IN THE CORONERS COURT **Court Reference: COR 2018 2778**

OF VICTORIA

AT MELBOURNE

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of Darren Brandon

Findings of:	Simon McGregor, Coroner
Delivered on:	6 April 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006
Hearing dates:	20, 21, 22, 25, 26, 27 & 28 November, 2 & 17 December 2019
Counsel assisting the Coroner:	Mr. Shaun Ginsbourg

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I, SIMON MCGREGOR, Coroner having investigated the death of Darren Brandon

AND having held an inquest into his death on 20, 21, 22, 25, 26, 27 & 28 November, 2 & 17 December 2019

at the Coroners Court of Victoria in Melbourne

find that the identity of the deceased was Darren Brandon

born on 30 July 1966

and the death occurred on 10 June 2018.

at the Royal Melbourne Hospital in Parkville

from:

I(a) hypoxic-ischemic encephalopathy[1] due to hanging.

HIS HONOUR

Introduction

1. This is an inquest into the death of Darren Brandon, a 51-year-old man who intentionally self-harmed two nights after his first reception in custody. He was promptly rushed to hospital, where he passed away two days later.

2. **Darren**, as his family requested he be called during the inquest, was temporarily homeless, and known by those close to him to have an acquired brain injury (**ABI**) and a history of self harm. Although he had two prior convictions from around 10 years ago, he had never been in jail before. Despite the availability of free legal assistance at the Ringwood Magistrates' Court on 5 June 2018, he chose to represent himself and did not get bail.

3. The inquest hearing commenced on 20 November 2019, and ran for two weeks. The hearing focused on the information systems surrounding Darren, as it was apparent from my precursor investigation that two different professional caregivers – Raquel Stephenson, a case manager, and Emma Robertson, a mental health worker - had each identified critical information about Darren, but that these systems had not been capable of utilising that information.

[1] Commonly known as 'cardiac arrest'.

The Coronial Jurisdiction

4. Darren's death was reported to a coroner under the Coroners Act 2008 (**the Act**), both because the death appeared to have occurred as a result of an accident or injury in Victoria, and because Darren was in custody immediately beforehand.[2] His custodial status also meant that a coroner's investigation of his death must include an inquest, pursuant to section 52(2) of the Act.

5. The coronial jurisdiction plays an important role in Victorian society. The role of a coroner is to independently investigate 'reportable' deaths so as to establish, where possible, identity, the cause of death and with some exceptions, the surrounding circumstances.[3]

6. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. The surrounding circumstances that a coroner is required to investigate are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[4]

8. In exercising my functions pursuant to the Act, I must have regard to the desirability of promoting public health and safety and the administration of justice.[5]

9. The circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally related to the death.

10. Although the jurisdiction is inquisitorial rather than adversarial,[6] it should operate in a fair and efficient manner.[7] When exercising a function under the Act, coroners are to have regard, as far as possible in the circumstances, to the notion that unnecessarily lengthy or

[2] Sections 4(1), 4(2)(a) and (c) of the Act.
[3] Section 67 of the Act.
[4] In the coronial jurisdiction facts must be established on the balance of probabilities 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.
[5] *Coroners Act 2008* (Vic) preamble, s l(a)-(c), and s 8(f).
[6] Second Reading Speech, *Legislative Assembly: 9 October 2008, Legislative Council: 13 November 2008*.
[7] *Coroners Act 2008* (Vic) s 9.

protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[8]

11. In *Harmsworth v The State Coroner,*[9] Nathan J considered the extent of coroners' powers, noting they are not "free ranging" and must be restricted to issues sufficiently connected with the death being investigated. His Honour observed that if not so constrained, an inquest could become wide, prolix and indeterminate. His Honour stated the Act does *not* provide a general mechanism for an open-ended enquiry into the merits or otherwise of the performance of government agencies, private institutions or individuals. Significantly, he added:

> *Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for much comment. Such discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.*[10]

12. In *Lucas-Smith v Coroners Court of the Australian Capital Territory*[11] the limits to the scope of a coroner's inquiry and the issues that may be considered at an inquest were also considered. As there is no rule that can be applied to clearly delineate those limits, 'common sense' should be applied. In this case, Chief Justice Higgins noted that:

> *It may be difficult in some instances to draw a line between relevant evidence and that which is too remote from the proper scope of the inquiry ...[i]t may also be necessary for a Coroner to receive evidence in order to determine if it is relevant to or falls in or out of the proper scope of the inquiry.*

13. Chief Justice Higgins also provided a helpful example of the limits of a coroner's inquiry, suggesting that factual questions related to cause[12] will generally be within the scope of the inquest.

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[8] *Coroners Act 2008* (Vic) s 8.
[9] (1989) VR 989.
[10] Ibid.
[11] [2009] ACTSC 40.

12 I note that in that matter, Chief Justice Higgins was referring to the cause of a fire, however, I consider this analogous to the cause of death.

14. 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 prevention role'.

15. In pursuit of their prevention role, coroners are also empowered to:
    (a) report to the Attorney-General on a death;
    (b) 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) 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.

16. The power to comment, arises as a consequence of the obligation to make findings. It is not free ranging. It must be a comment "on any matter connected with the death". The powers to comment and make recommendations are inextricably connected with, rather than independent of, the power to enquire into a death or for the purpose of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.[13]

17. Ultimately, however, the scope of each investigation must be decided on its facts and the authorities make it clear that there is no prescriptive standard that is universally applicable, beyond the general principles discussed above. [14]

18. The broader coronial context for this specific case is that inquests identifying problems with information exchange between agencies responsible for the welfare of people in custody are regrettably not uncommon.[15]

13 *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[14] See Ruling No.2 in the 'Bourke Street' *Inquest into the deaths of Matthew Poh Chuan Si, Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel* (COR 2017 0325 and Ors), Coroner Hawkins, 23 August 2019.

[15] See *Inquest into the Death of Jason Mike Henry 0962/00* (30 August 2002), unreported, per State Coroner Johnstone, especially at p.28, where the many of the State Coroner's recommendations address similar issues to those I will make in these Findings; Exhibit AF, Victorian Ombudsman, *Investigation into deaths and harm in custody*, Victorian Government Printer, March 2014, Melbourne, at p.6.

19. Finally, it is well established at common law, and in human rights jurisprudence, that the police and custodial agencies have a positive duty to exchange information which might affect a prisoner's wellbeing.[16] The assistance extended to the court by the interested parties properly reflected this paradigm.

Scope of the Inquest Hearing

20. As part of the investigation phase of the proceeding, many facts have been considered and agreed by the interested parties, such that no additional oral evidence was required on those topics at the final inquest hearing.

21. I circulated a document setting out the scope of the remaining oral evidence required at the hearing on 20 August 2019. There was some refinement of this document, and by the commencement of the inquest hearing, the Scope document read as follows:

> 1. *Did Magistrate La Rosa have before him on 5 June 2018 all of the information that was relevant to his decision about whether Darren should be granted bail?*
> 2. *If not:*
>
> *(a) what relevant information was not before his Honour,*
>
> *(b) what prevented the information from being placed before him, and*
>
> *(c) might the information have affected the outcome of the bail application?*
>
> 3. *Which person or persons had responsibility for the obtaining of information relevant to Darren's bail application and the placing of any such information before the Court on 5 June 2018? Did that person or persons take sufficient steps to meet that responsibility?*
> 4. *...*
> 5. *...*
> 6. *As at 6 June 2018:*
>
> *(a) what was the process by which Darren's eligibility for bail could have been revisited;*

[16] *Kirkham v Chief Constable of the Greater Manchester Police* [1989] EWCA Civ 3; [1990] 3 All ER 246; *Howard v Jarvis* [1958] HCA 19, (1958) 98 CLR 177; *Zalewski and Anor v Turcarolo* [1995] VicRp 76; [1995] 2 VR 562***;*** *S v Attorney-General* [2017] NZHC 2629; *Charter of Human Rights and Responsibilities Act 2006,* sections 9 & 10.

(b) who had the power or the responsibility to initiate or assist in that process; and

(c) what impact should the information obtained by Ms Robertson have had on the commencement or continuation of that process?

7. What, if any, documents accompanied Darren as he was processed from the police cells to the Melbourne Assessment Prison (MAP).

8. ...

9. ...

10. Was the Melbourne Assessment Prison sufficiently informed about the factors that were relevant to its suicide risk assessment of Darren?

11. If not, which of the following factors, if any, prevented this from occurring:

(a) the adequacy of information about Darren's psychiatric history available on the databases accessible by Ms Robertson and Melbourne Assessment Prison,

(b) the effectiveness of data transfer and communication channels between Ms Robertson, the custodial nursing service, the Ringwood police cells and Melbourne Assessment Prison,

(c) the system used by Melbourne Assessment Prison for monitoring and reviewing Darren's suicide risk on an ongoing basis, having particular regard to the information email sent by Ms Robertson to MAP Forensicare staff on the afternoon of 7 June 2018, and

(d) any other factors?

12. Did the design of and amenities in the King Unit cell in which Darren was placed contribute to his death? If so, are there any changes that should be made in that regard that would reduce the risk of future suicides?

Factual issues highlighted by the Scope

22. I have set out above, the structure of the Act, and the scope of the initial investigation, which informed the ultimate scope of the Inquest hearing. The net effect of these filters was to require me to make findings about the following matters concerning Darren's death:

a) The medical cause of Darren's death;

b) Darren's disabilities;

c) The events that led to the police arresting Darren and seeking to remand him in custody;

d) Ms Stephenson's email prior to the remand hearing on 5 June 2018;

e) The events surrounding the remand hearing at Ringwood Magistrates' Court on 5 June 2018;

f) The subsequent communication of information contained in Ms Stephenson's email, and Ms Robertson's concerns about Darren, to persons involved in Darren's placement and care in the custodial system;

g) The events surrounding the reception psychiatric assessment at MAP on 7 June 2018;

h) The events proximate to Darren's suicide;

i) Any causal links between Darren's death and:

(i) Ms Stephenson's email and its contents not being before Magistrate La Rosa when he refused bail;

(ii) The Victoria Police Custodial Health Service's (CHS) capacity to communicate Ms Stephenson's email, its contents, or the concerns raised by Ms Robertson, to MAP staff; and or

(iii) MAP staff's placement of Darren in the King Unit cell.

The medical cause of Darren's death

23. On 14 June 2018, an autopsy was performed on Darren by Dr Melanie Archer, a forensic pathologist employed by the Victorian Institute of Forensic Medicine.

24. Dr Archer concluded that the cause of death was cardiac arrest due to hanging, which had caused irreversible damage to the brain due to lack of blood flow, otherwise known as hypoxic-ischemic encephalopathy.

Darren's Disabilities

25. Darren was born on 30 July 1966. He reached the age of 51.

26. Darren grew up in Glen Waverley, Victoria. He was the second of three children to David and Joy Brandon. His brothers were Steven and David[17]

27. Darren went to St John Vianney's Primary School in Springvale and then to Syndal Technical School in Mount Waverley. Whilst at school, Darren was assessed to have a high IQ.

28. When aged 16, Darren commenced and then completed an apprenticeship as a motor mechanic. He found a niche working with prestige European vehicles. He then opened his own auto mechanics workshop in Glen Waverley.

29. When aged 18, he met Meryl Gunn, with whom he had a son, McKenzie, in July 1997 (now aged about 22).

30. Darren's 11-month older brother Steven recalls that Darren was

> a man full of empathy; he was humorous and very, very quick witted. He was also a brilliant mechanic ….
>
> Darren was full of life, meticulous in his planning, ran a successful business and was very generous. Often he would go out of his way for people in need even if it meant he got nothing in return[18]
>
> ….
>
> Prior to the accident, Darren's character was that of a pacifist and he was often the one calming people who were getting angry.

31. Between 1998 and 1999, Darren had two appearances at Ringwood Magistrates' Court. On the first occasion, he was convicted and fined for offences including drink driving and dangerous driving. On the second occasion, he was convicted of driving whilst disqualified and unregistered driving. He was placed on a six-month Community Based Order with a condition that he perform 100 hours of unpaid community work. He had no subsequent convictions, although he was charged with domestic violence

[17] Steven Brandon 22/1/19, CB10
[18] Ibid, CB10-11.

offences in 2015 and this ultimately precipitated his being in custody at the time he died.

32. Well prior to that incarceration, Darren's life had already taken a drastic turn. On 6 April 2003, the motorbike Darren was riding in Marysville 'high sided' and threw him into an embankment. He sustained multiple fractures and a closed head injury. He was left with chronic back, knee and elbow pain, impaired balance and memory (both short and long term), and tinnitus. He became dependent on oxycodone and alprazolam.[19] He was unable to work. His relationship with Ms Gunn broke down. He was forced to return home to live with his parents and rely on TAC payments. He developed depression, resulting in repeated attempts at suicide and self-harm, and admissions as a psychiatric patient at Delmont Hospital and the Melbourne Clinic, between 2011 and 2017.[20] Darren's GP, Dr Skinner, who gave evidence at the inquest, states that Darren became socially isolated, spent a large part of the day in bed, and had few interests and low motivation.[21] Steven later explained to police that, "My brother…had a motorbike accident 12 years ago which causes him to get depressed and angry".[22] In 2015, these outbursts culminated in a family violence incident that led to Darren being charged with unlawful assault and criminal damage, detailed below.

