IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 005913

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Robert Arthur Selby Lowe
Date of birth:	29 January 1937
Date of death:	4 November 2021
Cause of death:	1(a) Urinary tract infection in a man with Parkinson's disease
Place of death:	Hopkins Correctional Centre, 156 Warrak Road, Ararat, Victoria
Key words:	In care, long serving prisoner, urinary tract infection, natural causes

INTRODUCTION

1. On 4 November 2021, Robert Arthur Selby Lowe was 84 years old when he passed away from natural causes. At the time, Mr Lowe was incarcerated at Hopkins Correctional Centre.

2. In September 1994, Mr Lowe was convicted of kidnapping and murder in the County Court and sentenced to life imprisonment with no minimum term set. The verdict was upheld on appeal in November 1996.

3. Mr Lowe first entered prison custody in 1993 and was accommodated at the now decommissioned Pentridge Prison. He subsequently spent time accommodated at the former Metropolitan Remand Centre, Port Phillip Prison, Barwon Prison, and Hopkins Correctional Centre. He was accommodated at Hopkins Correctional Centre (formerly Ararat Prison) for most of his sentence.[1]

4. Mr Lowe's medical history included dependent oedema, osteoarthritis, dermatitis, vitamin D deficiency, Parkinson's disease, and dementia.

THE CORONIAL INVESTIGATION

5. Mr Lowe'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 care immediately before death, the death is reportable even if it appears to have been from natural causes.[2]

6. 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.

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

[1] Mr Lowe was transferred from Port Phillip to Ararat Prison on 6 October 1999. Ararat Prison subsequently became Hopkins and was officially opened by the Minister for Corrections on 15 October 2015. On 25 October 2017, Mr Lowe was transferred from Hopkins to Port Phillip on a medical transfer, before returning to Hopkins on 17 November 2017 where he remained accommodated until his death.
[2] 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.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Lowe'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.

9. This finding draws on the totality of the coronial investigation into Mr Lowe's death, 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.[3]

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

Identity of the deceased

10. On 4 November 2021, Robert Arthur Selby Lowe, born 29 January 1937, was visually identified by Jeremy Moore, a registered nurse employed by Correct Care Australia who was familiar with Mr Lowe having nursed him for three years.

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

Medical cause of death

12. Forensic Pathologist, Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 5 November 2021 and provided a written report of her findings dated 8 November 2021.

13. External examination of the body showed findings in keeping with the clinical history.

14. Examination of a post-mortem computed tomography (**CT**) scan showed cerebral atrophy, post-mortem intravascular gas, minor coronary artery calcifications and moderate aortic calcifications, large prostate, faecal loading, and uniform increase in the right lower lobe lung markings.

[3] 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.

15. Routine toxicological analysis of post-mortem samples detected paracetamol. In a supplementary report dated 30 November 2021, Dr Baber noted that there was an increased C-reactive protein 270 mg/L, which was in keeping with the presence of a urinary tract infection and possibly an associated sepsis.

16. Dr Baber provided an opinion that Mr Lowe died from natural causes, namely *"1(a) Urinary tract infection in a man with Parkinson's disease"*.

17. I accept Dr Baber's opinion.

Circumstances in which the death occurred

18. From 2017, Mr Lowe began experiencing issues with mobility and balance, which led to a number of falls. Two CT brain scans showed moderate atrophy, which was thought to have been a possible contributing factor. No other specific medical cause for his falls was identified.

19. From 2018, Mr Lowe received physiotherapy and occupational therapy to assist with his balance issues. However, he continued experiencing a number of falls, sustaining non-serious injuries. He increasingly relied on a wheelchair for mobility.

20. In 2019, Mr Lowe began receiving assistance with the Activities of Daily Living (**ADLs**).

21. In May 2019, Mr Lowe was assessed and investigated for persisting lower abdominal pain. He subsequently diagnosed with urethritis, which was treated with antibiotics.

22. In October 2019, Mr Lowe was admitted to the bed-based health unit for monitoring after a fall. He was discharged medically after 10 days but remained in the bed-based health unit indefinitely at the request of Corrections Victoria. At this time, Mr Lowe also commenced medical treatment for Parkinson's disease.

