IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002157

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Andrew William Staker
Date of birth:	25 January 1966
Date of death:	26 April 2021
Cause of death:	1(a) Pulmonary thromboembolism 1(b) Deep thrombosis 1(c) WHO Class 3 obesity
Place of death:	Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria, 3029

INTRODUCTION

1. On 26 April 2021, Andrew William Staker was 55 years old when he died while serving a sentence of imprisonment at Port Phillip Prison.

BACKGROUND

2. Mr Staker's medical history included alcohol abuse and polysubstance use, namely synthetic cannabis and cocaine, and he was previously prescribed methadone. He also reported history of self-harm and attempts to take his own life, including attempted overdoses and a self-harm incident involving a fire in his cell during an earlier prison term.

3. Mr Staker had an extensive criminal history spanning the 40 years prior to his death, including multiple charges for possessing, using and cultivating cannabis, and possessing amphetamine.

4. While in police custody in May 2014, Mr Staker reported that he identified as Aboriginal and this was recorded on multiple occasions throughout his corrections and health records. Further enquiries following Mr Staker's death revealed that he identified as a proud Barkindji man and was engaged with the Swan Hill Aboriginal community and The Torch, an indigenous cultural and arts program for indigenous offenders and ex-offenders. Throughout his most recent period of incarceration, Mr Staker was engaged with Aboriginal Program officers, the Aboriginal Cultural Support Worker and the Aboriginal Liaison Officer for culturally appropriate supports.

5. On 7 September 2020, Mr Staker was remanded into custody at the Metropolitan Remand Centre (**MRC**) and placed in protective quarantine in accordance with the facility's response to COVID-19. He was committed to stand trial in relation to multiple charges, including intentionally causing injury, threatening to kill and threatening serious injury, on 15 April 2021.

6. On 22 September 2020, Mr Staker was transferred to Port Phillip Prison. On 10 October 2020, several buprenorphine strips were seized from Mr Staker's cell. The following day, he was the victim in a stabbing incident, allegedly in relation to the seizure incident the previous day.

7. On 28 October 2020, Mr Staker was transferred to Ravenhall Prison due to his involvement in drug and assault-related incidents. On 31 December 2020, he was assigned an Identified Drug User (**IDU**) status and underwent three urinalysis tests, each of which were negative for illicit drugs.

8. On 12 January 2021, Mr Staker returned to Port Phillip Prison.

9. Throughout this period, Mr Staker was variously described by his case managers as abusive, volatile and manipulative, but at times patient, respectful and apologetic about his past behaviour. He is recorded as having made threats of self-harm and harm against others in order to obtain accommodation in a single cell. Mr Staker was often placed in protection or management units in response to incidents, his abusive behaviour, concerns of self-harm, or concerns for his safety. As a result, Mr Staker's ability to participate in education or employment programs during his incarceration was limited. He declined to engage with drug and alcohol programs.

10. According to Mr Staker's medical records from Justice Health, he regularly refused to attend various medical appointments, often without providing a reason. Throughout December 2020, he received several mental health assessments through the trap in his cell door. Mr Staker occasionally described his mood as low and his threats of self-harm as "*attention seeking*".

11. On 30 January 2021, Mr Staker was assessed as medically unfit for employment and was issued a medical certificate which excused him from work until 30 July 2021.

THE CORONIAL INVESTIGATION

12. Mr Staker's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Mr Staker's death was reportable as he was in the legal custody of the Secretary to the Department of Justice immediately before the time of his death.[1] Deaths of persons in custody, such as when serving a custodial sentence, are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

13. 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.

[1] Section 4(2)(c).

14. 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.

15. This finding draws on the totality of the coronial investigation into the death of Mr Staker, including evidence contained in his medical records and a coronial brief prepared by the Coroner's Investigator. While 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.[2]

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

Circumstances in which the death occurred

16. At approximately 5.35pm on 26 April 2021, Mr Staker was in the laundry room when he began experiencing breathing difficulties. Correctional Officers arrived immediately and initiated a Code Black to alert medical personnel. At approximately 5.39pm, medical personnel arrived and Mr Staker was fitted with an oxygen mask at approximately 5.44pm. At approximately 5.54pm, he transported by stretcher to the St Thomas medical centre, where he removed himself from the stretcher and sat in a nearby chair with his oxygen mask in place.[3]

17. A short time later, Mr Staker became pale and lost consciousness. A second Code Black was activated at approximately 6.01pm and Mr Staker was moved to the ground for cardiopulmonary resuscitation (**CPR**). Ambulance Victoria paramedics arrived at the medical centre at approximately 6.18pm and continued CPR, but were unable to revive Mr Staker and pronounced him deceased at 7.10pm.[4]

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[2] 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.

