New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Geoffrey Croft
Hearing date(s):	15 October 2026
Date of Findings:	26 October 2026
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Judge Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, manner of death, inmate patient with history of skin cancer, skin cancer checks in custody, diagnosis of melanoma, timeliness of diagnosis and definitive treatment, management of patient whilst in custody, preventative screening for chronic health conditions, prognosis and appropriateness of treatment
File number:	2022/00119411
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Findings pursuant to section 81(1) *Coroners Act 2009*:

Geoffrey Croft died on 22 April 2022 at Long Bay Hospital, Long Bay Correctional Centre, Malabar NSW 2036.

The cause of Geoffrey's death was the combined effects of cardiomyopathy and metastatic melanoma.

Geoffrey died of natural causes whilst being held in lawful custody. After a lesion on Geoffrey's scapula was first identified, there were delays in having him reviewed by a medical practitioner and performing a biopsy to confirm his diagnosis. These delays likely resulted in definitive treatment not being commenced at the earliest possible opportunity. However, it is not possible to conclude whether these delays ultimately had any material bearing upon Geoffrey's outcome. This is because the lesion was already so advanced and metastatic spread had already occurred before Geoffrey was first seen by a nurse and because the melanoma was one of the 50% of cases that did not respond to immunotherapy.

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1. Introduction

1.1 Geoffrey Croft had a history of cardiomyopathy and skin cancer. On 30 September 2019, he was convicted of criminal offences and taken into custody at a correctional centre. In around October 2019, Geoffrey spoke to his wife on the phone about having a mole on his back seen by a healthcare professional.

1.2 On 7 May 2020, Geoffrey was seen by a doctor and referred to hospital for further investigations. These investigations confirmed that a lesion on Geoffrey's right scapula was a malignant melanoma. Geoffrey was subsequently admitted to hospital for surgery to have the cancerous lesion excised and later commenced on immunotherapy.

1.3 Unfortunately, Geoffrey's melanoma did not respond to treatment. In August 2021, investigations showed metastatic spread of disease to Geoffrey's chest, lungs and bones. Following further admission to hospital in March 2022, it was decided that Geoffrey was no longer suitable for active treatment and he was commenced on palliative care.

1.4 Geoffrey was later returned to a medical unit in custody. On 22 April 2022, Geoffrey was tragically pronounced life extinct.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seek to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This type of examination typically involves consideration of, where relevant, the conduct of staff employed by Justice Health and Forensic Mental Health Network (**Justice Health**) and Corrective Services New South Wales (**CSNSW**).

2.4 In Geoffrey's case, the circumstances of his death raised several questions regarding whether the seriousness of the lesion on his back was recognised, the timeliness of his diagnosis, whether he was referred for definitive management in a timely and appropriate manner, and whether earlier diagnosis and institution of treatment might have materially changed the outcome for Geoffrey.

2.5 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Geoffrey's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge Geoffrey's life in a brief, but hopefully meaningful, way.

3.2 Geoffrey was adopted when he was an infant. He had an older brother. As a child, Geoffrey lived with his family on a rural property in Walcha. In the 1950s, Geoffrey and his family moved to Uralla where his father ran a sheep farm.

3.3 After leaving school, Geoffrey went to work in stock camps on cattle properties in Queensland and the Northern Territory performing droving work for parts of the year. During the busy season at his parents' property, Geoffrey returned to help and would also do stock work in the local area.

3.4 Geoffrey later met his future wife, Sanda, in around 1968. They married in 1974 and remained living in Uralla. Over the years, they expanded a property which Geoffrey had first bought in around 1969. Together they bred and raised cattle.

3.5 In 1978, their son, Daniel, was born. In 1980, their daughter, Abby, was born.

3.6 Geoffrey and Sandra remained at the property in Uralla until 2015 when they decided to downsize and semi-retire. They sold the family home and property. In 2016, they bought a smaller property and moved to Armidale.

3.7 Abby describes her father as a kind and gentle man who stood up for the underdog. There is no doubt that Geoffrey's death has had a profound and lasting effect on his family and loved ones, and that he remains deeply missed.

4. Geoffrey's medical and custodial history

4.1 In 2017, Geoffrey was arrested and charged with several criminal offences. He was initially received into custody but later granted bail.

