IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court reference: COR 2013 3056

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**DERMOT MICHAEL O'TOOLE**
Delivered on:	8 June 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	16 February 2017
Counsel assisting the Coroner:	Senior Sergeant Sharon Wade
Representation:	Dr I. Freckelton Q.C. and Mr L. Brown, for Corrections Victoria Ms C. Willshire, for the O'Toole family
Catchwords:	Homicide, offender on a parole order at the time of offence

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HER HONOUR:

BACKGROUND

1. Dermot O'Toole (**Mr O'Toole**) was 64 years old at the time of his death. He was devoted to his wife of 41 years, Bridget O'Toole (**Mrs O'Toole**). Mr and Mrs O'Toole were both born in Ireland and had been childhood friends and Irish dance partners. After marrying in 1972, they emigrated to Australia.

2. Mr O'Toole was a loving father to his three sons, Christian, Trent and Dale, and was never happier than when he was with his family. He was an adoring grandfather to three grandchildren and he was looking forward to the imminent birth of his fourth grandchild at the time of his death.

3. Mr O'Toole was a hardworking, kind and decent man who lived life to the fullest. He had a wonderful sense of humour and infectious laughter. Mr O'Toole had faced a number of serious health problems in his later life, with courage and determination.

4. Mr O'Toole was a qualified jeweller by trade and loved making beautiful jewellery. In 1983, he began his own jewellery business, eventually known as 'the Jewel Shed', in partnership with his wife. Mr O'Toole initially made his jewellery in an old tin shed at the back of their home, to be sold at markets. However, the business became successful enough for them to move into premises in Hastings. Mr O'Toole was described as devoted to the Hastings community, his customers and to his business.

5. At the time of his death, Mr and Mrs O'Toole had planned on working for a few more years, before retiring and travelling around Australia in a caravan.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Mr O'Toole's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[1]

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the

[1] Section 4 *Coroners Act 2008*
[2] Section 89(4) *Coroners Act 2008*

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.[3] 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 expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

10. For coronial purposes, the phrase "*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 Court's "*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 *Briginshaw* v *Briginshaw*.[4] 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.

[3] *Keown v Khan* (1999) 1 VR 69
[4] (1938) 60 CLR 336

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

14. On 16 July 2013, Mr John Madden visually identified Mr O'Toole's body as being that of his friend, Dermot Michael O'Toole, born 7 June 1949.

15. Identity is not in dispute in this matter and therefore requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

16. On 13 July 2013, Dr Heinrich Bouwer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr O'Toole's body. Dr Bouwer provided a written report, dated 7 November 2013, which concluded that Mr O'Toole died from a stab wound to the chest.

17. Dr Bouwer commented that Mr O'Toole had a number of superficial cuts and bruising and that there was no significant natural disease that may have caused or contributed to his death.

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

18. At lunchtime on 12 July 2013, Gavin Perry (**Mr Perry**) attended the Jewel Shed with his then partner. He spent approximately five minutes in the store, requesting an appraisal of a pair of his partner's earrings and was served by Mrs O'Toole. As he left, Mr Perry took certain actions to ensure he did not leave any fingerprints at the store.

19. Shortly before 5.00pm that day, Mr Perry re-entered the Jewel Shed. This time, Mr Perry was wearing a hooded sweatshirt, with the hood pulled up over his head, and dark sunglasses. He produced a large carving knife from inside his tracksuit pants and pushed through a hinged gate that separated the staff area from the rest of the store. He moved to grab a pad containing toe rings from behind the counter.

20. Mrs O'Toole saw what Mr Perry was attempting to do and tried to stop him. He started struggling with her, moving out into the customer area. Mr O'Toole rushed to protect his wife, moving toward Mr Perry, who then pushed Mrs O'Toole out of the way and struggled with Mr O'Toole. During the struggle, Mr O'Toole fell onto his back. Mr O'Toole immediately got back up to help his wife, following Mr Perry and Mrs O'Toole into the customer area.

21. Mr Perry scuffled some more with Mrs O'Toole, before stabbing at her and pushing her backward, into a glass cabinet. He then pushed Mr O'Toole again, who slipped over onto his

back. Mr O'Toole put his feet up toward Mr Perry, in a defensive manner. Mr Perry then moved around to Mr O'Toole's left shoulder area, and stabbed him twice in the upper chest with the knife.

