STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jeffrey Blundell
Hearing dates:	6 September 2023
Date of findings:	13 September 2023
Place of findings:	State Coroners Court, Lidcombe
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – death in custody – natural causes – medical care and treatment
File number:	2018/136203
Representation:	**Counsel Assisting the Coroner:** Jake Harris of Counsel, instructed by Ms Tina Wu of the NSW Crown Solicitor's Office
Findings:	I make the following findings: a. The person who died was Jeffrey Blundell. b. He died on 30 April 2018. c. He died at Prince of Wales Hospital, Randwick NSW 2031. d. The cause of death was cardiogenic shock, on a background of severe tricuspid valve regurgitation, severe right atrium and ventricle dilation, severe right heart failure and liver dysfunction, and severe irreversible pulmonary hypertension. e. The death was a result of natural causes.

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Introduction

1. On 6 September 2023, I conducted an inquest into the death of Jeffrey Blundell held at the Coroners Court in Lidcombe. A brief of evidence containing statements and other documents obtained in the coronial investigation were tendered.

2. In the preparation of my reasons below, I have been assisted by the helpful opening of Counsel Assisting.

The role of the Coroner

3. The function of an inquest is to identify the circumstances of death. Pursuant to s. 81 of the *Coroners Act 2009* (NSW), the role of a Coroner is to make findings as to the identity of the person who died, and the date, place, cause, and manner of the person's death.

4. When a person dies in custody, an inquest is mandatory under s.27 of the Coroners Act.

5. Jeffrey Blundell was granted bail at 3.15pm on 30 April 2018, about 6 hours prior to his death. As most of the medical treatment he received was during the time that he was in custody, I considered that it was important to hold an inquest in this matter, even though it was not mandatory.

Background

6. Mr Blundell was born on 5 November 1973 in Victoria. Mr Blundell and his mother moved to the Gold Coast area when he was a baby. I would like to offer my sincere condolences to Mr Blundell's family.

7. Mr Blundell suffered trauma as a child. He finished school in Year 9. He worked in a factory, and later described himself as an inventor and a poet. He suffered a motorbike accident in 1989 which led to ongoing back problems and he began to receive a Disability Support Pension from that time. Prior to entering custody, he was living in his car or staying at his mother's address in Southport, Queensland.

8. Mr Blundell used heroin from the age of 20 and was later on the methadone program, and had also used amphetamines, cocaine, benzodiazepines and alcohol. In the period prior to his death, Mr Blundell injected hydromorphone, or Jurnista, a semi-synthetic opioid.

9. Mr Blundell had diabetes, hepatitis C and liver problems, had developed infective endocarditis as a result of his intravenous drug use, as well as oesophagitis and duodenal ulcers.

10. Mr Blundell also had a history of mental health problems. A psychiatrist who reviewed Mr Blundell in 2011 and 2012 considered that he may have Bipolar Disorder and possibly Attention Deficit Disorder. Mr Blundell reportedly made several suicide attempts.

Care and treatment provided to Mr Blundell prior to entering custody

Presentation to Gold Coast University Hospital – 26 February 2018

11. At 4.06am on 26 February 2018, Mr Blundell presented to the Emergency Department ("ED") at Gold Coast University Hospital ("GCUH"). He reported back pain, swollen legs and shortness of breath on exertion. A drug screen was positive. His mother told doctors he had been diverting her medication and injecting it and had last used two days prior.

12. Investigations, including a trans-thoracic echocardiogram ("TTE"), revealed that Mr Blundell had severe tricuspid valve regurgitation ("TR"), a moderately dilated right atrium and a severely dilated right ventricle with impaired systolic function. The plan was to admit Mr Blundell as he required surgery. However, he discharged himself at 12:30pm against medical advice, stating that he wanted to get more Jurnista.

First admission to Gold Coast University Hospital – 27 February to 7 March 2018

13. On 27 February 2018, Mr Blundell was admitted to GCUH for eight days after reporting a heaviness in his legs for 2-3 weeks and shortness of breath on exertion. Blood cultures showed gram-positive cocci, however, it was unclear whether this was from a past infection or indicative of infective endocarditis currently. Mr Blundell was commenced on an antibiotic and a diuretic and an abdominal ultrasound showed he had an enlarged liver.

