IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004986

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Raymond John Blackney
Date of birth:	19 May 1940
Date of death:	7 September 2023
Cause of death:	1a: END-STAGE PARKINSON'S DISEASE (PALLIATED)
Place of death:	Port Phillip Prison 451 Dohertys Road Truganina Victoria 3029
Keywords:	In custody, death in custody, Port Phillip Prison, natural causes, palliative care, recommendation for purpose-built high needs facility

INTRODUCTION

1. On 7 September 2023, Raymond John Blackney[1] was 83 years old when he died at the St John's Unit of Port Phillip Prison. At the time of his death, Raymond was serving a custodial sentence.

Background and Medical History

2. From birth, Raymond experienced a moderate intellectual disability. He had difficulties communicating, hearing loss and relied on hearing aids.

3. On 15 September 2016, Raymond was remanded into custody on a set of serious charges, for which he was sentenced to a term of imprisonment of 18 years and 9 months. In 2019, he returned to court in relation to further serious charges, and was sentenced to a further term of imprisonment, with a new total of 20 years and a non-parole period of 14 years and 8 months.

4. Raymond was primarily accommodated at Hopkins Correctional Centre but also spent time at other prisons, including Port Phillip Prison.

5. On 24 May 2023, he was transferred to Port Phillip Prison for the final time.

6. Raymond had a complex medical history of depression, Parkinson's disease, hypertension,[2] hyperlipidaemia,[3] chronic obstructive pulmonary disease (**COPD**), kidney impairment, Type 2 diabetes mellitus, gout and vitamin B12 deficiency. While in custody, Raymond was diagnosed with Parkinson's dementia. He also exhibited challenging behaviours including violence and aggression.

7. There were several chronic health care plans (**CHCPs**) in place regarding Raymond's diagnoses, which recorded interventions and intended outcomes. He was supported by 24-hour personal care assistants who provided support with daily living such as personal hygiene, eating, medication[4] and activity participation. Raymond was considered a high falls risk[5] which was mitigated through means including regular occupational and physiotherapy, a low bed, safety mats and rubber furniture.

[1] Referred to throughout this finding as 'Raymond', unless more formality is required.
[2] High blood pressure.
[3] High cholesterol.
[4] At the time of his death, Raymond was prescribed polyethylene glycol eyedrops, morphine, midazolam, cyclizine lactate infusions and hyoscine butylbromide.
[5] In the year preceding his death, Raymond was involved in 77 incidents. The majority of these were due to falls.

8. In July 2022, the prison supervisor[6] referred Raymond to the Corrections Victoria Prison Disability Support Initiative (**PDSI**) as staff were concerned by Raymond's capacity to make informed decisions. Following an assessment, the PDSI determined that Raymond was no longer able to make informed decisions, due to the progression of his disability and cognitive impairments. Staff consulted with Raymond's wife and the Office of the Public Advocate, and it was determined that Raymond's medical needs would be *'managed through established clinical decision making-tools, with appropriate specialist care involvement and that guardianship was not required'.*

9. The PDSI identified that Raymond's needs would be best met in a secure psychogeriatric facility, since *'his care needs exceeded the resourcing available in a custodial setting'.* Staff experienced difficulties securing appropriate alternative accommodation for Raymond, and his declining health meant that these discussions were ultimately deferred.

THE CORONIAL INVESTIGATION

10. Raymond'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.

11. At the time of his death, Raymond was an individual placed 'in care or custody' for the purposes of section 52(2)(b) of the Act, given that he was serving a custodial sentence at Port Phillip Prison. Accordingly, the Act requires that I hold an inquest into his death.

12. Section 52(3A) of the Act provides an exception to this requirement. If I am satisfied that Raymond's death occurred due to natural causes an inquest need not be convened. Nonetheless, I am required, if it is possible, to make findings specified by section 67 of the Act including in the absence of an inquest.

13. 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.

[6] I note at this time, Raymond was at Hopkins Correctional Centre.

14. 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.

15. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Raymond'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.

16. This finding draws on the totality of the coronial investigation into the death of Raymond John Blackney 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.[7]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

17. On 21 March 2023, Raymond was admitted to the St Augustine's ward of St Vincent's Hospital Melbourne.[8] Clinicians discussed advanced care directives with Raymond's wife. She explained that Raymond previously expressed that *'he did not want measures taken to preserve his life if he was significantly cognitively and functionally impaired'*. Accordingly, Raymond was referred to the community palliative care team.

18. On 24 May 2023, Raymon was re-admitted to the St John's subacute unit at Port Phillip Prison for end-of-life care.

19. Raymond's multi-disciplinary care team met regularly, including with his wife. On 24 August 2023, clinicians initiated palliative care. On 1 September 2023, Raymond's oral medications were ceased in accordance with the advanced care directive.

[7] 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.

[8] St Augustine's ward is a ten-bed, maximum security in-patient unit that offers State-wide tertiary services to the Victorian prison population.

