IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003716

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Frederick William Boyle
Date of birth:	14 March 1949
Date of death:	8 July 2023
Cause of death:	1(a) Congestive heart failure on a background of recent influenza A infection, end stage dementia and Parkinson's disease with marked cognitive impairment
Place of death:	Port Phillip Prison 451 Dohertys Road, Truganina, Victoria, 3029
Keywords:	Death in custody; natural causes

INTRODUCTION

1. On 8 July 2023, Frederick William Boyle was 74 years old when he passed away at Port Phillip Prison (**PPP**) in Truganina, Victoria. Frederick is survived by his daughters, Sharon and Careesa.

2. Frederick was born in Cardiff, Wales as the tenth child to his parents David Boyle and Edith Owen. He married his wife, Edwina Boyle, in 1972 and migrated to Australia later that year. Frederick and Edwina's first child, Careesa, was also born in 1972, followed by Sharon in 1975. Frederick worked as a carpet layer in Australia for about 15 years and later became an armed security guard.

3. Frederick and Edwina's marriage deteriorated in about 1982 or 1983, in part due to his infidelity. Edwina was murdered on 6 October 1983; however, this was not discovered for another 23 years. A 1994 coronial inquest into Edwina's disappearance found that she was most likely deceased and "*suggest[ed] the possibility of Mr Boyle being responsible for her disappearance by taking her life, although there is no direct evidence of his involvement*". It does not appear that police investigated this suggestion following the inquest.

4. In 2006, Frederick's son-in-law located Edwina's remains in a metal drum at Frederick's home. Frederick was charged with Edwina's murder and was subsequently found guilty by a jury of same. In 2008, he was sentenced to 21 years' imprisonment with a non-parole period of 17 years. Frederick appealed his conviction and his sentence, however his application for leave to appeal both was refused.

5. After his remand and conviction, Frederick moved between various prisons which was stressful for him as he had to learn a new environment, inmates and routines. He looked forward to moving to Fulham Correctional Centre (**FCC**), as he had heard from other inmates that it was a lower security environment. This move occurred in 2012 and he quickly moved into one of FCC's self-contained cottages. He shared the cottage with three other inmates and enjoyed cleaning the unit for them each day.

6. Sharon first observed Frederick's shaky hands in about 2016 or 2017. This was soon accompanied by memory lapses and Frederick losing his train of thought. He was later diagnosed with dementia, although Sharon noted that her family was not given an official diagnosis or information about same. As Frederick's health deteriorated, one of the inmates in his cottage became his full-time carer. Once his condition became unsuitable to manage at

FCC in 2019, Frederick was transferred to Ravenhall Correctional Centre (**RCC**), where he was housed in a medical cell.

7. Frederick had an extensive history of serious and chronic health conditions including Parkinson's disease, Parkinson's dementia, non-insulin dependent diabetes, hypertension, obesity and transient ischaemic attack, congestive cardiac failure, gastro-oesophageal reflux disease and asthma.

THE CORONIAL INVESTIGATION

8. Frederick'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. 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.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Frederick's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of Frederick William Boyle 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.[1]

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

Circumstances in which the death occurred

13. On 18 June 2023, Frederick was admitted to St Vincent's Hospital Melbourne (**SVHM**), due to concerns about a chest infection. He was diagnosed and treated for hypoactive delirium and exacerbated chronic congestive cardiac failure in the setting of influenza A.

14. After a few days of treatment, Frederick was transferred from SVHM to PPP's St John's sub-acute inpatient unit for palliative and comfort care. His family were notified, and they were able to visit him to say goodbye.

15. On 8 July 2023, medical staff at PPP located Frederick unresponsive in his bed. Staff called a Code Black (for a death or serious medical event). As Frederick's advance care directive stated that he did not wish to be resuscitated, staff did not attempt this. An on-call doctor confirmed he was deceased at 11.02pm that evening. Staff notified all relevant parties including management, WorkSafe Victoria and Victoria Police. There were no suspicious circumstances identified in relation to Frederick's death.

Identity of the deceased

16. On 10 July 2023, Frederick William Boyle, born 14 March 1949, was visually identified by his daughter, Sharon Gili.

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

Medical cause of death

18. Forensic Pathologist Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 10 July 2023 and provided a written report of his findings dated 12 July 2023.

19. The post-mortem examination revealed findings in keeping with the clinical history.

[1] 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.