4.2 On 30 September 2019, Geoffrey was found guilty of some of these offences. On 25 October 2019, Geoffrey was sentenced to an aggregate term of imprisonment of 22 years with a non-parole period

of 10 years commencing on 30 August 2019. Geoffrey subsequently appealed his convictions but his appeal was ultimately dismissed.

4.3 Following sentence, Geoffrey was housed at Tamworth Correctional Centre. Over the years, he was transferred to several different correctional centres including the Metropolitan Special Programs Centre (**MSPC**) and Long Bay Hospital (**LBH**).

4.4 Upon first entering custody, a primary health screen was conducted during a Reception Screening and Assessment. Relevantly, Geoffrey indicated that he had a history of prostate and skin cancer including skin cancer on his lower lip. Justice Health obtained Geoffrey's medical records from his regular treating general practitioner (**GP**), Dr Tracy Maxwell. These records showed that Geoffrey had a history of nonmelanoma skin cancers (multiple squamous cell carcinomas and a modular basal cell carcinoma) with the most serious of these being a squamous cell carcinoma of the lower lip that had been treated surgically with a vermilionectomy on 15 February 2017. The records also indicated that Geoffrey had been seen by a dermatologist and at a skin cancer clinic in Tamworth for the treatment of skin lesions but with no serious skin lesions, or history of melanoma, diagnosed or treated.

4.5 According to Sandra, in around January or February 2020, Geoffrey reported during a visit that he had a lesion on his back and was trying to have someone look at it. During phone calls that Abby had with Geoffrey sometime prior to March 2020, Geoffrey reported that the lesion had become an open wound and was bleeding.

4.6 On 31 March 2020, Geoffrey asked that a Justice Health nurse examine the lesion on his shoulder after he reported seeing blood on his shirt. The lesion was observed to be approximately 3 centimetres in diameter and Geoffrey was referred to a nurse practitioner for review.

4.7 On 14 April 2020, Geoffrey was placed on a waitlist to see a GP with the following notation:

> Has Hx of skin cancer. Currently has an infected skin tag on the right upper shoulder. Please review.

4.8 On 7 May 2020, Dr Jacques Ette, a GP, reviewed Geoffrey and noted a large, solid, shiny red lesion in the right scapular area with no lymph nodes palpable. Geoffrey was referred to Prince of Wales Hospital (**POWH**) for a biopsy.

4.9 On 18 June 2020, Geoffrey was seen by Dr Mitchell Wong at POWH. A punch biopsy was performed. Dr Wong reported a rubbery circular mass approximately 3x3 centimetres in size overlying the right scapular which was losing and malodorous and raised 1 centimetre above the level of the surrounding skin. The punch biopsy report indicated an ulcerated primary melanoma at least 5.5 millimetres in Breslow thickness.

4.10 Geoffrey was referred to Dr Christopher Lehane, a general surgeon, for definitive management. A subsequent computed tomography (**CT**) scan and positron emission tomography (**PET**) scan showed no evidence of systemic metastasis.

4.11 On 4 August 2020, Geoffrey underwent surgery to widely excise the melanoma with 2 centimetre clearance margins. The resulting defect was covered with a split skin graft taken from the thigh. A sentinel node biopsy procedure in the right axilla was also performed.

4.12 The pathology report of the excised specimen indicated that it was an ulcerated, exophytic, polypoid melanoma measuring 70x60x25 millimetres with a pedicle 20 millimetres in diameter attached to the underlying skin. The specimen from the right axilla contained six lymph nodes, one of which was found to contain a focus of metastatic melanoma 2 millimetres in diameter. The primary tumour was 15 millimetres in Breslow thickness with the surface almost entirely ulcerated. As no junctional component was seen the possibility of metastatic melanoma could not be excluded.

4.13 In September 2020, Geoffrey was referred to Dr Melvin Chin, a medical oncologist at POWH for commencement of adjuvant immunotherapy treatment. This continued until July 2021.

4.14 Further scans in July and August 2021 identified a lymph node containing metastatic melanoma in the right supraclavicular region, melanotic lesions on the mid back and anterior chest, a lesion on the right lower eyelid (apparently a basal cell carcinoma), and multiple foci of metastatic melanoma in the lungs and bones.

