IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004826

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Robert Walter Burnett
Date of birth:	26 May 1939
Date of death:	17 August 2024
Cause of death:	1a: ASPIRATION PNEUMONIA IN THE SETTING OF ISCHAEMIC HEART DISEASE, TYPE 2 DIABETES MELLITUS AND DEMENTIA
Place of death:	Port Phillip Prison 451 Dohertys Road Truganina Victoria 3029
Keywords:	In custody, natural causes

INTRODUCTION

1. On 17 August 2024, Robert Walter Burnett[1] was 85 years old when he died following a period of palliative care at Port Phillip Prison.

2. Robert was born in Tremont, before moving with his family to Thorpdale. He eventually commenced working at Bayswater Boys Home, which was run by the Salvation Army, where he worked for approximately 10 years.

3. On 19 February 2016, Robert was remanded in custody and subsequently convicted of multiple sexual offences. On 29 October 2016, he received a custodial sentence of 18 years and 6 months. A number of these offences related to Robert exploiting his position as an employee of Bayswater Boys Home to sexually abuse the young boys in his care.

4. On 5 May 2022, Robert was admitted to St John's inpatient unit at Port Phillip Prison (**St John's**), after he experienced a stroke which resulted in residual cognitive impairment. Robert's ensuing cognitive and general health decline meant that he required assistance with all daily tasks. He remained at St John's until his death.

THE CORONIAL INVESTIGATION

5. Robert's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a *'person placed in custody or care'* within the meaning 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.

6. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. Moreover, the coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

7. 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] Referred to as 'Robert' throughout this finding unless more formality is required.

8. 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.

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

10. This finding draws on the totality of the coronial investigation into the death of Robert Walter Burnett, 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 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

11. At 6:00pm on 16 August 2024, Robert began vomiting 'coffee-ground' liquid. After advising that he felt better, Robert was assisted by staff to clean up, and his usual prescribed medication was administered.

12. Robert continued to vomit several more times during the night and at approximately 9:10pm, when staff entered Robert's cell, he again vomited dark brown liquid from his nose and mouth. The on-call Medical Officer was contacted, who provided a telephone order for an antinausea injection (metoclopramide). This was administered to Robert at 10:30pm.

13. In accordance with Robert's Advanced Care Directive (**ACD**), Robert was not transferred to hospital and comfort care was provided. Robert vomited again overnight and staff attended to monitor him and assist with clean up.

14. At around 4:00am on 17 August 2024, Robert again vomited coffee-ground liquid from his nose and mouth. Staff attended his cell and identified that his breathing had become laboured,

[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.

before suddenly ceasing at 4:08am. Robert's ACD provided that he was not to be resuscitated. At 7:10am, the on-call Medical Officer attended and declared Robert deceased.

Identity of the deceased

15. On 17 August 2024, Robert Walter Burnett, born 26 May 1939, was visually identified by a staff member.

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

Medical cause of death

17. On 19 August 2024, Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed a post-mortem computed tomography (**CT**) scan. Dr Lynch provided a written report of his findings dated 21 January 2025.

18. The findings of the post-mortem examination were consistent with the clinical history.

19. Toxicological analysis of post-mortem samples identified the presence of metoclopramide (for the treatment of nausea and vomiting) and paracetamol at therapeutic concentrations.

20. Dr Lynch provided an opinion that the medical cause of death was *'1(a) aspiration pneumonia in the setting of ischaemic heart disease, type 2 diabetes mellitus and dementia'.* Dr Lynch also provided an opinion that the cause of death was due to natural causes.

21. I accept Dr Lynch's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Robert Walter Burnett, born 26 May 1939;

    b) the death occurred on 17 August 2024 at Port Phillip Prison, 451 Dohertys Road Truganina, Victoria from *'1(a) aspiration pneumonia in the setting of ischaemic heart disease, type 2 diabetes mellitus and dementia'*; and

    c) the death occurred in the circumstances described above.

23. There is no evidence to suggest that the medical care provided to Robert was anything other than appropriate. I agree with the review conducted by the Department of Justice and Community Safety that Robert's custodial management in the last 12 months of his life, as well as the health response to his death, was appropriate. I have not identified any prevention opportunities.

24. Having considered all the available evidence, I am satisfied that Robert's death was due to natural causes and that no further investigation is required. Accordingly, I have exercised my discretion under section 52(3A) of the Act to finalise the investigation into Robert's death without holding an inquest.

I convey my condolences to Robert's brother and his sister-in-law.

ORDERS AND DIRECTIONS

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:

Senior Next of Kin

Secretary, Department of Justice and Community Safety

First Constable Samuel Spencer, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 24 March 2026

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.