33. In 2013, Darren was assessed by a clinical neuropsychologist, Jenny Todd. Her report noted that, since the accident, Darren had developed depression, had engaged in "three suicide attempts (reportedly cutting self, overdose and use of a gun)", self-harm, and had multiple admissions as a psychiatric patient. She reported that Darren displayed sound cognitive ability, at expected premorbid level, in verbal reasoning, visual planning and visual memory. However, she also said that

> the major difficulties noted on assessment were in very slowed, effortful processing of information, reduced verbal new learning and memory skills and reduced initiation/level of activity. It is also likely that visual reasoning and constructions skills (even though at an average to lower end of average range) are not at [the] expected level given Darren's employment background prior to his accident …. Darren's profile reflects his severe brain injury in combination with [the] effect[s] of depression, medication and pain.[23]

Ms Todd reported that Darren wanted to live independently, but that, in her opinion, he would require supported accommodation with daily attendant care, at least for the time

[19] Skinner, Exhibit E, CB1113.
[20] Dr Michael Gibbons (psychiatry registrar) 5/7/17, CB558.
[21] Skinner, Exhibit E, CB1113.
[22] CB 1032-1035.
[23] Undated report referring to assessment dates between 18/4/13 and 9/5/13, CB555.

being. She considered that the support he required included domestic tasks, and helping him keeping track of appointments.[24]

34. In 2015, TAC engaged the firm Lee Wilkinson and Associates to provide case management services for Darren. Raquel Stephenson, an employee of the firm, acted as Darren's case manager. Ms Stephenson gave evidence at the inquest and was an impressive witness. She was the first of two professionals who provided Darren with services above and beyond the usual standard, but which unfortunately the information systems surrounding Darren did not capture.

35. Ms Stephenson's role included taking him to medical appointments and helping him find alternative accommodation.[25] Ms Stephenson recalls that Darren was a very proud man who would downplay the severity of his physical and mental deficits in order to appear more independent than he actually was. He presented as very high functioning on most occasions, and he masked a lot of what was going on underneath very well.[26] He presented as very intelligent during conversation.[27] Ms Stephenson had difficulty finding suitable accommodation for Darren, however, because the TAC current funding was insufficient to pay for his own unit, and he was reluctant to live in shared accommodation.[28] She found it hard to engage with Darren, as he often refused or failed to attend assessments or appointments.[29]

36. In 2017, Darren was reviewed by a psychiatry registrar, Dr Michael Gibbons, during an approximately five-week admission to the Melbourne Clinic. The admission resulted from "a relapse in his depressive symptoms occurring [against] the background of family stressors." Dr Gibbons noted that there were no reported pre-injury psychiatric history or developmental concerns. He said that ever since the accident, Darren had

> struggled with [the] adjustment, ruminating on what he had lost, feeling guilty about potential burden to his parents and frustration around lack of improvement and being unable to navigate the care system. This despair has come out through severe depressive symptoms including episodes of suicidal ideation and attempts, as well as agitation …. Since at least [2013] he has remained on a combination of opioid pain relief and sedative mediation (Xanax, previously Phenergan). The combination of these medications has been

[24] CB1425, 1427.
[25] T51-3, 55-6, 170-1.
[26] T54-5; Stephenson 29/1/19, Exhibit A, CB16.
[27] T55.
[28] Stephenson 29/1/19, Exhibit A, CB17; T
[29] Stephenson 29/1/19, Exhibit A, CB16-18; T53-4, 56, 59, 74, 174-5.

a concern for his treating team but attempts made to reduce them have been unsuccessful through sessions with [an] addictions specialist.[30]

37. Dr Gibbons reported that a family meeting was held during his admission. It was clear that Darren's family was in crisis. His father had been in hospital for the last two months as a result of a stroke, and had been left with severe deficits. His mother was struggling to cope. Darren described ongoing guilt around the burden he placed on his family. Dr Gibbons recommended against a discharge to his family home on the basis that it would adversely impact on his mental state. However, it seems that alternative accommodation options were not then available.[31]

38. Dr Gibbons also noted that in the last week of Darren's stay at the Melbourne Clinic, he became more irritable, part of which was due to his frustration around planned medication changes, which he felt had worsened his pain. He recommended that any changes to Darren's pain medication be carefully managed.[32]

39. On 7 September 2017, whilst Darren's father was still in hospital, his mother fell down the front stairs of her house and died. His father was subsequently moved to a nursing home. The family home was placed on the market and sold. Darren left the house reluctantly after the locks were changed, and he had spent a period living in the back yard of the property as recently as April 2018.[33] His accommodation was unstable throughout May 2018.[34]

40. During this period, in March 2018, Ms Stephenson was directed by TAC to apply to VCAT, on Darren's behalf, for the appointment of a guardian. The application was for a limited order that would empower a guardian to make decisions about accommodation and access to services on Darren's behalf. The application was made as a last resort. Darren had become resistant to Ms Stephenson's efforts to place him in supported accommodation after he had lost the option of living with his parents, and the TAC were concerned that Darren would become homeless. Ms Stephenson doubted it would have any impact on Darren's life because he was a "free spirit" who did what he wanted. His ultimate goal was to live by himself, but Ms Stephenson considered

[30] Dr Michael Gibbons (psychiatry registrar) 5/7/17, CB558, 563.
[31] Dr Michael Gibbons (psychiatry registrar) 5/7/17, CB561.
[32] CB561-3.
[33] TAC file case note by Emma Flannery dated 05/04/18, of a phone call from Darren's case manager, Raquel Stephenson, CB480-81.
[34] See TAC file notes by Emma Flannery dated 09/05/19, CB406-415.

that despite this goal, he needed supported accommodation.[35] The VCAT application was still outstanding at the time of Darren's death.[36]

Darren goes missing

41. On 28 May 2018, Darren commenced a 10-week residential rehabilitation program at the Epworth Hospital's Transitional Living Centre (TLC) in Thornbury. The aim of the program was to equip Darren with the skills necessary to live independently.[37] Darren, however, left TLC on 3 June 2018, apparently dissatisfied with the accommodation. TLC later reported to Ms Stephenson that Darren had been quite angry that they were not providing him with the same medication that he had been taking beforehand.[38]

42. TLC staff reported Darren as a missing person to Preston Police Station. Ms Stephenson said that on 5 June 2018, Senior Constable Kavanagh, an officer from Preston Police Station, contacted Ms Stephenson and told her about the report.[39] Ms Stephenson said she had two phone conversations with Senior Constable Kavanagh that day. Senior Constable Kavanagh also informed Ms Stephenson that police had a warrant for Darren's arrest because he had missed a court date. Senior Constable Kavanagh advised her that it would be less embarrassing and confronting for Darren if she brought him to the local police station to have these matters cleared up.[40] They agreed that Ms Stephenson would take Darren to Knox Police Station because that was closer. Senior Constable Kavanagh undertook to contact Knox Police Station and tell them to expect Darren.[41] She told Ms Stephenson that police would "reschedule" the court date. She told Ms Stephenson during both phone calls that Darren was not in trouble with the police and said nothing to indicate that Darren would be arrested or taken into custody. This led Ms Stephenson to believe that Darren would be free to leave the police station after he had attended with her.[42]

43. Prior to this phone call, Ms Stephenson knew nothing about the domestic incident in October 2015 other than that it had involved an altercation between Darren and Steven,

[35] T57.
[36] T58-9.
[37] Discharge Report dated June 2018, CB322-4.
[38] T661-662.
[39] I did not require S/C Kavanagh to give evidence, as these are simply background circumstances. Accordingly, Stephenson's version of the conversation was never tested by being put to Kavanagh. None of this background represents any criticism of Senior Constable Kavanagh's actions.
[40] Stephenson 29/1/19, Exhibit A, CB17.
[41] T72-3.
[42] T63, 66, 158, 172.

and had given rise to an intervention order. She did not know that a criminal proceeding remained outstanding.[43]

44. Ms Stephenson found Darren at the Knoxfield shops with Steven and his cousin. She asked him to come with her to the police station, so that they could sight him and remove him from the missing persons list. She also told him that there was a "warrant out as well".[44] Darren agreed to go with her. She took Darren to Knox Police Station.[45] Police then executed a Magistrates' Court bench warrant on Darren that had been issued on 24 May 2018, in the circumstances set out below. The police took Darren to the Ringwood Magistrates' Court and applied for him to be remanded in custody. The Court hearing, at which Darren was remanded, and the events leading up to his placement in the King Unit cell of the Melbourne Assessment Prison (MAP) on 8 June 2018, are described below.

The backstory behind Darren's arrest and remand

45. The above recitation of the events leading up to Darren's arrest captures the suddenness, in Ms Stephenson's eyes, with which this all happened to her client. However, as I alluded to above, these events had actually been in train for some years, unbeknownst to her.

46. On 16 October 2015, Darren had an argument with his brother Steven at their parents' Glen Waverley home, during which Darren became violent. Steven had earlier come to the house and changed the locks in order to prevent Darren from locking him out. Darren had done this previously. Steven intended that both he and his brother would have a key. Steven's attendance nonetheless led to an argument with Darren. During this argument, Darren threw a merchant's EFTPOS terminal from the family business against a fridge, hit Steven on the head with a garden shovel, tried to stab him with a pair of garden shears, and smashed a window with a crowbar.

47. Steven called the police, who came to the house and arrested Darren. They took a written statement from Steven in which he expressed serious concern for his safety.[46] Steven told police that Darren had had a motorbike accident 12 years earlier which

[43] T74-6.
[44] T74.4-5.
[45] T73-4.
[46] Steven Brandon 16/10/15, CB1032-1034.

caused him to get depressed and angry.[47] Police took Darren to Glen Waverley Police Station and interviewed him. He did not make admissions. He was served with a Family Violence Safety Notice requiring him to appear at Ringwood Magistrates Court on 20 October 2015.

48. On 20 October 2015, Darren attended Court. The Court made an interim Family Violence Protection Order returnable on 14 December 2015.[48] On 14 December 2015, the Court made a 12-month final FVPO. Neither Steven nor Darren attended Court.[49]

49. Meanwhile, the separate criminal investigation progressed. On 26 April 2016, after some delays in the authorisation of the brief,[50] Leading Senior Constable Dale Annesley filed a charge sheet and summons requiring Darren to attend Ringwood Magistrates' Court on 26 October 2016 to answer the following charges arising from the incident on 16 October 2015 –

    a) intentionally damage property (two charges),
    b) unlawful assault with a weapon (two charges),
    c) unlawful assault, and
    d) wilful damage.

50. On 28 April 2016, L/S/C Annesley personally served the charges on Darren at his parents' home. L/S/C Annesley had no further contact with Darren.[51]

51. On 26 October 2016, Darren failed to appear despite his summons. Magistrate La Rosa issued a warrant for his arrest.[52]

52. On 18 March 2017, Darren was arrested and bailed to appear on 22 September 2017.[53] On 22 September 2017, about two weeks after his mother's death, Darren failed to answer bail. Magistrate Clifford issued a warrant for his arrest.[54]

53. On 11 November 2017, Darren was arrested and bailed to appear on 8 May 2018.[55] On 8 May 2018, Darren failed to appear. Magistrate Walsh issued a warrant for Darren's

[47] Ibid, CB1032.
[48] Certified Extract in Case F1356352, Ex H
[49] Steven Brandon 22/1/19, CB12.
[50] Annesley 11/6/19, Exhibit F, CB1121.
[51] Ibid, CB1122.
[52] [176].
[53] [177]-[178].
[54] [179].
[55] [180]-[181].

arrest.[56] TAC file notes record that Darren's accommodation was unstable at that point and that he met with Ms Stephenson that afternoon to discuss placement at a supported accommodation facility.[57]

54. On 21 May 2018, Darren was arrested and bailed to appear on 24 May 2018.[58] Yet again, Darren failed to appear on bail on 24 May 2018. Magistrate McGrane issued a warrant for Darren's arrest. TAC file notes record that Darren was at this stage living in his car and had been evicted from the car park outside his father's nursing home about three days earlier.[59] Meanwhile, Ms Stephenson was in the process of arranging for Darren to be admitted to TLC, as set out above.

55. On Friday, 5 June 2018, at about 12:30pm, Ms Stephenson took Darren into the foyer of Knox Police Station. Darren had agreed to come with Ms Stephenson to the police station after she had told him that police needed to sight him.

56. Senior Constable Thomas Walsh, who was performing watch house duties, spoke to Ms Stephenson and Darren in the foyer. S/C Walsh gave evidence at the inquest. Ms Stephenson explained why she had brought Darren in,[60] and that she understood that Preston police had contacted them ahead of her arrival with Darren. She waited in the foyer of the police station whilst S/C Walsh and a female police officer took Darren out the back. After 15-30 minutes, S/C Walsh returned and spoke to her. He told her that Darren would be taken to the Ringwood Magistrates' Court that afternoon.[61] Ms Stephenson told S/C Walsh that he had an acquired brain injury, and that she was his case manager and engaged through TAC. She described Darren's family history, and she provided him with her and Steven's contact details. She asked to be notified when Darren's hearing was going to take place so that she could attend. S/C Walsh told her to contact the Court herself.[62] S/C Walsh's handwritten notes at Exhibit 4 contain the mobile phone numbers for Ms Stephenson and Steven Brandon.

57. S/C Walsh states that after he had placed Darren under arrest, he took him to the custody area inside the station, and then presented him to Acting Sergeant Jason

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[56] [182].
[57] TAC file notes by Emma Flannery dated 09/05/19, CB412-415.
[58] CB182-184. The undertaking of bail is dated 15/5 however the arresting officer's endorsement on the warrant is dated 21/5.
[59] TAC file notes 21-24 May 2018, CB382-408. Note that concerns were raised about Darren's capacity to safely drive a vehicle given the combination of his injuries and medication, but these concerns never appear to have led to any interference with his driver's licence: Report of Associate Professor Michael McDonough, CB1439.
[60] The missing person issue and the outstanding warrant. T76.31-77.2.
[61] T81.6-8.
[62] T78-81, 157; Case notes of Raquel Stephenson, Exhibit C; Walsh 28/11/18, CB21; Handwritten Notes from S/C Walsh 05/06/2018, Exhibit 4, p2; CCTV at Knox Police Station, tendered as part of the Coronial Brief.

Kelly.[63] A/S Kelly gave evidence at the inquest. A/S Kelly was performing Section Sergeant duties and supervising the custody area.[64] The executed warrant, later filed with the Magistrates' Court, bears an endorsement that it was executed by Senior Constable Chris Gatehouse.[65] S/C Gatehouse also gave evidence at the inquest.

58. In terms of the systems in place at the time, the Victoria Police Manual (VPM) chapter titled Arrests and Warrant dated 26 March 2018 provided at clause 3.4 that –

> if [an] arrested person is brought before a bail justice or court, the executing member takes on the responsibility of the informant in relation to the procedure for remand.