4.15 On 18 October 2021, the basal cell carcinoma on Geoffrey's right lower eyelid and that the lesion on his right chest wall were excised. The latter was reported to be a melanoma deposit 15 millimetres in Breslow thickness. The presence of metastatic disease in the right supraclavicular lymph node was confirmed.

4.16 On 7 December 2021, Geoffrey commenced second line immunotherapy. However, the treatment was discontinued after two cycles because the disease had not responded and Geoffrey developed severe colitis as a side effect.

4.17 In January 2022, further scans showed enlarged lymph nodes in the chest and soft tissue masses indicating widespread metastatic melanoma.

4.18 On 15 February 2022, Geoffrey was commenced on targeted drug therapy.

4.19 On 17 March 2022, Geoffrey was taken to POWH with confusion, agitation and incontinence. He developed pneumonia and antibiotic therapy was commenced. Geoffrey's delirium was thought to be multifactorial and his admission was further complicated by an exacerbation of heart failure and thrombosis in a vein in his left leg.

4.20 On 21 March 2022, a decision was made to cease further active treatment and Geoffrey was transitioned to a palliative care pathway. In April 2022, Geoffrey had 28 teeth extracted over several sessions using local anaesthetic due to his very poor dentition.

4.21 On 8 April 2022, Geoffrey was returned to LBH where palliative care was continued. Over the next two weeks, Geoffrey became increasingly agitated and confused, and experienced hallucinations and difficulties with his left leg and foot and his left elbow.

4.22 On 22 April 2022, Geoffrey was tragically pronounced life extinct.

5. Post-mortem examination

5.1 On 29 April 2022, Dr Elsie Burger, forensic pathologist, performed a post-mortem examination of Geoffrey at Forensic Medicine Sydney. This identified the following relevant findings:

(a) a lytic lesion (strongly in keeping with a metastasis) present in the pelvis;

(b) evidence consistent with metastatic disease in the lungs and mediastinal lymph nodes;

(c) fluid collections in the pleural cavities; and

(d) vascular calcification in the aorta and coronary arteries with an aneurysm present in the abdominal aorta (but with no evidence of complications in the aneurysm).

5.2 In the post-mortem examination report dated 23 February 2023, Dr Burger opined that the cause of Geoffrey's death was the combined effects of cardiomyopathy and metastatic melanoma.

6. What issues did the inquest examine?

6.1 A list of issues was circulated amongst the sufficient interested parties before the inquest commenced. This list identified the scope of the inquest and the following issues for consideration:

(1) Whilst Geoffrey was in custody:

(a) was his risk of skin cancer adequately monitored?

(b) was the lesion on his back adequately managed after it was identified?

(c) was a reasonable and adequate process undertaken to arrange for him to undergo a biopsy after his 7 May 2020 GP review?

(d) was the management of his cancer and comorbidities reasonable and adequate?

(2) Would Geoffrey's prognosis and outcome have differed had there been earlier diagnosis of his cancer?

6.2 John Thompson AO is an Emeritus Professor of Melanoma and Surgical Oncology at The University of Sydney, an Honorary Emeritus Consultant, Melanoma and Surgical Oncology, Royal Prince Alfred Hospital, and a Senior Surgeon and Faculty Member, Melanoma Institute of Australia. He

was briefed to provide several expert reports addressing the above issues and also gave expert evidence at the inquest.

7. Was Geoffrey's risk of skin cancer adequately monitored?

7.1 Professor Thompson gave evidence that as a general matter, people at high risk for melanoma (people with fair skin, fair hair, and of Celtic origin) should have a skin check every six months. However, Professor Thompson acknowledged that the frequency of such checks are often not practical given the cost implications and being dependent upon individuals to actually arrange for such checks to be performed.

7.2 Professor Thompson explained that if a person has one or more non-melanoma skin cancers (such as basal cell carcinoma or squamous cell carcinoma) then "*the risk of developing melanoma is substantially increased*". Given Geoffrey's history of previous squamous cell carcinoma this placed him at increased risk of melanoma. Professor Thompson expressed this view regarding management of Geoffrey's risk of skin cancer whilst in custody:

> I think if people have a history of skin cancers, then in the outside world they would probably be reviewed at least every four to six months by a family physician, and so I would imagine that it would be prudent for people admitted to a correctional institution to be assessed in the same way, if that was feasible.

