IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001982

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of Cameron Richard Plant

Delivered On:	17 May 2022
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank
Hearing Dates:	17 May 2022
Findings of:	Judge John Cain, State Coroner
Counsel Assisting the Coroner:	Ms Abigail Smith, Acting Senior Solicitor to the State Coroner

INTRODUCTION

1. Cameron Richard Plant (**Mr Plant**) was born 9 May 1967 and was 52 years old at the time of his death. Mr Plant's parents are both deceased his father passed away when Mr Plant was in his twenties and his mother in 2015. Mr Plant was raised in Melbourne but had worked overseas for the last ten years working at various times in Malaysia and Dubai.

2. Mr Plant met Tania Kawood in Dubai in 2011 and they commenced dating and were married in Bali on 19 August 2016 and later registered the marriage in Victoria on 19 January 2017.

3. Mr Plant worked in the commercial radio industry and until November 2019 was the managing director of Shock Middle East when his employment was unexpectantly terminated. He subsequently found employment in event planning industry while he looked for other work in the radio industry. The outbreak of COVID-19 in early 2020 was creating some uncertainty.

4. At around that time Ms Kawood and Mr Plant decided to separate. This separation was described by Ms Kawood as amicable. They discussed future arrangements and Mr Plant decided to return to Australia while Ms Kawood decided to stay in Dubai. Mr Plant was able to obtain a ticket on a repatriation flight to Melbourne and departed Dubai arriving in Melbourne on 3 April 2020.

5. According to Ms Kawood, Mr Plant's health was generally good, apart from some elevated blood pressure and he had not been diagnosed or treated for any mental health or emotional illness.[1] However, there were several issues that were causing him some stress, including the end of his marriage, his employment status, and the general uncertainty about his future employment.

6. On arrival in Australia on 3 April 2020, Mr Plant was issued with a detention notice that required him to remain in Hotel Quarantine for 14 days. Hotel quarantine was part of the Victorian Governments response to the developing COVID 19 pandemic and was part of the national agreement where all states and territories agreed that all international arrivals would quarantine for 14 days. Hotel quarantine in Victoria was relatively new, having been established on 28 March 2020.

7. Mr Plant was detained at the Pan Pacific Hotel in South Wharf in Melbourne.

[1] Coronial Brief (**CB**), p14

8. Mr Plant was found deceased in his hotel room on 11 April 2020.

THE CORONIAL INVESTIGATION

9. Mr Plant's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.[2]

10. Pursuant to section 52(2) of the Act it is mandatory that an inquest be held where a death occurs in custody or care. As Mr Plant was in hotel quarantine at the time of his death it is mandatory that an inquest be held into his death.

11. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of a the deceased person, the cause of death and the circumstances in which the death occurred.[4]

12. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances.

13. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[6] or to determine disciplinary matters.

14. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

15. For coronial purposes, the phrase '*circumstances in which death occurred*'[7] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of the narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and casually relevant to the death.

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[2] *Coroners Act 2008* (Vic) s 4 and 4(2)(a).
[3] *Coroners Act 2008* (Vic) s89(4).
[4] *Coroners Act 2008* (Vic) preamble and s 67.
[5] *Keown v Khan* (1999) 1 VR 69.
[6] *Coroners Act 2008* (Vic) s 69(1).
[7] *Coroners Act 2008* (Vic) s 67(1)(c).

16. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's '*prevention*' role.

17. Coroners are also empowered:

    a) to report to the Attorney General on a death;[8]

    b) to comment on any matter connected with the death they have investigated, including matters of public health or safety or the administration of justice;[9] and

    c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[10]

18. These powers are the vehicles by which the prevention role may be advanced.

19. The findings draw on the totality of the material obtained in the coronial investigation of Mr Plant's death. That is, the court file, the Coronial Brief prepared by Senior Constable Brad Skerke and further material obtained by the Court.

