IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004161

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr B
Date of birth:	[redacted] 1963
Date of death:	07 August 2021
Cause of death:	*Subarachnoid Haemorrhage Secondary to Ruptured Pericallosal Aneurysm*
Place of death:	St. Vincent's Hospital Melbourne 41 Victoria Parade, Fitzroy, Victoria, 3065
Keywords:	*Death in custody, natural causes*

This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased, and his family members with pseudonyms to protect their identity and redact identifying information

INTRODUCTION

1. Mr B was 57 years old at the time of his death and was on remand at Port Phillip Prison (**PPP**) whilst awaiting a hearing at Melbourne Magistrates' Court.[1] The hearing was scheduled for 15 September 2021.

2. On 4 August 2021, correctional officers at PPP were notified by a prison inmate that Mr B was unwell. He soon deteriorated and was transferred to St Vincent's Hospital by Ambulance Victoria.

3. Mr B's condition further deteriorated, and he passed away on 7 August 2021.

THE CORONIAL INVESTIGATION

4. Mr B'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.

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 an officer to be the Coroner's Investigator for the investigation of Mr B's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as prison staff, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

[1] [redacted] will be referred to as Mr B in this Finding except where formality is required.

8. The Court also obtained Mr B's records from Justice Health and St Vincent's Hospital.

9. As advice was received from the pathologist that Mr B'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 B'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 B's medical history consisted of chronic hepatitis, insomnia, and anxiety. He had a long history of substance abuse and had recently relapsed following a period of abstinence after the death of a close friend.

12. Mr B had an extensive criminal history. He was first placed into custody in 1986 and subsequently spent 12 years of the next 35 years in prison.

13. On 24 August 2021, Mr B was arrested in relation to two counts of armed robbery. He was refused bail at Sunshine Police Station and had a committal mention at Melbourne Magistrates' Court on 25 August 2021, where he did not apply for bail.

14. Mr B was remanded into custody and due to face court on 15 September 2021. He was transferred to the Melbourne Assessment Centre on 26 June 2021 and subsequently to PPP on 30 June 2021.

15. Mr B was described as *polite* and *respectful* when speaking with prison staff and he was not involved in any incidents during his time at PPP.

16. Whilst at PPP, Mr B expressed a desire to work within the prison, maintain contact with his family, and to obtain full-time employment.

17. Mr B also received care from PPP's medical and psychological team throughout his stay, primarily for treatment of his insomnia, drug withdrawal, and for pathology. During his time

[2] Paragraph 31.
[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.

at PPP, Mr B continued taking the following prescription and non-prescription medications:

i. Esomeprazole;[5]
ii. Mirtazapine;[6]
iii. Paracetamol;[7] and
iv. Ibuprofen[8]

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

Circumstances in which the death occurred

18. At 10.00am on 4 August 2021, Mr B had an appointment with a PPP doctor to discuss recent pathology results. Mr B requested a colonoscopy and X-ray of his wrist, which had been sore.

19. At approximately 12.15pm, prison staff were notified by a prisoner that Mr B appeared to be unwell and had apparently collapsed. Staff attended to him, and a Code Black was initiated.[9] On initial observation, Mr B appeared to be disoriented, unable to speak, and was holding his head.

20. At 12.23pm, prison medical staff arrived on scene and attended to Mr B. He experienced two separate seizures lasting approximately five minutes each accompanied by vomiting. Prison staff called Triple Zero.

21. At 12.55pm, Ambulance Victoria arrived at PPP and attended to Mr B. They observed that he was in an *altered conscious state* whereby his eyes were open, and he was able to follow commands, but he was verbally unresponsive.

22. Mr B was conveyed to St Vincent's Hospital by ambulance and arrived at 1.36pm. He was immediately taken to a resuscitation cubicle and then transferred to the Intensive Care Unit at 3.57pm.

[5] Esomeprazole is a medication in the class of proton pump inhibitors. These medications regulate the amount of stomach acid that is produced to alleviate symptoms of reflux, ulcers, and oesophagitis.
[6] Mirtazapine is a medication used to treat depression.
[7] Paracetamol is a common painkiller.
[8] Ibuprofen is a common painkiller.
[9] A Code Black is called when there is a death or serious medical incident.

23. Initial investigations revealed a *catastrophic intracranial bleed due to an aneurysm*. Mr B was unconscious at this point and required ventilation and other supportive care. Mr B received emergency neurosurgery to assist his neurological recovery.

24. In the 48 hours following his surgery, Mr B did not regain consciousness and his clinical signs and scans indicated that he had experienced irreversible brain injury.

25. On 7 August 2022, doctors performed two separate clinical brain death tests and confirmed that brain death had occurred. Mr B was declared deceased at 1.15pm.

26. Mr B's family kindly consented to donation of his organs.

Identity of the deceased

27. On 10 August 2021, Mr B, born [redacted] 1963, was identified via fingerprint identification.

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

Medical cause of death

29. Senior Forensic Pathologist, Dr Brian Beer from the Victorian Institute of Forensic Medicine, conducted an examination on 10 August 2021 and provided a written report of his findings dated 11 August 2021.

30. The post-mortem examination revealed *findings in keeping with the clinical history.*

31. Dr Beer provided an opinion that the medical cause of death was *Subarachnoid Haemorrhage Secondary to Ruptured Pericallosal Aneurysm*, and that Mr B's death was due to natural causes.

32. I accept Dr Beer's opinion.

FURTHER INVESTIGATIONS

33. I also sought advice from the Coroners Court of Victoria's Health and Medical Investigations Team (**HMIT**) of the Coroners Prevention Unit (**CPU**)[10] to help determine whether Mr B's medical treatment had been appropriate.

34. The HMIT noted that Mr B had not had any headaches prior to the one that caused him to collapse on 4 August 2021 and that without this forewarning, the HMIT considered that events could not be either predicted or prevented.[11]

35. I accept the HMIT's advice on this matter.

FINDINGS AND CONCLUSION

36. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Mr B, born [redacted]1963;

    b) the death occurred on 07 August 2021 at St. Vincent's Hospital Melbourne 41 Victoria Parade, Fitzroy, Victoria, 3065, from *Subarachnoid Haemorrhage Secondary to Ruptured Pericallosal Aneurysm*; and

    c) the death occurred in the circumstances described above.

37. I convey my sincere condolences to Mr B's family for their loss.

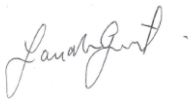
38. Pursuant to section 73(1B) of the Act, I order that this Finding (in a redacted format) be published on the Coroners Court of Victoria website in accordance with the rules.

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

    a) Mrs B, Senior Next of Kin
    b) Senior Constable Gsell, Coroner's Investigator

[10] The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners.
[11] Such headaches are called sentinel headaches, which are non-catastrophic subarachnoid haemorrhages that allow for diagnosis and management before the big bleed occurs.

Signature:



Coroner Sarah Gebert

Date : 07 October 2022

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.