59. The VPM chapter titled Bail and Remand dated 21 May 2018 provided the following guidance to members: –

    a) the arresting member is to follow the process contained in VPM Arrests and warrant to arrest for executing the warrant, including questioning the accused as to their reason for failing to appear and identifying if additional charges are required (12.2), and

    b) the informant must attend any later hearings if bail or any conditions are to be opposed (a corroborator may attend in place of the informant) (9.2)

60. A/S Kelly gave evidence that, notwithstanding that S/C Walsh had arrested Darren, he directed S/C Gatehouse to execute the warrant, because S/C Walsh was required to perform other duties.[66]

61. S/C Walsh and S/C Gatehouse were not able to say whether they asked Darren why he had failed to appear or what reason, if any, he provided.[67] A/S Kelly said that he vaguely recalled that after Darren had been placed in the holding cell, there may have been some discussion between himself and S/C Walsh and or S/C Gatehouse about Darren thinking that the warrants had been issued as a result of a clerical error.[68] A/S Kelly does not recall, but considers it more than likely he would have informed Darren he was not willing to grant him bail. He directed Senior Constable Chris Gatehouse to prepare an application for Darren's remand.[69] S/C Gatehouse introduced himself to Darren and told him that police would be making an application to remand him in custody. He states that he asked Darren "if he had any circumstances that would be

[63] Thomas Walsh 28/11/18, CB21.
[64] T208-9.
[65] CB186.
[66] T210.
[67] T185, 223-5.
[68] T209-10.
[69] T210-11.

beneficial to him being released on bail," and that Darren "was not able to provide me with any reason".[70]

62. S/C Gatehouse then prepared a remand application based on information he had obtained from A/S Kelly and following a conversation with Darren.[71] S/C Gatehouse does not recall whether he spoke to S/C Walsh prior to completing the remand application.[72] The application stated that Darren was homeless as a result of his mother's death, his father being placed in a nursing home, and his parent's house being sold. The application also stated that the police believed that Darren would continue to fail to appear in court if he was granted bail.[73] The application did not refer to Darren's acquired brain injury, mental illness, or that he had a case manager engaged through TAC. The proforma that was used to prepare the application did not contain any prompts or guidance that indicated that this information might be relevant.[74]

63. Whilst Darren was at the police station, police permitted him to telephone Ms Stephenson using the contact number that she had provided to S/C Walsh.[75] Ms Stephenson said that during the phone call, Darren expressed anger towards her and accused her of "setting him up".[76]

64. Police then took Darren to the Ringwood Magistrates' Court so that a Magistrate could determine the question of bail under s12 of the *Bail Act 1977*.

Recommendation to the Chief Commissioner of Police

Victoria Police manuals and guidelines should be amended to make it clear that whilst a suspect remains self-represented, contact details of identified support people must be passed along to each subsequent investigator, informant and the ultimate prosecutor, so that the prosecutor is able to assist the Court in the manner it will expect.

Ms Stephenson's Email

[70] Gatehouse 19/8/19, CB1127.
[71] T223, 226-7, 229.
[72] T228.
[73] Exhibit O, CB1510-1530.
[74] Exhibit O, CB1510-1530. Counsel, at T.901.30, was unable to get instructions in the short time she had available as to whether the proforma had already been amended since Darren's death. If that has happened, the Commissioner's response to the recommendation can set that out.
[75] T81; Handwritten Notes from S/C Walsh 05/06/2018, Exhibit 4, p2; CCTV at Knox Police Station.
[76] T81-2; Case notes of Raquel Stephenson, Exhibit C, p5.

65. Whilst Darren was being processed by the police, Ms Stephenson telephoned her employer, Ms Lee Wilkinson. She verbally composed an email that Ms Wilkinson typed for her and sent from Ms Stephenson's email address to the Ringwood Magistrates' Court Co-ordinator. The email, sent at 2:24pm,[77] attached three reports, including those of Ms Todd and Dr Gibbons, referred to above. In the body of her email, Ms Stephenson described Darren's recent loss of his mother, the nursing home placement of his father, his subsequent homelessness, and her ongoing attempts to place him in supported accommodation that would equip him to live independently. Ms Stephenson's requested in the email that the Co-ordinator pass it on to the legal aid lawyer who was appointed to assist Darren at Court.[78]

66. Between 3:00pm[79] and about 4:15pm,[80] Ms Stephenson's email and the attached reports were given by Court staff to Bronte Fisher, a lawyer employed by Victoria Legal Aid (**VLA**) and rostered on cell duty that day.

The lead up to the Remand Hearing

67. Ms Fisher gave evidence at the inquest. To the extent that their communications would attract client legal privilege under s118 of the *Evidence Act 2008*, the privilege was waived for the purposes of the investigation and inquest by Darren's brother Steven.[81]

68. Ms Fisher was admitted to practice in 2014 and had been employed by VLA for about 12 months. Her position with VLA was the first in which she had dealt with summary criminal matters. For approximately nine months she had worked in the youth crime section, engaged in Children's Court work. She had then transferred to VLA's Ringwood office and commenced working full time with the duty lawyer team at Ringwood Magistrates' Court. Throughout her initial period of approximately one month's duration at Ringwood, Ms Fisher merely observed other duty lawyers. She then commenced doing her own casework. Since the *Bail Act 1977* also applied in the

[77] Exhibit G.
[78] T83-86, Exhibit C.
[79] Exhibit G (Email from Leah Johnson at Ringwood MC undertaking to pass the email to VLA).
[80] T519.
[81] On 22 October 2019, Steven Brandon was granted Letters of Administration for Darren's estate: Exhibit AK. He thereby became a personal representative of Darren within the meaning of s117(1)(e) of the Act, so as to be capable of waiving privilege. He signed a waiver permitted release of the VLA file on that day: Exhibit AL. He was present in Court throughout the inquest and did not object to any evidence being adduced.

Children's Court, she had already gained considerable experience in summary bail applications in her earlier work with VLA.[82]

69. As a VLA employee, Ms Fisher was subject to the *VLA Duty Lawyer Guidelines – Criminal Law*. Clause 5 provides: [83]

> Summary of guidelines
>
> a) All people who are in custody and are appearing in court for the first time in relation to a matter must be helped by the Duty Lawyer Service. No means test is to be applied for this help.

70. Clause 6 then provides:

> Accused people in custody
>
> 6.1 An accused person who is in custody and has been brought to court for the first time in relation to a matter is a priority. The Duty Law Service must prioritise seeing all accused people in this category. No income test is to be administered. The Duty Lawyer will give advice and representation on the day or help the person to get legal representation either through an application for legal aid or by a referral to a private practitioner.
>
> 6.2 Where the accused has not requested the assistance of a private lawyer and the Duty Lawyer believes that it is appropriate that a bail application should be made on the day then the Duty Lawyer Service must prioritise that application. A Duty Lawyer will ordinarily appear to make the bail application.

71. Against this policy background, Ms Fisher spoke to Darren in the Ringwood Magistrates' Court cells sometime prior to 4:15pm. Darren told Ms Fisher that he would not be pleading guilty to the charges, as they had already been "thrown out of court by a Magistrate." Ms Fisher checked these instructions and established that the charges had not been thrown out. She returned to the cells a second time and explained this to Darren. He told her that he did not believe this and would not be pleading guilty.[84] Later during the remand hearing, Darren told Magistrate La Rosa that the case had been "dealt with already and um, was [sic] thrown in a court, in Ringwood two

[82] T47-50.
[83] Bundrock 13/8/19, Exhibit Z, CB1145-6; VLA Duty Lawyer Guidelines, CB997-1001.
[84] Bronte Fisher 6/11/19, Exhibit S, CB1629-1630.

years ago."[85] The most likely explanation for Darren's assertions that the criminal proceeding had been thrown out is that he had confused it with the the Family Violence proceeding, which had resulted in an order that expired in 2016. . However, it is not necessary to reach a conclusion about why Darren was insistent that the criminal proceeding had been finalised.

72. Ms Fisher does not recall much else about her communications with Darren. Based on entries in the VLA file, she believes Darren told her he was still living at his parent's premises at 23 Guinevere Parade, Glen Waverley.[86] As noted above, the independent evidence shows that, by this stage, the property had been sold. Ms Fisher recalls that she made a mobile phone call to Darren's brother Steven that afternoon, and that Steven told her that the Guinevere Parade address was no longer available to Darren.[87] It is likely that Ms Fisher made this phone call in an attempt to obtain independent evidence of a bail address for Darren. Darren's instructions that he would not plead guilty would have indicated to Ms Fisher that the charges could not be finalised that afternoon. In that event, he would have to remain in custody unless he was granted bail.[88]

73. Darren did not give instructions to Ms Fisher to represent him at the remand hearing, which in turn commenced at 4:50pm that afternoon.[89] Just prior to that, at about 4:15pm, Ms Fisher spoke to Emma Robertson, who was at that time employed to provide Forensicare's Mental Health Court Liaison Service at both the Heidelberg and Ringwood Magistrates' Court. Ms Robertson gave evidence at the inquest. She was an impressive witness. She was also the second professional to provide Darren with exemplary service, although as we will see, the information systems surrounding Darren were again unable to make full use of her assistance.

74. Ms Robertson's conversation with Ms Fisher took place outside her office and near the door to the cells where Ms Fisher had spoken to Darren.[90] Ms Fisher told Ms Robertson that Darren was "not providing instructions to legal aid" and "did not consent to Legal Aid representing him." She also said that Darren did not consent to the release of medical information from Ms Robertson's service to Victoria Legal Aid

[85] CB1058.
[86] VLA Court Attendance Record, CB1415.
[87] Bronte Fisher 6/11/19, Exhibit S, CB1630.
[88] Bronte Fisher 30/5/19, Exhibit Q, CB1007.
[89] Robertson 11/7/19, Exhibit 11, CB1130.
[90] T519.

and did not consent to participating in a mental health assessment.[91] When Darren appeared unrepresented at the hearing, he was asked by Magistrate La Rosa whether he had had an opportunity to speak to a lawyer. He (incorrectly) said that he had not had that opportunity.[92]

75. Why Darren did not give instructions to Ms Fisher to represent him at the hearing is a question that cannot now be answered. One explanation that Ms Fisher conceded was possible was that she had told Darren that she would not make a bail application for him that day if she represented him at the remand hearing.[93] Clause 6.2 of the VLA guidelines, set out above, did not require Ms Fisher to appear for Darren and make a bail application for him unless she considered that a bail application was "appropriate."[94] The determination of whether a bail application was appropriate, within the meaning of the guidelines, required her to make a professional judgment. That judgment depended to a significant extent, if not primarily, upon her assessment of the merits of the bail application.[95] Whilst Ms Fisher did not recall what view she took at the time, she agreed at the inquest that, having looked at that file, it is likely that she would have assessed Darren's prospects of bail as poor.[96] Kate Bundrock, the program manager for summary crime at Victoria Legal Aid, gave evidence at the inquest. She said that a duty lawyer acting under the guidelines who considered that a client had no more than a remote prospect of bail would ordinarily conclude that it was not 'appropriate' to make a bail application on their behalf.[97] Given that Darren later applied for bail at the hearing, it is possible that he chose not to instruct Ms Fisher to represent him so that he could ensure an application for bail was made that day.

76. However, this explanation is not the only one raised by the evidence. It is possible that Darren chose to represent himself independently of any discussion he had with Ms Fisher about whether she would make a bail application for him. Darren's acquired brain injury compromised his decision-making ability. Darren was resistant to accepting the advice and assistance of professional support workers with whom he dealt around that time. As stated previously, Ms Stephenson gave evidence that this was an ongoing problem she had in her dealings with Darren. Ms Fisher's clear recollection was that Darren did not accept her straightforward advice to him that his

[91] T497-498.
[92] T1057.
[93] T261-263.
[94] CB998.
[95] T257-8, 376.
[96] T253-4.
[97] T376.

charges had not been thrown out of court.[98] Further, as has been noted, Darren repeated this incorrect assertion during the hearing. When Ms Robertson attempted to engage Darren in a mental health assessment the following morning, he refused. Later, when Mr Tanti assessed him at MAP, he incorrectly stated that he was employed as a labourer, living with his brother in Knox, and that he had no history of suicide attempts or self-harm.

77. Given Darren's difficult behaviour towards professional support workers at time he dealt with Ms Fisher, it is not possible to find that any advice he may have received from Ms Fisher about the merits of his bail application, VLA's duty lawyer guidelines, or the provisions of the *Bail Act 1977* was causally connected to Darren's lack of representation at the remand hearing. It is also not possible to causally connect the fact that Ms Fisher did not hand Ms Stephenson's email to Magistrate La Rosa to these consequences. It cannot be supposed that Darren's instructions would have enabled Ms Fisher to provide Ms Stephenson's email or its contents to Magistrate La Rosa, or that Darren wanted or would have chosen to hand the material to the Magistrate himself. As will be seen, Darren did not say anything about his mental health or personal circumstances during the remand hearing, apart from an indirect reference to his mother's death. His submissions in support of bail, so far as he was allowed to make them, were based entirely on the incorrect assertion that the charges had been thrown out.

78. It follows from this analysis, and from the conclusion that Magistrate La Rosa did not obtain the material from elsewhere (dealt with below), that Magistrates La Rosa's ignorance of Ms Stephenson's email at the time he refused bail was not a "circumstance" in which Darren's death occurred, within the meaning of s67(1). Nonetheless, it may be the subject of comment under s67(3), as a matter connected to Darren's death and which relates to public health and safety or the administration of justice. This is considered further below.

