IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 7325

**FINDING INTO DEATH WITHOUT INQUEST**

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

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| Findings of: | Sarah Gebert, Coroner |
| Deceased: | Greg John HOWARTH |
| Date of birth: | 5 December 1960 |
| Date of death: | 23 December 2022 |
| Cause of death: | 1(a) Congestive Cardiac Failure in a man with Ischaemic and Hypertensive Heart Disease<br>Contributing Factors: Metastatic Cholangiocarcinoma (Treated), WHO Class III Obesity |
| Place of death: | St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria |
| Other matters | *Person placed in custody or care*, *natural causes* |

## INTRODUCTION

1. Greg John Howarth, born on 5 December 1960, was 62 years of age at the time of his death.

2. Mr Howarth was an inmate at Port Phillip Prison, having been incarcerated since 2019 for approximately 100 counts of serious sexual offences. He had an extensive criminal history dating back to 1989, which included drug trafficking, serious assaults and sex offences.

3. On 23 December 2022, Mr Howarth passed away at St Vincent's Hospital having been admitted for care that day.

## THE CORONIAL INVESTIGATION

4. Mr Howarth's death was reported to the coroner as he was considered to be *a person placed in custody or care* under section 3(1) of the *Coroners Act 2008* (**the Act**) and so fell within the definition of a reportable death under the Act.

5. 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.

6. 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.

7. Victoria Police assigned First Constable Harley Krause (**FC Krause**) to be the Coroner's Investigator for the investigation into Mr Howarth's death. FC Krause conducted inquiries on my behalf, including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from Consultant Physician Sue-Anne McLachlan of St Vincent's Hospital, the forensic pathologist who examined him and the Coroner's Investigator as well as other relevant documentation.

8. As part of the investigation, I referred the case to the Coroners Prevention Unit (**CPU**).[1] The CPU were asked to consider whether the care provided to Mr Howarth was adequate.

9. As advice was received from a pathologist that Mr Howarth's death was due to natural causes[2], a mandatory inquest was not required.[3]

10. This finding draws on the totality of the coronial investigation into Mr Howarth'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.[4]

**Background**

11. Mr Howarth had a history of metastatic cholangiocarcinoma, type 2 diabetes mellitus, supraventricular tachycardia, obstructive sleep apnoea (on CPAP), hypertension, dyslipidaemia, asthma/chronic obstructive pulmonary disease, fatty liver, osteoarthritis, and reflux.

12. On 27 August 2022 he was diagnosed with incurable metastatic cholangiocarcinoma of the gall bladder. A palliative chemotherapy/immunotherapy was recommended by his treating team and accepted by Mr Howarth.

13. Mr Howarth was seen in an oncology outpatient clinic for chemotherapy on 9 December 2022, and was using a wheelchair. He had declining renal function and had gained 10 kg in weight.

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

**Circumstances in which the death occurred**

14. Mr Howarth was admitted to St Vincent's Hospital, and was treated for fluid overload, and discharged on 21 December 2022.

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[1] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[2] Paragraph 23.

[3] S52(3A) of the Act.

[4] 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. From that time, he had increasing shortness of breath and leg swelling, and presented back to hospital on 23 December, with difficulty breathing.

16. Mr Howarth had a cardiac arrest whilst in hospital. Cardiopulmonary resuscitation (**CPR**) was unsuccessful and he was declared deceased at 4.28pm on 23 December 2022.

**Identity of the Deceased**

17. On 23 December 2022, Chris Bidlo, prison employee visually identified Greg John Howarth born 5 December 1960.

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

**Medical cause of death**

19. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy examination on 28 December 2022 and provided a written report of his findings dated 3 March 2023.

20. A toxicological analysis of post mortem samples identified the presence of drugs consistent with therapeutic use and treatment.

21. Dr Young made the following comments:

*Features of congestive cardiac failure were seen at autopsy, including pericardial and pleural effusions, peripheral oedema, anasarca, and pulmonary oedema. Congestive cardiac failure occurs when the heart is unable to maintain sufficient cardiac output to meet the demands of the body. In this case, it was due to ischaemic and hypertensive heart disease.*

*The heart was enlarged (heart weight 621 g), and showed chronic changes (myocardial fibrosis and severe triple vessel coronary artery atherosclerosis) and acute changes (acute myocardial infarction of the posterior left ventricular wall). Atherosclerosis is a disease process characterised by lesions (atheromas) of the inner lining of arteries that protrude into and obstruct the lumina of the arteries. This may lead to a myocardial infarction (death of heart muscle) if there is significant occlusion of a coronary artery by atheroma or a thrombus. The overarching disease process is called ischaemic heart disease. In this case, the myocardial infarction precipitated and/or exacerbated the congestive cardiac failure. The final mechanism of death would have been a cardiac arrhythmia ("heart attack").*

*The deceased had WHO class III obesity, and treated metastatic cholangiocarcinoma. Obesity is defined as having a body mass index (BMI) of 30 kg/m2 or greater. A further classification by the World Health Organisation (WHO) divides this into class I obesity (from 30 to 35 kg/m2 ), class II obesity (from 35 to 40 kg/m2 ), and class III obesity (greater than 40 kg/m2 ). Cholangiocarcinoma is a cancer of bile ducts. These would have placed increased physiological stress on the deceased's heart, increasing the risk of myocardial infarction and congestive cardiac failure.*

*Toxicological analysis of post mortem blood showed the presence of oxycodone, sotalol, duloxetine, metoclopramide and paracetamol. Ethanol (alcohol) was not detected. Toxicological analysis of urine showed the presence of oxycodone, sotalol, duloxetine, metoclopramide, paracetamol and olanzapine. These have not caused or contributed to death.*

*Rib fractures were seen, attributable to CPR. There was no post mortem evidence of any injuries which may have caused or contributed to death*

22. Dr Young provided an opinion that the medical cause of death was *Complications arising from widely disseminated primary pulmonary small cell carcinoma. 1(a) Congestive Cardiac Failure in a man with Ischaemic and Hypertensive Heart Disease: Contributing Factors: Metastatic Cholangiocarcinoma (Treated), WHO Class III Obesity.*

23. Dr Young stated that on the evidence available to him, he was of the opinion that the death was *due to natural causes*.

24. I accept Dr Young's opinion as to the medical cause of death.

**FURTHER INVESTIGATION**

25. Mr Howarth's medical care was reviewed by the CPU who concluded that he had many irreversible comorbidities, that his care was reasonable and his death could not have been prevented. The CPU were unable to identify any opportunities for prevention in the course of their review.

26. I accept the CPU's advice on these matters.

**FINDINGS AND CONCLUSIONS**

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

(a) the identity of the Deceased was Greg John Howarth, born 5 December 1960;

(b) the death occurred on 23 December 2022 at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria from *1(a) Congestive Cardiac Failure in a man with Ischaemic and Hypertensive Heart Disease; Contributing Factors: Metastatic Cholangiocarcinoma (Treated), WHO Class III Obesity*; and

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

28. I convey my condolences to Mr Howarth's family for their loss.

29. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet.

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

**Bernadette Howarth, senior next of kin**

**First Constable Harley Krause, Victoria Police, Coroner's Investigator**

Signature:


**Coroner Sarah Gebert**

Date: 30 November 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.