IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 0130

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Douglas Earnest Stott
Date of birth:	6 April 1948
Date of death:	7 January 2021
Cause of death:	1(a) Diffuse large B cell lymphoma
Place of death:	St Vincent's Hospital Melbourne, 41 Victoria Parade, Fitzroy, Victoria
Key words:	In custody, prisoner, lymphoma, natural causes, a custodial health care system, refusal of treatment

INTRODUCTION

1. On 7 January 2021, Douglas Earnest Stott was 72 years old when he died in hospital. At the time, Mr Stott was serving a term of imprisonment at the Langi Kal Kal (**LKK**) Prison at Langi Kal Kal, in regional Victoria.

2. Mr Stott was remanded into custody on 13 November 2019 and was subsequently found guilty on 16 December 2019 on charges including indecent assault of a male under the age of 16 years. He was sentenced to five years imprisonment, with a non-parole period of three years and his earliest eligible parole date was 7 November 2022.

THE CORONIAL INVESTIGATION

3. Mr Stott's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in custody or care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

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. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. This finding draws on the totality of the coronial investigation into Mr Stott's death. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

[2] 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

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

Identity of the deceased

7. On 14 January 2021, Coroner Audrey Jamieson made a formal determination identifying the deceased as Douglas Earnest Stott, born 6 April 1948, based on the police report of death to the coroner, a fingerprint analysis report, and the Victorian Institute of Forensic Medicine (**VIFM**) admission photograph and identification report.

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

Medical cause of death

9. Forensic Pathologist, Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of Mr Stott's body in the mortuary on 8 January 2021 and provided a written report of her findings dated 2 February 2021.

10. The post-mortem CT scan revealed a total left hip replacement, an enlarged spleen, left pleural effusions (water on the lungs) and anterior rib fractures. Dr Archer explained the enlarged spleen was in keeping with Mr Stott's history of haematological malignancy.

11. The post-mortem examination did not show evidence of an injury of a type likely to have caused or contributed to death.

12. Dr Archer provided an opinion that the medical cause of Mr Stott's death was from natural causes, namely *"1(a) Diffuse large B cell lymphoma"*.

13. I accept Dr Archer's opinion.

Circumstances in which the death occurred

14. Mr Stott was examined by a medical officer on 13 November 2019. He provided a medical history which included chronic lymphocytic leukemia, type II diabetes, osteoarthritis, past strokes, high cholesterol, and high blood pressure. A skin infection on Mr Stott's thigh was also noted and a course of antibiotics was prescribed. While in the community, Mr Stott had consulted with his oncologist for intermittent maintenance immunotherapy treatment. A

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provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

referral was made to the Oncology Unit at St Vincent's Hospital Melbourne (**SVHM**) for ongoing management and treatment.

15. Mr Stott's medication regime at the time of his death included ibrutinib, valaciclovir, sulphamethoxazole/trimethoprim, paracetamol (as required), salbutamol (as required), glicazide, amlodipine, valsartan, atorvastatin, linagliptin, metformin, folic acid, biotin, and Deep Heat (mentholatum).

16. On reception into custody, Mr Stott was assigned risk ratings of *"T2"* and *"M2*", the former indicating a *"significant risk of threat from others"* and the latter indicating a *"medical condition requiring regular or ongoing treatment"*.

17. From December 2019 until his passing, Mr Stott attended numerous medical and allied health appointments whilst in custody as well as several consultations with the Oncology and Haematology Units at SVHM via telehealth.

18. On 23 January 2020, Mr Stott consulted with the Oncology Unit at SVHM via telehealth. A plan was put in place for the specialist unit at SVHM to consult with Mr Stott's previous oncologist to develop a care plan.

19. On 13 February 2020, Mr Stott attended a telehealth appointment with the Haematology Unit at SVHM. Further information was provided by Mr Stott's community oncologist who explained Mr Stott had recently developed macrocytic anaemia and thrombocytopenia which required chemotherapy treatment. A plan was developed for Mr Stott to undergo further testing including CT scans and a bone marrow biopsy, which required admission to SVHM.

