IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 000270

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 on 15 April 2024[1]

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Craig Geoffrey Rickard
Date of birth:	10 August 1964
Date of death:	15 January 2020
Cause of death:	1(a) Hanging
Place of death:	18 Lawrence Street, Sebastopol, Victoria, 3356
Key Words	Grampians Health; Mental Health; Prisoner; Suicide

[1] This document is an amended version of the Finding into Death Without Inquest dated 4 April 2024. Corrections to paragraphs 76, 77, 78, 79, 80, 81, and 82 have been made pursuant to section 76 of the *Coroners Act 2008* (Vic) where indicated by bold type.

INTRODUCTION

1. On 15 January 2020, Craig Geoffrey Rickard was 55 years old when he was found deceased at home in circumstances suggestive of suicide. At the time, Mr Rickard lived in Sebastopol with his brother, Allan Rickard, and his sister in-law, Helen Rickard.

2. Mr Rickard was in an intimate relationship with his former partner Diane McPhan for around 12 years. The relationship broke down in about December 2018. Mr Rickard also had two children to a previous relationship with whom he had little contact with.

Medical History

3. Mr Rickard attended General Practitioner (**GP**) Dr Mohammed Jabbarpour of the Tristar Medical Group in Sebastopol. In October 2018, Dr Jabbarpour referred Mr Rickard for counselling to Clinical Psychologist Mr Conor Fogarty. He attended Mr Fogarty a total of nine times between 10 December 2018 and 31 May 2019. At their initial consultation, Mr Rickard presented in the context of his separation, although Mr Fogarty reported he did not appear significantly distressed over the separation.

4. Mr Rickard disclosed a long-term history of alcohol misuse as well as a more recent history of methamphetamine use. The overarching theme of his consultations with Mr Fogarty were concerns related to his self-worth and existential concerns. Having seen Mr Rickard on nine occasions, Mr Fogarty did not consider that he met the criteria for a formal diagnosis of depression or anxiety. Throughout their consultations, Mr Rickard denied being at risk of harm and Mr Fogarty considered him a low risk of self-harm.

THE CORONIAL INVESTIGATION

5. Mr Rickard'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.

6. 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.

7. 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.

8. Victoria Police assigned Constable Jack Hughes to be the Coroner's Investigator for the investigation of Mr Rickard's death. The Coroner's 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.

9. This finding draws on the totality of the coronial investigation into the death of Craig Geoffrey Rickard 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.[2]

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

Identity of the deceased

10. On 15 January 2020, Craig Geoffrey Rickard, born 10 August 1964, was visually identified by his brother, Allan Rickard, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

12. Forensic Pathologist Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on Mr Rickard's body in the mortuary on 16 January 2020 and provided a written report of his findings dated 22 January 2020.

13. The post-mortem examination showed a ligature injury to the neck. No unexpected signs of injury were observed.

[2] 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.

14. Routine toxicological analysis of post-mortem samples detected fluoxetine[3] and its metabolite, methylamphetamine[4] and amphetamine.[5]

15. Dr Bouwer provided an opinion that the medical cause of death was *1 (a) hanging*.

16. I accept Dr Bouwer's opinion.

Circumstances in which the death occurred

Ballarat Mental Health Service

17. On 12 September 2019 Mr Rickard self-presented to Ballarat Base Hospital Emergency Department (**ED**) reporting suicidal ideation with a plan to hang himself in the setting of alcohol and methamphetamine consumption. Records indicate his presentation was precipitated by financial and relationship stressors.[6] He was unable to be assessed by the Ballarat Mental Health Service (**BMHS**)[7] and left the ED without informing staff. Police were notified by BMHS of Mr Rickard's potential risk to himself.

18. On 23 September 2019, Mr Rickard attended Ms McPhan's home and attempted suicide by gassing himself while in his car. Ms McPhan called police who transported Mr Rickard to Ballarat Base Hospital under section 351 of the *Mental Health Act 2014* (Vic) ('**the MHA**').[8] Mr Rickard was assessed by the BMHS in the ED and was noted to be pleasant but difficult to engage in conversation.[9] A mental health review did not reveal any evidence of depressive symptoms and Mr Rickard was discharged for community mental health follow up.

