IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 003421

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*
*Section 67 of the **Coroners Act 2008***
*Amended pursuant to section 76 of the Coroners Act 2008 on 27 November 2015.*[i]

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of DEAN CHRISTOPHER COURTS

without holding an inquest:

find that the identity of the deceased was DEAN CHRISTOPHER COURTS

born on 24 January 1981

and that the death occurred on 5 July 2014

at Port Phillip Prison, Dohertys Road and Palmers Road, Truganina Victoria 3029

**from:**

I (a) PULMONARY THROMBOEMBOLISM.

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Courts was a 33-year-old man who was serving a custodial sentence at the Port Phillip Prison at the above address at the time of his death. His cell was in the Alexander South Unit of the prison.
2. Mr Courts entered into custody on 20 June 2013 at the Melbourne Assessment Prison and was transferred to Port Phillip Prison on 11 July 2013. His medical history included depression, Cluster B personality traits and polysubstance, drug and alcohol use. No other medical or surgical history was recorded by Corrections Victoria.

3. According to a Justice Health[1] review of Mr Courts' medical records, he attended reviews with prison medical officers at his request for minor ailments only, and received regular support to manage his mental health through the mental health team. The review stated that Mr Courts intermittently ceased his prescribed medications. The review found that health care was provided to Mr Courts at a quality and standard equivalent to that provided in the community through the public health system.

4. At about 7.50am on 5 July 2014, correctional staff commenced a 'hands on trap' prisoner count of the Alexander South Unit. This involves one officer opening the trap on the cell doors to sight and ensure the welfare of each prisoner and a second officer marking of a muster sheet. A correctional officer opened the trap door to Mr Courts' cell at about 8.08am and issued a verbal request for a response. Mr Courts did not respond but the correctional officer reported that they observed his foot move, which they took as a sign of life.

5. At about 10.18am, a correctional officer entered Mr Courts' cell to conduct a routine cell intercom check. Mr Courts was found lying on his bed facing the ceiling. He was not responsive, was cold to touch and the officer could not locate a pulse. The officer called for a 'code black' response (prisoner death or serious medical incident).

6. Correctional officers performed CPR until nursing staff responded. Further resuscitative efforts (application of defibrillator, ventilation, administration of Narcan) were unsuccessful. Paramedics arrived at 11.05am and confirmed that Mr Courts was deceased.

7. Between 10.20 and 10.50am, the duty manager contacted the prison control room and asked when the ambulance had been called. The duty manager was advised by control room staff that they had not requested ambulance attendance because they thought that nursing staff had done so. Nursing staff similarly thought that control room staff had requested ambulance attendance. Control room staff then called an ambulance at 10.50am. I will address this matter later in my finding.

8. An autopsy of Mr Courts' body and post mortem CT scanning (PMCT) were performed by the Director of the Victorian Institute of Forensic Medicine, Professor Stephen Cordner (Prof Cordner), who formed the opinion that the cause of his death was *pulmonary*

[1] Justice Health is a business unit of the Department of Justice and Regulation, and is responsible for the delivery of health services for persons in Victorian prisons. In Victoria, health services for persons in prisons are contracted out to health service providers. Justice Health sets the policy and standards for health care in prison and contract manages and audits the health service providers in the public prisons.

*thromboembolism*. Prof Cordner formed the opinion that Mr Cordner's death was due to natural causes, albeit while he was in custody.[2]

9. Prof Cordner stated that the main finding at autopsy was the presence of a pulmonary thromboembolism, commonly known as a 'clot on the lung'. Prof Cordner explained that such clots often arise in the deep veins of the legs, but that this could not be demonstrated in Mr Courts' case. Prof Cordner further explained that a reason for developing such clots can usually be found, such as co-existing disease, but that no such pre-disposing cause was known of or demonstrated in Mr Courts' case. Prof Cordner did state that people who are immobile for extended period are also susceptible to developing such clots, for example, passengers on long haul flights. Prof Cordner indicated the possibility of the existence of a genetic disorder that predisposed Mr Courts to developing a thrombus.

