CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 4th day of August 2021 and the 30th day of March 2022, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Julie Michele Dunn.

The said Court finds that Julie Michele Dunn aged 56 years, late of Northfield Women's Prison, Grand Junction Road, Northfield, South Australia died at Lyell McEwin Health Service, Haydown Road, Elizabeth Vale, South Australia on the 11th day of September 2019 as a result of sepsis secondary to disseminated pancreatic adenocarcinoma. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for inquest

1.1. Julie Michele Dunn was 56 years old when she died on 11 September 2019 at the Lyell McEwin Hospital (LMH). Ms Dunn was a prisoner serving a sentence at the time of her death. Her death was a death in custody for which an inquest was mandatory. These are the findings of that inquest.

1.2. Ms Dunn's remains did not require a post-mortem examination. She died from a natural cause that had a clear clinical course. That clinical course and the circumstances of her death were examined by an independent medical practitioner, Dr Alexandra Yuill, at Forensic Science South Australia (FSSA). The written report of a pathology review undertaken by Dr Yuill[1] cites Ms Dunn's cause of death as sepsis secondary to

[1] Exhibit C2

disseminated pancreatic adenocarcinoma. I find that to have been the cause of Ms Dunn's death.

2. Background

2.1. Ms Dunn grew up in Western Australia as the eldest of five children. In 2001 she moved to South Australia to be closer to a son.

2.2. On 21 April 2004 Ms Dunn was arrested for a murder committed by her on 3 December 2003 at Davoren Park. On 20 June 2007 she was sentenced to life imprisonment with a non-parole period of 18 years, backdated to the date she was taken into custody.

2.3. Ms Dunn served her sentence at Adelaide Women's Prison. She was still undergoing that sentence at the time of her death. I find that her custody was lawful.

3. Ms Dunn's medical history

3.1. Dr Daniel Pronk is the medical director of the South Australian Prison Health Service (SAPHS). Dr Pronk has described Ms Dunn's relevant medical history in his witness statement tendered to the Court.[2] On her admission to custody on 21 April 2004, Ms Dunn reported a history of chronic back pain which was treated with slow-release tramadol. She also reported a history of asthma and post-partum cardiomyopathy, a complication related to the caesarean delivery of triplets in 1994. She also reported having had her gallbladder and tonsils removed in the past.

3.2. SAPHS also received a later report that Ms Dunn had experienced bulimia in 1996 which was precipitated by the stress of having her children removed from her care.

3.3. Medical notes during her imprisonment, document the management of back pain and high blood pressure. Her back pain was originally managed with norspan pain patches. In 2017 at Ms Dunn's request, this treatment ceased and was replaced by oral analgesia and physiotherapy. Ms Dunn's hypertension was managed with medication.

[2] Exhibit C8a

3.4. During her period of incarceration at Adelaide Women's Prison, Ms Dunn was reviewed periodically for eye pain by a specialist ophthalmologist as an outpatient and for occasional dermatological conditions.

3.5. Ms Dunn experienced anxiety and depression and from early to mid 2019, Ms Dunn's anxiety and depression worsened. She reported a recurrence of bulimia. Her antidepressant medication was reviewed on multiple occasions, with the outcome being both improved pain control and mood.

3.6. From 13 June 2019 Ms Dunn was reviewed for weight loss associated with nausea and self-induced vomiting. At the time, this was attributed to an eating disorder in the context of life stressors. Her antidepressants were adjusted and she was referred for an updated psychiatric review.

3.7. On 19 June 2019 Ms Dunn complained of dizziness and lethargy in addition to loss of appetite. She was noted to have low blood pressure at the time. This necessitated titration of her antihypertensive medication.

3.8. On 4 July 2019 Ms Dunn was noted to have lost 7 kilograms within four weeks. Other symptoms included burping, epigastric burning and a sore throat. She reported ongoing nausea after eating but was able to keep some food down without vomiting. The assessment at this time was that Ms Dunn was experiencing an eating disorder due to life stressors.

3.9. A psychiatric review on 17 July 2019 noted an impression of major depressive disorder and generalised anxiety disorder on a background of likely borderline personality disorder. The presentation of purging was documented to be in the context of self-harm and self-punishment, rather than a true eating disorder which had emerged due to her life stressors. Ms Dunn's antidepressants were adjusted. An electrocardiogram and blood testing were recommended. Ms Dunn was also referred to a psychologist at this time for stress management support.

4. <u>Ms Dunn’s decline in health and death</u>

4.1. On 1 August 2019 Ms Dunn underwent blood tests. These showed an abnormal liver function and an elevated C-Reactive Protein (CRP). Ms Dunn continued to experience loss of appetite, nausea and lethargy. She did not report abdominal pain, but her

abdomen was reported to be tender on palpitation of the region of her liver. An abdominal ultrasound was ordered.