20. In writing this finding, I do not purport to summarise all of the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

21. All coronial findings must be made based on the proof of relevant facts on the balance of probabilities.[11] In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[12] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[8] *Coroners Act 2008* (Vic) s 72(1).
[9] *Coroners Act 2008* (Vic) s 67(3).
[10] *Coroners Act 2008* (Vic) s 72(2).
[11] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[12] 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.

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

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

22. On 14 April 2020 Cameron Richard Plant, born 9 May 1967, was visually identified by his cousin, Christian Stewart.

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

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

24. Specialist Forensic Pathologist Professor Noel William Francis Woodford from the Victorian Institute of Forensic Medicine, conducted an examination on 13 April 2020 and provided a written report of his findings dated 4 August 2020.

25. Toxicological analysis of post-mortem samples identified the presence of alcohol at a concentration of .004g/100mL and did not identify the presence of any common drugs or poisons.

26. Professor Woodford provided an opinion that the medical cause of death was:

    1 (a) HANGING.

27. I accept Professor Woodford's opinion as to cause of death.

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

28. On 3 April 2020 Mr Plant was transported from Melbourne Airport to the Pan Pacific Hotel in South Wharf, which was a designated hotel quarantine facility. He checked in at approximately 8am and was taken to his room. The room was a single suite containing a double bed and separate bathroom. The swipe card reader on the door of Mr Plants' hotel room shows that he did not leave his room after he entered on 3 April 2020.

29. Persons in hotel quarantine were contacted each day by a Health department staff member to conduct 'COVID-19 Assessment Symptoms Screening' and meals were left outside the room door for residents to collect. Mr Plant was last spoken to on 10 April 2020 at approximately 4.00pm by nursing staff. Nursing staff did not have any record of a complaint by Mr Plant or have any concerns for his welfare.

30. Mr Plants' telephone records indicate that various calls were made from his mobile phone and conversations with friends through a 'WhatsApp' group.[13] He spoke daily with his cousin Christian Stewart, who he had planned to stay with for a few days after his release from hotel quarantine, until he found a place to stay. Mr Stewart described Mr Plant as being in good spirits considering what he had been through (this being a reference to the recent breakdown of his marriage[14]). Ms Kawood was also in contact with Mr Plant, exchanging messages while he was in hotel quarantine. In his last few messages with Ms Kawood, Mr Plant described his need for some fresh air, complained about the hotel food and that he had been informed that there were some positive cases diagnosed in the hotel, but no other information was shared about the situation.[15]

31. At approximately 12.00pm on 11 April 2020, a senior staff member was notified that Mr Plant had not answered calls to his room since 4pm the previous day. He had also not taken his meal from the previous evening and was not answering his door. Due to other work commitments the senior staff member was delayed in following up this report and it was not until approximately 5pm that the situation was discussed with nursing staff.

32. Security staff were contacted to accompany nursing staff to investigate the situation. They attended at his room, knocked on the door but there was no response. Using a master swipe key-card the door was opened but the security latch was engaged, and it took a few minutes to disengage this before they could enter the room. On entering the room, they discovered Mr Plant in the shower area with cloth tied around his neck and attached to a tap in the shower.

33. Police and ambulance attended the scene and Mr Plant was declared deceased.

MENTAL HEALTH BACKGROUND

34. Mr Plant did not have a history of mental illness and it does not appear from the available evidence that he had ever sought treatment for a mental health condition. This is confirmed by Ms Kawood, although she does acknowledge that with Mr Plant's employment situation, the break down of their marriage and some issues with a property he owned in Port Douglas the months prior to his death had been particularly challenging and stressful for him.[16]

HOTEL QUARANTINE IN VICTORIA

[13] CB, p18
[14] CB, p21
[15] CB, p14
[16] Ibid.

35. A state of emergency under the *Public Health and Well-being Act 2008* (Victoria) in relation to COVID-19, was declared by the Minister for Health on 16 March 2020. The Federal Government announced mandatory hotel quarantine for all returning international travellers on 26 March 2020 and this required that the Victorian government have a hotel quarantine program ready to receive international travellers on 29 March 2020.