22. Mr Perry then struggled further with Mrs O'Toole, making stabbing motions with the knife toward her midriff while pushing her to the ground. He then fled the store.

23. Mr O'Toole briefly got to his feet, before collapsing on the floor. A number of people rushed to his aid and tried to resuscitate him, but he could not be revived and died at the scene.

REQUEST FOR AN INQUEST

24. On 10 December 2015, Mrs O'Toole wrote to the Court requesting that the then State Coroner, Judge Ian Gray, hold an inquest as part of the investigation into her husband's death. Mrs O'Toole stated that there were, in the O'Toole family's view, serious issues specific to Mr O'Toole's death which could not be addressed by findings in other investigations into deaths that were caused by persons who were on parole at the relevant time.[5]

25. In a letter to the Court, Mrs O'Toole stated that, in her view, the following matters were relevant to the investigation and required an inquest to be held, *viz*:

    (a) that Mr Perry had both an extensive criminal history and history of breaching parole orders and committing violent crimes while on bail;

    (b) that Mr Perry had multiple positive drug tests and engaged in standover behaviour while incarcerated;

    (c) that Mr Perry was assessed as being at high risk of reoffending only one month prior to his release on parole, but was released on the earliest possible date that he became eligible for parole;

    (d) that Mr Perry was released on parole despite not having completed the recommended High Intensity Violence Intervention Program (**VIP**), which was recommended late in his period of incarceration;

[5] The former State Coroner Judge Ian Gray had previously determined not to hold an inquest into Mr O'Toole's death as His Honour considered that the relevant parole matters, including the recent major reforms to the Victorian Adult Parole System, had been dealt with in the investigations into the deaths of Gillian Meagher, Sharon Siermans and Sarah Cafferkey

(e) that Mr Perry did not have a parole condition requiring him to undergo drug or alcohol testing, despite a history of drug abuse;

(f) that Mr Perry was identified by Community Corrections Services (**CCS**) as a Serious Violent Offender (**SVO**) and allocated to 'Stream B', meaning that he had less monitoring than a 'Stream A' offender. Mrs O'Toole requested a review and analysis of this decision;

(g) that Mr Perry changed residential address during his parole and Mrs O'Toole sought clarification as to whether or not the Adult Parole Board (**the Board**) had approved this address change;

(h) that Mr Perry missed a weekly supervision meeting on 13 June 2013 and failed to substantiate his absence, which had been deemed "*unacceptable*". Despite this, 12 days later, Mr Perry's parole supervision frequency was reduced from weekly to fortnightly; and

(i) that after Mr Perry failed to attend supervision on 9 July 2013, his parole supervision meeting was rescheduled to occur one week later, on 16 July 2013. Mrs O'Toole sought an explanation as to why Mr Perry was not rescheduled to attend a parole supervision meeting within 48 hours, as is the requirement for SVOs. Mrs O'Toole expressed the view that, had Mr Perry been required to attend a parole supervision meeting on 11 July 2013, it may have changed the course of events which led to Mr O'Toole's death the following day.

26. Judge Ian Gray retired from the Office of State Coroner on 18 December 2015 and I took over the investigation into Mr O'Toole's death when I commenced in the role of the State Coroner in January 2016.

27. In April 2016, the Court sought an additional statement from Corrections Victoria (**Corrections**), to respond to the issues identified by Mrs O'Toole in her request for an inquest.

28. On 15 July 2016, the Victorian Government Solicitors Office (**VGSO**), legal representatives for Corrections, provided a response to the Court, including an additional statement by Mr Roderick Wise (**Mr Wise**), the Deputy Commissioner of Operations, who is responsible for overseeing Victoria's prison system. Mr Wise's statement set out the legislative and policy reforms that were introduced in Victoria since 2014, changes which, it was asserted by Corrections, addressed Mrs O'Toole's concerns regarding the parole system in place at the time

of Mr O'Toole's death. The VGSO raised no objection to an inquest being held in this matter, but noted that the parole system in place in 2013 and the reforms to that system, which were introduced in direct response to the tragic deaths of Mr O'Toole and others, were explored at length in the 2015 inquest into the death of Sarah Cafferkey.[6][7]

29. On 2 November 2016, I notified Mrs O'Toole that I intended to hold an inquest into her husband's death.

SCOPE OF THE INQUEST

30. Prior to the commencement of the inquest, I held a Directions Hearing on 15 November 2016. I granted leave for the following interested parties to be represented at the Inquest:

    (a) Mr O'Toole's family, represented by Shine Lawyers; and

    (b) Corrections, represented by the VGSO.