19. As a result of the incident on 23 September 2019, police issued a Family Violence Safety Notice. The following day, the Ballarat Magistrates Court issued an interim Family Violence Intervention Order (**FVIO**) which prohibited Mr Rickard from contacting Ms McPhan.

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[3] Fluoxetine is a selective-serotonin reuptake inhibitor indicated for major depression.
[4] Methylamphetamine ("speed" or "ice") is a strong stimulant drug used recreationally.
[5] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine.
[6] Ballarat Health Services records pg 124/245.
[7] The 'Ballarat Mental Health Service' and 'Ballarat Health' have since been renamed 'Grampians Area Mental Health & Wellbeing Services' and 'Grampians Health' respectively.
[8] Section 351 of the MHA permits a police officer to apprehend a person if they appear to have a mental illness, and because of their apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to themselves or another person. As of 1 September 2023, the MHA was replaced by the *Mental Health and Wellbeing Act 2022* (Vic) and section 351 was replaced by section 232 which is similar in operation.
[9] Statement of Dr Anoop Lalitha dated 31/04/2323. I note this statement was provided on 1 May 2023 and it is clear the date included in the statement is a typographical error.

20. BMHS contacted Mr Rickard by phone on 24 September 2019. He was recorded to engage well, denied thoughts to harm himself and predominately complained of financial hardship. A face-to-face review was scheduled for the next day, however, Mr Rickard failed to attend or answer his phone when called. Instead, BMHS obtained collateral information from Mr Rickard's family and friends and notified police of his potential risk to himself.

21. On 26 September 2019, Mr Rickard broke into Ms McPhan's home and left a note saying that he would suicide by hanging at a particular location. Police were notified and attended the address included in Mr Rickard's note. They discovered him in his car with a noose located in the boot and again took him to Ballarat Base Hospital under section 351 of the MHA.

22. Mr Rickard was again assessed by the mental health team, denied suicidal ideation and cited his children as protective factors. He was informed that police attended to charge him with a breach of the FVIO and remand him in custody. A short time later, Mr Rickard absconded from the ED. Police were notified and he was returned to the ED by police the next day. On this occasion, Mr Rickard was assessed by Psychiatrist Dr Ravi Mutha who did not consider he satisfied the criteria for involuntary treatment and he was discharged into police custody.

23. Whilst in police custody on 1 October 2019, Mr Rickard attempted suicide by tying socks around his neck. Police members found him unconscious, but he regained consciousness minutes later. Again, Mr Rickard was taken to the Ballarat Base Hospital pursuant to section 351 and police members remained in the ED with him pending assessment. Mr Rickard was ultimately assessed as stable with low risk of self-harm and discharged from the ED to police custody.[10]

24. Upon his discharge, mental health clinicians at the Ballarat Base Hospital were of the understanding that Mr Rickard was to be taken to the Metropolitan Remand Centre.[11]

25. On 3 October 2019, Mr Rickard's case was presented at a multidisciplinary team meeting at Ballarat Base Hospital. It was decided that Mr Rickard's case was to be closed and he was for a referral to the service upon his eventual release from custody.

Release from Custody

26. Mr Rickard remained in custody until he appeared at the Ballarat Magistrates' Court on 12 December 2019. He was found guilty of Persistent Contravention of a FVIO, stalking, and

[10] Statement of Dr Anoop Lalitha dated 31/04/2323.
[11] As above.

other related charges. He received a combined sentence of 74 days imprisonment reckoned as time served as well as a 12-month Community Corrections Order (**CCO**). As part of his CCO, Mr Rickard was required to:

a) Attendance at, and supervision by, Ballarat Community Correctional Services (**BCCS**);

b) Undergo assessment and treatment (including testing) for drug abuse; and

c) Undergo mental health assessment and treatment.

