IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 003499

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**LEISTER JOHN ROSS**
Delivered on:	**13 SEPTEMBER 2016**
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	**13 SEPTEMBER 2016**
Counsel assisting the Coroner:	**Ms Rebecca Johnston-Ryan**

HIS HONOUR:

BACKGROUND

1 Leister John Ross was 45 years old at the time of his death. He is survived by his parents John and Marjorie Ross, his son Kullum and his extended family, with whom he shared close and loving relationships.

2 Leister was, immediately before his death, a person placed in the legal custody of the Secretary to the Department of Justice. Although I am satisfied there is no evidence to suggest the involvement of any other person in this death, I could not determine that Leister's death was due to natural causes.

3 A coronial brief of evidence, a report from the Department of Justice & Regulation Office of Correctional Services Review ('OCSR Report'), a statement from the Operations Manager of Port Phillip Prison and submissions from the Ross Family were provided to this Court. Following a mention hearing on 19 August 2015, further statements have been provided to the Court by St Vincent's Hospital, G4S Custodial Services Pty Ltd (G4S), and the Ross Family. I have used this information to assist my finding.

4 Leister was an Aboriginal prisoner who was received into custody on 11 July 2013 with his earliest eligibility date for parole on 5 September 2014.[1]

5 Leister had a past medical history of depression, Post-Traumatic Stress Disorder, self-harm, hepatitis C, chronic back pain, left shoulder injury, tendon repair to his left hand, arthroscopy and right knee reconstruction, poly-substance abuse and smoking. Leister was transferred to Port Phillip Prison on 24 June 2014 in preparation for an orthopaedic outpatient appointment at St Vincent's Hospital. He was on the waiting list for an arthroscopy to remove a foreign body from his right knee. Leister received regular and sustained support from health staff, and a care plan was in place to manage his mental health through regular contact with the mental health team. Leister was prescribed Seroquel 25mg nightly, Effexor 75mg daily, 2 tablets of paracetamol twice daily as required, and Suboxone 20mg daily.[2]

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[1] Office of Correctional Services Review: Review into the death of Leister Ross at Port Phillip Prison on 10 July 2014.

[2] Above n 1, Appendix 1; Justice Health medical records of Leister Ross.

6 At inquest, a summary was read into evidence by Coroner's Legal Officer, Rebecca Johnston-Ryan. I am satisfied that the summary accurately reflects the evidence.

THE PURPOSE OF A CORONIAL INVESTIGATION

7 Leister's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and immediately before death he was a person placed in custody or care.[3] Consequently, this matter is a mandatory inquest.[4]

8 The jurisdiction of the Coroners Court of Victoria is inquisitorial[5]. 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.

9 It is not the role of the coroner to lay or apportion blame, but to establish the facts.[6] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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

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

12 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.

13 Coroners are also empowered:

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

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[3] *Coroners Act 2008* (Vic) s 4.

[4] See *Coroners Act 2008* (Vic) s 52(2)(b); *Coroners Act 2008* (Vic) s 3(i), definition of 'person placed in custody or care'.

[5] *Coroners Act* 2008 (Vic) s 89(4).

[6] *Keown v Kahn* (1999) 1 VR 69.

(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.

14 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*.[7] 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*

15 Leister was visually identified by Correctional Officer A on 10 July 2014. Identity is not disputed and requires no further investigation.

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

16 On 27 August 2015, Dr Rufaro Diana Jaravaza, Forensic Medicine and Pathology trainee, Victorian Institute of Forensic Medicine (VIFM), conducted an examination of Leister's body which was overseen by Professor Stephen Cordner, Professor of Forensic Medicine at the VIFM. Dr Jaravaza provided a written report, dated 24 November 2014, concluding a reasonable cause of death to be 'I(a) undetermined in a man in correctional services custody with a chronic history of illicit drug use'. I accept her opinion in relation to the cause of death.

17 Dr Jaravaza reported a palpable red bruise in the right cubital fossa, with subcutaneous haemorrhage consistent with recent venepuncture, highly suggestive of recent illicit drug administration, given there was no history of therapeutic venepuncture.

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[7] (1938) 60 CLR 336.

18 Pulmonary oedema and congestion was reported which, whilst non-specific, may occur in cases of respiratory or cardiac failure, which may be due to drug intoxication or natural diseases including seizure-related deaths.

