CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATH OF JASON DOUGLAS MENZIES

[2025] SACC 30

Inquest Findings of her Honour Deputy State Coroner Roper

14 November 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man who died due to multiple sclerosis while in custody on remand. The inquest explored the standard of medical care provided and the circumstances which led to his rapid clinical deterioration and death.

Held:

1. Jason Douglas Menzies, aged 33 years of Northfield, died at the Royal Adelaide Hospital on 19 December 2022 as a result of the Marburg variant of multiple sclerosis.

2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MR D EVANS

Hearing Date/s: 05/09/2025

Inquest No: 21/2025 **File No/s: 3128/2022**

INQUEST INTO THE DEATH OF JASON DOUGLAS MENZIES [2025] SACC 30

Introduction and reason for inquest

1 Jason Menzies was only 33 years old when died at the Royal Adelaide Hospital on 19 December 2022.

2 At the time of his death, Mr Menzies was in the lawful custody of the Department for Correctional Services. He had been arrested for criminal offences on 31 July 2022 and refused bail. As Mr Menzies died in custody, an inquest into the cause and circumstances of his death was mandatory.[1]

3 In late November 2022, Mr Menzies became unwell with a suspected viral illness. His condition rapidly declined, and despite intensive medical treatment, he died on 19 December 2022.

4 During his hospital admission, the precise cause of Mr Menzies' illness was not identified. Two neurological diseases were suspected: acute disseminated encephalomyelitis and the Marburg variant of multiple sclerosis. A post mortem examination was necessary to determine the cause of Mr Menzies' death.

What was the cause of death?

5 A post mortem examination was conducted by forensic pathologist, Dr Neil Langlois, of Forensic Science SA. Dr Langlois found extensive brain and spinal cord plaques of demyelination consistent with acute multiple sclerosis, which is known as the Marburg variant.

6 Multiple sclerosis is an inflammatory demyelinating disease of the central nervous system. Demyelination refers to damage to the protective covering (myelin sheath) that surrounds nerve fibres. When the myelin sheath is damaged, nerve impulses are impaired, causing neurological symptoms.

7 Dr Langlois arranged for specialist examination of Mr Menzies' brain and spinal cord, which was performed by neuropathologist, Dr Quick. Dr Quick found extensive bilateral involvement of the brain and all levels of the spinal cord by large, confluent active plaques.

8 Dr Quick opined that the plaques were not characteristic of acute disseminated encephalomyelitis, another demyelinating disease, but were consistent with acute multiple sclerosis, Marburg type. She noted that the rapid clinical course of Mr Menzies' illness was also consistent with acute multiple sclerosis, Marburg type.

9 Taking the findings of Dr Quick into consideration, Dr Langlois opined that Mr Menzies' death was caused by the Marburg variant of multiple sclerosis, and I so find.

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[1] Coroners Act 2003, section 21(1)(a)

Who was Mr Menzies?

10 Mr Menzies had a sister and two stepbrothers. His early years were turbulent, and he left school at the age of 14 years. He was introduced to alcohol at a very young age and endured periods of homelessness as a teenager.

11 When Mr Menzies was 16 years old, he reunited with his mother. He had previously resided with his father. Following their reunification, Mr Menzies enjoyed a strong relationship with his mother and his extended family. Sadly, however, his short life was plagued by drug and alcohol addiction, which led to criminal offending and incarceration.

12 Mr Menzies gained employment in the timber and fishing industries. To his credit, he was able to abstain from drugs and alcohol for periods of time, on one occasion, for as long as three years. However, he returned to methamphetamine use following the breakdown of his relationship with the mother of his child, born on 21 April 2014. This led to his first period of incarceration in 2015.

Did Mr Menzies receive appropriate medical treatment when his symptoms of multiple sclerosis first presented?

13 Upon his initial admission into custody, Mr Menzies underwent a health assessment that was conducted by nursing staff of the South Australian Prison Health Service (prison health). He reported feelings of anxiety and advised that he had used heroin recently. He did not report any other health complaints and advised that he did not often seek medical attention in the community.

