IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003588

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	David Sean Takwalai
Date of birth:	29 February 1976
Date of death:	1 July 2022
Cause of death:	1(a) Coronary artery atherosclerosis
Place of death:	Metropolitan Remand Centre, Middle Road, Ravenhall, Victoria, 3023
Keywords:	Death in custody, Natural causes

INTRODUCTION

1. On 1 July 2022, David Sean Takwalai (Mr Takwalai) was 46 years old when he passed away while in custody at the Metropolitan Remand Centre (MRC) in Ravenhall. Prior to his incarceration, Mr Takwalai resided in Melbourne with his partner.

2. According to Mr Takwalai's sister, Ms Rachel Sabih, there is a history of "heart issues" in their family, with both parents and grandparents suffering with cardiac related conditions. He did not have a formal diagnosis of any cardiac related diseases.

THE CORONIAL INVESTIGATION

3. Mr Takwalai'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.[1]

4. Mr Takwalai was a person in care or custody pursuant to section 3 of the Act. 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. An inquest is not mandated in Mr Takwalai's circumstances, as he passed away as a result of natural causes.[2]

6. 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.

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

8. This finding draws on the totality of the coronial investigation into the death of David Sean Takwalai including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

[1] Section 4 of the *Coroners Act 2008* (the Act).
[2] Section 52(3A) of the Act.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred

9. Prior to being transferred to the MRC, Mr Takwalai was seen by a Registered Nurse at the Melbourne Custody Centre on 23 June 2022. During this consultation, Mr Takwalai disclosed recent memory loss following an assault and head injury some six weeks prior. Mr Takwalai declined further examination of his head, and the consultation was otherwise unremarkable.

10. At about 4.50pm on 30 June 2022, Prison Officer Salera and Prison Officer Hawker undertook the lock up count. They attended at Mr Takwalai's cell where they observed Mr Takwalai, and he acknowledged them with a wave.

11. The following morning at about 8.05am, Prisoner Officer Cook and Prisoner Officer Capasso were conducting a prisoner count. They arrived at Mr Takwalai's cell where they observed him through the window lying on his side, he did not appear to be moving. A Code Black was called, and Prison Officers performed cardiopulmonary resuscitation and defibrillation.

12. Despite the efforts of the Prisoner Officers, Mr Takwalai could not be revived, and he was declared deceased at the scene.

Identity of the deceased

13. On 7 July 2022, David Sean Takwalai, born 29 February 1976, was identified via fingerprint identification.

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

Medical cause of death

15. Forensic Pathologist Dr Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 5 July 2022 and provided a written report of her findings dated 7 September 2022.

[3] 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.

16. In her report, Dr Parsons commented:

The cause of death in this 46 year old man is coronary artery atherosclerosis.

At autopsy, the deceased had plaque rupture with an early thrombus. This would lead to an acute myocardial infarction and sudden death, the mechanism of which would be a cardiac arrhythmia due to myocardial ischaemia.

Myocardial ischaemia is the imbalance between supply (perfusion) and demand of the heart for oxygenated blood. In the vast majority of cases this is due to coronary artery disease as we see here. People with coronary artery disease are at an increased risk of sudden death usually due to a cardiac arrhythmia. Risk factors for the development of coronary artery disease include hypertension, hypercholesterolaemia, smoking, being a male and a family history….

There was no evidence of trauma or drugs in the deceased system that would have caused or contributed to death.

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

18. Dr Parsons provided the opinion that the medical cause of death was 1 (a) coronary artery atherosclerosis. Dr Parsons determined the death was due to natural causes.

19. I accept Dr Parson's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was David Sean Takwalai, born 29 February 1976;

    b) the death occurred on 1 July 2022 at Metropolitan Remand Centre, Middle Road, Ravenhall, Victoria, 3023, from coronary artery atherosclerosis; and

    c) the death occurred in the circumstances described above.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the court's website.

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

Ashley Takwalai & Susan Younger, Senior Next of Kin

Ms Monika Zvara

Mr Joshua Teng, Department of Justice and Community Safety

Ms Kellie Dell'Oro, Meridian Lawyers on behalf of Correct Care Australia

Ms Lisa Altit, Justice Assurance and Review Office

Ms Scott Swanwick, Justice Health

Detective Senior Constable Shannon Symons, Coroner's Investigator

Coroner Kate Despot

Date: 26 January 2024

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.