10. Post mortem toxicological analysis revealed the presence of mirtazapine in blood at ~0.1mg/L and presumptively detected in urine, sertraline in blood at ~0.04mg/L in blood and detected in urine, paracetamol in blood at trace levels (<5mg/L) and detected in urine and tramadol detected in urine.

11. Prof Cordner noted the presence of tramadol in urine and stated that this was probably not prescribed. Prof Cordner formed the view that the tramadol played no direct part in Mr Courts' death, but commented that '*although as a matter which can only be speculated upon, it may have contributed to an extended or deeper period of immobility in that way predisposing him to the development of a thrombus, which has then dislodged and travelled up to and blocked the arteries to the lungs*'.[3]

12. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Mr Courts' death was reportable as he was a *person placed in custody or care*.[4] This is one of the ways in

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[2] Report of Professor Cordner dated 11 November 2014.

[3] The Office of Correctional Services Review commented on this aspect of Prof Cordner's report by confirming that Mr Courts was not prescribed tramadol at the time of his death, and that he returned a negative result to urinalysis testing on 14 June 2014 (the only time he was subject to testing). The Office of Correctional Services Review stated that there was no intelligence indicating any abuse of prescription medication by Mr Courts and that the data reviewed indicated that there was no specific increase in drug use at Port Phillip Prison prior to Mr Courts' death.

[4] See section 3 *Coroners Act 2008* (Vic) for the definition of a 'person placed in custody or care' and section 4(2)(c) of the definition of 'reportable death'.

which the *Coroners Act 2008* (Vic) recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

13. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[5] an inquest is mandated when a person dies whilst in the care or custody of the State,[6] unless a Coroner considers that the death is due to natural causes. A death may be considered due to natural causes if the Coroner has received a report from a medical investigator that includes an opinion that the death was due to natural causes.[7]

14. The focus of the coronial investigation of Mr Courts' death was therefore on the adequacy of clinical management and care provided to him in relation to the last months of his life. No concerns about clinical management and care were stated in the initial police report of Mr Courts' death to the Coroner. I also examined the Office of Correctional Services Review (OCSR)[8] and Justice Health reports pertaining to Mr Courts in order to understand his clinical course.

15. In considering the nature and effectiveness of the response to Mr Courts' death, I was advised by the OCSR that Port Phillip Prison conducted a debrief following the death, where it was identified that:

    a. there was a delay in calling an ambulance due to confusion among staff; and

    b. there was a delay in having a doctor attend the prison to certify Mr Courts' death.

16. The OCSR stated that in relation to the delay in calling an ambulance, Port Phillip Prison has modified its operational instructions such that if the attending nurse believes an ambulance is required, they are to use the mobile phone of a duty manager or supervisor in attendance and liaise directly with the 000 operator.

17. In relation to the delay in doctor attendance to certify death, the OCSR reported that the prison's doctor was in surgery at the time of Mr Courts' death and that, as they were driving to

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[5] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

[6] Section 52(2) and the definition of 'person placed in custody or care' in section 3.

[7] See sections 52(3A) and (3B).

[8] The Office of Correctional Services Review (OCSR) is part of the Department of Justice and Regulation but separate from the operational functions of the corrections system. The OCSR conducts reviews of all deaths in custody, consistent with the requirement under the *Corrections Act 1986* that the Secretary of the Department of Justice and Regulation monitor performance in the provision of correctional services to achieve the safe custody and welfare of prisoners and offenders. The OCSR prepares reports that are provided to the Coroner to assist their investigations.

the prison, they stopped to provide support at a road traffic accident. The OCSR stated that representatives of the prison and St Vincent's Hospital met and that the hospital confirmed that its doctors have been instructed not to undertake any other duties or tasks whilst on-call to Port Phillip Prison.