36. The Victorian hotel quarantine program was established as a multi-agency operation involving the Department of Health and Human Services (now known as the Department of Health) (**DoH**), the Department of Jobs Precincts and Regions, the Victoria Police, the Department of Transport and the Department of Premier and Cabinet. Throughout this period key area of responsibility for DoH, relevant to this investigation was the oversight and delivery of health and well-being services for returned travellers and the delivery of public health functions.

37. This structure continued until 27 June 2020 when the Victorian Government announced that the Department of Justice and Community Safety and Corrections Victoria (**DJCS**) were to become involved in the hotel quarantine program. On 30 June 2020, the Victorian Government announced the establishment of the Board of Inquiry into the hotel quarantine program. International flights to Victoria were suspended from 2 July 2020.

38. On 30 November 2020, the Premier of Victoria announced the establishment of COVID-19 Quarantine Victoria (**CQV**) which was an administrative office attached to DCJSC, charged with overall responsibility for the accommodation program for returned travellers. CQV continues to be responsible for the operation of the hotel quarantine program in Victoria.

39. Further, on 4 June 2021, the Commonwealth Government entered into a Memorandum of Understanding with the Victoria Government for the delivery of a Centre for National Resilience in Mickleham, known as the Victorian Quarantine Hub (**VQH**). VQH is a purpose-built quarantine facility, which is intended to facilitate the return of overseas travellers.[17]

40. The VQH commenced operations on 21 February 2022, following which a phased commissioning occurred, with the facility having approval to operate 500 beds. VQH accepted its first residents on 22 February 2022 and has now replaced the previous hotel quarantine program.[18]

[17] Supplementary statement of Emma Cassar dated 4 April 2022, pg 2.
[18] Supplementary statement of Emma Cassar dated 4 April 2022, pg 2.

41. CQV is responsible for the operation of the VQH while it is used as part pf the public health response to the COVID-19 pandemic. Specifically, CQV oversees the operating and service model, as well as the procurement of external service provision.

FURTHER INVESTIGATIONS

42. The focus of my investigation into Mr Plants' death was the support and assistance, particularly mental health support, that was provided to residents detained in hotel quarantine.

43. Section 7 of the Act makes clear that a coroner should 'avoid unnecessary duplication of inquiries and investigations.' In this context, there are three investigations that are relevant, the first being the Safer Care Victoria investigation, the second being the Board of Inquiry into the Hotel Quarantine Program (**Board of Inquiry**) and the third being WorkSafe Victoria. Those investigations are outlined in further detail below.

Safter Care Victoria Investigation

44. Following the death of Mr Plant, the Secretary of DoH requested that Safer Care Victoria (**SCV**) conduct an independent review into the incident. SCV as part of DoH describes itself as the 'the states healthcare quality and safety improvement specialist.'[19]

45. On 10 June 2020, the completed report was delivered to the Secretary of DoH.

46. The SCV report made several key findings and recommendations aimed at providing improved services for residents in hotel quarantine to better understand their risk and manage their wellbeing whilst in hotel quarantine. I have not set out the findings in full but have summarised the key elements.

47. The key findings of SCV review can be summarised as:

- There was insufficient staff to manage the workload resulting in initial and ongoing welfare checks being deployed, and subsequent checks were often infrequent.

- Access to detainee health and welfare information to assist in providing adequate care to detainees was poorly managed due to lack of comprehensive, central and accessible repository for such information.

[19] Safer Care Victoria Annual Report 2020-21.

- Health and welfare information was collected in a fragmented manner, involving multiple entities and teams and multiple formats.

- As it was common for some detainees to not answer daily COVID-19 symptom check calls, almost always for innocuous reasons unanswered calls alone did not typically trigger immediate escalation, beyond attempting follow-up calls.

