IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005272

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	John Stuart Knox
Date of birth:	19 November 1944
Date of death:	4 October 2021
Cause of death:	1(a) Pancreatic cancer
Place of death:	Port Phillip Prison 451 Dohertys Road, Truganina, Victoria, 3029
Keywords:	DEATH IN CUSTODY; NATURAL CAUSES; PANCREATIC CANCER; ABDOMINAL AORTIC ANEURYSM; JAUNDICE; ASBESTOSIS

INTRODUCTION

1. John Stuart Knox was 76 years old when he was found deceased on 4 October 2021. At the time of his death, Mr Knox was serving a prison sentence at Port Phillip Prison.

2. Mr Knox had been receiving palliative care due to a diagnosis of pancreatic cancer.

THE CORONIAL INVESTIGATION

3. Mr Knox's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). 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.

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. Victoria Police assigned Senior Constable Sean Betts to be the Coroner's Investigator for the investigation of Mr Knox's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Mr Knox 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]

[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.

IDENTITY OF THE DECEASED

8. On 4 October 2021, John Stuart Knox, born 19 November 1944, was visually identified by his doctor Jia Li, who signed a formal statement of identification to this effect.

MEDICAL CAUSE OF DEATH

9. On 5 October 2021, Dr Melanie Archer, Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Archer reviewed the Victorian Police Report of Death Form 83 and post-mortem computed tomography (**CT**) scan and provided a written report of her findings.

10. Examination of the post-mortem CT scan showed a pancreatic mass with a biliary stent, and an in-dwelling urinary catheter. There was an intact abdominal aortic aneurysm. There was emphysematous change in the lungs, with bibasal consolidation. The external examination showed low body weight and jaundice, in keeping with the known history of palliative pancreatic cancer. The external examination of the body did not show evidence of an injury of a type likely to have caused or contributed to death.

11. On the basis of the information available, Dr Archer was of the view the death was due to natural causes. Dr Archer provided an opinion that the medical cause of death was 1 (a) pancreatic cancer. I accept Dr Archer's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On 16 September 2020, Mr Knox was diagnosed with unresectable pancreatic adenocarcinoma and was transitioned into palliative care. His condition declined rapidly.

13. At about 10:30am on 4 October 2021, correctional officers found Mr Knox unresponsive in his bed. A medical officer attended and pronounced him to be deceased at 10:37am.

REVIEW OF CUSTODIAL MANAGEMENT

14. As Mr Knox died whilst he was in custody, a review of his care and management was conducted by the Justice Assurance Review Office (**JARO**). It was determined that Mr Knox's custodial management by Corrections Victoria and Port Phillip generally met the required standards. It was noted that there was a lack of file notes on Mr Knox's file while accommodated at Port Phillip Prison between 19 May 2021 and his death. The response to his death was consistent with established procedures.

15. Justice Health reviewed Mr Knox's medical record and determined that there was nothing to suggest that the healthcare provided was not in accordance with the Justice Health Quality Framework 2014. I accept the findings of JARO and Justice Health and consider that the treatment and management of Mr Knox was appropriate.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was John Stuart Knox, born 19 November 1944;

    b) the death occurred on 4 October 2021 at Port Phillip Prison 451 Dohertys Road, Truganina, Victoria, 3029, from pancreatic cancer; and

    c) the death occurred in the circumstances described above.

17. Having considered all of the circumstances, I am satisfied that Mr Knox's death was due to natural causes.

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

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:

Yolande Fleming, Senior Next of Kin

Scott Swanwick, Justice Health

Lisa Altit, Justice Assurance Review Office

Senior Constable Sean Betts, Coroner's Investigator

Signature:

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Jacqui Hawkins, Deputy State Coroner

Date : 03 November 2022