IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 4938

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*
*Section 67 of the Coroners Act 2008*

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| Findings of: | **JUDGE SARA HINCHEY, STATE CORONER** |
| Deceased: | **ARTHUR FARRELL SYDNEY** |
| Date of birth: | 17 April 1941 |
| Date of death: | 28 September 2015 |
| Cause of death: | Acute myocardial infarction and ischaemic coronary artery disease, with the contributing factor of diabetes mellitus |
| Place of death: | Port Phillip Prison, Truganina, Victoria |
| Catchwords: | Deceased person in custody or care; natural causes. |

**TABLE OF CONTENTS**

**HER HONOUR:**

## BACKGROUND

1. Arthur Farrell Sydney (**Mr Sydney**) was a 74-year-old man who was in custody at Port Philip Prison at the time of his death. He was married to Elizabeth Sydney for over 30 years prior to his death.

2. Mr Sydney's known past medical history included type 2 diabetes mellitus, high blood pressure and a history of myocardial infarction (in 1985), prostate cancer (in 2007), triple bypass (in 2009), vascular disease, chronic and worsening kidney disease (which was considered to likely require dialysis in the near future), foot ulcer (related to peripheral vascular disease) and angina.

3. Mr Sydney had managed his diabetes for many years, including self-administering insulin four times daily.

4. On 15 June 2015, Mr Sydney's consulting vascular surgeon stated that his chance of progressive atheroma was high.[1]

5. On 24 August 2015, Mr Sydney was sentenced to eight years and six months in prison. He had served approximately one month of his sentence at the time of his death.

6. During his short term of imprisonment, Mr Sydney was placed at three different prisons and transferred to hospital twice for medical reasons.

7. On 2 September 2015, Mr Sydney was transferred to the East Grampians Medical Centre for review. His blood pressure medications were adjusted on this occasion.

8. From 16-22 September 2015, Mr Sydney was hospitalised at St. Vincent's Hospital, after reporting feeling unwell. The discharge summary noted his diagnosis as hypercalcaemia (high calcium levels) in the setting of chronic kidney disease, likely due to his medications. Further outpatient appointments were planned with the Cardiology and Renal Clinics.

[1] Coronial brief, p53.

9. On 22 September 2015, Mr Sydney was discharged from St Vincent's Hospital back to Port Philip Prison. On 28 September 2015, Mr Sydney was found unconscious in his cell and was unable to be revived.

10. On 1 October 2015, Mr Sydney's family wrote to the Court outlining concerns about Mr Sydney's health management while imprisoned. Their concerns are also outlined in the statement of Doug Creswell.[2] They alleged that:

    (a) Mr Sydney was not receiving all of his daily medications, including an alleged change in his insulin regime;

    (b) Mr Sydney's diabetic dietary needs were not being met;

    (c) Mr Sydney was not provided a sleep apnoea machine in prison;

    (d) the prison failed to seek treatment for Mr Sydney's vomiting for approximately five days;

    (e) there were inconsistent reports regarding Mr Sydney's insulin administration (whether he had self-administered or the prison nurse had administered the insulin);

    (f) Mr Sydney was kept in a small cell with no disabled facilities; and

    (g) Mr Sydney appeared confused in the days before his death, which they believed may have been due to changes in his medications.

11. I have considered these concerns and have determined that some of the concerns fall outside the scope of the coronial jurisdiction. The remainder of concerns identified did not cause the death, however I make comments about the further investigation of the relevant concerns in the comments section of this finding.

[2] Coronial brief, p10.

## THE PURPOSE OF A CORONIAL INVESTIGATION

12. The role of a coroner is to investigate reportable deaths to establish, if possible, the identity, of the deceased, the medical cause of death and, with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability.[3]

13. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[4] The *Coroners Act 2008* (Vic) (**the Act**) provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[5]

14. Mr Sydney's death constituted a '*reportable death*' under the Act, as the death occurred in Victoria and, at the time of their death, he was a person considered to be "*in custody*".[6]

15. The Act provides that a coroner must hold an inquest into all deaths which occurred while a person is "*in custody or care*",[7] except in those circumstances where the death is considered to be due to natural causes.[8]

16. In accordance with section 52(3B) of the Act, a death may be considered to be due to natural causes if the coroner has received a report from a medical investigator, in accordance with the *Coroners Court Rules* 2009, that includes an opinion that the death was due to natural causes. I have received such a report in this case. Therefore, I limit my findings with respect to the circumstances in which the death occurred and exercise my discretion not to hold an inquest.

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[3] In the coronial jurisdiction facts must be established on the balance of probabilities 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.
[4] Section 89(4) *Coroners Act 2008.*
[5] See Preamble and s 67, *Coroners Act 2008*.
[6] Section 3 and 4 *Coroners Act 2008.*
[7] Section 52(2)(b) of the *Coroners Act 2008*.
[8] Section 52(3A) of the *Coroners Act 2008.*

## MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

### Identity of the Deceased, pursuant to section 67(1)(a) of the Act

17. On 30 September 2015, Mr Sydney was identified by his step-son, Douglas Cresswell, as being Arthur Farrell Sydney, born 17 April 1941.