20. Examination of the post-mortem computed tomography (**CT**) scan showed cerebral atrophy, no intracranial haemorrhage, no skull or cervical spine fractures, coronary artery calcification, non-specific lung markings, and renal cysts.

21. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

22. Dr Beer provided an opinion that the medical cause of death was *1(a) Congestive heart failure on a background of recent influenza A infection, end stage dementia and Parkinson's disease with marked cognitive impairment.* Dr Beer opined that the death was due to natural causes.

23. I accept Dr Beer's opinion.

FURTHER INVESTIGATIONS

24. Following Frederick's death, the Department of Justice and Community Safety (**DJCS**) completed a 'Review into the death of Mr Fred Boyle' (**'the Review'**). Given Frederick's extensive period of incarceration, the Review focused on the medical treatment provided in the 12 months prior to his passing. The Review made the following conclusions:

    a) Frederick's case management in the 12 months prior to his passing was effective and appropriate. His case manager developed local plan goals with him and had monthly case management meetings with his case worker. As Frederick's mental and physical capacity deteriorated, it became more challenging to progress his goals and actively involve him in case management meetings.

    b) Frederick's parole preparation was not clearly documented. On 24 March 2023, a Case Management Review Committee (**CMRC**) meeting occurred to discuss Frederick's medical, mental and physical state, as well as his ongoing needs. The CMRC did not recommend parole for Frederick as it would present "*an unnecessary risk to his health and wellbeing*". Nevertheless, RCC staff submitted his parole application on 4 April 2023 and his application remained under consideration at the time of his passing. The main issue identified by DJCS was that the CMRC meeting was not properly documented.

    c) Overall, health staff managed Frederick's falls risk appropriately, however DJCS found that action could have been taken to mitigate the risk of harm caused by bed

rails. Due to Frederick's delirium and confusion, the use of bed rails was inappropriate, without clinical rationale to the contrary.

d) There were five instances from September 2022 to April 2023 where custodial staff were either unable, unwilling or were delayed in opening his cell door so that health staff could attend to Frederick. Custodial staff did not escalate any of the health staff's requests to gain access to Frederick's cell, nor did they document these occurrences in his local plan file notes or record them as incidents on the Prisoner Information Management System (**PIMS**).

e) Frederick's medication management was impacted by a distributor supply issue. There were seven documented occasions when Frederick was at RCC and did not receive his prescribed medication for the treatment of Parkinson's disease. While a missed dose can exacerbate symptoms and increase the risk of falls, there was no evidence to suggest that Frederick suffered additional symptoms or falls due to this. Justice Health investigated the issue and noted that it was not unique to Frederick; rather it was a broader issue with the distributor of the medication and was raised directly with the pharmacy that supplies medications to prisons.

f) Frederick's palliative care was appropriately managed and was in accordance with his advance care directive.

g) The response to Frederick's death was appropriate and compliant with required policies and procedures.

25. In relation to the delay or refusal of custodial staff to open Frederick's cell door, DJCS noted there was a broader response by Corrections Victoria (**CV**) in relation to this issue, as it affected other inmates. The CV Assistance Commissioner has since provided standing approval for custodial staff to open cell doors after hours (when locked down), without the need to obtain prior approval from the CV Duty Director. Custodial staff are now permitted to retrospectively notify the CV Duty Director to reduce unnecessary delays in accessing patients in sub-acute health units.

26. I am satisfied that the Review by DJCS was comprehensive and thorough. While there were some deficiencies identified, these were largely incidental and did not cause or contribute to Frederick's passing.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Frederick William Boyle, born 14 March 1949;

    b) the death occurred on 8 July 2023 at Port Phillip Prison 451 Dohertys Road, Truganina, Victoria, 3029, from congestive heart failure on a background of recent influenza A infection, end stage dementia and Parkinson's disease with marked cognitive impairment; and

    c) the death occurred in the circumstances described above.

28. I find that Frederick died from natural causes. I am satisfied that there are no issues or concerns with respect to the care Frederick received during his incarceration.

I convey my sincere condolences to Frederick's family for their loss.

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:

Sharon Gili, Senior Next of Kin
Careesa Patton, Senior Next of Kin
Justice Assurance and Review Office
Justice Health
St Vincent's Hospital
Detective Senior Constable Kacey Williams, Coronial Investigator

Signature:

Coroner Dimitra Dubrow

Date: 23 September 2025

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.