IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 4341

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, PETER WHITE, Coroner having investigated the death of Andrew Kellett
without holding an inquest:
find that the identity of the deceased was Andrew Kellett
born on 8 November 1990
and the death occurred between 11 and 12 September 2016
at 280 Palmers Road, Truganina, Victoria
from:

1 (a) CARDIOMEGALY

Pursuant to section 67(1) of the **Coroners Act 2008**, there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Andrew was 25 years old at the time of his death.
2. As a child, Andrew was diagnosed with short-term auditory memory which effected his ability to learn. He had also been diagnosed with bi-polar, depression and schizophrenia before his incarceration.
3. Andrew had a history of hearing voices asking him to do various tasks and had previously mentioned to his General Practitioner that he had suicidal thoughts.
4. From 7 September 2016 until his death, Andrew was in the custody of Port Phillip Prison in the Salamander Unit, cell 718. His cell-mate was Thomas Vandersluys. There was no evidence of conflict or animosity between the pair.
5. On 11 September 2016, Andrew and Thomas were in their cell watching a movie together. At approximately 8:00p.m, Andrew began to smoke a homemade cigarette made from tea and crush Nicotine.[1] There is no evidence that this homemade cigarette contributed to Andrew's death.

[1] Coronial Brief of Evidence (Statement of Thomas Vandersluys).

6. The movie ended and Thomas recalls Andrew had fallen asleep. Thomas turned off the television and went to bed.

7. On 12 September 2017 at 7:51a.m, prison staff were conducting a muster count to ensure the health and wellbeing of inmates. Staff reached cell 718 and called out to Thomas and Andrew. When Andrew did not reply Thomas attempted to rouse him but was unsuccessful. Staff then entered the cell and found Andrew unresponsive. A 'code black' was called and medical staff were notified.[2]

8. Medical staff arrived at 7:55a.m and attempted to resuscitate Andrew until Ambulance Victoria paramedics ("the paramedics") arrived and took over. However, paramedics were unsuccessful in resuscitating Andrew and he was pronounced dead at 8:16a.m.[3]

9. Forensic Pathologist, Dr Heinrich Bouwer of the Victorian Institute of Forensic Medicine, performed a post mortem autopsy. Dr Bouwer provided me with a report of his findings. Upon completion of the post mortem autopsy examination Dr Bouwer formulated that Andrew died from *Cardiomegaly.*

10. Dr Bouwer commented cardiomegaly, or cardiac enlargement, is associated with increased myocardial oxygen demand which may predispose the heart to cardiac arrhythmias (so-called heart attack).

11. Dr Bouwer commented:

> *"The most common causes of cardiac enlargement in the community are hypertension, cardiac valve disease, ischaemic heart disease and cardiomyopathy. It may also be due to certain drugs or toxins. There was no known medical history of hypertension and there was no evidence of ischaemic of valvular heart disease at autopsy."*

12. Post mortem toxicology studies were also performed. Testing revealed only the presence of paracetamol and caffeine and not nicotine.

13. The Act provides that a coroner must hold an inquest into all death which occurred while a person is *"in custody or care"*,[4] except in those circumstances where the death is considered to be due to natural causes.[5]

14. A death may be considered to be of natural causes if the coroner has received a report from a medical investigator, in accordance with the *Coroners Court Rules* 2009, that includes an opinion that the death was due to natural causes.[6] I have receive such a report in this case. Therefore, I limit my findings with respect to the circumstances in which the death occurred and exercise my discretion not to hold an inquest.

15. As part of my investigation, Detective Senior Constable Frank Fierro provided me with a coronial brief of evidence ("the brief"). The brief contains statements from Andrew's

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[2] Coronial Brief of Evidence (Statement of Adam Sugden).
[3] Coronial Brief of Evidence (Statement of Tony Guastalegname).
[4] Section 52(2)(b) of the Coroners Act 2008.
[5] Section 52(3A) of the Coroners Act 2008.
[6] Section 52(3B) of the Coroners Act 2008.

parents, his girlfriend, prison staff, emergency services and Detective Senior Constable Frank Fierro.

16. On the evidence before me, I am satisfied that Andrew Kellett died from *Cardiomegaly* at the age of 25.
17. Pursuant to section 71(1B) of the Act, I order that this finding be published on the internet.

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

Ms Emma Marshall, Senior Next of Kin;

Mrs Vicki Kellett, mother of the deceased;

Detective Senior Constable Frank Fierro, Coroner's Investigator;

Mrs Joanne Herbert, St Vincent's Hospital; and

Ms Emma Catford, Office of Correctional Services.

Signature:

PETER WHITE
CORONER
Date: 13/10/2017