- There was a lack of specific formal policy about the threshold for escalating concerns about repeated unanswered COVID-19 Assessment calls, tracking procedures were also lacking.

- Workload and delegation challenges meant that Authorised Officers were sometimes required to prioritise multiple competing demands, resulting in delays in attending to potential detainee health and welfare concerns.

- Forms for collecting detainee information were not well designed to elicit information regarding past or current mental health concerns, self-harm or suicidal ideation.

48. Further, SCV made thirteen recommendations:

- Develop and implement a detainee arrival pack that consolidates the current suite of 'onboarding' forms into a single onboarding form (for data entry into the central repository in Recommendation H), alongside printed information for detainees.

- Design the new onboarding form to: include a specific question(s) about past or current self-harm and suicidal ideation; be clear, direct and use plain language does not use relative, subjective words such as 'significant' to delineate what information is important; encourage disclosure beyond binary answers; address mental wellbeing from both medicalised and non-medicalised perspectives; and provide specific examples of common support needs.

- Establish a formal process to ensure each (newly consolidated) detainee onboarding form is reviewed by a single staff member within 48 hours, adopting a holistic approach, to identify and act upon any immediate or ongoing support needs or health and welfare risks factors, identify detainees requiring further risk and assign an initial risk level (see Recommendation D).

- Establish a formal process for nursing staff (with additional clinical advice if required) to assign and monitor a health and welfare risk level (low, medium or high) for each detainee, based on all information available (e.g. onboarding form, 'initial screening call', staff observations).This level should be dynamic and changeable at any time in the face of new information or circumstances, with a schedule for regular review of each detainee's risk level.

- Replace current daily COVID-19 Assessment symptom screening calls with daily 'health and welfare screening calls', delivered by nursing staff for detainees of all risk levels. Include in these calls the COVID-19 Assessment symptoms screening questions, and other basic health and welfare questions to screen for unmet support needs or elevated safety and welfare risks.

- For detainees classified as medium or high risk only, extend the purpose of the new daily 'health and welfare screening calls' (see Recommendation E) to specifically discuss, monitor and provide support around their specific health and welfare issues.

- For detainees classified as low risk, make the provision of regular 'check-in calls' from the welfare team an optional, opt in addition to receiving the mandatory 'health and welfare screenings calls' (to provide social contact and practical needs-check) (see Recommendation E). Implement processes for welfare team members with concerns to escalate these for potential re- classification of a detainee as higher risk.

- Implement a comprehensive central repository for detainee's personal information (including health and welfare information) accessible to all staff with a role in providing services, care, support and oversight for detainees. Include functionality to provide an 'alerts list' for each shift to identify detainees with a medium or high risk level, and the reasons for those ratings.

- In the central repository of detainee personal information, design the section for logging health and welfare calls (from the nursing and welfare teams) to include a specific field(s) for users to record the dates and times of both answered and unanswered calls to detainees (with the list of unanswered calls automatically visible to users).

- Offer detainees the option (at onboarding and throughout their detainment, for example via text message or email) to nominate a time slot each day in which they

prefer to take calls from welfare and/or nursing staff, and call detainees during the nominated time slot.

- Implement a formal policy about when to escalate situations in which detainees are not answering calls from nursing or welfare teams – using a decision-tree approach that accounts for factors such as number and frequency of unanswered calls, detainee's existing health and welfare risk factors, and previous behaviour in answering/not answering calls.
- Increase and/or more strategically roster the number of AOs on duty at one time to ensure adequate baseline capacity, and rapid response surge capacity that AOs can directly and immediately request if they are task- or demand- overloaded.
- Establish a formal selection process for staff taking up new roles that accounts for their skills, preferences and attributes. Require that welfare team members have relevant background or experience (e.g. mental health, counselling, social work, peer support etc). Complement this with targeted initial and ongoing training and supervision (including for remote working staff) for all new and current staff.