31. In setting a scope of hearing for the Inquest, I took into account:

    (a) the extensive information provided to the Court in the Sarah Cafferkey matter, together with the additional information which had been provided by Mr Wise in response to questioning from the Court in this matter; and

    (b) the fact that the Adult Parole System has changed dramatically since Mr Perry was granted parole

32. In those circumstances, the following scope of issues (**scope**) was proposed for examination during the Inquest:

    (a) consideration of the effectiveness of the suite of assessment tools presently used by Corrections for the assessment and management of the risk of recidivism by offenders;

    (b) whether Corrections recommendations regarding the granting of parole to a particular prisoner are reflected in the Board's decisions;

    (c) an examination of the system for imposition of drug and alcohol testing conditions on serious violent offenders with a history of drug and alcohol abuse, when they make an application for parole;

[6] Letter from VGSO to Ms Mullen, dated 15 July 2016
[7] COR 2012 4886

(d) an examination of the system for enforcing attendance at supervision by parolees; and

(e) what audit processes are in place to ensure that the system for supervision and management of parolees is working in practise?

33. Submissions were made concerning the scope of the inquest at the directions hearing.

34. The legal representatives for the O'Toole family sought to expand the scope to include the individual circumstances of Mr Perry's 2013 grant of parole and his management and supervision while on parole.

35. As the matters proposed by the family encompassed an examination of the previous Adult Parole System rather than an examination of the way in which the Adult Parole System is presently working, I determined not to expand the scope to include those matters.

THE EVIDENCE

36. On 16 February 2017, I conducted an inquest into Mr O'Toole's death. Senior Sergeant Sharon Wade of the Police Coronial Support Unit appeared to assist me. Dr Ian Freckelton QC with Mr Liam Brown, appeared on behalf of Corrections. Ms Christine Willshire appeared on behalf of Mr O'Toole's family.

37. Mr Wise was the only witness called at the inquest.

The effectiveness of the suite of assessment tools now used by Corrections

38. Mr Wise gave the following evidence to the Court in relation to this matter:

(a) Since January 2015, Corrections has been using the Level of Service Intervention tools (**LS tools**) for Parole Suitability Assessments (**PSA**) and case management purposes;[8]

(b) the LS tools replaced the Victorian Intervention Screening Assessment Tool (**VISAT**). Mr Wise said that the LS tools "*take more cognisance of dynamic risk factors and environmental and situational type risk factors than the VISAT did*;"[9]

(c) the LS tools include a screening version tool (**SV tool**), which is completed at the commencement of the prison sentence. Also available is a '*Risk, Needs and Responsivity*' tool (**RNR tool**), which, unless a prisoner is rated as low risk, is administered to all

[8] Transcript of inquest into the death of Dermot O'Toole, p8
[9] T9

offenders upon their entering the prison system,[10] and again shortly after any release on parole;[11]

(d) the RNR tool takes account of dynamic risk factors and environmental and situational risk factors, which is why it is considered useful for case management. Corrections also presently uses a '*Risk of Harm Matrix*' as part of the assessment process.[12] Devised in-house by Corrections,[13] this tool aims to identify risks which might otherwise be overlooked by the other tools in the suite:[14]

> "*We knew that there had been cases where people who had been convicted of very serious crimes had come up on our risk scales as being of low risk and the risk of harm matrix tried to bring that into some perspective*…"[15]

(e) the LS tools are applied to prisoners coming into custody and offenders coming into Community Correctional Services (**CCS**);[16]

(f) the tools not only give Corrections an indication of the risk of general reoffending, but also highlight some areas of criminogenic need that should be addressed through case management during the offender's time in custody or on a Community Correction Order or parole;[17]

