IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004873

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Jeffrey George Nirens
Date of birth:	16 October 1951
Date of death:	25 August 2022
Cause of death:	1a: intracranial haemorrhage 1b: haemorrhagic transformation of ischaemic stroke in the setting of anticoagulation therapy
Place of death:	Northeast Health Wangaratta, Green Street, Wangaratta, Victoria, 3677
Keywords:	In custody – natural causes, anticoagulation

INTRODUCTION

1. On 25 August 2022, Jeffrey George Nirens was 70 years old when he died in hospital following a stroke while serving a custodial sentence at Beechworth Correctional Centre.

THE CORONIAL INVESTIGATION

2. Jeffrey'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.

3. 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. A coroner need not hold an inquest if a person's death in care or custody was 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. Judicial Registrar Katherine Lorenz, then coroner, initially held carriage of this investigation. I took carriage of this matter upon my appointment in September 2024 and following Judicial Registrar Lorenz's departure.

7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Jeffrey's death. The Coronial Investigator conducted initial inquiries on the Court's behalf, including taking statements from witnesses. The Court was also assisted by the provision of the Department of Justice and Community Safety's report of their review into the death.

8. This finding draws on the totality of the coronial investigation into the death of Jeffrey George Nirens. 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]

BACKGROUND

9. Jeffrey entered custody in September 2017 with known health concerns including chronic headache. Jeffrey was seeing a private neurologist in the community for this.

10. Records from Jeffrey's various treating clinicians in the community were provided to prison medical officers. These records noted chronic small vessel ischaemia in the brain which increased his risk for stroke. Repeat imaging of the brain between May 2018 and December 2021 showed progressive degenerative changes.

11. A referral was made to the neurology department at St Vincent's Hospital Melbourne (**SVHM**).

12. Throughout his custodial term, Jeffrey declined to attend many appointments at SVHM citing safety concerns about having to be transferred via Port Phillip Prison. These related to threats by other prisons and alleged assaults in January 2018 which were reported to custodial staff at the time.

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

Circumstances in which the death occurred

13. On 9 August 2022, Jeffrey was transferred to Beechworth. During the inter-prison health assessment, his blood pressure and temperature were recorded as normal. He was placed on a transfer quarantine regime in line with the Victorian prison system's response to the COVID-19 pandemic.

14. On 15 August 2022, Jeffrey was called to the medical centre to discuss the upcoming cystoscopy appointment at SVHM that was rescheduled from June 2022 following his decision to refuse treatment. Again, Jeffrey declined to transfer via Port Phillip.

15. Jeffrey stated he did not feel safe, he had been to Port Phillip on several occasions in preparation for appointments that were cancelled, and that he did not want to be placed in

[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.

quarantine again. Jeffrey was informed that it may be many months before another appointment was available.

16. On 23 August 2022, Jeffrey presented to custodial staff with slurred speech and weakness down one side of his body. Medical staff were notified, and Jeffrey was conveyed to Wangaratta Hospital by ambulance the same day.

17. On arrival, Jeffrey was noted to have presented with several hours of slurred speech, limb weakness, and difficulties finding words. A CT brain scan showed no bleeding and so he was treated presumptively for ischaemic stroke with input from the Victorian Stroke Telemedicine (**VST**) service.[2]

18. Treatment included dual anti-platelet therapy and enoxaparin as pharmacological prophylaxis for venous thromboembolism (**VTE**).[3] An MRI brain scan was ordered to confirm the diagnosis.

19. On 24 August 2022, Jeffrey was noted to be well with stable but ongoing neurological deficits. The MRI was performed in the morning and revealed a left frontal ischaemic stroke with some haemorrhagic transformation and trace subarachnoid blood. As a result, the antiplatelet therapy was ceased to reduce the risk of further bleeding.

20. At 3:20pm Jeffery reported a headache. At 8:00pm Jeffery was administered prophylactic enoxaparin, which had not been withheld. This was documented by the hospital as not optimal in the setting of haemorrhagic transformation.

21. On 25 August 2022, at about 5:10am, a MET call was made as Jeffrey had an acutely reduced conscious state.

22. At 5:55am, a CT brain scan was performed to exclude a new ischaemic stroke or progression of bleeding.

23. The scan showed a large left sided intracerebral haemorrhage with ventricular extension and mass effect. This was assessed as a large, nonsurvivable bleed with a recommendation for a palliative approach.

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[2] VST service helps doctors work together across different hospitals to give the best care to stroke patients, no matter where they are. It connects 19 hospitals in Victoria with stroke specialists who can give advice on treating stroke symptoms.

[3] Venous thromboembolism (**VTE**), a pathology that includes deep vein thrombosis (**DVT**) and pulmonary embolism (**PE**), is a common cause of preventable mortality and morbidity among hospitalised patients.

24. Jeffrey's family attended the hospital, and a family meeting was held to discuss the hospital admission and administration of prophylactic enoxaparin.

25. Jeffrey died later that afternoon at 3:54pm.

Identity of the deceased

26. On 29 August 2022, Jeffrey George Nirens, born 16 October 1951, was visually identified by a relative, who completed a statement of identification.