Board of Inquiry

49. On 30 June 2020, the Victorian Government announced the establishment of a Board of Inquiry into the hotel quarantine program. The terms of reference were broad and included issues related to the health and wellbeing of returned travellers in hotel quarantine.

50. On 21 December 2020, the Board of inquiry delivered its final report to the Victorian Government. There were eleven recommendations (Recommendations 40 – 51) directly relevant to this investigation. These recommendations, specifically address the health and wellbeing issues relevant to returning travellers held in hotel quarantine. The Board of Inquiry also reviewed and considered the SCV findings and recommendations.

51. The Board of Inquiry made the following recommendations[20]:

    - The Quarantine Governing Body ensures that daily health and welfare checks be embedded into the operation of each quarantine facility.

[20] Recommendations 40 – 51 of the COVID-19 Board of Inquiry final report, Vol 1, p34.

- Site Managers arrange standard daily health and welfare checks on people in quarantine, to be conducted with the assistance of available technology, such as a visual telehealth platform, where the individual is willing and able to participate in this way or as otherwise directed by the Clinical Manager.

- The Quarantine Governing Body provides direction, advice and resourcing as to the use of visual telehealth platforms to enable a case management approach to an individual's health needs, which may enable family, interpreters, existing or preferred healthcare professionals and supports to participate in case conferencing directed to the health and wellbeing of those in quarantine facilities

- That the daily health and welfare checks be conducted by appropriately skilled personnel who are also able to screen for any unmet needs or concerns, rather than limited to a check on COVID-19 symptoms.

- Suitable health and welfare check by appropriately skilled personnel should be conducted on those in home-based quarantine.

- The Quarantine Governing Body ensures the ability to provide daily fresh air and exercise breaks for people placed in quarantine facilities is factored into not only the physical layout, but also the staffing of the facility, to ensure there is provision for safe, daily opportunity for people in quarantine facilities to have access to fresh air and exercise breaks.

- The Quarantine Governing Body ensures that each facility program operates on an understanding and acknowledgment that a number of people placed in quarantine facilities will experience a range of stressors as a result of being detained in a quarantine facility for 14 days.

- The Quarantine Governing Body ensures that all reasonable steps are taken to assist those who will be particularly vulnerable and require additional skilled support by reason of their being held in quarantine.

- The Quarantine Governing Body ensures that every effort is made to provide multiple forms of communication of information throughout the period of quarantine to assist in reducing the distress and anxiety that some people will experience in quarantine.

- The Quarantine Governing Body should address the need to provide accurate, up-to-date and accessible information to all people seeking to enter Victoria through international points of entry, including in community languages, to ensure best efforts at communication are made for all international arrivals.
- Site Managers ensure that clear, accessible and supportive styles of communication should be regularly used to enable people to have consistent and accurate information about what supports are available to them and who to contact if they have a complaint, a concern or an enquiry while quarantined in a facility.
- To assist in creating support for people in quarantine facilities and ensuring that there is information available in a range of formats and languages, Site Managers should assign a role to an appropriate person who can coordinate communications and use various platforms (for example visuals, signs, social media, etc.) to encourage those in quarantine facilities to connect with one another. These platforms can also be used to regularly communicate general and relevant information.

52. Being mindful of section 7 of the Act and having reviewed the Board of Inquiry Final Report[21] and the SCV report[22] (including the recommendations), I am satisfied that no further investigation of the circumstances surrounding the death of Mr Plant is required.

53. The recommendations of both the Board of Inquiry and SCV, are in my opinion appropriate and if implemented adequately address the health and wellbeing of returning travellers held in hotel quarantine.

54. The focus of my investigation then turned to the implementation of the recommendations by the governing body managing hotel quarantine.

55. In order to understand the steps taken to implement the recommendations the court contacted, the COVID-19 Response Division of the DOH and CQV requiring that they both provide statements responding to two questions:

    - Whether the current arrangements for returned travellers are consistent with the recommendations made in the SCV report; and

[21] COVID-19 Hotel Quarantine Inquiry Vol 2, Chapter 12, commencing at p 10.
[22] This report is summarised in the COVID-19 Hotel Quarantine Inquiry, Vol 2, Chapter 12 at p 25.