7.3 Shaun Connolly, Director of Nursing Clinical Support at Justice Health, gave evidence that during the period that Geoffrey was in custody no system-wide process existed for performing regular skin checks on inmates. Instead, Mr Connolly explained that the process was patient-led, meaning that an inmate patient could request a skin check through an enquiry and self-referral service. This would lead to the inmate being seen by a primary healthcare nurse who could in turn facilitate a skin check.

7.4 Alternatively, if the need for a skin check was identified during a routine assessment or screening process for chronic diseases, such a check could be arranged for an inmate. This is consistent with the Justice Health *Preventative Health Screening* Procedure (**PHS Procedure**) issued on 12 October 2023. Its aim is to identify those inmates at risk of chronic conditions and initiate intervention strategies to prevent such conditions. The purpose of this preventative health screening model is to collect and provide information to patients on risk factors that can cause chronic diseases, commence care planning for patients who are at risk of developing a chronic condition, and refer patients for follow-up or further assessment as clinically indicated. It also provides that one of the two patient groups targeted for preventative health screening due to their increased risk for developing chronic conditions are patients who are aged 55 years and over.

7.5 The PHS Procedure also relevantly provides that:

(a) the preventative health screening model commences 12 months post reception for patients 55 years and over and then every two years or based on clinical judgement;

(b) one of the core elements for the prevention of chronic disease is skin cancer; and

(c) one of the resources available on the Patient Health Information Portal is an information package titled, *Men's Health Skin Cancer* which provides information regarding prevention of chronic health conditions and what to look out for.

7.6 Mr Connolly gave evidence that information resources like the *Men's Health Skin Cancer* package are generally kept at clinics and health centres in correctional centres and accessible by patients when they attend these locations. These resources are also kept in wings where patients are accommodated at some correctional centres.

7.7 As to the practicality of conducting regular skin checks for all inmates in custody, Mr Connolly gave this evidence:

> I think that the volume of patients, like, that we are talking about, I think that would be incredibly complex to implement across a wide system. So currently today, there are 14,200 patients in custody and 70% of that cohort are male. That is spread across 37 correctional centres in New South Wales […] Justice Health certainly wants to have for patients exactly the same access to preventative health mechanisms that they would have in the community or when not in custody, because it is effectively a community space. But it would be very much contingent on resourcing and funding that process.

7.8 **Conclusions:** Given Geoffrey's history of squamous cell carcinoma and risk profile for melanoma, it would have been prudent for him to have had a skin check at least every six months. After Geoffrey entered custody, no widespread screening system to perform checks for skin cancer existed. This remains the case today. This is because of the resource limitations involved in arranging for such checks given the significant size of the inmate population spread across multiple correctional centres in New South Wales, including in regional areas where access to healthcare practitioners is more limited than in urban areas.

7.9 Instead, the performance of skin checks was patient-led meaning that inmate patients could seek to access such checks via a self-referral system or if the need for a check was identified during a routine assessment. When Geoffrey first asked a nurse to examine the lesion on his shoulder in March 2020, he had been in custody for approximately six months. The PHS Procedure which exists today provides that a preventative health screening model commences 12 months after an inmate is received into custody and then continues every two years or based on clinical judgement. Therefore, even if the PHS Procedure had existed in 2020, it is unlikely that any steps in diagnosing and managing Geoffrey's melanoma would have been taken any earlier. Overall, the available evidence indicates that Geoffrey's risk of skin cancer was adequately monitored whilst he was in custody.

8. Was the lesion on Geoffrey's back adequately managed after it was identified?

8.1 On 31 March 2020, Geoffrey asked for the lesion on his back to be reviewed after noticing blood on the back of his shirt. Professor Thompson gave evidence that this is a common presentation of melanoma in male persons, particularly older male persons. A Justice Health progress note entry made by a Primary Care Nurse Unit Manager records the following:

Patient requested I review his back – states he notes blood on his tshirt at times.
[On examination]
lesion noted
R upper back
Approx. 3cm diameter – raised
Plan:
Refer to [Nurse Practitioner] for review
Reassurance provided to patient
Advised patient to notify RN/CSNSW if any concern

8.2 Mr Connolly gave evidence that the plan to refer Geoffrey to a Nurse Practitioner for review should have resulted in an entry being made on the Justice Health Patient Administration System (**PAS**). This would have placed Geoffrey on a waiting list to be seen by a Nurse Practitioner. However, there is no record of such a PAS waitlist entry ever having been made.

