IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3944

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***
Amended pursuant to section 76 of the Coroners Act 2008 as at 9 June 2020

Findings of:	Coroner Jacqui Hawkins
Deceased:	Douglas Norman Povey
Date of birth:	19 August 1945
Date of death:	28 July 2019
Cause of death:	I(a) Dilated cardiomyopathy and chronic renal disease Contributing Factors: Diabetes mellitus
Place of death:	Ballarat Base Hospital, 1 Drummond Street, Ballarat, Victoria, 3350

BACKGROUND

1. Mr Douglas Povey was 73 years old at the time of his death. He was in his fifth year of a 12 year term of imprisonment at Langi Kal Kal Prison in Langi Kal Kal. Mr Povey would have been eligible for parole in December 2021.

2. According to Mr Povey's medical records he had a number of significant medical issues including Type 2 diabetes, hypertension, asthma, ischaemic heart disease, cardiac stents, severe ischaemic cardiomyopathy, back surgery and was a former smoker. In early 2019, medical tests discovered Mr Povey had severe cardiac dysfunction. He had frequent contact with medical services throughout his imprisonment and regular consultations with the St Vincent's Hospital Melbourne Cardiology Clinic.

3. In mid-2019 Mr Povey's kidney function deteriorated and he was transferred to the Ballarat Base Hospital, where he died a week later. His death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* as his was in custody at the time of his death.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[1]

5. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

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

Identity of the deceased

6. Mr Douglas Povey was visually identified by Peter Cartledge, Corrections Officer on 28 July 2019. Identity was not in issue and required no further investigation.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

Medical cause of death

7. On 30 July 2019, Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination of the body of Mr Povey and reviewed the Form 83 Victoria Police Report of Death, e-Medical Deposition of Ballarat Base Hospital, medical records from Langi Kal Kal prison and the Ballarat Base Hospital, and the post mortem computed tomography (CT) scan.

8. The post mortem CT scan showed bilateral pleural effusions, minor coronary artery calcification, soft tissue swelling to the right side of the forehead, right hydrocoele and gallstones.

9. Toxicological analysis of post mortem blood detected the presence of a number of therapeutic medications.

10. Dr Baber provided an opinion that the medical cause of death was 1(a) Dilated cardiomyopathy and chronic renal disease with contributing factors diabetes mellitus and was due to natural causes.

Circumstances in which the death occurred

11. On 21 July 2019 at approximately 7am, Mr Povey informed custodial staff that he was not feeling well and was struggling to get out of bed. Mr Povey was assessed by health staff and it was agreed that he would be transferred by ambulance to Ballarat Base Hospital where he was admitted for review.

12. Following his admission to hospital, Mr Povey's condition deteriorated and he went into renal failure. Due to his poor prognosis, Mr Povey was placed on a palliative pathway.

13. Mr Povey died on 28 July 2019.

14. The Justice Assurance and Review Office (JARO) and Justice Health reviewed the circumstances of Mr Povey's death and concluded that he was an aging prisoner with multiple medical comorbidities and that his medical care and custodial management were in accordance with the prescribed standards.

15. Having considered the evidence I am satisfied that no further investigation is required.

FINDINGS

16. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

    (a) the identity of the deceased was Douglas Norman Povey born 19 August 1945;

    (b) Mr Povey died on 28 July 2019 from 1(a) Dilated cardiomyopathy and chronic renal disease with contributing factors diabetes mellitus and his death was due to natural causes;

    (c) in the circumstances described above.

17. I order pursuant to section 73(1B) of the *Coroners Act 2008*, that this finding be published on the Coroners Court of Victoria Website.

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

The family of Mr Povey;
Information recipients; and
Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 9 June 2020