27. Upon his release from custody, Mr Rickard reported to his case manager at BCCS on 13 December 2019 as required. He attended his next scheduled appointment on 18 December 2019 and appeared well.[12] The screening performed at this appointment did not indicate any suicide or self-harm concerns, and he was given a referral for a drug and alcohol assessment.

28. His case manager also referred Mr Rickard to his GP for a mental health assessment which he attended the following day on 19 December 2019. The GP provided a Mental Health Care Plan with a new referral to Mr Fogarty. Mr Rickard did not contact or otherwise re-engage with Mr Fogarty following this referral.

29. Throughout December, Mr Rickard continue to engage with his case manager from BCCS without any apparent issues.

30. On 7 January 2020, a new BCCS case manager was assigned. They performed a suicide and self-harm screening during which Mr Rickard disclosed suicidal ideation. A case note from BCCS shows that Mr Rickard's case manager increased his suicide rating to category 'S1' and his psychiatric rating to 'P2.'[13] The implications of these ratings will be discussed below.

31. A risk management plan was developed which included for Mr Rickard attending the psychiatric admissions ward at Ballarat Health Services should he feel that he was escalating. The case manager confirmed that Mr Rickard had the phone numbers for the Ballarat Crisis Assessment and Treatment (**CAT**) team and Men's Lifeline saved in his phone, and also contacted Mr Rickard's GP to confirm his medication and provide an update.

[12] JARO Review into the death of Mr Craig Rickard (PID 86604914) in the community on 15 January 2020.
[13] Ballarat Community Correctional Services records, Offender Management File, Part 5 pg 73.

32. Mr Rickard's next and final contact with BCCS was over the phone on 14 January 2020. He asked to re-schedule that day's appointment and also reported that he failed to attend for drug urinalysis the week before. During the conversation he did not report any escalation of his previous suicidal ideation.

33. Between late December 2019 and early January 2020, Mr Rickard appears to have breached the FVIO by sending over 270 text messages and making multiple attempts to call his former partner by phone. This was reported to police on 9 January 2020 who intended to charge Mr Rickard and take him into custody. No charges had been laid before his death and it is unclear if Mr Rickard was aware of this possibility.

34. On 14 January 2020, Mr Rickard travelled from Ballarat to Torquay with his brother Allan and Allan's daughter Michelle, as well as Michelle's infant daughter. Allan felt his brother appeared normal during the trip and reported that he slept briefly in the car during the journey.

35. When the group returned home to Ballarat at about 5.00 pm, Mr Rickard put on a load of washing before his brother drove him to an unknown friend's house in Sebastopol. Later analysis of his phone by police showed that while he was out, Mr Rickard sent a series of messages to Ms McPhan at 11.50 pm on 14 January 2020 which suggested a clear intent to end his life.

36. Mr Rickard returned home at about 12.30 am. He and his brother sat around the dining table and had a cigarette together and talked for about 20 minutes. Allan did not consider that anything seemed out of the ordinary with his brother and retired to bed a short time later.

37. From 1.00 am onwards, Mr Rickard sent another series of text messages to Ms McPhan indicating he intended would hang himself. The final message was sent at 2.26 am and the evidence suggests this was the last time Mr Rickard was known to be alive.

38. Later that morning at about 4.45 am, Helen entered the kitchen to turn the kitchen light off and lock the house up for the night. Prior to locking the rear door, Helen checked that Mr Rickard was not outside smoking. She saw a ladder in the carport and on closer inspection discovered Mr Rickard hanging from a rope in the carport. Helen immediately raised the alarm and she and Allan attended to Mr Rickard who appeared already deceased before contacting emergency services and cutting him down.

39. They commenced cardiopulmonary resuscitation (**CPR**) before Victoria Police members arrived at about 4.55 am shortly followed by Ambulance Victoria paramedics who assessed Mr Rickard and formally verified him deceased at the scene.

40. Attending police conducted a search of the scene and did not locate a suicide note or anything to suggest that Mr Rickard had died in suspicious circumstances.

