IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 3726**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**TIMOTHY LEIGHTON RICHARDSON**
Date of birth:	**27 OCTOBER 1936**
Date of death:	**17 JULY 2019**
Cause of death:	**ISCHAEMIC HEART DISEASE**
Place of death:	**SUNSHINE HOSPITAL** **176 FURLONG STREET, ST ALBANS, VICTORIA 3021**

HIS HONOUR:

BACKGROUND

1. Timothy Leighton Richardson was born on 27 October 1936. He was 82 years old at the time of his death. Mr Richardson was serving a custodial sentence at Hopkins Correctional Centre (**Hopkins**).

2. Mr Richardson's medical history included glaucoma, heart disease, asthma, angina, reflux and hypertension. He had an extensive history of cardiac disease, including coronary artery grafts in 1989 and a heart attack in late January 2019 when he was treated at St Vincent's Hospital Cardiac Care Unit. He was subsequently transferred to Hopkins on 27 February 2019 and his condition stabilised for a short time.

3. On 17 June 2019, Mr Richardson sustained a fall and was transferred to the subacute inpatient unit for observation. He was returned to his usual accommodation on 18 June 2019, and a CT scan was conducted on 18 June 2019. The CT scan identified, among other things, cardiomegaly and severe heart failure.

4. On 20 June 2019, prison staff discovered Mr Richardson on the floor of his cell, unable to stand. He was transferred and admitted to St Vincent's Hospital before being moved to St Augustine's secure inpatient unit.

5. On 5 July 2019, he was transferred to Port Phillip Prison and placed in the St John's secure inpatient unit.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Mr Richardson's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death he was a person placed under the custody of the Secretary to the Department of Justice.[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[3]

[1] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008*.
[2] Section 52(2)(b) *Coroners Act 2008*.
[3] Section 52(3A), *Coroners Act 2008*.

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. 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.

8. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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

10. 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.

11. 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.

12. Coroners are also empowered:

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

    (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.

13. 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

[4] Section 89(4) *Coroners Act 2008.*
[5] *Keown v Khan* (1999) 1 VR 69.

Briginshaw v *Briginshaw*.[6] 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*

14. Timothy Leighton Richardson was visually identified by his cousin, Elizabeth Andrews, on 17 July 2019. Identity is not disputed and requires no further investigation.

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

15. On 22 June 2019, Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on the body of Timothy Leighton Richardson and provided a written report dated 21 August 2018, concluding a reasonable cause of death to be "I(a) Ischaemic heart disease". I accept his opinion in relation to the cause of death.

16. Toxicological analysis of post mortem specimens was not carried out.

17. Dr Bouwer noted the external examination was consistent with the reported circumstances and the death was due to natural causes.

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

18. On 7 July 2019, Mr Richardson was discovered unresponsive at the Port Phillip Prison subacute unit. He was consequently transported via ambulance to Sunshine Hospital for ongoing treatment.

19. On 15 July 2019, medical staff at Sunshine Hospital advised that due to Mr Richardson's declining condition and extensive heart disease, he required comfort and palliation measures.

20. Mr Richardson was confirmed deceased at 5:30am on 17 July 2019.

FINDINGS

21. Having investigated Timothy Leighton Richardson's death, and having considered all of the available evidence, I am satisfied that no further investigation is required.

[6] (1938) 60 CLR 336.

22. I find that Timothy Leighton Richardson died of natural causes, and that the care provided to him by the Department of Justice and the relevant medical service providers was reasonable and appropriate in the circumstances.

23. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Timothy Leighton Richardson, born 27 October 1936;

    (b) that Timothy Leighton Richardson died on 17 July 2019, at Sunshine Hospital, St Albans, from ischaemic heart disease; and

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

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

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

    (a) Mr Richardson's family, senior next of kin;

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 30 March 2020