IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002492

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Person E
Date of birth:	[redacted] November 1952
Date of death:	11 May 2023
Cause of death:	1a: organising diffuse alveolar damage 2: hypertensive heart disease, right ventricular hypertrophy, coronary artery atherosclerotic stenosis, chronic obstructive pulmonary disease.
Place of death:	Ballarat Base Hospital (Grampians Health), Ballarat Central, Victoria, 3350
Keywords:	In custody – natural causes

INTRODUCTION

1. On 11 May 2023, Person E was 70 years old when he died at Ballarat Base Hospital.

2. At the time of his death, Person E was serving a term of imprisonment at Hopkins Correctional Centre which commenced 17 September 2019.

3. Person E had multiple health conditions including dyslipidaemia, hypertension, and chronic obstructive pulmonary disease (**COPD**). Person E received treatment and health care in custody for these conditions.

THE CORONIAL INVESTIGATION

4. Person E'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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Person E's death. The Coronial Investigator conducted initial enquiries on the Court's behalf, including taking statements from witnesses.

10. Section 7 of the Act requires coroners to liaise with other investigating bodies to avoid unnecessary duplication of inquiries and investigations. To this effect, the Court assisted by provision of the Department of Justice and Community Safety's report of their review into the death.

11. This finding draws on the totality of the coronial investigation into the death of Person E. 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

12. On 18 April 2023, Person E reported to custodial staff that he had been suffering from dizziness and blood noses, and that he was short of breath and having trouble breathing.

13. A Code Black was called, and nursing and medical staff attended.

14. Person E disclosed that he had lost his regular inhaler and had not used it for the last few days.

15. Person E was alert but had low oxygen saturations (85%) and was administered oxygen before being transferred to the prison health centre.

16. On examination, Person E's vital signs were abnormal, and an ambulance was called to convey him to East Grampians Health Service (**EGHS**). Person E was discharged the same day and returned to the prison health centre at 8pm.

17. However, Person E continued to deteriorate. He became drowsy, clammy to touch, had laboured breathing with audible wheeze, and had reduced oxygen saturations. Another ambulance was called.

18. Person E transiently improved with treatment by paramedics. However, he continued to deteriorate and developed chest pain. As such, Person E was then conveyed to Ballarat Base Hospital (**BBH**), arriving at 9:50pm.

[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.

19. Person E was diagnosed with an infective exacerbation of COPD and admitted to the general medical ward.

20. Despite treatment, Person E deteriorated further and was transferred to the Intensive Care Unit (**ICU**) on 28 April 2023.

21. On 3 May 2023, Person E was transferred back to the general medical ward.

22. Person E remained unwell despite treatment with broad spectrum antibiotic therapy, systemic steroids, bronchodilators, and oxygen supplementation with high flow nasal prongs.

23. On 10 May 2023, after discussion with Person E, management was switched to comfort care only.

24. Person E passed away in the early hours of 11 May 2023.

Identity of the deceased

25. On 11 May 2023, Person E, born [redacted] November 1952, was visually identified by a custodial staff member who completed a statement of identification.

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

Medical cause of death

27. On 15 May 2023, Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy and provided a written report of the findings.

28. The autopsy showed severe organising diffuse alveolar damage (**DAD**) affecting all lobes of the lungs with no histological features to indicate an aetiology identified.

29. Other significant findings were signs of hypertensive heart disease and mild chronic renal disease. There were no injuries found at autopsy that may have caused or contributed to the death.

30. Dr Beer explained that DAD is a stereotyped response to injury in lung tissue. DAD consists of an intra-alveolar exudate (often described as hyaline membrane) in association with marked hyperplasia of type II pneumocytes that may appear cytologically bizarre and pleomorphic. Hyaline membranes consist of a mixture of proteinaceous exudate, surfactant from type II pneumocytes, and cellular debris.

31. DAD can progress to organizing pneumonia which may result in permanent pulmonary fibrosis or resolve with the restoration of normal lung architecture and function. In this case, there was a non-specific pattern of DAD which can be caused by many different types of injuries including shock, some types of infection, chemotherapeutic agents, irradiation, and oxygen toxicity. The outcome depends on host factors, the severity of lung injury, and whether the inciting cause of DAD is corrected.

32. Dr Beer also commented that the pre-existing lung and heart disease would have reduced respiratory reserve and would have contributed to the death.

33. Dr Beer provided an opinion that the medical cause of death was:

> 1(a) organising diffuse alveolar damage
> 2 hypertensive heart disease, right ventricular hypertrophy, coronary artery atherosclerotic stenosis, chronic obstructive pulmonary disease.

34. Dr Beer also provided an opinion that the death was from natural causes.

35. I accept Dr Beer's opinion.

FURTHER INVESTIGATIONS

Department of Justice and Community Safety Review

36. 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.

37. The review found that, overall, Person E's custodial health care was appropriate and did not cause or contribute to the death.

38. The review identified two quality improvements which would have improved Person E's healthcare but were unrelated to the death. These have since been delivered and the report made no further recommendations.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Person E, born [redacted] November 1952;

b) the death occurred on 11 May 2023 at Ballarat Base Hospital (Grampians Health), Ballarat Central, Victoria, 3350, from *organising diffuse alveolar damage* in the setting of *hypertensive heart disease, right ventricular hypertrophy, coronary artery atherosclerotic stenosis, chronic obstructive pulmonary disease*; and,

c) the death occurred in the circumstances described above.

40. Person E entered custody with significant medical co-morbidities. I am satisfied that his ongoing healthcare in custody was reasonable, and that the death was not preventable.

41. As noted above, Person E'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.[2] This determination can be based on an opinion from the forensic pathologist that the death was from natural causes.[3]

42. 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.

Pursuant to section 73(1B), this finding must be published on the Court's website in accordance with the rules. I direct for the published finding to be a de-identified version of this finding.

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

Senior Next of Kin
Department of Justice and Community Safety, c/o Victorian Government Solicitor's Office
Correct Care Australasia, c/o Meridian Lawyers
Grampians Health
Leading Senior Constable Ashley Sherrif, Coronial Investigator

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

Signature:

Coroner Dimitra Dubrow

Date: 15 August 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.