

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2013 1953

**FINDING INTO DEATH WITH INQUEST**

*Form 37 Rule 60(1)*

*Section 67 of the Coroners Act 2008*

**Inquest into the Death of: EDWARD TAPPE**

Delivered On:	20 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Date:	20 May 2014
Finding Of:	AUDREY JAMIESON, CORONER
Police Coronial Support Unit	Leading Senior Constable Andrea Hibbins

I, AUDREY JAMIESON, Coroner having investigated the death of **EDWARD TAPPE**

AND having held an inquest in relation to this death on 20 May 2014

at MELBOURNE

find that the identity of the deceased was **EDWARD TAPPE**

born on 27 March 1955

and the death occurred on 5 May 2013

at St Augustine's Ward, St Vincent's Hospital, 41 Victoria Parade, Fitzroy 3065

**from:**

1 (a) METASTATIC COLORECTAL CANCER

**in the following circumstances:**

1. On 20 May 2014, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act) was held into the death of Mr Edward Tappe, because immediately before his death, Mr Tappe was "a person placed in....care" as it is defined in the Act. Mr Tappe had been in prison since 2003 for convictions related to sexual offences.

#### **BACKGROUND AND CIRCUMSTANCES**

2. Mr Tappe was 58 years of age at the time of his death. He resided in Prison immediately prior to his death and had a close relationship with his ex-wife, Ms Elizabeth Braddock. He had three children from another relationship.
3. Mr Tappe had served eight terms of imprisonment at the time of his death, mostly related to sexual offences. He was remanded to the Melbourne Assessment Prison on 17 December 2003, sentenced on 23 April 2004 and subsequently transferred to Port Phillip Prison. He was transferred to Hopkins Correctional Centre on 9 February 2005 and remained there until 26 July 2011 when he was returned to Port Phillip Prison for medical treatment. On 29 February 2012, he was transferred to Langi Kal Kal Prison and on 24 October 2012 was returned to Port Phillip Prison and admitted to St Augustine's Ward, St Vincent Hospital.
4. Mr Tappe had a past medical history that included a left total hip replacement, acute myocardial infarction and chronic obstructive pulmonary disease. He was diagnosed with colorectal cancer in July 2011 at St Augustine's Ward of St Vincent's Hospital. He

underwent a right hemicolectomy and completed seven chemotherapy cycles before expressing that he no longer wished to undergo this treatment. He refused treatment from February 2012 until he was transferred to St Vincent's Hospital in October 2012, when he experienced an episode of acute abdominal pain. Radiological investigations demonstrated new areas of metastatic cancer. Palliative chemotherapy recommenced and he received palliative care input for the management of his symptoms. Repeat radiological tests on 19 March 2013 showed further progressive disease.

5. On 17 April 2013, Mr Tappe was admitted to St Augustine's Ward for management of severe abdominal pain. He received palliative care and died on 5 May 2013.

### **FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE**

6. Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. No evidence of other disease or injury was identified. Dr Bedford ascribed the cause of Mr Tappe's death to metastatic colorectal cancer.

### **POLICE INVESTIGATION**

7. The circumstances of Mr Tappe's death have been the subject of investigation by Victoria Police. Police obtained statements from Ms Braddock and St Vincent's Correctional Health Service's Acting Clinical Director Dr Bruce McLaren. Reports were obtained from Justice Health and the Office of Correctional Services Review (OCSR).
8. The OCSR report identified two minor delays following Mr Tappe's death – one relating to a delay in reporting Mr Tappe's death to the Coroners Court of Victoria (CCOV), the other relating to a delay in contacting Mr Tappe's next of kin.
9. The OCSR report identified that a delay in contacting the CCOV of approximately four hours occurred due to a misunderstanding between the relevant Correctional Officer and St Vincent's Hospital. The Port Phillip Prison Duty Manager subsequently notified the CCOV.
10. The OCSR noted the delay in contacting Mr Tappe's next of kin occurred as the Prisoner Information Management System was offline at the time of his death. Staff contacted Port Phillip Prison to obtain Mr Tappe's next of kin information from his Individual Management File. The OCSR review recommended staff to record next of kin details on the

*St Augustine New Admission of a Prisoner* form. Port Phillip Prison adopted this recommendation on 10 May 2013.

## **FACTORS CAUSING OR CONTRIBUTING TO DEATH**

11. The evidence supports a conclusion that Mr Tappe died on 5 May 2013 and that the cause of his death was metastatic colorectal cancer. The circumstances under which Mr Tappe died were, according to the pathologist, consistent with Mr Tappe's relevant past medical history. There was no evidence to suggest any other cause or contribution to his death. Mr Tappe died from natural causes related to his underlying progressive disease.

## **FINDING**

I am satisfied that the administrative changes introduced by Port Phillip Prison in May 2013 were adopted with the aim of preventing a similar delay in contacting a deceased prisoner's next of kin in the future.

I accept and adopt the medical cause of death as ascribed by Dr Paul Bedford and I find that Edward Tappe died from natural causes being metastatic colorectal cancer.

AND I further find that there is no relationship between the cause of Mr Tappe's death and the fact that he was "a person placed in care".

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the following be published on the internet.

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

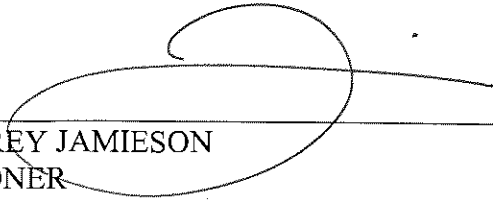
Ms Elizabeth Braddock

Ms Melanie Kyezor, Clinical Risk Manager, St Vincent's Health

Mr Jonathan Kaplan, Office of Correctional Services Review

Senior Constable M Arsic

Signature:



AUDREY JAMIESON  
CORONER  
Date: 20 May 2014

