IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0199

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Michael James McBain
Date of birth:	19 August 1974
Date of death:	10 or 11 January 2019
Cause of death:	1(a) Subarachnoid haemorrhage 1(b) Ruptured anterior communicating artery aneurysm
Place of death:	Metropolitan Remand Centre, Middle Road, Ravenhall, Victoria

INTRODUCTION

1. Michael James McBain was a 44-year-old man who was in custody at the Metropolitan Remand Centre at the time of his death.

2. Mr McBain died on 10 or 11 January 2019 from natural causes.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr McBain's death was reported to the Coroner as he was in custody immediately before his death, and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers.

6. Section 52(2)(b) of the *Coroners Act 2008* states that a coroner must hold an inquest *if the deceased was, immediately before death, a person placed in custody or care.*

7. Section 52(3A) of the *Coroners Act 2008* states *the coroner is not required to hold an inquest in the circumstances set out in subsection (2)(b) if the coroner considers the death was due to natural causes.*

8. On the basis of advice from forensic pathologist Dr Joanna Glengarry that Mr McBain's death was from natural causes, I formed the view I was able to make findings without holding an inquest.

9. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

[1] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

IDENTITY

10. On 16 January 2019, Michael James McBain, born 19 August 1974, was identified via circumstantial evidence and his fingerprints.

11. Identity is not in dispute and requires no further investigation.

BACKGROUND

12. Mr McBain's medical history included lower back pain, hypertension, hypothyroidism, anxiety and depression, and hepatitis C.

13. Mr McBain's parents confirmed that he was prescribed Lyrica for a serious back injury that he had sustained while working on the railways in 2014. The injury caused ongoing pain and meant that he could not sit for longer than 10 minutes at a time.

14. Mr McBain's parents noted he was significantly affected by the death of his brother in 2005 and started *"going off the rails"*. They later became aware of his drug use when he started working on the railways. At this time, they believed he used marijuana only but later started using ice with one of his partners. His drug use culminated in Mr McBain being refused supervised access with his children, which affected him emotionally. Mr McBain's parents stated that at this time, he turned to drinking, drugs, and gambling to cope.

15. On 20 December 2018, Mr McBain was involved in a domestic dispute with his sister, her partner, and a house guest that culminated in a standoff with police. He was subsequently coaxed from the house and arrested. He was thereafter taken to Ballarat Base Hospital for medical and mental health assessment. Once he was medically cleared, he was discharged and transported to Ballarat Police Station. *En route*, Mr McBain attempted suicide and lost consciousness. He was returned to Ballarat Base Hospital by paramedics before being returned to police custody. Mr McBain's parents noted that while he was in custody in police cells, he did not have access to any of his medication.

16. Mr McBain was subsequently remanded into custody and arrived at the Metropolitan Remand Centre on 24 December 2018.

17. Mr McBain's parents stated that they had regular contact with their son while he was at the Metropolitan Remand Centre. They said:

... he gave every indication he was happy until they took his medication of [sic] *him in prison. Michael placed a medical request on 06/01/2019 saying that he had been taken off his medication too early and was requesting them back. But he still sounded okay on the phone to us, but he mentioned that he was in a wheel chair for a week after this with gout.*

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

18. At 7.45pm on 10 January 2019, Mr McBain was secured in his cell in the Billingham Unit of the Metropolitan Remand Centre. Another inmate was secured in an adjoining cell, which was connected via an open doorway.

19. Sometime during the night, Mr McBain's neighbouring inmate heard him snoring unusually loudly. When he awoke the next morning, he observed Mr McBain on his back in bed and believed that he was asleep.

20. At approximately 7.57am on 11 January 2019, two prison officers attended Mr McBain's cells to conduct a pre let out count. They observed Mr McBain to be on his back on his bed and that his hands were discoloured.

21. Upon establishing Mr McBain was unresponsive to verbal commands, they called a Code Black (a medical emergency). They entered his cell and again attempted to rouse Mr McBain verbally, but he remained unresponsive and appeared to be deceased. Medical staff subsequently confirmed that Mr McBain had been deceased for some time.

22. Ambulance paramedics thereafter attended and declared life extinct at 8.27am.

23. A police search of Mr McBain's cell found a handwritten note in which he noted he had been taken off chronic pain medication (Lyrica) and as a result was refusing to take his blood pressure and thyroid medication and an anti-inflammatory.

CAUSE OF DEATH

24. On 14 January 2019, Dr Joanna Glengarry, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination and provided a written amended report, dated 1 May 2019. In that report, Dr Glengarry concluded that a reasonable cause of death was *'Subarachnoid haemorrhage'* and *'Ruptured anterior communicating artery aneurysm'*.

25. Toxicological analysis identified the presence of mirtazapine.

26. Dr Glengarry commented the post-mortem examination showed a large subarachnoid haemorrhage (bleeding across the surface of the brain and around the base of the brain) due to a rupture of an aneurysm of the anterior communicating artery. An aneurysm is an *"outpouching"* and thinning of a vessel wall which may spontaneously rupture and cause bleeding. Dr Glengarry noted that many of these have no symptoms and the first presentation may be rupture, as in this case. In this case, the type of aneurysm is known as a berry aneurysm, so called due to its rounded shape. It is estimated to be present in approximately three percent of the adult population. The cause is not well defined, but genetic factors may be important with an increased incidence in family members of those affected. They may be associated with other inherited syndromes such as Marfan's disease or other connective tissue disorders. Other risk factors include hypertension (high blood pressure) and smoking.

27. Dr Glengarry also noted findings within the heart and kidneys suggested the effects of high blood pressure upon these. Whilst high blood pressure does not necessarily cause berry aneurysms to form, it may increase the risk of rupture.

