IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 000072

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**DAMIEN NOBILE**
Date of birth:	14 September 1978
Date of death:	4 January 2016
Cause of death:	1(a) ACUTE EPIGLOTTITIS CONTRIBUTING FACTORS CORONARY ARTERY ATHEROSCLEROSIS
Place of death:	Ararat Medical Centre, Ararat, Victoria

HER HONOUR:

Background

1. Damien Nobile was born on 14 September 1978. He was 37 years old when he died unexpectedly in custody from acute epiglottitis.[1]

2. On 3 December 2015 Mr Nobile was received into custody at the Hopkins Correctional Centre for breach of a parole order. He resided with two cellmates, Joshua Escott and Christopher Berry.

3. Mr Nobile had a medical history of back pain, migraine, anxiety, left-sided tonsillectomy[2] and episodes of bowel obstruction following an appendectomy. He smoked 25-30 cigarettes a day. In the two days prior to his death he had a sore throat which was treated conservatively with analgesia.

The coronial investigation

4. Mr Nobile'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 have a natural cause but occur in custody, as in this case.

5. Coroners independently investigate reportable deaths to find, if possible, identity, 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. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[3]

6. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

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1 A rapidly progressive inflammation of the epiglottis (the flap of tissue at the base of the tongue which covers the trachea during swallowing), usually caused by bacteria. Swelling of tissues around the epiglottis is associated with fever, difficulty swallowing, drooling, hoarseness of voice and stridor. It may lead to abrupt blockage of the upper airway and death.

2 According to Mr Nobile's cellmate Joshua Escott this was due to a lymphoma 'throat cancer'. His general practitioner Dr Prasad Fonseka stated that it was *'due to ulceration (pt could not give the histological diagnosis)'*.

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.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Nobile's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence. I also received a report into Mr Nobile's death from the Office of Correctional Services Review, which included a Justice Health review of Mr Nobile's health care whilst in custody.

9. I also referred the matter to the Coroners Prevention Unit (**CPU**) for review of Mr Nobile's medical management. The CPU is staffed with independent physicians and healthcare professionals. Its role is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. I also received a copy of report from the Office of Correctional Services Review (**OCSR**) into Mr Nobile's death.[4]

10. Mr Nobile's death was reportable because it was unexpected but also because he was in prison at the time of his death. Deaths of persons in prison are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes a coronial investigation must take place but the holding of an inquest is not mandatory.

11. Having considered all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. I also determined that as Mr Nobile's care at Hopkins Correctional Centre was reasonable and he died of natural causes there was no public interest in holding an inquest.

Circumstances in which the death occurred

12. Mr Nobile presented to the medical centre at Hopkins Correctional Centre on 4 January 2016 at 2.42pm. He complained of suffering a sore throat for the previous two days, a bad taste in his mouth and difficulty swallowing.

4 Formerly the Office of Correctional Services Review (OCSR), now known as the Justice & Assurance Review Office (JARO).

13. He was reviewed by Dr Fonseka who examined his throat. There was minor inflammation around the right tonsil. Vital signs do not appear to have been documented in the medical record, but were apparently normal. It was thought Mr Nobile did not have a bacterial infection so he was treated symptomatically with simple analgesia and advised to return to the medical centre if symptoms persisted.

14. Mr Nobile was taking celebrex (an anti-inflammatory medication) and paracetamol. A salbutamol inhaler was prescribed at an asthma consultation on 3 December 2015, which appears to have been used only once. No previous record of asthma appears in Mr Nobile's medical history.

15. At approximately 8.20pm Mr Nobile called the control room from his cell and reported difficulty breathing and said his throat was swelling up. He requested medical review. A registered nurse attended the unit at approximately 8.30 or 8.35pm, after reviewing Mr Nobile's medical history. She reviewed Mr Nobile through the trap door to his cell. According to the medical record of this attendance Mr Nobile was talking and breathing without difficulty. No vital signs were taken. The nurse asked whether Mr Nobile had taken drugs, eaten any food to which he may be allergic or suffered a spider bite. He responded 'no' to these questions. She noted that Dr Fonseka had seen Mr Nobile that afternoon and that no orders for antibiotics or other treatment were made because it was not considered that he had a bacterial infection. Mr Nobile was very anxious so the nurse reassured him and a medical review at 9.00am the following morning was planned.

16. By 9.30pm Mr Nobile had deteriorated. His cellmate Mr Escott recalled that Mr Nobile was *'getting cold and shaky and he started to freak out'*. He was spitting, couldn't breathe and was *'looking at [Mr Escott] as if he was a kid, he was really scared, he started to cry'*. At 9.45pm Mr Nobile's cellmates used the intercom and stated that Mr Nobile had trouble breathing and could no longer talk. The officer in the control room said he would attend to the request, but nobody assisted.

17. At 9.50pm Mr Nobile's cellmates again used the intercom to contact staff. A different officer, who was unaware of the previous request, answered the call. Mr Escott and Mr Berry were frustrated and requested *medical* to attend the cell quickly as Mr Nobile was *'hysterical'*, struggling to breathe, suffering a panic attack and had *'the chills'*. At this time a

fire alarm was sounding in another unit so prison officers had been dispatched there to investigate.

18. At 10.01pm the supervisor and a prison officer arrived at the cell door. The same nurse was radioed and her immediate attendance was requested. She initially declined to attend, but relented when she *'sensed urgency'* in the custodial officer's voice.

19. On her arrival at the unit the cell door was open and three custodial officers were present. The nurse could hear Mr Nobile wheezing on inspiration. He had not been wheezing during her previous attendance. She believed Mr Nobile was suffering from asthma. After some discussion about the necessity for an ambulance, the nurse arranged for Mr Nobile to be taken to the on-site medical centre by motorised buggy. On arriving at the medical centre at 10.15pm Mr Nobile was noted to have difficulty breathing and to be wheezing and panicking. He was given oxygen and a salbutamol nebuliser. Oxygen saturations were noted to be 97% and no other vital signs were recorded.