14 On 3 August 2022, Mr Menzies was prescribed the antidepressant medication amitriptyline and the antipsychotic medication periciazine to manage his symptoms of anxiety. Mr Menzies was assessed via the Clinical Opiate Withdrawal Scale to detect and treat opioid withdrawal. He was subsequently administered buprenorphine.

15 On 25 November 2022, Mr Menzies presented to prison health staff with a sore throat. He was diagnosed with a viral infection and provided with analgesia. At that time, Mr Menzies was accommodated at the Yatala Labour Prison (Yatala).

16 Two days later, Mr Menzies was reviewed by a prison health nurse. He reported feeling unwell with a sore throat, which was inflamed. A swab of his throat was taken to test for Group A Streptococcus infection. Covid-19 testing was also performed, returning a negative result. Mr Menzies was then reviewed by a doctor, who prescribed antibiotics for a possible bacterial tonsilitis infection.

17 On 29 November 2022 Mr Menzies was medically reviewed again, reporting that he was feeling better, but still had a sore throat.

18 On 1 December 2022, Mr Menzies was taken to the Royal Adelaide Hospital as he was complaining of acute urinary retention which was causing pain. This was thought to be a side-effect of the use of amitriptyline. An indwelling catheter was inserted to drain the urine, and Mr Menzies was discharged back to Yatala with advice to wean off amitriptyline.

19 The following day, 2 December 2022, Mr Menzies was assessed by the prison health doctor. He advised that he still had a sore throat, but his catheter was working well. He

was eating and drinking normally again, and his physiological observations were within normal limits, apart from an elevated heart rate. At that time, it appeared that Mr Menzies was on the road to recovery.

20 In the opinion of Dr Langlois, Mr Menzies' sore throat may have been due to human metapneumovirus infection, which was detected a few days later, whereas his urinary retention was likely caused by multiple sclerosis. I accept the opinion of Dr Langlois and find that Mr Menzies first experienced symptoms consistent with multiple sclerosis on 1 December 2022.

21 I find that prison health staff responded appropriately by transporting Mr Menzies to hospital for investigation of his urinary retention and arranging for a doctor to review him the day after he was discharged from hospital. I further find that the treatment he received at the Royal Adelaide Hospital was reasonable, bearing in mind that there were no neurological symptoms apparent at that time. It is only with the benefit of hindsight that Mr Menzies' urinary retention could be said to have warranted more intensive investigation at the Royal Adelaide Hospital.

Did Mr Menzies receive adequate medical care at the Royal Adelaide Hospital?

22 On 3 December 2022, Mr Menzies was woken by prison staff who observed that he was confused and appeared uncoordinated. He was returned to the Royal Adelaide Hospital via ambulance due to concerns of possible urinary sepsis. Mr Menzies had a fast heart rate and low oxygen saturations. He was pale, clammy and hot to touch. His cognitive presentation was poor, he was unable to follow basic directions, and he was uncoordinated.

23 When Mr Menzies first arrived at the Royal Adelaide Hospital he was unable to provide a meaningful history and appeared confused. He had a profoundly altered clinical state. Upon examination he was noted be shaking, mumbling incoherently with a fever, and had a faint blanching rash across his upper chest and face. He was hyper-reflexic[2] and sustained beats of clonus were observed.[3] A CT brain scan was performed in the Emergency Department which did not reveal any acute pathology.

24 Mr Menzies was assessed by a consultant emergency physician and then admitted under a General Medicine Unit. Broad spectrum antibiotics were administered, and Mr Menzies was monitored in the Intensive Care Unit. He required intubation and ventilation. A series of investigations were performed to determine the cause of Mr Menzies' presentation, including a lumbar puncture and blood tests. At this time, meningoencephalitis was considered a possible cause.

25 Numerous tests for infection were conducted, including a test for Japanese encephalitis. One of those tests revealed a human metapneumovirus infection. Testing for Epstein-Barr virus showed evidence of past infection.

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[2] Hyper-reflexia occurs when the skeletal muscles have an increased or overactive reflex response
[3] An abnormal reflex response that involves involuntary and rhythmic muscle contractions

26 An MRI was performed which showed widespread brain and spinal cord changes consistent with a demyelinating disease.

27 Consultant neurologist, Dr Janakan Ravindran, reviewed Mr Menzies on 5 December 2022. He considered the results of the MRI and formed the view that the imaging was in keeping with an acute demyelinating encephalomyelitis or Marburg's presentation of tumefactive multiple sclerosis.