The Remand Hearing

79. Darren's hearing at Ringwood Magistrates' Court commenced before Magistrate La Rosa at 4:50pm on Friday 5 June 2018. The hearing took 9 minutes and was audio

[98] T300.

recorded.[99] In accordance with his instructions, Darren did not have a legal representative during the hearing. However, both Ms Fisher and Ms Robertson sat in the Courtroom whilst the hearing took place.[100]

80. Acting Sergeant Bianca Smith, a police prosecutor, appeared for the prosecution.[101] A/S Smith appeared as a witness at the inquest. Prior to the hearing, she had been working as a prosecutor at Ringwood for 11 years, after having completed Victoria Police's training course in 2006. She had had ongoing training since then. A/S Smith was shown the Melbourne Prosecutions Standard operating procedures, [102] which she said had an equivalent counterpart that applied to prosecutors at Ringwood. [103] She was also shown the VPM's' policy rules for "Court Processes", the corresponding procedures and guidelines supporting that same policy, [104] and the chapter titled "Bail and Remand", as in force at the time of the hearing.[105] A/S Smith accepted that these documents provided no real guidance about a police prosecutor's role in a summary bail application.[106]

81. A/S Smith said that the preparation for bail applications by police prosecutors at Ringwood Magistrates' Court was essentially undertaken by a police prosecutor in the triage management/mention office in the Court complex. The triage management/mention prosecutor would receive the bail documentation from the informant or an officer representing the informant and, based on the information provided by the informant, would complete a proforma document to assist the prosecutor in court.[107] A/S Smith said that, if time permitted, the prosecutor in court would prepare for an application by reading these documents beforehand. Sometimes, however, they did not have time to review the documents prior to reading them aloud in court.[108]

82. The hearing that took place before Magistrate La Rosa that afternoon commenced with an exchange between his Honour and A/S Smith. A/S Smith explained the reasons why Darren fell within the exceptional circumstances category and added that, as a result of Darren's failures to appear, he posed an unacceptable risk. It can be heard on the audio

[99] Audio recording and transcript, ex X, CB1056-60.
[100] Robertson 11/7/19, Exhibit 11, CB1131; Bronte Fisher 8/7/19, Exhibit R, CB1161.
[101] Smith 6/6/19, Exhibit V, CB1141.
[102] CB766.
[103] T300.
[104] FF-095363, CB889.
[105] FF-117128, CB910.
[106] T310-317, especially 311.1-3, 315.19 and 316.20.
[107] T317-319; Ringwood Magistrates' Court Remand / Bail Application, CB1641.
[108] T317.

recording of the hearing that there were some prolonged silences before Magistrate La Rosa spoke to Darren. It is likely that his Honour was reading the documents on the Court file when these silences took place. Whilst A/S Smith could not actually see what was on the Court file at this point,[109] other evidence shows that it contained,[110]

b) a cover sheet that bore handwritten notations of the adjournments, warrants, and failures to appear,

c) the original charges and preliminary brief, including Darren's criminal history (set out above), and the police statement made by Steven,

d) the executed warrants and signed bail undertakings, and

e) the further charges of failing to answer bail.

The Court file did not contain the remand application prepared by S/C Gatehouse, which described Darren's homelessness as a result of his mother's death, his father being placed in a nursing home, and his parent's house being sold. There is nothing to indicate this or any other document was handed to his Honour during the hearing.

83. Magistrate La Rosa then addressed Darren, who confirmed that he wanted to apply for bail.[111] Magistrate La Rosa told Darren that as a result of recent changes to the law, he had to show exceptional circumstances. His Honour asked Darren to identify what he relied upon as exceptional circumstances. Darren conceded that there were no exceptional circumstances. He said that the case had been "dealt with already" in Ringwood two years ago. He said that the case had been "brought back" by police after he had given them information about his mother's death in September 2017. He said he now had "no way of getting a hold of paperwork". He said his current detention was "absurd" and "ridiculous". Magistrate La Rosa put to Darren that he had signed a bail undertaking on 11 November 2017. Darren replied: "When was that?" Magistrate La Rosa recited the remaining chronology of the proceedings, noting that Darren had "the audacity" to suggest the charges had been thrown out. Then, without giving Darren a further opportunity to address him, announced his refusal of the application. At about 4:59pm, Magistrate La Rosa ordered that Darren be remanded.

84. After Darren was removed from the court, Magistrate La Rosa addressed Ms Fisher in the body of the courtroom. He told her that he had assumed during the hearing that she had explained the exceptional circumstances test to Darren. His Honour asked her, in

[109] T333.5-6.
[110] T331-3; CB156-218.
[111] Preliminary police brief prepared by the informant, S/C Dale Annesley, CB172.

effect, whether there were any custody management issues relevant to Darren. Ms Fisher said -

> Your Honour, there's significant mental health issues, I don't have any direct information from him on that but I have received a report from a worker he has.

Ms Fisher agreed with Magistrate La Rosa's suggestion that he make a notation directing that Darren be seen by a nurse. Ms Fisher then said, "Your Honour, he has an acquired brain injury as well." Magistrate La Rosa responded, "All right. It still doesn't get him to … exceptional circumstances."[112]

85. I infer that Magistrate La Rosa was unaware of Ms Stephenson's email during the hearing. His Honour was an experienced Magistrate with a criminal law background.[113] Had his Honour been aware of the material, he would have known he was bound by the rules of natural justice to ensure that Darren was aware that he had it. His Honour would have appreciated the potential forensic significance of the material, and he would have raised its contents with either the prosecutor or Darren. His Honour would not have asked Ms Robertson or Ms Fisher to assist him with custody management issues without reference to the material. Moreover, his notations about custody management issues would have referred to Darren's risk of suicide, if not the likelihood of opiate withdrawal as well, both of which were clearly noted in the material. The notations made by his Honour, described below, did not refer to these issues. For these reasons, it is inconceivable that Magistrate La Rosa was aware of Ms Stephenson's email during the hearing but did not in any way reveal this to observers to the proceedings.

86. The electronic entries made by Magistrate La Rosa include notations to the effect that:

    a) Darren had admitted that he had no exceptional circumstances, and had failed to appear in answer to bail on three occasions, and

    b) he had mental health issues, and an acquired brain injury, and "needs to see nurse ASAP".[114]

87. After the hearing, Ms Robertson told Ms Fisher that she would attempt to engage Darren in a mental health assessment the following morning. Ms Fisher gave Ms Robertson a copy of Ms Stephenson's email and the attached reports. [115]

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[112] CB1060.
[113] Jason Silveri, *Magistrate steps out from the background*, (2003) 77(1-2) LIJ, 27.
[114] CB1008.

88. Darren was then taken to the Ringwood Police Station cells. At 5:30pm, police conducted a "detainee risk assessment." The assessment form states "Refusal", which suggests that Darren did not fully participate in the assessment.[116] There are no relevant risk factors recorded on the assessment form. On the same day, Darren signed a consent to the release of his medical information by and to Victoria police.[117]

The legal framework of the Remand Hearing

89. Section 4 of the *Bail Act 1977* is headed "Accused held in custody entitled to bail". Sub-section (1) creates a presumption of bail. It provides that any person accused of an offence and being held in custody in relation to that offence shall be granted bail during any "postponement", which includes an adjournment of the hearing of an offence. For many years, modern case management protocols have required that contested summary hearings be scheduled at a prior mention hearing. These protocols mean that when police arrest and charge a person and do not grant bail prior to taking him or her before a magistrate, the hearing of the charges will have to be adjourned if the accused does not plead guilty. Section 4(1) then provides a presumption of bail.

90. The remainder of s4 sets out situations in which the presumption does not apply. These situations are mostly defined by reference to the nature and seriousness of the offence with which the accused is charged. The fact that Darren had previously failed to appear in answer to bail placed him in a category of case to which the presumption of bail no longer applied[118]. As has also been indicated, Darren was required by the Act to show "exceptional circumstances". This is expanded upon below.

91. Before looking further at the provisions that applied the exceptional circumstances test to Darren, it should be observed that s4(2)(d) created an overarching prohibition against bail where there was an "unacceptable risk" that an applicant would fail to answer bail or engage in other proscribed conduct. Whilst this provision did not place a persuasive burden on an applicant, one or more previous failures to appear would support a finding of unacceptable risk against an applicant, if he or she could not satisfactorily explain why they should not do so. [119]

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[115] Emma Robertson 11/7/19 Exhibit 11, CB1132.
[116] CB1285-1286.
[117] CB1287.
[118] Section 30 of the *Bail Act 1977,* as modified by schedules 1 & 2.
[119] The unacceptable risk test, then contained in s4(2)(d), has since been relocated in the Act at s4E(1), but not with any material consequence for this case.

92. Putting the unacceptable risk test to one side, it is also instructive to trace the position of applicants for bail who are alleged to have failed to answer bail earlier in the same proceedings. It should be kept in mind that there is no record that anyone had actually asked Darren why he had failed to answer bail.

93. When it was first enacted in 1977, the *Bail Act* contained s4(2)(c), which required a court to refuse bail to a person in custody for failing to answer bail, unless the person could show that "the failure was due to causes beyond his control." Section s4(2)(c) was repealed by the *Justice Legislation (Sexual Offences and Bail) Act 2004*.[120] The 2004 amending Act also inserted s4(4)(d), which required a court to refuse bail to a person charged with an offence under the Act (including failing to answer bail contrary to s30(1)) unless the person could "show cause why his detention in custody [was] not justified." Whilst the show cause test was not clearly defined, it was necessarily less stringent than the "exceptional circumstances" test, explained further below. At that stage, the exceptional circumstances test was reserved for very serious charges such as murder and commercial drug trafficking.

94. In 2015, Coroner Gray recommended to the Attorney General, in the *Inquest into the Death of Luke Geoffrey Batty*,[121] that consideration be given to the reinstatement of s4(2)(c).[122] However, this recommendation was overtaken by a wholesale review of the Act, in 2017, by the Hon Paul Coghlan QC.[123]

95. As a result of the Coghlan review, the *Bail Amendment (Stage One) Act 2017* commenced operation on 21 May 2018. The Act effected two significant changes to the position of a person in custody who was charged with failing to answer bail. First, the show cause test was replaced with the arguably more stringent show "compelling reason" test.[124] This test now applied to any person charged with an offence listed in the new Schedule 2 to the Act. Item 30 of Schedule 2 was an offence against the Act. Secondly, the exceptional circumstances test was broadened so as to apply to any person charged with a Schedule 2 offence whilst on bail for another Schedule 2 offence.[125] This change applied to Darren's case for the following reasons:

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[120] *Justice Legislation (Sexual Offences and Bail) Act 2004* (Vic) s 10.
[121] COR 2014 0855.
[122] p107.
[123] *Bail Review, First advice to the Victorian Government*, 3 April 2017, the Hon Paul Coghlan QC.
[124] Mr Coghlan had recommended that the test require the applicant to show "good reason": Recommendation 4, p39.
[125] Section 4(2)(c).

a) On 21 May 2018, Darren was charged with failing to answer bail, contrary to s30(1) of the Act, back on 8 May 2018. [126] This was a Schedule 2 offence. On that day,[127] Darren entered an undertaking of bail to appear on 24 May 2018.[128]

b) On 5 June 2018, a further charge was filed for failing to answer bail contrary to s30(1), allegedly committed on 24 May 2018.[129] Darren thereby faced a Schedule 2 offence allegedly committed whilst on bail for another Schedule 2 offence.

As may be seen from this analysis, Darren's first charge of failing to answer bail, on 8 May 2018, merely placed him in the show compelling reasons category. It was his second charge of failing to answer bail, on 24 May 2018, that placed him in the exceptional circumstances category.

96. The exceptional circumstances test requires that an applicant demonstrate that his or her case is "unusual, out of the ordinary, [or] special."[130] However, the courts have also emphasised that the exceptional circumstances threshold, whilst high, is not impossible to reach. It may be achieved through a combination of circumstances that, viewed in isolation, are otherwise unexceptional. [131]

97. To appreciate the contemporary position, it remains only to observe that on 1 July 2018 – after Darren's remand hearing and death – the provisions of the *Bail Amendment (Stage Two) Act 2018* took effect.[132] At least two aspects of these subsequent amendments are relevant to the consideration of proposed comments and recommendations, discussed below. First, the amendments inserted s3AAA, which lists the "surrounding circumstances" that a bail decision maker is required to take into account when considering any of the show compelling reasons test, the exceptional

[126] CB185.
[127] As observed at n8, there is conflicting evidence about the date that Darren entered bail to appear on 24 May 2018. On one view, the charge of failing to answer bail was not laid until six days after he entered bail. It is arguable that, as a result, Darren would not have been on bail for that offence when he re-offended, within the meaning of Item 3(a) of Schedule 1, and therefore remained in the compelling reason category when he came before Magistrate La Rosa. However, the better view is that, by virtue of the fact that the first fail to appear charge was laid on 21 May 2018, Darren was on bail by the time of the alleged commission date of the further offence, 24 May 2018. These submissions are addressed accordingly. Given the issues in the inquest, it is unnecessary to determine the issue.
[128] CB183.
[129] Extract only at CB1013.
[130] *DPP v Tang* (1950) 83 A Crim R 593, 596 cited in Hampel et al, *Bail Law in Victoria* (Federation press, 2nd ed, 2015) 12.
[131] *Application for Bail by LT* [2019] VSC 143, [36].
[132] The amending Act commenced earlier, but the substantive provisions did not commence until they were triggered by provisions in the *Bail Amendment (Stage One) Act 2017* (Vic).

circumstances test, or the unacceptable risk test. Section 3AAA was recommended by Coghlan on the basis that it codified existing practice. [133]

98. Secondly, the amending act has relocated the provisions that uplift a person charged with failing to answer bail whilst on bail for the same offence, to the exceptional circumstances category, and those that create the overarching, unacceptable risk, exception to the presumption of bail. However, the substantive effect of these provisions has not been changed in any manner that is material for present purposes. [134]

The relevance of Ms Stephenson's email

99. Ms Stephenson's email contained the following information relevant to the remand application hearing:

> a) Darren's acquired brain injury, the mere fact of which was known to the Magistrate, had profoundly affected his life and mental capacity in ways that were detailed in the material. His injury was severe. It had resulted in major cognitive difficulties in the form of "very slowed effortful processing of information, reduced verbal new learning and memory skills and in reduced initiation/level of activity" whilst leaving other abilities, such as verbal reasoning, relatively intact.
>
> b) While prior to his motorcycle accident in 2003, Darren had been productively self-employed and in a relationship with a woman he planned to marry, Darren's injury had deprived him of his capacity to work and ability to live independently. His relationship subsequently broke down, and he returned to live with his parents. He had depended on their care. He reported severe depressive symptoms, an impaired ability to sense the passing of time, trouble remembering recent events and conversations without the use of aids to help with his memory, and difficulty keeping appointments. [135]

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[133] *Bail Review, First advice to the Victorian Government*, 3 April 2017, the Hon Paul Coghlan QC [4.46]ff. Mr Coghlan refers to Hampel et al, *Bail Law in Victoria* (Federation press, 2nd ed, 2015) 12 as a reliable source setting out the authorities and practice prior to the enactment of s3AAA: see p12-44 of Hampel et al.