19 Dr Jaravaza noted hepatic cirrhosis and a large spleen indicating portal hypertension, but no other signs of liver failure were noted.

20 Dr Jaravaza reported previous brain damage, which is associated with an increased risk of epilepsy. Leister had no history of seizures, however Dr Jaravaza reported that it is possible Leister had a first seizure and death associated with this. There were no findings to suggest that Leister's death was due to trauma.

21 Toxicological analysis of blood, urine and hair detected methylamphetamine in blood (~0.1mg/L), urine (detected >2.5mg/L) and hair (~2.6ng/mg), amphetamine[8] in urine (~0.5mg/L) and in hair (~0.3ng/mg), buprenorphine[9] in blood (~1ng/mL) and in urine, buprenorphine metabolite norbuprenorphine in blood (~2ng/mL) and in urine, diazepam[10] in blood (~0.1mg/L), urine (~0.02mg/L) and hair (~0.06ng/mg), diazepam metabolite nordiazepam in blood (~0.1mg/L), urine (0.06mg/L) and hair (~0.08ng/mg), temazepam in urine (~0.1mg/L), oxazepam in urine (~0.1mg/L), venlafaxine[11] in blood (~0.2mg/L) and in urine, venlafaxine metabolite desmethylvenlafaxine in blood (~0.3mg/L) and in urine, amitriptyline[12] in urine, amitriptyline metabolite nortriptyline in blood (~0.01mg/L) and in urine, zopiclone[13] in blood (~0.01mg/L) and in urine, pregabalin[14] in blood (~1mg/L), paracetamol[15] in blood (trace detected <5mg/L) and in urine, alprazolam[16] in urine, codeine[17] in urine (~0.01mg/L), naloxone[18] in urine, quetiapine[19] in urine, and tramadol[20] in hair (~0.1ng/mg).

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[8] Amphetamines is a collective word to describe Central Nervous System stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as "speed" or "ice".

[9] Buprenorphine is used to treat pain and opioid dependency. It is an opioid with partial agonist activity. The drug has morphine-like effects, although they tend to be self-limiting at higher concentrations due to its partial antagonist activities.

[10] Diazepam is a sedative/hypnotic drug of the benzodiazepines class.

[11] Venlafaxine is indicated for the treatment of depression.

[12] Drugs such as amitriptyline are used to treat depression.

[13] Zopiclone is a cyclopyrrolone derivative used in the short-term treatment of insomnia.

[14] Pregabalin, an analog of the inhibitory neurotransmitter gamma-aminobutyric acid, is used clinically as an analgesic, anticonvulsant, and anxiolytic agent.

[15] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.

[16] Alprazolam is a triazolobenzodiazepine derivative used as a short acting antidepressant and anxiolytic agent. It is also used to treat generalised anxiety, phobic and panic disorders.

[17] Codeine is a narcotic analgesic related closely to morphine but having approximately one-tenth the activity of morphine as an analgesic and possessing antitussive activity.

[18] Naloxone is a synthetic opioid antagonist that is used for the treatment of opioid dependency by preventing or reversing the adverse side effects including respiratory depression, sedation and hypotension.

[19] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.

[20] Tramadol is a narcotic analgesic used for the treatment of moderate to severe pain.

22 Dr Dimitri Gerostamoulos, Manager of Forensic Toxicology at the VIFM, reported that the results were consistent with the use of methylamphetamine, buprenorphine, diazepam, venlafaxine, amitriptyline, zopiclone, pregabalin, alprazolam, naloxone, quetiapine, codeine and paracetamol. Information from the Department of Health indicated that at the time of death there was no valid treatment permit for buprenorphine in relation to Leister. Dr Gerostamoulos further reported that the results of hair testing indicated previous exposure to a number of drugs including methylamphetamine, diazepam, and tramadol.

23 Dr Jaravaza reported that the drugs detected in blood in combination may prove lethal, even when individually no one drug was at a toxic level. Amitriptyline, diazepam, and zopiclone are Central Nervous System depressants, and each at high levels can result in respiratory depression. Venlafaxine and quetiapine can increase the QT interval, which can lead to fatal abnormal heart rhythms and cause death. Quetiapine, venlafaxine and amitriptyline may cause this adverse effect, especially in persons who have congenital long QT syndrome. It is unknown whether Leister had this congenital condition. Venlafaxine in combination with methylamphetamine may result in a fatal serotonin syndrome.