- Whether the current arrangements for returned travellers are consistent with the recommendations (numbered 40 – 51) of the Board of Inquiry Report.

56. In response to these questions, detailed statements were provided by both the DoH and CQV.

COVID-19 Quarantine Victoria

57. CQV was established as on 1 December 2020 as an administrative office attached to the DJCS with overall responsibility for the hotel quarantine program.

58. Prior to the establishment of the VQH, CQV had the day-to-day responsibility of hotel quarantine and the wellbeing of returned travelers. A statement provided by CQV set out the most relevant steps taken to acquit the recommendations of the SCV report and the relevant sections of the Board of Inquiry report.

59. Ms Emma Cassar, Administrative Office Head of CQV stated, 'It is my view that the CQV Program is not only consistent with the relevant recommendation but operates at a higher standard than that anticipated by the relevant recommendations made in the SCV report and the Coates Inquiry'.[23]

60. Ms Cassar's statement also sets out in some detail the steps taken and programs implemented to address each of the recommendations made by the SCV report and the Board of Inquiry. The statement grouped the various actions into themes of Health and Wellbeing Checks, Resident Wellbeing, Information Sharing, Collection of Information, and Staffing. The response is extensive and thorough. I am satisfied that the steps taken, and programs implemented addressed each of the recommendations.

61. The focus of my investigation then turned to the implementation of the recommendations at and the VQH.

62. The Court contacted CQV and requested that a supplementary statement be provided responding to three questions:

    - Provide a brief summary outlining the background to and purpose of the VQH;

    - Explain what role CQV has, in providing oversight and management at the VQH; and

[23] Statement of Emma Cassar dated 13 September 2021.

- With reference to the information contained in first statement provided by CQV, please confirm whether the current arrangements for returned travellers detained at the VQH are consistent with:

  i) The recommendations made in the Safer Care Victoria Incident One Report dated 10 June 2020?

  ii) The recommendations numbered 40 – 51 in the COVID-19 Hotel Quarantine Inquiry Final Report and Recommendations Volume 1, dated 1 December 2020?

63. In response to these questions, a detailed supplementary statement was provided by CQV authored by Ms Emma Cassar.

Victoria Quarantine Hub

64. The supplementary statement provided by Ms Cassar is most relevant to the steps taken to implement the recommendations in the SCV report and the relevant sections of the Board of Inquiry report, as well as ensuring that the service providers contracted by CQV are adhering to the specified standards in undertaking their work at the VQH.

65. At VQH, CQV is responsible for the operations, service model and procurement of external services. The day-to-day services that were previously delivered by hotels including, catering, linen and laundry, cleaning and waste management have now been outsourced to external service providers by CQV. CQV has also partnered with Health Service Providers to deliver primary, general and mental health services at VQH.

66. The supplementary statement sets out how the current arrangements at the VQH are consistent with or surpass the recommendations made by the SCV report and Board of Inquiry. As with the previous statement provided by CQV, the supplementary statement separates the actions taken into themes of Health and Wellbeing Checks, Resident Wellbeing, Information Sharing, Collection of Information, and Staffing.[24]

67. Ms Emma Cassar, stated *'the VQH is a safer and more functional quarantine facility than CQV's prior Hotel Quarantine Program'*.[25] In this regard, the operation of the VQH within

[24] Supplementary statement of Emma Cassar dated 4 April 2022, pg 5.
[25] Supplementary statement of Ms Emma Cassar, dated 4 April 2022, pg 7.

the broader CQV Program demonstrates that the current arrangements for returned travelers are consistent with the recommendations made by the SCV report and Board of Inquiry.