20. Ambulance Victoria were called at 10.25pm and paramedics arrived at the medical centre at 10.40pm. Initial vital signs showed severe tachycardia of 140 beats per minute and severe respiratory distress with a rate of 40 breaths per minute. Mr Nobile was treated with oxygen, salbutamol, ipratropium bromide and adrenaline. He was transported to the East Grampians Health Service in Ararat by code one ('lights and sirens').

21. On arrival at East Grampians Health Service Mr Nobile went into cardiorespiratory arrest. He was treated according to Advanced Life Support protocols but could not be resuscitated. Mr Nobile was declared deceased at 11.31pm on 4 January 2016.

Identity of the deceased

22. Mr Nobile was visually identified by Leo Harrington, Operations Manager at Hopkins Correctional Centre, on 5 January 2016. Identity was not in issue and required no further investigation.

Medical cause of death

23. On 6 January 2016, Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy on the body of Damien Nobile after reviewing a post mortem CT scan.

24. The autopsy revealed a swollen, erythematous[5] epiglottis with fibrin[6] deposition and abscess formation, heavy and congested lungs with dirty pulmonary oedema,[7] slight cardiomegaly,[8] moderate narrowing of the left anterior descending and right coronary arteries and an absent appendix.

25. Toxicological analysis of post mortem specimens taken from Mr Nobile was non-contributory.

26. After reviewing toxicology results, Dr Baber completed a report, dated 18 February 2016, in which she formulated the cause of death as '1(a) acute epiglottitis' with a contributing factor of coronary artery atherosclerosis. Dr Baber was of the opinion, and I accept, that Mr Nobile's death was due to natural causes. I accept Dr Baber's opinion as to the medical cause of death.

Adequacy of Mr Nobile's medical assessment on 4 January 2016

27. The CPU considered that Dr Fonseka's assessment at 2.42 pm appeared reasonable, although the lack of documentation of vital signs was regrettable and prevented a conclusive review of his treatment.

28. The main issue identified by the CPU was the nurse's assessment at 8.30 pm. It was unsatisfactory that the assessment occurred through the cell trap door without vital signs being taken. A more detailed clinical review was required. The nurse's documentation of this attendance is very brief and does not reflect the two cell mates' description of Mr Nobile's state at that time.

29. Correct Care Australasia provided a statement to the Court through their solicitors.[9] It advised that it undertook a debriefing case review with relevant medical staff at the Hopkins Correctional Centre following Mr Nobile's death.

30. The case review identified the following issues:

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5 Red.
6 Insoluble protein formed when blood coagulates.
7 Fluid accumulation in the lungs.
8 Enlarged heart.
9 Provider of healthcare services in Australian prisons.

- Because the request for health staff to attend Mr Nobile at the unit was not characterised by corrections staff as a Code Black or resuscitation situation, the nurse did not take any medical equipment with her to assess the prisoner;

- It was difficult to assess the prisoner on the nurse's first attendance as the cell was not opened by corrections staff, so assessment occurred via the trap door; and

- The clinical records would have been enhanced with additional detail regarding event times and clinical review undertaken.

31. As a consequence of this review, Correct Care have since made the following changes to their processes:

- Hopkins Correctional Centre Medical Clinic introduced a minor response bag for nurses to take with them when they attend to assess prisoners away from the clinic. The minor response bag includes equipment for the nurse to undertake a range of clinical observations and vital signs. It is designed to be lightweight and can be easily carried by nursing staff. Correct Care reviewed all emergency response bags across its sites, and is currently standardising these as much as possible. The sites will have a minor response bag to attend a request to review a prisoner and an emergency response bag to attend to a code black or resuscitation situation;

- Correct Care Health Service Managers reiterated to their nursing staff the importance of nurses requesting corrections staff to open cells if the nurse considers it is required to undertake a physical review of the prisoner;

- Correct Care developed a *'Medical & Nursing Response Record'* form for health staff to promote contemporaneous documentation of information at the time of reviewing a prisoner in their cell/unit and to prompt the staff to record vital signs and other relevant information. The pro forma response record is available in the minor response bag and the emergency response bag.

32. I acknowledge that there are difficulties in the assessment and management of patients in custodial care. However, a sentence of imprisonment does not mandate inferior health care. To the contrary, prisoners are entitled to access the same level of medical treatment as the

rest of the community. Custodial medical and nursing staff always need to be mindful of this fact.

33. It is apparent that Mr Nobile did not receive the medical care to which he was entitled. However, it is not clear whether a more thorough review at 8.30pm, or indeed, any different medical treatment would have altered his outcome. Given the review and improvements that have been implemented by Correct Care I am satisfied there is no need to make any recommendations in this case.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Damien Nobile, born 14 September 1978;

(b) Mr Nobile died on 4 January 2016 at East Grampians Health Service, Ararat, Victoria, from acute epiglottitis with contributing factors of coronary artery atherosclerosis;

(c) his death was due to natural causes; and

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

Publication

Given this death occurred in custody and the death was due to natural causes I direct that this finding be published on the Internet pursuant to section 73 (1B) of the *Coroners Act 2008*.

I convey my sincere condolences to Mr Nobile's family.

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

Ms Sharon Stiles, Joint Senior Next of Kin

Mr Frank Nobile, Joint Senior Next of Kin

Office of Justice Assurance & Review Office

Correct Care Australasia, c/- Meridian Lawyers

Senior Constable Chris Ryan, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 9 March 2018