JUSTICE ASSURANCE AND REVIEW OFFICE

41. The Justice Assurance and Review Office (**JARO**) provides impartial oversight of the Victorian corrections system.

42. When a person dies within three months of release from custody, and while serving a Community Corrections Order, JARO will conduct a review to ascertain whether the case management in custody and in the community met the required standards, and whether the person complied with the conditions of their Community Corrections Order.

43. JARO advised that the '*Victorian correctional system employs a series of alerts, which are attached to prisoner and offender records to ensure communication about significant issues experienced by that person. Typically, risk ratings are entered only when a prisoner or offender is identified as having issues within that area.*'[14]

44. At the time of his death, Mr Rickard had recorded risk ratings of 'S2' in relation to his suicide and self-harm risk, and 'P3' in relation to his psychiatric risk rating.

Custodial Management

45. When first placed in custody on 2 October 2019, Mr Rickard was initially placed on hourly observations due to his recent suicide attempts. On 6 October 2019, a suicide and self-harm assessment was performed during which Mr Rickard presented with no concerns and his suicide risk rating was lowered accordingly.

46. Throughout the remainder of his sentence, Mr Rickard did not report any further concerns and his suicide and self-harm risk was not reassessed. He met with his case manager on a monthly basis as required, and was not involved in any incidents while in custody. He also participated in two education programmes while in custody.

[14] JARO Review into the death of Mr Craig Rickard (PID 86604914) in the community on 15 January 2020.

47. Given he was only in custody for a relatively short period of time, JARO considered there were limited opportunities for transition and reintegration activities.

48. JARO found that Mr Rickard's custodial management met the standards prescribed by Corrections Victoria.

Management of CCO

49. Following Mr Rickard's release and disclosure of suicidal ideation to his community case manager on 7 January 2020, a BCCS case note suggested that his case manager updated his risk ratings to 'S1' and 'P2.'

50. However, Mr Rickard's risk ratings in his Department of Justice 'Risk History' records, which formally record an offender's risk ratings, document Mr Rickard's suicide risk rating on 7 January 2020 as 'S2' and his psychiatric risk rating remained unchanged at 'P3.'[15] These ratings remained unchanged until his death.

51. It follows that the risk ratings included in the Department of Justice records were inconsistent with the case note made by Mr Rickard's case manager on 7 January 2020. JARO was unable to determine why there was a discrepancy in the records.

52. It is relevant to note that in its review, JARO reported it is "*not in a position to comment on the suitability of Mr Rickard's suicide/self-harm (S) or psychiatric (P) risk ratings, as these are clinical matters*.[16]

53. JARO considered the discrepancy between the records on 7 January 2020 reflected a missed opportunity to accurately record Mr Rickard's suicide/self-harm risk rating, but did not consider that it adversely affected his management by BCCS.

54. JARO found that the management of Mr Rickard's CCO by BCCS met the prescribed standards.

BCCS MANAGERS REVIEW

55. After being notified of Mr Rickard's death, the Manager at BCCS also performed a review of Mr Rickard's management by BCCS.[17]

[15] Ballarat Community Correctional Services records, Offender Management File, Part 5 pg 8.
[16] JARO Review into the death of Mr Craig Rickard (PID 86604914) in the community on 15 January 2020, page 2.
[17] Andrew Flintrop, CCS Manager's Review dated 25 February 2020.

56. The Manager's review highlighted the risk management plan implemented for Mr Rickard on 7 January 2020 after he presented with suicidal ideation included providing phone numbers for lifeline and the Ballarat CAT team, advice that Mr Rickard ought to present to the ED if his suicidal ideation escalated, advice to utilise his brother as a support network, and his case manager contacting his GP.

57. The Manager's review did not identify any concerns with the management of Mr Rickard's CCO. The review did not provide any clarification on the discrepancy of the records from 7 January 2020.

CPU REVIEW

58. As part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**) as to the appropriateness of the management and care provided to Mr Rickard proximate to his death.

59. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any particular concerns which have been raised.

