IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004522

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Maahi Tukapua
Date of birth:	15 September 1947
Date of death:	26 August 2021
Cause of death:	1(a) Acute on chronic renal failure and multi-factorial encephalopathy in a man with cirrhosis and dilated cardiomyopathy (palliated)
Place of death:	Port Phillip Prison 451 Dohertys Road, Truganina, Victoria, 3029
Keywords:	Death in custody

INTRODUCTION

1. On 26 August 2021, Maahi Tukapua was 73 years old when he passed away at Port Phillip Prison. At the time of his death, Mr Tukapua was serving a term of imprisonment.

2. Mr Tukapua had a significant medical history which included poly-articular gout, chronic kidney disease, biventricular congestive cardiac failure, global cardiac systolic dysfunction, dilated left and right ventricles of the heart, asthma, type II diabetes, hypercholesterolaemia, hypertension, ischaemic heart disease, liver dysfunction, cataracts, and gastro-oesophageal reflux disease.

3. Mr Tukapua was prescribed a range of medication to manage his medical conditions, which included Breo Ellipta (fluticasone furoate and vilanterol), carvedilol, colecalciferol, rosuvastatin, glicazide, insulin glargine, furosemide, colchicine, metformin, esomeprazole, allopurinol, spironolactone, linagliptin, and albuterol.

4. Mr Tukapua was remanded into custody on 23 February 2021 on multiple historical child sex offence charges. On 5 March 2021, he was sentenced in the County Court following pleas of guilty to one charge of indecent assault; one charge of sexual penetration with a child under 10 years; one charge of committing an indecent act with a child under 16 years; and two charges of sexual assault with a child under 16 years. The total effective sentence was six years and nine months, with a non-parole period of four years and one month.

THE CORONIAL INVESTIGATION

5. Mr Tukapua's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Tukapua's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Maahi Tukapua including evidence contained in the coronial brief. 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.[1]

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

Circumstances in which the death occurred

10. On 23 February 2021, Mr Tukapua was remanded into custody at the Melbourne Assessment Prison (**MAP**). Upon arrival he was assessed by medical staff. He provided a medical history and signed consent forms to allow information to be provided by his community health providers. He denied any thoughts of suicide or self-harm and was noted to be cooperative with staff. He was assigned a placement risk rating of T2 and a medical risk rating of M2. A rating of T2 refers to a significant risk of threat from others while a rating of M2 refers to a medical condition requiring regular or ongoing treatment.

11. Mr Tukapua was transferred to Ravenhall Correctional Centre (**RCC**) on 25 February 2021. A medical officer reviewed Mr Tukapua and an integrated care plan was commenced to monitor his progress. Various referrals were made to St Vincent's Hospital Melbourne (**SVHM**) outpatient clinics to assist in the management of Mr Tukapua's various medical conditions.

[1] 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.

12. On 10 March 2021, Mr Tukapua was transferred to Hopkins Correctional Centre (**HCC**). He remained there until 12 April 2021, when he was transferred to the Metropolitan Remand Centre (**MRC**) to enable attendance at the Royal Victorian Eye and Ear Hospital (**RVEEH**) for a laser eye procedure. Mr Tukapua returned to HCC on 16 April 2021.

13. From 16 April 2021 to 12 July 2021, Mr Tukapua attended various medical appointments while incarcerated at HCC. On 20 May 2021, Mr Tukuapua attended a Nephrology review at SVHM and expressed a reluctance to return to hospital for treatment. As a result, a conservative management approach was initiated. On 23 June 2021, Mr Tukapua declined a transfer to Port Phillip Prison (**PPP**) in preparation for cardiac investigations at SVHM on the basis that he described feeling humiliated attending appointments while handcuffed.

14. On 5 July 2021, Mr Tukapua attended a review with a medical officer who noted his acute chronic renal failure, declining renal function and increased hyperkalaemia. The following day, an electrocardiogram (**ECG**) demonstrated abnormalities and his pathology results were also poor. A medical officer discussed the results with the Renal Registrar at SVHM, who agreed that Mr Tukapua should be transferred to SVHM for medical management. He was then transferred to SVHM via ambulance and was admitted to St Augustine's, a secure inpatient unit.

15. On 12 July 2021, Mr Tukapua was discharged from SVHM back to the MRC as he was noted to be medically stable. He remained at the MRC until 21 July 2021, when he was transferred to HCC. He was reviewed by a medical officer the next morning.

