IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 4972

**FINDING INTO DEATH WITHOUT INQUEST**

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

I, JACQUI HAWKINS, Coroner having investigated the death of Stanley Brian Taylor

without holding an inquest:
find that the identity of the deceased was Stanley Brian Taylor
born on 28 September 1937
and the death occurred on 19 October 2016
at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065
**from:**

1 (a) ACUTE BRONCHITIS ON A BACKGROUND OF CARDIOMEGALY WITH CORONARY ARTERY DISEASE

1. Stanley Taylor was 79 years old at the time of his death. Mr Taylor was serving life imprisonment for his involvement in the 1986 car bomb explosion that killed a police officer and injured over 20 others, commonly referred to as the 'Russell Street bombing.'

2. Mr Taylor had an extensive medical history including cardiac disease, previous coronary artery grafts and insertion of stents, atrial fibrillation, abdominal aortic aneurysm, type II diabetes mellitus, chronic obstructive pulmonary disease, diverticulitis, high blood pressure and high cholesterol. He was a smoker for 53 years of his life.

3. Mr Taylor's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

4. A coroner must hold an inquest if the deceased was, immediately before death, a person placed in custody, in accordance with section 52(2)(b) of the *Coroners Act 2008* (Vic). Pursuant to section 52(3A) of the Act, I am not required to hold an inquest in these circumstances, if I consider that the death was due to 'natural causes'. In accordance with section 52(3B) of the Act, a death may be considered to be due to 'natural causes' if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to 'natural causes'.

5. I have received a report in this case. I also note that no issues have been identified or concerns raised regarding Mr Taylor's health management. Therefore, I make my findings with respect to the circumstances and exercise my discretion not to hold a public hearing through an inquest.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability[1].

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Taylor's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

8. The Office of Correctional Services Review (OCSR) conducted a review into the death of Mr Taylor. The OCSR found that the correctional management of Mr Taylor during his final term of imprisonment was appropriate. Justice Health conducted a review into Mr Taylor's death. Their review found there was nothing to suggest that the healthcare provided was not in keeping with the Justice Health Quality Framework. There were no recommendations made as a result of the review of OCSR and Justice Health.

9. In writing this Finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

**Identity**

10. Stanley Taylor was visually identified by Corrections Officer, Bruce Cooper on 19 October 2016. Identity was not in issue and required no further investigation.

**Medical cause of death**

11. On 21 October 2016, Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Taylor and reviewed the post mortem computed tomography (CT) scan and the Form 83 Victoria Police Report of Death.

12. Dr Bedford reported that the post mortem examination confirmed the presence of severe heart and lung disease with a markedly enlarged heart with narrowing of coronary arteries and evidence of infection in the lungs and in particular the bronchi.

13. Toxicological analysis of blood collected ante mortem on 19 October 2016 and post mortem was non-contributory.

14. Dr Bedford provided an opinion that the medical cause of death was 1(a) ACUTE BRONCHITIS ON A BACKGROUND OF CARDIOMEGALY WITH CORONARY ARTERY DISEASE and that on the basis of the information available at the time of completing his report, he was of the opinion that the death was due to natural causes.

**Circumstances in which the death occurred**

15. On 19 October 2016 at approximately 6.16am, a fellow prisoner in the Alex North Protection Unit of Port Phillip Prison informed custodial staff that Mr Taylor was suffering chest pains and shortness of breath. A 'Code Black'[2] was called and medical staff attended. At approximately 7.30am, an ambulance transported Mr Taylor to St Vincent's Hospital. On arrival, Mr Taylor appeared unwell, was in respiratory distress and hypoxic. A number of investigations were conducted. The auscultation of the chest revealed deceased air entry in both lungs, with bilateral crackles at the bases. Examination of his cardiovascular system revealed a rapid, irregular weak pulse. His peripheries were cool due to atrial fibrillation. An electrocardiogram (ECG) revealed no signs of acute myocardial infarction and a chest x-ray identified an increased opacity of the right lung base of the lungs which was considered to be pneumonia.

16. At approximately 11.30am, Mr Taylor's condition suddenly deteriorated. He became unresponsive, sweaty and his heart rate dropped. An ECG identified a small ST elevation, which

[2] A Code Black signifies a serious medical event / death.

was new compared to the previous ECG. He received oxygen via a mask and was administered intravenous atropine. Despite this, his heart rate dropped further and he had no recordable blood pressure. Dr Claudiu Radeanu, Consultant Emergency Physician at St Vincent's Hospital reported that chest compressions were not commenced given the poor prognosis due to comorbidities. A 'not for resuscitation' order was on his medical file and he had expressed to the admitting medical registrar earlier that day that he wished to be kept comfortable if his condition deteriorated.

17. Mr Taylor was declared deceased at 11.46am.

**Findings**

18. Having considered the evidence I am satisfied that no further investigation is required.

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

20. I find that:

    a. the identity of the deceased was Stanley Brian Taylor born 28 September 1937; and

    b. Stanley Taylor died on 19 August 2016 from 1(a) *acute bronchitis on a background of cardiomegaly with coronary artery disease*;

    c. in the circumstances described above.

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

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

The family of Mr Taylor;
Information recipients; and
Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 24 May 2017

Coroners Court of Victoria