IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 6218

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**NOEL FAURE**
Date of birth:	26 November 1954
Date of death:	30 December 2016
Cause of death:	Complications of Hepatocellular Carcinoma
Place of death:	Hopkins Correctional Facility, 132 Warrak Road, Ararat, Victoria
Catchwords:	Deceased person in custody and care; natural causes.

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HER HONOUR:

BACKGROUND

1. Noel Faure (**Mr Faure**) was a 62-year-old man who, at the time of his death, was in custody at the Hopkins Correctional Facility located at 132 Warrak Road, Ararat, Victoria.

2. Mr Faure is survived by his brother, Keith Faure, and niece, Renee Faure.

3. Mr Faure's past medical history included depression, hypertension, psychosis, gastro-oesophageal reflux, Hepatitis C with associated cirrhosis, portal vein thrombosis with stenting, sarcoidosis, and prior lumbar spine surgery.

4. On 2 February 2016, Mr Faure was reviewed by a medical practitioner at the Hopkins Correctional Centre who arranged routine pathology testing. The results of the testing were consistent with chronic liver disease.

5. On 24 February 2016, Mr Faure presented with epigastric pain lasting a few hours. The medical practitioner ordered blood tests and arranged an abdominal ultrasound, which was performed on 15 April 2016. The ultrasound showed a 4cm mass in Mr Faure's right lobe of the liver on a background of cirrhotic change, raising the possibility of a hepatocellular carcinoma.

6. A computed tomography scan (**CT scan**) of Mr Faure's abdomen was ordered on 20 April 2016 to confirm a diagnosis.

7. Mr Faure presented to medical practitioners on 28 April 2016 and again on 3 May 2016, while waiting for the CT scan to be performed. The practitioners discussed the likely diagnosis of hepatocellular carcinoma with Mr Faure. Mr Faure stated that he did not wish to attend a specialist appointment in Melbourne or undergo further active treatment, and stated that he would prefer palliative care. The practitioners considered Mr Faure to have a good understanding of his condition.

8. On 10 May 2016, Mr Faure presented with pain across the shoulders and some constipation. Mr Faure declined an offer of a referral to St Vincent's Hospital. The medical practitioner commenced Mr Faure on Targin tablets to manage his pain.

9. On 2 June 2016, Mr Faure presented with ongoing abdominal pain and pain across the back. The medical practitioner increased the dosage of Targin in response to this presentation.

10. On 17 June 2016, Mr Faure presented with further back pain. The medical practitioner made an urgent booking for Mr Faure to receive a CT scan, as the initial scan had been cancelled.

11. On 22 June 2016, the CT scan was conducted and confirmed an 8cm mass in Mr Faure's liver, consistent with hepatocellular carcinoma. The scan also found evidence of cirrhosis and portal hypertension.

12. On 30 June 2016, Mr Faure met with a medical practitioner and discussed the CT scan findings. Mr Faure was offered a referral to St Vincent's Hospital which he accepted. A referral was sent to the hepatobiliary clinic at St Vincent's for an urgent consultation.

13. On 27 July 2016, Mr Faure was reviewed and his pain medication increased.

14. On 15 August 2016 and again on 29 August 2016, there was a teleconference consultation with St Vincent's Hospital. Mr Faure was advised that he had aggressive liver cancer that could not be removed surgically, but was offered chemotherapy at St Vincent's Hospital to slow the progress of the tumour. A tentative appointment was made to allow Mr Faure time to consider this option.

15. On 2 September 2016, Mr Faure declined the offer of treatment at St Vincent's Hospital.

16. On 12 September 2016, Mr Faure was reviewed and an Advanced Care Directive was discussed. Mr Faure directed that he did not want CPR or extended life support, and indicated that he only wanted palliative care.

17. Following the appointment at which Mr Faure indicated that he wanted palliative care, his pain control was stabilised. He was observed to be slowly deteriorating, and demonstrated increasing dependency on others. In particular, it was reported that Mr Faure required his brother to assist him with many of his daily activities.