(g) the LS tools have been used extensively in North America and other Australian states for many years and have been validated in those jurisdictions.[18] Corrections is "*some way off*" from obtaining strong data about the predictive value of those tools in this State because the LS tools have only recently been introduced in Victoria;[19]

(h) in NSW, where the tools have been used for about ten years, they have been determined to have "*good validity*."[20] In Mr Wise' view, there is no reason to think that Victoria will differ greatly from the NSW population;[21]

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[10] T18
[11] *ibid*
[12] T9
[13] *ibid*
[14] T9-10
[15] T9
[16] T8
[17] *ibid*
[18] *supra*
[19] T11
[20] T12
[21] *ibid*

(i) to the extent that the tools have been used to date, Victorian practitioners' anecdotal feedback is that the LS tools provide good evidence on which they can structure their case management responses;[22]

(j) while the LS tools provide a level of risk of general reoffending, Corrections also applies the Violence Risk Scale (**VRS**) to violent offenders to obtain a risk assessment as to the prisoner's risk of violent re-offending;[23] and

(k) unlike the VISAT, the LS tools give significant weight to pre-detention drug-use patterns in relation to the significance of drug or alcohol abuse as part of the overall structure of risk assessment.[24]

39. Mr Wise said that the "*parole system has changed radically*"[25] in comparison with the system in place when Mr Perry was granted parole. In particular, Mr Wise said that Mr Perry would now have to apply for parole before he could be considered, and that he would not have been considered for parole at all, if he had not undertaken treatment for his violent offending.[26] Mr Wise's evidence was that this "*would not occur now*."[27]

40. Mr Wise had "*no doubt*" that Mr Perry would have been assessed as being at high risk of re-offending under the LS tools.

41. Mr Wise said that there are far fewer offenders on parole at present. In 2012, there were close to 1800 offenders on parole. At the present time, there are significantly less than 900 offenders on parole.[28]

42. In Mr Wise' view, this decrease is partly because of the increased scrutiny which now exists, meaning that it is arguably harder to get parole under the present system. Another part of the equation is that '*return to prison*' rates have increased because of an increased response when parolees breach their parole conditions. However, he said that by far the biggest factor in the decrease in persons in the community on parole, is because Courts are handing down far fewer sentences with parole as a component.[29]

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[22] T11
[23] T18
[24] T17
[25] T14
[26] T14-15
[27] T15-16
[28] T22
[29] T23

43. I accept that Mr Wise's evidence indicates that the LS tools, in combination with the additional tools that Corrections use including the VRS and the Risk of Harm Matrix, are a significantly improved suite of tools which provide a much more rigorous assessment of an offender's real risk level. In particular, I note that the new suite of tools takes into account the risk posed by pre-detention drug use.

Are Corrections' recommendations reflected in Adult Parole Board decisions?

44. Mr Wise gave evidence that, anecdotally, there is a high degree of alignment between Corrections recommendations as to whether parole should be granted to a particular offender and the Board's decision in relation to that offender.[30] He said that this was particularly so for violent offenders.[31]

45. Mr Wise stated that Corrections and the Board had a very solid relationship and that the Board had access to all relevant Corrections documents in relation to a parolee, when determining whether or not to grant parole and whether to impose any conditions on the grant of parole.[32]

46. Mr Wise indicated that the Board is often in possession of additional information, which Corrections does not have access to, such as victims' submissions, letters from the parolee's family members and Victoria Police intelligence material.[33] The principal reason that Corrections does not have access to this material is that it is generally gathered by the Board sometime after Corrections makes its recommendation in relation to a particular case.[34]

47. The Board may also call an offender in for an interview, whether by video link or in person. It can also request any further information that it might wish to consider prior to making its decision.[35] Mr Wise said that all of these pieces of information are taken into account when considering whether to grant parole to a particular offender.[36]

48. I accept that the evidence indicates that there is, at the present time, no relevant lack of communication between the Board and Corrections which would lead to any concern that parole is being granted to an offender in circumstances where it ought not be.

