IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 000741

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	MD
Date of birth:	1942
Date of death:	7 February 2025
Cause of death:	1(a) Complications of large bowel obstruction in a man with diverticular disease and other co-morbidities
Place of death:	St Vincent's Hospital Melbourne, 41 Victoria Parade, Fitzroy, Victoria
Key words:	*Person placed in custody or care, large bowl obstruction, multiple co-morbidities*

INTRODUCTION

1. On 7 February 2025, MD was 82 years old when he died in hospital due to a large bowel obstruction.

2. At the time of his death, MD was incarcerated at Port Phillip Prison.

THE CORONIAL INVESTIGATION

3. MD'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. 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.

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. Victoria Police assigned First Constable Hugh Wellington to be the Coroner's Investigator for the investigation of MD'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.

7. In addition, I asked the Coroners Prevention Unit (**CPU**)[1] to review the medical care MD received proximate to his death.

8. This finding draws on the totality of the coronial investigation into MD's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

[1] The CPU was established in 2008 to strengthen the coroner's prevention role and to assist in formulating recommendations following a death. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. The CPU may also review the medical care and treatment in cases referred by the coroner as well as assist with research into public health and safety.

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.[2]

Background

9. MD was born in England. He moved to Australia in 1949 with his family. In his adult years he worked in labouring-type jobs such as mining. In 1969, MD married BD, and they went on to welcome three children together.

10. From about 1997, MD began experiencing multiple health issues and he had limited mobility, using an electric scooter to mobilise.

11. In March 2021, MD was arrested and interviewed for sexual penetration of a minor. In December 2022, he was arrested by extradition warrant to Tasmania. MD was subsequently sentenced to 4 years and 6 months imprisonment, with a non-parole period of 2 years and 3 months.

12. From about mid-May 2024, MD was incarcerated at various prisons across Victoria. He was last accommodated at Port Phillip Prison. He was granted parole in February 2025 and was looking forward to returning home in March 2025.

13. MD's medical history included atrial fibrillation, a stroke in 2015, obstructive sleep apnea, Sydenham's chorea with a longstanding right-hand tremor, epilepsy, depression, hypertension, ischemic heart disease, peripheral vascular disease, benign prostate hypertrophy, abdominal aortic aneurysm and diverticular disease.

14. In December 2024, MD was treated in hospital due to hypotension with low oxygen saturation and worsening leg oedema. He had been experiencing recurrent falls in the preceding weeks. Following investigation, he was diagnosed with heart failure with preserved ejection fraction and stage four chronic kidney disease with a cardiorenal cause. Secondary diagnoses also included an L1 burst fracture, osteoporosis, normocytic anemia, hypoglycemia, constipation, reduced oral intake, and right lower leg swelling, with the likely cause deemed to be a pseudoaneurysm. He was discharged on 9 January 2025 with plans for follow-up appointments with the renal outpatient clinic and cardiology outpatient clinic.

[2] 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.

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

Circumstances in which the death occurred

15. On 5 February 2025, MD suffered a fall with head strike on the background of several days of abdominal pain and vomiting. He was transported to St Vincent's Hospital for assessment.

16. Initial investigations demonstrated known atrial fibrillation and a supratherapeutic INR (international normalised ratio) of 5.7 (on warfarin). A chest x-ray incidentally revealed multiple dilated loops of bowel, prompting further imaging. A CT (computed tomography) scan of the abdomen and pelvis confirmed a large bowel obstruction secondary to an obstructing sigmoid mass.

17. The general surgical team was consulted and confirmed the diagnosis of large bowel obstruction. A colorectal fellow assessed MD and recommended a laparotomy and Hartmann's procedure, noting there was a high risk of mortality.

18. However, on review by the perioperative medicine team, MD was considered too high risk for emergency surgery, with anticipated complications including respiratory failure, prolonged recovery, postoperative dialysis, and risk of poor functional outcome. It was recommended that a palliative approach be considered as a more appropriate management pathway given long-term outcomes would likely be poor. The Intensive Care Unit team agreed.