14. Mr Blundell was informed that he required a heart valve replacement, but this could not be performed while he continued to use intravenous drugs. He declined a referral for drug and alcohol treatment.

15. At 2.30pm on 7 March, Mr Blundell was discharged against medical advice. He had been found acutely intoxicated and was held briefly under the *Guardianship Act 2000 (QLD).* When he sobered up, he was strongly advised against leaving and was advised of the risks. He was given a follow-up appointment in an infectious diseases clinic. There is no evidence he attended.

Second admission to Gold Coast University Hospital – 9 to 12 March 2018

16. At 6.40pm on 9 March 2018, police found Mr Blundell slumped in his car, apparently drug affected, and took him back to GCUH, where he was admitted for four days.

17. During this admission, Mr Blundell was reviewed and a decision was made to cease antibiotics. He continued to leave the ward and it was believed he was injecting drugs. He again declined alcohol and drug treatment and discharged himself against medical advice, being clinically stable at the time.

18. The discharge summary noted that his primary medical issue was intravenous drug use, and that a valve replacement would be performed if he stopped injecting drugs.

Arrest and imprisonment on 18 March 2018

19. On 18 March 2018, Mr Blundell was arrested by police at Cabarita Beach, NSW and charged with drive while disqualified and custody of a knife. Warrants for two previous drive while disqualified charges were also executed. He was refused bail and taken to Tweed Heads Local Court, where he appeared on 19 March 2018. The Court refused bail and adjourned his matter to 16 April.

Care and treatment provided to Mr Blundell after entering custody

Presentation to Lismore Base Hospital ED – 20 March 2018

20. Mr Blundell reported heart problems upon attending police custody. He was taken to Lismore Base Hospital ED for review as he was in custody in NSW and could not be treated in Queensland.

21. At Lismore Base Hospital, Mr Blundell reported shortness of breath, a sharp pain in his chest, and also had swelling around his eyes (believed to be an allergic reaction). A chest X-ray showed a heart at the upper limits of normal size. An abdominal ultrasound was also performed, which identified a 2-3cm mass near his umbilicus. Mr Blundell was guarding his right upper quadrant.

22. Upon review in the ED, Mr Blundell reported he had not used intravenous drugs for three to four months. He said that his regular medication included Jurnista, which was not true.

23. Mr Blundell was reviewed by a cardiologist who reviewed the TTE report from GCUH. The cardiologist believed Mr Blundell may have perforation of a leaflet of the valve but did not believe that his chest pain was cardiac-related, and there were no current

concerns about infective endocarditis. An ECG was normal (although it showed a long QT interval).

24. Mr Blundell was then discharged back to Lismore police cells, with a plan for a further TTE in three months.

Entry into custody

25. On 21 March 2018, Mr Blundell entered custody at Grafton Correctional Centre. Upon reception, Justice Health and Forensic Mental Health Network ("Justice Health") recorded that Mr Blundell had last used intravenous drugs two days prior and he was placed "two-out" due to his medical issues.

26. On 22 March 2018, Mr Blundell was taken to the Justice Health clinic complaining of chest pain, before he was transported by ambulance to Grafton Base Hospital ("GBH").

First presentation to Grafton Base Hospital ED – 22 March 2018

27. At hospital, Mr Blundell complained of epigastric pain. An electrocardiogram ("ECG") was performed, which showed no acute issue, and blood tests for troponin and inflammatory markers were normal. A doctor noted that he was complaining of chest and abdominal pain and was requesting opiates. A further chest X-ray was not considered necessary. Diuretics were commenced. He was also seen by a drug and alcohol worker, who planned to see him again if admitted, or suggested he access drug counselling in prison.

28. Mr Blundell was then returned to prison.

29. In the early hours of 26 March 2018, Mr Blundell was found supine on the floor of his cell. He was taken to Justice Health, complaining of chest pain. At 2.52am, he was transported to GBH by ambulance.

