IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3070

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**LANCE ROBERT NIKKELSON**
Date of birth:	**26 OCTOBER 1971**
Date of death:	**16 JUNE 2019**
Cause of death:	**COMPLICATIONS OF CIRRHOSIS AND METASTATIC HEPATOCELLULAR CARCINOMA**
Place of death:	**ST VINCENT'S HOSPITAL, 41 VICTORIA PARADE, FITZROY, VICTORIA 3065**

HIS HONOUR:

BACKGROUND

1. Lance Robert Nikkelson was an Aboriginal man who was born on 26 October 1971. He was 47 years old.

2. On 27 December 2016, Mr Nikkelson was remanded into the custody of Corrections Victoria. Consequently, at the time of his passing, Mr Nikkelson was incarcerated at Port Philip Prison, Truganina, Victoria, following transfer from Hopkins Correctional Centre (**Hopkins**), Ararat, Victoria.

3. According to the Justice Assurance and Review Office (**JARO**), while in custody, Mr Nikkelson was involved in the Koori Art Program and had some success in selling his artworks. Mr Nikkelson's case management notes recorded that he was generally compliant, and when settled in his accommodation, he was easy to engage with, polite and motivated to seek employment.

Medical history

4. Mr Nikkelson had a history of polysubstance use, hepatitis C and liver cirrhosis. He was prescribed methadone daily and was dose reducing with a plan to cease treatment at the time he passed. He previously received treatment for his hepatitis C in 2016, but did not complete the antiviral course. In 2017, Mr Nikkelson underwent further antiviral treatment for hepatitis C, however, it was ultimately unsuccessful, and according to Justice Health, he refused to undergo further treatment despite their encouragement.

5. On 20 May 2019, Mr Nikkelson complained to medical staff at Hopkins of abdominal pain. He was assessed by nursing staff who concluded he was suffering severe constipation, and was placed in a ward in the prison's health centre. After further testing including an abdominal ultrasound on 21 May 2019 at St Vincent's Hospital, and easing of his symptoms, he was returned to the general prison population. Regular laxatives were prescribed.

6. On 27 May 2019, Mr Nikkelson reported acute abdominal pain and was transferred to the prison's health centre. Justice Health noted that Mr Nikkelson initially refused transfer to hospital, however, finally agreed on 28 May 2019. Transfer to hospital was arranged, and according to the E-Medical Deposition Form, Mr Nikkelson was admitted to St Vincent's Hospital on 29 May 2019.

7. Following investigations at St Vincent's Hospital, Mr Nikkelson was diagnosed with end stage liver disease and a multifocal liver lesion with widespread metastases. His condition rapidly deteriorated, and he was placed in the hospital's palliative care unit.

THE PURPOSE OF A CORONIAL INVESTIGATION

8. Mr Nikkelson's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death he was a person in the custody of the Secretary to the Department of Justice.[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[3]

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. 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.

10. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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

12. For coronial purposes, the 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.

13. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

14. Coroners are also empowered:

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[1] Section 4, definition of 'Reportable death', *Coroners Act 2008*.
[2] Section 52(2)(b) *Coroners Act 2008*.
[3] Section 52(3A), *Coroners Act 2008*.
[4] Section 89(4) *Coroners Act 2008*.
[5] *Keown v Khan* (1999) 1 VR 69.

(a) to report to the Attorney-General on a death;

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] 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 that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

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

16. Lance Robert Nikkelson was identified on 24 June 2019, using fingerprint identification. Identity was not disputed and required no further investigation.

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

17. On 17 June 2019, Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on the body of Lance Robert Nikkelson and provided a written report dated 18 June 2019, concluding a reasonable cause of death to be "I(a) Complications of cirrhosis and metastatic hepatocellular carcinoma". I accept his opinion in relation to the cause of death.

18. Toxicological analysis of post mortem specimens detected methadone and its metabolite EDDP,[7] midazolam,[8] oxazepam,[9] metoclopramide[10] and ondansetron.[11]

19. Dr Dodd stated that the death was due to natural causes.

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[6] (1938) 60 CLR 336.
[7] Methadone is a synthetic narcotic analgesic. It is used for the treatment of opioid dependency or for the treatment of severe pain.
[8] Midazolam is an imidazobenzodiazepine derivative that is clinically used as a preoperative medication, antiepileptic, sedative-hypnotic and anaesthetic induction agent.
[9] Oxazepam is a sedative/hypnotic drug of the benzodiazepine class.
[10] Metoclopramide is an anti-emetic drug used for the treatment of nausea and vomiting.
[11] Ondansetron is an indole derivative that has serotonin 5-HT3 receptor blocking activity. It is used clinically to control nausea and vomiting in post-operative patients and in those receiving cytotoxic chemotherapy and radiotherapy.

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

20. After admission to hospital on 29 May 2019, investigations revealed a portal vein thrombosis in tandem with new liver masses and evidence of lung metastases. A liver biopsy was attempted, however, Mr Nikkelson deteriorated and was ultimately palliated.

21. On the evening of 16 June 2019, Mr Nikkelson passed away.

Review of care

22. JARO conducted a review into Mr Nikkelson's death and custodial management. They concluded that the response to Mr Nikkelson's death met the standards prescribed by Corrections Victoria.

23. In carrying out my investigation, I was assisted by the Health and Medical Information Team of the Coroners' Prevention Unit.[12] Mr Nikkelson's medical records revealed he had a history of non-compliance with medical assessments and treatment, which prevented earlier diagnosis of his medical conditions. Consequently, the CPU concluded that Mr Nikkelson's medical treatment was reasonable in the circumstances and accorded with his wishes.

FINDINGS

24. Having investigated Lance Robert Nikkelson's death, and having considered all of the available evidence, I am satisfied that no further investigation is required.

25. I find that the care provided to Mr Nikkelson by the Department of Justice and St Vincent's Hospital was reasonable and appropriate in the circumstances.

26. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Lance Robert Nikkelson, born 26 October 1971;

    (b) that Lance Robert Nikkelson died on 16 June 2019, at St Vincent's Hospital, from complications of cirrhosis and terminal cancer; and

    (c) that the death occurred in the circumstances described in the paragraphs above.

27. I convey my sincerest sympathy to Mr Nikkelson's family and friends.

[12] The CPU assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the Coroner and is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

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

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

(a) Mr Nikkelson's family, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

MR JOHN OLLE
CORONER
Date: 9 June 2020