20. On 7 September 2023, at approximately 3:50am, a custodial staff member and nurse entered Raymond's cell. Upon entry, Raymond was experiencing difficulty breathing. A second nurse entered the cell and at 3:53am, a Code Black was activated.[9]

21. At 5:15am, a clinician verified Raymond deceased.

IDENTITY OF THE DECEASED

22. Victoria Police compared a fingerprint impression obtained from the deceased against a fingerprint impression obtained from Raymond Blackney during his life. Victoria Police confirmed the impressions were consistent. On 14 September 2023, based on the positive comparison, Dr Jan Jenkinson of the Victorian Institute of Forensic Medicine (**VIFM**) provided an Identification Report.

23. My colleague, Coroner David Ryan, reviewed the available evidence and determined that the cogency and consistency of all evidence relevant to identification supported a finding that the identity of the deceased was Raymond John Blackney, born 19 May 1940. Accordingly, his Honour signed a Determination by Coroner of Identity of Deceased (**Form 8**), dated 18 September 2023.

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

MEDICAL CAUSE OF DEATH

25. Forensic Pathologist, Dr Hans de Boer (**Dr de Boer**) of the VIFM conducted an examination on the body of Raymond Blackney on 8 September 2023. Dr de Boer considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), post-mortem computed tomography (**CT**) scan and medical records provided by Justice Health and provided a written report of his findings dated 2 October 2023.

26. The post-mortem CT scan demonstrated bilateral tree-in-bud consolidations[10] which Dr de Boer considered were suspicious of pneumonia. Also identified were coronary artery calcifications and diffuse idiopathic skeletal hyperostosis of the spine.

27. There were no injuries identified which were likely to have caused or contributed to the death.

[9] A Code Black indicates a death or medical emergency.

[10] *'Tree-in-bud'* refers to small, centrilobular nodules connected to the branching linear opacities, resembling a budding tree. They are often indicative of bronchiolar involvement and variously underlying conditions, including infection and/or other diseases.

28. Toxicological analysis of post-mortem samples identified the presence of morphine at a concentration of ~ 0.07 mg/L and midazolam at a concentration of ~ 0.1 mg/L.

29. Dr de Boer provided an opinion that the medical cause of death was 1(a) *end-stage Parkinson's disease (palliated)*. Dr de Boer stated the death was due to natural causes.

30. I accept Dr de Boer's opinion.

REVIEW BY THE DEPARTMENT OF JUSTICE AND COMMUNITY SAFETY

31. The Justice Assurance and Review Office (**JARO**) and Justice Health units of the Department of Justice and Community Safety (**DJCS**) completed a review of the circumstances of Raymond's death (**DJCS review**). The DJCS review concluded that Raymond's custodial management and healthcare (including palliative care) was appropriate and well-managed.

32. However, the DJCS Review spoke to the difficulty of Raymond requiring a higher level of care than was available in a custodial setting:

> *'In accordance with recommendations made by [Raymond]'s multidisciplinary care team, [Raymond] would have benefited from a purpose-built high needs facility'.*

33. It continued that *'purpose-built high needs facilities provide specialist care and support to people with high and complex needs, as well as a safe and stable living environment'.* The DJCS Review identified that such facilities were not available for Raymond at the time, and would have been beneficial for him. Nonetheless, it determined that the care that Raymond received from his multidisciplinary team met the relevant requirements.

34. The DJCS Review recommended that '*[t]hat Justice Health in collaboration with key stakeholders undertake a thematic review into current and projected high care health needs of people in prison*'. This was an acknowledgment of '*the missed opportunity for [Raymond]'s health care needs and the growing aged and high needs prison population*'.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Raymond John Blackney, born 19 May 1940;

b) the death occurred on 7 September 2023 at Port Phillip Prison 451 Dohertys Road, Truganina Victoria 3029, from 1(a) *end-stage Parkinson's disease (palliated)*; and

c) the death occurred in the circumstances described above.

36. Having considered all of the circumstances, I am satisfied that Raymond John Blackney died due to natural causes. Pursuant to section 52(3A) of the Act, I have determined not to hold an inquest into his death for this reason.

37. While I agree that a high-needs facility would have offered Raymond John Blackney with more specialist care, and would have provided the optimal environment for staff to manage his challenging behaviours and complex health presentation, I find that his care and management was reasonable in the circumstances.

38. While his periods in the Canton Unit of Hopkins Correctional Centre reportedly exacerbated his dementia, Raymond John Blackney had chronic health conditions and extensive comorbidities. Accordingly, the factual matrix of Raymond John Blackney's death does not support a conclusion that him being 'in custody' at the time of his death – according to the Act – had a causal relationship with his death.

39. I note the recommendation put forward in the review of Raymond John Blackney's death conducted on behalf of the Department of Justice and Community Safety (**DJCS**), and support the same, noting that a high-needs facility would have facilitated the care and management of Raymond John Blackney.

40. The considered review of Raymond John Blackney's death conducted on behalf of DJCS has obviated the need for any coronial recommendations in this space.

I convey my condolences to those who cared for Raymond for their loss.

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:

Ms Faye Blackney, Senior Next of Kin

Department of Justice and Community Safety, c/- Mr Marco Boscaglia

Sergeant Christopher Black, Coronial Investigator

Signature:

Ingrid Giles

Coroner

Date: 7 July 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.