Second presentation to Grafton Base Hospital ED – 26 March 2018

30. Mr Blundell was triaged in the ED at 3.06am. He reported a sharp left-sided chest pain, worse when breathing in or moving. The doctor who reviewed him noted Mr Blundell's noted a lump in the abdominal wall which had been "*present for months, no recent change*". On examination, Mr Blundell looked well, had no chest pain and his observations were normal. His abdomen was soft, not tender, bowel sounds were present, and the lump was located and was "*non-reducible*". An ECG was undertaken, which showed a low voltage sinus rhythm. He was given a sandwich and his normal medications and was discharged back to prison at 4.15am.

Review by Justice Health

31. On 27 March 2018, Mr Blundell was reviewed by a Justice Health doctor, Dr Kehoe, at Grafton Correctional Centre. Dr Kehoe noted Mr Blundell's recent admissions and drug use. He later completed a referral form for cardiology for a possible valve replacement.

32. On 29 March 2018, Mr Blundell completed a patient self-referral form, asking to be taken off the "green card" because he felt well and did not need it anymore. He also said, "*I have dun to much jail I 44 years of age".*

33. On 3 April 2018, Mr Blundell presented to Justice Health with chest pain. The after-hours service ("ROAMS") was consulted and he was given Ibuprofen and returned to the yard.

34. At 8.00pm, he was unable to walk, experienced diarrhoea and was moaning. The after-hours service was contacted again, and Mr Blundell was placed in a camera cell for observation.

35. At 3.31am, Mr Blundell was transferred by ambulance to GBH.

First admission to Grafton Base Hospital – 4 to 7 April 2018

36. Blundell was admitted to GBH for three days, reporting that he had a two-day history of melaena (dark black stools) and haematemesis (vomiting blood). An abdominal CT scan did not show any intra-abdominal pathology. He was anaemic and a blood transfusion was commenced.

37. At 4.39pm that day, an endoscopy showed oesophagitis, duodenitis and identified three duodenal ulcers. The ulcers were considered to be the likely cause of Mr Blundell's symptoms. An ECG the following day showed severe right heart dilation.

38. On 6 and 7 April 2018, Dr Joel Budge reviewed Mr Blundell and reported that his haemoglobin level had increased following the transfusion without any ongoing bleeding. He was content for Mr Blundell to be discharged with medication to treat stomach ulcers and recommended avoiding non-steroidal anti-inflammatory drugs ("NSAIDs").

39. Mr Blundell was discharged back to prison on 7 April 2018 and was placed in a cell with 24-hour CCTV monitoring.

40. On 8 April 2018, Mr Blundell made a cell alarm call because he was experiencing rectal bleeding and was transferred back to GBH by ambulance at 3.50pm.

Second admission to Grafton Base Hospital – 8 to 20 April 2018

41. At triage, Mr Blundell complained of abdominal pain. A chest X-ray identified no free air under the diaphragm (which would have indicated a perforation).

42. At 5.10pm, Mr Blundell was reviewed by Dr Bartell. Mr Blundell looked pale and sweaty. His abdomen was soft, but he had pain in the epigastric area. Dr Bartell's impression was that Mr Blundell was feeling pain from the ulcers and he was given Fentanyl, after which he significantly improved.

43. At about 8.58pm, Dr Budge reviewed Mr Blundell. Dr Budge was suspicious that Mr Blundell's presentation may have had something to do with his desire to move out of a camera cell.

44. Over the next few days, Mr Blundell continued to report chest or abdominal pain and asked for pain medication, which was provided.

45. At about 3.00pm on 9 April, Mr Blundell reported feeling unwell and complained of abdominal pain. Observations record that Mr Blundell was stable, however he had chronic hypertension. The plan was to arrange a further X-ray to determine if there was a perforation.

46. During the early hours of 10 April, Mr Blundell desaturated and required oxygen via nasal prongs. He was intermittently given oxygen over his subsequent days in hospital.