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[30] T36
[31] *ibid*
[32] T37
[33] *ibid*
[34] *supra*
[35] *supra*
[36] T36

The system for imposition of drug and alcohol testing conditions on the parole orders of Serious Violent Offenders

49. As set out above, Mr Wise gave evidence that the new LS tools give significant weight to pre-detention drug-use patterns, regarding the significance of drug or alcohol abuse as part of the overall structure of risk assessment in relation to a particular offender.[37] By comparison, he acknowledged that under the VISAT tool, "*a lot of weight"* was given to Mr Perry's *"performance in prison over the previous 12 months*."[38]

50. He said that mandatory drug testing is currently a condition on approximately 60% of parole orders.[39]

51. Mr Wise said that drug testing poses some practical issues in its effectiveness as a condition on a parole order, citing for example the disruption it may pose to a parolee's employment (which is a protective factor in relation to reoffending) and the pragmatic problem of finding available appointments at collection centres combined with the ability of parolees to attend any such appointment at short notice.[40] However, Corrections also accepted that it needs to give further consideration to random drug testing and conducting spot checks for parolees "*because drug use is such a significant criminogenic risk factor*."[41]

52. Mr Wise said that if Mr Perry had been considered for parole under the present regimen, a testing condition would have been applied to his parole.[42] However, he also noted that if there had been any suggestion that Mr Perry was using drugs, in 2013, the Leading Community Corrections Officer (**LCCO**) had the power to write to the Board to request that a testing condition be added to his parole order.

53. His evidence on this point highlighted what in my view, amounts to a significant gap even in the present system, namely, that to the LCCO, Mr Perry had "*presented well throughout his supervision sessions and certainly didn't appear to be using drugs…*."[43]

54. It was put to Mr Wise that Mr Perry was clearly using drugs in the weeks prior to Mr O'Toole's death, even though he might not have appeared to those assessing him to be doing so. He acknowledged the truth of this fact.[44]

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[37] T17
[38] T34
[39] T23
[40] T30
[41] T48; Corrections Victoria submission, paragraph 11
[42] T31
[43] T28

55. When asked about his views in relation to this matter, Mr Wise agreed that drug testing gives more information, but stated that parole officers and LCCOs are "*very used to seeing people under the influence (of illegal substances).*"[45] He stated that drug use usually manifests itself not just through the parolee's appearance, but also, for example, their reliability.[46]

56. Mr Wise noted that Mr Perry's LCCO had the drug and alcohol portfolio within her office and was very familiar with people who were using drugs.[47] The LCCO was also the liaison point for working with the service agencies that deal with drug use and was therefore experienced in detecting drug use.[48] It is an incontrovertible fact that despite her level of experience and specialist drug and alcohol knowledge, Mr Perry's LCCO detected nothing untoward in Mr Perry's conduct or presentation prior to him murdering Mr O'Toole.

57. In his finding into the death of Sarah Cafferkey, Judge Gray noted that Steven Hunter (**Mr Hunter**) was using drugs and had admitted exposure to drug use through associates during his parole period. Judge Gray commented that "*(Mr) Hunter's case workers were overly prepared to accept his self-assessment of his progress on parole. They did not bring sufficient rigor or scepticism to the task. (Mr) Hunter was able to play the system.*"[49] This appears to have been the case, at least in part, in relation to Mr Perry's drug use. Mr Perry, a seasoned drug user, was able to hide his substance abuse from his parole officer, a LCCO whose area of expertise was drug and alcohol use detection.

58. Submissions put on behalf of the O'Toole family included that there was a defect in the parole system that relied upon the observations of a parolee's "*apparent*" drug use. Their submission quoted Judge Gray's finding into the death of Sarah Cafferkey's reference to over-reliance on self-reporting of parolees.[50]

59. I agree with the submissions put on behalf of the O'Toole family in relation to this matter. I note that Mr Wise acknowledged, and Corrections accepted, that further consideration should be given to implementing random drug testing and spot checks for parolees[51] and I deal with this matter at the conclusion of this finding.