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

Medical cause of death

28. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and provided a written report of the findings.

29. The examination showed findings in keeping with the clinical history.

30. Toxicological analysis of antemortem samples collected in the hospital identified the presence of Jeffrey's regular medications and paracetamol only.

31. Dr Baber provided an opinion that the medical cause of death was:

    1(a) intracranial haemorrhage

    1(b) haemorrhagic transformation of ischaemic stroke in the setting of anticoagulation therapy

32. I accept Dr Baber's opinion.

FURTHER INVESTIGATIONS

Department of Justice and Community Safety Review

33. When a person dies in prison, the Department of Justice and Community Safety (**DJCS**) conducts a review of the circumstances and management of the death.

34. The review found a missed opportunity to support alternative care arrangements in the context of Jeffrey's repeated refusals to attend external medical appointments. The report noted that the *"Right to Decline Medical Treatment"* policy was followed. This policy requires clinicians to explain the clinical reason for appointments and the risks of not attending. This occurred throughout Jeffrey's management.

35. The report noted that:

> "…patient confidentiality requires absolute confidentiality of patient information, except where work-related disclosure is required. Under this policy, disclosure of health information without patient consent is permitted to 'inform appropriate placement and management arrangements to ensure the safety and welfare of the patient'.
>
> Given Mr Nirens' health risks were potentially heightened by his refusal to attend recommended external appointments, health staff could have considered disclosing this information to custodial staff under the policy exception. The disclosure could have withheld private health information and advised Mr Nierens was refusing treatment due to the requirement to transfer and security concerns at Port Phillip. This would have enabled the case manager to work with him to explore alternative opportunities to engage.
>
> Health staff were also not precluded from engaging with custodial staff with Mr Nierens' consent. If health and custodial staff liaised with the Sentence Management Unit regarding Mr Nierens' reclassification to Beechworth, the outcome may have resulted in an earlier transfer. This was a missed opportunity to facilitate care for an elderly and vulnerable prisoner."

36. The conclusions of the report are acknowledged. However, even if alternative arrangements had been made, I do not consider that the stroke and subsequent death would have been prevented. Jeffrey was at a known increased risk of stroke from his small vessel disease. This was managed at the local level with medications and other interventions.

Northeast Health Wangaratta Review

37. The medical cause of death acknowledges that anticoagulation therapy may have contributed to the death. The administration of enoxaparin, an anticoagulant, would have increased the risk of further bleeding.

38. However, haemorrhagic transformation is a known complication of ischaemic stroke; this may have occurred even if there had been no administration of enoxaparin. As such, it is difficult to assess the degree of contribution to the subsequent bleed.

39. Nonetheless, not ceasing the enoxaparin was swiftly identified by the hospital and it was recognised that this was not optimal care. The clinical course and the possible contribution of enoxaparin to the subsequent stroke was disclosed as such to Jeffrey's family prior to the death.

40. A subsequent In-Depth Care Review (**IDCR**) conducted by Northeast Health Wangaratta (**NHW**) in 2025, following the Court's request for information, concurred and documented the following:

> "It is not clear whether [enoxaparin] administration was likely to have caused or exacerbated the haemorrhage, but we believe it was unlikely…there is no definitive link found in our search of research studies to suggest anticoagulants increase hemorrhagic transformation rates in ischemic stroke, although there is always a risk due to the nature of the medication."

41. The ICDR did not reference any internal or external policy or guidelines. No recommendations were made.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Jeffrey George Nirens, born 16 October 1951;

   b) the death occurred on 25 August 2022 at Northeast Health Wangaratta from *intracranial haemorrhage* secondary to *haemorrhagic transformation of ischaemic stroke in the setting of anticoagulation therapy*; and,

   c) the death occurred in the circumstances described above.

2. I am satisfied that Jeffrey died from natural causes and that his custodial health management was appropriate and did not cause or contribute to the death.

3. It is not possible to determine whether the death would have been prevented had the enoxaparin not been administered on the evening of 24 August 2022 given that haemorrhagic transformation is a known complication of ischaemic stroke and may have occurred regardless.

4. As noted above, Jeffrey's death was reportable because, immediately before his death, he was person placed in custody. Section 52 of the Act requires an inquest to be held in these cases, except in circumstances where the person is deemed to have died from natural causes.[4] This determination can be based on an opinion from the forensic pathologist that the death was from natural causes.[5]

5. I consider that no further investigation is necessary which would otherwise require an inquest and, accordingly, I have exercised my discretion under section 52(3A) of the Act to not hold an inquest.

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

Pursuant to section 73(1B) of the Act, this finding must 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:

Monika Skladowski, Senior Next of Kin

Department of Justice and Community Safety

Correct Care Australasia Pty Ltd

Northeast Health Wangaratta

Victorian Stroke Telemedicine (VST) service

Signature:

Coroner Dimitra Dubrow

Date: 10 October 2025

[4] Section 52(3A) of the Act.
[5] Section 52(3B) of the Act.

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.