18. A further issue was identified in relation to the visual observation or 'hands on trap' prisoner count that was undertaken on the morning of 5 July 2014. The OCSR reported that a Deputy General Manager's file note was issued to the relevant correctional officer for not conducting the count according to policy when checking on Mr Courts. The OCSR further stated that since the death of Mr Courts and two other prisoners at Port Phillip Prison in July 2014, the prison is currently amending the practice to specifically require the correctional officer to obtain both a verbal and physical response from each prisoner.

19. The OCSR concluded in its report that it was satisfied that the Port Phillip Prison internal review addressed all relevant issues pertaining to Mr Courts' death. The OCSR stated that it did not consider that the issues would have prevented Mr Courts' death, considering that staff first found him cold and unresponsive and that the prison's medical response was timely. I accept this conclusion and note that whilst the above issues represented deficiencies in the prison management, they did not cause or contribute to Mr Courts' death, and have been appropriately identified and addressed.

20. The family of Mr Courts, via their legal representatives, submitted that a relevant matter for consideration is Mr Courts' history of methamphetamine use in the four years prior to his incarceration, and his time spent in protective custody prior to his death. The family requested further investigation of a possible relationship between the custodial management of Mr Courts and the risk factors associated with methamphetamine use, specifically increased risk of blood clots.

21. The family submission was put to Prof Cordner for comment on whether, in his view, the factors raised by the family (including immobility for 13 months before Mr Courts' death, prescribed medications, methamphetamine use and injuries described by the family) could have caused or contributed to Mr Courts' death from pulmonary thromboembolism

22. Prof Cordner provided a supplementary report in response, dated 29 July 2015. Prof Cordner concluded as follows:

> *As a matter of experience, I am not aware of prescription type drug abuse, and/or amphetamine abuse being a risk factor for thrombosis (and thus a risk factor for pulmonary*

*thrombo-embolism). As a rule, where thrombosis and pulmonary thrombo-embolism occurs spontaneously (ie no obvious cause) we now suggest that the surviving first order family members consult their doctors about what investigations they might have. This occurred in this case, but I do not know the outcome of that advice. If family members were found to have some heritable form of thrombophilia, in the circumstances it would make it likely that the deceased also had this. (Actual DNA testing of the deceased is not yet readily available for us to test the deceased directly for these sorts of conditions).*[9]

23. Prof Cordner further stated that as a purely theoretical proposition, repeated long periods of deep sleep associated with drug abuse might predispose to the development of deep venous thrombosis (and thus pulmonary thromboembolism), but that to his knowledge it has not been identified on an evidence basis as a factor particularly predisposing to thromboembolism in drug users.

24. Prof Cordner did note that particular drugs have been associated with such an increased risk of thrombosis. However, Prof Cordner stated that the effects of amphetamines on the cardiovascular system are not likely to increase the direct risk of venous thrombosis, but that the effects are mainly on the *arterial* side of the circulation. Prof Cordner invited the family of Mr Courts to present any literature that demonstrated a link between one or more of the drugs mentioned and thrombosis, in order for him to provide further comment.

25. The family of Mr Courts submitted material in support of their position that Mr Courts' amphetamine use might be a risk factor for pulmonary thromboembolism, and the Court asked Prof Cordner to undertake a review and provide comments.

26. Prof Cordner provided a further supplementary report to the Court, and stated as follows:

*The material can be dealt with collectively. It discussed the cardiovascular effects of amphetamine. These effects included elevated blood pressure, accelerated atherosclerosis, arterial thrombosis and arterial spasm. These effects act on the arteries (left side of the circulation) and the heart. The material provided does not disclose any link between amphetamine use and venous (right side of the circulation) thrombosis leading to pulmonary thrombo-embolism.*[10]

27. Prof Cordner went on to explain the accepted mechanisms for arterial thrombosis in association with amphetamine use, being arterial spasm and acute plaque change in accelerated atherosclerosis. Prof Cordner stated that currently, increased platelet aggregation due to amphetamine use, thus causing thrombosis, is not well documented or proven. Prof Cordner is not aware of any peer-reviewed publication showing a direct link between

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[9] Supplementary report of Professor Cordner dated 29 July 2015.