Supplementary report of Professor Stephen Cordner

24 At my request, a supplementary report was provided by Professor Cordner to provide information where possible regarding the time of death of Leister.

25 Professor Cordner noted that while it is often thought that time of death can be established with precision, in his opinion there was an inadequate evidence base from which he was able to provide an expert opinion on the matter. Historically, attempts to establish time of death have been via the temperature of the deceased together with assessment of lividity and rigor mortis. Professor Cordner noted that after death, the temperature of a body will begin to approach that of the surrounding medium over time. The rate of heat loss varies according to numerous factors such as the actual body temperature at the time of death, the difference in temperature between the body and the surrounding medium and variations in this after death, the size and weight of the person, the amount of clothing and/or bedding and whether it is wet or dry, the extent of body surface exposed to the surrounding medium, the surface upon which the body is resting, and whether the surrounding air is moving or still.

26 Professor Cordner noted that despite the difficulty in estimating time since death from temperature, one of the most useful practical guides is the nomogram published by Henssge. Professor Cordner stated that in using the Henssge nomogram the tabulated results would tend

to conclude that Leister's death would have occurred, with a high level of likelihood, before 3:45a.m. on 10 July 2014. Professor Cordner provided that on the basis of the information available he could not conclude the specific time of death as being that suggested by the application of the Henssge nomogram. Professor Cordner stated that *"Henssge's nomogram, in my view at least, runs the risk of providing a cloak of scientific respectability to the assessment of a phenomenon governed by many variables which are difficult to quantify in particular cases."*[21]

27 The observations of lividity and rigidity were made at approximately 2:00p.m. on the day of death, some hours after Leister's body was discovered. Initial observations of rigidity by the medical officer were made to simply confirm in the medical officer's mind that a death had occurred. Professor Cordner reported that rigidity of some degree can develop within half an hour of death, or be postponed for many hours or days in some situations. Professor Cordner noted that the forensic pathologists' observations of lividity and rigidity add very little if anything to conclusions about Leister's time of death.

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

28 On 24 June 2014, Leister was medically assessed as fit for transfer to Port Phillip Prison, in preparation for an orthopaedic appointment at St Vincent's Hospital. A comprehensive health assessment was conducted on transfer. No recent illnesses were reported, and Leister was physically well but troubled by back pain. Leister's past poly-substance abuse was noted.

29 On 8 July 2014, Leister commenced sharing a cell with inmate SR[22]. SR stated that on the evening of 9 July 2014, he and Leister watched the State of Origin match from approximately 9:00p.m., and when the match concluded Leister put on a foreign film. At this time, SR fell asleep. The prisoners had been informed that due to industrial action, the cells would remain locked until 10:00a.m. the following morning.

30 On 10 July 2014 at approximately 7:45a.m., Correctional Officer A conducted a Hands On Trap muster on the prisoner cells, which involves opening the hatch of cell doors and making sure that the Correctional Officer receives a response from each prisoner inside the cell. After opening SR and Leister's hatch, SR raised his hand to indicate he was okay. Correctional

[21] Supplementary report of Professor Stephen Cordner, 7.

[22] It is unnecessary to disclose the identity of the cell mate for the purposes of this finding.

Officer A called out to Leister twice and observed him lying on his back. Correctional Officer A observed Leister's leg move, which he stated is common for prisoners to do instead of making or giving a verbal response.[23]

31 At approximately 10:00a.m., SR awoke and dressed. He attempted to rouse Leister by putting his hand on Leister's leg and shaking him, but Leister did not appear to respond. SR assumed he was sleeping, and went for breakfast. Shortly after, SR was alerted by inmates to go upstairs who were concerned that Leister did not look right. SR went upstairs and once again attempted to wake Leister to no avail. Inmates raised their concerns with Correctional Officers at 10:45a.m.[24]

32 Correctional Officer A attended to Leister, and formed the opinion that it appeared he had passed away. Correctional Officer A administered cardiopulmonary resuscitation and called a 'code black' requesting medical assistance. Health staff from St Vincent's Correctional Health Services attended immediately, and Dr Stephen Nutter confirmed that Leister was deceased.[25]

FURTHER INVESTIGATION

Hands on Trap (HOT) Muster

33 The HOT muster is performed daily at Port Phillip Prison prior to the unlocking of prisoners in the morning, and its purpose is to ensure no breaches of security of escapes overnight and to ensure the welfare of prisoners.