28. There was no evidence of violence or injury of a type likely to have caused or contributed to death.

29. Dr Glengarry concluded that Mr McBain's death was due to natural causes.

30. I accept Dr Glengarry's opinion as to cause of death.

REVIEW OF TREATMENT

Justice Assurance and Review Office review

31. When a person dies in prison, the Justice Assurance and Review Office (**JARO**) conducts a review of the circumstances and management of the death.

32. The JARO noted that on 24 December 2018, during his reception assessment, Mr McBain was reported as presenting as very teary, with a low mood and at risk of self-harm. He was assigned a suicide/self-harm risk rating of 'S3', which denoted that there was a potential risk of suicide or self-harm. Following a review by the Risk Review Team, Mr McBain was assessed as having no overt risk of suicide and was focused on his upcoming court matters and family support. Mr McBain's suicide/self-harm risk rating was subsequently

downgraded to S4 and he was placed in the Billingham Unit, where he remained until his death.

33. Following his transfer to the Billingham Unit, Mr McBain engaged with his new caseworker and appeared to be settled. His conversations with case managers appeared to be meaningful, with an emphasis placed on encouraging him to maintain contact with family and friends.

34. On 7 January 2019, during a counselling session with Gamblers Help, Mr McBain allegedly expressed thoughts of self-harm. An 'At Risk' assessment was conducted with the nurse concluding that there were no self-harm issues present.

35. The JARO noted that the handwritten note found in Mr McBain's cell outlined concerns regarding the provision of medications. While the note referenced a cell intercom call being made to staff at the Remand Centre between 8.00pm and 9.00pm on 7 January 2019 requesting medications, Corrections Victoria confirmed that there was no record of such a call having been made. The JARO's review did not identify any information substantiating the claims in the handwritten note.

36. In conclusion, the JARO found that Mr McBain's custodial management by Corrections Victoria met the required standards and that the response to his death was consistent with established procedures.

Justice Health review

37. When a person dies in prison, Justice Health also reviews the medical care provided to the person while there were in custody.

38. Justice Health noted that upon transfer to the Metropolitan Remand Centre, Mr McBain's medical history was noted to have been lower back pain, high blood pressure, hepatitis C, and thyroid disease. He was prescribed mirtazapine, pregabalin, perindopril, celecoxib, and thiamine to assist with these conditions.

39. It was noted that Mr McBain was not compliant with his thyroid medication. He had been taking Lyrica (pregabalin) 150mg twice daily but it was decided that Mr McBain would be weaned from the Lyrica has it was not clinically indicated, and he had been misusing it in the community.

40. While at the Remand Centre, Mr McBain's blood pressure readings were high on several occasions. He was reminded to take his medication after self-reporting that he had was not taking his prescribed perindopril. On two occasions, high blood pressure readings necessitated an immediate dose of amlodipine to improve his blood pressure control.

41. On 3 January 2019, Mr McBain reported he had a painful right ankle and noted he had suffered gout in the past. He was provided with pain relief and anti-inflammatory medication.

42. On 10 January 2019, Mr McBain was reviewed by a psychiatry registrar. He described his mood as low but denied having any thoughts or intentions or plans to suicide or self-harm. The psychiatry registrar concluded that Mr McBain was currently moderately depressed in the context of borderline personality traits and recent ongoing stressors, high substance abuse, as well as physical health issues. His dose of mirtazapine was subsequently increased.

43. Justice Health concluded that based on a file review of Mr McBain's medical record, there was nothing to suggest that the healthcare provided to Mr McBain was not in accordance with the Justice Health Quality Framework 2014.

Health and Medical Investigation Team review

44. The Court's Health and Medical Investigation Team (**HMIT**)[2] also reviewed the circumstances of Mr McBain's death to determine whether his death could have been prevented.

45. The HMIT agreed with Dr Glengarry that approximately three percent of the adult population have intracerebral artery aneurysms. The incidence of rupture of these aneurysms is approximately one in 100,000 population/ year. This low-rate of rupture combined with the relatively high-rate of adverse outcome from corrective surgery is the reason why population screening for intracranial aneurysms is not recommended.

46. Rupture of an intracranial aneurysm usually results in a sudden onset severe 'thunderclap' headache or neck-ache that may be associated with severe vomiting, seizures, or decreased conscious state. The treatment goal in these cases is to repair the aneurysm to prevent further

[2] The HMIT is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

and more serious aneurysmal bleeds. In approximately 13 percent of cases, the initial bleed is of such magnitude that there is no warning headache, only sudden death.

47. It appears that there were no warning signs of Mr McBain's imminent death. There is no evidence that he complained of any headache to prison staff in the weeks leading to his death.

48. The HMIT noted that from a review of the available evidence, it did not appear that the care Mr McBain received whilst in remand contributed to his death. His death was not predictable and thus not preventable. I agree with this conclusion.

FINDINGS AND CONCLUSION

49. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Michael James McBain, born 19 August 1974, died on 10 or 11 January 2019 at the Metropolitan Remand Centre, Middle Road, Ravenhall, Victoria, from subarachnoid haemorrhage and ruptured anterior communicating artery aneurysm in the circumstances described above.

50. I convey my sincere condolences to Mr McBain's family for their loss.

51. Pursuant to section 73(1B), I direct this finding be published on the Internet.

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

Ian and Brenda McBain, senior next of kin
Justice Assurance and Review Office
WorkSafe (care of Thomson Geer)
Correct Care Australasia (care of Meridian Lawyers)
Ballarat Health Services
Office of the Chief Psychiatrist
Detective Leading Senior Constable Paul Barrow, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 18 September 2020