19. Following discussions with MD and his wife, he was transitioned to palliative management.

20. MD passed away at 3.43pm on 7 February 2025.

Identity of the deceased

21. On 7 February 2025, MD, born 1942, was visually identified by his wife, BD.

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

Medical cause of death

23. Forensic Pathologist, Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 10 February 2025 and provided a written report of his findings dated 13 February 2025.

24. The post-mortem examination was consistent with the reported circumstances.

25. A post-mortem CT scan showed dilated large bowel loops with a transition at sigmoid colon, but no pneumoperitoneum. Contrast was seen in the urinary bladder, kidneys and gallbladder. The chest showed coronary artery calcification, a cardiac pacemaker and increased lung markings. An intact abdominal aortic aneurysm was seen in the abdomen, and a large popliteal aneurysm was seen in the right leg. The left hip showed previous surgery. The head showed an old right middle cerebral artery territory ischaemic stroke, no intracranial haemorrhage, and previous surgery.

26. Dr Young provided an opinion that the medical cause of death was *"1(a) Complications of large bowel obstruction in a man with diverticular disease and other co-morbidities"* which he considered was a natural cause death.

27. I accept Dr Young's opinion.

FURTHER INVESTIGATION

Department of Justice and Community Safety review

28. When a person dies in prison, the Justice Assurance and Review Office (**JARO**) and Justice Health collaboratively review the circumstances and management of the death and the medical care and treatment provided to the person in custody.

Custodial management

29. The Department of Justice and Community Safety (**DJCS**) found that MD's case management by Ravenhall and Port Phillip in the 12 months prior to his death was appropriate and considered his health needs and physical limitations.

Medical management

30. The DJCS review noted that MD had a complex medical history, including diagnoses of respiratory conditions, chronic kidney disease and cardiovascular conditions.

31. He was given a medical (**M**) risk rating of M2, which denoted medical conditions requiring regular or ongoing treatment. This rating was maintained throughout MD's time in custody to reflect that his medical conditions required ongoing care.

32. Health staff developed an integrated care plan (**ICP**), and MD engaged in regular reviews and appointments. The health team scheduled regular appointments and diagnostic testing, including physiotherapy, podiatry, optometry, dental, and external cardiology. Health staff also regularly updated MD's care plan based on the findings of these reviews.

33. MD was also identified as a falls risk early in his admission to custody and his medical records evidenced this as a consideration throughout his admission. Health staff regularly reviewed his falls risk and considered it with daily care planning.

34. DJCS found that that health staff responded appropriately to MD's increased needs due to his ongoing complex health needs and gradual decline. The medical team regularly met with MD and regularly reviewed his file to monitor his changing medical needs and provided care accordingly.

Coroners Prevention Unit review

35. MD's wife raised concern that it was difficult to understand why the mass in MD's bowel had not been identified earlier given he was frequently in and out of hospital with his various medical issues.

36. As part of my investigation, I obtained advice from the CPU as to whether MD's condition should have been identified earlier.

37. The CPU advised that medical staff would only 'look for' bowel cancer when a patient has either experienced a change in bowel motion, unexplained weight loss, or iron deficiency anaemia. It appears that MD only had bowel issues a few days before his last presentation.

38. The CPU further considered that given MD's extensive comorbidities, it is unlikely that an earlier diagnosis would have resulted in a different outcome as those long-term comorbidities most likely would have precluded most treatments (such as surgery, chemotherapy).

39. The CPU concluded that the care was reasonable, and MD's death was not preventable. I accept the CPU's advice on these matters.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was MD, born 1942;

(b) the death occurred on 7 February 2025 at St Vincent's Hospital Melbourne, 41 Victoria Parade, Fitzroy, Victoria, from complications of large bowel obstruction in a man with diverticular disease and other co-morbidities; and

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

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

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:

BD, senior next of kin
St Vincent's Hospital Melbourne
Justice Assurance and Review Office
First Constable Hugh Wellington, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 23 January 2026

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.