28 Dr Ravindran recommended urgent plasma exchange in an attempt to gain rapid control over the disease process. Plasma exchange involves separation of the plasma from the other components of blood and replacing it with healthy donor plasma. While Mr Menzies received plasma exchange on six occasions, he showed no clinical improvement. He was also administered intravenous methylprednisolone to relieve his inflammation.

29 A repeat MRI of Mr Menzies' brain was performed on 16 December 2022 which revealed a rapidly progressing neurological disease. The imaging was considered to favour monophasic fulminant demyelination (Marburg variant), with acute disseminated encephalomyelitis considered less likely.

30 Mr Menzies' condition continued to deteriorate, and it was determined that all possible treatment options had been pursued to no avail. Mr Menzies' parents and sister visited his bedside with social work support on 18 December 2022. A family meeting followed where it was agreed that Mr Menzies should be extubated and provided comfort care. Mr Menzies was observed to cease breathing just before 10pm on 19 December 2022.[4] A doctor declared life extinct at 10:14pm.

31 The Marburg variant of multiple sclerosis is rare and leads to severe disability or death within weeks to months. I find that there was no earlier opportunity to diagnose this rare and devastating illness such that the death of Mr Menzies could have been prevented.

32 Mr Menzies' health declined rapidly from 3 December 2022, as would be expected given the cause of his death. This was not the result of a lack of appropriate medical care and attention.

33 I find that the care provided to Mr Menzies by the Department for Correctional Services and by the medical staff at the Royal Adelaide Hospital was appropriate.

What causes acute multiple sclerosis?

34 Mr Menzies was a young and relatively healthy man until his illness in late November 2022. It is therefore important to know what it was that caused him to develop acute multiple sclerosis to identify any prevention opportunities that may exist.

35 Unfortunately, this is a question that eludes a conclusive finding. As noted by Dr Langlois, the cause of multiple sclerosis, and particularly the Marburg variant, is unknown.

Mr Menzies was suffering from a respiratory tract infection caused by human metapneumovirus in the days preceding his death. Despite the temporal connection

[4] Exhibit C3 at [7]

between the onset of Mr Menzies' viral illness and his death by multiple sclerosis, there is no published literature indicating that the human metapneumovirus is linked to the onset of multiple sclerosis.

36 There is a known association, however, between infection with the Epstein-Barr virus and multiple sclerosis. Mr Menzies' blood test results were consistent with him having experienced a past infection with the Epstein-Barr virus.

37 I received into evidence an academic article entitled 'Longitudinal analysis reveals high prevalence of Epstein-Barr virus associated with multiple sclerosis', authored by Bjornevik et al and published in the journal *Science* on 21 January 2022.[5] This article tested the hypothesis that multiple sclerosis is caused by Epstein-Barr virus by examining a cohort of over 10 million military personnel. The authors found that the risk of multiple sclerosis increased 32-fold after infection with the Epstein-Barr virus.

38 However, as observed by the authors, most people who are infected with the Epstein-Barr virus do not develop multiple sclerosis. It appears that this virus can trigger the onset of multiple sclerosis in certain individuals, although infection alone cannot be considered the sole cause. Unfortunately, there is currently no approved vaccination for the Epstein-Barr virus.

39 I find that the cause of Mr Menzies' multiple sclerosis has not been established on the balance of probabilities.

40 Accordingly, no prevention opportunities have been identified and I make no recommendations.

41 I wish to acknowledge the grief experienced by the family of Mr Menzies, particularly in the context of his death occurring while in custody. While the short life of Mr Menzies was marked by addiction, it is apparent that he was valued and loved by his family, who were by his side during his final days.

Keywords: Death in Custody; Prison; Natural Causes

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[5] Kjetil Bjornevik et al., Longitudinal analysis reveals high prevalence of Epstein-Barr virus associated with multiple sclerosis. Science 375, 296-301 (2022)