[3] Coronial brief, G4S Officers Report Forms; Coronial brief, Notification of incident referred to police dated 28 April 2021.

[4] Coronial brief, G4S Officers Report Forms; Coronial brief, Notification of incident referred to police dated 28 April 2021.

Identity of the deceased

18. On 26 April 2021, Grant Hossack visually identified the deceased as Andrew William Staker, born 25 January 1966.

19. Identity is not in dispute and requires no further investigation.

Medical cause of death

20. Forensic Pathologist Dr Judith Fronczek, supervised by Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 29 April 2021 and provided a written report of her findings dated 24 June 2021.

21. At autopsy, Dr Fronczek identified natural disease in the form of cardiomegaly (enlarged heart), and commented that the most common cause of cardiomegaly is hypertension, which can cause increased myocardial oxygen demand and fatal arrhythmias.

22. Dr Fronczek also identified pulmonary thromboembolism, which is caused when a thrombi is dislodged, usually from the deep veins of the calves (as was identified in Mr Staker's lower left leg) and travels to the lungs. This in turn causes chest pain, shortness of breath, and death due to cardiac and respiratory compromise. Dr Fronczek identified that Mr Staker was at an increased risk of pulmonary thromboembolism due to his weight. She noted that other risk factors include immobility, infection, trauma, malignancy, or a genetic predisposition to thrombosis.

23. Dr Fronczek did not identify any evidence of injury that would have caused or contributed to death.

24. Toxicological analysis of post-mortem samples identified the presence of fluoxetine[5] and olanzapine,[6] at levels consistent with therapeutic use.

25. Dr Fronczek provided an opinion that the medical cause of death was 1(a) Pulmonary thromboembolism, 1(b) Deep thrombosis, and 1(c) WHO Class 3 obesity. She considered that Mr Staker's death was due to natural causes.

26. I accept Dr Fronczek's opinion.

[5] Fluoxetine is a selective-serotonin reuptake inhibitor indicated for major depression and obsessive compulsive disorder.
[6] Olanzapine is an atypical antipsychotic drug with a similar structure to clozapine.

REVIEW OF CARE AND CUSTODIAL MANAGEMENT

27. Following Mr Staker's death, independent reviews were conducted in relation to his medical management by Justice Health and custodial management by the Justice Assurance and Review Office (**JARO**). Justice Health did not identify any issues arising from Mr Staker's emergency management at the time of the incident. Several opportunities for improvement were identified in respect of Mr Staker's failure to attend his health appointments and management of his cardiovascular and diabetes; however, no improvement opportunities were identified in relation to the circumstances of his death. JARO similarly did not identify any issues with Mr Staker's custodial management and advised that his management met the standards prescribed by Corrections Victoria.

28. Having reviewed the available evidence, I am satisfied that the emergency response by custodial staff was appropriate, as was Mr Staker's custodial management by Corrections Victoria. I am therefore satisfied that no further investigation is required.

29. As noted above, Mr Staker's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was serving a custodial sentence and therefore in the legal custody of the Secretary to the Department of Justice. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr Staker died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

FINDINGS AND CONCLUSION

30. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Andrew William Staker, born 25 January 1966;

    b) the death occurred on 26 April 2021 at Port Phillip Prison, 451 Dohertys Road, Truganina, Victoria, 3029, from 1(a) Pulmonary thromboembolism, 1(b) Deep thrombosis, and 1(c) WHO Class 3 obesity; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Staker's family for their loss.

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.

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

Maureen Bryant, Senior Next of Kin

Allison Will, Justice Assurance and Review Office

Debra Coombs, Victorian Government Solicitor's Office

Sergeant Ryan Balzer, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 03 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.