IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2016 1939**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**BARRY FOSTER**
Date of birth:	**24 DECEMBER 1936**
Date of death:	**30 APRIL 2016**
Cause of death:	**ACUTE MYOCARDIAL INFARCTION**
Place of death:	**ST VINCENTS HOSPITAL** **41 VICTORIA PARADE** **FITZROY VICTORIA 3065**

HIS HONOUR:

BACKGROUND

1. Barry Foster was born on 24 December 1936. He was 79 years old at the time of his death and was imprisoned at Hopkins Correctional Centre.

2. Barry had a past medical history of Chronic Obstructive Airway Disease, asthma, and an incidental pulmonary nodule. He was documented as a heavy ex-smoker.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Barry's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death he was a person in custody.[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[3]

4. The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

6. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is

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[1] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008.*
[2] Section 52(2)(b) *Coroners Act 2008.*
[3] Section 52(3A), *Coroners Act 2008.*
[4] Section 89(4) *Coroners Act 2008.*
[5] *Keown v Khan* (1999) 1 VR 69.

confined to those circumstances which are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

9. Coroners are also empowered:

   (a) to report to the Attorney-General on a death;

   (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

11. Barry was identified by circumstantial evidence on 6 May 2016. Identity is not disputed and requires no further investigation.

[6] (1938) 60 CLR 336.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

12. On 1 May 2016, Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine, an inspection on Barry's body and provided a written report dated 26 May 2016, concluding a reasonable cause of death to be "I(a) Acute myocardial infarction". I accept his opinion in relation to the cause of death.

13. The post mortem Computed Tomography (CT) Scan showed coronary artery calcification.

14. Dr Young noted that on the basis of the information available to him, Barry's death was due to natural causes.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

15. On 29 April 2016 Barry was reviewed by health care staff at Hopkins Correctional Centre, after complaining of short term tightening across his chest. An electrocardiogram (ECG) was conducted but showed no abnormalities. Barry's blood pressure was elevated and he was prescribed hypertensive medication.

16. At approximately 5.45am on 30 April 2016, Barry informed the Control Room Operator at Hopkins Correctional Centre that he was feeling unwell. At 6.20am the nurse at Hopkins Medical Centre realized that Barry's condition was serious and called an ambulance. Ambulance paramedics transferred him to the East Grampians Health Service. Barry's condition continued to deteriorate, and at 12.46pm he was transferred by Air Ambulance to St Vincent's Hospital. Barry's custody was transferred to Port Phillip Prison. Barry's condition declined rapidly, and during a cardiac procedure Barry suffered a cardiac arrest. Despite extensive resuscitative efforts, Barry could not be revived and he was declared deceased at 10.17pm.

FINDINGS

17. Having investigated Barry's death, and having considered all of the available evidence, I am satisfied that no further investigation is required.

18. I find that the care provided to Barry by the Department of Justice and St Vincent's Hospital was reasonable and appropriate in the circumstances.

19. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Barry Foster, born 24 December 1936;

(b) that Barry Foster died on 30 April 2016, at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria from acute myocardial infarction; and

(c) that the death occurred in the circumstances described in the paragraphs above.

20. Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

(a) Barry's senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

MR JOHN OLLE
CORONER
Date: 30 May 2017