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[44] *ibid*
[45] *supra*
[46] T29
[47] T29
[48] *ibid*
[49] Finding into the death of Sarah Cafferkey, paragraph 339
[50] Submissions on behalf of the O'Toole family, dated 3 March 2017, paragraph 3.4
[51] T48; Corrections Victoria submission, paragraph 11

The system for enforcing attendance at supervision by parolees

60. Mr Wise gave evidence that under the present system, once a prisoner is granted parole, the RNR tool is required to be completed within four weeks of the commencement of parole.[52] In most cases, this will be the second time that particular assessment tool has been applied to a prisoner.[53] Its application at this stage "*takes into account changes in circumstances and environment*."[54] In relation to this improvement to the system, Mr Wise said:

> "*It might be, for example…that a prisoner gets out with solid protective factors around them and a family home to go back into, a relationship, all of the those sorts of things that are normally associated with someone being able to reduce their risk of reoffending, but within a very short time that can change….they can have… fights or arguments. They can lose the stable accommodation…the LS-RNR will give us a…much more flexible, quick understanding of how that risk might be escalating. And we hope through our case management of the offender in the community…we would pick up on that escalation of risk*."[55]

61. Mr Wise said that similar to the old system,[56] under the present system of parole, the Board would normally require an intensive regimen of reporting for supervision a couple of times per week.[57] A prisoner might also be required to be involved in community work, or to complete work books and a "*range of other things*."[58] He said:

> "*We find that prisoners who've come from a very structured environment inside prison very often struggle to deal with that freedom that they've got in the community, and so putting a large degree of structure around their days can be of great assistance*."[59]

62. Mr Wise explained that a significant change in the system is that violent offenders are now managed exclusively by Senior Parole Officers who only deal with parolees (as opposed to a range of parolees and also those on community corrections orders).[60] The caseload of these officers has reduced significantly (from about 50 cases before the introduction of the new system, to about 10 cases presently).[61]

63. The great advantage of the new system is that violent offenders are now being supervised by parole officers who are more senior, more experienced and more skilled.[62] This, together with

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[52] T19
[53] *ibid*
[54] *supra*
[55] T20
[56] T21
[57] T20
[58] *ibid*
[59] *supra*
[60] T21-22
[61] *ibid*
[62] *ibid*

the reduced caseload, means that they can concentrate on closely supervising their parolees, and are in a position to double-check important matters particular to that parolee, through conducting home visits and undertaking other activities.[63] All of this gives a far better picture of the parolee's true situation.[64]

64. In addition to the advantages of the new system outlined above, Senior Parole Officers (**SPOs**) are supervised by a Principal Practitioner, who does not usually have a caseload of their own. These Principal Practitioners are available to provide "*a sort of consultant's advice*" to the SPOs and also engage in formal supervision of the SPO's caseload, to identify issues with case management and to offer solutions.[65]

65. When questioned about Mr Perry's failure to attend supervision appointments, Mr Wise said that Corrections staff are "*much more likely to put in a report to the (Adult) Parole Board if someone is showing a pattern of non-attendance or failure to attend or failure to comply with the conditions of their parole order*"[66] and that they are presently "*more likely to do that earlier than they were back in 2012/13*."[67]

66. Mr Wise acknowledged that Mr Perry's history demonstrated two instances where he had failed strictly to comply with his parole conditions in relation to attendance at supervision meetings.[68]

67. He said that Corrections "*would normally expect a pattern to be evident*"[69] or if not a pattern, sufficient frequency of absences that the parole officer "*might have spoken to the parolee and indicated that further absences without a reasonable excuse will result in us reporting their circumstances to the Board.…*"[70] He said that Mr Perry:

> "*hadn't reached that stage. He had attended reasonably steadily and where he had not attended he made up the time…there was no evidence of which I'm aware that he was avoiding his obligations.*"[71]

68. Mr Wise gave evidence that what a SPO needs to be aware of is a pattern of "*disengagement*," giving a picture that this person may not be suitable to be able to be given the trust to reintegrate into the community.[72] He said that "*if there was a suspicion that he was involved in*

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[63] T22
[64] *ibid*
[65] *supra*
[66] T24
[67] *ibid*
[68] *supra*
[69] *supra*
[70] T25
[71] *ibid*
[72] T25-26

wrongdoing or that he was avoiding supervision for some other reason then we would take action much more quickly."[73]

69. Mr Wise also said that he would expect an SPO to take action very quickly if they "*know that a particular offender is more liable to offend under certain circumstances and you see those circumstances*."[74]