68. I am satisfied that the current arrangements in place at the VQH address each of the recommendations made by the SCV report and Board of Inquiry. I am also satisfied that the health and wellbeing of returning travelers is appropriately assessed in a timely way and that the programs and arrangements provide appropriate ongoing review and support to returning travelers at the VQH.

69. In addition, the procedures are now put in place and programs implemented through the use of external services providers, appear to adequately address all of the relevant health, wellbeing and mental health matters. Returned travelers are now provided with an initial mental health assessment within 24 hours of arrival at VQH and ongoing access to appropriate services including support officers and telehealth services which appear to be comprehensive.

WorkSafe Victoria

70. Lastly, following Mr Plant's death, WorkSafe Victoria commenced an investigation. To date, no person or persons have been charged with offences in connected to Mr Plant's death.

71. In making this finding, I have been careful not to compromise any potential future prosecution in the course of my investigation.

72. I note that if new facts and circumstances become available in the future, section 77 of the Act allows any person to apply to the Court for an order that some or all of these findings be set aside. Any such application would be assessed on its merits at the time.

FINDINGS AND CONCLUSION

73. Having investigated the death of Cameron Richard Plant and having held an inquest in relation to his death on 17 May 2022 at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Cameron Richard Plant, born 9 May 1967;

    b) the death occurred on 11 April 2020 at Pan Pacific Hotel Melbourne, Room 523 / 2 Convention Centre Place, South Wharf, Victoria, 3006, from HANGING; and

    c) the death occurred in the circumstances described above.

74. Having considered all of the circumstances, I am satisfied that Mr Plant intentionally took his own life.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

75. The Honourable Jennifer Coate AO, the Chairperson of the Board of Inquiry in her final report stated, "The lack of a plan for mandatory mass quarantine meant that Victoria's Hotel Quarantine Program was conceived and implemented 'from scratch', to be operational within 36 hours, from concept to operation. This placed extraordinary strain on the resources of the State, and, more specifically, on those departments and people required to give effect to the decision made in the National Cabinet and agreed to by the Premier on behalf of Victoria. This lack of planning was a most unsatisfactory situation from which to develop such a complex and high-risk program".[26]

76. The systems and processes in place to support health and wellbeing of returning travellers at the time of Mr Plants entry to hotel quarantine were clearly inadequate. This is at least in part attributable to the hasty and inadequately planned implementation of the Hotel Quarantine arrangements in place in April 2020. The SCV report and the Board of Inquiry final report both highlighted the shortcoming in the planning and preparation for managing the health and wellbeing of returning travellers held in quarantine.

77. Much has been done to improve the arrangements to adequately assess and support returning travellers while in hotel quarantine. I am satisfied that the CQV have now put in place appropriate and adequate arrangements to support returning travellers through the duration of their quarantine period. I am not in a position to say whether had these arrangements been in place at the time of Mr Plant's entry into hotel quarantine that his death would have been prevented.

78. Nevertheless, I am satisfied that the CQV and the new arrangements that have been implemented, as described by Ms Cassar in her two statements, would have provided the best opportunity to either support Mr Plant in maintaining his mental health, or alternatively identifying that Mr Plant's mental health was deteriorating and providing him with timely assistance.

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[26] Covid 19 Hotel Quarantine Inquiry Final report, Vol 1, p6

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

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Tania Kawood, Senior Next of Kin

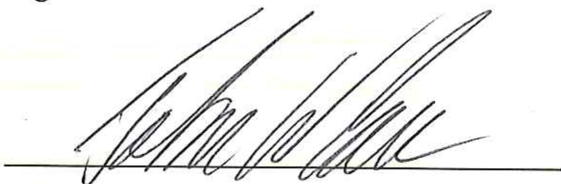
Senior Constable Brad Skerke, Coroner's Investigator

Secretary Department of Health

Secretary Department of Justice and Community Safety

Ms Emma Cassar, COVID-19 Quarantine Victoria

Signature:



JUDGE JOHN CAIN
STATE CORONER

Date: 17 May 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.