47. Dr Budge reviewed Mr Blundell again on 10 April at 9.47am. Dr Budge was unsure if his claims of being unwell were genuine or not and believed Mr Blundell was trying to avoid going back to gaol. Nevertheless, Dr Budge sought a review by a cardiologist, given Mr Blundell's severe valvular disease.

48. Cardiologist Dr Norman Burrell reviewed Mr Blundell at 10.35am that day and did not believe there was a serious underlying cause for Mr Blundell's reported symptoms, recording that Mr Blundell was "*clearly trying to avoid going back to jail*".

49. There were discussions as to where Mr Blundell should be transferred considering his current condition. On 10 April, Dr Kehoe from Justice Health discussed with GBH a transfer to a metropolitan gaol as Mr Blundell required "*custody structure with 24/24 nursing cover*". On 11 April 2018, there was a multidisciplinary meeting which noted that Mr Blundell would not be taken back to gaol in his current condition. Enquiries were made about releasing Mr Blundell from custody on medical grounds.

50. Dr Budge reviewed Mr Blundell again that day and noted that he was hyperventilating, had lactic acidosis due to hyperventilation or possibly hypoxia. Dr Budge also noted that

if there was a true cardiac component to Mr Blundell's presentation, they were at their limits at Grafton. A CT angiogram was also performed.

51. In the evening of 12 April, Mr Blundell complained of headaches.

52. In the evening of 13 April, Mr Blundell reported chest pain and was noted to be displaying some drug-seeking behaviour. A troponin result showed a raised level at 622 and he was transferred to the Cardiac Care Unit ("CCU"). He was placed on a cardiac monitor, given fentanyl for pain and placed on anticoagulants (clexane) which he had previously refused. At 11.00pm, a blood transfusion commenced.

53. On 14 April, Dr Ashokumar reviewed Mr Blundell at 9.30am. He noted the history and atypical chest pains, with raised troponin, and that the ECG did not show any evidence of myocardial ischaemia. He planned further blood tests and to discuss the matter with GCUH. GCUH suggested an angiogram (CTCA), which was booked for 19 April and suggested that Mr Blundell was not a candidate for anticoagulants due to his ulcers.

54. On 15 April, Mr Blundell's troponin levels were trending downwards.

55. During the afternoon, Mr Blundell's mother Judy phoned the hospital expressing distress after Mr Blundell informed her that he wasn't going to survive the night. She spoke with a doctor and was reassured.

56. On 16 April 2018, Mr Blundell's case was listed at Tweed Heads Local Court. A bail application was sent to the Court by Corrective Services NSW. The Registrar receiving the email noted that the matter had been heard already and had been adjourned to 30 April 2018, but that the application would be passed to the duty solicitor. The duty solicitor spoke with Mr Blundell and it was decided that a bail application would not be pursued at that stage and might be sought on 30 April if he was still in hospital.

57. On 17 April 2018, Dr Ashokuar reviewed Mr Blundell and recorded that he was haemodynamically stable, afebrile, and still had signs of right heart failure.

58. On 18 April 2018, staff at GBH spoke with Dr John Ryan at the Prince of Wales Hospital ("POWH") for an inpatient transfer for tricuspid valve replacement. Dr Ryan advised that Mr Blundell was not a candidate for a valve replacement as he had recently had a large upper gastro-intestinal bleed and would need six to eight weeks to recover. Dr Ryan suggested that GBH optimise medical management and re-refer in six to eight weeks.

59. However, there was a further contact between Dr Demarchi at GBH and Dr Adikari at POWH and Dr Adikari agreed to discuss with the consultant whether Mr Blundell would be appropriate for an angiogram.

60. Judy also contacted the Health Care Complains Commission for advice that day. She was concerned about the delay and was concerned that Mr Blundell's bail status was preventing him from receiving treatment.

61. At 4.43pm, Mr Blundell appeared very unwell with reports of sudden central chest pain. The ECG revealed a non-ST segment myocardial infarction, NSTEMI. Dr Ashokumar was consulted.