60. Following a preliminary review of the matter, the CPU requested a statement from BMHS regarding Mr Rickard's clinical management as well as clarification of the plan for him to be re-referred to the service once released from custody. A statement was subsequently provided by Dr Anoop Lalitha, Director of Clinical Services for the Grampians Area Mental Health and Wellbeing Services.

61. As part of their review, the CPU were assisted by Dr Lalitha's statement, the JARO report and BCCS Manager's review, the records from Ballarat Health, Tristar Medical Group, and BCCS, and the court file.

Ballarat Mental Health Services

62. The CPU noted BMHS had no contact with Mr Rickard since his presentation on 1 October 2019. He was discharged from the service on 3 October 2019 after discussion at a clinical review meeting and being remanded in custody.

63. When discharged, the CPU noted BMHS documented that Mr Rickard was for re-referral when released from custody, however it was not documented that the plan was communicated to anyone external to BMHS. In Dr Lalitha's statement, he advised the responsibility of re-referring Mr Rickard to the service lay with the relevant correctional service (in this case, BCSS).

64. The CPU acknowledged that the last contact BMHS had with Mr Rickard was over three months prior to his death, and in that time he was engaged with other services and served a period of incarceration. Additionally, when Mr Rickard did engage with BMHS, he did not present with a diagnosable mental illness and was aware of how to self-refer to BMHS if required.

Ballarat Community Correctional Services

65. As assessing compliance with Correctional Service procedures is not within the scope of the CPU, their appraisal of BCCS's management of Mr Rickard was limited to the management of his mental health.

66. Prior to his disclosure of suicidal ideation on 7 January 2023, the CPU considered Mr Rickard did not present with evidence of an acute mental illness during his engagement with BCCS. Previously, Mr Rickard's case manager directed him to attend his GP for a Mental Health Care Plan which he did on 19 December 2019 and the CPU considered this appropriate.

67. When Mr Rickard disclosed suicidal ideation, his case manager encouraged him to attend hospital if he felt as though he was escalating, discussed social supports, instructed Mr Rickard to make an appointment with a psychologist, contacted his GP, and ensured he had contact numbers for support services. Again, the CPU considered this response to be reasonable and appropriate.

68. During Mr Rickard's next and final contact with BCCS over the phone on 14 January 2020, he reported no increase in mental health symptoms since the previous week. As there was no evidence of a deterioration in his mental state, the CPU did not consider there was an indication to contact emergency services on his behalf.

Tristar Medical Group

69. After his release from custody, Mr Rickard attended his GP Dr Jabbarpour only once, on 19 December 2019. Medical records indicate he presented with depression and anxiety

aggravated on a background of incarceration. The referral to psychologist Mr Fogarty included a past history of suicidal ideation but no current suicidal ideation. Dr Jabbarpour suggested a follow-up appointment in two weeks' time which Mr Rickard failed to arrange.

70. The CPU did not identify any evidence of acute risk at this time of the consultation and considered the treatment provided by Dr Jabbarpour was reasonable and appropriate.

71. The CPU advised that there was no mention in the Tristar Medical Group records of the conversation between the BCCS case manager and a GP which occurred following Mr Rickard's disclosure of suicidal ideation. While the absence of documentation by the GP who received the case manager's call was not in line with contemporary practice. However, as Mr Rickard failed to attend the Tristar Medical Group afterwards, the failure to record did not contribute to his death or otherwise adversely affect any treatment.

CPU Conclusion

72. The CPU advised it appeared Mr Rickard's suicide was likely impulsive and in response to his perceived need for contact or attention from Ms McPhan not being met. Mr Rickard appeared to have a history of impulsive suicidality in response to similar, previous such incidents involving his former partner.

73. Predicting suicide in people who experience impulsive suicidal ideation in response to external stressors is difficult as it is unclear when a stressor may occur and whether the person will experience suicidal ideation in response. Suicide attempts in such people tend to be impulsive and unpredictable.

