

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 4419/08

Inquest into the Death of MICHAEL GOLDMAN

Delivered On: 17th May, 2010

Delivered At: Melbourne

Hearing Dates: 17th May, 2010

Findings of: IAIN TRELOAR WEST

Representation: Mr Broad for Corrections Victoria

Place of death/Suspected death: St Vincent's Hospital

SCAU: Leading Senior Constable Kelly Ramsey

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FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 4419/08

In the Coroners Court of Victoria at Melbourne
I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: GOLDMAN
First name: MICHAEL

AND having held an inquest in relation to this death on 17th May, 2010 at Melbourne find that the identity of the deceased was MICHAEL GOLDMAN and death occurred on the 29th September, 2008

at St Vincent's Hospital, Victoria Parade, Fitzroy, Victoria 3065

from

1(a) METASTATIC CARCINOMA OF THE PROSTATE

in the following circumstances:

1. Michael Goldman, aged 60 years, was an inmate of Port Phillip Prison at the time of his death. Mr Goldman last entered the prison system on the 15th July 2002, when he was remanded into custody at the Melbourne Assessment Prison on charges including attempted murder. He was subsequently sentenced at the Melbourne Supreme Court on 27th May 2004 to a total of 14 years imprisonment, with a non parol period of 11 years.

2. Upon reception into the prison, Mr Goldman's physical and psychological health needs were assessed as per Justice Health protocols, as was his risk of suicide or self harm. He gave a history of multiple past medical conditions and during the period of his incarceration, it became evident that he was suffering from additional medical conditions, including chronic back pain. In September 2006 he was diagnosed with prostate cancer and in mid 2007, he underwent brachytherapy. In May 2008, investigations revealed findings consistent with progressive bony metastatic disease and as a consequence, Mr Goldman was transferred to St Vincent's Hospital and an orchidectomy procedure was performed. Due to the bony metastases he was hypercalcemic which created difficulties for walking when he was discharged, despite the

condition being treated with bisphosphonate therapy. In August Mr Goldman was for the first time seen in the Oncology Unit at St Vincent's Hospital where he was commenced on hormonal therapy, however, the cancer did not respond to treatment. Following return to the prison, Mr Goldman's deteriorating health continued to be a significant source of pain, necessitating regular opioid analgesia. In addition, he suffered paralysis of the right side of the face due to nerve compression by bone metastases. On 25th September 2008, Mr Goldman was transferred back to St Vincent's Hospital for review, however, as further chemotherapy treatment was considered not appropriate, the decision was made that palliative management be pursued. Michael Goldman subsequently died at approximately 9.40pm on the 29th September, 2008.

3. I formally find that Michael Goldman died of natural causes, whilst an inmate of the Victorian prison system.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death

1. In December 2008, Mr Goldman's partner, Ms Tanya Kamenetska, wrote to the coroner alleging negligence and lack of care and compassion by all doctors involved in the management. It was said that Mr Goldman made numerous complaints of pain and other symptoms to health care professionals within the prison, both leading up to and following his diagnosis, that were not acted on. When Ms Kamenetska attempted to intercede on his behalf, both within the prison and within the hospital system, she was effectively ignored. She further alleges that between May and August 2008 Mr Goldman received no treatment other than analgesic pain relief.

2. Examination of the nine volumes of medical records relating to Mr Goldman, does not support a finding of failure to provide proper and prompt medical interventions. A review of the prisoner's indent report from September 2004 through to September 2008, indicates that of the 81 recorded entries, 51 are health related. In addition, his medical management appears to be well documented throughout his extensive medical records. Whilst I acknowledge the endeavours of Ms Kamenetska to ensure appropriate medical management and the frustration she appears to have experienced in dealing with health care professionals, it must also be acknowledged that all health providers need to abide by legislative requirements of privacy and confidentiality.

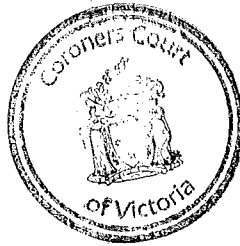
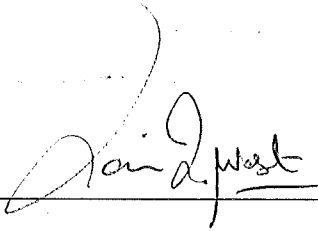
3. A review of Michael Goldman's death, undertaken by Justice Health concluded that he received appropriate and timely medical interventions, however, a systemic failure was identified in that there was a failure to implement Chronic Health Care Plans. These plans are developed and implemented for prisoners with high and or chronic health care needs and act as a prompt for health care providers. The review concluded that the absence of a plan in this case would not have affected the health outcome.

RECOMMENDATIONS:

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

1. That Justice Health ensure and monitor the implementation of Chronic Health Care Plans, where indicated, by all Justice Health's contracted care providers.

Signature:



Iain West
Deputy State Coroner

Date: 18th May, 2010