8.3 Instead, on 14 April 2020, Geoffrey was placed on a waitlist to be reviewed in the GP Clinic. It was noted that he had a history of skin cancer and that he "*currently has an infected skin tag on the right upper shoulder*". Geoffrey's priority was classified as semi-urgent meaning that he was to be seen within 4 to 14 days. Professor Thompson gave evidence that he considered this timeframe to be reasonable.

8.4 However, Professor Thompson considered that Geoffrey's presentation after 14 March 2020 should have prompted more urgent review. First, although Geoffrey's lesion was initially described as "*an infected skin tag*", Professor Thompson noted that it was also described as a mass 3 centimetres in diameter meaning that there was "*clearly and incorrect interpretation of what was actually there*". Second, the fact that the dressings over the lesion need to be changed daily meant that the tumour had ulcerated and was already an advanced tumour and probably infected. However, Professor Thompson expressed the view that whilst a medical practitioner would have recognised Geoffrey's presentation as something more serious, it is not a presentation that would have routinely formed part of nursing training.

8.5 The priority category allocated to Geoffrey on 14 April 2020 meant that he should have been reviewed by a GP by 28 April 2020. Instead, Geoffrey was not seen by Dr Ette until 7 May 2020, a delay of nine days.

8.6 Mr Connolly gave evidence that from the perspective of Justice Health, there are several factors which may influence the process by which an inmate patient is seen within a nominated referral time (such as 4 to 14 days). First, whether a patient is seen is dependent on access being provided by CSNSW. Second, a patient may decide to cancel an appointment schedule for a particular day. Third, Mr Connolly gave evidence that in early 2020, access to patients generally "*was incredibly complex*" due to the impact of the COVID-19 pandemic. He explained that there was "*enormous safeguarding of workforce [and] patients*", particularly for cohorts of elderly patients and that this "*would have absolutely been a factor in, I think, the review being nine days post the priority timeframe*".

8.7 **Conclusions:** After Geoffrey was first reviewed by a nurse on 31 March 2020, he ought to have been seen by a nurse practitioner. It is unclear from the available evidence why this did not occur. However, two weeks later on 14 April 2020, Geoffrey was appropriately placed on a waitlist to be seen by a GP within 4 to 14 days. The expert evidence established that this was a reasonable timeframe for review.

8.8 Instead, Geoffrey was seen 23 days later. Whilst the reason for this delay of nine days is not entirely clear, it is likely that the impact of the COVID-19 pandemic had some bearing upon the timeframe. At the time, the safeguarding of inmates, particularly older inmates, and Justice Health staff meant that access to healthcare services was more limited. Ultimately, it is not possible to define the impact caused by the extension of the waitlist timeframe although it would appear that a referral to confirm Geoffrey's diagnosis and commence definitive treatment was in turn delayed.

8.9 Geoffrey was regularly reviewed by nursing staff during the period before he was seen at POWH. The fact that the dressing over his lesion required regular changing should have suggested to a medical practitioner that Geoffrey's presentation was serious and that more urgent review was required. However, the expert evidence established that it is unlikely that nursing staff would have been trained to recognise the seriousness of Geoffrey's presentation.

9. Was the process for a biopsy to be performed reasonable and adequate?

9.1 At his review on 7 May 2020, Dr Ette referred Geoffrey to POWH for an urgent biopsy. The referral form completed by Dr Ette indicated that Geoffrey was referred to the general surgery team with a clinical urgency category of 1. According to the NSW Health *Management of Outpatient (Non-Admitted) Services* Guideline, the recommended timeframe for patients with referrals categorised as Category 1 – Urgent to be seen was "*within 30 days of referral receipt*".

9.2 On 18 June 2020, the punch biopsy was performed by Dr Wong at POWH. This occurred 42 days after the urgent referral made on 7 May 2020. On 25 June 2020, the histopathology report from the biopsy sample became available which confirmed a malignant melanoma.