74. I accept the CPU's advice.

FURTHER INVESTIGATION

75. Having received the CPU's advice, I directed further statements be obtained from Corrections Victoria to clarify the discrepancy in documentation of Mr Rickard's suicide risk rating and to understand if there had been any contact with BMHS, and also from BMHS for clarification about the notion of Mr Rickard's "re-referral" to their service.

Corrections Victoria

76. Ms Jenny **Roberts**[18], Executive Director of Community Operations and Parole, Justice Services, provided a statement to the Court dated 24 November 2023.

77. Ms **Roberts** advised that an 'S1' risk rating refers to an immediate risk of suicide or self-harm and applies to a person who has voiced an intention to suicide/self-harm or has recently attempted suicide or self-harmed. Such a rating requires an immediate referral to an area mental health service, ambulance and/or police.

78. Conversely, Ms **Roberts** advised an 'S2' rating was appropriate for someone voicing suicidal ideation with current plan or intent. Among other things, it is considered an appropriate response is to liaise with the person's treating practitioners.

79. Ms **Roberts** noted that Mr Rickard did not articulate a clear plan to end his own life on 7 January 2020 and therefore his presentation appeared consistent with an 'S2' rating. Moreover, Ms **Roberts** considered the case manager's actions in contacting Mr Rickard's GP, confirming support numbers and advising to attend the hospital amongst others were appropriate for a 'S2' suicide rating.

80. In relation to the discrepancy in documentation of the risk ratings, Ms **Roberts** noted the case manager who authored the case note which included risk ratings of 'S1' and 'P2' later consulted a senior staff member, in line with practice guidelines, who ultimately updated Mr Rickard's Department of Justice 'Risk History' record.

81. Ms **Roberts** theorised that the case manager's consultation with the senior member of staff may have identified that risk ratings of 'S1' and 'P2' were ultimately more appropriate and hence resulted in the discrepancy.

82. Ms **Roberts** confirmed that it appeared BCCS had some knowledge of Mr Rickard's involvement with BMHS immediately prior to his incarceration. A letter from Ballarat Health Services dated 1 October 2019 confirmed the plan to engage with Mr Rickard in the community upon his release from custody was included within Mr Rickard's BCCS file.[19]

[18] This and the following paragraphs have been amended pursuant to section 76 of the *Coroners Act 2008* (Vic) to correct Ms Jenny Roberts name from 'Smith' to 'Roberts'.
[19] Ballarat Community Correctional Services records, Offender Management File, Part 5 pg 127.

83. I note that the letter dated 1 October 2019 was prepared on the request of Mr Rickard's legal representative in relation to his, at the time, pending proceedings at the Ballarat Magistrates' Court, and that the letter was prepared two days prior to his discharge from BMHS.

BMHS (Now Grampians Area Mental Health & Wellbeing Services)

84. In an additional statement dated 15 November 2023, Dr Lalitha advised that there are several ways a person could be re-referred back to the Grampians Area Mental Health & Wellbeing Services (**GAMHWS**), formerly BMHS, after their release from prison.

85. Firstly, Dr Lalitha stated that if a prison service considered that a prisoner required a referral upon their release, it is standard practise that the prison service would complete a referral to the relevant area mental health service. Dr Lalitha reported that prison services have access to region specific health referral guides.

86. Another avenue for individuals to be referred to GAMHWS after a custodial sentence is by a Community Correctional Services (such as BCSS) making a direct referral. Dr Lalitha stated this would occur in situations where a Community Correctional Service have concerns for someone's mental health, or to satisfy a condition of a CCO.

87. Dr Lalitha confirmed that GAMHWS do not have any policies/ procedures/ protocols/ guidelines concerning mental health patients whose management is interrupted by episodes of incarceration.

88. It remains unclear as to what mechanism Mr Rickard was to be re-referred to the BMHS following his eventual release from custody. When his episode of care was closed at the multidisciplinary team meeting on 3 October 2019, clinicians had no way of knowing when he would be released, if he would be granted bail and on what conditions, or if he would eventually be released on a CCO.

