IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3853

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	David John Campbell
Date of birth:	9 August 1959
Date of death:	27 July 2019
Cause of death:	Intracerebral haemorrhage
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052

INTRODUCTION

1. On 27 July 2019, David John Campbell (**Mr Campbell**) was 59 years of age when he died in the Royal Melbourne Hospital.

2. At the time of his death, Mr Campbell was in the legal custody of the Secretary to the Department of Justice and Community Safety (**DJCS**) serving a term of imprisonment at Hopkins Correctional Centre (**Hopkins**) in Ararat, Victoria.

THE CORONIAL INVESTIGATION

3. Mr Campbell'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 as defined in the Act is a mandatory report to the Coroner, even if the death appears to have been from natural causes.[1]

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. The Justice Assurance and Review Office (**JARO**) of the DJCS conducted a review of the custodial management and healthcare provided to Mr Campbell. I have reviewed the material provided by JARO, as well as medical records from the East Grampians Health Service and Royal Melbourne Hospital to assist the coronial investigation and inform this finding.

7. This finding draws on the totality of the coronial investigation into the death of Mr Campbell. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to

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[1] See generally sections 3 and 4 of the Act and section 4(2)(c) which deals with people in custody or care immediately before their death.

my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Identity of the deceased

8. David John Campbell, born 9 August 1959, was visually identified by his partner, Hendrikje Vanderhoven who signed a formal Statement of Identification to this effect on 23 July 2019 before a member of the clinical staff of the Royal Melbourne Hospital.

9. Identity is not in dispute and required no further investigation.

Medical cause of death

10. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 29 July 2019 and provided a written report of his findings dated same. In preparation of his report, Dr Lynch reviewed the Victoria Police Report of Death, VIFM contact log, medical records and deposition from the Royal Melbourne Hospital and the routine post-mortem computed tomography (**CT**) scan.

11. The post-mortem external examination revealed signs of medical intervention but nothing else of note.

12. The CT scan showed a left thalamic haemorrhage, intraventricular haemorrhage, cerebral oedema, burr holes and calcific coronary artery disease.

13. Routine toxicological analysis of ante-mortem plasma samples detected levetiracetam[3], labetalol[4], metoprolol[5], prazosin[6], metoclopramide[7] and paracetamol[8] in therapeutic concentrations and likely administered as part of medical intervention.

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[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.

[3] Antiepileptic used for the control of partial onset seizures.

[4] Competitive alpha-and beta-adrenergic receptor antagonist used in the treatment of hypertension.

[5] Anti-hypertensive drug.

[6] Alpha-adrenergic blocking agent specific for alpha-1 (or post-synaptic) receptors used in the treatment of high blood pressure and other conditions.

[7] Anti-emetic drug used for the treatment of nausea and vomiting.

[8] Analgesic drug.

14. Dr Lynch formed the view that death appeared to be due to natural causes and provided the opinion that the medical cause of death was 1 (a) *intracerebral haemorrhage*.

15. I accept Dr Lynch's opinion.

Circumstances in which the death occurred

16. On 16 July 2019, at approximately 5:35am, custodial staff at Hopkins were alerted by another prisoner that Mr Campbell had collapsed in his cell and was unrousable. Hopkins' custodial and health staff attended to Mr Campbell. He was dry retching and appeared pale and clammy. As his condition appeared to stabilise, he was prepared for transfer to Hopkins' medical centre for further evaluation and/or hospital transfer.

17. At approximately 6:05am, as Mr Campbell was being assisted into a wheelchair, he became limp and unresponsive. He was immediately placed back on the floor and first aid was administered. Ambulance Victoria paramedics were requested to attend at approximately 6:12am and arrived at about 6:35am.

18. At approximately 7:10am, Mr Campbell arrived at the Eastern Grampian Health Service where he was placed into an induced coma and intubated. A CT scan confirmed that Mr Campbell was suffering a left thalamic intracerebral haemorrhage with an intraventricular rupture and raised intracranial pressure.

19. He was subsequently transported to the Royal Melbourne Hospital (**RMH**) by air-ambulance, arriving at approximately 11:42am. An external ventricular drain was inserted, and he was admitted to the intensive care unit where he remained intubated and ventilated.

20. Over the next few days, Mr Campbell's sedation was weaned but his neurological recovery was poor. About 48 hours after sedation was completely ceased, discussions were held with his family and it was agreed further medical treatment would be futile. Mr Campbell was extubated and placed under palliative care.

21. Mr Campbell remained unresponsive and his health continued to deteriorate over the next 11 days. At about 10:22pm, on 27 July 2019, Mr Campbell ceased breathing and was pronounced deceased.

22. Mr Campbell's family kindly consented to the donation of his organs.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was David John Campbell, born 9 August 1959;

    (b) the death occurred on 27 July 2019 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052;

    (c) the cause of death was an intracerebral haemorrhage; and,

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

24. Having considered all the available evidence, I am satisfied that Mr Campbell's custodial and healthcare management was appropriate and met the required standards in accordance with the *Justice Health Quality Framework 2014*.

25. 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.

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

    Hendrikje Vanderhoven, Senior Next of Kin

    Dr Sophie Ping, East Grampians Health Service

    Scott Swanwick, Justice Health

    Michelle Gavin, Justice Assurance and Review Office

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 18 May 2021

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.