9.3 Liesel Straka is the Nursing Unit Manager for the Adult Outpatient Department at POWH. She described the following process in 2020 by which inmate patients from LBH were referred to POWH:

(a) referrals from Justice Health were processed by administration staff at POWH;

(b) an initial screening was performed by administration staff to ensure that sufficient information was provided and that the referral had been sent to the correct outpatient department;

(c) referrals were then provided to the relevant medical team (based on the information provided in the referral) to be triaged;

(d) although a referral from Justice Health may be assigned an urgent category rating, the medical team would decide the priority of the referral for themselves;

(e) the triage process would occur during a clinic for a particular medical team which was held once per week; and

(f) the referred patient would then be allocated to a future clinic for review which was also held once per week.

9.4 Ms Straka gave evidence that she does not have any insight into the triage process and is unaware of the reason why a referred patient is allocated to particular medical team.

9.5 In Geoffrey's case, the referral from Dr Ette indicated that he was referred to a general surgery team. In 2020, general surgery teams held clinics once every four weeks on average. Geoffrey was triaged and allocated to be seen by a general surgeon at a clinic on 18 June 2020. The same general surgeon also held a clinic on 21 May 2020. Further, Justice Health records indicate that two inmates were seen by a different general surgeon at clinic on 11 June 2020.

9.6 Professor Thompson expressed the view that, resources permitting, Geoffrey ought to have been seen at the first available clinic on 21 May 2020. In his first report, Professor Thompson expressed the view that "*a delay of almost six weeks in obtaining a biopsy from what was obviously a very advanced and aggressive tumour was excessive*" and that "*attempts should have been made to expedite the biopsy*". Professor Thompson elaborated on this during his evidence:

> [I]f Mr Croft was, in other circumstances, being managed by, say, his family doctor, I would have expected a much more prompt biopsy to have been arranged and I think most family physicians, if they were given an appointment several weeks in advance, would object and would contact whoever they had referred the patient to and said, "I believe this is something that should be attended to more urgently." So, in other circumstances, I think yes, a more urgent biopsy should and probably would have been arranged.

9.7 However, Professor Thompson agreed that if the first clinic that Geoffrey could have been seen at on 21 May 2020 was full or oversubscribed then it would have been appropriate for him to be seen at the next available clinic on 18 June 2020. Professor Thompson acknowledged that it is not possible to determine from the available information why Geoffrey could not be seen any earlier than 18 June 2020. Indeed, Professor Thompson gave this evidence:

> Now, if you only have a clinic once every four weeks and you've got the next one already booked up, then it's a situation that is very hard to deal with.

9.8 **Conclusions:** The performance of a punch biopsy on 18 June 2020, fell outside the recommended timeframe for a patient with Geoffrey's priority to be seen. Instead of being seen within 30 days, Geoffrey was seen 42 days following referral. There were at least two other general surgery clinics held on 21 May 2020 and 11 June 2020, and two other inmate patients were seen at the latter clinic. It can be accepted that a triage process generally, by its very nature, involves considering patient acuity and clinical urgency. However, the particular features and considerations given to the triage process between April to June 2020 is unknown. Therefore, it is not possible to know whether there was any opportunity for Geoffrey to have been seen at one of the earlier clinics.

9.9 Without any available evidence as to what factors were present and occurred in Geoffrey's case, no meaningful assessment can be made as to the reasonableness and adequacy of this process. It can be accepted that if the clinic with the same general surgeon on 21 May 2020 was already full, then it was appropriate for Geoffrey to be seen at the next available clinic on 18 June 2020.

10. Was the management of Geoffrey's cancer and his comorbidities reasonable and adequate?

10.1 In his reports, Professor Thompson expressed the view that once Geoffrey's diagnosis had been established by the histopathology report of 25 June 2020, there was no undue delay with his management. Indeed, Professor Thompson considered that Geoffrey "*received adequate, appropriate and timely nursing and medical assessment and treatment at [POWH] from the time that he was first seen there*". Professor Thompson also gave evidence that once Geoffrey's diagnosis was confirmed, his treatment (involving tumour excision and immunotherapy) was:

(a) "*exactly as you would expect*";

(b) "*in line with community standards*"; and

(c) "*was exactly as anyone in a community would have been treated and that was entirely appropriate*".