70. Mr Wise confirmed that Mr Perry failed to attend a parole supervision meeting on 13 June 2013, four months into his parole period, asserting that he had work commitments. He gave evidence that Mr Perry had failed to provide any documented evidence of having worked on that day and because of that, his absence was deemed '*unacceptable*.'[75]

71. Approximately one month later, Mr Perry failed to attend a parole supervision meeting on 9 July 2013, stating that he was ill.[76]

72. Mr Wise said that apart from these two absences, Mr Perry had otherwise, "*presented well throughout his supervision sessions and certainly didn't appear to be using drugs and so those non-attendances were essentially the extent of his non-compliance.*"[77]

73. Mr Wise gave evidence that, in 2013, the relevant Deputy Commissioner's Instruction (**DCI**) to parole officers ('*DCI 8.2 Case Management – Parole*') was ambiguous about what should happen if a parolee missed a supervision appointment without an adequate explanation.[78] Corrections submitted that that ambiguity now been remedied.[79] Mr Wise stated that a missed appointment must be rescheduled and occur within 48 hours of the missed appointment.[80] If the appointment is rescheduled within 48 hours and the parolee fails to attend, it is deemed to be an '*unacceptable absence*.'[81] Further, DCI 8.2 now requires that where there is non-compliance with parole reporting, the relevant SPO (for SVOs) must discuss the issue with the Principal Practitioner, as it is recognised that this behaviour may be indicative of an avoidance strategy or escalation in the parolee's risk of harm to others.[82]

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[73] T25
[74] T26
[75] T28
[76] *ibid*
[77] *supra*
[78] T40
[79] Corrections Victoria submission, paragraph 16
[80] Statement of Rod Wise, dated 15 July 2016
[81] *ibid*
[82] Above n 81, paragraph 16

74. Non-attendance at supervision appointments may result in further intervention such as an initial compliance review or a final compliance review.[83] The Board may be advised of a problem by way of a 'risk and compliance report' and Corrections may recommend that action be taken, including:

    (a) a warning;

    (b) the parolee being summoned to appear before the Board;

    (c) a variation of conditions, for example placing the parolee on electronic monitoring; or

    (d) cancellation of parole.

75. Mr Wise said that Corrections can also send a formal written direction to attend supervision at any time.[84]

76. I accept this evidence. I note that the above changes, along with the Adult Parole System reforms that require community safety to be prioritised above all other considerations, have led to a reduced tolerance for a parolee's failure to comply with parole conditions and an increase in reports to the Board and recommendations for altered parole conditions or parole cancellation.

77. The O'Toole family submitted that it was unclear whether a parole officer's decision to reduce a parolee's supervision requirements (in Mr Perry's case, from weekly to fortnightly) could potentially happen under the new parole system. However, I consider that this concern was also addressed in the focus shift in the Adult Parole System reforms and the parole supervision practice reforms, such as those mentioned above.

78. Corrections submitted that they, along with the Board and the Victorian Government, are committed to assessing the extent to which the various reforms to the Adult Parole System have reduced the level of risk to the community.[85] Accordingly, Corrections has engaged Deloitte to evaluate the Adult Parole System reforms implemented since the Callinan Review. An interim report is due by the end of 2017.[86]

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[83] *ibid*
[84] *supra*
[85] Above n 81, paragraph 17
[86] *ibid*

Audit activities to ensure that the system is working in practise

79. Mr Wise told the Court that Corrections is conducting a four-stage review of the effectiveness of the LS tools.

80. Corrections is currently conducting a review of approximately 1000 completed risk assessments, to "*make doubly sure*" that they have been scored correctly.[87] This is being done at an early stage to ensure that future assessments of the efficacy of the LS tools are based on information that was "*properly recorded*."[88]

81. Those assessments will then be reviewed against the end data, including any reoffending by the prisoner, to get an early indication of the LS's predictive value.[89] In its submission, Corrections stated that the "*validation process … will not be completed until 2018*."[90]

82. Mr Wise gave evidence that Corrections has also engaged KPMG to conduct a process evaluation, which will address the application of the LS tools:

> "*they will make sure…that we're applying the tool appropriately and at the…appropriate stages…that the training is appropriate and all of those sorts of issues*."[91]

83. Mr Wise said that in the longer term, the efficacy of the LS tools will be reviewed based on reoffending data.[92]

RECOMMENDATIONS PURSUANT TO SECTION 72 (2) OF THE ACT

Prisoners' health and medical records

84. During questioning by Ms Willshire, Mr Wise confirmed that Corrections does not have a right of access to prisoners' health and medical records. Mr Wise stated that health records are confidential information and, while health practitioners within the system can access those records for treatment purposes, custodial and Community Corrections staff must rely on prisoner self-reporting to ascertain their health and medical history. Likewise, Mr Wise advised that a prisoner's consent is required before reports from a medical practitioner can be provided to the Board.