18. Identity was not in issue and requires no further investigation.

### Medical cause of death, pursuant to section 67(1)(b) of the Act

19. On 1 October 2015, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Mr Sydney's body and provided a written report, dated 23 November 2015. In that report, Dr Dodd concluded that a reasonable cause of death was '*1(a) acute myocardial infarct, 1(b) ischaemic coronary artery disease and contributing factors of diabetes mellitus*'.

20. Toxicological analysis of the post mortem samples taken from Mr Sydney identified the presence of glucose at approximately 4.3 mmol/L, paracetamol at approximately 12 mg/L, sodium and chloride ions and elevated creatinine and urea levels.

21. Dr Dodd reviewed the toxicology report and made the following comments in his report:

    (a) the sodium and chloride ions were essentially within normal limits;

    (b) the creatinine and urea levels were elevated, which indicated a state of renal impairment; and

    (c) calcium and magnesium ions were requested with the magnesium level being "*slightly*" elevated.

22. On the basis of the information available at the time of completing his report, Dr Dodd provided an opinion that Mr Sydney's death was due to natural causes.[9]

[9] Medical Examiner's Report, page 13.

**Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act**

23. At approximately 9.00am on 28 September 2015, Mr Sydney presented to the Nurse Clinic for his usual blood-glucose monitoring and insulin administration. He was also issued with a laxative. Mr Sydney did not report any health concerns to the nurse during this visit.

24. At approximately 10.00am, Mr Sydney told his cellmate that he was going to use the toilet. Mr Sydney's cellmate then left the cell.

25. At approximately 10.30am, Mr Sydney's cellmate returned and found Mr Sydney slumped over the toilet, vomiting. The cellmate notified staff, who activated a '*Code Black*' (Medical Emergency call).

26. The medical response team attended Mr Sydney immediately, removing him out of the cell and onto the floor, where he then became unconscious. An ambulance was called and emergency resuscitation measures were commenced, including cardiopulmonary resuscitation (**CPR**), intravenous fluid therapy and application of an automatic external defibrillator.

27. The first of two ambulances arrived at 10.48am. The air ambulance arrived at 10.50am.

28. Mr Sydney could not be revived and CPR was ceased at 10.59am. The attending medical practitioner declared Mr Sydney deceased at 11.08am.

**COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT**

29. The Office of Correctional Services Review (**OCSR**) reviewed Mr Sydney's death and health care. A report was provided which concluded that:

    (a) "*the holistic management of Mr Sydney was appropriately managed in line with prescribed procedures*"; and

    (b) the "*incident response and aftermath of (his) death was well managed by Port Phillip Prison*".

30. Justice Health also reviewed Mr Sydney's healthcare and medical management and the circumstances of his death. A report was prepared in which no recommendations were made for systemic improvements arising from Mr Sydney's death in custody.

31. In light of the family's concerns, I sought further information from the OCSR regarding Mr Sydney's diet and medical management. I also referred the matter to the Coroners Prevention Unit (**CPU**) for an opinion as to whether Mr Sydney's medical management (including diabetes diet and insulin management) and subsequent myocardial infarction was linked in any way.

32. The CPU is an internal unit of the Court which employs, amongst others, independent healthcare professionals to review files and medical records and to provide an opinion regarding medical treatment/management. An independent healthcare professional at the CPU reviewed Mr Sydney's records and provided a short report (**the CPU report**) which concluded that:

    (a) Mr Sydney's medical management was appropriate; and

    (b) his myocardial infarction was due to disease progression and not associated with his medical care.[10]

33. The CPU report noted:

    (a) that the three corrections facilities that Mr Sydney was housed in provided him with healthy diabetic diet options and encouraged him to take those options to maintain a healthy blood-glucose level; and

    (b) "*although long-term optimal glucose control is important to reduce the risk and progression of coronary artery disease, short term changes in glucose level would not in themselves cause a myocardial infarction.*"

34. Having considered the evidence I am satisfied that no further investigation is required.

35. I am satisfied that Mr Sydney's medical care and management was reasonable and appropriate and that there are no prevention issues arising from the circumstances of Mr Sydney's death.

[10] CPU report dated 8 March 2017.

**FINDINGS AND CONCLUSION**

36. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Arthur Farrell Sydney, born 17 April 1941;

    (b) the death occurred on 28 September 2015 at Port Phillip Prison, Truganina, Victoria, from acute myocardial infarction and ischaemic coronary artery disease, with the contributing factor of diabetes mellitus; and

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

37. I convey my sincerest sympathy to Mr Sydney's family.

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

    (a) Elizabeth Sydney, senior next of kin;

    (b) Detective Senior Constable Matt Jerabek, Victoria Police, Coroner's Investigator;

    (c) Office of Correctional Services Review;

    (d) Justice Health;

    (e) St. Vincent's Health.

39. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the *Coroners Court Rules* 2009.

Signature:


**JUDGE SARA HINCHEY**
**STATE CORONER**
**DATE: 24 MAY 2017**