62. On 19 April, it was reported that an angiogram was available at Lismore on the following Monday. However, plans were advancing for transfer Mr Blundell to POWH instead, and at 12 noon POWH accepted the transfer.

63. At 12.27pm that day, Judy sent a copy of the GBH discharge summary to a solicitor, asking for Mr Blundell to be granted bail so that he could be transferred to GCUH. She noted that she was 77 years old and was unable to travel to Sydney. It is unclear whether this request was ever considered by the Court.

64. On 20 April, Mr Blundell was transferred by air ambulance to POWH.

Admission to Prince of Wales Hospital – 20 to 30 April 2018

65. At POWH, Mr Blundell was reviewed and a bedside TTE was performed. The impression was a possible perforation of duodenal ulcer, mild right heart failure with underlying severe TR and right ventricle impairment, and a recent NSTEMI. He was not suitable for antiplatelets due to his ulcers.

66. Blood cultures revealed gram-positive cocci resembling staphylococcus capitis and Mr Blundell commenced antibiotics (initially vancomycin and flucloxacillin). An abdominal CT scan did not show definite intro-abdominal or pelvic gas.

67. Mr Blundell was moved to the CCU. He was reviewed by gastroenterology (Dr Bye/Dr Brooks), cardiology (Dr Yu/Dr Adikari) and later respiratory (Dr Ainge-Allen) and infectious diseases (Dr Story) teams.

68. On 23 April 2018, Dr Adikari made the following entry:

> *"It is likely that Mr Blundell's episode of chest pain and elevated troponin on 11/4/18 was due to a PE rather than a cardiac event. His pulmonary*

hypertension may be due to CTEPH [which refers to chronic thromboembolic pulmonary hypertension].

Extensive D/W between Dr Yu, Dr Ooi and Dr Kushwaha re treatment options … Decision for anticoagulation if cleared by gastro +/- IVC filter if not cleared for anticoagulation and evidence of LL DVTs [lower limb deep vein thromboses]"

69. On 23 April 2018, Mr Blundell commenced anticoagulants after the gastroenterology team confirmed this was appropriate.

70. On 25 April 2018, Mr Blundell desaturated and the ECG monitor showed a right bundle branch block. In the afternoon, a PACE call was made following a further desaturation and loss of consciousness. Mr Blundell was not being compliant with the nasal prongs. He was transferred to the ICU and a Hudson mask was used to administer oxygen.

71. On 27 April 2018, a resuscitation plan was created after Mr Blundell showed signs of shock, multi-organ failure and heart failure, with neither CPR nor intubation being advised.

72. By 29 April 2018, a decision had been made that Mr Blundell would receive palliative care and he was moved back to the CCU. Extensive end-of-life conversations were had with Judy. Mr Blundell was administered hydromorphone for pain relief.

73. On 30 April 2018, Judy agreed to withdraw active treatment but expressed her desire for Mr Blundell to be released from custody. A medical certificate was sent to Tweed Heads Local Court. At 3.15pm, Magistrate Viney dispensed with bail and formally adjourned Mr Blundell's charges to 21 May 2018.

Circumstances of death

74. At 9.05pm, Dr Story and Nurse Bruno heard a thud and an oxygen line being disconnected. They attended Mr Blundell's room and found him prone on the floor with blood coming from his mouth, incontinent and breathing shallowly. A PACE call was made but was cancelled in light of the resuscitation plan.

75. Dr Story confirmed the death at 9.05pm.

Autopsy

76. On 3 May 2018, a limited autopsy was performed by Dr Van Vuuren, who recorded the cause of death as "*Combined effects of myocardial infarction and liver cirrhosis*." As noted below, a different cause of death has been proposed by the experts.

77. Toxicology showed the presence of frusemide, hydromorphone, lignocaine, metoclopramide, quetiapine, sildenafil (all of which were administered in hospital) and also a toxic to lethal level of tramadol.