[134] Section 4E (1) of the *Bail Act 1977*.

[135] Raquel Stephenson gave evidence that Darren "didn't seem to forget the appointments she organized for him but would contact her immediately beforehand and tell that he couldn't attend": T56. Relevantly the reports note that Darren would use "a variety of memory aids, e.g., digital voice recorder, diary/notepads, sets alarms on his mobile phone": CB1426.

c) Since the accident, Darren's psychiatric history included depression, with three suicide attempts (reportedly including cutting himself, overdose and use of a gun) and reports of self-harm. He had multiple psychiatric admissions.

d) In the previous eight months, Darren's mother had died as a result of a fall, and his father was placed in a nursing home. This forced the sale of the home Darren had been living in, leaving him homeless.

e) Ms Stephenson, who was his TAC-funded case manager, had recently placed Darren in supported accommodation. Ms Stephenson reported in the material that the placement had "failed with his arrest", although it is evident from other material that the placement also failed as a result of Darren absconding prior to his arrest. Ms Stephenson did note of Darren that "compliance is an issue."[136]

100. This information was relevant to Magistrate La Rosa's decision because it provided admissible evidence[137] about the following matters:

a) The information contained in the material would have placed an entirely different complexion on Darren's behaviour during the hearing - which the Magistrate described as audacious - in that it would have revealed that Darren's relatively intact verbal skills belied his major cognitive impairment.

b) Darren's failures to answer bail, rather than being contumacious, were caused or contributed to by his cognitive impairment, the recent loss of the care of his parents upon which he had depended, and his unstable lifestyle consequent on those factors.

c) The following, further factors that were relevant in Darren's favour to the question of whether there were exceptional circumstances that would justify a grant of bail:[138]

(i) Darren's personal circumstances, home environment, background,[139]

(ii) his "special vulnerability" of cognitive impairment,[140]

(iii) the availability of treatment and support services,[141] and

[136] Email from Ms Stephenson and three attached medical reports, Exhibit C, CB1422-50.
[137] The Magistrate was entitled under the *Bail Act 1997* (Vic) to receive and take into account evidence given otherwise than on oath which he considered credible or trustworthy in the circumstances: s8(1).
[138] See n99. Note that, for convenience, the following list refers to factors contained in s3AAA, which had not yet commenced, but which was said by the Hon Paul Coghlan QC to codify the existing practice of courts when considering bail applications
[139] *Bail Act 1977* (Vic) s 3AAA(g).
[140] Ibid s 3AAA(h).

(iv) the likelihood that, he would not receive a custodial sentence for the charged offences,[142] given that *Verdins* principles would be engaged by his mental impairment,[143] and his lack of history of violent offending and very limited criminal history overall, which in any event revealed that Darren had previously complied with a (non-custodial) CBO.[144]

101. These factors were also relevant, with different emphasis, to the question of whether Darren posed an unacceptable risk. Some of these factors were supportive of bail. For example, the level of acceptable risk would have been assessed in the light of Darren's vulnerability in custody,[145] and the unlikelihood of an ultimate custodial sentence. The availability of case management from Ms Stephenson may have permitted Magistrate La Rosa to impose conditions requiring Darren to accept services from her and to take the availability of those conditions into account when assessing the level of risk. [146] On the other hand, Darren's homelessness and past poor compliance with the conditions upon which Ms Stephenson had been able to provide assistance, in combination with his previous failures to appear, were significant factors in favour of a finding of unacceptable risk.

102. Given the mixed utility of the information contained in Ms Stephenson's email, and Darren's repeated failures to appear, it is not possible, nor proper, to make a finding as to whether Magistrate La Rosa would have granted bail had the Stephenson email information been before him. The most that can be said it is that the material was relevant and would have provided significant support in favour of granting bail.

103. The fact that the information was not available is a systems issue, the examination of which may lead to prevention opportunities. Indeed, Ms Fisher gave this evidence about this very issue:

> I think … if you had the benefit of the reports, not being on duty, not seeing other clients, having [Ms Stephenson] come to court to give evidence, um then with a prepared bail application, he might've got bail.[147]

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[141] Ibid s 3AAA(i).
[142] Ibid s 3AAA(l).
[143] For a useful summary, see the *Victorian Sentencing Manual*, ch 6.2.2, https://resources.judicialcollege.vic.edu.au/article/669236/section/843517 (as at 9 December 2019).
[144] *Bail Act 1977* (Vic) s 3AAA(c).
[145] *JARO* report conclusion, [10] at CB 255.
[146] Ibid s 4(3)(f).
[147] T294.

104. In the context of Ms Fisher's reference to the demands of her work as a duty lawyer, the inquest heard evidence that Darren's matter had been dealt with by Magistrate La Rosa in his capacity as "duty Magistrate" that day. The duty list had been established at Ringwood to enable the Court to deal with urgent matters such as late remand applications outside of normal sitting times. The running of the list was facilitated by the duty Magistrate commencing to sit later in the day, and the prosecutor being permitted to start work late and paid overtime if necessary.[148] This enabled the Magistrate and prosecutor to work into the evening and complete the business in the duty list. By contrast, Ms Bundrock gave evidence that VLA's staffing and funding arrangements did not presently permit VLA to expect duty lawyers to work beyond normal office or court sitting hours. Fortunately for their clients and the community, VLA duty lawyers often worked unpaid overtime hours to ensure that clients were represented.[149]

105. Notwithstanding that it cannot be found that had Magistrate La Rosa would have granted bail had he been aware of Ms Stephenson's email, I find that the course of the hearing would likely have been significantly altered in one or more of the following ways:

a) It is not safe to infer, as some interested parties submitted, from His Honour's remark made to Ms Fisher after Darren had left the court room that His Honour would not have altered his decision even if he had been aware of the Stephenson email.[150] The nature and level of detail in the email and reports may well have cast a whole new light on Darren's behaviour and future prospects.

b) His Honour would probably have made a more detailed notation on the remand documentation, that was capable of drawing the custodial authorities' attention to Darren's significant history of suicide attempts and self-harm (albeit that, as will be seen, there is currently no procedure to ensure that custodial authorities appropriately act upon these notations).

c) His Honour would probably have been reluctant to order a 34 day period of remand, without taking steps to case manage the matter either by discussing the possibility of resolution, or by arranging the investigation of support services in the

[148] T328-329.
[149] T360-361.
[150] "All right. It [ABI] still doesn't get him to … exceptional circumstances." at CB1060.

(nearer) future, via the Court Integrated Services Program (CISP),[151] the Mental Health Court Liaison Service, or Ms Stephenson.

What prevented Ms Stephenson's email from being placed before Magistrate La Rosa?

106. It is not possible to attribute any cause, other than Darren's decision not to instruct Ms Fisher to represent him at the hearing, to the fact that Ms Stephenson's email was not placed before Magistrate La Rosa. There is no evidence that Ms Fisher acted other than professionally and appropriately, in the difficult circumstances she found herself in with Darren, or that she did anything less than what was practicable to assist him.

Responsibility of the duty lawyer

107. The duty lawyer's role is necessarily subject to instructions, even when acting as a "friend of the court". Ms Fisher had no duty to do any more than she did to place relevant information before Magistrate La Rosa, given the structure of the *Bail Act*.

Responsibility of the prosecution

108. It is well established that the prosecutor in a criminal trial has a duty to act fairly, and that this duty overrides any interest in securing a favourable outcome for the party whom he or she represents. In a criminal trial, the duty of fairness requires the prosecutor to call all credible and reliable witnesses, irrespective of whether they assist the prosecution case.[152] The duty of fairness has been said to extend to require a prosecutor to prevent a court from falling into appealable error on a question of bail.[153] The duty extends to summary proceedings, and therefore police prosecutors.[154] If an accused is unrepresented, the presiding judicial officer should ensure that the accused understands his or her procedural rights during the hearing.[155]

109. In the context of defining a prosecutor's disclosure obligations, the Court of Appeal has accepted that the prosecution is indivisible, in that knowledge held by an informant

[151] T147.
[152] *R* v *Apostilides* (1984) 154 CLR 563.
[153] *GP* v *R* (2010) 27 VR 632, [64]-[65] (Bongiorno J).
[154] *Wilson v Police* [1992] 2 NZLR 533, cited in *R* v *Garofalo* [1999] 2 VR 625, 632 [58], although, to be clear, I make no finding that any appealable error occurred. That is not the purpose of a coronial inquest.
[155] *MacPherson* v *R* (1981) 147 CLR 512.

is deemed to be susceptible to disclosure obligations irrespective of whether the prosecutor is personally aware of it.[156]

110. On the other hand, the prosecutor is required to act as an adversary of the accused. The prosecutor is not expected to be free of partisanship in the same way as is a judge.[157] She does not need to balance the duty to advocate fairly against concern for the wellbeing of the accused.[158]

111. In the light of these principles, police prosecutors should place before a Magistrate any credible and reliable information that is available to police about the relevant circumstances. Police prosecutors depend upon informants making them aware of this material.

112. In her oral evidence, A/S Smith demonstrated that she knew her duty to provide such information if she had it, but that is a credit to her individual professionalism rather than the effectiveness of the police procedures she was working within. She also acknowledged that she had little control over what information ended up on the brief, and scant opportunity to check whether a given matter had been properly prepared before it reached her. [159]

113. In the present case, there was credible and reliable information available to the police that was relevant to Darren's bail and remand hearing (including the notation of custody management issues in the event of refusal), yet it was not brought to Magistrate La Rosa's attention. In particular, the police LEAP database contained an entry that detailed TLC's missing person's report to police a few days earlier.[160] Ms Stephenson and Darren had attended Knox Police Station, on 5 June 2018, after being requested to do so by police for the purpose of "clearing" the report. When they attended, Ms Stephenson provided further relevant information when she spoke to police in the foyer. This information, listed below, was not provided by police to prosecutor A/S Smith:

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[156] *R* v *Farquharson* (2009) VR 410, 464-5 [210]-[215].
[157] *R* v *Karounos* (1995) 63 SASR 451, 465 (King CJ).
[158] *Grimwade* v *State of Victoria* (1997) 90 A Crim R 526.
[159] T.316 to 320, 338.07, to 339.18.
[160] LEAP records produced 29/11/19, Exhibit 14, although Counsel for the Commissioner of Police explained in some detail, and I accepted, that the exact LEAP record at the time could not now be reproduced, as this was a dynamic digital record. See T.892.05, and the subsequent transcript references therein. At T.890.9, Counsel for the Commissioner of Police explained to the court that the Police describe the naming of a person in the LEAP database as an "involvement" with Police, encompassing a potentially wider variety of activity than simply being a suspect or a witness.

a) Darren had an acquired brain injury, depression, and a pre-2013 history of suicidal attempts and thoughts. (This information was contained in this missing person's report filed by TLC, as described in the LEAP records,[161] and therefore ought to have come to the attention of Knox police when they cleared this report as a result of Darren's attendance that afternoon).

b) He had voluntarily attended the police station and "handed himself in" in order to assist in the execution of the warrant.

c) He had the TAC funded support of a case manager who had made herself available for the hearing.

d) He had recently been in TAC funded supported accommodation at the Transitional Living Centre but had absconded, and so was temporarily homeless until a VCAT guardian could be appointed to make decisions for him.

114. In the present case, there were several aspects of police procedure that governed Darren's arrest and the police opposition to his bail which did not equip the prosecutor to do all that could have been done to provide Magistrate La Rosa with a complete picture of this self-represented litigant. These deficiencies are matters that are appropriate for comment or recommendation:

a) The procedures did not encourage, let alone ensure, the continuity of information gathered by police during the original investigation, through to Darren's later arrests on the bench warrants, and onward to the ultimate prosecutor.

b) The procedures offered little or no guidance to the arresting police member as to what information was relevant to the question of bail, beyond that which would support refusal.

c) The procedures for the "briefing" of the police prosecutor through a triage / mention prosecutor and a proforma document did not sufficiently assist the prosecutor in obtaining relevant instructions.

d) The procedures did not inform police prosecutors of their duty to assist the court by providing credible and reliable information available to them about the circumstances relevant to a bail application, irrespective of whether such information would support a police informant's position on bail.

Recommendations to the Chief Commissioner of Police

[161] Exhibit 14, pp11 and 12, T.823. The actual missing persons report was not in evidence.

In recognition of the inherent vulnerability of people taken into Police custody, the Commissioner revisit the relevant parts of the Victoria Police Manual with a view to ensuring all relevant information in the possession of Victoria Police is conveyed to the police prosecutor.

The proforma documents used for the preparation of remand applications be amended to prompt the provision of relevant information known to the police about the surrounding circumstances to the prosecutor and the court.

The VPM should inform police prosecutors of their duty to assist the court by providing credible and reliable information available to them about the circumstances relevant to a bail application, irrespective of whether such information would support a police informant's position on bail.

115. It should be recalled in this context that, at the time of Darren's bail hearing, s3AAA, which explicitly set out the "surrounding circumstances", had not yet commenced. The commencement of s3AAA, as part of the Stage 2 reforms, led to the update on the Victoria Police Manual chapter titled "Bail and Remand".[162] The policy contained in the chapter applies to "police bail decision makers" and informants in bail and remand applications, but not prosecutors.[163] Clause 3.2 sets out the circumstances listed in s3AAA.[164] When a police bail decision maker considers bail, cl 7.1 directs the informant to make enquiries about the surrounding circumstances, including, helpfully, guidance as to what specific inquiries should be made.[165] However, there is no equivalent to cl 7.1 where the informant seeks to apply to a court or bail justice to remand an accused. Clause 9 directs the informant to prepare certain documentation.[166] There is no evidence as to what enquiries, if any, these documents prompt the informant to carry out prior to a remand application.