18. On 21 November 2016, Mr Faure was noted to be vague and less focused. A serum ammonia was performed, which was significantly elevated, consistent with the diagnosis of hepatic encephalopathy. Mr Faure was commenced on lactulose, to encourage ammonia excretion, but demonstrated little improvement.

19. On 5 December 2016, Mr Faure developed double vision. A left eye lateral rectus palsy was found on examination. Mr Faure's brother reported that Mr Faure had experienced this symptom some years before, with his cerebral sarcoidosis. A trial of increased steroid was commenced, but with little benefit.

20. On 19 December 2016, Mr Faure was unable to stand without assistance, and demonstrated increasing faecal incontinence. Mr Faure was provided with full time nursing care. However, he continued to deteriorate, demonstrating increasing confusion and a lowered conscious state.

THE PURPOSE OF A CORONIAL INVESTIGATION

21. Mr Faure's death was determined to be a "*reportable death*" under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and immediately before the death he was a person placed in custody or care.[1]

22. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

23. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

24. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

25. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

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[1] Section 3 and sections 4(1) and (2)(c) of the *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008*.
[3] *Keown v Khan* (1999) 1 VR 69.

26. The Act mandates that a coroner must hold an inquest into all deaths deemed to have occurred while a person is in "*custody or care*"[4] except in those circumstances where the death is considered to be due to "*natural causes*".[5]

27. A death may be considered to be due to "*natural causes*" if the coroner has received a report from a medical investigator that includes an opinion that the death was due to natural causes.

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

Identity of the Deceased, pursuant to section 67(1)(a) of the *Coroners Act 2008*

28. On 30 December 2016, Mr Faure was identified by Sally Millard, a registered nurse at the Hopkins Correctional Facility as being Noel Faure, born 26 November 1954.

29. Identity is not in dispute in this matter and therefore requires no investigation.

Medical cause of death, pursuant to section 67(1)(b) of the *Coroners Act 2008*

30. On 3 January 2017, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Mr Faure's body and provided a written report, dated 11 January 2017. In that report, Dr Lynch concluded that Mr Faure died from "*Complications of Hepatocellular Carcinoma*".

31. In addition to the external examination he performed, Dr Lynch also had access Mr Faure's relevant medical history. In his report Dr Lynch commented that Mr Faure "*had a history of liver cancer which appears to have complicated cirrhosis which has developed in the setting of chronic Hepatitis C. He was being treated palliatively with morphine*". Dr Lynch further commented that the conclusions he made as a result of his external examination of Mr Faure's body were consistent with Mr Faure's relevant medical history.

32. On the basis of the information available at the time of completing his report, Dr Lynch provided an opinion that Mr Faure's death was due to natural causes.

33. I accept the cause of death proposed by Dr Lynch.

[4] Section 52(2)(b) of the *Coroners Act 2008*.
[5] Section 52(3A) of the *Coroners Act 2008.*

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the *Coroners Act 2008*

34. On 20 December 2016, Mr Faure was moved to the Health Centre at the Hopkins Correctional Facility at 132 Warrak Road, Ararat and provided with palliative care.

35. At 10:41pm, on 30 December 2016, Mr Faure passed away in the presence of nursing staff.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

36. I am satisfied that Mr Faure's death was due to natural causes. I am satisfied that the medical care and management provide to Mr Faure immediately prior to his death was reasonable and appropriate in the circumstances. It is for those reasons that I limit my findings with respect to the circumstances in which Mr Faure's death occurred and exercise my discretion not to hold an inquest.

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

FINDINGS AND CONCLUSION

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

    (a) that the identity of the deceased was Noel Faure, born 26 November 1954;

    (b) that the death occurred on 30 December 2016 at the Hopkins Correctional Facility, 132 Warrak Road, Ararat, Victoria, from Complications of Hepatocellular Cancer; and

    (c) that the death occurred in the circumstances set out above.

39. I convey my sincerest sympathy to Mr Faure's family.

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

    (a) Mr Keith Faure, senior next of kin;

    (b) First Constable Brittany Collard, Coroner's Investigator;

    (c) Ms Emma Catford, Office of Correctional Services Review;

41. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
DATE: 23 June 2017