4.2. On 9 August 2019 Ms Dunn's ultrasound imaging showed multiple liver lesions and a bulky pancreas. A CT scan of Ms Dunn's chest, abdomen and pelvis was ordered. This imaging demonstrated that Ms Dunn had primary pancreatic cancer with liver and possible lung metastases. Bilateral pulmonary emboli were also noted which was subsequently managed with subcutaneous Enoxaparin. Ms Dunn was transferred directly from radiology to hospital. On that day Ms Dunn was admitted to LMH general medical unit under the care of Dr Ghani whose statement was tendered to the inquest.[3]

4.3. On 20 August 2019 Ms Dunn underwent a procedure for the insertion of a biliary stent for a blocked common bile duct. Ms Dunn subsequently developed a fever and was commenced on antibiotics despite a negative septic screen. A differential diagnosis of malignancy mediated fever was considered at this time.

4.4. On 5 September 2019 Ms Dunn was noted to be anaemic and was administered one unit of red blood cells. Despite these measures, she continued to deteriorate with intermittent confusion and drowsiness noted. She was spending most of her time in bed and needed help with activities of daily living.

4.5. On 6 September 2019 a review was undertaken by the oncology team. It was deemed that Ms Dunn was not fit for palliative chemotherapy. Ms Dunn continued to experience abdominal pain throughout her medical admission. On 22 August 2019 the palliative care team prescribed Ms Dunn with oral opioids including short and long-acting Oxycodone which was later changed to continuous subcutaneously administered morphine. Other medications were used to manage her insomnia and appetite, and to manage neuropathic pain. Ms Dunn's anxiety was managed with clonazepam. Dexamethasone was prescribed to support her energy levels and appetite as well as to manage cancer related oedema.

4.6. On 10 September 2019, given the poor prognosis of her malignancy and her functional decline, the focus of Ms Dunn's care changed to that of comfort and palliation.

[3] Exhibit C7, affidavit of Dr Ghani

4.7. Ms Dunn died on 11 September 2019 at approximately 3:30am. She was subsequently certified deceased by junior medical officer Olivia Salagaras.

5. Conclusion

5.1. The circumstances of Ms Dunn's death were investigated by Detective Brevet Sergeant Sarah McFarlane of SAPOL, whose comprehensive report was tendered to the inquest[4].

5.2. The only issue identified by Ms McFarlane in respect of Ms Dunn's medical care relates to the timing of the eventual diagnosis of metastatic pancreatic cancer. With regard to this issue, I refer to the evidence of Dr Pronk, to whom I have already referred. In his witness statement, Dr Pronk states as follows:

> 'Regarding the question of whether Ms Dunn's pancreatic cancer could have been detected sooner, this is a very challenging question to answer and with the benefit of hindsight there were clinical signs and symptoms for several months prior to diagnosis that were likely related to the cancer. That being said, her clinical picture was complicated by the fact that the deceased had a history of purging behaviour linked to significant life stress, and her symptoms were in my opinion very reasonably initially attributed to a relapse of this behaviour owing to the acute stress she was under. In my experience the diagnosis of pancreatic cancer can be difficult to make and is often only identified when the patient becomes significantly symptomatic, by which time the cancer has often metastasised and is at an advanced and inoperable stage. Whether or not any meaningful intervention could have occurred if the cancer had have been identified several months earlier when the deceased began to experience gastrointestinal symptoms is impossible to say, and the rate of progression from a primary pancreatic cancer to local and distant spread is outside of my area of expertise to comment on.
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> I feel that once it was identified that the deceased's liver function tests were abnormal the escalation of further investigation and diagnosis of her cancer occurred in a timely fashion and her care from that point to her death was appropriate.' [5]

I have accepted Dr Pronk's analysis of the situation regarding the timing of Ms Dunn's diagnosis and of her management after diagnosis.

5.3. Ms McFarlane also directs the Court's attention to an associated issue that is raised by Ms Dunn's son, Mr Aaron Irwin, in his statement.[6] In his statement, Mr Irwin indicates that on regular fortnightly visits to his mother, she would complain of pain in her stomach and that she was simply given Panadol and sent back to her unit. I observe that in July of 2019, which was about a month prior to her eventual diagnosis, Ms Dunn

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[4] Exhibit C9
[5] Exhibit C8a
[6] Exhibit C4 and C4a

had exhibited symptoms including burping and epigastric burning and that she reported ongoing nausea after eating but was able to keep some food down without vomiting. I am unaware of any other gastric symptomatology that she reported. The assessment, as seen, was that this was attributed to an eating disorder. Having regard to the evidence of Dr Pronk, I do not believe that this diagnosis has been shown to be unreasonable.

5.4. Having regard to all of the circumstances surrounding Ms Dunn's death, as revealed in the extensive investigation by Ms McFarlane, I share Ms McFarlane's view that the deceased's care was appropriate whilst incarcerated and that the diagnosis of pancreatic cancer was ultimately identified in a time frame that was not unreasonable. I also agree with Ms McFarlane and find that once the liver function tests were identified as being abnormal, the escalation of further investigation and diagnosis of Ms Dunn's cancer occurred in a timely fashion and that her care from that point was appropriate.

5.5. There is no question but that Ms Dunn's care at the LMH was appropriate. Ms McFarlane has arrived at and expressed the same conclusion in her report. I so find.

5.6. I make no recommendations.

Key Words: Death in Custody; Natural Causes; Prison

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 30th day of March, 2022.

Deputy State Coroner

Inquest Number 12/2021 (1887/2019)