IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 3024**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

(Amended pursuant to section 76 of the Coroners Act 2008 as at 25 February 2019)[1]

Findings of:	**PHILLIP BYRNE, CORONER**
Deceased:	**THOMAS MURPHY**
Date of birth:	**16 JANUARY 1982**
Date of death:	**ON OR ABOUT 25 JUNE 2018**
Cause of death:	**I (a) ACUTE MYOCARDIAL INFARCTION** **1 (b) ISCHAEMIC HEART DISEASE**
Place of death:	**FULHAM CORRECTIONAL FACILITY, HOPKIN ROAD, FULHAM, VIC, 3851**

[1] Paragraph 9 the name Mr Collins is removed and replaced with Mr Murphy.

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

I, PHILLIP BYRNE, Coroner, having investigated the death of THOMAS MURPHY without holding an inquest:
find that the identity of the deceased was THOMAS MURPHY
born on 16 January 1982
and the death occurred on or about 25 June 2018
at Fulham Correctional Facility, Hopkin Road, Fulham, VIC, 3851

from:

1 (a) ACUTE MYOCARDIAL INFARCTION

1 (b) ISCHAEMIC HEART DISEASE

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

BACKGROUND

1. Thomas Murphy, 36 years of age at the time of his death, was found deceased in his single cell at Fulham Correctional Centre (Fulham) where he had been since November 2017. Mr Murphy had a past medical history including asthma, depression/anxiety, post-traumatic stress disorder, poly drug use, including methamphetamine ("ice") and cannabis. He was prescribed antidepressant and antipsychotic medications and methadone.

BROAD CIRCUMSTANCES

2. At 7.00am on 25 June 2018, Mr Murphy was located unresponsive in his cell (in which he was the sole occupant) by a staff member who attended to unlock the cell door. Attending ambulance paramedics pronounced Mr Murphy deceased.

REPORT TO CORONER

3. The death of Mr Murphy was reported to the coroner. Having considered the circumstances, and having conferred with a forensic pathologist, I directed an autopsy and ancillary tests.

4. Subsequently, under the hand of Forensic Pathology Registrar Dr Melanie Archer, I received an Autopsy Report in which Dr Archer advised Mr Murphy's death was due to natural causes:

    1 (a) acute myocardial infarction

    1 (b) ischaemic heart disease.

    Dr Archer commented that the autopsy demonstrated that Mr Murphy suffered from "severe coronary atherosclerosis involving all three main arteries, with occlusion (blockage) of up to 90%."

5. Toxicological analysis of a post mortem specimen demonstrated citalopram (an antidepressant), quetiapine (an anti-psychotic) and methadone, all prescribed and at therapeutic levels.

FURTHER INVESTIGATION

6. After Mr Murphy was found deceased at Fulham, following established protocols, police attended. It was considered there were no suspicious circumstances, a position confirmed by autopsy.

7. Again, following established protocols, Mr Murphy's death was subject of a review by the Justice Assurances and Review Office (**JARO**). As part of the review, Justice Health reviewed the medical management of Mr Murphy while in custody. I left my investigation in abeyance awaiting the JARO and Justice Health reviews. In January 2019, I received the JARO review report, which incorporated the Justice Health review report.

CONCLUSIONS

8. I am entirely satisfied there are no suspicious circumstances, or third-party involvement, in Mr Murphy's untimely death.

9. Having examined the JARO and Justice Health reports, I am satisfied that:

    - the custodial management of Mr Murphy met the required standards prescribed by Corrections Victoria; and
    - the health care provided to Mr Murphy, particularly during his terminal illness, was in accordance with the Justice Health Quality Framework 2014.

10. I have concluded no further investigation is warranted. As I am satisfied Mr Murphy's untimely death was due to natural causes, and finalise my investigation by way of Finding Without Inquest.

FINDING

11. I formally find Thomas Murphy died at Fulham Correctional Centre on or about 25 June 2018 due to:

    1 (a) acute myocardial infarction

    1 (b) ischaemic heart disease.

12. Pursuant to section 73 (1) (B) of the Coroners Act 2008 (Vic), I direct that this finding be published on the Coroners Court of Victoria website.

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

    Mr Rodney Murphy, Senior Next of Kin;

    Mr Scott Swanwick, Justice Health, Department of Justice and Regulation;

    Ms Michelle Gavin, Director, Justice Assurance and Review Office; and

    Leading Senior Constable Adam Leenders, Coroner's Investigator

Signature:

PHILLIP BYRNE
CORONER

Date: 20 February 2019