IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006747

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Harold Edward Burgess
Date of birth:	20 August 1933
Date of death:	23 November 2022
Cause of death:	1a: unascertained- natural causes
Place of death:	Port Phillip Prison, Group Camp, 451 Dohertys Road, Truganina, Victoria, 3029
Keywords:	Natural causes – in custody, unascertained

INTRODUCTION

1. On 23 November 2022, Harold Edward Burgess was 89 years old when he died in the St John's Unit at Port Phillip Prison. The unit is an inpatient medical ward and is managed by St Vincent's Correctional Health Services (**SVCHS**).

2. Harold was sentenced to imprisonment in July 2016. From late 2020, nursing staff noted a decline in Harold's cognitive function. In February 2021, Harold was diagnosed with dementia by a psychiatrist.

3. On 23 December 2021, Harold was transferred to the St John's Unit for management of his dementia and other medical co-morbidities.

THE CORONIAL INVESTIGATION

4. Harold'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.

5. 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.

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

8. 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.

9. This finding draws on the totality of the coronial investigation into the death of Harold Edward Burgess. 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 6 November 2022, John had a fall in the unit resulting in serious injuries.

11. John was conveyed to St Vincent's Hospital Melbourne (**SVHM**) and was reviewed by the neurosurgical team. John's injuries included acute and sub-acute cervical spine fractures. The neurosurgical team determined that, owing to his frailty and medical co-morbidities, John was unsuitable for surgical management. The team recommended conservative management only.

12. On 9 November 2022, John was transferred back to St John's Unit at Port Phillip Prison. John continued to deteriorate and was treated with a palliative approach within the unit.

13. On 23 November 2022, health staff observed that John was very pale in colour and did not appear to be breathing. A subsequent assessment confirmed that John had passed away.

Identity of the deceased

14. On 24 November 2022, Harold Edward Burgess, born 20 August 1933, was visually identified by prison health staff, who completed a statement of identification.

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

Medical cause of death

16. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 25 November 2022 and provided a written report of the findings.

[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.

17. No clear cause of death was identified. Nonetheless, Dr Bedford provided an opinion that the death was from natural causes and formulated the medical cause of death as *1(a) unascertained- natural causes.*

18. I accept Dr Bedford's opinion.

FURTHER INVESTIGATIONS

Department of Justice and Community Safety Review

19. 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. The review was completed collaboratively by the Justice Assurance and Review Office (**JARO**) and Justice health, business units within DJCS. A report of review was produced which was subsequently provided to the Court.

20. The report clarified that the fall on 6 November 2022 met the criteria for a Serious Adverse Patient Safety Event (**SAPSE**).[2] This should have been assigned an incident severity rating (**ISR**) category 2 and triggered a formal incident review.[3] This did not occur at the time of John's death.

21. St Vincent's Correctional Health Service (**SVCHS**) advised Justice Health that at the time of the fall, there was an IT outage at Port Phillip Prison. A hard copy incident report was not completed.

22. During the review process, SVCHS acknowledged that the fall should have been an ISR 2 event and undertook a retrospective formal review which was then provided to Justice Health.

23. As the fall was unwitnessed, the SVCHS review did not make any final determinations on the cause of the fall or whether it was preventable. However, it did consider the possibility that an unresolved urinary tract infection resulted in delirium and increased his risk of falls.

[2] *Health Services (Quality and Safety) Regulations 2020*, r 3B. SAPSE are events or incidents that have resulted in unexpected or unintended harm to patients receiving healthcare.
[3] ISR is the 4-tiered severity rating system for adverse events, including SAPSE:
ISR 1 – severe/death
ISR 2 – moderate
ISR 3 – mild
ISR 4 – no harm/near miss.

24. The report concluded that SVCHS completed a thorough review of the unwitnessed fall and implemented appropriate remedial action, including a hardcopy failsafe reporting option. As such, no further actions were recommended in the report.

25. Overall, the report concluded that Harold's care throughout his custodial sentence met the required standards under the Justice Health Quality Framework and was appropriate.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Harold Edward Burgess, born 20 August 1933;

    b) the death occurred on 23 November 2022 at Port Phillip Prison, Group Camp, 451 Dohertys Road, Truganina, Victoria, 3029, from 1(a) unascertained- natural causes

    c) the death occurred in the circumstances described above.

27. As noted above, Harold'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]

28. Notwithstanding that exact cause of Harold's death could not be determined, I am satisfied that Harold died from natural causes and that his custodial health management was appropriate and did not cause or contribute to the death.

29. 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 Harold's family for their loss.

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

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

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

M Burgess, Senior Next of Kin

Department of Justice and Community Safety

St Vincent's Hospital Melbourne

Signature:

Coroner Dimitra Dubrow

Date: 14 May 2025

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.