IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 0410

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of HENRY FRANCIS OAKLEY

without holding an inquest:
find that the identity of the deceased was HENRY FRANCIS OAKLEY
born 20 August 1930
and the death occurred on 29 January 2016
at St Vincent's Hospital Melbourne, 41 Victoria Parade, Fitzroy Victoria 3065
from:

1 (a) PNEUMONIA

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Henry Francis Oakley was 85 years of age at the time of his death. He was a long term inpatient at St John's Hospital at Port Phillip Prison. Mr Oakley's medical history included ischaemic heart disease, chronic obstructive pulmonary disease, atrial fibrillation and dementia. He was prescribed medications including amitriptyline, risperidone, esomeprazole and sertraline.

2. In December 2015, Mr Oakley developed a likely lower respiratory tract infection, which lasted several weeks, despite treatment with oral antibiotic therapy. At approximately 6.00pm on 28 January 2016, Mr Oakley was found shivering by nursing staff at St John's Hospital, Port Phillip Prison, with a reduced Glasgow Coma Scale (GCS) [1] score and tachypnoea. He was transferred by ambulance to the Emergency Department (ED) at St Vincent's Hospital Melbourne, and assessed to have a GCS of 6. Mr Oakley's chest x-ray revealed left sided consolidation and auscultation found bibasal crepitations. He was commenced on treatment with intravenous fluids, ceftriaxone and azithromycin.

3. Mr Oakley arrived at the hospital with a clearly documented advanced care plan which stated he did not wish to have life prolonging treatments. Given Mr Oakley's sudden and serious deterioration; significant medical comorbidities; and failure to respond to treatment measures in the ED; the decision was made to withdraw active management of his lower respiratory chest infection. Mr Oakley was palliated and provided with comfort measures for end of life care. At 2.05am on 29 January 2016, Mr Oakley was declared deceased.

4. Mr Oakley's death was reportable pursuant to section 4 of the Coroners Act 2008 (Vic) ('the Act') because he was immediately before death a person placed in custody, as defined by section 3 of the Act.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Mr Oakley, reviewed a post mortem computed tomography (CT) scan and e-medical deposition form from St Vincent's Hospital Melbourne, and referred to the Victoria Police Report of Death, Form 83. Dr Lynch noted that the CT scan revealed sternal wires and increased lung markings on the left side. Toxicological analysis of post mortem blood detected morphine,[2] hydroxyrisperidone,[3] amitriptyline and its

[1] The Glasgow Coma Scale is a quick, practical standardised system for assessing the degree of conscious impairment in the critically ill and for predicting the duration and ultimate outcome of coma, primarily in patients with head injuries. The scale is now measured out of 15, with 15/15 being the best possible score.

[2] Morphine is a narcotic analgesic used to treat moderate to severe pain.

[3] 9-hydroxyrisperidone (paliperidone) is the metabolite of risperidone, which is an atypical antipsychotic prescribed for schizophrenia and some behavioural disorders.

metabolite nortriptyline,[4] and sertraline.[5] On the basis of the information available to him, Dr Lynch ascribed the cause of Mr Oakley's death to natural causes, being pneumonia.

Police investigation

6. Senior Constable (SC) Rohan Frost, the nominated coroner's investigator,[6] conducted an investigation of the circumstances surrounding Mr Oakley's death, at my direction, including the preparation of the coronial brief. Upon attending St Vincent's Hospital Melbourne following Mr Oakley's death, police did not find any evidence of third party involvement.

7. The summary to the coronial brief indicated that Mr Oakley was sentenced to four years imprisonment relating to historical sex offences on 10 April 2014. He was received into the custody of Corrections Victoria on this date.

8. Mr Oakley suffered from dementia and his progressively deteriorating condition of pneumonia caused him to move from Langi Kal Kal Prison, to Hopkins Correctional Centre, and finally to St John's Hospital at Port Phillip Prison, where he was a long term inpatient from 3 December 2014 to 28 January 2016.

Department of Justice and Regulation - Office of Correctional Services Review

9. By way of letter dated 5 May 2016, Emma Catford, Director at the Office of Correctional Services Review (OCSR) provided the Court with a report inclusive of an overview of Mr Oakley's management in custody and the circumstances of his death. The report also included a review conducted by Justice Health of Mr Oakley's health management.

10. The OCSR reviewed the death of Mr Oakley and concluded that his management during his final term of imprisonment was appropriate and that the prison responded promptly and effectively in managing the circumstances around his death. There were no recommendations arising from the OCSR and Justice Health reviews of Mr Oakley's death.

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[4] Amitriptyline is used to treat depression – it is metabolised to nortriptyline, which is also active as an anti-depressant.

[5] Sertraline is an anti-depressant drug for use in cases of major depression.

[6] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

COMMENT

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Section 52 of the Act mandates the holding of an Inquest if the deceased was, immediately before death, a person placed in custody, save for circumstances where the person is deemed to have died from natural causes, pursuant to section 52(3A). In the circumstances, noting that Dr Lynch has opined that Mr Oakley's death was the result of natural causes, being pneumonia, it is therefore appropriate to conclude the investigation by way of an in-chambers Finding.

FINDINGS

The investigation has identified that Mr Oakley was suffering from multiple co-morbidities throughout his term of imprisonment, and that his health declined significantly in the last weeks of his life. On the evidence available to me, I find that the provision of care to Mr Oakley during his imprisonment at St John's Hospital at Port Phillip Prison, and at the St Vincent's Hospital, appears to have been reasonable and appropriate. I further find that there was no causal connection between the fact that Mr Oakley was a person placed in custody and the cause of his death.

I accept and adopt the medical cause of death as identified by Dr Matthew Lynch and find that Henry Francis Oakley died from natural causes, being pneumonia.

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

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

Mr Alan Oakley
Ms Emma Catford, Office of Correctional Services Review
Senior Constable Rohan Frost

Signature:

AUDREY JAMIESON
CORONER
Date: **15 December 2016**