89. Dr Lalitha advised:

> *GMHWS community teams keep the episode of care open for the clients who are in the Melbourne Assessment prison until a final outcome from the court about the incarceration is provided*.

90. The Melbourne Assessment Prison (**MAP**) is often the first prison where a prisoner is remanded and processed. It is commonplace for a prisoner to be transferred from the MAP to another facility only days after first arriving. In Mr Rickard's case, he spent just the three days at the MAP before being transferred to the Metropolitan Remand Centre on 5 October 2019, two days after his episode of care was closed with BMHS, and then later to the Ravenhall Correctional Centre where he remained until released from prison.

FINDINGS AND CONCLUSION

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

    d) the identity of the deceased was Craig Geoffrey Rickard, born 10 August 1964;

    e) the death occurred on 15 January 2020 at 18 Lawrence Street, Sebastopol, Victoria, 3356;

    f) the cause of Mr Rickard's death was hanging; and

    g) the death occurred in the circumstances described above.

92. The available evidence, including the lethality of the means chosen and the nature of the text messages sent by Mr Rickard proximate to his death, supports a finding that he intentionally took his own life, likely as an impulsive act in the setting of ongoing frustration of his desire to contact his former partner despite the existence of the FVIO.

93. Risk rating classification aside, I am satisfied that the response by Mr Rickard's BCCS case manager following reports of Mr Rickard experiencing suicidal ideation was reasonable and appropriate. Relevantly, his GP was notified, and Mr Rickard was provided sound advice to attend the emergency department if his mental health deteriorated.

94. While a plan for Mr Rickard to be re-referred to the BMHS after his release from custody formed at the multidisciplinary team meeting on 3 October 2019 could not be criticised. However, there was no established mechanism for his re-referral, and it appears the BMHS were relying on Mr Rickard either self-presenting or being referred to them by his GP or other healthcare provider. When the plan was made on 3 October 2019, clinicians had no way of knowing which service/s Mr Rickard might be engaged with following his incarceration. In that setting it was not surprising that BCCS were not notified of the BMHS discharge plan for re-referral.

95. That said, it is clear Mr Rickard knew how to access public mental health treatment as he had done so in the past, and was advised to do so by his BCCS case manager shortly prior to his death.

96. The available evidence does not support a finding that there was a causal relationship between the deficiencies in the discharge planning and Mr Rickard's death or that Mr Rickard's outcome would have been different had he re-engaged with BMHS after his release from custody.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comment:

1. Mr Rickard's death highlights the vulnerability of recently released prisoners and the difficulties they encounter upon their release from custody.

2. It is no secret that a significant number of offenders involved with the criminal justice system have complex mental health needs that coincide with periods of incarceration. In Mr Rickard's case, his incarceration in 2019 was preceded by multiple mental health presentations to the Ballarat Base Hospital ED within a short period of time. It is unlikely that a relatively short period of incarceration would alleviate mental health issues of such intensity. In Mr Rickard's case, it is self-evident that he remained at risk of deliberate self-harm or suicide.

3. In a statement dated 15 November 2023, Dr Lalitha confirmed that Grampians Area Mental Health do not have any policies/procedures/protocols/guidelines concerning mental health patients whose management is interrupted by episodes of incarceration. There was also no policy was in place at the relevant time of Mr Rickard's involvement with the service.

4. Although I am not satisfied that a causal connection exists between the sub-optimal discharge planning at BMHS and Mr Rickard's death, the failures appear symptomatic of a lack of guidance for clinicians regarding the management of mental health patients who are also involved with the criminal justice system.

5. I therefore <u>invite, without formally recommending, that Grampians Health considers implementing a framework for mental health patients whose management is interrupted by episodes of incarceration, and how best to re-engage with such patients on release from custody.</u>

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

PUBLICATION OF FINDING

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:

Leah Rickard, senior next of kin

Justice Assurance and Review Office

Ballarat Community Correctional Services

Grampians Health (formerly Ballarat Health Services)

Tristar Medical Group

Constable Jack Hughes, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date : 15 April 2024

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.