116. I was prepared to make a further recommendation that the VPM be amended to direct an informant when preparing a remand application before a bail justice or court to make inquiries about the surrounding circumstances set out in s3AAA, and to

[162] FF-117861, CB1078-1099.
[163] CB1079.
[164] CB1081.
[165] CB1099.
[166] A Form 1372 or Form 286, CB1091.

provide this information to the prosecutor when attending the remand hearing. However, I accept the Commissioner's advice that it has already been thus amended.[167]

Other information systems used to manage prisoners such as Darren

117. From the time that Darren was taken into custody, information relevant to his placement and care was managed via a complex network of databases and systems. The function and attributes of these systems, and the evidence of what they contained about Darren, is set out in a spreadsheet that was tendered during the inquest, and is reproduced at the foot of these Findings as Annexure A.[168] To understand this next section of these Findings, however, it is at least necessary to have some sort of summary of the different controllers and parameters of the various systems:

a) Client Management Interface (CMI)

A state-wide database recording all contacts by patients with public health services, accessible by Forensicare staff but not by the police or CHS staff.

b) Custody Module / The Thin Blue Line

A police database that provides for the electronic management of prisoners across Victoria that is accessible to police and CHS staff, but is not accessible by prison staff except to the extent of viewing risk assessments such as P and S ratings[169] assigned during police custody through E Justice (below).

c) E Justice

A system used to record prisoner risk ratings such as the P and S ratings and LEAP (see below) warnings about risks posed by a prisoner to custodial and clinical staff. The database is accessible to police, custodial, and clinical staff, whether they work in the police custodial or prison system.

d) HEALTHe

[167] T901.14, and the supporting closing submission on behalf of the Commissioner made on 9 December 2019 at paragraph [30].
[168] Exhibit AJ.
[169] A P-rating denotes the acuity of a prisoner's psychiatric health, whereas an S-rating, as explained elsewhere denotes the level of a prisoner's risk or history of suicide attempts or self-harm: Sullivan 4/11/19, Exhibit 13, CB1555-6; T763.

CHS's official medical record that brings together all current health information held by CHS and is accessible by CHS staff but not police members generally, nor clinicians working in the prison system.

e) JCare

The information system used exclusively in the prison system for the recording of prisoner medical information. Clinicians working in the prison system have access to this database from a computer within the prison,[170] whereas police and CHS staff do not have access.[171]

f) Law Enforcement Assistance Program (LEAP)

A police database that contains law enforcement information about people both in and out of custody. LEAP is generally accessible by police only, however, warning flags issued by the system are linked to E Justice and thereby visible to users of that system.

g) Patient Management Interface (PMI)

A program used by Thomas Embling Hospital and other Forensicare services to record and store health information.

h) Prisoner Information Management System (PIMS)

An operational database which records details on all prisoners in custody, and is utilised in the day-to-day management of prisoners. It is accessible by Forensicare prison services and Forensicare's Mental Health Advice and Response Service (**MHARS**, formerly the Mental Health Court Liaison Service where Ms Robertson worked), and by some police to a limited extent.

i) Prisoner Information Record (PIR)

The physical file of documents that are kept about a prisoner whilst in police and prison custody, and which accompany a prisoner when he or she is transferred.

[170] T784.

Reception clinicians are able to review these documents when prisoners are transferred from police custody to prison.

j) Remand warrant notations

Custody management issues identified by a remanding Magistrate as set out on the remand warrant that forms part of the physical bundle of documents that accompany a prisoner through the police custodial and prison system.

The subsequent use of Ms Stephenson's email, and Ms Robertson's concerns about Darren

118. On 6 June 2018, at 9:30am, Ms Robertson saw Darren in the cells and attempted to conduct a mental health assessment. He engaged reluctantly before prematurely terminating it. He told Ms Robertson he did not want to be assessed in a cell, through a glass window.[172] Ms Robertson noted that Mr Brandon was focussed on getting out of custody and obtaining pain management medication.[173]

119. At 10:50am, Ms Roberson phoned Bronwyn Love, a nurse employed by the Victoria Police Custodial Health Service. Ms Robertson states she asked Ms Love to prioritise Darren's transfer from police cells to the prison system due to concerns about his mental state and complex physical needs. At 11:23am, she sent a follow up email to Ms Love in which she summarised the information she had obtained from Ms Stephenson which read[174]

> Given recent stressors of family and of unexpected arrest and unwillingness to participate in assessment with me, I am concerned about his risk of engaging in SASH [sc suicide and self-harm] whilst in custody ….
>
> Given Darren's complex presentation and his uncertain risk at present, I believe he would benefit from a priority move to MAP if possible.

Ms Robertson attached the following documents to this email:

a) The covering email that had been sent by Ms Stephenson the previous day.

b) The first four pages of the five page report prepared by Jenny Todd (clinical neuropsychologist), in 2013.

[172] Emma Robertson 11/7/19, Exhibit 11, CB1132.
[173] Ibid.
[174] Ibid.

c) The last nine pages of a 14 page report prepared by Associate Professor Michael McDonough (addiction specialist physician), on 11 October 2016.

d) The report prepared by Dr Michael Gibbons (psychiatry registrar), on 5 July 2017.[175]

Ms Robertson then proceeded to complete her notes and entered these, and the reports, onto PMI, Forensicare's proprietary database.[176]

120. Bronwyn Love and Rebecca Cotton both state that they were working as custodial nurses for CHS throughout the day on 6 June 2018. Rebecca Cotton said that she received the email from Emma Robertson about Darren, and that, based on this information, assigned Darren an S3 risk rating on a Victoria Police database accessible to all CHS state known as the Thin Blue Line or the Custody Module at 11:29am. At the same time, Ms Cotton copied the text from Ms Robertson's covering email and attachments, onto the HEALTHe system.[177]

121. At 12:04pm, Darren was reviewed by Dr Tarek Ibrahim, a senior medical advisor employed by CHS, at the Ringwood police cells.[178] Dr Ibrahim gave evidence at the inquest. During his review, Dr Ibrahim twice asked Darren whether he was suicidal or had any suicidal thoughts, to which Darren replied "no" both times.[179] Dr Ibrahim recorded on HEALTHe that "He is not suicidal, he is not going to harm self. He is on the med move list." Dr Ibrahim based this assessment on Darren's presentation and self-report.[180] Although Dr Ibrahim had access to the HEALTHe records, it is not clear how he took the information provided by Ms Robertson into account, if at all, in assessing Darren's suicide risk.[181] In any event, he did not revise the S3 rating assigned by Ms Cotton, and did not know that he had the ability to do so.[182]

122. During his consultation, Dr Ibrahim reviewed a summary of Darren's medication, which had been faxed by Dr Skinner's practice to CHS at 11:46am that morning.[183] The information revealed that Darren was prescribed high doses of opioid medication,

[175] HEALTHe records, CB1292-1302, 1304-1314.
[176] This may be meant as a reference to the Police Information Management System.
[177] Love 31/10/19, Exhibit 10, CB1549-51; Cotton 30/10/19, Exhibit 5, CB1546-8; Wong 4/11/19, Exhibit AB, CB1159-65; and HEALTHe records, CB1280, 1292-1314.
[178] CB1282-1283
[179] Mathanu 3/12/18, CB30.
[180] T547-8, CB1282-1283.
[181] T565-566.
[182] T559.
[183] T544, 565-566.

including 160mg of Oxycontin daily.[184] When Dr Ibrahim discussed this medication with Darren, Darren explained that he was taking this medication because he suffered from back pain and multiple fractures.[185] Nonetheless, Dr Ibrahim prescribed Darren an "opioid withdrawal pack", which substituted the opioid medication in his current regime with different medications that contained almost no opioids.[186] Dr Ibrahim took this course because he believed that, under his employment by CHS, his authority to prescribe opioid medication was restricted to the opioid withdrawal pack, irrespective of a prisoner's medical needs.[187]

123. At approximately 12.45 am on 7 June 2018, Darren complained that he was not feeling well and had chest pains.[188] Darren was moved to a holding cell so he could be better monitored by police.[189] At approximately 1.30am, an ambulance was called to attend and assess Darren.[190] The ambulance arrived at approximately 1.45am.[191] Darren was taken by ambulance to the Emergency Department at Maroondah Hospital. He underwent a series of tests before he was returned to Ringwood Police Station later that morning. His discharge summary noted that there was no evidence of cardiac abnormality.[192]

124. On the afternoon of 7 June 2018, Darren was transferred from the Ringwood Police Station cells to Melbourne Assessment Prison, arriving at approximately midday.[193] The CHS medication chart and a copy of the discharge summary from Darren's visit to Maroondah Hospital earlier that day accompanied Darren in the secure box in the prison van in which he was transferred.[194]

125. Documents uploaded to the HEALTHe database, including Ms Stephenson's email, and the concerns expressed by Ms Robertson, were not handed over by CHS to MAP. This did not occur because there was no clear procedure for the transfer of medical information held by CHS to MAP,[195] when prisoners were transferred from police cells other than the Melbourne Custody Centre. Further, although CHS has documented

[184] T570; Patient Health Summary 6/6/18, CB 1303.
[185] T568.
[186] T574-5; CB1303, 1315. See CB286 for a clearer copy of the medications chart.
[187] T544-6, 549-51, 555, 576-9, 582.
[188] Unofficial statement of Langmaid, CB34.
[189] Ibid.
[190] Ibid.
[191] Mathanu 3/12/18, CB30.
[192] Justice Assurance and Review Office Report, CB244; Letter from Eastern Health, CB288-9.
[193] JARO Report, CB248.
[194] Swanwick 5/9/19, CB1111.
[195] T390, 467-68, 644. Cf T626, 390.

numerous written procedures for custodial nurses, they were not given adequate induction or ongoing training about these procedures.[196]

Darren's reception and psychiatric assessment at MAP

126. After his arrival at MAP on 7 June 2018, Darren underwent a reception medical assessment, which was performed by Dr Sima Riazi, a medical officer. Dr Riazi is a locum doctor supplied by Skilled Medical, a medical agency, to Correct Care Australasia, who are in turn contracted to provide medical services at MAP.[197] Darren gave Dr Raizi a medical history that included an acquired brain injury and depression. Based on the medical documents that had arrived with Darren, Dr Riazi prescribed a continuation of opioid withdrawal medication that Darren had been taking in the police cells. Following the assessment by Dr Riazi, Mr Brandon underwent a reception mental health assessment, which was performed by Matthew Tanti, a registered psychiatric nurse engaged by Forensicare, who are responsible for the provision of mental health services at MAP.[198] Mr Tanti gave evidence at the inquest and impressed me as a conscientious and compassionate nurse.

127. The assessment by Mr Tanti included a review of information recorded on the Client Management Interface (CMI), which showed a record of suicidal ideation in 2011 and a diagnosis of depression in 2017.[199] Mr Tanti also had regard to the fact that CHS had assigned Darren an S3 risk rating.[200]

128. Mr Tanti's assessment was undertaken using a locally developed structured assessment tool, known as the Mental Health Intake Screening Assessment. This tool is based on the Jail Screening Assessment Tool, which is an instrument internationally validated for the detection of mental illness and suicide risk in compatible settings. The assessment takes about 15-30 minutes to complete. Up to five Forensicare staff attend reception and complete up to 35 reception psychiatric assessments each day, six days a week.[201]

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[196] T388-389, 465-466.
[197] Selisky 26/9/19, Exhibit AE, CB1148 (save that the reference to the involvement of Skilled Medical is based on the advice of Correct Care).
[198] Tanti 29/10/19, Exhibit AC, CB1540-2.
[199] Tanti 29/10/19, Exhibit AC, CB1543; JCare records, CB264; T677-8; CMI records, CB1289-90. A summary of the information recorded on CMI is also contained in Ms Robertson's statement: CB1132.
[200] CB1555, T683. There is no evidence that Dr Riazi had access to CMI data.
[201] Sullivan 4/11/19, Exhibit 13, CB1554; T680.

129. Mr Tanti's record of the assessment, which includes information provided by Darren, is recorded on JCare, a database used exclusively in the prison system for the recording of prisoner health information.[202] During the interview, Darren told Mr Tanti the following:

a) He lived with his brother in Knox.[203]

b) He was employed as a labourer.[204]

c) He suffered severe pain as a result of a motor vehicle accident that had left with an acquired brain injury and metal through most of his body.[205]

d) He was managed on pain and anti-depressant medication, which he listed, and stated that he "can't live without [his] meds."[206]

e) He had never attempted suicide.[207]

f) He did not have any current thoughts, plan or intent of suicide or self-harm.[208]

130. Mr Tanti assigned Darren an S4 suicide risk rating, as explained above. He considered that the protective factors for Daren were as follows:

a) Darren's presentation was calm, coherent and relaxed and he did not appear behaviourally disturbed.[209]

b) He was supported by his brother, with whom he said he lived.

c) He was future focussed.

d) He gave strong assurance of safety.

e) He was aware of a self-referral process if he had suicidal thoughts.