20. Following this consultation, Mr Stott refused to transfer to Port Phillip Prison (**PPP**) in preparation for admission to SVHM. At that time, it was the standard process for prisoners requiring medical treatment at SVHM to be transferred via PPP as a conduit.

21. On 24 February 2020, Mr Stott attended a review in preparation for a telehealth appointment with the SVHM Haematology Unit. He was adamant that he would not transfer via PPP for treatment. As an alternative meant to encourage Mr Stott to attend, it was suggested that he would be transported to SVHM directly from Hopkins Correctional Centre (**HCC**).

22. On 3 March 2020, Mr Stott was unable to attend a booked CT scan at Ballarat Health Service as the prison was unable to provide transport and the appointment was re-booked.

23. On 13 March 2020, Mr Stott signed a '*Refusal of Treatment'* form as he refused to transfer to SVHM via PPP for treatment on 20 March 2020. Mr Stott understood that the testing that was required and the importance of attendance but nevertheless refused despite medical advice and encouragement.

24. On 26 March 2020, a SVHM haematologist contacted the prison with concerns about Mr Stott's failure to attend. Mr Stott later attended a consultation with the SVHM Haematology Clinic via telehealth and was advised he needed to attend a chemotherapy appointment at SVHM. Arrangements were made for Mr Stott's appointments to occur within the same day to minimise disruption to his placement due to transport constraints.

25. Mr Stott thereafter attended telehealth appointments with the SVHM haematologist with the prison medical centre arranging pathology tests as required. His health appears to have been relatively stable in the intervening period albeit with reports of nausea and poor appetite.

26. On 13 August 2020, Mr Stott attended a telehealth review appointment with his haematologist. It was noted on this occasion that Mr Stott had lost 16 kilograms in six months, although he was still considered overweight. A nutritional health shake was prescribed to improve his nutritional intake which appeared effective.

27. On 19 October 2020, Mr Stott attended a consultation with gastroenterology at SVHM for investigations of his anaemia. As a result, Mr Stott was booked for a colonoscopy in November 2020.

28. On 4 November 2020, Mr Stott was transferred to PPP in preparation for a colonoscopy at SVHM. He remained in transfer quarantine until a negative COVID-19 result was available, as was the standard SVHM process at the time. On 5 November 2020, Mr Stott expressed his disappointment that he had to remain there in quarantine. As a result, he refused to have the procedure, and once again signed a *'Refusal of Treatment'* form. He was returned to LKK prison the next day.

29. On return to LKK, Mr Stott was reported to have been argumentative that he had been transferred to PPP although he had been informed of the process for transfer to SVHM. Health staff continued to monitor his progress.

30. On 17 December 2020, Mr Stott attended a review with the haematologist via telehealth to monitor his progress. No changes were made to his treatment.

31. On 30 December 2020, Mr Stott was reviewed at a Nurse Clinic where concerns were raised about his general wellbeing and his decreased appetite. He was assessed as being "*generally weaker*". The next day, Mr Stott re-attended a Nurse Clinic and stated that he was not feeling well but had no specific symptoms. An assessment revealed he was tired and lethargic, his tongue showed signs of dehydration and he became more unsteady. It was decided that Mr Stott would be transferred to Ballarat Health Service Emergency Department.

32. On 1 January 2021, medical staff at Ballarat Health Service advised Mr Stott that his organs were shutting down and he was to be transferred to SVHM.

33. On 7 January 2021 at 12:05am, SVHM nursing staff found Mr Stott unresponsive and in cardiac arrest. They called a Code Blue (medical emergency) and commenced cardiopulmonary resuscitation (**CPR**), however, he was unable to be revived and was verified deceased at 1.17am.

REVIEW OF TREATMENT IN CUSTODY

34. When a person dies in prison, the Justice Assurance and Review Office (**JARO**) conducts a review of the circumstances and management of the death. Justice Health conducts a review regarding the medical care and treatment provided to prisons in custody.

