IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 6052

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Katherine Lorenz
Deceased:	Nalaka Mudiyanselage Wijeratne
Date of birth:	14 January 1975
Date of death:	6 November 2020
Cause of death:	1(a) Coronary artery atherosclerosis
Place of death:	Karreenga Annexe (Prison), 1200 Bacchus Marsh Road, Lara, Victoria, 3212

INTRODUCTION

1. On 6 November 2020, Nalaka Mudiyanselage Wijeratne was 45 years of age when he died at Karreenga Prison (**Karreenga**).

2. At the time of his death, Mr Wijeratne was serving a sentence of imprisonment at Karreenga where he had been accommodated since April 2019. He had a medical history of hyperlipidaemia and was a former smoker.

3. On the afternoon of his death, Mr Wijeratne participated in a fitness bootcamp, involving a combination of cardio and strength training. About 15 minutes into the session, the instructor observed that Mr Wijeratne was showing signs of fatigue and advised him not to push himself too hard and to try to lower his heart rate. Mr Wijeratne left the session and retuned to his cottage at about 3:35pm.

THE CORONIAL INVESTIGATION

4. Mr Wijeratne's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Following Mr Wijeratne 's death, the Justice Assurance and Review Office (**JARO**) of the Department of Justice and Community Safety conducted a review of the custodial management and healthcare provided to Mr Wijeratne. I have reviewed the information and material provided by JARO including a Death in Custody Report prepared by Justice Health,

a business unit within the DJCS responsible for delivering health services to Victorian prisoners.

8. This finding draws on the totality of the coronial investigation into the death of Mr Wijeratne. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

9. On 6 November 2020, at approximately 4:26pm, a duress alarm was activated in the Beacon B cottage of Karreenga by an inmate who found Mr Wijeratne behind a cell door unresponsive and not breathing.

10. At about 4:27pm, custodial staff called a Code Black, denoting a death or serious medical emergency, and commenced cardiopulmonary resuscitation (**CPR**).

11. Prison medical staff arrived at 4:28pm and assumed treatment. A defibrillator was applied but no pulse or heart rhythm could be detected. Emergency Services were called at 4:30pm.

12. Ambulance Victoria paramedics arrived at 4:45pm, taking over treatment. CPR was continued for several minutes but, despite efforts, Mr Wijeratne could not be revived and was confirmed deceased at 4:54pm.

13. Following Mr Wijeratne's death, JARO conducted a review and found that his management met the standards prescribed by Corrections Victoria. Justice Health reviewed Mr Wijeratne's health records and found nothing to suggest that the healthcare afforded to Mr Wijeratne was not in accordance with the *Justice Health Quality Framework 2014*. Justice Health made no recommendations for systemic improvements arising from Mr Wijeratne's death

[1] 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 of the deceased

14. On 6 November 2020, Nalaka Mudiyanselage Wijeratne, born 14 January 1975, was visually identified by a fellow prison inmate at Karreenga, who signed a statement of identification.

15. Identity was not in dispute and required no further investigation.

Medical cause of death

16. Forensic Pathologist Dr Chong Zhou, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 10 November 2020 and provided a written report of their findings dated 29 January 2021.

17. The post-mortem examination revealed severe atherosclerosis of the left anterior descending and left circumflex coronary arteries causing myocardial ischaemia.

18. Dr Zhou commented that ischaemic heart disease predisposes to the development of cardiac arrhythmias and sudden death. Risk factors for the development of coronary heart disease in the community can include smoking, hypertension, diabetes mellitus, hypercholesterolaemia, obesity, male gender and genetic factors.

19. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

20. Dr Zhou provided an opinion that death was due to natural causes that could be reasonably formulated as 1 (a) *coronary artery atherosclerosis*.

21. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

22. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Nalaka Mudiyanselage Wijeratne, born 14 January 1975;

    b) the death occurred on 6 November 2020 at Karreenga Annexe (Prison), 1200 Bacchus Marsh Road, Lara, Victoria, 3212, from *coronary artery atherosclerosis*; and

    c) the death occurred in the circumstances described above.

23. Having considered all the available evidence, I am satisfied that Mr Wijeratne's custodial and healthcare management was appropriate and met the required standards in accordance with the *Justice Health Quality Framework 2014*.

24. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Shanthi Fernando, Senior Next of Kin

Scott Swanwick, Justice Health

Correct Care Australasia, C/- Kelly Dell'Oro, Meridian Lawyers

Signature:

Coroner Katherine Lorenz

Date : 28 March 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.