Mr Tanti planned a review by a registered psychiatric nurse within two weeks, and to seek collateral information from his GP and St Vincent's Hospital, which was his last reported contact on CMI.[210]

131. Whilst Mr Tanti was aware that Darren had previously been assigned an S3 rating, he did not review the reports earlier obtained by Ms Robertson, or the information she

[202] Sullivan 4/11/19, Exhibit 13, CB1554**;** JCare records, CB274-282.
[203] JCare records, CB275.
[204] Ibid.
[205] Ibid, CB279.
[206] Ibid.
[207] Ibid.
[208] Ibid, CB281.
[209] T725.
[210] Ibid [279]; T720-21.

entered onto PMI, including her expressed concerns about Darren's suicide risk.[211] Mr Tanti had access to this information through the PMI system. However, it was not the practice of reception staff at MAP to access PMI.[212] Dr Danny Sullivan, Forensicare's Executive Director of Clinical Services, who gave evidence at the hearing, explained why this was so:

a) JCare, not PMI, was the health record used within the prison system.

b) PMI's content was limited to Forensicare treatment, whereas the CMI provided statewide contacts with public mental health services.

c) CMI's broader base of information made it more suitable for screening purposes at a reception assessment, compared to the narrower, but potentially voluminous information contained on PMI[213]

132. Before Mr Tanti gave evidence, he was given a copy of the information that had been uploaded by CHS to the HEALTHe database. It should be kept in mind that, consistently with Forensicare's usual practices, Mr Tanti had not reviewed these documents at the time of the MAP reception assessment. This information included the text copied from Ms Robertson's email to CHS and the attached documents she provided from Ms Stephenson's email. Mr Tanti's attention was drawn to differences between the information contained in these documents, and that upon which he had based his reception psychiatric assessment. Much of this latter information was provided by Darren himself. The differences included the following:

a) Ms Stephenson's email revealed Darren's recent loss of his mother, the placement of his father in a nursing home, and Darren's homelessness following the eviction and sale of his parent's home by his brother. By contrast, Darren had told Mr Tanti that he was living with his brother, and he had not disclosed the recent stressors involving his parents.[214]

b) The reports revealed that Darren's motor vehicle accident in 2003 had left him permanently incapable of employment, to the point that he lacked independent living skills. By contrast, Darren had told Mr Tanti that he was working as a labourer, and the fact that Darren was wearing a hi-vis vest helped convince Mr Tanti that his account was genuine. [215]

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[211] T683.
[212] T716
[213] Dr Danny Sullivan 4/11/19, Exhibit 13, CB1554-5.
[214] T688-90
[215] T689, 700.

c) The reports revealed that Darren had attempted suicide on three occasions, and self-harmed, prior to 2013.[216] By contrast, Darren had denied any suicide attempts and had not reported any self-harm. Further, the CMI record disclosed no more than suicidal ideation, which did not necessarily imply an attempt, in 2011.[217]

d) The reports revealed multiple psychiatric admissions in private hospitals that were not visible on CMI.[218]

e) The reports revealed episodes of aggression, and ongoing agitation and negative attitudes that were not noted by, or apparent to, Mr Tanti.[219]

Mr Tanti then gave evidence that, had he been aware of the collateral information contained on the HEALTHe database, it is likely that he would have given Darren a S3 rating.[220] The significance of this properly made concession cannot be overstated.

133. Had Darren been assigned a rating of S3 or higher (ie S1, S2 or S3), MAP's operating procedures would have prevented him from being placed in the King Unit cell where he later hanged himself. In the event of an S3 or higher rating, MAP's operating procedures would have instead required that he be placed in a BDRP compliant cell[221] - which those in King Unit were not - and he would have been kept under at least hourly observation by prison officers.[222]

134. Darren arrived in the King Unit between 3:40pm and its lockdown at 4:30pm.[223]

135. At 4:05pm, Ms Robertson learned, by phoning Ringwood Police Station, that Darren had been transferred to MAP. She informed Ms Stephenson, whom she had been encouraging to continue contact with Darren whilst he was in custody. At 5:06pm, Ms Robertson sent an email to Vanessa Houston, of MAP Forensicare administration. The email attached reports that she had previously forwarded to Bronwyn Love at CHS. In the email to Ms Houston, Ms Robertson wrote that Darren "has quite a severe ABI and a history of SASH and chronic depression."[224] No action

[216] T691.
[217] CMI only provides information public health services and a classification code for the category of diagnosis: CB1132, T499, 782-3. Consequently, CMI did not show Darren's admissions at Delmont and The Melbourne Clinic, or include a reference to Darren expressing suicidal admission in a discharge summary from an admission to Maroondah in 2011: T499, 512, 693, 782-3.
[218] T693.
[219] T709-10.
[220] T715, 727.
[221] BRDP is the acronym for the Building Design Review Project, which aimed to remove ligature points from Victorian prison cells.
[222] Selisky 26/9/19, Exhibit AE, CB1150.
[223] JARO report, CB228.
[224] CB1140.

was taken on the basis of the information in the email prior to Darren hanging himself the following morning.

136. The data recorded on JCare makes it likely that Ms Robertson's email to MAP Forensicare was uploaded by administrative staff on 8 June 2018, after Darren had hanged himself. Dr Sullivan states that, in these circumstances, a clinician would not have accessed the information unless and until Darren had a follow up appointment.[225]

137. The only medical documents that accompanied Darren when he was transferred from the police cells to MAP were CHS medication chart and a copy of the discharge summary from Darren's visit to Maroondah Hospital relating to his admission in the early hours of 7 June 2018 with stomach cramps.[226]

138. These documents did not adequately inform MAP reception staff about the factors that were relevant to their suicide risk assessment of Darren. Mr Tanti's evidence demonstrated that the collateral information provided to CHS by Ms Robertson, including her expressed concerns about Darren's suicide risk, would probably have led him to assign Darren an S3 rating if he had been aware of it.

139. The factor that prevented MAP from being informed was the lack of a clear procedure for the handover of medical information from CHS to MAP reception staff when a prisoner was transferred from suburban police cells to MAP. Dr Michael Wong, the Acting Chief Custodial Health Officer, gave evidence at the inquest. He conceded the lack of a clear procedural responsibilities at the time.[227] He gave evidence that CHS had since commenced a new procedure that involved the electronic transmission of a PDF document containing a prisoner's HEALTHe records at the time of their transfer from police cells to prison. The procedure was then being performed by CHS administrative staff on weekdays, and the nurse managers on Saturdays, with very few prisoner transports ever occurring on Sundays.[228] I commend him for this timely response, and am further pleased to read the Commissioner's update that this is now occurring on Sundays as well.[229]

140. Whilst there was a delay between the receipt of the information emailed by Ms Robertson directly to MAP Forensicare, and its upload onto JCare by administrative staff, this is not causally connected to Darren's death. The primary responsibility for

[225] CB1558.
[226] Swanwick 5/9/19, CB1111. See also Riazi 14/10/19, CB1276; T459.
[227] T600.17.
[228] T602-4, 646-647, 663-4.
[229] See Commissioner's submissions dated 3 December 2019 at [49].

the handover of this information fell to CHS, as the agency which transferred management of Darren's care to MAP reception staff. Ms Robertson had provided this information to CHS more than 24 hours prior to the transfer. Her subsequent email to MAP Forensicare was no more than a backup procedure. It was reasonable to expect some delay in the processing of this information given that it was received at about 5pm. There was evidence that Forensicare has since changed its procedure to minimise this kind of delay, by providing a central email address to which MHARS clinicians can email collateral information as soon as they receive it, so that it would thereafter be accessible upon the prisoner's transfer to a prison, irrespective of the timing and destination of their transfer.[230]

141. Nonetheless, based on the evidence of Dr Sullivan, there is currently no clear procedure for the review of collateral information upon its receipt by Forensicare prison services. It is simply uploaded to JCare by administrative staff and it is not reviewed unless and until a prisoner has a follow up appointment.[231] This procedure does not allow for the possibility that collateral information might significantly impact upon a prisoner's suicide risk or psychiatric needs such that it should be to be acted on sooner than when a review might otherwise occur.

Recommendations to all institutional Parties

To enhance existing continuity of care, the various custodial health stakeholders train their staff about what information on their systems is visible to other stakeholders.

Given that forensic clinicians have indicated that they would be most assisted by being able to obtain all necessary information from a single database, the interested institutional parties in this inquest, and such other stakeholders as they determine necessary for an effective review process, including but not limited to Justice Health, should meet to consider the viability of such an innovation, and report back to me once they have done so.

Recommendations to the Chief Commissioner of Police

[230] CB1157-8.
[231] T792.

That police custodial officers be directed that, upon receipt of remand documentation for a prisoner issued by a court, that they immediately note and act upon any custodial management issues noted on the documentation, including by bringing any health or suicide or self-harm risk issues to the notice of CHS.

That Chief Commissioner of Police ensure that current and future health care providers and administrators receive training on how the applicable continuity of care policies are to be complied with whilst they fulfil their respective responsibilities.

That CHS implement a procedure for the electronic transfer of HEALTHe records upon the handover of a prisoner from police custody to a prison, whenever the transfer occurs.

COMMENT: I commend the proactive steps taken by CHS to commence the electronic transfer of HEALTHe records upon the handover of a prisoner from police custody to a prison, whenever such a transfer occurs, albeit that the procedure has not yet been formalised.

Recommendation to Corrections Victoria and Forensicare

That CV and Forensicare ensure that, upon the arrival of a prisoner at a prison, the appropriate reception staff promptly note and act upon any custodial management issues recorded on the accompanying documentation in a timely fashion, including by capturing life threatening health, suicide or self-harm risk issues in JCare, or otherwise bringing it to the attention of the appropriate clinical staff working at the prison. This should include a timely remedial mechanism for admission documentation which arrives after the prisoner has been through the reception processes.

COMMENT: I commend the adoption of a new procedure that enables MHARS clinicians to immediately forward collateral information received when a prisoner is in police custody to a central email address monitored by Forensicare reception staff at all prisons to which the prisoner might later be transferred. The Coroner notes that this procedure does not absolve CHS of the primary responsibility for the effective handover of medical information upon transferring a prisoner from police cells to a prison.

Events proximate to Darren's suicide

142. Darren was placed in King Unit cell number 27 with two other prisoners, 52 year old Greg Welsh, and approximately 46 year old Minh Phan. Mr Welsh talked to Darren in the evening. Darren was upset. During the evening Darren described himself as an "arsehole" and a "fucking mongrel", but didn't say why.[232] Mr Phan had limited English speaking skills and couldn't follow the conversation, but to him it seemed that the interaction between the three of them was friendly and relaxed.[233]

143. At 5:08am, after Mr Welsh and Mr Phan had fallen asleep, Darren pressed the cell intercom. He told MAP staff in the control room that he was bleeding from the neck and couldn't see the injury because there was no lighting in the cell. At 5:15am, two MAP prison officers came to the cell. One of them shone their torch in through the observation window. They tried to unlock the cell trap door to facilitate communication, but failed because their keys did not work. They saw that Darren had what looked like a bleeding pimple. He did not appear distressed. He appeared reassured when they told him what it was. They left around a minute later.[234] At around this time, Mr Phan woke up and saw Darren speaking to a prison officer at the cell door but did not understand what was said.[235]

144. Shortly before 7:27am, Mr Phan woke up and saw Darren had hanged himself from the shower rail. He woke Mr Welsh and showed him. Mr Welsh immediately pressed the intercom, at 7:27am, and told a prison officer in the control room what had happened. The prison officer's initial attempt to get a watch staff member to go to the unit was unsuccessful because staff members were in the process of a shift changeover that was then about to take place.[236] At 7:30am, a "Code Black", denoting a serious medical incident or death, was called by MAP staff. At 7:33am, prison staff opened the cell, cut Darren down, and commenced CPR. Medical staff arrived a few seconds later. At 7:51am, paramedics arrived in the unit and continued CPR. Between 8:32 and 9:20am, Darren was removed from the unit and taken to the Royal Melbourne Hospital.[237]

145. On 10 June 2018, at 7:19am, Darren was pronounced dead.

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[232] Gregory Welsh 8/6/18, Exhibit I, CB37; Steven Day 8/6/18, CB73.
[233] Phan 8/6/18, CB46.
[234] JARO report, CB234, 235.
[235] Phan 8/6/18, CB46.
[236] JARO report, CB238.
[237] JARO report, CB235.

146. During the autopsy later performed by Dr Archer, she observed there was no defined ligature mark, but did note abrasions and bruising on the front and sides of Darren's neck. She considered that this injury was consistent with the use of a towel as the ligature.[238]

Did the design of Darren's King Unit cell contribute to his death?

147. The sad answer to this question is yes. The shower rail inside the cell was known to be a ligature point well prior to Darren's death.[239] Darren was issued with a towel for use in that shower as part of his reception into that cell.

148. The incidence of suicide in prison is markedly higher than in the general population, both in Australia and globally.[240] Hanging is by far the most common, unnatural cause of death in custody in Australia.[241] Dr Sullivan agreed that the removal of ligature points would have reduced the risk of suicide. He also said, however, that the removal of ligature points would not have eliminated the possibility of suicide by Darren if he had been "hellbent on killing himself."[242] Nicholas Selisky, the Governor of MAP, who gave evidence at the inquest, said there were unfortunately many ways to commit suicide in prison other than by hanging.[243]

149. However, the possibility that Darren would have committed suicide by some other means if the cell had been BDRP compliant, particularly if he had been under an hourly observation regime applicable to an S3 prisoner, is speculative. I find that the presence of a ligature point in Darren's King Unit cell is a proximate cause of Darren's death.

150. The more complete answer though is that since Darren's death, MAP has completed its long running BDRP compliance works in all cells. I note that this project has been on foot for many years now, and it is pleasing to see it has finally been completed.[244]

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[238] Autopsy Report dated 2/10/18, CB130.
[239] See for instance *Inquest into the Death of Adam Sasha Omerovic* [2014] VicCorC 13 (24 January 2014). More generally, see the list of the relevant recent reviews at [2.4] of the JARO report, CB 231.
[240] T774.
[241] Eg, *Deaths in custody in Australia to 30 June 2011*, Australian Institute of Criminology, p30, cited in Exhibit AF, *Investigation into deaths and harm in custody*, Victorian Ombudsman, *Investigation into deaths and harm in custody*, Victorian Government Printer, March 2014, Melbourne, [297].
[242] T773.
[243] T745.
[244] Statement of Governor Selisky at [15], CB1150.