23. Over the following years, Mr Lowe's physical and cognitive health continued to gradually decline. His mobility deteriorated, and he increasingly required assistance with his ADLs.

24. On 23 March 2020, Mr Lowe signed an Advanced Care Directive. In the event he required future medical treatment, including end of life care, he consented to cardiopulmonary resuscitation (**CPR**) but did not want intubation, ventilation with a machine, dialysis, or tube feeding via nasogastric tube or gastrostomy tube.

25. On 3 November 2021, Mr Lowe developed fever, and a mild increase in his confusion. It was thought likely he had a urinary tract infection. Medical investigations were conducted, and he was commenced on oral antibiotics (1000mg Cephalexin) pending those results.

26. The following day, 4 November 2021, Mr Lowe tolerated breakfast and had a small fluid intake. He was noted to be stuttering and difficult to understand. His observations were taken, and antibiotics were administered. It was noted that Mr Lowe's blood pressure was low at 84/48, which was reported to the Medical Officer (**MO**).

27. The MO reviewed Mr Lowe after breakfast noting he was afebrile but likely dehydrated. The MO recommended to continue antibiotics, provide regular medications, intravenous fluids, and for nursing staff to conduct hourly observations.

28. Mr Lowe's condition was noted to improve in response to fluids, with his blood pressure improved and was recorded as 125/57 at 1.30pm. He was eating and drinking and sitting up in bed. At 5.40pm nursing notes record that he had dinner sitting on the side of his bed and that his speech was clearer. At approximately 7.50pm, nurses observed Mr Lowe moving in bed via closed-circuit television (**CCTV**).

29. At approximately 8.10pm, prison officers unlocked the health ward to allow two nurses to enter and administer Mr Lowe's oral antibiotics and change his continence aid. The two nurses subsequently found Mr Lowe unresponsive on his bed.

30. The prison officers called a 'Code Black' and contacted emergency services. The nurses commenced CPR and attached a defibrillator machine, which advised that a shock would not be administered. The nurses and prison officers continued administering CPR until Ambulance Victoria paramedics arrived at 8.29pm.

31. Upon their arrival, paramedics found Mr Lowe in arrest, grey in colour and with no palpable pulse. His pupils were fixed and dilated. A cardiac monitor was attached and indicated that Mr Lowe was in asystole. Given Mr Lowe was in a non-viable cardiac rhythm and the lack of response during almost 30 minutes of CPR, treatment was ceased. Paramedics verified Mr Lowe's death at 8.35pm.

REVIEW OF TREATMENT IN CUSTODY

32. 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 the prisoner in custody.

JARO review

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

Justice Health review

34. Justice Health noted that Mr Lowe had a Chronic Health Care Plan in place and was reviewed by health and allied health staff on a regular basis. He also presented to the health centre for various health matters as appropriate.

35. Based on a file review of Mr Lowe's medical record, Justice Health considered that there was nothing to suggest the healthcare provided to Mr Lowe was not in accordance with the *Justice Health Quality Framework 2014.*

36. However, Justice Health identified that despite the diagnosis of Parkinson's disease, Correct Care Australasia (the primary health provider at the prison) did not assign Mr Lowe with an 'M' rating as required under the relevant Corrections Victoria Commissioners Requirement. Justice Health considered that an 'M2' or higher rating should have been applied to Mr Lowe, which would have indicated he had a medical condition requiring regular or ongoing treatment.

37. On this basis, Justice Health made recommendation that Correct Care Australasia ensure all health staff comply with the relevant Corrections Victoria Commissioners Requirement. Justice Health considered this omission did not contribute to Mr Lowe's death.

Concerns regarding Mr Lowe's medical care proximate to his death

38. During my investigation, I received correspondence from Dr Colin Rattray-Wood, who provided locum services to Hopkins Correctional Centre throughout 2021.

39. Although mistaken about the relevant dates, Dr Rattray-Wood informed me that he examined Mr Lowe on 6 November 2021 and was of the opinion that Mr Lowe's condition was different

to previous similar illnesses when he had urinary tract infections. That day, Mr Lowe had episodes of hypotension. Dr Rattray-Wood considered that haemodynamic instability was a clear warning sign *"that something more sinister was happening at this time."*

40. He recalled that he approached the Health Services Manager and recommended that Mr Lowe be transported to hospital for treatment and observation. Dr Rattray-Wood stated he documented his assessment and recommendations in Mr Lowe's medical notes.