34 G4S acknowledged that the HOT muster that took place on the morning of 10 July 2014 was not carried out in accordance with the relevant operational instruction Number 13 – *Prisoner Counts*. The operational instruction required the performing officer to sight each prisoner as they place their hand on the trap. G4S advised that training provided to staff was in accordance with this operational instruction. Correctional Officer A's statement indicates that he observed a movement of Leister's leg, but G4S submit that it is highly probable that this movement may have been caused by his cell mate waking and jumping off the top bunk bed in the shared cell.[26]

[23] Coronial brief of evidence, statement of SR, dated 10 July 2014, 15.
[24] Above n 9, 16-17.
[25] Above n 1, Appendix 1.
[26] Submissions of G4S Custodial Services Pty Ltd, dated 18 April 2016, 13-15.

35 The Ross Family were critical of the failure to correctly perform the HOT muster by G4S Correctional staff, and suggested that uncertainties regarding the time and cause of death may have been ascertained were the HOT muster performed correctly.

36 G4S suggested that the non-compliance with the HOT muster operational instruction did not contribute to Leister's death. Firstly, the time of death evidence is suggestive of death after lockdown at 7:30p.m. on 9 July 2014 and prior to 7:45a.m. to 8:00a.m. on 10 July 2014, at which time the HOT muster was performed. Secondly, the possible spontaneity of Leister's death may indicate that there was no intervention which could have avoided it. Thirdly, there is no evidence to suggest that had emergency first aid been performed at or around the time of the HOT muster that Leister's death could have been avoided.

37 Correctional Officer A was issued with a correctional file note on 10 July 2014 for failing to correctly perform the HOT muster. A subsequent process review of the HOT muster after Leister's death has resulted in amendment to the relevant operational instruction, and now requires prisoners to provide a verbal response to staff performing the HOT muster and be observed to move. This amendment in process was provided to operational staff of the prison, and staff training materials have been updated and implemented accordingly.

Industrial Action at Port Phillip Prison

38 The industrial action that took place on 10 July 2014 was not contributory to Leister's death, given the strong likelihood that Leister was deceased prior to the HOT muster. Despite suggestions that concerns regarding Leister's welfare may have been realised earlier in the morning if industrial action had not taken place, his cell mate genuinely believed he was asleep and was aware that he was ordinarily a heavy sleeper. As Leister was not required to attend work, his "sleeping in" would not necessarily have raised welfare concerns any sooner in the event that industrial action had not taken place.

Response to Code Black by Port Phillip Prison and St Vincent's Hospital Staff

39 The OCSR report raised concerns about potential delay in staff response to the Code Black emergency. The statement of Mr Ian Pugh Thomas, General Manager of Port Phillip Prison, indicates there is no evidence to suggest that any staff involved reported any delay in attendance. All staff reported that they treat all Code Black calls as nothing but urgent and they respond immediately. On this occasion, staff treated the Code black as serious and urgent and immediately attended. They were not unduly delayed in attending the Unit.

40 St Vincent's Hospital Registered Nurse Dale Bence indicated that at approximately 10:45a.m. on 10 July 2014 upon the call of a Code Black over the handheld portable radio he immediately called out for assistance and responded together with two other St Vincent's Hospital staff members. Mr Bence's statement highlights the distance between his usual place of work and the Fishburn West Unit where Leister resided, taking approximately three to four minutes to travel there given the distance and the security checkpoints. When an update was received stating that Leister was not breathing and that CPR was in progress, he picked up his speed to ensure the response trolley and necessary resuscitation equipment were available as soon as possible.[27]

Drug Use and Testing

41 Leister had a long history of substance abuse, and was classified as an Identified Drug User (IDU) Level 3 prisoner, the highest IDU status possible at the prison. From incarceration in July 2013, Leister returned six positive urine test results. The OCSR report stated that prison staff were aware that Leister used drugs. Leister was not screened on arrival at the prison, nor at any time in the 16 days he resided in Port Phillip Prison. His cell was not searched during this time.[28]

42 The Ross Family suggested that in Mr Thomas's discussions with the OCSR he stated it was his expectation that prisoners with significant drug history would receive drug screening on admission to Port Phillip Prison. Mr Thomas's statement of 23 December 2015 clarified that his comments were made without specific reference to drug testing performed at Barwon Prison prior to Leister's transfer to Port Phillip Prison, and were made in response to a suggestion that the prison might implement reception screening.