151. Various other improvements have also been made to the prison environment following Darren's death.[245] The Justice Assurance and Review Office (**JARO**) are independent of Corrections Victoria, although both bodies are accountable to the same Minister. Their investigation and report of Darren's death has confirmed that the following recommendations for improvement have already been accepted by Corrections Victoria:

a) That the General Manager (GM) of MAP explore solutions to resolve the lack of lighting in cells, including when the electricity is tripped and ensures that a lighting option is available.

b) That the GM of MAP provide additional mentoring and training to control room staff, which reinforces the requirement for a Code Black to be called immediately, in circumstances where a prisoner uses the cell intercom and states they are in an emergency situation.

c) That Corrections Victoria consider the multi-purposes of body-worn cameras (**BWC**) and provides clarity around the aims and expectations of its use within the correctional system. This may include updating the broad policy requirement for BWC to be activated 'in the event of an incident or major disturbance' where its application to every incident is not appropriate.

d) That the GM of MAP do the following:

   (i) Reinforce that all staff who are actively involved in an incident response are expected to complete officer's reports. This should include details of what 'active involvement' means;

   (ii) Ensure that senior management are accountable for officer's reports being completed and submitted after incidents.

e) That Justice Health liaise with CHS to explore how they can better obtain, record and utilise information relating to health risk ratings.

f) That Corrections Victoria liaise with Victoria Police to explore opportunities to leverage the data obtained by both agencies to inform the management of offenders and the reception of new prisoners, especially first-timers.

[245] Actions arising from formal debrief, Appendix C of the JARO Report, CB 259.

g) That the GM of MAP consider ways to strengthen the support provided to first-timers by -

(i) considering the viability of a 24-hour welfare check for all first-timers, irrespective of their initially assigned risk ratings;

(ii) crystallising best practice for inducting new prisoners into local policy. This may include consideration of one-on-one conversations with the prisoner, completing a 'day of arrival' checklist and observing the prisoner in the unit; and/or

(iii) considering the viability of piloting a first-night program, aimed at providing additional support and information to prisoners spending their first night in custody.

152. I commend Corrections Victoria for seizing this opportunity to improve facilities and practices at MAP.

COMMENT: I note that all cells, including those in King Unit at MAP, are now BDRP compliant. I also note that suicide risk assessments are fallible, as this case demonstrates. The removal of known means of suicide and self-harm from all parts of prisons should receive continuing consideration and priority.

Conclusion

153. The heightened vulnerability of first-time prisoners is well known.[246]

154. In this case, the JARO investigator's report reached an insightful conclusion, which I shall adopt :

> Mr Bandon's death has highlighted the current challenges faced by the system, including the surging prisoner population and its impact on front-end locations, such as the MAP, and the complexities of managing an increasing (and complex) cohort: first time prisoners. It has also highlighted the critical role the reception process plays in identifying prisoners' immediate risks and needs, and enabling them to adapt to the prison environment, in

[246] *JARO* report conclusion, [10] at CB 255.

addition to the importance of information sharing between all parties who have a role to play in the management of prisoners.[247]

155. I have concluded that Darren's death was preventable, on the balance of probabilities, had there been better information sharing between the interested institutional parties[248] involved. The evidence establishes that if the Victoria Police Custodial Health Service had provided MAP with the SASH risk information that Emma Robertson supplied to them the day prior to his transfer, MAP staff would not have paced Darren in one of their few remaining cells with known ligature points.

156. None of the many professionals who dealt with Darren during this troubled period prior to his death were careless. I am satisfied that all those involved attempted to acquit their duties as best they could. Two professionals – Racquel Stephenson and Emma Robertson - stood out in particular, as providing Darren with skill, care and attention above and beyond that which could reasonably be expected of them.[249] The tragedy here though is that the information sharing systems were inadequate to capitalise on the excellent work of Ms Stephenson and Ms Robertson.

157. One last matter that ought be noted was that at the conclusion of the closing submissions, Steven Brandon rose and addressed the Court and the interested parties with some generous remarks,[250] the sentiments behind which were shared by all those involved in this inquest. They are worthy of being incorporated into this Finding so that they thereby become part of the public record:

> MR BRANDON: I was just going to thank everybody here for um picking this ah difficult situation and looking at hopefully making something good come out of this. So, thank you all for your efforts.

158. With those remarks in mind, I wish to convey my sincere condolences to Darren's family for his tragic death, and in turn thank them for their assistance with the inquest at this difficult time.

159. It remains only to address the formalities distinctly required by the Act.

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[247] Ibid.
[248] Each of whom are public authorities for the purposes of the *Charter*.
[249] Ms Stephenson and Robertson, as detailed above.
[250] T814.23

FINDINGS

160. Having investigated the death and held an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

a) The identity of the deceased was Darren Brandon, born 30 July 1966;

b) The death occurred on 10 June 2018 at the Royal Melbourne Hospital in Parkville from hypoxic-ischemic encephalopathy[251] due to hanging; and

c) The death occurred in the circumstances described above.

RECOMMENDATIONS

161. Pursuant to section 72(2) of the *Coroners Act 2008*, **I recommend:**

Recommendations to all institutional Parties

1. *To enhance existing continuity of care, the various custodial health stakeholders train their staff about what information on their systems is visible to other stakeholders.*

2. *Given that forensic clinicians have indicated that they would be most assisted by being able to obtain all necessary information from a single database, the interested institutional parties in this inquest, and such other stakeholders as they determine necessary for an effective review process, including but not limited to Justice Health, should meet to consider the viability of such an innovation, and report back to me once they have done so.*

Recommendations to the Chief Commissioner of Police

3. *Whilst a suspect remains self-represented, contact details of identified support people must be passed along to each subsequent informant and the ultimate prosecutor, so that prosecutor is able to assist the Court in the manner it will expect.*

4. *In recognition of the inherent vulnerability of people taken into Police custody, the Commissioner revisit the relevant parts of the Victoria Police Manual with a view to*

[251] Commonly known as 'cardiac arrest'.

ensuring all relevant information in the possession of Victoria Police is conveyed to the police prosecutor.

5. *That police custodial officers be directed that, upon receipt of remand documentation for a prisoner issued by a court, that they immediately note and act upon any custodial management issues noted on the documentation, including by bringing any health or suicide or self-harm risk issues to the notice of CHS.*

6. *That Chief Commissioner of Police ensure that current and future health care providers and administrators receive training on how the applicable continuity of care policies are to be complied with whilst they fulfil their respective responsibilities.*

7. *That CHS implement a procedure for the electronic transfer of HEALTHe records upon the handover of a prisoner from police custody to a prison, whenever the transfer occurs.*

Recommendation to Corrections Victoria and Forensicare

8. *That CV and Forensicare ensure that, upon the arrival of a prisoner at a prison, the appropriate reception staff promptly note and act upon any custodial management issues recorded on the accompanying documentation in a timely fashion, including by capturing life threatening health, suicide or self-harm risk issues in JCare, or otherwise bringing it to the attention of the appropriate clinical staff working at the prison. This a should include a timely remedial mechanism for admission documentation which arrives after the prisoner has been through the reception processes.*

COMMENTS

162. Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. *I commend the proactive steps taken by CHS to commence the electronic transfer of HEALTHe records upon the handover of a prisoner from police custody to a prison, whenever such a transfer occurs, albeit that the procedure has not yet been formalised.*

2. *I commend the adoption of a new procedure that enables MHARS clinicians to immediately forward collateral information received which a prisoner is in police custody to a central email address monitored by Forensicare reception staff at all prisons to which the prisoner might later be transferred. The Coroner notes that this procedure does not absolve CHS of the primary responsibility for the effective handover of medical information upon transferring a prisoner from police cells to a prison.*

3. *I note that all cells, including those in King Unit at MAP, are now BDRP compliant. The Coroner notes that suicide risk assessments are fallible, as this case demonstrates. The removal of known means of suicide and self-harm from all parts of prisons should receive continuing consideration and priority.*

OTHER ORDERS

163. Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

d) Steven Brandon, senior next of kin;

e) Corrections Victoria;

f) Chief Commissioner of Police;

g) Rebecca Cotton;

h) Bronwyn Love;

i) Victoria Legal Aid;

j) Bronte Fisher;

k) Forensicare;

l) Correct Care Australasia;

m) Raquel Stephenson;

n) Emma Robertson;

o) Bianca Smith;

p) Justice Assurance and Review Office;

q) Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability; and

r) Royal Commission into Victoria's Mental Health System.

Signature:

SIMON MCGREGOR
CORONER
6 April 2020

Annexure A – Prisoner data sources summary chart

Data source	Description	Owner / operator	Who has access?	How and by whom is it typically used?	Relevant data entries or records, maker and timing if known and relevant
Client Management Interface (CMI)	The state wide mental health database [1554]	DHHS	All public health services (including Forensicare) who are subject to the Mental Health Act [1554] CHS only has access via Forensicare VicPol members do not have access	Forensicare's administration staff receive a list of incoming prisoners at the start of each working day, download the relevant data from the CMI (where such data exists) and input the CMI data into JCare. [1555] MHCLS / MHARS contacts are recorded in manner that is deidentified in that it cannot be traced back to the client by others who access CMI. [1557]	CMI snapshot compiled by Robertson on 6/6/18 [1327]-[1328]
Custody Module / The Thin Blue Line	"The Custody module provides for the electronic management of prisoners across Victoria. This includes prisoner transfers between Victoria Police and Corrections Victoria [903] A Vicpol database that records information about the health and welfare of prisoners in police custody [1564]"	Vicpol [1564] [903]	Vicpol members CHS staff [1564] MAP staff can access risk ratings [1695]	The Custody Module is maintained at every station where prisoners [903-909]. CHS staff able to make entries onto the custodial module including adding or amending data such as risk ratings, a chronology of care, medication administration and conversations with police members. CHS staff are expected to regularly conduct cross-checks of HEATHe and the Custody Module to ensure relevant information about a detainee is available to police members. There is no universal electronic medical record, which can be accessed across all custody areas (both police and prisons) [1564]	Prisoner Information Record and Custody Overview [1634]-[1638] and [1645]-[1648]

E Justice	The system used to record prisoner risk ratings such as the P and S ratings, and LEAP warnings about risks posed by prisoners to custodial and clinical staff [1555] EJustice is a vital link for the sharing of information relevant to prisoner and offender backgrounds, risks and management strategies [245]. Corrections Victoria primarily use PIMS EJustice and Centurion, whereas Victoria Police use the Thin Blue Line, which has an interface with Ejustice [245, footnote 73].	Corrections Victoria	All custodial and clinical staff [1555] VicPol members have access to E-Justice risk ratings as the information is shared across different systems when there is an agreement in place regarding these risks being transferred to the custody and attendance modules from EJustice.	Clinicians conducting reception assessments [1555]	Redacted records (Ex R, see also Ex 6)
HEALTHe	CHS's official medical record and brings together all current health information held by CHS about detainees from CHS and the health assessments from the doctors and nursing staff. [1564]	CHS [1564]	CHS staff [1564] VicPol members do not have access	CHS nurses are expected to record all interactions relating to persons in custody on HEALTHe and update the risk ratings of detainees if necessary [1564]	Screenshots [1649]-[1654] Triage records report including full Cotton entry of information provided by Robertson [1278]-[1281] Doctors consultation notes 6/6/19 [1282]-[1284] Various uploaded documents [1278]-[1320]
JCare	The information system used exclusively in the prison system for the recording of prisoner	Justice Health	Forensicare prison services clinicians [1555]. VicPol members do not	Forensicare prison clinicians are contractually obliged to use JCare to record the health, medical and treatment history of each prisoner who receives	Overview and encounters entered 7-11/6/18 J[261] - [282] Authority and reception

	health information. [1554]		have access	forensic mental health services in accordance with accepted clinical practice. [1554]. Forensicare administration staff who receive relevant collateral information about a prisoner would make an "encounter note" and upload it to JCare where it would be seen by a clinician if (and only if) the prisoner had a follow up appointment [1557]-[1558]	assessment notes [284], fax cover [283] Documents uploaded from PIR file [286]-[290] Medication charts at MAP [291]-[293] Consent unsigned [294] Medical reports emailed by Robertson and uploaded on 8/6/18 [295]-[314] Miscellaneous document [316]-[319]
Law Enforcement Application Package (LEAP)	A Vicpol database that contains law enforcement information about people both in and out of custody	Vicpol	Vicpol members Warnings issued by LEAP about risks posed by prisoners to custodial staff are accessible via E Justice by all custodial and clinical staff [1555]	Warnings accessible via E Justice accessed by clinicians conducting reception assessments [1555]. CHS staff have some, limited access [1564]	Criminal history [154]-[155] printed 28/1/19
Patient Management Interface (PMI)	A program utilised at Thomas Embling Hospital and in other Forensicare services to record and store health information [1554]	Forensicare	All Forensicare clinicians [1554]	This system is typically not utilised by Forensicare staff at MAP when conducting a reception assessment for reasons set out by Sullivan at [1554]-[1555]. MHCLS / MHARS clinicians will record contact with a client onto PMI, including the nature of the contact, client details and can upload collateral information [1557]	Robertson notes [1322]-[1325], 6-7/6/18 Authority to Forensicare signed by Darren witnessed by Robertson [1326] CMI snapshot compiled by Robertson on 6/6/18 [1327]-[1328] Email and attachments from Stephenson uploaded by Robertson on 6/6/18 [1329]-[1370]
Prisoner Information	An operational database which records details on	Corrections Victoria	Forensicare prison services clinicians	Clinicians conducting reception assessments [1555]	Redacted records (Ex S)

Management System (PIMS)	all prisoners in custody, past and present, and is utilised in the day-to-day management of prisoners. (Source 2003 AG's report)		[1555] Mental Health Court Liaison Service (now MHARS) [1557] Some VicPol members have limited access		
Prisoner Information Record (PIR)	The PIR is used to refer to the document generated from the Custody Module see 904 and 1634 and the physical bundle of documents that accompany a prisoner. Hard copies of relevant medical records and court documents (such as a remand warrant) should arrive with a prisoner, in a locked luggage compartment in the prison van, when they are transferred from police cells to MAP [1488]	Vicpol/Corrections Victoria	Vicpol MAP staff	MAP clinicians including Forensicare [1148]	Dr Ibrahim medication chart and Eastern Health discharge documents 6-7/6/18 [286]-[290] and 1634
Remand warrant notations	Custody management issues identified by a remanding Magistrate. Remand warrants are issued by Courtlink in the Magistrates' Court and are generally handled as a hardcopy.	Magistrates' Court / remanding Magistrate	Corrections Victoria if the person is remanded in prison Vicpol members (if the person is remanded in custody in police cells)	There is no system that ensures that this document comes to the attention of CHS staff	Remand warrant [1008]-[1013], Magistrate La Rosa, 5/6/18 at 1700 [1060]