[10] Supplementary report of Professor Cordner dated 27 October 2015.

amphetamine use and the development of venous thrombosis and pulmonary thromboembolism.

28. Prof Cordner stated that the arterial/left and venous/right sides of the circulation are very different, and noted that it is entirely understandable that lay people reading the literature submitted might think that it indicates that because amphetamine use can be associated with arterial thrombosis, it would also be associated with venous thrombosis and therefore pulmonary thromboembolism. However, Prof Cordner stated that '*it does not follow, because the mechanisms of how the thrombosis occurs in each case is quite different; and whereas amphetamine contributes to the mechanism in arteries, it does not in veins*'. I accept Prof Cordner's evidence that the material submitted by the family of Mr Courts does not evidence a direct link between amphetamine use and the development of venous thrombosis and pulmonary thromboembolism.

29. Prof Cordner extended an invitation to the family of Mr Courts to meet with him personally to address any further issues. The Court has encouraged Mr Courts' family to accept Prof Cordner's offer to meet with him. I thank Prof Cordner for his assistance and for extending his offer to the family.

30. The Court received statements from Mr Courts' mother, Ms Debra Courts, Mr Courts' brother, Mr Jake Courts and Mr Courts' grandmother, Ms Valerie Guy. The statements from Mr Courts' family reveal him to have been a loving and much-loved father and family member, and evidence his kind and caring nature and the impact of his death on his family. I thank Ms Courts, Mr Jake Courts and Ms Guy for providing these reflections and acknowledge their grief and loss.

31. I note Ms Courts' concerns expressed in her statement that Mr Courts experienced adverse treatment by police and by prison staff. I am unable to further investigate these concerns as Mr Courts' death was due to natural causes, and there is no evidence of a causal connection between his treatment in prison and his death. The matter therefore falls outside the scope of the coronial investigation into Mr Courts' death. Ms Courts has been informed that it is open to her to raise her concerns directly with Victoria Police and Corrections Victoria.

32. Based on the evidence before me, I am satisfied that the health care provided to Mr Courts during his time in custody was appropriate and consistent with the care delivered in the Victorian public health system. The evidence does not support a finding that there was any

want of clinical management and care on the part of treating medical and nursing staff, or that any such want of clinical management or care caused or contributed to Mr Courts' death.

**Findings pursuant to section 67 of the *Coroners Act 2008***

33. I find that:

    a. the identity of the deceased was Dean Christopher Courts;

    b. Mr Courts' death was due to natural causes; and the cause of his death is pulmonary thromboembolism, on 5 July 2014, at Port Phillip Prison, Dohertys Road and Palmers Road, Truganina Victoria 3029, in the circumstances described above.

I convey my sincere condolences to Mr Courts' family and friends.

Pursuant to section 73(1B) of the *Coroners Act 2008*, a copy of this finding must be published on the Court website.

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

**Ms Debra and Mr Christopher Courts, Senior Next of Kin c/o Ms Meghan Fitzgerald, Fitzroy Legal Service**

**Ms Joanne Herbert, St Vincent's Hospital (Melbourne) Limited**

**Mr Jonathan Kaplan, Director, Office of Correctional Services Review**

**DSC Warren Normoyle, Victoria Police Crime Department Drug Task Force**

**DSC Karina Prodan, Victoria Police, Coroner's Investigator.**

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 20/11/15[i]

Coroners Court of Victoria

[i] The original finding was signed by the Coroner and dated 20 November 2015. This version of the finding has been amended pursuant to section 76 of the *Coroners Act 2008*, by correction of an accidental slip in paragraph 2 of the finding.