[27] Statement of Dale Bence, dated 9 September 2015, 1-2.
[28] Statement of Colin Angus, dated 29 May 2015, 10.

43 It was the position of the Ross Family that while a procedure was implemented to ensure all prisoners with an IDU 3 status be drug screened within 5 days of arrival, it should have been in place at the time of Leister's death. Given such a small percentage of the prison population hold IDU 3 status, the Ross Family suggested that the task to ensure screening on arrival and at regular intervals during incarceration could not be overly onerous. G4S noted its current testing regime within 5 days of arrival, and indicated this provides reasonable screening for higher risk prisoners. G4S expressed the view that a requirement to drug screen prisoners upon admission would be operationally impractical and of limited value for detecting or deterring drug use at the prison.

44 G4S suggest that drug testing of Leister already available to G4S upon his arrival or within the 5 day window would not have improved the available information or detected drug use at Port Phillip Prison. G4S submitted that testing of Leister in the 16 days prior to his death would not have avoided death, because drug testing at prison locations did not appear to prevent his continued drug use and the pathological findings do not clearly indicate evidence linking Leister's drug use and his death.

45 G4S have active drug detection strategies in place to try and reduce introduction of drugs into the prison from external sources. Despite efforts to detect introduction of contraband, it is difficult for any prison to ever be entirely free of illicit drugs or to prevent prisoners from consuming prescription drugs not belonging to them.

Notification to Next of Kin

46 The distress of the Ross Family regarding the delay in formal notification of Leister's death is apparent from their submissions and the correspondence and statements of Leister's cousin Karyn Ross. The notification was organised some four and a half hours after Leister's death, and by the time Victoria Police contacted Leister's father John Ross, he had already heard of Leister's death from a relative who was also an inmate at Port Phillip Prison at the time. Karyn has highlighted the importance of swift notification of death, stating that from a cultural perspective it is vital to ensure that the news of a death of a family member of the Aboriginal community is conveyed quickly, directly, and respectfully to close family members of the deceased person.[29]

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[29] Correspondence of Karyn Ross dated 23 July 2015, 3-4.

47 The protocol in place for death notification following a death in custody is for police to notify the next of kin. G4S policy requires staff to provide next of kin details to police and any additional information where required. Mr Thomas's statement indicates that staff acted according to this policy following Leister's death.

48 Enquiries by Mr Thomas revealed that police were notified of the death within 2 minutes of confirmation by medical staff. It is not known when staff provided next of kin details to police, but Victoria Police officer Detective Senior Constable Karina Prodan confirmed that notification was actioned following my attendance at the Unit and after officers had spoken with other prisoners. DSC Prodan confirmed that police protocol is to ensure a crime has not been committed before notifying the family of the death.

49 G4S protocol requires the Aboriginal Legal Service to be informed of the death of an Aboriginal and/or Torres Strait Islander, and at the time of Leister's death this protocol was followed.

50 G4S indicated that while it was unfortunate that John Ross was notified by another family member before police could make contact with him, the formal notification of the death was made without undue delay.

Recording of Next of Kin Details at Port Phillip Prison

51 Mr Thomas's statement indicates that since 2013, on admission to Port Phillip Prison prisoners would be given the opportunity to nominate and update the details of their emergency contact and next of kin. It is unclear from the evidence available whether Leister was given the opportunity to nominate and update these details upon admission to Port Phillip Prison. It is important that next of kin and emergency contact details are recorded and updated regularly, to ensure that notification can be made promptly in the event of a prisoner death.

52 G4S have identified and implemented improved practices regarding the recording of next of kin details. The admissions and orientation processes at the Prison clearly set out the expectations of admissions and Unit staff in checking and updating next of kin information in electronic databases. The admission process protocol (Admission of Prisoners – *Operational Instruction No 34*) has been amended to improve the quality of next of kin details collected from prisoners and updated by staff.

Preservation of the scene

53 While there is no demonstrable link between the preservation of the death scene and Leister's cause of death, the Ross Family submit that a failure to adequately preserve the scene has led to an inability to properly investigate the circumstances of Leister's death and an inability to reach the mandatory findings pursuant to section 67 of the *Coroners Act* 2008. While the Ross Family do not suggest that Leister's death was the result of a homicide, the family have asserted that on the basis of the RCIADIC recommendations, deaths in custody should be conducted on the basis that the death may be a homicide.