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[87] T13
[88] *ibid*
[89] *supra*
[90] Above n 81, paragraph 6
[91] T13
[92] *ibid*

85. Although it is clear in this case that Mr Perry had accurately reported his medical and mental health history to Corrections staff who were assessing his suitability for parole, I note that there is a risk that prisoner self-reporting may be inaccurate and therefore unreliable. Clearly, it is highly desirable that an objective record of a prisoner's medical history, including relevant drug and alcohol history, is routinely available to Corrections and to the Board.

86. As such, **I RECOMMEND** that the Minister for Corrections explore whether Corrections Victoria and the Adult Parole Board should be granted coercive powers to obtain the health and medical records of offenders, in order that they are accurately informed of all relevant matters when conducting risk assessments for parole applications.

Drug and alcohol testing

87. The submission from the O'Toole family suggested that I should make the following recommendations:

    (a) a mandatory drug testing condition should be considered for all parolees with a past significant drug history; and

    (b) random drug testing should be considered for all parolees with a past significant drug history and new (drug testing) modalities involving hair/saliva also be explored.[93]

88. Corrections submitted that recommendations were unnecessary because:

    (a) "*the system for assessment of parole suitability has been wholly revised since 2013. Under the system now in place, consideration is always given to an offender's pre-custodial drug history, especially if this is associated with his or her offending behaviour. Therefore, under the new assessment regime it can be expected that, if necessary to manage the risk of harm to the community perpetrated by a parolee, a drug testing condition will be imposed*;" and

    (b) Corrections is already evaluating new technologies and methodologies for the drug testing and will continue to do so.[94]

89. I am satisfied that Corrections has addressed the main concerns in relation to drug testing conditions being applied to the parole order of a parolee with a pre-custodial drug history. However, I consider that Corrections ought commit to ensuring that there is an objective means

[93] Above n 50, paragraph B '*Conclusion*'
[94] Corrections' Submissions in Reply to Submissions on behalf of the O'Toole family, dated 9 March 2017

of testing parolees for drug use, through the imposition of random drug testing requirements to parolees with a significant past history of drug and alcohol abuse. The introduction of this measure would reduce reliance on CCOs' observations and parolees' self-reporting, which has, unsurprisingly, been inherently and tragically unreliable.

90. The implementation of objective testing methods to support the other changes to the Adult Parole System would give the Victorian community added confidence in those changes.

91. In those circumstances, **I RECOMMEND** that Corrections give consideration to the best manner of integrating random drug testing into the supervision and reporting regime for any parolee subject to a drug and alcohol testing condition as part of their parole order.

FINDINGS AND CONCLUSION

92. Having investigated the death of Dermot Michael O'Toole and having held an inquest in relation to his death on 16 February 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Dermot Michael O'Toole, born 7 June 1949;

    (b) that Mr O'Toole died on 12 July 2013, at 35B High Street, Hastings, Victoria, from a stab wound to the chest; and

    (c) that the death occurred in the circumstances set out above.

93. I convey my sincere sympathy to Mr O'Toole's family and friends at his tragic death in 2013.

94. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

    (a) Mrs Bridget O'Toole, senior next of kin.

    (b) The Hon Gayle Tierney MP, Victorian Minister for Corrections.

    (c) The Hon Martin Pakula MP, Victorian Attorney General.

    (d) Corrections Victoria.

    (e) Adult Parole Board.

    (f) Shine Lawyers.

(g) Victorian Government Solicitors Office.

(h) Detective Leading Senior Constable Leigh Smyth, Coroner's Investigator.

(i) Detective Inspector Michael Hughes, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 8 June 2017