Expert evidence

Dr Cameron Bell

78. Dr Cameron Bell, a gastroenterologist, undertook a review of Mr Blundell's condition and opined that he was correctly diagnosed following endoscopy at GBH on 4 April 2018, namely duodenal ulcers, oesophagitis and duodenitis, leading to blood loss and anaemia. He saw no support in the material for a finding of liver cirrhosis.

79. Dr Bell expressed a view that an endoscopy was not indicated until Mr Blundell complained of blood in his vomit or stool, because, prior to that point, there had been variations in his complaints and he also had severe cardiac disease.

80. The ulcers were either caused or contributed to by use of painkillers prescribed for back pain. They were probably the cause of some of Mr Blundell's complaints of pain in the chest or abdomen, but some of that pain was likely cardiac in origin.

81. In Dr Bell's view, the care and treatment Mr Blundell received, both at the gaol and at hospital, was appropriate.

82. Dr Bell opined that Mr Blundell's risk of re-bleeding from his ulcers would have been very low *"under normal circumstances".* However, he was unable to comment on that risk in the context of cardiac surgery. It is possible, in his view, that a follow-up endoscopy would have been beneficial.

Professor James Tatoulis

83. Professor James Tatoulis, cardiothoracic surgeon, also undertook a review and noted that Mr Blundell's cardiac condition was complex. Mr Blundell had severe tricuspid valve regurgitation, which had been caused by prior infections on the valve, which had damaged the value and caused perforations. The infections were the result of intravenous drug use, and in particular the use of non-sterile syringes. This condition caused severe dilation of the right atrium of the heart, due to the increased right heart

pressures, and subsequently right heart failure. That led to enlargement of the liver and liver dysfunction and swelling in Mr Blundell's lower limbs. Mr Blundell also suffered pulmonary hypertension, because vegetations from the heart valve had broken off and lodged in the lungs. All of the above factors led to cardiogenic shock, meaning there was insufficient blood flow to supply Mr Blundell's bodily organs.

84. Professor Tatoulis was of the view that, although surgery was theoretically required, a valve repair may not have been possible due to the extent of damage and dilation of the valve. Surgery was initially delayed to allow Mr Blundell's general health to improve and to give him an opportunity to cease intravenous drug use, or there would have been a further risk of infection.

85. Professor Tatoulis considered the duodenal ulcers to have been "*extremely problematic and dangerous*" because Mr Blundell would have needed anticoagulants during heart surgery, which could have caused severe or fatal gastrointestinal bleeding. A delay of three to six months was required to allow complete healing of the ulcers before proceeding.

86. In any event, Professor Tatoulis noted that surgical repair would not have corrected the right ventricular dilation and dysfunction and may have made it worse. And it could not have improved Mr Blundell's pulmonary hypertension, which in his view would have precluded surgery.

87. Overall, Professor Tatoulis considered that Mr Blundell had an inoperable condition. In his view, Mr Blundell received a high standard of care at each hospital and also in custody. The care he received was identical to that which would be expected for a community patient.

88. Professor Tatoulis opined that the cause of death was the result of cardiogenic shock, causing progressively diminished blood flow, leading to hypoxia, cardiac arrest and death.

89. I accept the cause of death provided by Professor James Tatoulis, a cardiothoracic surgeon with an in-depth knowledge of the complexity of the condition afflicting Mr Blundell.

90. Overall, both experts considered that the care provided to Mr Blundell both at the gaol and at hospital, was appropriate.

Findings required by s. 81(1)

91. Taking into account all of the evidence before me in the inquest, I make the following findings pursuant to s. 81(1) of the *Coroners Act 2009*:

Identity – the person who died was Jeffrey Blundell.

Date of death – Jeffrey Blundell died on 30 April 2018.

Place of death – Jeffrey Blundell died at Prince of Wales Hospital, Randwick NSW 2031.

Cause of death – the cause of death was cardiogenic shock, on a background of severe tricuspid valve regurgitation, severe right atrium and ventricle dilation, severe right heart failure and liver dysfunction, and severe irreversible pulmonary hypertension.

Manner of death – the death was a result of natural causes.

I close this inquest.

Magistrate Teresa O'Sullivan
NSW State Coroner
13 September 2023