) Lung cancer
Place of death:	Port Phillip Prison, 451 Dohertys Road, Truganina Victoria 3029
Keywords:	Death in custody; natural causes

INTRODUCTION

1. On 13 September 2024, John Stuart Richards was 81 years old when he passed away at Port Phillip Prison (**PPP**) at Truganina, Victoria.

2. John's medical history included lung cancer (diagnosed in 2009), prostate cancer, metastatic cancer of unknown origin, chronic obstructive pulmonary disease (**COPD**), type 2 diabetes, chronic kidney disease and pyelonephritis, hypercholesterolaemia, cardiovascular diseases including hypertension, atrial fibrillation, cerebrovascular accident, ischaemic heart disease, atherosclerosis and vascular dementia.

3. John entered prison in April 2014. Upon entering prison, he disclosed his medical history as listed above and noted that he had had the lung cancer removed surgically, and did not receive chemotherapy. This condition was therefore considered to be resolved, however in 2016, John was diagnosed with metastatic cancer of an unknown origin. Since 2020, John was receiving palliative care in prison after suffering a stroke. His condition was regularly reviewed, and his care needs were increased as required.

THE CORONIAL INVESTIGATION

4. John'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.

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.

7. This finding draws on the totality of the coronial investigation into the death of John Stuart Richards. 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]

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

Identity of the deceased

8. On 13 September 2024, John Stuart Richards, born 10 March 1943, was visually identified by his carer, Rhonda Pacula.

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

Medical cause of death

10. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 16 September 2024 and provided a written report of her findings dated 26 September 2024.

11. The post-mortem examination revealed findings consistent with the reported circumstances.

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

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

14. I accept Dr Fronczek's opinion as to the medical cause of death.

Circumstances in which the death occurred

15. On 10 September 2024, a medical officer (**MO**) reviewed John and in keeping with John's wishes, changed the care plan to reflect that he wanted to receive comfort measures only and did not wish to be transferred to St Vincent's Hospital Melbourne. The MO prescribed subcutaneous pain management.

[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.

16. On 12 September 2024, an MO reviewed John and, pursuant to his verbal directions, completed an Advance Health Directive which formally documented John's wishes to be included on the 'Do Not Resuscitate' (**DNR**) register. The MO documented John's further wishes to remain in the St Johns sub-acute unit at PPP to receive end of life care, which was a familiar environment to him.

17. At about 9.20am on 13 September 2024, nursing staff administered medication and attended to John's hygiene needs. They documented that he displayed no signs of distress or discomfort. At 10.30am, nursing staff checked on John and again documented that he was not in distress or discomfort but noted a change of breathing to "*shallow and paused*".

18. At about 10.40am, John stopped breathing, and a Code Black was immediately called. As John was registered on the DNR list, resuscitation was not attempted, and John was confirmed deceased at 10.53am.

19. Victoria Police attended PPP as per standard protocol and investigated the circumstances of John's passing. Police did not identify any suspicious circumstances or signs of third-party intervention in connection with his death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was John Stuart Richards, born 10 March 1943;

    b) the death occurred on 13 September 2024 at Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria 3029, from *1(a) lung cancer*; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to John'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.

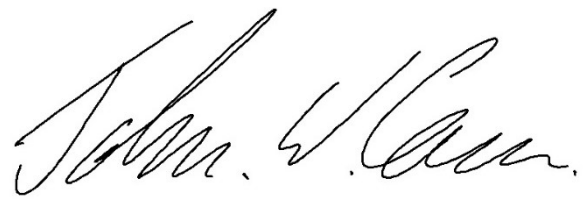
I direct that a copy of this finding be provided to the following:

Grant Richards, Senior Next of Kin

Justice Assurance Review Office

Constable Mackenzie Singleton, Coronial Investigator

Signature:



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Judge John Cain

State Coroner

Date: 4 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.