IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2014 / 2095

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: NEYKO DINKOV

Delivered On:	18 December 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	18 December 2014
Findings of:	PHILLIP BYRNE
Representation:	Mr Marc Fisken, assisting the Coroner

I, PHILLIP BYRNE, Coroner, having investigated the death of NEYKO DINKOV

AND having held an inquest in relation to this death on 18 December 2014
at MELBOURNE
find that the identity of the deceased was NEYKO DINKOV
born on 14 August 1959
and the death occurred on 25 April 2014
at Fulham Correctional Centre, Hopkins Road, Sale
from:

1 (a) ISCHAEMIC HEART DISEASE

in the following circumstances:

1. Mr Neyko Dinkov, 54 years of age at the time of his death, was a dual Canadian and Bulgarian citizen serving a six month sentence of imprisonment at Fulham Correctional Centre in Sale.

2. Mr Dinkov had no significant medical history that he disclosed to corrections staff upon admission to prison.

3. On 18 November 2013 Mr Dinkov arrived in Australia at Melbourne Tullamarine airport. He was immediately arrested on arrival by Federal Police, charged with an importing offence and remanded in custody. Subsequently he was sentenced to a term of imprisonment.

4. On 19 April 2014 Mr Dinkov was transferred to the Fulham Correctional Centre.

5. On 25 April 2014 Mr Dinkov played a number of games of football on a tennis court located near his unit. He then walked back to his unit.

6. At approximately 11.50am he arrived back at his unit and slumped over in the doorway, unconscious. First aid was administered, first by fellow inmates, then by staff and finally by ambulance paramedics who arrived at approximately 12pm.

7. However, despite resuscitation attempts Mr Dinkov never regained consciousness with paramedics formally pronouncing him deceased at 12.45pm.

8. As the death was unexpected the matter was referred to the Coroner. Upon coronial direction a full autopsy and ancillary tests were carried out at the Victorian Institute of

Forensic Medicine by Senior Forensic Pathologist Dr Michael Burke. Dr Burke found no evidence of any injury that would have contributed or led to death. He stated;

> *"The post mortem examination showed significant heart disease with coronary artery atherosclerosis and associated myocardial fibrosis. The degree of heart disease would be consistent with causing sudden death as a result of a cardiac arrhythmia (heart attack)."*

9. Dr Burke then goes on to state that there is "no evidence to suggest that the death was due to anything other than natural causes."

10. Following established protocols the Office of Correctional Service Review (OCSR) conducted a review into Mr Dinkov's death. A copy of the review has been made available to the Court. I have carefully examined that report. Although the OCSR identified what they considered some deficiencies in the performance of correctional officers on the scene initially after Mr Dinkov's collapse I am not satisfied those perceived deficiencies in the initial response prior to the arrival of the "medical team", altered the outcome; they were not causal factors in the death. Having said that, although I do not propose to make a formal recommendation I support the OCSR recommendation that:

> *"Fulham Correctional Centre update its Operating Instructions to specify that staff have a duty of care to take control of the provision of first aid to prisoners where practicable"*

In supporting that recommendation I note that all correctional staff at the facility are trained in the delivery of first aid. I concur with the findings of that review and accept that all aspects of the management of Mr Dinkov, while in custody were appropriate.

11. Again following established protocols, Justice Health reviewed the death of Mr Dinkov. A report of that review constitutes Appendix 1 of the OCSR report. Justice Health is responsible for the delivery of health services to prisoners in custody in Victoria. I accept their finding that the provision of health care to Mr Dinkov was appropriate throughout his term of incarceration both in Melbourne and at Fulham Correctional Centre where he died.

12. As Mr Dinkov's death occurred while he was in custody the matter was required to proceed as a mandatory inquest. I have today held a summary inquest.

13. I formally find that Mr Neyko Dinkov died from natural causes, namely ischaemic heart disease.

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

Ms Luba Dinkov

Office of Correctional Services Review

Leading Senior Constable Julian Wildenberg, Wellington Police Station, Sale

Signature:

PHILLIP BYRNE
CORONER
Date: **18 December 2014**