16. On 26 July 2021, custodial staff noted that Mr Tukapua "*appeared to be vague*" and frail but denied any pain or shortness of breath. Mr Tukapua was assessed by a medical officer that day and was noted to be unable to process or answer simple questions. A slight discolouration of sclera was also noted, and his pulse was slow, suggesting an issue with his pacemaker. He also complained of being "*itchy all over*". He was transferred back to SVHM via ambulance for further treatment and review on 26 July 2021.

17. Upon his transfer to SVHM, Mr Tukapua was again admitted to St Augustine's, where he was treated for acute on chronic renal failure, liver cirrhosis and encephalopathy. He was discharged from St Augustine's on 3 August 2021 and transferred to PPP, where he was admitted to the St John's Unit for ongoing palliative care. An acute resuscitation plan was initiated for conservative management only.

18. Upon arrival at the St John's Unit, Mr Tukapua was noted to be unable to independently mobilise and he was prescribed morphine for symptom management. He initially tolerated small amounts of food, however, as his condition deteriorated, he increasingly declined meals. He also declined regular blood tests.

19. At about 5.40pm on 8 August 2021, Mr Tukapua was found by staff lying on the floor after suffering an unwitnessed fall. He complained of some pain but did not have any injuries and his vital signs remained stable. On 18 August 2021, Mr Tukapua was assessed as being competent by a consultant physician and an Advanced Care Plan was completed. Mr Tukapua decided that he would only receive comfort care, and resuscitation would not be attempted.

20. On 26 August 2021, Mr Tukapua's condition continued to deteriorate, and he became unresponsive. A video call was attempted with his family. At about 1.00pm, Mr Tukapua stopped breathing. A Code Black was called, and Mr Tukapua was declared deceased at 1.06pm.

21. Following Mr Tukapua's passing, Justice Health and the Justice Assurance and Review Office (**JARO**) conducted reviews of the care and treatment provided to Mr Tukapua during his incarceration. Both Justice Health and JARO found that Mr Tukapua's custodial management met the required standards, and his death was managed consistently with their established procedures.

Identity of the deceased

22. On 30 August 2021, Maahi Tukapua, born 15 September 1947, was visually identified by his daughter, Isobel Tetevano.

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

Medical cause of death

24. Forensic Pathology fellow Dr Chong Zhou, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 27 August 2021, and provided a written report of her findings dated 13 September 2021.

25. The post-mortem examination revealed findings consistent with the reported circumstances and did not show any evidence of injuries of a type likely to have caused or contributed to death.

26. The post-mortem CT scan showed coronary artery calcifications, a pacemaker and pacing wires in situ, small bilateral pleural effusions, and increased lung markings within the right lower lobe with partial involvement of right upper and middle lobes. There were changes consistent with a remote cerebral infarct within the left posterior cerebral artery territory. There was no evidence of skeletal trauma or acute intracranial pathology.

27. Dr Zhou commented that jaundice and scleral icterus were present secondary to cirrhosis. Multiple linear crusted abrasions were present throughout the body which likely represented scratch marks secondary to pruritis (itchy skin) which can be a symptom of liver failure.

28. Toxicological analysis of post-mortem samples was not recommended and therefore was not performed.

29. Dr Zhou provided an opinion that the medical cause of death was *1(a) Acute on chronic renal failure and multi-factorial encephalopathy in a man with cirrhosis and dilated cardiomyopathy (palliated)"*. Dr Zhou stated that the death was due to natural causes.

30. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

31. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Maahi Tukapua, born 15 September 1947;

    b) the death occurred on 26 August 2021 at Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria, 3029, from acute on chronic renal failure and multi-factorial encephalopathy in a man with cirrhosis and dilated cardiomyopathy (palliated); and

    c) the death occurred in the circumstances described above.

32. Mr Tukapua's death was reportable pursuant to section 4(2)(c) of the Act because, immediately before his death, he was a person placed in custody. Section 52 of the Act requires an inquest to be held in such cases, except in circumstances where the coroner considers that the death was due to natural causes. I am satisfied that Mr Tukapua died from natural causes and that no further investigation is required. There are no issues arising in relation to the medical management provided whilst he was in custody. Accordingly, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death.

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:

Bernadette Tukapua, Senior Next of Kin

Lisa Altit, Justice Assurance and Review Office

Senior Constable Susan Robinson, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 12 February 2024

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.