54 The Ross Family submitted that the potential for other prisoners to enter and exit Leister's cell after unlocking at 10:30a.m., and the failure to separate Leister's cell mate SR from other inmates following Leister's death compromised the prison's ability to preserve evidence from the scene. The Ross Family queried the adequacy of the scene preservation in the context of the possibility that drug use may have contributed to Leister's death. Despite a palpable red bruise on his right cubital fossa highly suggestive of recent illicit drug use, there was no drug paraphernalia found in Leister's room.

55 G4S confirmed with DSC Prodan that police protocol regarding actioning a death notification is to ensure that a crime has not been committed before notifying the family of the death.[30] The statement of DSC Prodan states that there were no signs of a struggle or anything out of place in the cell, and that Leister had been moved to the floor in order to better facilitate resuscitation attempts. It is evident that DSC Prodan turned her mind to the possibility of suspicious circumstances before concluding that there was no supporting evidence for this possibility.

56 While I note the Ross Family's belief that the death scene was inadequately secured and may lead to an inability to make findings regarding the cause and circumstances of Leister's death, this matter is not sufficiently proximate to Leister's death. I am satisfied that sufficient information is available to assist me with discharging my statutory obligations to make findings regarding the identity, cause of death, and circumstances of death in relation to Leister.

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[30] Above n 12, 21.

FINDINGS

57 Having investigated the death of Leister, and having held an Inquest in relation to his death on 13 September 2016 at the Coroners Court of Victoria, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Leister John Ross, born 9 March 1969; and

(b) that Leister John Ross died on 10 July 2014, at Port Phillip Prison at the corner of Dohertys Road & Palmers Road, Truganina from an undetermined cause in a man in correctional services custody with a chronic history of illicit drug use; and

(c) that the death occurred in the circumstances described in paragraphs 28 to 32 above.

58 Upon consideration of all available evidence, I find that Leister was most likely deceased prior to the HOT muster taking place on 10 July 2014. Regardless of the appropriateness of the HOT muster completion, I am unable to conclusively find that uncertainties regarding Leister's specific time and cause of death would have been further clarified if his unresponsive state was identified during the HOT muster.

59 I find that there were shortcomings in relation to conducting the HOT muster on 10 July 2014. However, I acknowledge the improvements made by Port Phillip Prison in response to such shortcomings. I am satisfied that Correctional Officer A did view Mr Ross move his leg in response to his name being called. I note the subsequent concession of Correctional Officer A that, in hindsight, the leg movement may have been the involuntary result of SR alighting from the top bunk. I accept that although the muster was sub-optimal and not in accordance with policy in place at the time, the action of Leister in moving his leg in response would have been considered common for a prisoner to do instead of making or giving a verbal response.

60 I acknowledge the improvements implemented by G4S at Port Phillip Prison regarding the recording of next of kin and emergency contact details for prisoners.

61 I find that the care provided to Leister by St Vincent's Correctional Health Service was reasonable and appropriate in the circumstances.

62 I find that the response to the Code Black call by Port Phillip Prison staff and St Vincent's Correctional Health Service staff was reasonable and appropriate in the circumstances.

63 I convey my sincerest sympathy to Leister's family and friends.

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

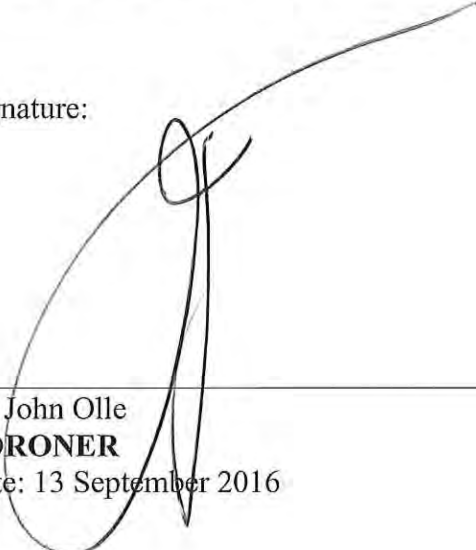
65 I direct that a copy of this finding be provided to the following:

(a) Leister's family, senior next of kin.

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:



Mr John Olle
CORONER
Date: 13 September 2016