41. Dr Rattray-Wood recalled that the Health Services Manager stated she did not feel comfortable taking that action and preferred to wait until her line manager arrived, which as anticipated within 30 minutes. He did not know whether his recommendation for transfer was escalated but noted that Mr Lowe not subsequently transported to hospital. He was concerned that:

> *... Mr Lowe died following a possible refusal to accept the recommendations of a senior and well experienced medical practitioner who knew this patient well.*
>
> *... if Mr Lowe had been transferred to a hospital with more advanced testing and monitoring then the severity of his condition may have been more clearly defined and a decision made about the appropriateness of instituting life-saving treatment.*

42. In light of Dr Rattray-Wood's correspondence, I obtained Mr Lowe's medical records, including a copy of his Advanced Care Directive.

43. Medical records capture Dr Rattray-Wood's note at 8.51am which records Mr Lowe's observations (pulse rate 80, respiratory rate 20, afebrile, clear chest, and no abnormality detected on examination of his abdomen). Noting that Mr Lowe was likely dehydrated, Dr Rattray-Wood recommended that antibiotics be continued, intravenous fluids, hourly nursing observations, and regular medications. Mr Lowe was for medical review following administration of intravenous fluids. Dr Rattray-Wood also noted the following:

> *Per A recent A&E recommendations 85 yrears [sic] of age with haemodynamic instability -> hospital to DW HSM - are we sending to hospital or managing on site which would imply a palliative intent*

44. Mr Lowe was administered intravenous fluids at approximately 9.30am at which time his blood pressure was recorded to be 94/53.

45. By about 11.30am, the intravenous infusion was ceased, and Mr Lowe tolerated a bag of chips and a Fortisip drink. He was noted to be less lethargic but was still sleeping on and off. His blood pressure was recorded as 102/41.

46. At 1.12pm, Mr Lowe tolerated Weet-Bix and coffee. His blood pressure continued to rise and was recorded as 125/57 at 1.30pm, pulse rate was 89, oxygen saturation was 100%, respiratory rate 16, and temperature was 36.1ºC.

47. At 5.40pm, Mr Lowe tolerated half his dinner. He was noted to be more alert and spent time communicating with staff, with his speech was noted to be clearer. It was noted, *"MO advised of BP and happy to continue Roberts management as per care plan."* A note was made to *"CCmx as per long term care plan"*, indicating to continue the current management plan.

48. It is unclear whether the MO referred to in the note at 5.40pm was Dr Rattray-Wood.

49. There are no further contemporaneous medical notes.

50. Dr Rattray-Wood's concern was that Mr Lowe's haemodynamic instability indicated he required hospital transfer, but his recommendation was not followed.

51. However, I note that in the hours following Dr Rattray-Wood's morning review, and following administration of intravenous fluids, Mr Lowe's condition improved. His confusion decreased; he was able to engage in coherent conversation with staff; he ate and drank on more than one occasion; and his vital signs improved.

52. There was no indication that Mr Lowe required hospital treatment and certainly no indication that his death was imminent. It appears that this was also the MO's opinion who, at 5.40pm, was content to continue the current management plan, that is without escalation to a tertiary hospital emergency department, which is a reasonable inference to draw from the clinical notes made at the time.

53. The available evidence does not support a finding that there was any want of clinical management or care that caused or contributed to Mr Lowe's death.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Robert Arthur Selby Lowe, born 29 January 1937;

(b) the death occurred on 4 November 2021 at Hopkins Correctional Centre, 156 Warrak Road, Ararat, Victoria;

(c) Mr Lowe died from natural causes, namely urinary tract infection in a man with Parkinson's disease; and

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

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:

Senior next of kin
Correct Care Australasia Pty Ltd (care of Meridian Lawyers)
Justice Health
Justice Assurance and Review Office
Dr Colin Rattray-Wood
Kate Houghton, Secretary, Department of Justice and Community Safety
Sergeant Owen Lyons, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 14 June 2023

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.