10.2 **Conclusions:** The expert evidence established that once Geoffrey's diagnosis was confirmed, the management of his melanoma and his comorbidities was entirely reasonable and adequate and consistent with the treatment that would have been provided if Geoffrey was in the community and not in custody. That is, the treatment and management instituted for Geoffrey followed the same clinical course as for a person with a similar presentation in the community.

11. Would Geoffrey's prognosis and outcome have differed had there been earlier diagnosis of his cancer?

11.1 Professor Thompson gave evidence describing prognosis for melanoma generally and the particular characteristics of Geoffrey's melanoma:

> The vast majority of melanomas that present in Australia are less than one millimetre in Breslow thickness and have a reasonably good prognosis, maybe a 95% 10 year survival rate. Once you get up to three and four and five millimetres, the prognosis is dramatically worse, the likelihood of spread to regional lymph glands and to distant metastatic sites increases dramatically. This initial assessment was 5.5 millimetres. In fact, it turned out in the end to be 15 millimetres. That is huge. I mean, that is a very, very thick, advanced melanoma, which I might say had clearly taken some considerable time to get to that point.

11.2 Professor Thompson also gave evidence that metastatic disease in sentinel lymph nodes often occurs 12 to 18 months before a melanoma on the skin is diagnosed. In Geoffrey's case a positive sentinel lymph node was identified at the time of his initial surgery on 4 August 2020. Professor Thompson therefore expressed the view that by October 2019, when Geoffrey first reported the lesion on his back, "*there is little doubt that […] metastatic spread had already occurred both to*

regional lymph glands and to systemic sites". Professor Thompson explained that given how advanced the lesion was by October 2019, "*it may well be that the horse had bolted completely by that time*".

11.3 Ultimately, Professor Thompson gave evidence that if Geoffrey's diagnosis had been confirmed at an earlier point in time, it is "*certain that systemic immunotherapy would have been commenced earlier*". However, Professor Thompson also gave evidence that it is not possible to know whether the outcome for Geoffrey would have been any different. Further, Professor Thompson noted that Geoffrey was in the category of 50% of patients for whom immunotherapy does not control metastatic melanoma.

11.4 **Conclusions:** Earlier diagnosis of Geoffrey's melanoma is likely to have led to earlier commencement of definitive treatment. However, it is not possible to know whether any earlier commencement of such treatment would have materially altered Geoffrey's outcome. This is because even by October 2019 when Geoffrey reportedly discussed with Sandra and Abby having the lesion on his back looked at, metastatic spread had already occurred. Further, Geoffrey's melanoma was of a kind for which immunotherapy is ineffective in 50% of cases.

12. Findings

12.1 I acknowledge and express my gratitude to Ms Kate Holcombe, Counsel Assisting, and her instructing solicitor, Ms Connie Livanos. The Assisting Team has provided exceptional assistance during the conduct of the coronial investigation and the inquest. I am extremely grateful for their commitment efforts, and for the empathy that they have shown to Geoffrey's family throughout the coronial process.

12.2 I also thank Detective Senior Constable Amy Adair, the NSWPF Officer-in-Charge, for her role in the NSWPF investigation and for compiling the initial brief of evidence.

12.3 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Geoffrey Croft.

Date of death

Geoffrey died on 22 April 2022.

Place of death

Geoffrey died at Long Bay Hospital, Long Bay Correctional Centre, Malabar NSW 2036.

Cause of death

The cause of Geoffrey's death was the combined effects of cardiomyopathy and metastatic melanoma.

Manner of death

Geoffrey died of natural causes whilst being held in lawful custody. After a lesion on Geoffrey's scapula was first identified, there were delays in having him reviewed by a medical practitioner

and performing a biopsy to confirm his diagnosis. These delays likely resulted in definitive treatment not being commenced at the earliest possible opportunity. However, it is not possible to conclude whether these delays ultimately had any material bearing upon Geoffrey's outcome. This is because the lesion was already so advanced and metastatic spread had already occurred before Geoffrey was first seen by a nurse and because the melanoma was one of the 50% of cases that did not respond to immunotherapy.

12.4 On behalf of the Coroner's Court of New South Wales and the Assisting Team, I offer my sincere and respectful condolences to Geoffrey's wife, Sandra, his daughter, Abby, his son, Daniel, and his other family members, loved ones and friends for their tragic and devastating loss.

12.5 I close this inquest.

Judge Derek Lee
Deputy State Coroner
26 October 2026