35. The JARO found that *"Mr Stott's custodial management by Corrections Victoria and Port Phillip met the required standards and that the response to his death was consistent with established procedures.*"

36. Similarly, Justice Health stated that *"there is nothing to suggest that the healthcare provided to Mr Stott was not in accordance with the Justice Health Quality Framework 2014. As such Justice Health makes no recommendations for systemic improvements arising from the death of Mr Stott."*

FINDINGS AND CONCLUSION

37. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Douglas Earnest Stott, born 6 April 1948;

    (b) the death occurred on 7 January 2021 at St Vincent's Hospital Melbourne, 41 Victoria Parade, Fitzroy, Victoria;

(c) the cause of Mr Stott's death was natural causes, namely diffuse large B cell lymphoma; and

(d) the death occurred in the circumstances described above.

COMMENTS

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

38. It is unclear whether Mr Stott's refusal to attend treatment in March and November 2020 materially contributed to his condition deteriorating more rapidly than was otherwise expected. It appears his refusal for treatment was solely based on his unwillingness to be transferred to PPP in order to access treatment at SVHM, rather than an unwillingness to engage in the treatment itself.

39. I have previously commented on the obstacle posed to access to health care in a custodial health care system heavily reliant on using PPP as a conduit for outpatient specialist appointments and access to tertiary care at SVHM.[3]

40. In its report regarding Mr Stott's death, the JARO noted the following changes implemented since my previous comments:

> *On 7 October 2020, the department advised that in February 2019, Justice Health conducted a review of the Centralised Hospital Pathway by which prisoners access secondary and tertiary healthcare via Port Phillip. The review led to the development of nine strategies aimed at improving flow and coordination of healthcare, including using capacity in order front-end prisons and developing clinical escalation protocols for prisoners who refuse treatment due to a reluctance to be transported to Port Phillip. The escalation protocols set out what steps are to be taken when a prisoner's refusal of treatment via the Centralised Hospital Pathway poses an unacceptable clinical risk. This is determined following a comprehensive assessment by the Medical Officer treating the prisoner. In such instances, the matter is to be escalated to the Sentence Management Division (SMD) to arrange direct transfer to the required hospital service, bypassing Port Phillip. Justice Health has requested changes to JCare to reflect the clinical escalation workflows.*

[3] Finding into Death with Inquest of Joseph Mallia (COR 2013 0635), published 2 April 2015; Finding into Death with Inquest of Travis Lee Fernandez (COR 2014 5936), published 14 January 2020.

41. Justice Health confirmed that the Sentence Management Division was notified of Mr Stott's refusal to attend a medical appointment on 17 March 2020. Sentence Management Division was not informed of Mr Stott's reason for not attending his medical appointment.

42. I asked Justice Health whether the clinical escalation protocols for prisoners who refuse treatment due to a reluctance to be transferred to Port Phillip were in effect at the time of Mr Stott's incarceration. Justice Health informed me that the protocols were not in place as they were introduced incrementally (phase 1 in late 2020 and phase 2 in late 2021).

43. In February 2021, Justice Health introduced a number of features to JCare. This included the activation of a new Risk and Escalation pathway when external health appointments are cancelled. The intention of the protocol is to mitigate unacceptable risk when a patient is not able to attend an appointment. It is expected that this will trigger alternative options to get a patient to an external appointment. An alert and a task are created for the Health Service Manager and Administration Support Officer to review and assess the risk of the cancellation. When an External appointment is manually cancelled, the Escalation and Risk Protocol is activated which requires entries against a number of mandatory fields, which includes a consideration as to whether the cancellation/refusal poses a clinical risk, plans put in place to mitigate the risk, and further escalation if required.

44. In 2022, a policy was implemented to ensure that where a risk is identified and escalated, suitability for an alternate prison pathway for access to St Vincent's Hospital will be reviewed in consultation between the Health Service Provider, Justice Health, and Sentence Management Division subject to risk assessment, security classification, and prison bed availability.

45. I am satisfied that had these changes been in place proximate to Mr Stott's death, his refusal to attend SVHM via PPP would have been addressed and escalated earlier and alternative arrangements may have been put in place. However, given the aggressive nature of Mr Stott's cancer, I am of the view that the treatment refusal was most likely immaterial to the ultimate outcome.

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

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

Norma Reynolds, senior next of kin

Correct Care Australasia (care of Meridian Lawyers)

Justice Assurance and Review Office

St Vincent's Hospital Melbourne

Signature:

Coroner Paresa Antoniadis Spanos

Date: 05 October 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.